Cultural perspectives of mental health beliefs and treatment expectations within the Chinese immigrant community

Yiyi Yin

Submitted in fulfilment of the requirements for the degree of:
Professional Doctorate of Counselling Psychology
City University London
Department of Psychology

November 2016

City, University of London
Northampton Square
London
EC1V 0HB
United Kingdom

T +44 (0)20 7040 5060

THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR DATA PROTECTION/CONFIDENTIALITY REASONS:

pp. 257-279: **Part two. Client study.** Cultural sensitivity in an ethnically matching therapeutic relationship: A supportive expressive psychodynamic therapy client study.

THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR COPYRIGHT REASONS:

pp. 283-298: **Empirical article.** International journal of culture and mental health.

Table of Contents

Preface **8**

PART ONE: Doctoral Research **13**

Abstract **15**

Chapter One Introduction **16**

1.1 Purpose of the study 18

1.2 Research significance and research question 20

1.3 Researcher's own position and interest 22

1.4 Outline of Chapters 22

Chapter Two Literature review **26**

2.1 Overview 26

2.2 Definition of terms 28

2.3 Social-economic overview of China 29

2.3.1 Changing of Chinese culture context – the generation subculture 32

2.4 Overview of Chinese Immigrants in the UK 33

2.5 Mental health of immigrants in the UK – An overview 34

2.6 Mental Health and Service use of Chinese Immigrants in the UK 37

2.7 Conceptual framework 45

2.7.1 Cultural dimensions theory - individualism and collectivism *46*

2.7.2 Dynamism of Chinese philosophies *51*

2.7.2.1 The Meaning of "being Chinese" – a historical overview *52*

2.7.2.2 Confucianism *53*

2.7.2.3 Taoism *57*

2.7.2.4 Buddhism *58*

2.7.2.5 Traditional view on health - Mind and Body holistic view *60*

2.7.3 Mental health stigma - symbolic interactionism approach 62

2.7.4 Cultural competence - user perspectives and expectations 66

2.8 Identifying a research gap 70

Chapter Three Thesis research approach and method 74

3.1 Rationales for the Study 74

3.1.1 Rationale for Qualitative Research *74*

3.1.2 Rationale for the use of Constructivist Grounded Theory *75*

3.1.2.1 Ontology and epistemology concerns *75*

3.1.2.2 Theoretical perspective *77*

3.1.2.3 Grounded theory overview *78*

3.1.2.4 Constructivist grounded theory overview *80*

3.2 Research design and methods 82

3.2.1 Recruitment process *82*

3.2.2 Data collection process *85*

3.2.3 Data translation process *89*

3.2.4 Data analysis process *90*

3.3 Ethics of the study 97

3.4 Rigour 98

3.5 Reflexivity 100

Chapter Four Analysis and Results 105

4.1 Introduction 105

4.2 Four main categories 106

4.3 Category one: Experiences in the context of cultural perspectives 106

4.3.1 Overview of Category One 118

4.4 Category two: Changing mental health beliefs 122

4.4.1 Overview of Category Two 129

4.5 Category three: Evaluation of the current mental health service 131

4.5.1 Overview of Category Three 139

4.6 Category four: Review of treatment expectations 144

4.6.1 Overview of Category Four 152

4.7 Constructing the theoretical model 156

4.7.1 Theoretical Integration 157

4.7.2 Presenting the theoretical model 159

Chapter Five Synthesis, critique, reflection and implications 161

5.1 Synthesis of key findings in the theoretical model 161

5.1.1 Experiences in the context of cultural perspectives 163

5.1.2 Changing of mental health beliefs 165

5.1.3 Evaluation of the current service 167

5.1.4 Review of the treatment expectations 169

5.2 Critique 171

5.3 Reflections 176

5.4 Implications of the study 181

5.4.1 Community and family focused mental health promotion and prevention 181

5.4.2 Linguistically and culturally accessible mental health services 182

5.4.3 Multiple services collaboration 183

5.5 Suggestions for future research 184

References 187

Appendices 254

PART TWO: Client Study 260

PART THREE: Journal Article 284

List of tables and figures

Table 1	**Breakdown of the Demographic Information**	85
Figure 3.1	**Coding process**	94
Figure 3.2	**Analytic process in conducting constructivist grounded theory**	96
Figure 4.1	**Category One**	122
Figure 4.2	**Category Two**	130
Figure 4.3	**Category Three**	144
Figure 4.4	**Category Four**	156
Figure 4.5	**Layered interrelationship with categories**	158
Figure 4.6:	**Chinese immigrant's mental health beliefs and treatment expectations when accessing current mental health service constructed within the context of Chinese cultural perspectives model**	159

Acknowledgements

I have benefited from the support, encouragement and guidance of many people over the past three years leading up to the production of this thesis. In particular, my thanks go to my supervisor Dr Don Rawson for his invaluable advice and patience. I also want to thank Marina, Miriam and Giulia from Class 2016 at City University who have offered me so much help and kindness.

A special thank you for the participants who have given their time to share their personal and intimate accounts. I hope this is a step towards much needed change for our community.

Above all I am immensely grateful to my husband Nguk, who has believed in me and supported me throughout this whole journey, and my son Jett, who is a constant source of inspiration to me.

City University Declaration

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Preface

Detailed here are the three core components of this Doctoral Thesis Portfolio. The first part comprises empirical research investigating the cultural perspectives of mental health beliefs and treatment expectations within the Chinese immigrant community. This study uses a constructivist grounded theory approach from the perspective of mental health service users and considers the implications for mental health service professionals. The second part is a client study of cultural sensitivity in an ethnically matching therapeutic relationship and the third part is an empirical article on my research.

Part 1: The research

This section consists of an original piece of research aiming to explore the mental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community in the UK. Using a constructivist grounded theory methodology, intensive interviews were used to collect data from twelve participants. The participants were all first generation Chinese immigrants who had direct experience of using mental health services in the United Kingdom within the previous five years.

Constructivist grounded theory methodology is a qualitative methodology underpinned by a relativist ontological position, the epistemological stance of constructivism and the theoretical perspective of symbolic interactionism.

The research aim was to focus on the exploration of social contexts and cultural processes surrounding the participants, while at the same time understanding their values and beliefs about mental health issues. This study attempts to address gaps within the current literature and increase understanding in the current discourse. The findings have implications for delivering a culturally competent service within the mental health field for the Chinese community. The analysis is presented and discussed in the light of the extant empirical literature and the implications for practice and further research are also discussed.

Part 2: Professional practice

This section contains an example of therapeutic work in the form of a client study which illustrates the importance of cultural sensitivity in an ethnically matching therapeutic relationship. The client study illustrates my knowledge and practice of supportive expressive psychodynamic therapy in working to treat a client suffering from social anxiety. The case was formulated within the supportive expressive psychodynamic model and interventions discussed within the framework of that model. During this process I have demonstrated that cultural sensitivity is a key component in any therapeutic relationship and shared cultural similarities between a patient and therapist can both enrich and impede the treatment process. This client study also attempts to demonstrate how culturally related issues can influence the development of CCRT (Core Conflict Relationship Theme) in supportive expressive psychodynamic therapy.

Part 3: Journal article - International Journal of Culture and Mental Health

This section presents an empirical article which focuses on the data collection process (including method and results) of the research outlined in Part 1. The empirical article is written with the intention to submit to the International Journal of Culture and Mental Health. The peer-reviewed journal provides an innovative forum, both international and multidisciplinary, for addressing cross-cultural issues and mental health. The journal acknowledges that culture as it comes to bear on mental health is a rapidly expanding area of inquiry and research within psychiatry and psychology, and other related fields such as social work, with important implications for practice in the global context. The journal is viewed as an essential resource for health care professionals working in the field of cross-cultural mental health.

Chinese immigrants began to settle in the UK as early as the 19th century, and are also the fastest growing ethnic group today. However, the research interest and policy focus on the Chinese immigrant community does not reflect either their long-standing presence or these recent developments. There are also few studies that address the intersection of culture in the field of mental health within the Chinese immigrant population. This study explores mental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community in the UK. Using a constructivist grounded theory methodology, intensive interviews were used to collect data from twelve participants. The data analysis results

in the emergence of four categories: experiences in the context of cultural perspectives, changing mental health beliefs, evaluations of the service and a review of treatment expectations. From the data analysed, this study suggests a more comprehensive understanding of mental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community.

Thematic connection for the portfolio

This portfolio comprises three related pieces of work. They are linked by issues of cultural sensitivity and problems of Chinese clients understanding and expressing their emotional experience within the Western therapeutic model and services settings. The client study investigates the unexpected paradox of working with a client from a shared Chinese cultural background where I myself was the therapist. The research work focuses on understanding the cultural perspectives in the context of mental health within the subject population. Findings from the study are practically relevant and able to guide future action for how counselling psychology can be more effectively practised within the Chinese immigrant community in both primary and secondary care sectors. The empirical article presents the findings from my research with the intention to submit to the International Journal of Culture and Mental Health. The new BPS ethos suggests that mental health care is better located within a social, rather than medical, framework (Kinderman, Schwannauer, Pontin & Tai, 2011), which makes understanding an individual's cultural context extremely important for counselling psychologists.

There are both personal and professional drivers for my interest in studying mental health needs within the Chinese community. As part of the requirement of the DPsych program, each trainee counselling psychologist needs to undertake 40 hours of personal therapy throughout the training; so as a first generation Chinese immigrant, I have had first-hand experience in accessing mental health services in the UK. During this time, my quest to understand Chinese cultural perspectives in relation to my own mental health issues made me curious about the experiences of other Chinese immigrants. Additionally, I also undertook a placement for over two years at a clinic providing mental health services to Chinese immigrants, which allowed further involvement with the Chinese community. On realising that gaps exist both within my personal knowledge and in the current literature, I began to explore the subject of Chinese

cultural perspectives in relation to mental health in more detail. My own experience and journey convinced me that the mental health beliefs and treatment expectation of Chinese immigrants must be explored in the context of Chinese cultural perspectives and these perspectives need to be incorporated in the development of culturally competent services for the studied population.

Part one – Doctoral Research

Cultural perspectives of mental health beliefs and treatment expectations within the Chinese immigrant community

A Constructivist grounded theory study from the perspective of mental health service users and its implications for mental health service professionals

By
Yiyi Yin
Supervised by Dr Don Rawson

Submitted in partial fulfilment of the requirements for the degree of:
Professional Doctorate of Counselling Psychology
City University London
Department of Psychology

City University Declaration

This dissertation is an original work by Yiyi Yin. This dissertation received research ethics approval from the City University Research Ethics Committees. “Cultural perspectives of mental health beliefs and treatment expectations within the Chinese immigrant community - A study from the perspective of mental health service users and its implications for mental health service professional”. Approval reference: PSYCH(P/F) 14/15 128, 13th March, 2015.

Abstract

This research study explores the mental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community in the UK. Using a constructivist grounded theory methodology, intensive interviews were used to collect data from twelve participants. The participants were all first generation Chinese immigrants who had experience of using mental health services in the United Kingdom within the previous five years. The data analysis resulted in the emergence of four categories: experiences in the context of cultural perspectives, changing mental health beliefs, evaluations of the service and a review of treatment expectations. Category one accounts for the ways in which participants construct and perceive the meanings of their experiences, viewpoints, emotions and attitudes in relation to Chinese cultural perspectives surrounding the subject of mental health. Category two explores the way that initial mental health beliefs are changed by the experiences individuals have while accessing mental health services. Category three sheds light on how the mental health service is evaluated by the individual. Category four considers treatment expectations for the current mental health service. In examining all the above categories, a layered interrelationship emerges which contributes to the construction of the theoretical model. This study suggests a theoretical model that allows the understanding of mental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community.

The current literature indicates that Chinese immigrants and their mental health needs have received little attention to date. The theoretical model presented here offers a novel framework that accounts for a multiplicity of aspects that are pertinent to the construction of mental health beliefs and treatment expectations in the context of Chinese cultural perspectives for the studied population. The insight gained can be utilised by counselling psychologists as a guide to assist in working with Chinese clients and providing a culturally appropriate and competent service. Furthermore, learning can also be gained from elements of traditional Chinese philosophy to inform and inspire counselling psychologists in the UK.

CHAPTER ONE: INTRODUCTION

A journey of a thousand miles begins with a single step
– Lao Tsu

The history of Chinese immigrants settling in Britain can be traced back as early as the 19th century (Yee & Au, 1997). Initially mostly working in the shipping industry and then later expanding into cooking and laundry work, the earliest Chinese immigrants established a small community in both London and Liverpool (Yee & Au, 1997). Throughout the 20th and 21st century the number of Chinese immigrants has continued to rise, especially in recent years. A recent figure released by the Office for National Statistics indicates that China now provides the largest number of new immigrants to the UK (ONS, 2014). An ECRAN report has also stated that the United Kingdom has the largest Chinese population in Europe (Latham & Wu, 2013). This unprecedented growth in the Chinese population in the UK is a result of the combination of large numbers of Chinese students and economic immigrants arriving due to the current rapid economic expansion in China (Lam, Sales, D'Angelo, Lin, & Montagna, 2009). The total number of Chinese students enrolled in British institutions of higher education reached 87,895 in 2014 (UK Council for International Student Affairs, 2013-2014). This figure is an increase of over 300 percent compared to the number of Chinese students who came in 2001 (ONS, 2001), which makes China the country sending the largest number of international students to the UK (UK Council for International Students Report, 2013-2014). In addition to Chinese students, there has also been a substantial growth in skilled migrants, such as academic, technical and professional persons, moving from China to Europe, including the UK (Zhang, 2003). Major economic transformations in China for the past three decades have resulted in the country's strong and consistent economic growth, which has seen a huge expansion in both the private and public sectors in China (Zheng & Yang, 2009). With the UK relaxing its visa rules to attract Chinese investors (Bennett, 2014), the number of Chinese economic immigrants is likely to grow considerably in the UK. The expansion of students and skilled professionals from China has greatly impacted the UK's economic structure and immigration culture; this change has also altered the current migration dynamics.

Although there has been a reasonably long history of Chinese settlement in Britain, while also being the fastest growing ethnic group in the UK (ONS, 2011), the research interest and policy focus on the Chinese immigrant community does not reflect either their long-standing presence or these recent developments. A review of the current literature has revealed there are very few UK-based studies on the Chinese immigrant population. There are also few studies that address the intersection of culture in the field of mental health within Chinese immigrant populations. Furthermore, while there is an evolving literature around the topic, in-depth qualitative work aiming to understand the experiences of the mental health services users within the Chinese immigrant population for evaluating cultural competency is still very limited.

In the field of counselling psychology, the need to provide a mental health service that is culturally sensitive or responsive has been acknowledged for many years (Zane, Hall, Sue, Young, & Nunez, 2004). A large set of skills and knowledge is needed for mental health professionals to provide services that are culturally sensitive for the diverse populations in the UK. This includes paying particular attention to obvious language barriers and also acknowledging cultural perspectives in the context of mental health. These sets of skills and knowledge are referred to as cultural competence (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007). Cultural competency is a complex task which involves both specific and generic skills (Lo & Fung, 2003) that are essential to counselling psychologists in practice and in training. It is crucial for counselling psychologists and professionals working within the mental health services to be open about and interested in cultural perspectives so that they can anticipate and recognise how and when these issues affect the overall provision of the service. Although the importance of cultural competence is widely recognised for mental health professionals, studies within this area focusing on the Chinese immigrant community are scarce.

The lack of research literature on understanding the mental health needs of Chinese immigrants and the lack of awareness from mental health professionals on the intersection between Chinese culture and mental health issues are the two primary concerns for this study. An overview of these subjects leads to the purpose of the study. This chapter also highlights the research significance and research question. Furthermore, the researcher's own position and interest is reflected upon. Finally, an outline of each chapter is provided.

1.1 Purpose of the study

The purpose of the study is to understand the cultural perspectives of mental health beliefs and treatment expectations within the Chinese immigrant community. The study aims to focus on the exploration of social contexts and cultural processes surrounding the participants, while at the same time understanding their values and beliefs about mental health issues.

The concept of culture is also incredibly complex and diverse. As early as the 19th Century, Taylor (1920) defined culture as "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (p. 145). This early definition still rings true in many aspects today. Damen (1987) defined the term culture as "learned and shared human patterns or models for living, day-to-day living patterns. These patterns and models pervade all aspects of human social interaction. Culture is mankind's primary adaptive mechanism" (Damen, 1987, p. 367). Geert Hofstede (1984), a world famous social psychologist who specialises in cultural differences, has defined culture as "the collective programming of the mind which distinguishes one group of people from another" (p. 12). Based on this definition, Hofstede also developed a renowned culture dimension theory which describes the effects of a society's culture on the values of its members, and how these values relate to behaviour, using the structured dimensions of the culture model (1984). Particularly relevant to this study is Downs' (1971) definition, which saw culture as "a mental map which guides us in our relations to our surroundings and to other people" (p. 8) – a useful definition to consider as we begin to explore the relationship between mental health and culture.

From these definitions, it is safe to say that culture is core to what it means to be human. Our collection of values, beliefs, behaviours, customs and attitudes all contribute to the overarching notion of culture. As a detailed discussion of this notion is beyond the scope of this thesis, within the framework of the current study, the definition of culture in the context of health behaviour is applicable when described as the "unique shared values, beliefs, and practices that are directly associated with a health-related behaviour, indirectly associated with a behaviour, or influence acceptance and adoption of the health education message" (Pasick, D'Onofrio, & Otero-Sabogal, 1996, p. 142). When concerning mental health, "culture" can be understood as our "inherited ideas, beliefs,

values and knowledge which shapes our explanation and understanding mental health related illness; impacts our mental health seeking help behaviour and possibly changing our interaction with mental health professionals" (U.S. Department of Health and Human Services, 2001, p. 56).

Cultural perspectives play a significant role in mental health treatment. Previous studies have suggested that mental illness and culture are interlinked and mental health professionals should be sensitive to this phenomenon (Guarnaccia & Rodriguez, 1996). Culturally-bound coping strategies, a unique culturally formed family orientation, culturally specific stigma, ethnic matching (Kim, Ng, & Ahn, 2005), a shared worldview (Torrey, 1986), culturally specific communication styles (Sue & Zane, 1987), different client expectations (Fischer, Jome, & Atkinson, 1998) and differing degrees of acculturation (Atkinson, Kim, & Caldwell, 1998; Zane et al., 2004), can all impact the mental health beliefs, treatment seeking behaviours and treatment expectations of an individual immigrant client.

While it is imperative to understand different cultural perspectives relating to mental health care, we also need to understand that culture is dynamic. Culture continually changes and is influenced both by people's beliefs and the demands of their environment (Lopez & Guarnaccia, 2000). In the immigration setting which this study focuses on, people from China arrive in the UK with their cultural beliefs already in place. Their adaptation process begins, which leads to "acculturation", a socialisation process by which minority groups gradually learn and adopt selective elements of the host country's culture (Talley & Crews, 2012). Through this interaction process between the minority's and host country's cultures, an immigrant group often forms its own unique "immigrant culture", distinct from both Chinese culture and the dominant host country's culture (Talley & Crews, 2012). With these complex issues in mind, this study represents a rare examination of these cultural perspectives by analysing the Chinese immigrants' own voices, including their mental health beliefs, their evaluation of the current mental health services and their treatment expectations.

Chinese culture is often considered to be collectivistic (Hui, 1988), instilling in the group a strong sense of duty, interdependence and harmony (Oyserman, Coon, & Kemmelmeier, 2002). The group of Chinese participants in this study come from a

collectivistic culture, so their experiences in seeking help with mental health related issues in a more individualistic culture (the UK) provides an exciting opportunity for a close examination of their mental health beliefs and treatment expectations in the context of Chinese cultural perspectives. This study will build a co-operative path which will allow Chinese immigrant service users and mental health care professionals to communicate more efficiently by providing explanations of this cultural background to professionals while also providing feedback about mental health care information from the professionals to the Chinese community to reduce mental health related stigma.

Academically, the emergence of a theoretical model resulting in an overall conceptual integration (Glaser & Strauss, 1967, p. 110) from this study could help enhance the cultural understanding of Chinese immigrants within the current mental health services setting. The theoretical model developed from the study should strengthen counselling and policy recommendations for the provision of a more sensitive, meaningful, effective and culturally competent service in the field of counselling psychology.

1.2 Research significance and research question

It was acknowledged by the National Institute for Health and Care excellence (NICE) that respecting culture is one of the principles that underpins the nature and extent of the care provided by the NHS (NICE, 2005). In order for counselling psychologists to provide effective mental services to an increasingly diverse society, greater insight into issues of cultural sensitivity need to be incorporated (Zane et al., 2004). To administrate a service that is both culturally sensitive and competent is a complex task which involves various skills, both specific and generic (Lo & Fung, 2003). These skill sets are essential to counselling psychologists in practice and in training. As counselling psychologists and professionals working within the mental health services, it is crucial for us to be open to and interested in different cultural perspectives so that we can understand how and when these issues affect the overall provision of the service. Some of the skills and knowledge needed to provide culturally competent mental health care services include paying attention to language barriers, acknowledging and understanding how culture influences attitudes towards mental health related issues and the ability to act accordingly. Bhui referred to this set of skills and knowledge as other key factors relating to cultural competence (Bhui et al., 2007). Although the importance of cultural competence is widely recognised by mental health professionals, studies

within the Chinese immigrant community are scarce. I believe this study is important in understanding the cultural perspectives in the context of mental health within the subject population. Such a study will generate a "working theory" (Dwivedi, 2009) in the form of a theoretical model that is both relevant and able to guide future action for how counselling psychology is more effectively practised within the Chinese immigrant community in both the primary and secondary care sectors. The new BPS ethos suggests that mental health care is better located within a social, not medical framework (Kinderman, Schwannauer, Pontin, & Tai, 2011), which makes understanding an individual's cultural context extremely important for counselling psychologists.

This study is designed with NICE (2011) guidelines in mind, which outline how primary and secondary care clinicians should collaborate to develop local care pathways that promote access to services for people with common mental health disorders from a range of socially excluded groups, including minority ethnic groups. In addition, the National Service Framework for Mental Health (Department of Health, 1999) sets out standards for mental health promotion. Some of the key points mentioned are promoting social inclusion for people with mental health problems, opposing stigma and discrimination in the community and improving access to psychological therapies. This study will attempt to address gaps within the current literature and increase understanding in the current discourse. The potential findings have implications for delivering a culturally competent service within the mental health field, not only for the Chinese community, but also for other ethnic minority communities within the larger population.

The research question for the study is: how to understand mental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community? The interview questions are specifically designed to answer the research question, along with the analysis of interview findings and the development of theoretical model. I believe this study is crucial in understanding cultural perspectives in relation to mental health for the subject population. The theoretical model generated from this study is both relevant and able to guide future action for how counselling psychology is more effectively practised within the Chinese immigrant community in both the primary and secondary care sectors.

1.3 Researcher's own position and interest

As counselling psychologists, reflective practice is valued as an important responsibility and obligation to both the self and society (BPS, Professional Practice Guidelines, 2008). When conducting a qualitative study, the inter-connections between a researcher's intellectual assumptions around subject location(s) in relation to class, race, sexuality, gender (and so on) and the researcher's beliefs or emotions can all impact the nature and outcome of the study (Kirby & McKenna, 1989). Therefore, it was important for me to initiate a reflexive thinking process and be conscious of my own positions and interests in the early stages of the research process.

There are both personal and professional reasons which facilitated my interest in studying mental health needs within the Chinese community. As part of the requirement for the DPsych program, each trainee counselling psychologist needs to undertake 40 hours of personal therapy throughout the training; so as a first generation Chinese immigrant, I have had first-hand experience of accessing mental health services in the UK. During this time, my quest into understanding Chinese cultural perspectives in relation to my own mental health issues made me wonder about the experiences of other Chinese immigrants. Additionally, I also undertook a placement for over two years at a clinic providing mental health services to Chinese immigrants, which allowed further involvement with the Chinese community. On realising the gaps that existed both within my personal knowledge and in the current literature, I began to explore the subject of Chinese cultural perspectives in relation to mental health in more detail. The idea was further developed through discussions with my program director in year one and during the writing of the pre-research proposal in year two.

Considering my own position and interest in the study, I was aware that my experiences and assumptions could skew the outcome. Therefore, great measures were taken to ensure that reflexivity was incorporated at every stage of the research process. Details of reflexivity are further explained in chapters 3 and 5.

1.4 Outline of the Chapters

The research question (how to understand mental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community) was developed through a combination of personal and

professional interests. The study aims to develop an increased understanding of the area of enquiry through the novel contribution it provides (Charmaz, 2006; Clarke, 2005) on the subject of cultural perspectives on mental health within the Chinese community that could contribute to both the service users and mental health professionals at large, in particular for counselling psychologists, who regard respect for the diversity of beliefs as one of the BPS principles (BPS Professional Practice Guidelines, 2014).

The thesis is divided into five chapters to help answer the research question effectively and methodically. Chapter 1 briefly outlines the history and current development of Chinese immigration in the UK, the lack of research literature on understanding cultural perspectives in the field of mental health for Chinese immigrants and the lack of awareness from mental health professionals on the intersections between Chinese culture and mental health issues. The aim to address some of these issues is mentioned, as well as the current research aim. The research significance and research question are identified and the researcher's own positions and interests are reflected upon.

Chapter 2 consists of the preliminary literature review, which provides the basis for identifying a gap in the current field of study with regard to the research question. The reason for only conducting a preliminary literature review is because arguments have been made by grounded theory researchers that the literature review should only be conducted once the analysis is complete to avoid preselecting data for categories that have already been determined by other theories, which might hinder the emergence of new theories by forcing the data (Glaser & Strauss, 1967; Glaser, 1978; Strauss, 1987; Strauss & Corbin, 1990, 1998). However, other grounded theory researchers emphasise the importance of a literature review at the beginning stages of conducting research, as it helps researchers understand and recognise existing knowledge in the field of investigation and identify gaps in the field of study (Morse, 2007). To meet the requirements of directing the researcher to the current subject field by providing an indication of the extent of current theories and research, a limited and purposive preliminary literature is conducted in Chapter 2, as suggested by various studies (Urquhart, 2007; Birks & Mills, 2010). This review of the literature is used as a conceptual framework comprising four sensitising concepts, which are essential throughout the overall process of grounded theory studies (Charmaz, 2006). Charmaz (1995) further argues that literature is particularly instrumental when compared against

emerging categories during the data analysis stage. Consequently, comparative literature reviews and the use of literature as a conceptual framework are discussed in Chapters 3, 4 and 5. In the preliminary literature review conducted in Chapter 2, a background overview of China as a country is presented. This chapter also includes a definition of the terms used in this thesis. As this study is concerned with Chinese immigrants in the UK, an overview of this population is also given. This chapter also provides an exploration of the overall mental health status of the Chinese immigrant population, which includes the prevalence of mental illness and the level of service use. Furthermore, mental health is disused in relation to immigration status, which is relevant to our study of the first generation of Chinese immigrants. In addition to the contents mentioned above, theoretical sensitivity is discussed with sensitising concepts forming the conceptual framework for the study.

Chapter 3 introduces the rationale for the study, particularly the use of constructivist grounded theory as the research methodology. This chapter also details the research design and methods, which includes recruitment, data collection, data translation and data analysis, as well as some visual presentation to help illustrate the process. The ethics of the study and issues of rigour are also incorporated in this chapter. This chapter also includes reflective self-interviews that make evident the researcher's efforts in being reflective throughout the analysis stage. The constructivist grounded theory methodology has guided the process of data gathering, coding, analysis, memo writing and the development of the theoretical model in the study.

Chapter 4 consists of the analytic processes combined with a simultaneous comparative literature review. Four major categories emerged from the interview data: experiences in the context of cultural perspectives, changing mental health beliefs, evaluations of the service and a review of treatment expectations. Each category has been discussed in detail with supporting extracts from the translated transcripts from the interviews. Furthermore, data is compared to show links across the four categories and to attempt theoretical integration leading to the construction of the theoretical model (Charmaz, 2006; Bryant & Charmaz, 2007).

Finally, Chapter 5 synthesises the findings from Chapter 4 in relation to the literature used as a conceptual framework in shaping the emerging theoretical model. Chapter 5

also includes reflections on the overall research process and the limitations of the study. The chapter concludes with the implications of the research findings for counselling psychologists and offers suggestions for future research.

CHAPTER TWO: LITERATURE REVIEW

You cannot open a book without learning something.

- *Confucius*

2.1 Overview

This chapter starts by offering a definition of the terms used in the study followed by background information and a social-economic overview of China, as Bhugra (2004) suggested that people carry their knowledge and expressions of distress with them when they migrate from one culture to another. This study focuses on the experience of first generation Chinese immigrants; therefore, a social-economic overview of China is important to understand the context of this study.

As this study is concerned with Chinese immigrants in the UK, an overview of this population is provided. This review further provides an exploration of the overall mental health status of the Chinese immigrant population, which includes the prevalence of mental illness and the level of service use amongst this population. Furthermore, mental health is discussed in relation to immigration status.

In addition to this content, the preliminary review in this chapter was also conducted for the purposes of orienting the researcher to the chosen topic (Urquhart, 2007). The review allowed for a wide engagement and familiarisation with ideas in the literature, which is essential for theoretical sensitivity (Bryant & Charmaz, 2007; Dey, 2007) and allows the researcher to develop a theoretical model from the overall conceptual linkages (Charmaz, 2006)

Theoretical sensitivity begins with sensitising concepts, a term originated by Blumer (1954) that "suggest directions along which to look" (p. 7) during the research process. In qualitative studies, sensitising concepts provide guidelines for research in specific settings and help focus attention on the important features of the study (Bowen, 2006). Through specifying previous background research and literature on the chosen subject, a critical review is given incorporating a conceptual framework comprising sensitising concepts to "provide an anchor for the reader and to demonstrate how ... grounded theory refines, extends, challenges or supersedes extant concepts" (Charmaz, 2006, pp. 168-169). The current research begins by examining Chinese cultural perspectives in

relation to mental health, which bring particular concepts into the study (Charmaz, 2006). The sensitising concepts for the study are cultural dimensions theory (particularly individualism versus collectivism), the dynamism of Chinese philosophies, the symbolic interactionism approach to understanding mental health stigma and cultural competence from the user's perspectives and expectations. These concepts were generated after a systematic review of the current literature on Chinese culture and mental health studies on Chinese populations. These sensitising concepts form the conceptual framework which links various concepts and serves as a catalyst for the formulation of the theory (Seibold, 2002). Each sensitising concept is further defined and explored in the following section.

This chapter finishes by providing a critical review of the literature and identifying research gaps in the field of study. The use of sensitising concepts within the conceptual framework is employed throughout the method chapter (Chapter 3), the analysis and results chapter (Chapter 4) and the synthesis chapter (Chapter 5).

To find relevant research, the internet, libraries and the bibliographies of relevant literature were consulted. Databases such as Psycinfo, Googlescholar, mental health journals and PhD theses were used. Search terms for the review included (but were not limited to): Chinese and mental health, culture and mental health, immigration and mental health, Chinese culture, cultural competence, culturally appropriate mental health service, culturally related mental health beliefs, mental health care treatment expectations and culture and immigrants. Because of inconsistent use of the term "immigrant" (Claassen, Ascoli, Berhe, & Priebe, 2005), the search criteria was extended to include articles on "ethnic minorities" and "migrants". Both Chinese and English language literature has been included in the review.

The primary focus of this review centres around literature produced in the UK, including both mental health related research published locally on Chinese immigrants in the UK and non-UK published journals on the subject matter, which includes multi-country research that covers data from the UK. However, most of the studies on immigrant mental health have been conducted in the US, so further reviews of literature published in the United States, Canada, Australia and New Zealand have also been undertaken to draw a parallel understanding from a global context. A computerised database search, investigating the references and bibliographies of those studies, is also included in the review.

2.2 Definition of Terms

To set the context for the findings of the literature review, some definitions of important terms are provided below.

Mental health: A state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community (WHO, 2014).

Chinese immigrants: The question of what to call people of Chinese descent living outside of China has led to a debate in ethnic and Chinese studies (Benton & Gomez, 2008). For the purpose of this study, the term "Chinese immigrants" refers to those who were born in China (Mainland China, Taiwan and Hong Kong) but now reside in the UK.

Culture: For this study, culture is defined as the learned and shared human patterns or models for living, day-to-day living patterns and mankind's primary adaptive mechanism (Damen, 1987). In the context of healthcare, culture is perceived to be "*unique shared values, beliefs, and practices that are directly associated with a health-related behaviour, indirectly associated with a behaviour, or influence acceptance and adoption of the health education message*" (Pasick et al., 1996, p. 145). As previously stated, the concept of culture is broad and dynamic; therefore, a study built around the concept of culture cannot be static. The researcher's views on culture evolve constantly as "culture" is subject to multiple influences. The fluidity of culture is particularly pertinent in understanding immigrant health behaviour (Pandalangat, 2011).

Cultural Perspectives: Cultural perspectives are defined as the philosophical perspectives, meanings, attitudes, values, beliefs and ideas that underlie the cultural practices and products of a society which represent a culture's view of the world. (Heidari, Ketabi, & Zonoobi, 2014).

Mental Health Service: In the UK, mental health services are run by NHS organisations as well as voluntary sector organisations (including charities such as Mind) and private companies that are commissioned by the NHS. These organisations that run mental health services are called "service providers" (Department of Health, 2013). Most people with mental health problems are cared for by their GP and the primary care team (NICE, 2011). There are also community-based services, early intervention services and services for children and young people to provide mental health support if

needed. In 2010 the government launched the Improving Access to Psychological Therapies (IAPT) plan to make psychological therapies more available on the NHS. The IAPT program has allowed people to access psychological therapies through various avenues such as GP surgeries, universities, schools, colleges, at work places through the Employee Assistances Scheme and other voluntary and charitable organisations (NHS, 2014). To establish an overall understanding across all services, the study will include all mental health services in the UK.

Service user: Refers to Chinese immigrants who have used mental health services in the UK.

2.3 Social-economic overview of China

Bhugra (2004) suggested that immigrants carry their cultural knowledge and expressions of distress with them when they immigrate. This study focuses on the experiences of first generation Chinese immigrants; therefore, a social-economic overview of China is provided here.

China, officially known as the People's Republic of China (PRC), is the world's most populous country with a population of over 1.37 billion (Chinese National Census, 2014). Comprised of over 9.6 million square kilometres, China has enormous diversity both in its landscape and population. There are 55 nationally recognised ethnic minority groups in the PRC, with Han Chinese comprising the majority of the population at 91.51% (Chinese National Census, 2014).

In recent years, China's economic growth has taken the world by storm. In 2015, China became the world's largest economy in terms of purchasing power, a title that was previously held by the USA for over a hundred years (IMF, 2015). It was only after the 1978 economic reforms that China began to re-enter the world stage and become an economic powerhouse. In less than four decades the country went through major economic transformations at an extremely rapid pace. This extraordinary economic performance has impacted China's social structures, family relationships, traditional values and beliefs. As a result of the market-oriented economic reforms since the late 1970s, China has achieved an impressive annual gross domestic product (GDP), with growth averaging nearly 10% in 2014 (Morrison, 2015).

This growth was achieved mostly by rapid urbanisation (World Bank, 2011). Due to the varied geographic composition of China, the economy of the inland western part of the country has predominantly been focused on agriculture, whilst the eastern costal area has been more trade and business driven. The higher financial returns to labour in non-agricultural sectors have motivated many farmers to migrate out of agricultural areas to cities around China (Cook, 2000). It was suggested by a World Bank Report that over half a billion people have moved from rural agricultural areas to seek work in manufacturing and services in cities such as Shanghai, Guangzhou and many other special economic zones and export-oriented industries over the last 30 years (World Bank, 2011). Economists have predicted that by 2035 almost 70% of China's population will live in urban areas (Seto, Güneralp, & Hutyra, 2012). This urban transformation has been vital in the reduction of poverty, given that 679 million people in China were raised out of extreme poverty between 1981 to 2010 (World Bank, 2011). However, this vast migration and continual urbanisation has exerted great pressure on China's social structure and welfare system, including health care. These reforms and urbanisation have contributed to disparities in social structures, due to economic policy liberation and lack of provision in social equity (WHO, 2011). The increasingly wide gap in the inequalities of health outcomes between cities and rural areas, and between the rich and poor, (Chao-lin & Kesteloot, 1997; Pei, 2006; Wang, 2004) poses a major challenge for the Chinese government. An example given by the WHO (2005) highlights the difference between the maternal mortality rate of 9.6 in Shanghai (the financial capital of China) compared to Tibet (northeast of the Himalayas), which is 339. This alarming difference shows the vast scale of the task at hand to minimise regional disparities in China. Furthermore, fast paced urbanisation could create high levels of mental stress that adversely impact psychological wellbeing (Li et al., 2006).

Another major challenge relating to health care in China's current social-economic environment is that it is an aging nation: China's elderly population is growing rapidly. As a result of China's strict "one-child" policy imposed in 1979 and low mortality rates, China's elderly population is predicted to be well over 300 million by 2050 (UN Dept. of Economic and Social Affairs, 2010). Traditionally the Chinese elderly were cared for at home by family members, as according to the Confucian principle of filial piety, the younger generation of adult children is expected to care for their elderly parents (Gu, Dupre, & Liu 2007). This could create increasingly tiresome and stressful family relations between the generations. Lack of institutional care for the elderly also adds to

the problem. A study conducted by Gu and colleagues (2007) found that only 2% of the elderly population are cared for outside of their homes. In comparison, in the UK the percentage is 4.6% for people who are 65 and over and 18.6% for people who are 85 and over (ONS, 2014). However, the increase in urbanisation, industrialisation and migration have all threatened traditional family support networks (Jackson, 2010), which decrease the availability of family care. As the elderly population continues to grow, more elderly people will seek care in professional institutions (Gu, Dupre, & Liu 2007). Lack of support for both the elderly and their carers places enormous strains on the current health care and social service infrastructures, which creates potentially adverse effects for mental health issues.

A brief overview of the Chinese mental health care system also reveals serious problems. Underutilisation of mental care services in China is a major concern and seeking help from mental health professionals is more likely to be seen as a last resort by Chinese citizens (Zhang et al., 2013). In 2012 a study stated that while there are currently over 170 million people suffering from a diagnosable psychiatric disorder in China, only 15 million people have ever received treatment (Xiang, Yu, Sartorius, Ungvari, & Chiu, 2012). The study also pointed out that there are only 4,000 adequately trained and qualified psychiatrists in China serving over 1.37 billion people (Xiang et al., 2012). A severe lack of workforce and resources in mental health care will pose a major challenge to the government.

2.3.1 The changing Chinese cultural context – generational subcultures

As previously mentioned, the concept of culture is broad and dynamic. As Tung (1996) suggested, "Culture is an evolving set of shared beliefs, values, attitudes and logical processes which provide cognitive maps for people within a given societal group to perceive, think, reason, act, react and interact" (p. 491). Culture therefore evolves over time and is not static. Consequently, a study built around the concept of culture needs to also acknowledge the changing Chinese cultural context, in particular generational subcultures.

According to Mannheim (1952), each generation has its unique characteristics and subculture, which are largely due to the major socio-political events that the members of the generation encountered during their formative years. Further studies have suggested

that significant macro-level social, political, and economic events that occurred during a generation's impressionable pre-adult years result in a generational identity comprising a distinctive set of values, beliefs, expectations, and behaviours that remain relatively stable throughout a generation's lifetime (Inglehart, 1997; Strauss & Howe, 1991). This concept is particularly relevant to the study of Chinese culture, as in a little over six decades, the Chinese have been exposed to startling political and social changes. Major political movements like the Communist Revolution in 1949, the Cultural Revolution in 1966 and the market reforms in 1981 have all undoubtedly influenced the mental framework of a Chinese-born person born between the 1960s and 1990s. Since China opened to the world nearly four decades ago, market competition, economic restructuring, the uneven distribution of wealth and western cultures have become embedded in the everyday life of Chinese people, and undoubtedly caused changes to traditional Chinese cultural values systems. And the subculture of different generations has also reflected the country's particular historical period with changed values and priorities.

In relation to management style, Ralston and colleagues (1999) noticed there is a growing spirit of individualism and more Western ways of thinking are being adopted by young Chinese people when doing business. According to a study on generational differenced conducted by Shuai, Mi & Zou (2015) on people born in the 1970s, 1980s and 1990s, it was found that an increasing degree of individualism was correlated with generational difference. The group born in the 1990s showed more individualistic thinking and those born in the 1970s displayed more collective consideration. The concept of individualism and collectivism in relation to Chinese culture will be further explored in the conceptual framework section of the literature review (Chapter 2.7).

As suggested earlier, the change in cultural context is an ongoing evolutionary process that involves changes in the priorities of values at both individual and societal levels, all of which need to be explored when studying first generation immigrants (Levkoff, Macarthur, & Bucknall, 1995) including the differences in generational subculture.

2.4 Overview of Chinese Immigrants in the UK

Chinese immigrants have a long history of settling in Britain, initially establishing small communities in both London and Liverpool in the 19th century (Au & Ping, 1997).

Throughout the years, the Chinese community rapidly expanded across the UK. According to recent figures, there is a sharp increase in the number of Chinese nationals being granted UK visas (ONS, 2015). The Chinese community in the UK is thought to be the oldest and largest in Europe (Latham & Wu, 2013).

The previous socio-economic overview of China suggests that the recent economic expansion in China is contributing to the growth in the number of Chinese immigrants, especially in the number of students (ONS, 2015). The Chinese community in the UK is likely to grow even more considerably given the new relaxed visa rules aiming to attract Chinese investors (Bennett, 2014) which are impacting the current migration dynamics in the UK.

In addition to the new immigrants, there are also thousands of Chinese illegal immigrants currently living in the UK. “Illegal immigrants” are defined as workers who cross the borders into foreign countries without the required authorisation, or who initially enter legally but then abuse their residence permit or visa (Agiomirgianakis & Zervoyianni, 2001). As the numbers are not documented in any official statistics, it is hard to know how many Chinese immigrants currently live in the UK illegally. Research conducted over a decade ago by Xiamen University found that half of new immigrants from Fujian province came to the UK via irregular channels (Qu et al., 2011), which suggests the number of Chinese illegal immigrants in the UK is influential in shaping the overall Chinese immigrant demographic dynamic. Illegal immigrants often work in harsh conditions, living in cramped and over-crowded accommodation (Trades Union Congress, 2008; Wills et al., 2010). In June 2000, the bodies of 58 illegal immigrants were discovered by British customs officers inside a Dutch truck in Dover: all had suffocated due to the hot weather. Another incident in February 2004 saw 23 Chinese workers drowned in Morecambe Bay while picking cockles from the beach. These two horrific incidents indicate the seriousness of the Chinese illegal immigration problem at present. According to census statistics (ONS, 2001), the catering business remains the largest industry for Chinese people. To reduce trade competition, many Chinese restaurants and takeaway owners have moved their businesses outside of big cities, resulting in a more widespread population. According to Tran (2006), Chinese immigrants are the most dispersed minority ethnic group in the UK. Nonetheless, London still sees the highest concentration of the Chinese population, with nearly one third of Chinese immigrants residing in the capital (ONS, 2001).

When talking about Chinese immigrants, one must understand that "Chinese" is not a homogenous term. The diversity within the Chinese immigrant community reflects the diverse population of China itself. Enze Han (2013) mentions how westerners often perceive China as a uniform state. This simplified vision of China often overlooks the tremendous differences within the population, which also exist within the Chinese immigrant population. There are currently over six different dialects spoken among Chinese immigrants, with Mandarin Chinese and Cantonese being the two most prominent ones (Wei, 1994).

With the ever changing immigration landscape of recent years and heritage-related issues inherited from the past, the health needs of Chinese immigrants are likely to be complex and dynamic, particularly concerning issues relating to mental health, where very few studies have been conducted.

2.5 Mental health of immigrants in the UK – An overview

As this study aims to explore the mental health needs of Chinese immigrant, first an overview of mental health of immigrants in the UK is needed. The immigrant population in the UK is constantly changing, partly influenced by global socio-economic trends and partly by the UK's own revisions of political policies. In recent years there has been a surge in the immigrant population of the UK. Statistics show that immigration has increased by 95% from 329,000 in 1991 to 641,000 in 2014 (ONS, 2014). Total net migration in 2014 was estimated to be 2.53 million and there are approximately 5.3 million people with a non-British nationality currently living in the UK (ONS, 2015). Studies have suggested that migration has significant effects on health, as migrants have shown higher rates of physical (Gleize et al., 2000) and mental illness (Gavin, Kelly, Lane, & O'Callaghan, 2001). Racism, discrimination and social barriers are among some of the difficulties that immigrants might face, which could be potentially stressful for the individual (Williams, Neighbors, & Jackson, 2003).

The publication "Aliens and Alienists: Ethnic Minorities and Psychiatry" (Littlewood & Lipsedge, 1982) provided an important pathway for many current studies. This study selected a few migrant groups (such as West Indians, Turkish Cypriots and Hasidic Jews) and studied the psychological consequences related to their migration process.

The study also investigated the prejudice ethnic minorities faced during the migration process and the diversity within each group. In the publication, Littlewoods and Lipsedge (1982) examined the epidemiology of mental health illnesses among ethnic minorities, the immigrant population and black British people. They concluded that mental illness amongst these groups could be an understandable response to societal disadvantage and prejudice. This study was conducted over 20 years ago and so the data and conclusions are obviously outdated. However, this study generated much debate within the field of cultural psychology and has no doubt stimulated further research and clinical practice in cross-cultural studies within psychology and psychiatry.

In recent years the textbook "Clinical Topics in Cultural Psychiatry", published in 2011 (Bhattacharya, Cross, & Bhugra, 2011), provided a more comprehensive and modern overview of the impact of migration on mental health related symptoms. The textbook (Bhattacharya et al., 2011) summarised some of the mental health disorders experienced by immigrant populations and ethnic minorities from previous studies. The rates of deliberate self-harm and suicidal thoughts amongst Caribbean and Pakistani immigrants are significantly higher in the UK (Nazroo, 1997). Schizophrenia is also six times more common for African-Caribbean immigrants when compared to the native population (Harrison, 1990).

A study conducted by Bhugra and Jones (2011) found Egyptian and Asian immigrants have increased rates of bulimia and anorexia nervosa. Studies on asylum seekers have also pointed out that the wide variety of cultural backgrounds often present particular challenges to the mental health services (Ryan, Huebner, Diaz, & Sanchez, 2009; Silove, Steel, & Watters, 2000). A recent meta-analysis (Swinnen & Selten, 2007) found an increase in mood disorders linked to migration, although the mean relative risk was relatively low.

Various hypotheses have been proposed to understand the potential contributors to psychological distress among immigrant populations. A lack of language skills and social support networks are among some of the possible factors (Furnham & Bochner, 1986). There are often conflicts in belief and value systems when immigrants try settling in the UK, which could also cause emotional and mental stress. Views on mental health care often differ among immigration populations, which could potentially result in mismatches between the user and the mental health service. A study conducted by Davies and his colleagues (1996) discovered the pathway to mental health services

among immigrants in London has a high rate of involuntary admission and police involvement instead of through the consultation of GPs (Davies, Thornicroft, Leese, Higgingbotham, & Phelan, 1996). However, as this study was conducted almost 20 years ago and was limited to only two areas in south London, further studies with an expanded geographical area are needed before drawing specific conclusions. For example, Jacob and colleagues (Jacob, Bhugra, Lloyd, & Mann, 1998) commented that the percentage of Asian women reported to have a common mental disorder was similar to the number of White British women in a GP surgery survey. Bhattacharya et al. (2011) appeared to agree with Jacob's (1998) study and commented that there is no significant difference in the prevalence of common mental disorders between immigrants and the White population, including both genders and across ethic groups (Bhattacharya et al., 2011).

Previous studies have suggested that the migration process is viewed as a stressful event and could negatively impact psychological health in general (Furnham & Bochner, 1986). Nevertheless, due to the complexity in the studied population and contributing factors, further studies are needed to establish a more concrete link between migration and mental health disorders (Bhugra, 2003, 2004; Littlewood & Lipsedge, 1997). The precise picture of the mental health of immigrants still remains one of the most complex conundrums. The ways in which immigrants approach and prepare for migration differ; their experiences are also varied when it comes to their migration and settling processes. Finally, subsequent cultural and social adjustment for immigrants needs to be considered as part of their mental health framework. This is a wide scope of factor analysis which encompasses individual and social contexts and is needed when assessing and planning intervention strategies for immigrant communities at large. As the landscape of immigrant in the UK is rapidly changing, further studies regarding the mental health needs of immigrants are urgently needed.

2.6 Mental Health and Service use of Chinese Immigrants in the UK

Many of the studies mentioned earlier on mental health and migrants do not focus on Chinese immigrants specifically; however, they do provide background information on the stress that Chinese immigrants potentially face, which is related to their mental health status. Due to the lack of population-based research, there is little knowledge about the extent of the mental health problems facing the Chinese community,

particularly the first generation of Chinese immigrants. Chinese immigrants moving to the UK need to incorporate their existing beliefs, behaviours and values into the culture of the host country, a process described as "acculturation" (Berry, 1998, 2003, 2008; Noh & Kaspar, 2003). The acculturation process can be stressful and cause reductions in the mental health and wellbeing of ethnic minorities (Berry, 1998; Smart & Smart, 1995; Thomas, 2006). Their resettlement and migration experiences, often combined with social isolation, could all potentially be adverse to their mental health status and quality of life in general (Furnham & Li, 1993).

There has been a tremendous growth in the number of Chinese immigrants to English speaking countries (including the UK, United States, Canada, Australia and New Zealand), which has led to an increasing interest in the overall health status of this immigrant group (Kuo & Porter, 1998). However, the total number of studies focused on this particular group is still low. After conducting searches through PubMed (Medline), Google scholar and various bibliographies of previous studies, it was found that only a handful of studies have been conducted focusing specifically on the mental health needs of the Chinese immigrant community, despite the growing number of Chinese migrants in the UK.

The heterogeneous demographic and cultural profiles of Chinese immigrants in the UK have also added to the difficulties of studying this population. A mixed method study conducted by Huang and Spurgeon (2006) on the mental health of Chinese immigrants in Birmingham discovered that 60% of the surveyed group reported symptoms of poor mental health. The same research also revealed that the social support and psychological adjustment for most first-generation Chinese immigrants in Birmingham relies heavily on the Chinese immigrant community, and that contact with the non-Chinese community is minimal. Such closely associated relationship patterns were also observed by Shen and Takeuchi (2001) in their study of Chinese communities in the USA.

A large scale quantitative study was conducted by NICE (Bajekal et al., 2001) to study the health and lifestyle of the Chinese population in England. This study recruited over a thousand participants with a response rate of 70%. According to this study, 75% of the Chinese people reported their general health to be "very good" or "good". Only 4% reported their general health to be "bad" and less than 1% reported it as "very bad". This pattern was similar to the general population at the time of the study. A self-reported Chinese Health Questionnaire (CHQ) was used as a measure of mental health.

The CHQ was translated from the General Health Questionnaire, which was used by the Health and Safety Executive to identify possible psychiatric disorders in the general population. Questions on general levels of happiness, sleep disturbance, anxiety and depression were included in the self-report booklet for the participants to complete. The study revealed that 7% of Chinese people had shown an indication of a psychiatric disorder, which is lower when compared with the general population (Bajekal et al., 2001). Although the study lacked an in-depth qualitative perspective, it did provide important and compelling findings for future investigation.

The lower prevalence of mental health disorders in the Chinese immigrant population in the UK has also been supported by other studies (Weissman et al., 1996; Calderwood & Tait, 1999; Sproston & Primatesta, 2004). According to Nazroo (1997) Chinese immigrants suffer the lowest rates of hospitalised mental illness when compared to other ethnic minorities.

Studies about specific mental disorders within the Chinese population are rare. Some studies did include the Chinese immigrant population, but due to limited sample sizes, no definite correlations could be drawn. For example, it was found that psychosis among ethnic groups in London was higher when compared with general White populations; however, the Chinese sample size in the study was very small (King, Coker, Leavey, Hoare, & Johnson-Sabine, 1994). An earlier cross-national comparative study conducted by Torrey (1987) suggested a lower prevalence rate of schizophrenia in China; but this finding is slightly outdated and its application to Chinese immigrants in the UK is limited.

Some studies conducted in the USA are helpful in exploring mental disorder prevalence in Chinese immigrants. For example, Yeung and his colleagues discovered the prevalence of depression was 19.6% among Chinese-Americans (Yeung et al., 2002). Other studies of immigrants have suggested that depression tends to be more prevalent among elderly immigrants (including Chinese) due to their lack of social support resources, language difficulties, loss of physical abilities, experiences of discrimination, difficulty in acculturation into the host country and social isolation (Gelfand & Yee, 1991; Mui, 1998).

Wellbeing in mental health is related to a wide range of social and health factors. These factors could impact mental health at many different levels. At a personal level, it is

impacted by genetic predisposition, lifestyle, family structure, personal relationship status and mental health beliefs. At a wider social and community level, mental health is impacted by social isolation, access to local supportive resources and social economic status (McCulloch & Goldie, 2010). Despite a general low prevalence of mental health disorders on the surface, Chinese immigrants are often categorised as severely lacking in social support, which is a close associative factor for mental health wellbeing (NICE, 1999; Tran, 2009). Previous research conducted on migrants in general has suggested that there are disadvantages facing immigrants (official and illegal) relating to their mental health and their access to health care in their host country (Laurence, Macha & Dhananjayan, 2005). In the context of the migration process, the stress of migration combined with displacement issues and problems of adapting to the new host country can greatly impact the mental health of migrants (Murphy, 1977; Ho, Au, Bedford, & Cooper, 2002). Ho et al. (2002) also suggested that health care is not always a priority for Chinese immigrants when compared to accommodation, employment and education, which partially explains the underrepresentation of Chinese immigrants within the health care system.

Another major issue reflected in the current literature is the underutilisation of mental health services by the Chinese immigrant community. This issue has been explored by a number of studies which suggest that the Chinese community in general underutilise the mental health services when compared to other ethnic minorities (Pitson, Whitfield & Walker, 1999; Chen & Kazanjian, 2005). There is evidence that the Chinese population is underrepresented in NHS services across all disciplines, both within primary and secondary services (Smaje & Le Grand, 1997). Studies have also suggested that Chinese psychiatric patients are facing similar problems of underrepresentation (Wong & Cochrane, 1989; Li, 1991). This underrepresentation is also seen in the numbers of Chinese students using student mental health services in some leading higher education institutions (University of Nottingham, 2011). A report published by the NHS Executive Mental Health Task Force two decades ago noted that Chinese and Vietnamese communities were “invisible” to the mainstream mental health service providers (NHS Executive Mental Health Task Force, 1994).

There has been an increase in the number of studies that are relevant to Chinese immigrants and their experience of mental health services. For example, in 1999 a study was conducted using quantitative methods focussing on the barriers of access for

Chinese immigrants attempting to utilise mental health services. The barriers identified included language, the interviewees' perceptions of symptoms, lack of knowledge about the current services and lack of access to bilingual health professionals (Pui-Ling & Logan, 1999). One recent mixed method study has also been conducted to examine the mental health issues of Chinese immigrants in the Birmingham area (Huang & Spurgeon, 2006). This study suggested that among 113 Chinese respondents over 60% reported symptoms of poor mental health. The study also found that the psychological distress experienced by Chinese immigrants continues to be largely invisible. In addition, studies done in North America provide considerable evidence that Asian immigrants (including Chinese) underutilise mental health services (Sue & McKinney, 1975; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Chen, Sullivan, Lu, & Shibusawa, 2003; Lee, Martins, Keyes, & Lee, 2011).

These recent developments in the Chinese community present an urgent need for this study in order to understand this growing population. Clearly further attention is needed to establish a more comprehensive picture of the overall mental health status of Chinese immigrants in the UK. Their views and experiences regarding mental health care provide important information that needs to be incorporated into the current health care system.

Insufficient language skills are believed to have a significant impact on acculturative stress (Kim, 1984; Lueck & Wilson, 2010). Insufficient English language skills can lead to social isolation and difficultly in acculturation. Language is one of the main challenges in the daily lives of most first generation Chinese immigrants. A recent study (Pharoah & Lau, 2009) revealed that the level of English is still relatively poor amongst Chinese immigrants, with 68% of all migrants claiming to have little or no English language skills. This percentage is even higher (88%) for illegal migrants (Pharoah & Lau, 2009). The catering business remains the largest industry for Chinese people working in the UK (ONS, 2001). A qualitative study conducted by Yu (2000) found that many Chinese immigrants (especially the elderly), having worked long and unsociable hours for years in Chinese restaurants and take-away shops, found their English language skills were understandably limited due to a lack of opportunities for development. A lack of English language skills will make attempting to access mainstream services more difficult. A NHS report published in 1994 (NHS Executive Mental Health Task Force, 1994) pointed out that lack of English language skills is one

of the major difficulties facing Chinese immigrants trying to access mental health services. The findings from this report were reinforced by a quantitative study conducted by Pui-Ling and Logan (1999), which identified some of the barriers to meeting the mental health needs of the Chinese community. It found language is one of the main barriers for Chinese immigrants seeking mental health help; further research from both the UK and US on Chinese immigrants recognised language as the main barrier (Huang & Spurgeon, 2006; Chung & Lin, 1994; Takeuchi, Sue, & Yeh, 1995; Ying & Miller, 1992).

Cowan (2001) pointed out that Chinese immigrants have a relatively poor awareness of mental health concepts due to language issues. Ponterotto et al. (2009) suggested that the vocabulary used in the English language to describe one's internal experiences and emotions is extensive, whilst in the Chinese language such descriptions might not match or even exist, which can often lead to misunderstanding. Interpretation services for Chinese immigrants are available, but they are mostly concentrated in London (Tran, 2009). Given the dispersed nature of the Chinese immigrant population in the UK, the interpretation services currently available are unlikely to eliminate the language barrier nationwide. Yee and Shun (1997) also found that mental health appointments involving an interpreter would place extra constraints on a physician's time, and when combined with a lack of experience of working with Chinese patients, can lead to inaccurate diagnoses and inadequate treatment explanation. Furthermore, using interpreters to communicate complex mental health matters could be problematic because, as often in mental health care, the use of interpreters involves multiple agencies (Tran, 2009). Without proper co-ordination and supervision, the interpreting service could potentially be detrimental for the Chinese mental health service user. Chinese mental health service users in the past have reported finding interpreting services unreliable and sometimes unprofessional (CMHA, 2007; Tran, 2009), which resulted in them showing little or no faith that the health professional had understood their problems.

The negative relationship between socio-economic status and mental illness has long been explored in various studies (Skapinakis, Weich, Lewis, Singleton and Araya, 2006; Hudson, 2005; Graham, 2004; Goldie & McCullock, 2010). A recent WHO report has also provided more evidence for this negative relationship as the prevalence rates for neuropsychiatric disorders among low and middle income countries are much higher, and the devastating consequences for these disorders include homelessness, poor

education and high unemployment rates, which result in high rates of poverty (WHO, 2010).

Chinese immigrants started settling in the UK in the mid-nineteenth century, mostly around the busy ports of the time such as Liverpool, the Isle of Wight, London and Cardiff (Fisher, Lahiri & Thandi, 2007). After the first wave of Chinese seamen moved to the UK, their descendants and other new immigrants started to venture into the laundry business across the UK in the 1920s. Later they also expanded into the catering business, which is still the main industry that employs Chinese immigrants (ONS, 2001). Because most of these businesses depend on low labour costs to make a profit, it is often family members (including children) that work together at the family shop. In the past, the Chinese immigrants in the UK were characterised by their financial achievement and homogeneity in their professions, with most of them working in small family businesses (Fisher et al., 2007). Recent changes in Mainland China's economic landscape has made a difference in the Chinese immigrants' socioeconomic make up, as many Chinese students seeking higher education relocate to study in the UK and later settle here. At first glance, the social-economic status of Chinese immigrants appears to be positive. According to the "Socio-Economic Integration of Migrants" report (Dustmann & Frattini, 2011), Chinese immigrants scored highest both on educational achievement and wages in the years 2008 to 2009. Chinese immigrants are often characterised by relatively high academic achievements and high household incomes when compared to other ethnic groups (Chan, 1998; Dai, 2013). In a study on "Health and Social Research in Multi-ethnic Societies", the British-Chinese were found to be doing well on many socio-economic indicators, including low incarceration rates and high rates of health (Nazroo, 2006). However, a closer look at this population reveals a different picture. It was noted in the previous chapter that the Chinese immigrant population in the UK is highly dispersed and also ethnically diverse, making it challenging to conduct relevant studies. According to a study conducted in 2006, the majority of the first generation of Chinese immigrants still work in the catering trade (Clark & Drinkwater, 2006). Clark and Drinkwater (2006) also found that the lack of variation in employment and the adoption of a family operated business model by Chinese immigrants has strengthened the maintenance of a Chinese cultural identity; at the same time, the family focused model has potentially reduced the Chinese immigrants' social interaction with the non-Chinese community. In addition, to avoid competition, many Chinese immigrants choose to open their catering businesses in

remote areas. This approach increases success in business terms but also results in the dispersal of the Chinese population and increases social isolation (Clark & Drinkwater, 2006). This strong cultural identity and relative social isolation are likely to have a major impact on the Chinese immigrant's mental health status (Furnham & Bochner, 1986; Foyle, Beer & Watson,1998). There are currently very few UK based studies on the poverty level of Chinese immigrants in lower-skilled jobs and a lack of understanding of their mental health continues to be problematic. Huang and Spurgeon (2006) discovered a relatively higher prevalence of gambling problems among Chinese catering workers in Birmingham (Huang & Spurgeon, 2006). Overall, a national picture is lacking from the research perspective.

Additionally, illegal immigrants, refugees, asylum seekers and undocumented workers are often neglected in studies on Chinese populations (Song, 2015). One study conducted by Pieke and Biao in 2009 looked at working condition for illegal immigrants from the Fujian provinces working in London's Chinatown. It was discovered that these workers are more likely to be exploited because of their illegal status (Pieke & Biao, 2009). These difficulties are likely to pose a threat to the mental wellbeing of this population.

Another major problem facing Chinese immigrants in the UK is social isolation. An ONS report conducted in 2011 identified personal and social relationships to be the one of the most important aspects when measuring well-being (ONS, 2011). Leading scholars have argued that "social connections and relationships" should be a key dimension in measuring socio-economic status (Stiglitz, Sen, & Fitoussi, 2010, p. 15). Social isolation is a particular area of concern for Chinese immigrants, as most of the first generation of Chinese immigrants still work within the catering industry (Pang & Lau, 1998; Huang & Spurgeon, 2006). This relative uniformity in employment often results in unsociable working hours and limited social contact outside of their working environment. Furthermore, to avoid competition with rival businesses, Chinese immigrants often choose to open their businesses in remote areas, which increases the chance of social isolation (Tran, 2009). A study conducted by Yu (2000) on 100 Chinese participants found over half of participants in the study described their moods as a little sad or very sad most of time and over a third felt anxious and uncertain about their future. Social isolation is also a major contributor in mental health care issues. In a previous study, Chau and Yu (1999) also found that many Chinese women felt lonely

and helpless at times, which could greatly impact their mental health. Most of the first generation of Chinese immigrants are far from their relatives and friends and lack the emotional support needed to aid their psychological adjustment, which is a significant issue in evaluating the mental health status of the Chinese population (Chau & Yu, 2002).

Compared with other ethnic groups in the UK, Chinese immigrants are often viewed as a silent and self-sufficient community (Mau, 2013; Cole et al., 2009). Their dispersed nature also makes Chinese immigrants less visible in the wider community, which could lead to neglect in their health service provision (Department of Health, 2004). Overall, further studies are needed to understand the Chinese immigrants' mental health status within a wider societal framework to achieve a more positive outcome in providing mental health services to this population.

2.7 Conceptual frameworks

Many studies have highlighted that cultural perspectives are indispensable when considering the influence and implications of mental health issues (Littlewood & Lipsedge, 1997; Fabrega, 1995; Ivanov & Buck, 2002; Kirmayer & Looper, 2006; Bhattacharya et al., 2011). Sam and Moreira (2002) suggest that culture and mental illness are two concepts that are embedded in each other. According to Castillo (1997), cultural perspectives can shape mental health in four ways: the individuals' own personal experiences of the mental illness and associated symptoms, the expression of the individual's symptoms within the context of their cultural norms, the interpretation of the expressed symptoms and how they are subsequently diagnosed and how the mental illness is treated and ultimately the outcome. The US Surgeon General's report on mental health summarised that "the cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services" (U.S. Department of Health and Human Services, 1999, p. 23).

However, the term "culture" has sparked much debate, as explored in the previous chapter. Downs (1971) viewed culture as "a mental map which guides us in our relations to our surroundings and to other people" (p. 35), which is particularly

applicable to this study as it sets out to explore the relationship between mental health and culture. To expand further on Downs's interpretation, culture in the context of health behaviour can be seen as: "unique shared values, beliefs, and practices that are directly associated with a health-related behaviour, indirectly associated with a behaviour, or influence acceptance and adoption of the health education message" (Pasick et al., 1996, p. 142). From these definitions, it is safe to say that our collection of values, beliefs, behaviours, customs and attitudes all contribute to the overarching notion of culture. A discussion of this notion in the context of mental health is undoubtedly overwhelming, but after conducting a wide ranging literature review in order to identify key studies to answer the current research question (how can we understand mental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community?), a conceptual framework for the empirical fieldwork of the research was established. This comprised four sensitising concepts: cultural dimensions theory (particularly the individualism versus collectivism dimension), the dynamism of Chinese philosophies, the symbolic interactionism approach to understanding mental health stigma and cultural competence from the user's perspectives and expectations.

2.7.1 Cultural dimensions theory - individualism versus collectivism

As previously mentioned, culture is complex and all-encompassing. Many researchers in the past have attempted to classify cultures using the ideology espoused by Kluckhohn (et al., 1962): "In principle ... there is a *generalized framework* that underlies the more apparent and striking facts of cultural relativity" (p. 317). There has been lots of research conducted in this field (Hall, 1976; Douglas; 1973; Cattell, 1949; Lynn & Hampson, 1975; Lynn, 1971), but amongst these concepts, the cultural dimensions theory developed by Hofstede (1980, 1983, 1984, 1993, 2010) has received major recognition due to its impressive sample size and systematic scoring system (Minkov, 2007). Hofstede (2011) defined culture as "the collective programming of the mind that distinguishes the members of one group or category of people from others" (p. 3) which can be categorially analysed and later measured. Hofstede's cultural dimensions theory provides a systematic framework for assessing the differences between nations and cultures that is highly relevant to the current study, as a meaningful

comparison needs to be made in a study on Chinese cultural perspectives in the context of the UK mental health services.

Hofsted's (1980) original work on cultural dimensions theory is based on the concept that cultural value can be placed upon four dimensions: the power distance index (equality versus inequality), individualism versus collectivism, uncertainty avoidance and masculinity versus femininity. According to Hofstede (2011), "power distance" is concerned about human inequality, particularly within institutions such as the family and how individuals in these institutions accept and expect power to be distributed, both equally or unequally. Individualism and collectivism relate to the degree of integration from individuals into groups. The uncertainty avoidance index is concerned with a society's tolerance of ambiguity and uncertainty and masculinity is the culture's desire to differentiate gender roles (Milner, Fodness & Speece, 1993).

Further investigation into the cultural dimensions theory, particularly in the work of Michael Harris Bond (1987) with Chinese scholars (Chinese Culture Connection, 1987) led Hofstede to identify a fifth dimension: long-term vs. short-term orientation. Long-term orientation represents societies that are more focused on future rewards, particularly promoting perseverance, thrift and adapting to changing circumstances; while short-term orientation focuses on fostering shared societal qualities related to the past and the present such as national pride, respect for tradition, preservation of face and fulfilling social obligations (Hofstede, 1991; 2011). Bond (1987) found that long-term orientation is embedded with Confucian values, so this dimension was initially referred to as the Confucian work dynamism (Bond 1987). Bond's (1987) study was later replicated and extended by Hofstede and Minkov (2010) who found that East-Asian countries such as the Chinese are more long-term orientated; countries like USA, Australia and the UK are more short-term orientated (Hofstede & Minkov, 2010). Hofstede added a final dimension from his work with Minkov (Hofstede & Minkov, 2010). The sixth dimension was named as indulgence versus restraint, which examines the attitude towards gratification and fun.

Cultural dimensions theory does not include individual aspects, nor can it predict individual behaviour; therefore, other factors need to be taken into consideration when applying cultural dimensions theory to individual studies. However, the theory does provide a framework for understanding a given culture, which is pertinent to the current study. In particular, the individualism versus collectivism dimension has been widely

conceptualised when conducting studies on comparing European & American to East-Asian cultural frames (Hui, 1988; Chan, 1994; Kitayama, Markus, Matsumoto, & Norasakkunkit, 1997; Yamaguchi, 1994). The dimension of individualism versus collectivism is well explored by psychologists (e.g. Kim, Triandis, Kâğitçibaşi, Choi, & Yoon, 1994; Triandis, 1995, 2007; Kashima, Kashima, & Aldridge, 2001; Oyserman, Coon, & Kemmelmeier, 2002). Cultural psychologists such as Bond et al. (2010) and Triandis (1995) have suggested individuals living in different societies are likely to have differing experiences of psychological processes, which is closely related to their cultural perspectives. The individualism versus collectivism framework can help answer how culture matters (Bond et al., 2010), which is closely related to the current research question (how to understand cultural perspectives in the context of mental health). The individualism versus collectivism dimension therefore serves as a prominent path within cultural dimensions theory for this study.

According to Oyserman and Kemmelmeier (2002), the core of individualism is the assumption that individuals are independent of one another. Hofstede (1980) defined individualism as a focus on rights above duties, a concern for oneself and immediate family, an emphasis on personal autonomy and self-fulfilment, and a belief that the individual's identity is based on his/her personal accomplishments. Schwartz and Bilsky (1990) further define individualistic societies as fundamentally contractual, consisting of narrow primary groups and negotiated social relations, with core obligations and expectations focused on achieving status. Other definitions around individualism have all been centred on personal goals, personal uniqueness, and personal control (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985; Hsu, 1988; Kagitcibasi, 1994; Markus & Kitayama, 1991; Sampson, 1977; Triandis, 1995). In relation to the construction of the self-concept in psychology, individualism implies that creating and maintaining a positive sense of self is a fundamental human responsibility (Baumeister, 1998). Feeling good about the self, personal success and having a unique or distinctive personal attitude and opinions are valued (Oyserman & Markus, 1993; Triandis, 1995) and individual traits are central to self-definition (Fiske, Kitayama, Markus, & Nisbett, 1998). These views shed light on how the self-concept is constructed within the individualism framework.

The core assumption of collectivism is that groups bind and mutually obligate individuals (Oyserman & Kemmelmeier, 2002). In his work with Bond, Hofstede

(Hofstede & Bond, 1984) described collectivism as a situation where people feel they belong to larger societies that care for them, and in return those people remain loyal to the group. Darwish and Huber (2003) highlighted seven key characteristics of collectivism: emphasising loyalty to the group, emotional dependence on groups and organisations, less personal privacy, group decisions take precedence, interdependence within the group, an understanding of personal identity situated within the group and a greater emphasis on the needs and interests of others. In constructing a self-concept, collectivism stresses group membership as the central aspect of identity (Hofstede, 1980; Hsu, 1988; Markus & Kitayama, 1991) and personal sacrifice for common goals and maintaining harmonious relationships as valued personality traits (Markus & Kitayama, 1991; Oyserman, 1993; Triandis, 1995).

In relation to mental health well-being and the expression of emotions, collectivism emphasises satisfaction stemming from successfully fulfilling social roles and obligations (Kim, 1994; Markus & Kitayama, 1991) while restraining personal emotional expression in favour of group harmony (Kwan & Singelis, 1998). Boundaries between in-group members are well "defined and firm" in collectivist culture (Kim, 1994; p. 33).

Varner & Beamer (2005) also identified the process of saving "face" as an important feature in a collectivist culture. "Face" is defined as the "claimed sense of favourable social self-worth and the estimated other-worth in an interpersonal situation" (Ting-Toomey & Kurogi, 1998, p. 188). Ting-Toomey and Oetzel (2002) further explained that "face" is associated with "identity respect, disrespect, dignity, honour, shame, guilt, status, and competence issues" (p. 145). In Chinese culture, "face" actually comprises two interlinked concepts: "lian" and "mian zi". "Lian" is often used to describe the confidence of society in a person's moral character, whereas "mian zi" represents the social aspect of how one's dignity, prestige and status are perceived in the eyes of others (Bond & Hwang, 1986). An individual's "face" can be seen as a perceived position in the social network; it can also be drawn from personal wealth, physical appearance, professional career background, educational level and family background (Ho, 1976). The concept surrounding face is important for understanding Chinese cultural perspectives, particularly "mian zi". The social implication of face and its relation to mental health is further explored in the sensitising concept of the dynamism of Chinese philosophies.

Studies about mental illness have suggested that individualism and collectivism influence how individuals perceive and respond to mental illness (Heinrichs et al., 2006). A meta-analysis conducted by Oyserman and Kemmelmeier (2002) found evidence from previous research that supports the notion that individualism is associated with higher self-esteem, whereas collectivism is associated with an emphasis on meeting the expectations of others (Lay et al., 1998). Similarly, the concept of "relationship harmony" contributed more to the satisfaction of Hong Kong undergraduates when compared to the life satisfaction of U.S. undergraduates (Kwan, Bond, & Singelis, 1997). After conducting the meta-analysis, Oyserman and Kemmelmeier (2002) believed individualist and collectivist cultural frames are influential when individuals try to make sense of their self-concept from the social, collective and related aspects of the wider society, which is closely associated with their mental health.

When examining the concepts of individualism and collectivism in association with the UK and China, scores generated by the Hofstede Centre (www.geert-hofstede.com) showed that the UK has one of the highest of individualist scores (at 89 points), which suggests the UK has a more independent, self-focused way of living. By contrast (with a score of 20), China has a highly collectivist culture, which suggests people place higher importance on the interests of the group and not necessarily on themselves. It has been suggested that psychological treatment and mental health are embedded within a framework that is characterised by inherent Western values which are agentic and individualistic (Hays, 1995). Dwairy and van Sickle (1996) suggest mental health professionals tend to emphasise individualism and promotion of the self, as opposed to collectivism and promotion of the group. As previously mentioned, individualism and independence are placed as common values in Western societies such as the UK, but these values could contrast drastically with the common collectivist values that are maintained by Chinese groups. The emphasis on Western values in mental health services leads to a monolingual and standard use of English, which could be problematic when working with Chinese immigrants seeking help (Sue & Sue, 1977; Sue & Frank, 1973; Sue & Kirk, 1972).

Since its development, cultural dimensions theory has received criticism from many areas. Schwartz (1999) argued that Hofstede's model lacks relevancy in accurately determining and measuring cultural disparity. There have also been claims that

Hofstede's study is outdated and no longer suits the current climate (Bergiel, Bergiel, & Upson, 2012). However, Hofstede's (1980) cultural dimensions theory remains one of the most widely used pieces of research among scholars and practitioners in studying cross-cultural psychology, as well as in international management and cross-cultural communication (Søndergaard, 1994). Hofstede was considered a pioneer and pathfinder in developing a systematic way to understand culture with rigour and relative accuracy (Søndergaard, 1994). This study uses Hofstede's cultural dimensions theory (specifically the individualism and collectivism dimension) as a sensitising concept to help understand Chinese cultural perspectives in the context of mental health.

2.7.2 Dynamism of Chinese philosophies

As mentioned earlier, Bond's work (1987) on "Confucian Work Dynamism" (later referred to as long-term versus short-term orientation) provided a new dimension when examining Chinese culture and is highly influential when understanding Chinese value orientation. "Confucian Work Dynamism" was originally based on the Chinese value survey questionnaire that Bond developed with a group of Chinese scholars (Chinese Culture Connection, 1987). The survey identifies a core set of Asian values that was based on ancient Chinese and Confucian philosophical teachings (Hofstede, 1991). Empirical results (Hofstede & Bond, 1988; Hofstede 1997) further indicate that people from Hong Kong, Thailand, the People's Republic of China, Korea and Japan score highly on Confucian Dynamism values.

Confucianism, which Liu (2004) argues is the basis for social and interpersonal relationships in Chinese culture, is explicit about how individuals should conduct themselves in social and natural surroundings. Confucianism, Taoism and Buddhism are considered to be the three major branches of philosophy in China (Bond, 2010), which forms the dynamism of Chinese philosophies (Garfield & Edelglass, 2011). Confucianism, Taoism and Buddhism all maintain different levels of harmonies between people and nature, communities, people and society and mind and body. As previously mentioned, Chinese and other Eastern cultures are generally considered to be more traditional and collective compared to the more individual-centred nature of Western cultures like the UK (e.g. De Mente, 2000; Alon, 2003). According to Nisbett (2003), there are significant differences between Eastern and Western cultural ideals in

areas like social structures and the attitudes of both individual and group philosophies. Therefore, exploring the dynamism of Chinese philosophies could help us understand Chinese cultural perspectives in the context of mental health. An overview of each philosophical school and its relationship to mental health is outlined here; in addition, a traditional view on health is also explored. Firstly, a brief historical view on the meaning of "being Chinese" (Tu, 1994) is provided.

2.7.2.1 The meaning of "being Chinese" – a historical overview

According to Hall (1990), our understanding of our culture emerges from a common historical experience and cultural codes. When applied specifically, a culturally unified "one people" (Hall, 1990, p. 223) with a constant and lingering frame of reference and meaning arrives from China's historical and cultural backgrounds, which underlie the notion of "Chineseness". The term itself is attached to the discourse of Chinese culture and is commonly communicated in studies on related subjects (Tu, 1994). The name China, meaning "Middle Kingdom" (Zhong Guo), projects a China-centric worldview suggested by various studies on Chinese identities (Wu, 1991; Tu, 1994). An influential study on the meaning of being Chinese compiled by Tu (1994) suggests that it is widely accepted among Chinese people that the greatness of the Han (206 B.C.–220 A.D) and Tang dynasties (618 A.D –906 A.D) still provides a continuance of cultural standards even today. Belonging to an ancient and unified civilization has always been an important aspect of being Chinese and this idea is shared among Chinese in China and abroad (Wu, 1991). Wu's study on the construction of Chinese and Non-Chinese identities (1991) further suggests that the terms "Chinese people" (Zhongguo Ren) and "Chinese nation" (Zhonghua Minzu) represent a cohesive identity beyond nationality and citizenship which is instead based on cultural and historical connections (Wu, 1991). Wu (1991) further argued that overseas Chinese immigrants, although no longer residing in China, are still natural members of the Chinese nation (Zhonghua Minzu). Wu's study also included ethnic minorities in China, as he believed non-Han groups such as Mongolians and Tibetans have been assimilated into Chinese culture in many aspects "because of the irresistibly superior Han civilisation that had carried on unchanged for thousands of years" (Wu, 1991, p. 151). Such a sense of continuity and unity is at the base of understanding Chinese culture. This study supports the idea that there is a common cultural heritage amongst Chinese people in their understanding of

mental health that is worth exploring, regardless of where they might currently reside or where they might have originally come from.

Although China has 55 nationally recognised ethnic minority groups, over 90% of China identify as Han Chinese, so the cultural backdrop of China is likely to be relatively homogeneous (Lam et al., 2010). This study focuses on some of the core values and beliefs shared by all Chinese groups (include Chinese immigrants) that are significant when understanding and interpreting mental health. China is historically a largely agrarian culture, which requires a high level of co-operation and mutual support (Yang, 1986). The development of schools of thought in China such as Confucianism and Taoism are mostly focused on achieving societal harmony and downplaying individual demands.

2.7.2.2 Confucianism

Confucianism is explicit about how individuals should conduct themselves in social and natural surroundings. The core to this philosophical doctrine is that every individual is attached and defined by various social roles, and the duties required by these social roles must be fulfilled before an individual's own desires (Feng & Bodde, 1983; Munro, 1985; Mu, 1997; Hansen, 2000; Berger, 2008). The notion of "guanxi" (relationship) is core to traditional Confucian teaching. It has been defined with five major dyadic aspects (or "wu lun"): the emperor over the officials, the father over the son, the husband over the wife, the elder brother over the younger ones and between friends (Waley, 2005). These relationships are mostly hierarchical, except between friends, which highlight superiority, obedience and sense of order (Huang, 1997). Hierarchical interpersonal relationships such as family over the individual, respect for elders, a child's obedience to their parents and a student's respect for their teacher are of the upmost importance in Confucianism and can not be challenged. The harmonisation of society can only be achieved by following such guidance (Chang & Kemp, 2004; Chin, 2005). As previously mentioned, the concept of the self in collectivist societies such as China is constructed within the group (Hofstede, 1980; Kim, 1994; Markus & Kitayama, 1991). This viewpoint is emphasised in Confucian teaching, as an individual's personal identity is judged on how he/she behaves within the group. If individuals fail to meet their societal and cultural demands, conflict will arise (Hwang 1978).

Because of this emphasis on social roles and interpersonal relationships in Confucian doctrine, the unique notion of "guanxi" is highly pervasive and grounded in Chinese society. The notion does not only describe interpersonal relationships between two people, but is also a guide to the etiquette of conducting social exchanges and social obligations (Wang, Wang, Ruona, & Rojewski, 2005). A well connected person is often seen as having great "guanxi", which indicates a person's social status and is highly valued in a Confucian society (Hackley & Dong, 2001). "Guanxi" also has a reciprocal nature; favours given through "guanxi" are expected to be returned in the future. This entangled social web fuels interpersonal dependency (Becker, 2002) and needs to be factored in when understanding cultural perspectives in the context of mental health care.

Confucian morality and values guide people to act in accordance with social norms and to pay great consideration towards other members of the group in order to maintain harmony and avoid any kind of public embarrassment. This is closely related to the term "main zi", another social concept that is ingrained in Chinese culture. "Mian zi" literally means face (Lockett, 1988), but as a concept, "mian zi" is the recognition by others of an individual's social standing and position in society. In Chinese culture, it is not only vital to maintain good relationships (guanxi) but also important to protect a person's dignity or prestige (mian zi). Fundamentally speaking, "mian zi" in Chinese terms encompasses social reputation and has enormous social importance in Chinese culture (Hwang & Han, 2010). An individual's "mian zi" can be seen as a perceived position in the social network; it can also be drawn from personal wealth, physical appearance, professional career background, educational level and family background (Ho, 1976). "Mian zi" is a dynamic concept that changes with one's circumstances and operates on a reciprocal basis that can be earned, given, taken away, lost and saved due to one's behaviour (Hwang & Han, 2010). As the core of the Confucian doctrine sees the individual as a "person in relation" rather than free standing (Hwang & Han, 2010; Chin, 2005), an individual's misbehaviour can result an entire family losing "mian zi", which results in the loss of trust within a social network or a loss of social influence (Bond et al., 2015; Bond & Hwang, 1986).

Traditional Confucian values continue to exert a great deal of influence on modern Chinese culture, including the medical and health care sectors (Guo, 1995; Chen, 2001). Therefore, when the concept of "mian zi" is explored under mental health settings, it

explains how mental health beliefs and treatment-seeking behaviours are understood in the context of Chinese cultural perspectives. It was found in a pioneering study by Hector Tsang and his colleagues (Lam et al., 2010) that mental illness is often perceived as the result of some kind of moral downfall by the individual and their family. Such a "moral contamination" can cause loss of "mian zi" for both the individual and the family; some might even experience social exclusion from the local community (Yang et al., 2010). The focus on personal duties and social goals in Confucianism suggests that Chinese people often hold a sense of responsibility and obligation towards the family and the group (Bedford & Hwang, 2003), so a failure to fulfil one's duty and obligations can lead to feelings of guilt and shame. The feeling of guilt develops when individuals feel that they have violated the moral order and are responsible for a negative outcome (DeRivera, 1984; Lindsay-Hartz, 1984). Shame is caused by a negative sense of the self (Thrane, 1979; Hultberg, 1988, Babcock & Sabini, 1990). In the context of Confucian teaching, shame relates to the feeling of losing "mian zi" in the eyes of oneself or others because of a failure to fulfil expected roles (Bedford & Hwang, 2003). Guilt and shame often go hand in hand and are considered to be trans-diagnostic problems in mental health (Gilbert & Irons, 2009).

Confucianism emphasises an orderly society that individuals are appropriately situated within, allowing a harmonious society to be achieved through the collective effort of the whole community. In the relationship dyadic "wu lun", the role of husband is placed higher than his wife (Waley, 2005) which suggests men have more social status than women (Pek & Leong, 2003; Marshall, 2008; Singelis, Bond, Sharkey, & Lai, 1999). Confucianism believes women should behave submissively and the "three obedience and four virtues" (San Cong Si De) were imposed on women. The ideals of the "three obedience" instructs that a woman must obey her father, her husband and her sons (Yutang, 1958). The "four virtues" are ways for a woman to conduct herself in the right manner in terms of behaviour, speech, demeanour and diligent work (Brooks & Brooks, 1998). In Confucian teaching, a husband can divorce his wife for being infertile (or not bearing a son), out of jealousy, for not obeying his parents, for illness or even talking too much (Brooks & Brooks, 1998). Women, on the other hand, are not entitled to the same rights. Traditional views of gender roles and gender stereotypes are deeply rooted in Confucianism, with the man being seen as the master of the family whilst the women assume a caretaker role (Wong, 1972; Chan & Lee, 1995; Chan, 2000). Although in today's society about half of Chinese women are expected to participate in paid

employment (Cheung, 2009) and there are more educational and professional opportunities available for women, the Confucian ideas of gender roles and principles still prevail in Chinese families (Wong, 1972; Chan & Lee, 1995; Chan, 2000). Research in Mainland China, Taiwan and Hong Kong have also further suggested that the traditional view of gender roles and gender stereotypes are still strongly embedded in Chinese society (Tang, Pun, & Cheung, 2002). Although further research is needed in the rapidly changing Chinese society, it was suggested that many Chinese still believe that a woman's place is with her family and she is a "leftover woman" (or "sheng nv") if she is not married, despite a change in attitude towards women's working and education rights (Zhou, Dawson, Herr, & Stukas, 2004). A report published by the World Health Organization (WHO, 2004) suggests that gender influences how much control men and women have over key aspects of their lives and can affect mental health.

Another focal point for ancient Chinese traditions is the high emphasis on moderation, both towards behaviour and emotions. In other words, one should never behave or express emotion that is considered excessive by the surrounding groups (Nivison & Van Norden, 1996; Ivanhoe, 2000; Ji, Lee & Guo, 2010). In line with Confucius's teachings, strict self-regulation when expressing emotions is highly valued and encouraged in Chinese society. The doctrine of moderation (Zhong Yong) in Confucianism advocates a collective harmony in Chinese culture (Ho, 1995; Ho & Chiu, 1998; Yang & Sternberg, 1997; Yip, 2004) and strongly promotes a sense of self-regulation, which potentially prevents an individual from advocating for their own rights, equality and dignity (Read & Wallcraft, 1995). Studies by Potter (1998) found that Chinese culture places a greater emphasis on controlling emotions and expressing them in moderation. Recent studies conducted by Tsai (2007) support this concept, as it was found the desirable mental state for Chinese people in Hong Kong is consistent with low-arousal and moderate descriptions (such as peaceful, calm and relaxed).

An emphasis on education and self-cultivation in Confucian teaching is also relevant when understanding cultural perspectives in the context of mental health. It was suggested by Hsu and colleagues (Hsu & Wu, 2015) that Chinese people think that education is not limited to the classroom or learning skills for a profession: it is an important aspect for the individual to cultivate throughout their lifetime. The concept of self-cultivation (xiu yang) means "rectifying one's mind and nurturing one's character

with a particular art or philosophy" (Hwang & Chang, 2009, p. 1011). In Confucianism, self-cultivation is seen to reflect the moral quality in a person and has been highly praised for centuries (Yao, 2000). Confucianism highly encourages individuals to try and "help themselves" to solve a problem; in the context of mental health treatment, this self-cultivation approach could suggest Chinese clients are more likely to adopt the role of students while the professionals are seen as teachers during treatment (Hwang & Chang, 2009). As Duan and Wang (2000) explain: "clients may feel comfortable with getting what is expected from the expert" (p. 14).

Many researchers have argued that Confucianism is still deeply integrated in Chinese societies (Yeung & Tung, 1996; Hackley & Dong, 2001) and others have suggested that Confucian cultural traditions play a significant role in understanding the Chinese community in the UK (Gervais & Jovchelovitch, 1998; Jones, 1979; Payne, Chapman, Holloway, Symour, & Chau, 2005; Watson, 1977; Yu, 2006). Gervais and Jovchelovitch (1998) pointed out that Confucian ideas have been leading the Chinese way of life for 2000 years and therefore the influence of Confucian cultural ideas is likely to be still persistent even after two or three generations of acculturation into British society. This statement is particularly important when understanding the cultural perspectives of the first generation of Chinese immigrants. It has been suggested (Hsiao, Klimidis, Minas, & Tan, 2006) that the Confucian cultural heritage can be considered as an important element of psychopathology when working with Chinese patients, as interpersonal harmony is regarded as a key element of maintaining the Chinese patients' mental health. Guilt and shame can result from Chinese patients' failure to fulfil culturally expected roles, which can contribute to disturbance of interpersonal relationships and the diminishing of self-worth.

2.7.2.3 Taoism

In addition to the Confucian philosophical school of thought, studies have shown that some ideas from Taoism (such as the principles of Yin and Yang) also play an important role in shaping the ways in which Chinese people organise their life (Chen, 2001; Yip, 1999). Taoism was founded by Lao Tsu and Chuan Tsu in the late Zhou dynasty (1046–256 BC), and grew to be influential during the Han dynasty (206 BC–220 AD) (Fung, 1948; Wu, 1986; Cheng & Wong, 1995). Taoism is most well-known

for its "Yin-Yang" cyclical symbol, which represents two opposing yet complementary forces within the universe (Tao), where the two dots in the symbol signify things should be viewed in relation to their opposite (Tzu, 2012; Nisbett, 2003; Yubo & Ying, 2002; Yip, 1999). According to Lao Tsu, the "Tao" is the law of nature, which is infinite; within the "Tao" every element is dynamic and can be reversed (Tzu, 2012). In the view of Taoism, mental health represents a peace of mind; happiness is only attainable when relating to the universe. The individual must follow the "Tao" and respect the natural trajectory of each element to achieve mental peacefulness (Fung, 1983; Hansen, 2000; Wu, 1985). Achieving a sense of transcendence despite human angst in the infinite universe is highly valued in Taoist teaching and is believed to be the secret to ultimate happiness (Tzu, 2012). Contentment with life is encouraged and cupidity is seen as obstructive (Liu & Leung, 2010). Because of this emphasis on the balance of nature in Taoism, the causes of illness, including mental illnesses, are seen as excessive striving that leads to the loss of peace of mind. From a Taoist perspective, people who experience mental illness can be seen as crude or fragile and unable to follow the rules of Tao, which can be potentially shameful in the eyes of society (Liu & Leung, 2010). The Taoist philosophical system has been known to provide coping mechanisms in health behaviour, including mental status (Cheng, Lo, & Choi, 2010).

2.7.2.4 Buddhism

Similar to Taoism, Buddhism also advocates the restraint of desire. These beliefs originated from India and later expanded into China and peaked in popularity during the Tang (581-618) and Song (960-1279) Dynasties. Together with Confucianism and Taoism, these three belief systems coexisted in China both in ancient times and in the present day (Jones, 2005). One of the fundamental doctrines of Buddhism is that human suffering is unavoidable and our existence is impermanent (Teiser & Lopez, 1999). Buddhism's teachings centre around the core concepts known as the "Four Noble Truths" and the "Eightfold Path" (Littleton, 1996). The "Noble Truths" are that suffering is central to all lives, suffering is caused by ignorance and excessive desires, desire and ignorance can be contained through Buddhist disciplines and that following Buddhist teaching can end suffering (Littleton, 1996). The "Eightfold Path" deals with the specifics of how to end human suffering by understanding and learning the nature of reality and the truth about life, showing commitment to the Buddhist way of living,

speaking only in a helpful and compassionate way, living in a way that does not cause pain or hurt to other beings (human and animal), being mindful of the value of the moment, expanding our learning through meditation, living a life consistent with Buddhist values and following through with no excuse (Littleton, 1996). In the view of Buddhism, mental illnesses are related to self-indulgent desires or wrongdoing by the ancestors (Chepenik & Mallory, 2013). Such an understanding provides valuable clinical implications for the practice of counselling psychology.

Leung (2010) argued that although Confucianism, Taoism and Buddhism are different (even at times contradictory) schools of thought, they have been merged together over thousands of years to form culturally guiding principles and to promote standards of a good life for Chinese people. Confucianism places high importance on the social realm and an emphasis on governance and obedience with key values in education. Confucianism, as the dominant philosophical system (Yan, 2005; Zhang et al., 2002), provides Chinese society with ethical guidelines that maintain social order. Taoism, with its deep roots in nature, sees human beings as part of an infinite universe (Liu & Leung, 2010) and offers paradoxical and enigmatic views about one's health, well-being, procreation, and longevity. This is hugely influential on the ways Chinese people cope with stress (Young, Tseng, & Zhou, 2005). Buddhist teaching assumes the world we live in is transient, and in the Chinese context it has been mainly used to deal with mortality and the afterlife (Chang & Dong-Shick, 2005; Yip, 2003). That all three intertwining belief systems work harmoniously is the achievement of "Chinese pragmatism" (Quah, 2003, p. 1999).

These three traditional Chinese philosophical beliefs are instrumental in helping us understand how mental illness is perceived and interpreted within the studied population. Yip (2003, 2005) has suggested that wider Chinese culture displays a self-absorbed or self-demanding tendency, which means Chinese people are more inclined towards self-control and self-discipline. Sue (1997) similarly observed that during psychotherapy, clients with traditional Chinese cultural backgrounds are more likely to externalise their locus of control. The Chinese concepts of mental health, ingrained through the influence of traditional Confucianism, Taoism and Buddhism, suggests that Chinese people are more likely to be constrained by their social orientations and relationships (Yang, 1995).

Yip (2005) further explored this subject and suggested that Chinese cultural perspectives are related to mental health care issues in many different aspects.

According to Yip (2005), traditional Confucian concepts of mental health encourage individuals to restrain their emotions and avoid interpersonal conflict, as the individual's needs are supressed to create a harmonious society. Yip (2005) believes these introverted Chinese concepts of mental illness are still strong amongst Chinese people (Suen, 1983; Tong, 1986) and are different from Western mental health concepts. Yip's work intended to discuss traditional Chinese cultural beliefs about mental health by considering the influence of Chinese schools of thought like Confucianism and Taoism. While Yip's (2004, 2005) study could have benefitted from adding a Buddhist aspect and increasing the number of case studies, it did provide a valuable overview to the traditional Chinese cultural beliefs in relation to mental health.

Reviewing the three major philosophical schools of thought suggests that individuals are seen within their interpersonal social network and that individuals hold responsibility not only for themselves but (more importantly) to their family and extended networks in Chinese society. The core to these philosophical doctrines is that every individual is attached and defined by various social roles, and the duties required by these social roles must be fulfilled first before the individual's own desires (Feng & Bodde, 1983; Munro, 1985; Mu, 1997; Hansen, 2000; Berger, 2008).

2.7.2.5 Traditional views on health – the "Mind and Body" holistic view

It is important to consider traditional Chinese holistic views on health when understanding Chinese immigrants' views on mental health in the context of cultural perspectives. This holistic view of body and mind is embedded in the history of China and has a strong influence on how many people view health (including mental health) today (Bond, 2010). This holistic philosophical outlook goes back to 700 BC to the first textbook of Chinese medicine, the "Yellow Emperor's Internal Classic" (Huang Di Nei Jing) which laid down the concept of the body and mind as a whole (Yee & Au, 1997). This traditional approach to health and illness emphasises the balance within the Taoist (Ying and Yang) framework and sees the body, mind, spirit as networks of coalescing elements working together to maintain an individual's overall wellbeing (Yee & Au, 1997). This perceived balance can be within the individual (internal) or connected to his/her environment (external), hot or cold, emptiness or excess (Chin, 2005; Liu, Zhou, & Wen, 2008). All these elements are viewed within the dynamic of the Ying and Yang

framework as complementary (rather than oppositional) to achieve an intricate balance, as one cannot exist without the other (Ehling, 2001). By contrast, perceived imbalance can lead to mental and physical illness (Chang & Kemp, 2004). “Huang Di Nei Jing” also includes a chapter on mental health. According to the text, to achieve and maintain a healthy mental balance, individuals must desire less and pursue fewer goals, should be less distracted and preoccupied and learn to rest and relax, should be grateful and satisfied with the gains of their daily lives while supressing extreme emotions to free individuals from mental burdens (Savers, 2004). Instead of the analytical approach which is adopted by most Western cultures, the Chinese tend to view their daily demands through a holistic approach. This simply translates into the idea that nothing exists in isolation and there is an interconnectivity in everything we do, see and experience (Nisbett, 2003; Nisbett, Peng, Choi & Norenzayan, 2001). Many Chinese believe that good health in both mind and body can be achieved through exercise, a balanced diet and maintaining harmony with yourself and your social relationships (Chin, 2005).

Based on the traditional mind and body holistic view, the use of traditional Chinese medicine (TCM) is also unique to Chinese culture. According to Zhang’s study (2012) on the relationship between TCM and emotionally or mentally related disorders, the Chinese often believe that excess emotions can cause negative “qi” (energy) that damages internal organs and manifests itself in various emotional and behavioural symptoms (Liu & Leung, 2010). Some of the common treatments considered in TCM for mental imbalance are qi gong, acupuncture and herbal medicine (Edzard, Rand, & Stevinson, 1998; Tsang, Fung, Chan, Lee, & Chan 2006; Rathbone et al., 2007).

This holistic view of mind and body is well adopted amongst Chinese populations (Xu & Yang, 2009) and continues to shape how Chinese people view emotional distress and mental illness. In the holistic view, emotional problems are easily conceptualised and expressed through physical complaints, so in turn, the treatments will also focus on bodily dysfunctions (Zhang, 2012; Bond, 2010). Studies have suggested that it is common for Chinese people seeking help with mental health problems to describe their emotional and psychological problems by using physical symptoms (Davey & Zhao, 2012). Sue and Sue (1977) also observed that a clean distinction between "physical" and "mental" well-being is a difficult concept for Chinese immigrants to grasp when accessing mental health services in the US.

2.7.3 Mental health stigma – symbolic interactionism approach

A study conducted by Li and his colleagues found that language barriers, cultural stigma the somatisation of mental symptoms are common issues amongst Chinese immigrants when seeking help for mental health problems (Li, Yee, Ng, & Logan, 1999). Further studies suggest the stigma associated with mental illness is prevalent amongst the Chinese community (Fung, Tsang, Corrigan, Lam, & Cheng, 2007; Cowan, 2001). Other studies have found that the stigma surrounding mental illness is particularity pervasive and problematic in the Chinese community (Yang & Kleinman, 2008).

Stigma, originating from the ancient Greek word marking the moral downfall of a particular person (Fink, 1992; Falk, 2001), was later adapted by Goffman (1963) to describe, discredit and disgrace common social attitudes towards mental illness (Goffman, 1963). Stigma was further explained by Thornicroft and colleagues (Thornicroft, Rose, Kassam, & Sartorius, 2007) as an overarching term that comprises three elements: ignorance, prejudice and discrimination. In Thornicroft's view, ignorance is associated with knowledge, prejudice with attitudes and discrimination with behaviour (Thornicroft et al., 2007). A stigmatised view of an individual with mental illness is that he or she is "marked" to be flawed, with fewer values in society (Dovidio, Major, & Crocker, 2000). Mental illnesses are often "stigmatized and seen as a source of shame" in Chinese society (Abdullah & Brown, 2011) and these attitudes have long been documented in various studies (Pearson & Chan, 1993; Triandis, 1995; 2007; Chou, Mak, Chung, Chan, & Ho, 1996). Sevigny et al. (1999) further state "that all observers of Chinese society would agree that there are still many forms of prejudice or stigma towards mental illness" (p. 42). A study conducted by Yang (2007) also supports these comments, as Chinese groups consistently demonstrate the use of more negative stereotypes and social restrictions towards people with mental illness (Yang, 2007). Other studies have suggested that people with mental illness are seem as a "bad seed" or a "genetic taint" to their family in the traditional Chinese viewpoint (Sue & Morishima, 1982; Pearson & Chan, 1993). Some of the damage resulting from mental health related stigma includes the experience of rejection and discrimination from family, friends and employers, which can aggravate the feelings of loneliness and impede the treatment process (WHO, 2001).

There have been many studies conducted examining many different aspects of stigma since Goffman (1963) introduced the concept and various models have been generated to explain the phenomena. The social psychological model (Major & O'Brien, 2005) assumes that social norms, beliefs and attitudes are reflected and reinforced through social and interpersonal interactions (Goffman, 1963) and that when individuals apply their understanding of mental illness that has been acquired through those interactions by themselves or others, stigma develops. Accompanying this developed stigma, the individual might begin to anticipate the discrimination, rejection and shame associated with mental health illness, which can cause individuals to alter their own behaviour and avoid social interactions, which results in a diminished quality of life (Link, 1982; Angermeyer, Link, & Majcher-Angermayer, 1987; Lennon, Link, Marbach, & Dohrenwend, 1989; Rosenfield, 1997). The attribution model of stigma focuses on how the characteristics of mental illness itself can affect others' perceptions (Corrigan & Mathews, 2003). The model examines how an individual's perceived control over their mental illness leads to stigmatisation, as suffering from mental illness reflects poorly on the individual (Corrigan, 2000; Crocker, Major, & Steele, 1998; Goffman, 1963; Jones, 1984). In the attribution model, mental illnesses associated with danger and fear (such as schizophrenia) are more stigmatised compared to those not associated with fear, such as anxiety (Martin, Pescosolido, & Tuch 2000).

Given the complexity of this issue, the Framework Integrating Normative Influences on Stigma (FINIS) model was developed (Pescosolido, Martin, Lang, & Olafsdottir, 2008) to recognise how stigma functions at different levels. The model suggests that the stigma stemming from the micro, macro and meso levels is intricately linked and mutually reinforcing (Pescosolido et al., 2008). The model attempts to understand the relationships between these levels in the formation of the stigma. The FINIS model acknowledges the importance of the media in the development of mental health stigma, which can be observed in Chinese society. Negative portrayals of mental disorders in the popular media escalate the association between mental health problems with violence and danger. Song et al., 2005, p. 177) observed that the Chinese media often report on negative events related to mentally ill patients, sometimes labelling them as "the unpredictable bomb". Chung and Wong (2004) also found that such negative media portrayals can cause Chinese mental health patients to feel increasingly hurt, rejected and self-stigmatised.

In understanding how stigma functions in Chinese society, this study draws on the symbolic interactionist perspective of understanding mental health stigma, which suggests the "labelling" of the mental illness leads to changes in perception (Scheff, 1974; Goffman, 1963; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). The symbolic interaction model of stigma places the emphasis between the social interactions of individuals who are labelled 'mentally ill' and their social environment (Roe, Joseph, & Middleton, 2010). This framework invests in understanding the meanings generated in such interactions, which validates perspectives from the mental health service users (Clifford, Charman, Webb, Craig, & Cowan, 1991). Given the emphasis that Chinese society places on the ideal of a harmonious society occurring through stable interpersonal relationships and social relations, I believe that the symbolic interaction model of stigma is relevant to this study.

The symbolic interaction model of stigma proposes that mental health stigma is situated primarily within the social sphere (Scheff, 1974). The meaning of mental illness related behaviour is continually interpreted through the utilisation of language and symbols. Social responses to such behaviours are shaped by shared cultural meanings (Markowitz, 2005). Symbolic interactionism is based on the notion of a "looking glass self" (Cooley, 1902) which assumes the self and social identity are developed by social processes and through the experiencing of oneself (Becker & McCall, 2009; Corrigan, Markowitz, & Watson, 2004; Mead, 1913; Scheff, 2007). This view of the self is consistent with the collectivist view of the self. In regard to the potential stigma derived from mental health issues, an individual's self-identity is potentially experienced as deviant from what is socially normal, which can lead to feelings of social exclusion (Corrigan, 2005; Giddens & Sutton, 2013; Scheff, 2007). This study has explored the importance of "mian zi" within Chinese society, which can also be viewed as a form of symbolic capital (Yang & Kleinman, 2008) within the symbolic interaction model of stigma. Sue et al. (1994) and Uba (2003) both acknowledged that mental health problems within Chinese society are often perceived as shameful for the whole family and can cause the affected family to lose "mian zi" and even threaten marriage prospects for all family members (Kung, 2003).

The stigmatisation of mental health issues has probably worsened through the many social and political movements that Chinese society has endured in the past six decades, particularly the Cultural Revolution, which began in 1966, where psychiatric disorders

were specifically pointed out as dangerous and harmful (Munro, 2002). Before the end of the Cultural Revolution in 1978, psychiatric patients were treated in the same way as political outcasts and their punishments were often severe or even fatal (Munro, 2002). Early literature on the symbolic interaction model of stigma saw Szasz (1960) argue that the label 'mentally ill' is a socially constructed phenomenon arising within the institutionalised settings of mental health services. This argument is still very relevant when understanding mental health stigma in the Chinese community. As noted before, mental health systems in China (Liu et al., 2011) are primarily hospital-based care systems. The institutionalised settings of mental health services in China could facilitate our understanding about the stigma surrounding mental health within the Chinese community.

The somatisation of mental illness is closely associated with the issues surrounding mental health stigma. Chinese people are more inclined to express their psychological distress through bodily related symptoms (Tseng & McDermott, 1975; Kleinman, 1977; Nguyen, 1982; Gaw, 1993; Chun, Enomoto, & Sue, 1996). Aspects of somatisation can include psychological distress being linked or attributed to physical illness and individuals experiencing psychological distress but seeking medical help for the physical symptoms (Clarke et al., 2008; Fabrega, 1990). While the somatisation of mental illness can be related to the traditionally holistic Chinese views on health, somatisation can also be viewed as the "cultural idiom of distress" (Kleinman, 1986, p. 152). Kleinman (1986) observed the phenomena of neurasthenia in his study conducted in a Chinese psychiatric clinic and concluded that somatisation is a result of a negotiation between social and personal requirements. By expressing emotional distress through physical symptoms, individuals believe that they can seek treatment in a non-stigmatised and blameless way (Katz, 2014). Earlier empirical research conducted by Chang (1985) suggests that Chinese participants reported more physical problems when compared to white or black participants; further studies in the US have shown Chinese Americans with mood disorders exhibit more somatic symptoms compared to White Americans (Hsu & Folstein, 1997). A study conducted in Australia (Parker, Cheah, & Roy, 2001) found that Chinese depression patients scored higher in somatic items and lower in cognitive forms of depression when compared to other Australian patients. Many other studies have also noted that emotional distress is often presented with somatic symptoms such as neurasthenia in Chinese culture (Kleinman, 1986; Farooq, Gahir, Okyere, Sheikh, & Oyebode, 1995; Kirmayer, 2001; Mak & Zane, 2004). This

unclear description of emotional distress increases the difficulties of identifying psychological problems for mental health professionals when working with Chinese populations (Israel, Schulz, Parker, & Becker, 2001). Cheung (1982) argued somatisation emerges under the control of social rules that allow when and where different symptoms can be expressed. This suggests that it is not that Chinese populations suppress or repress their emotionally related symptoms, but that their social context influences what is or can be presented (Cheung, 1982), which is in line with the symbolic interaction perspectives of mental health stigma.

Most of the studies on mental health stigma are conducted using quantitative survey methods (Link, Cullen, Struening, Shrout, & Dohrenwend, 2004), and culturally specific data is scarce (Corrigan & Watson, 2002). The studies on somatisation within the Chinese community are also rare and outdated, which suggest further research is needed when examining mental health stigma and solmisation within the Chinese community. However, the above studies do provide a useful framework when understanding mental health stigma from the symbolic interaction perspectives and how somatisation effects Chinese immigrant populations. Culture arguably provides a context for the ways we experience, express and communicate our psychological distress (Andersen & Guerrero, 1997). The literature reviewed has revealed the presence of a compelling level of deep-rooted mental health stigma in Chinese culture. Culturally related stigma and somatisation determines mental health beliefs, help-seeking behaviours and treatment expectations for Chinese immigrants. Cultural components must be taken into consideration when working with Chinese populations and providing mental health care.

2.7.4 Cultural competence – user perspectives and expectations

As discussed previously in Chapter 1, the need to provide a culturally competent service has been recognised for nearly thirty years in the field of counselling psychology (Zane, Nagayama Hall, Sue, Young, & Nunez, 2004). Since its emergence in an article by Cross and colleagues (Cross, Bazron, Dennis, & Isaacs, 1989; Thomson, 2005), cultural competence has been acknowledged as a major force in reducing healthcare disparities both in the UK and the US (Carter-Pokras & Dogra, 2005; Papadopoulos, 2006). Furthermore, cultural competence is believed to be instrumental in addressing diversity issues and to be a core knowledge requirement for health care practitioners

(Papadopoulos, 2006; Bhui et al., 2007). Despite being widely acknowledged in mental health practice, there is apparently no unifying definition for the term cultural competence. Cross (2008) defines cultural competence as "a set of congruent behaviours, attitudes, and policies that come together in a system or amongst professionals and enable that system, or those professionals to work effectively in cross-cultural situations" (p. 7). Tse (2005) highlighted the values from different ethnic backgrounds in his definition and saw cultural competence as "the ability of individuals and systems to respond respectfully and effectively to members of all cultures, races, classes and ethnic backgrounds and religions in a manner that recognises, affirms, and values the cultural similarities and differences and their worth" (p. 23). Campinha-Bacote's (1999) definition emphasised the role of the health provider and viewed cultural competence as "the process in which the healthcare provider consciously strives to achieve the ability to effectively work within the cultural context of a client, be it an individual, family, or community" (p. 203). Despite these differences in definitions, there is a general understanding that cultural competence encompasses a large set of skills and knowledge which includes paying particular attention to obvious language barriers and also acknowledging cultural perspectives in the context of mental health (Bhui et al., 2007). Furthermore, cultural competence is viewed as a continually evolving skill that an individual can develop through education (Papadopoulos, 2006). The need to consider cultural perspectives in mental health services and the potential for health professionals to develop their cultural competence using the information generated from this study are pertinent to the current work.

Different models have been developed to help facilitate the understanding of cultural competence. The earlier work of Cross et al. (1989) proposed that cultural competence develops through six stages: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence and cultural proficiency. Campinha-Bacote's (1999, 2002) model of cultural competence argued that cultural competence comprises five interrelated aspects: cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desire. Leininger's Sunrise Model (Reynolds & Leininger, 1993) described how cultural competence can be incorporated through education about different cultural values and ways of life about such factors like religious, philosophical and spiritual beliefs, kinship and social ties, political and legal factors, economic factors, educational factors and technological factors. Leininger's model of cultural competence requires health care professionals to evaluate,

acknowledge and respect cultural differences in world views and social structures to provide comprehensive and culturally sensitive care (Reynolds & Leininger, 1993). Papadopoulos, Tilki and Taylor (1998) developed a cultural competence model for the UK health service which consists of four aspects: cultural awareness that begins with an examination of the health professional's own personal beliefs and values, cultural knowledge that can be enhanced through meaningful contact with other communities, cultural sensitivity with an aim to achieve equal partnerships with patient in care and cultural competence that incorporates and applies awareness, knowledge and sensitivity. The cultural competence framework developed by Brach and Fraser (2000) is probably the most comprehensive as it includes nine categories. Developed from extensive fieldwork and across various sectors, Brach and Fraser's framework conceptualises that cultural competence in health settings can be improved by using interpreter services, recruiting and retaining minority staff, continually training staff in cultural competence, coordinating with traditional healing practices such as acupuncture, engaging community health workers for their advocacy, promoting health concepts in culturally appropriate ways, including family and or community members if necessary, encouraging immersion in another culture which can help health professionals to overcome their ethnocentrism, and bringing about accommodation from administrative and organisational levels (Brach & Fraser, 2000).

Although various models have been developed to address cultural competence, research incorporating the patient's or health service user's perspectives and expectations about cultural competence are relatively scarce. Few studies conducted in the US and UK asked patients from other cultures to identify their caring needs (Davies, 2006; Hall, Hall, Pfriemer, Wimberley, & Jones, 2007; Toofany, 2007; de Pheils & Saul, 2009). Toofany (2007) identified that language was reported as the main barrier for patient needs not being met. A report titled "Cultural competency and quality of care: obtaining the patient's perspective" suggested that service users are an important source of information about their culture and that incorporating their perspectives and expectations about culturally and competent services into the current measures of quality will provide important data and create opportunities for health providers (Ngo-Metzger et al., 2006).

In an effort to incorporate patients' and service users' perspectives into the health service, a "patient-centred" approach has been recognised as crucial to providing culturally competent health care. The Royal College of General Practitioners conducted an independent inquiry into patient-centred care in the 21st century which was published by NICE in 2014 (NICE, 2014). It suggests "patient centred" care is "care that is holistic, empowering and that tailors support according to the individual's priorities and needs" (p. 4). The explanatory model (Kleinman & Benson 2006) is a rare cultural competency focused approach that was developed to meet the requirement for the delivery of person-centred service in mental health, as well as the engagement of service users, their families and carers. In Kleinman and Benson's model (2006), providing cultural competence services involve six stages: Stage 1, ethnic identity (which means asking about ethnic identity and whether it matters for the patient); Stage 2, what is at stake? (which focuses on evaluating what is at stake for the patients, their families and others in an episode of illness); Stage 3, understanding the illness narrative for an individual patient (as different cultural meanings may have implications for care); Stage 4, assessing psychosocial stresses; Stage 5, identifying the influence of culture on clinical relationships; and Stage 6, to treat the problems within a cultural competent approach. Lewin, Skea, Entwistle, and Zwarenstein (2001) undertook a study on the patient-centred approach in clinical consultations and suggested that the patient-centred care approach impacted positively on patient satisfaction.

In Stage 3 of the explanatory model, Kleinman and Benson devised a series of questions to understand the patient's definition of illness and treatment expectations, such as: "What do you call this problem? What do you believe is the cause of this problem? What course do you expect it to take?" (p. 304). An understanding of the treatment expectations of the service users will help facilitate a better provision of service, as noted by Kleinman and Benson. Studies on treatment expectations within the Chinese community when accessing mental health services are scarce and mostly conducted in the US. One earlier study conducted by Sue (1977) on Asian-Americans suggested that Asian-Americans are likely to terminate counselling prematurely when compared to Western clients, potentially because their treatment expectations had not been met. Leong and Lee (2006) suggested that cultural variables could be influential when assessing Chinese clients' treatment expectations. This is due to traditional mental health beliefs, the stigma attached to the subject and the fear of losing "mian zi". These factors could cause a mismatch of treatment expectations between mental health

professionals and Chinese service users (Leong & Lau,2001). Kim and Atkinson's (2002) research found Asian-American clients resonate better with counsellors that adopt a more "immediate resolution" approach. The findings from this study were linked with Sue and Zane's (1985) earlier research, which prioritised "the need for attaining some type of meaningful gain early in therapy" (p. 42) for American-Chinese clients. The treatment expectations for Chinese mental health service users should be considered within their cultural framework and more culturally competent treatment plans for this population need to be facilitated.

This current review conducted on cultural competence established that cultural competence is an essential measurement for health services across all disciplines. However, limited research incorporating service users' perspectives and a lack of understanding on treatment expectation suggests further studies are needed for better provision of "patient centred" care. This current study aims to explore the cultural perspectives of Chinese immigrants in relation to mental health beliefs and treatment expectations, so their viewpoint and their perceptions are important when considering how to better provide mental health services to the Chinese immigrant community. Cultural competency is a complex task which involves both specific and generic skills (Lo & Fung, 2003), all of which are essential to counselling psychologists in practice and in training. It is crucial for counselling psychologists and professionals working within the mental health services to be open to and interested in cultural perspectives so that they can anticipate and recognise how and when these issues affect the overall provision of the service. Although the importance of cultural competence is widely recognised for mental health professionals, studies within this area focusing on the Chinese immigrant community are scarce.

2.8 Identifying a research gap

A review of the literature about Chinese cultural perspectives in relation to mental health was conducted in the following five categories: the social-economic overview of China, an overview of Chinese immigrants in the UK, the mental health and service use of Chinese immigrants in the UK, immigrant status and mental health and the conceptual framework on understanding cultural perspectives in relation to mental health. During the review process, the Oxford Handbook of Chinese psychology (Bond,

2010) provided a comprehensive and commanding review of Chinese psychology and was an invaluable resource for forming a conceptual framework for this study. While the reviewed literature varies in research aims and methods, they nonetheless have all reflected pertinent issues which facilitated the understanding of mental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community. The overall consideration for the intersectionality of these aspects reviewed reflects the complexity of the research question.

The literature review revealed that the majority of mental health studies concerning Chinese immigrants have been conducted in the USA. The majority of the studies conducted in the UK are outdated and lack in-depth knowledge from the mental health service users' view in connection with a Chinese cultural perspective.

One quantitative study conducted by Wong and Cochrane (1989) simply measured the number of Chinese patients in psychiatric hospital admission; the study suggested an underutilisation of the psychiatric service by Chinese immigrants. The study was conducted almost 20 years ago and lacks a qualitative perspective in further understanding the reasons for the underutilisation of the mental health services by the studied population.

Focusing on the perspective of mental health professionals, one survey conducted by Li (1991) found that 62% of psychiatrists think that Chinese patients pose "greater management problems", with language and culture being named as the main difficulties. This study is slightly outdated and was regionally focused, with data only collected from the Merseyside area.

Li, Logan, Yee and Ng (1999) conducted a mixed method study on the barriers meeting the mental health needs of the Chinese community. They used a 12-item Chinese Health Questionnaire (12-CHQ) to interview 401 participants, with a further semi-structured interview conducted on 71 participants. The study found the main barriers for Chinese immigrants accessing the mental health services were language, the interviewees' perceptions of their symptoms as somatic rather than psychiatric in origin, the lack of knowledge about statutory services and the lack of access to bilingual health professionals. Their study concluded that the mental health needs of these Chinese people were not adequately met by statutory services in the UK. This mixed method study is impressive in regard to the number of participants recruited; however, the study

does not attempt to further explore the connection to Chinese cultural perspectives and simply listed the barriers in accessing the mental health services for Chinese users. While the study helped mental health professionals gain some understanding about the barriers for Chinese service users, it did not offer a working theoretical model, so the study cannot offer systematic ways for mental health professionals to overcome some of the challenges that Chinese service users were facing.

Green and colleagues (Green, Bradby, Chan, Lee, & Eldridge, 2002) conducted a study on the mental health of Chinese women in Britain. This qualitative study carried out 42 interviews with Chinese women living in East London and Essex and explored subjects like migration, employment and health (specifically mental health). This in-depth interview study again examined the barriers to the use of primary and secondary mental health services by women of Chinese origin, particularly relating to stigma, the cultural specificities of the expression of mental distress, the use of alternative therapies (such as traditional Chinese medicine) and informal social support networks. However, the study only reflects female views on the subject of mental health. Without a male perspective, Green (Green et al., 2002) cannot be seen to provide an overview in understanding the issues faced by the larger Chinese immigrant community.

A report conducted by the Chinese Mental Health Association (Yee & Au, 1997) generated useful information about the delivery of mental health services to the Chinese community. The report identifies that the mainstream mental health services fail to meet the mental health needs of Chinese people by sometime “dumping” mentally ill Chinese people on Chinese community centres or mental health initiatives, but that these bi-lingual and culturally sensitive services provide a complementary role for mainstream mental health services. The report also identified some common errors committed by Western psychiatrists when dealing with Chinese patients, including the normalisation of mental illness behaviour displayed by Chinese patients, misinterpreting culturally derived behaviour as mental illness and the use of treatments unsuited to Chinese patients (Blackwell, 1997). The report suggests a better awareness of Chinese cultural etiquette and use of “cultural consultants” could be helpful. A specific role is nominated in a report by Li-Howard (1997) for Chinese Community Psychiatric Nurses, as they would liaise between mental health services, Chinese community organisations and individual patients with their families. The report produced sheds light on the delivery of mental health services to the Chinese community; however, the report was generated

from the point of view of Chinese mental health associations and lacks an overall in-depth understanding of Chinese cultural perspectives.

Another regional mixed-method study (Huang & Spurgeon, 2006) explored the mental health of Chinese immigrants in Birmingham and found that over 60% of the group reported symptoms of poor mental health in a questionnaire survey. Further qualitative research shows that the psychological distress experienced by immigrants of Chinese origin continues to be a largely invisible cause for concern. The study yielded interesting results, but suffers from the inevitable limitations arising from being regionally based.

Meeting the mental health needs for this population is a pressing matter, and a greater depth of research in the UK is needed. Moreover, most studies reviewed did not incorporate the patients'/users' perspectives, which can be considered the most important element in providing a culturally competent service (Ngo-Metzger et al., 2006). Clearly there is a lack of research that could provide rich data to create a deeper understanding of the research subject, in particular on mental health beliefs and treatment expectations. In addition, by validating the participants' own experiences we can understand the subject matter from within the Chinese community. This is the research gap this study aims to fill.

CHAPTER THREE: THESIS RESEARCH APPROACH AND METHODS

Sharpen your tool before tackling a task

Analects - Confucius

This chapter introduces the rationale for the study, particularly the use of constructivist grounded theory as the research methodology. This chapter also outlines the research design and methods, which includes the recruitment process, data collection process, data translation process and data analysis process for this study. The ethics of the study and issues surrounding reflexivity and rigour are also incorporated in this chapter. The constructivist grounded theory methodology has guided the process of data gathering, coding, analysis, memo writing and theory development in the study of the cultural perspectives of mental health beliefs and treatment expectations within the Chinese immigrant community. The study aims to focus on the exploration of social contexts and cultural processes surrounding the participants, while at the same time understanding their values and beliefs about mental health issues.

3.1 Rationales for the Study

3.1.1 Rationale for Qualitative Research

The main purpose of this study was to investigate the cultural perspectives on mental health beliefs and mental health treatment expectations within the Chinese immigrant community. Considering the explorative and interpretative nature of the research question, a qualitative methodology was deemed to be more suitable than a quantitative methodology. A qualitative methodology can be defined as a procedure that uses language rather than numbers and is an interpretative, naturalistic approach: "Qualitative research embraces the concept of inter-subjectivity usually understood to refer to how people may agree or construct meaning: perhaps to a shared understanding, emotion, feeling, or perception of a situation, in order to interpret the social world they inhabit" (Nerlich, 2004, p. 18). Denzin and Lincoln (2008) believe that the focus of qualitative research is to make sense of social phenomena and the meanings people bring to them. Qualitative methods have an advantage when we hope to understand people's feelings or study participants' reflective experiences (Denzin & Lincoln, 2008). Further studies by Alasuutari (1996) also suggest that a qualitative study provides a

fresh viewpoint on the issues we investigate and also seeks to understand the construction of a culture (Alasuutari, 1996).

3.1.2 Rationale for Constructivist Grounded Theory

3.1.2.1 Ontological and epistemological concerns

The decision to adopt a qualitative approach (specifically constructivist grounded theory) was underpinned by my own ontological and epistemological positioning. Ontology and epistemology can be defined as beliefs about the nature of reality and a framework for knowledge respectively (Orlikowski & Baroudi, 1991). Ontology and epistemology provide positions about my individual assumptions about human knowledge, the nature of the realities I encountered in my research and what is of particular importance or value to me. These assumptions shaped my research question, the chosen research method and how I interpreted the findings. My own ontological stance for this study was relativist. In this study, I presumed that reality is socially constructed and cannot be understood independently from social and cultural factors (Orlikowski & Baroudi, 1991). Ontological perspectives are concerned with the ways of viewing social reality (Orlikowski & Baroudi, 1991), which can vary depending on the nature of the study and the researcher's own decisions. Beck sums up my own ontological stance when he suggested that "the purpose for social science is to understand the social reality as different people see it and to demonstrate how their views shape the action which they take within that reality" (as cited in Anderson & Bennett, 2003, p. 153). I believe the lived experiences of these Chinese immigrant participants cannot be viewed in isolation, but rather through interpretation with reference to their cultural background (Graue & Walsh, 1998; Byrne-Armstrong, Higgs, & Horsfall, 2001). The relativist worldview that underlies this study enabled me to understand how the participants developed varied and multiple subjective meanings of their experiences (Creswell, 1998) when receiving mental health treatment in the UK as a Chinese immigrant.

The relativist ontological stance guided me to consider the main epistemological position of Constructivism. Constructivism refers to the process by which the researcher/observer creates reality, by giving meaning to what is observed (Jonassen, 1991; Von Glasersfeld, 1988; Watzlawick, 1984). Constructivism assumes reality is constructed through a person's active experience and an individual's interpretation or construction; furthermore, constructivism implies that all interpretations are equally

valid and that no single "truth" or interpretation exists (Dickerson & Zimmerman, 1996). Constructivism embraces a multiplicity of perspectives when studying the research context (Guba & Lincoln, 1994), which is of particular relevance to this study. Guba and Lincoln (1994) further argued for the value of looking at the social construction of what is real, weighted against the constraints of relativism and multiple realities. Constructivism takes the assumption that all information is subject to interpretation by the researcher; this epistemological stance does not deny reality, rather it denies that reality can be rationally accessed outside of our personal perspectives (Ernst von Glasersfeld, 2001). The constructivist view of reality is consistent with the relativist ontological stance of this study. With the research aiming to explore the cultural perspectives on mental health beliefs and mental health treatment expectations within the Chinese immigrant community, their experiences needed to be interpreted in relation to their culture context (Byrne-Armstrong et al., 2001). Therefore, I believe the use of a constructivist epistemological position was appropriate to achieve the aim of this study.

Constructivist theorists advocate knowledge as "a process of actively interpreting and constructing individual knowledge representations" (Jonassen, 1991, p. 5). There are some fundamental beliefs shared by constructivist theorists: that knowledge is based on theory, that the separation of the researcher and the subject is not possible, that separation between theory and practice is equally unattainable and objectivity is impossible (Mir & Watson, 2000). Constructivists believe researchers are a part of the research process rather than objective observers, so their values must be acknowledged by themselves and by their readers as part of the outcome of studies (Appleton & King, 1997; De Laine, 1997; Guba & Lincoln, 1989; Stratton, 1997). Constructivists see the researcher's inter-subject experiences as central to the research process. Therefore, as a Chinese immigrant researcher interviewing Chinese immigrant participants on the subjects of mental health and our shared culture background, I believed it would certainly create interrelationships between myself and the participants that needed to be reflected upon (Mills, Bonner & Francis, 2006). A constructivist researcher would consider his/her own biases as pertinent when conducting research. Because a researcher is aware of the subjectivity of his/her work, a more rigorous set of ethics and a more reflective approach needs to be incorporated throughout the research process. As suggested by Soobrayan (2003), a constructivist researcher "is constantly and consistently called upon to consciously and deliberately engage with the ethical, truth

and political implications of his research and writing" (p. 107). Guba and Lincoln (1998) argued that constructivist research is based upon a relativist ontology, which subscribes to the view that there are "multiple realities" because reality is "constructed subjectively in the mind of each person depending on context" (p. 42) which is consistent with the current study.

3.1.2.2 Theoretical perspective - Symbolic Interactionism

In relation to the considerations of the relativist ontological position and constructivist epistemological stance, a further investigation into theoretical perspective is needed. Theoretical perspective can be viewed as the underlying philosophical assumption about the researcher's view of human and social life within the world (Crotty, 1998). The epistemological stance of constructivism helped me to identify the theoretical perspective of this study as symbolic interactionism, as the epistemology of constructivism is generally "founded embed in symbolic interactionism" (Crotty, 1998, p. 4). Symbolic interactionism, largely influenced by the work of George Herbert Mead (Mead, 1934) and other sociologists (Blumer, 1969; Dewey, 1981; Cooley, 1902; Simmel & Wolff, 1950; Goffman, 1978) is considered to be one of major frameworks in sociological theory (Giddens, Duneier, & Appelbaum, 2003). Griffin (1997) identified symbolic interactionism with three core principles: meaning, language and thought or perception, which represents a person's self and socialisation into a larger community. In symbolic interactionism, individuals attach subjective meaning to their life experiences, which arise out of their relationships with others and develop their identities (Goulding, 1999; Flick, 2013). This principal of meaning is regarded as the central aspect of human behaviour in symbolic interactionism (Griffin, 1997). Language is also considered instrumental in symbolic interactionism (Berger & Luckmann, 1991), as it allows individuals to negotiate meaning through symbols, identify roles, interact with others and develop perspectives. Thought or perception is influenced by an individual's ability to understand all the aspects of their current situation and is also facilitated by their own perspectives on their interactions. Charon (2001) suggested that these perspectives convey certain biases, assumptions, judgements and ideas which can hugely influence an individual's actions in the socio-cultural world. From the perspective of symbolic interactionism, the concept of the "self" is a construct that has specific meanings gained through interpretations embedded in social interactions with significant others using language (Mead, 1913, 1934). Social identity emerges through

reflections in other people, gained through social interaction, which was highlighted in the notion of the "looking-glass self" (Cooley, 1902).

When examining the relationship between these theoretical perspectives and the current study, I believe symbolic interactionism is congruent with both the constructivist epistemological stance and the purpose of this study, which was to investigate cultural perspectives on mental health beliefs and mental health treatment expectations within the Chinese immigrant community. As mentioned earlier, symbolic interactionism assumes that individuals develop meanings based on shared interactions and how they accordingly act and behave (Blumer, 1969). In the study about the understanding of mental health in the context of cultural perspectives, the symbolic interactionism perspective guides the research to explore how the participants' sense of self and socio-cultural identities develop in relation to mental health (Mead, 1913; Scheff, 2007). Furthermore, language is viewed as a tool to record and pass aspects of culture and cultural heritage in symbolic interactionism (Hertz, 1973). This viewpoint is particularly important when understanding the Chinese's immigrants' experiences in their use of language in relation to the concept of mental health.

The relativist ontological position, the epistemological stance of constructivism and the theoretical perspective of symbolic interactionism (together with the research aim) determined my decision to use constructivist grounded theory as the research methodology for this study, as the combination of interpretative, constructivist and qualitative research approaches was consistent with my theoretical framework.

3.1.2.3 Grounded theory overview

Grounded theory was developed by Barney Glaser and Anselm Strauss in the early 1960s and can be defined as "*the discovery of theory* from data systematically obtained from social research" (Glaser and Strauss, 1967, p. 2). Grounded theory was originally developed in the discipline of sociology (Glaser & Strauss, 1967), and has since become very popular as a qualitative research method in psychology (Rohleder & Lyons, 2015). According to Crooks (2001), grounded theory is ideal for exploring integral social relationships and the behaviour of groups where there has been little exploration of the contextual factors that affect individuals' lives. Its goal is to explain "how social circumstances could account for the interactions, behaviours, and experiences of the

people being studied" (Benoliel, 1996, p. 413). By conducting research with grounded theory, the researcher hopes to "get through and beyond conjecture and preconception to exactly the underlying processes of what is going on" so that counselling psychologists and other professionals working within the mental health service field "can intervene with confidence to help resolve the participant's main concerns" (Glaser, 1978, p. 40).

Grounded theory methodology has developed over the years. However, the key components of grounded theory methodology remain constant. These include the simultaneous involvement of data collection and analysis, data driven analysis rather than hypotheses, constant comparative methods at each stage of the research, theory development throughout the research process, memo-writing to elaborate categories, specifying their properties, defining relationships between categories and identifying gaps, sampling lead-by-theory construction and literature review and conducting an independent data analysis (Bryant & Charmaz, 2007). These defining components of grounded theory method are aligned with the current study and its qualitative nature, the limited availability of literature and the decision to generate a theory based on a thorough analysis of the collected data. Grounded theory recommends that researchers begin their studies with as few predetermined ideas as possible (Dey, 1999), which suggests that an extensive literature review was not necessary before beginning the study (Hickey, 1997; Guba & Lincoln, 1985). This works well with the current literature gaps in the field of interest. In particular, grounded theory provides guidelines and a framework for researchers to conduct their study, but also allows flexibility in the overall research process for individual researchers to tailor it to their own needs. This is a particularly attractive feature for a novice researcher like me who seeks guidance and direction when conducting research. At the same time, it acknowledges the importance of flexibility because of the explorative nature of the study.

One of the major benefits of adopting the grounded theory approach was that the method met the need for a qualitative exploration of the subject of interest; however, on further investigation, it appeared the original grounded theory rests on a positivist epistemology (Hayes, 2013). Glaser and Strauss (1967) promote the "discovery of theory from data" (p. 2); this implies "theory" objectively exists and can be positively "discovered". The classic grounded theory appeared more inductive in nature (Hayes,

2013), which was not consistent with both the relativist ontological position and constructivist epistemological stance of this study. Given my theoretical framework, a constructivist grounded theory method was adopted as it reformats the interactive relationship between researcher and participants throughout the research process and sees the researcher as an author (Mills et al., 2006) rather than a discoverer of theory.

3.1.2.4 Constructivist grounded theory overview

Constructivist grounded theory was developed by Charmaz (1991, 2006, 2009, 2012). The approach assumes that data and theories are constructed by both the researcher and the research participant rather than emerging or being discovered fully formed (Allen, 2010; Charmaz, 2006). Constructivist grounded theory believes reality "arises from the interactive process and its temporal, cultural, and structural contexts" (Charmaz, 2000, p. 524) and the approach has been viewed as a methodology that applies the strategies of traditional grounded theory within a constructivist paradigm (Mills et al., 2006; Annells, 1997). Whilst conducting the literature review for this study, I came across a number of research articles using constructivist grounded theory from various disciplines, including social sciences such as psychology (Corbet-Owen & Kruger, 2001; Dodson & Dickert, 2004; Madill, Jordan, & Shirley, 2000), all of which cite the important work of Charmaz in formulating their own arguments for their research. Personally, there were two major benefits in adopting constructivist grounded theory as the research method: the methodology for approaching theoretical resources and the acknowledgment of the interaction that occurs between the participants and the role the researcher adopts.

When conducting the initial literature review for this study, I realised that the concept of "Chinese culture" is so vast that some theoretical resources would be needed to begin the process of understanding and interpretation (Riessman, 1993) of the chosen subject. According to Charmaz (1990), these theoretical resources can come from the researcher's own substantive interests that guide the research question, or sets of sensitising concepts from various schools of thought or the researcher's personal experiences and values. The review of the available theoretical resources facilitates the "emergence" of the theory, a "flip flop" of interplay between pre-existing ideas and the researcher's conceptualisation of the theory, which is a key constructivist revision of grounded theory (Charmaz, 1990). A theoretical model generated by constructivist grounded theory focuses on the active and continuous analytic process which introduces

new discourse to current knowledge (Charmaz, 1990), which is what this study intended to achieve.

Furthermore, the acknowledgment of the role of the researcher and the recognition of the interaction between the researcher and participants were what made me believe that constructivist grounded theory was the most suitable research method for this study. Constructivist grounded theory restructures the interaction between researchers and participants in the research process. Charmaz (1991) saw the researcher as a co-producer in the study, encouraging them to "*add . . . a description of the situation, the interaction, the person's affect, and [their] perception of how the interview went*" (p. 33). It is also my belief that the researcher and the participants were both necessary for understanding the meaning of the experience shared during the research process (Charmaz, 2000; Lincoln & Guba, 1985). It would have been difficult, if not impossible, for me to take a bystander-style approach during the overall process. Specifically, as a Chinese researcher conducting research on Chinese immigrants, my own background, experiences and interpretation would inevitably be a factor when seeking an understanding of how Chinese immigrant service users interpret the mental health service and the treatment process within their social context. I intended to go beyond the spoken words to discover concepts about their values, beliefs, and ideologies and I saw myself positioned as a "*co-producer*" to enrich this data (Mills et al., 2006, p. 7). Charmaz (1995b) also holds a similar view, as she emphasised that the interaction between the researcher and participants "*produces the data, and therefore the meanings that the researcher observes and defines*" (Charmaz, 1995b, p. 35). This perspective coincided with my own relativist ontological stance and constructivist epistemological concerns that concur with Charmaz's method, which "assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and viewed, and aims toward an interpretive understanding of subjects' meanings'" (Charmaz, 2000, p. 250). Therefore, this study was conducted with the guiding principle of constructivist grounded theory, not only as a way to learn about the world, but also as a method for developing theories to understand them (Charmaz & McMullen, 2011).

3.2 Research design and methods of analysis

The research was designed with constructivist grounded theory as the guiding approach. The overall process was divided into four stages: recruiting, interviewing (data collection), translating and analysing.

3.2.1 Recruitment Process

Although there are no specific guidelines as to how many participants are needed in order to complete one study, qualitative researchers have recommended using a sample size ranging from as few as 6 participants to as many as 30 for a grounded theory study (Creswell, 1998). Mental health is a heavily stigmatised subject in the Chinese community (as previously mentioned in Chapter 2) and as such the recruitment process for research participants was particularly challenging. Participants were recruited through advertising flyers placed both at City University and Chinese community mental health charities, through social media (Facebook, Weibo) and through six weekly advertisements in a national Chinese newspaper. Through these approaches a total of 12 participants were recruited for the study. The study examines the cultural perspectives on mental health beliefs and treatment expectations within the Chinese immigrant community in the United Kingdom so I determined that all participants for this study needed to be first generation immigrants. Previous research suggests that cultural perspectives are more pervasive with first generation immigrants who were not born in the host country when compared to the second generation of immigrants (Kruzykowski, 2011; Gordon, 1964). Regardless of gender, all participants had to be over 18 years old and have experience of using mental health services in the United Kingdom. In 2011, the Department of Health released a policy paper for the new government (Department of Health, 2011) about a mental health strategy for England. It aimed to help more people with mental health problems while promoting public understanding of mental health and reducing stigma and discrimination. It was hoped that this new strategy would decrease negative attitudes and behaviours towards people with mental health problems (Lawton-Smith & McCulloch, 2015). For the study to be updated and relevant to the current mental health service climate, the participants had to have received their treatment within the previous five years.

Geographically speaking, 10 participants were from London and 2 participants were from outside London. The geographical distribution coincided with the Census (ONS,

2001) report that London is the home for the majority of Chinese immigrants in the United Kingdom, with one in three Chinese immigrants living in London. Eight female participants and four male participants were recruited. The gender difference in the study was consistent with findings in other studies, which suggest that women are more emotionally expressive (and hence more willing to share personal experiences) than men (Hall, Carter, & Horgan, 2000; see also LaFrance & Banaji, 1992; Niedenthal, Kruth-Gruber, & Ric, 2006). Other research also suggests that gender influences the response rate, with a higher rate of females participating in studies (Smith, 2008; Cull, O'Connor, Sharp, & Tang, 2005). In addition, the practice of emotional restraint is a key feature of Chinese culture (Kleinman, 1986). This is particularly true for Chinese men, where showing their emotions can be seen as a sign of weakness and can even bring shame to their family (Sue, 1994; Sundararajan & Averill, 2007). The gender sample difference in participants is acknowledged during the analysis process in Chapter 4.

A total of five participants were recruited through advertisements placed in the most widely circulated Chinese (language) newspaper in the United Kingdom, *U.K. Chinese Times* (See Appendix 1). In addition, three participants were recruited through social media, specifically a widely-used Chinese version of Twitter (Weibo). One participant was recruited through my personal network and three participants were recruited through advertising flyers. The average age of the participants was 32, with 5 participants born in the 1980s, 3 participants born in the 1990s, form the majority of the participants group. Given the previous discussion on the changing Chinese cultural context, in particular the generation subculture, it is possible that because of the increased level of self-awareness associated with an individualistic thinking framework (Shuai, Mi, & Zou, 2015), the participants from these two generations were more likely to take part in a study on mental health beliefs and treatment expectation. Table 1 contains a breakdown of the demographic information for all the participants. The average years of immigration for the participants was 9 years, with 15 years being the longest immigration time to the UK and 5 years being the shortest immigrant period for the participants. Given the different length of immigration among the participants, it was possible that their level of "acculturation" (Berry, 1998, 2003, 2008; Noh & Kaspar, 2003) would be different, hence my decision to give participants the choice for the interviews to be conducted in either English or Mandarin Chinese to minimise any potential inaccuracies caused by limitations of vocabulary or expression in either

language. Language can be a barrier to allowing participants to clearly express their experiences (Squires, 2008; Lee, Sulaiman-Hill, & Thompson, 2014). Conducting interviews in the preferred language of the participant was one way of overcoming that barrier and meeting their cultural needs. It also showed respect for the participant's cultural preference (Ponterotto et al., 2009). Pragmatically speaking, this choice also allowed me to include participants from a wider range of social backgrounds, as it provided less restriction on the levels of education and social integration into the United Kingdom to ensure that the study covered as wide a selection of first generation Chinese immigrants as possible. Amongst the 12 participants, 11 chose to be interviewed in Mandarin Chinese, with one interview conducted in English. All the interviews were recorded and transcribed verbatim, and then translated into English (11 in total) for the final presentation by the researcher. As a bilingual researcher, I combined the functions of both researcher and translator. All participants' details were kept confidential during this process. Table 1 contains a breakdown of the demographic information for all the participants.

Table 1: *Breakdown of the Demographic Information*

	Gender	**Pseudonym**	**Age (in years)**	**Year of immigration**	**Year of accessing mental health service**
Participant 1	Female	Rose	27	2010	2011 & 2012
Participant 2	Male	Stone	33	2006	2014
Participant 3	Female	Lily	28	2009	2012
Participant 4	Female	April	24	2008	2013 & 2015
Participant 5	Female	May	24	2011	2013
Participant 6	Female	June	47	2003	2014
Participant 7	Male	Wood	28	2008	2014
Participant 8	Male	Max	38	2004	2014
Participant 9	Female	August	37	2001	2010
Participant 10	Female	Poppy	47	2003	2014
Participant 11	Male	Jay	28	2004	2015
Participant 12	Male	Henry	25	2012	2014

3.2.2 Data Collection Process

Conducting data collection using the constructivist grounded theory approach allowed me to understand the participants' experiences from an angle that was "*within*". As suggested by Charmaz, "*seeing research participants*" and their "*lives from the inside often gives a researcher otherwise unobtainable views*" (Charmaz, 2006, p. 14). The data collected using this approach could reveal the participants' views, feelings, intentions and actions as well as the contexts and structures of their lives in a wider social context, which was instrumental to the study. Charmaz believes people "*construct data*" and therefore the data collection process in the constructivist grounded theory approach must involve the gathering of "*rich data*" (Charamz, 2006, p. 10) from the participants. To also acknowledge the interactive process highlighted by Charmaz (2006, 2012), an "*in-depth*" interview data collection method was used for the study. This allowed for great flexibility, continuity of thought, a high level of quality information (Minichiello et al., 1990) and an interaction between the researcher and participants. This approach was considered the best means of securing the personal and private concerns of respondents by Chenitz and Swanson (1986). Also known as "*intensive interviewing*" (Sarantakos, 2005, p. 282), this method has long been a useful data-gathering method in various types of qualitative research and is also believed to be a suitable method for studies with an interpretive nature (Charmaz, 2006). In-depth interviews normally last between 30 and 120 minutes (Boyce & Neale, 2006). Given the complexity of the subject that I was discussing with my participants, I felt it was appropriate to set aside at least 45 to 60 minutes for each interview, and the length of interview was pre-communicated to all participants so they could arrange their schedules accordingly.

A total of 6 interviews were conducted using City University rooms and 6 interviews were conducted outside the university. I would travel to meet the participant in their suggested public locations, such as a community library or local café. It was important for me to be able to meet the participants' individual needs, as I believed it demonstrated sincerity, commitment and respect on my part. Each interview began with a participant briefing, detailing the nature of the study and structure of the interview. An interview opening is "*how it started*" (Hermanns, 1995, p. 183): an opportunity to build rapport and also invite the participants to tell their stories. Confidentiality was addressed and a consent form was also signed by each participant at the beginning of the interview.

After obtaining basic information from each participant (age, year of entry to the UK and year of treatment), I started the interview with open-ended questions (How did you seek help for mental health issues? What was your expectation before you enrolled for the mental health treatment? What were your experiences during the treatment? How might culture affect the mental health issues you experienced?). The interviews were semi-structured, which means there were some pre-planned questions I wanted to ask. However, depending on the flow of each interview and the different experiences shared by each participant, I did not insist upon asking specific questions in a specific order. The flow of the conversation with each participant determined the order of questions. In certain situations, the questions asked were changed slightly due to an individual participant's gender, age and circumstances.

Some guiding principles were used for each interview. I understood that it was necessary to create an environment that was comfortable for each participant so they would be willing to share their experiences with me, especially about a sensitive subject such as mental health, a concept referred to as "*toning*" or "*atmosphering*" (Martin & Gynnild, 2011). As the in-depth interviews were specifically semi-structured to encourage the flow of the conversation with each participant, it was important for me to be equipped with empathetic interview skills that enabled me to conduct the interviews in a respectful and non-judgmental way, a skill considered to be essential in conducting interviews in constructivist grounded theory (Allen, 2011). The in-depth interview method also allows dialogue and elaboration (Minichiello, Aroni, Timewell, & Alexander, 1990) to occur in this process. Talking about mental health related issues can be difficult and emotional at times, so to be respectful and empathetic for each participant it was important that I did not force a specific topic on them. Instead I let the participant lead the conversation as they wished. Because of its flexibility, the in-depth interview method also enabled me to gain clarification on what the participants were saying (if required) during the interview process and return to an earlier point if needed, which proved to be immensely important during the data collection stage. The explorative aspects of an in-depth interview were consistent with Charmaz's suggestions of using the techniques of constructivist grounded theory (Charmaz, 2006). I hoped that with my open-ended questions I would be able to encourage unanticipated statements and stories to emerge which would yield richer data (Charmaz, 2006). Self-reflective skills are essential when conducting interviews; keen interest and

interpersonal understanding were expressed throughout the research process, as it was important for the participants to feel validated during the interview. The researcher also needs to be mindful that the questions are used to explore, not to interrogate (Charmaz, 1991). It was my belief that the role of the interviewer was not a passive one, nor was my role as an interviewer to simply extract data. I saw myself as part of this co-investigative process, as suggested by Kvale and Brinkmann (2009).

Interviewer and interviewee should be seen as communicating within the bounds of social interaction, as suggest by Alvesson (2003). However, it is important for the researcher to be aware of the power dynamic during the interview, as research is often set up and conducted within power relationships (Wiles, Charles, Crow, & Heath, 2006). From the participants' point of view, I was a stranger seeking information that was highly personal, private and related to a culturally stigmatised subject. If interviews had been conducted without sensitivity, the experience could have been unpleasant or even hurtful. As mentioned previously in Chapter 2, Chinese culture is heavily influenced by Confucian ideology, which emphasises social hierarchy and highly values education. As a Chinese doctoral student interviewing Chinese immigrant mental health service users, I was aware that the situation might create a power imbalance as the participants might see me as somewhat superior. To address the possible issue of a power dynamic, I made an extra effort to appear open and empathetic throughout the interview process. I would also meet with participants at their local community libraries or cafes to give them a greater sense of familiarity with their environment. In addition, all the skills that I acquired during my time as a trainee counselling psychologist were used during interviews; skills like empathy, active listening and non-verbal communication cues were employed to reduce the effects of any perceived skew in the power dynamic throughout the data collection. During the interview process all the participants were informed that they did not need to answer any questions that made them feel uncomfortable. However, despite the effort in addressing the power dynamic issue during interviews, it would still be naive of me to think that the power imbalance between a researcher and a participant could be totally eliminated, as Law (2004) suggested: "what is presented does not necessarily speak for itself- it has to be interpreted. This act of interpretation places the power of representation in the hands of the researcher- a power about which the researcher must be aware of and reflect on" (p. 94). I understood that ultimately I had the power as I was the person that would be

writing the account of participants, a power that I treated with the utmost respect and sensitivity.

Most previous research has suggested that Chinese immigrants are generally reluctant to discuss personal experiences and issues with strangers, especially mental health issues, as it is a highly stigmatised subject (Leong & Lau, 2001; Lee, Lee, Kaplan & Perez-Stable, 2014; Papadopoulos, 2009). This subject is something I could relate to. Even after three years of professional training, as a first generation Chinese immigrant I still find it difficult to express my feelings. Therefore, I paid particular attention to building rapport and trust during the interview process. As Charmaz (2006) pointed out, the trust between the researcher and the participant is pivotal to the study. I found that I was able to listen and observe with sensitivity and often found the interaction between myself and the participants engaging and encouraging. It was very important for me to understand the participants' definitions of terms and situations as I attempted to fully comprehend their assumptions, implicit meanings, and tacit rules (Charmaz, 2012). According to Charmaz (2012), the constructivist grounded theory method works best when the researcher engages in data collection as well as data analysis. I saw the interviews as opportunities to explore the nuances of meaning while gaining first-hand experience as a researcher.

3.2.3 Data translation Process

The interviews were conducted in either English or Mandarin Chinese depending on the individual participant's preference. This decision was made because language is "an important part of conceptualization, incorporating values and beliefs" (Temple 2002, p. 5); or as Evans-Pritchard (1951, p79) suggests: "in learning the language one learns the culture and the social system which are conceptualized in the language" (cited in Bradby, 2002). Gergen (1989) further elaborates the view that language is a social artefact, constructed within a historical and cultural context. Language is believed to be an instrumental element of an individual's identity; aspects of identity such as gender, ethnicity, and religion are constructed and attributed in using different languages (Filep, 2009). The initial literature review also revealed that bilingual speakers frequently report a greater emotional resonance in their mother tongue (Caldwell-Harris & Ayçiçeği-Dinn, 2009). Temple (2002) wrote about her experience as a Polish speaker conducting a study in Polish: "Research participants often assume a shared knowledge

of history and cultural traditions and a certain sympathy with Polish perspectives on these" (p. 15). This was an effect that I wanted to achieve in my own study with Chinese participants. It was an advantage that I practise as a bi-lingual therapist, as researchers have noted that bilingual therapists can resonate more effectively when they speak in the client's mother tongue (Altarriba & Santiago-Rivera, 1994; Spielberger & Sharma, 1976; Schrauf, 2000). A researcher's own background is also important when conducting an interview in different languages (Filep, 2009). I believe that my own background as a first generation Chinese immigrant also helped me to be more aware of the specific cultural contexts that arose when conducting the interviews. The advantage of conducting interviews in both Chinese and English was that the raw data was filled with detailed narratives. Having translated the transcripts myself, matching meanings between two languages, I became very familiar with the material and was able to reach a further understanding and gain insight into the available data through the translation process.

Charmaz (2012) also acknowledged that as researchers we adapt language and meanings as we record data, so the data is never entirely raw. This point particularly resonated with me when I started translating the data from Mandarin Chinese into English. During the process of translation, my own conceptual framework, the use of language and understanding of the world, were all elements that I was highly aware of. When conducting qualitative research in multicultural settings, translation will always be an integral part of the process and it can be instrumental in how the data is handled (Tarozzi, 2013). As Vygotsky mentions (1987), the issue of finding the right words in English that represent a full sense of the Mandarin Chinese words of the participants was a demanding task that required a great deal of attention. There are no specifically prescribed procedures for translation in the context of constructivist grounded theory research; however, the researcher's ability to conceptualise and commit to constant comparison is paramount for quality translation (Shklarov, 2010).

Filep (2009) suggested that some questions need to be considered prior to translation. These are whether to adopt a literal or non-literal translation strategy and how to deal with meanings and messages that words or phrases carry in one cultural context and not in another. It was important for me to consider how to translate words that may only exist in Mandarin Chinese (for example, "mian zi"). The difficulties I experienced in translating the data were not just centred on the actual language used, but also on the

cultural framework surrounding language that has yet to be translated or "*interpreted*" (Filep, 2009, p. 14). I decided to take a more literal approach in my translation, as Charmaz advocates working with the data closely, while at the same time keeping an open mind to the possibilities that arise from the data (2012). All transcripts were back translated for validation purposes, as suggested by Birbili (2000). In addition, a 2- to 3-minute extract from each recording was examined by an independent third-party professional translation company.

3.2.4 Data Analysis Process

The data analysis process in constructivist grounded theory is highlighted by Charmaz and her colleagues (Morse, Stern, Corbin, Bowers, Clarke & Charmaz, 2009), who said: "The comparative and interactive nature of grounded theory at every stage of analysis distinguishes grounded theory from other approaches and makes it an explicitly emergent method" (p. 163). Charmaz also calls for an "immersion" of the data that requires the researchers to include raw data in the continued process of memo writing (Morse et al., p. 526) as a way of preserving the participants' voices and meanings in the final theoretical outcome (Charmaz, 1995b, 2001).

Some of the key components in constructivist grounded theory data analysis include initial coding, focus coding, memo writing, theoretical sampling, saturation, and discovering the argument (Charmaz, 2006). Coding in qualitative studies generally means naming segments of data with a label that simultaneously categorises, summarises and accounts for each piece of data (Bowker & Star, 1999). Coding, according to Charmaz, is the first step for a researcher when making analytic interpretations and is the pivotal link between collecting data and developing an emergent theory to explain the data (Charmaz, 2006). The constructivist grounded theory coding consists of at least two phases: (a) an initial phase (either word by word or line by line) and (b) a focused phase where the most significant or frequent initial codes are sorted, synthesised, integrated and organised (Charmaz, 2006). There are different approaches to coding as outlined by Mason (1996): literal, interpretive and reflexive. The literal approach is an analytical process that focuses on, for example, the exact use of particular language or grammatical structure (p. 54). The interpretive approach focuses on the researcher's effort in attempting to determine meanings from a participant's account. The reflexive approach pays attention to the researcher's own

contribution to the data analysis process. According to Mason (1996), it is most common for researchers to use combinations of the above approaches, which was how I approached my data, with both interpretive and reflexive outlooks.

During the data analysis stage, I was faced with a decision to code the data manually or to use computer assisted software such as NVivo. There are advantages and disadvantages to both (Welsh, 2002). For this study, I decided to code the data manually rather than using coding software, a decision that I made while translating the transcripts. I believe that initial coding happened simultaneously whilst I was translating the data at hand. It is understandable that the researcher's own use of language plays a crucial role in how coding is conducted and analysed, as our own use of language also reflects our views and values and confers form and meaning on the studied realities and therefore no researcher can be neutral (Charmaz, 2006). This concept was especially relevant in conducting my own study as two very different languages were involved in both data collection and data interpretation. I believe that the translation of Mandarin Chinese data into English added an extra layer and complexity of pre-analysis even before the coding begins. The overall process was challenging as it required the researcher to be extremely observant and vigilant when analysing the data. Lack of pre-existing literature on the subject helped during the initial coding stage as I did not have any pre-formed hypotheses regarding the data. This made it easier for me to be led by my data rather than try to force the data in a certain direction, precisely as advised by Charmaz (2006). The line-by-line coding also helped me to start a detailed investigation of what the participants might have experienced. Engaging in line-by-line coding was valuable to me in refocusing the later interviews and prompted me to re-examine the data.

The insight I gained through initial line-by-line coding shaped and directed subsequent research from an early stage. After instigating the initial coding manually, I progressed to focus coding, at this stage, I attempted to synthesise and explain the initially coded data. My understanding of focus coding is derived from Charmaz (2006, 2012), who suggests that significant or frequent initial codes are used to sift through large amounts of data during focus coding. Using constant comparison was crucial to this process as new comprehensions of earlier statements often prompted me to revisit earlier data, a

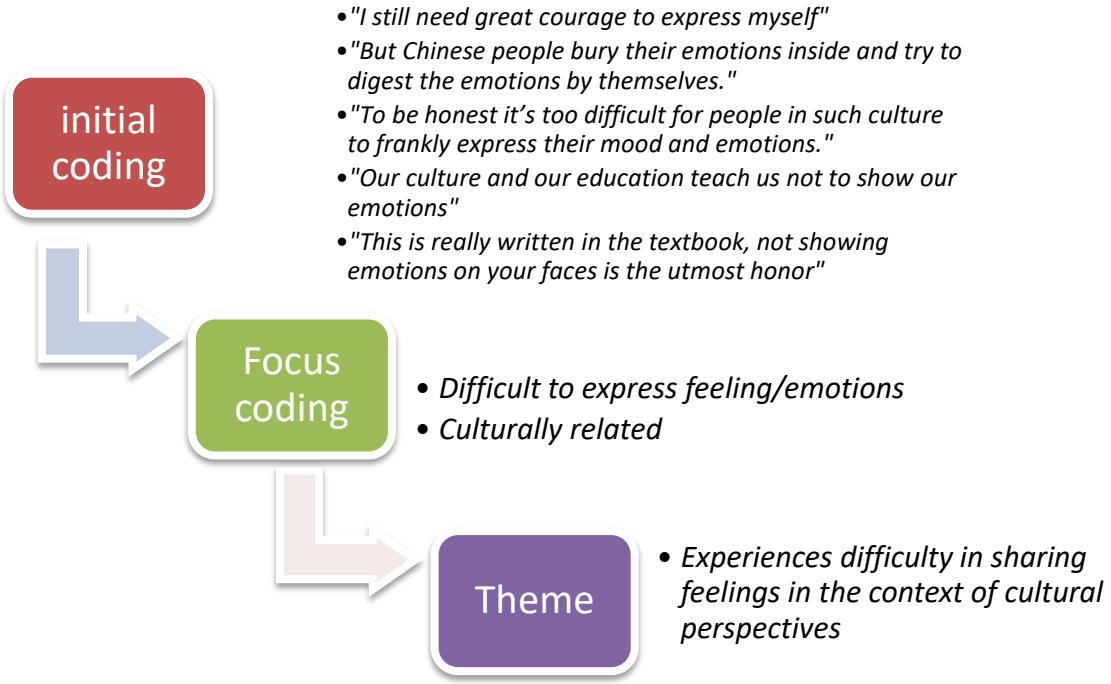
feature noted as a "major strength" of constructivist grounded theory (Charmaz, 2006, p. 60).

The next stage is theoretical coding. To Charmaz (2006, 2012), theoretical coding represents potential relationships arising between categories that developed through focus coding; these relationships can be specific and interactive. Charmaz (2006) advises that theoretical coding must come after the focus coding to avoid creating a forced framework for the data. According to Charmaz (2006), the concept of theoretical sampling "involves constructing tentative ideas" from the data and then examining these ideas through further empirical enquiry (p. 102). Theoretical sampling guided me during the early recruitment phase. For example, one of my female participants made an interesting comment about gender inequality issues in China and how this has contributed to her mental health issues; with the theoretical sampling approach, I was able to actively recruit more male participants to help me explore the subject further from a different gender perspective. During the analysis stage, theoretical sampling was used to seek relevance in data and develop categories to form the emerging theory. When raising a code to a category, I engaged in a sequential process using a clear definition of a category, clarifying its properties, specifying the conditions under which the category had arisen and finally noticing any changes in the category and showing its relationship to other categories, as suggested by Charmaz (2006).

A constructivist grounded theory is generated by themes which emerge from data analysis. Themes are common threads extending throughout the interviews and capture the essence of meaning or experience drawn from varied situations and contexts (Morse & Field, 1995). The identification of the themes requires the researcher to search beyond surface information and immerse themselves in the data (Charmaz, 2006). Throughout the data analysing process, major themes emerge and are categorised to yield the final grounded theory (Bowen, 2006), and the use of sensitising concepts is pivotal during this process. As previously mentioned in the preliminary literature review chapter (Chapter 2), sensitising concepts gives researchers a general sense of reference and guidance in analysing data (Blumer, 1954). In constructivist grounded theory, sensitising concepts are used as "background ideas that inform the overall research problem" and offer "ways of seeing, organizing, and understanding experience… sensitizing concepts may deepen perception, they provide starting points for building

analysis" (Charmaz, 2003, p. 259). According to Blumer (1954), sensitising concepts can be tested, improved and refined. For constructivist grounded theory studies, researchers are able to identify categories in the data and make sense of participants' experiences based on their cognitive frame of reference (Dey, 2007) which is comprised of sensitising concepts. In regard to this study, sensitising concepts were used to lay the foundation for examining the codes and formulating categories. These sensitising concepts resulted from a thorough review of the literature, which formed the conceptual framework for the study that includes cultural dimensions theory (in particular the individualism and collectivism dimension), the dynamism of Chinese philosophies, the symbolic interactionism approach to understanding mental health stigma and cultural competence models with the user's perspectives (as illustrated in Chapter 2). Understanding these concepts helped me set the context for the study, provided me with an analytic framework, served as a point of reference and guided me in the categorisation of the data. However, I was aware that although sensitising concepts might help me to identify some important aspects of the research situation, they could also cause me to overlook other aspects (Gilgun, 2002), which I paid particular attention to during the analysis process. Using Rose's (P1) interview as an example, a process of initial coding, focus coding, theoretical coding and categorising is illustrated in Figure 3.1

Figure 3.1 Rose's (P1) coding process

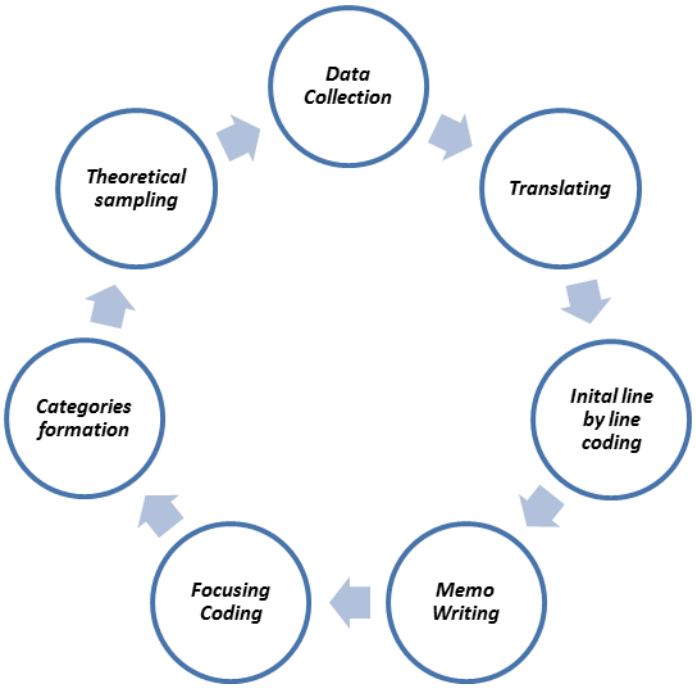


Throughout the analysis process, I searched for meaning in the data that could help answer the research question (how to understand mental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community?) with consideration of certain sensitising concepts (cultural dimensions theory, Confucian dynamism, the symbolic interactionism approach to understanding mental health stigma and cultural competence models). In the above example, we can see from the initial line-by-line coding that Rose repeatedly stated that she found expressing emotions difficult in her narratives; therefore, this issue is important when trying to understand her experiences; therefore, I engaged in focus coding to help address this issue. Following on from focus coding and the constant comparison approach to the data (both within the same interview and other interviews) while using the dynamism of Chinese philosophies as a sensitising concept, the data suggests that Confucian values promote emotional restraint (Liu, 2004). This theme was not previously selected, but emerged through the research process, which is key to constructivist grounded theory. A detailed analysis of the themes that emerged through the data analysis process will be further explored in Chapter 4.

Memo writing is another methodological aspect that is instrumental to constructivist grounded theory. Memo writing allows the researcher to link the data collection with the specific study so that data is closely examined throughout the research process (Charmaz & McMullen, 2011). This method was of particular importance in the earlier conceptualisation stage of the research, as writing successive memos helped me become involved in the analysis of the data and also solidified some of my early concepts. With a large amount of data collected, which had to be transcribed and translated simultaneously, it was pivotal for me to use memo writing to navigate through my study. Charmaz (2000, p. 517) suggests that memo writing provides an aid for "linking analytic interpretations with empirical reality". She argues that "interpretive theorising can move beyond individual situations and immediate interactions" and invokes the possibility that interactions identified at local levels can involve "larger social structures" (Charmaz, 2006, p. 129). Bryant & Charmaz (et al, 2007) also recognise that the charts, drawings, and records generated from memo writing are also helpful in recording the research journey. For example, my memos would include attempts to define a code or category, creating comparisons between data and identifying gaps in the study. The process of memo writing should not be mechanical but purposeful (Morse, Stern,

Corbin, Bowers, Charmaz, & Clarke, 2009), a point that I kept reminding myself of during the data analysis stage. The large amount of data that emerged from the narratives required me to follow Charmaz's (Bryant & Charmaz et al., 2007) suggestion of writing memos as soon as new ideas and categories surfaced, while at the same time constantly collecting data and coding. Ideas were refined through regular and continuous memo writing. I was eventually able to gain a deeper understanding through re-examining the data, which initially appeared to be scattered and overwhelming. In line with Charmaz (2006), I found that memo writing holds a personal importance to me as it was not supposed to be communicated to an audience. The style and presentation of the memo was of no concern to me, so I was able to be more expressive and spontaneous in a way that I could not in other areas of my research. It was essential this overall process was recorded and reflected by memo writing, which I frequently referred back to during the analysis stage. The constant comparison approach and reflective memos that I wrote during the process helped me to be vigilant and flexible during the research process and be mindful of any emerging information. The processes of data collection, translating, initial coding, focus coding, theoretical sampling and memo writing when conducting a constructivist grounded theory are not linear; they are in fact interlinked, as illustrated in Figure 3.2. A detailed analysis of the study is presented in Chapter 4 and relevant discussion is made in Chapter 5.

Figure 3.2 Analytic process in conducting constructivist grounded theory



One of the challenges I faced during the data analysis stage was knowing when theoretical saturation was achieved so I could cease data collection. As mentioned earlier, the recruitment process was challenging, as mental health is a highly stigmatised subject in Chinese culture. It took seven months of active recruiting (August 2015 to February 2016) to gather the final 12 participants. According to Charmaz (2012), theoretical saturation is achieved if no new properties emerge in the theoretical categories. Nonetheless, according to Mason (2010), the concept of theoretical saturation lacks practical guidance for novice researchers like me. Again, I relied on constant comparison and reflective memo writing in recognising data saturation. The data collection ceased after 12 participants, as I believed I had gathered sufficient data to support my theoretical categories (Charmaz, 2012).

3.3 Ethics of the study

The research was conducted in line with the BPS (2009) and HCPC Codes of Ethics and Conduct (2010). During the recruitment stage and prior to commencement of the interviews, participants were informed about their right to withdraw up to four weeks after the interview. As with grounded theory, once the data had been analysed into the theory, the participants would not be able to exercise their rights to withdraw. All participants were informed about the confidentiality of the data, with the assurance that the data would only be used for research purposes and be accessed by selected personnel such as supervisors and researchers. All data was stored safely with password protection. Participants were given a copy of the analysis and the opportunity to review the material if the study is published. Each participant was briefed at the beginning and end of each interview. An ethical approval code for the research was obtained from the City University Research and Ethics Committee (PSYCH(P/F) 14/15 128) and no additional approval was needed from third parties. It was the researcher's duty to ensure all participants were well-informed about the purpose and processes of the study. The participants were briefed about both the risks and benefit in participating the study.

The in-depth semi-structured interview method used for this study has many benefits, such as allowing the researcher to work in partnership with the participant and explore the core issues. The interviews needed to be conducted with transparency and empathy, which could strengthen the relationship between the researcher and participants and

allow greater insight into the issues of the study. However, as a researcher, I had to also acknowledge that insight comes with certain ethical risks that need to be addressed both before and during the interview process, especially when discussing issues and private matters that could be potentially traumatic. The World Health Organization's Ethics Research Committee (WHO, 2011) outlines some of the common causes for potential harm which this type of study could result in:

1. Psychological trauma for participants.
2. Breaches of confidentiality and privacy.
3. Stigmatisation through either breach of confidentiality or inadequate attention to gender or privacy issues.
4. Failing to respect a participant's traditional cultural values." (p27)

It was of the upmost importance for me to be aware of these potential problems when the interviews were being conducted and be constantly reflective during the interviewing process. The recruitment of participants for this study was conducted without any monetary compensation. The potential benefits and positive impact of this study was fully explained for the service users to engage with.

3.4 Rigour

Methodological rigour and continuous vigilance were aspired to in order to achieve reliability and validity in the research, which is particularly important in qualitative research as analysis can be subjective to an individual researcher's input. Due to the lack of numbers in qualitative research, some leading researchers have argued that new criteria need to be adopted to determine reliability and validity in the qualitative paradigm (Lincoln & Guba, 1985; Leininger, 1994; Warren, 2002). Guba (1981) published an influential work on the subject of the reliability and validity of qualitative research and combined both into the concept of "*trustworthiness*" (p. 75). Guba also proposed four categories that "trustworthiness" can be assessed by: credibility (validity), dependability (reliability), transferability (generalisability), and confirmability (objectivity).

Validity refers to the "degree to which what is observed or measured is the same as what was purported to be observed or measured" (Robson, 2002, p. 553). Qualitative research often lacks standardised statistical methodology to measure the result, so a

qualitative study could be criticised for not being as scientific as a quantitative study. To ensure that I was accurately representing the data, I needed to reflect on my values and stances while also paying attention to the participant's willingness or ability to be open and congruent with their true thoughts and feelings. This is considered to be the main risk surrounding the validity of qualitative studies (Silverman, 2011). Reflectiveness is crucial when conducting a study using constructivist grounded theory methodology, as the researcher co-constructs meaning with the participants. Detailed reflective processes are explored in the reflexivity section and in Chapter 5. Throughout the data collection stage, various efforts were made to engage the participants in open conversation to share their thoughts and feelings openly (as illustrated in the data collection section) with the aim to build validity for the study. To enhance validity, it is important for the researcher to explain how the theoretical constructs were derived from the data collected and be reflective of which perspective these constructs reflect on (Gasson, 2004). In constructivist grounded theory method, initial data must be presented in the analysis process to demonstrate a link between the emerging theory and the original data, which is explored in Chapter 4. Constant comparison is also critical when addressing the validity of the study, which I carried out throughout the research process.

Reliability refers to the consistency of the results (Guba, 1981). Potential methods to satisfy reliability issues include clearly defining the data collection and data analysis procedures, ensuring these procedures are properly recorded throughout the process and presenting the data in a transparent and informative way (Gasson, 2004). I believe recording the interviews and later transcribing and translating the material myself added to the reliability. Final extracts from the interview were used in the final report, which demonstrate that my interpretation was well supported by the evidence (Lewis & Ritchie, 2003). Memo writing was also instrumental in building reliability, as discussed earlier.

Generalisability describes the extent to which the current research findings can be applied to other settings (Guba, 1981). With a relatively small number of participants (total of 12), the generalisability of this study focuses on recognising the experiences that arise specifically from Chinese culture and the Chinese immigrant population, rather than seeing what people have in common in a much more general sense (Willig, 2001). The aim of this research was to achieve an understanding of this group, as

suggested by Charmaz (2011). The implication of these research findings is considered in Chapter 5. With a relativist ontological stance and a constructivist epistemology, this study does not claim to be totally objective. In the case of this study, rigorous and reflexive self-awareness is substituted for objectivity (Gasson, 2004) to account for the subjectivity in the research findings, which was explored in detail in Chapters 2, 3 and 5.

Elaborating on Guba and Lincoln's original work (1981), Patton (2002) further identified standards of quality and credibility as signifiers about the issue of subjectivity in qualitative research. He also nominated "*dependability, a systematic process systematically followed*," (p. 546) and "*triangulation, capturing and respecting multiple perspectives*" (p. 546) as two key elements when checking the quality of qualitative research. Different types of triangulation methods were identified by Patton (1999): method triangulation, triangulation of sources, analyst triangulation and theory/perspective triangulation. Method triangulation involves using different data collection methods to check for consistency in findings. I did consider conducting a focus group in addition to the in-depth interviews in my own study. However, as the subject of mental health is highly stigmatised in Chinese culture, I believed that a focus group would not have been appropriate for this research topic as participants might not have been willing to discuss the subject openly. Triangulation of sources could be conducted in the form of respondent validation or member check (Mays & Pope, 1995), where the researcher returns to the participants asking them to validate the analysis. Whilst this triangulation of sources could potentially help to refine the themes of the study and generate theory, this process could have resulted in participants changing their viewpoints and even withdrawing from the study (Long & Johnson, 2000). Given that the subject of mental health is highly personal and sensitive, even potentially traumatising, I concluded that re-engaging participants on the topic for respondent validation was not appropriate for this study.

Analyst and theory perspective triangulation can be conducted through peer review (Barbour, 2001). During the research process, I worked closely with my supervisor and peers to conduct an analyst triangulation by comparing code and debriefing notes to ensure the adequacy of the study (Guba & Lincoln, 1981; Lincoln & Guba, 1985; Guba & Lincoln, 1982). In addition, I asked one independent researcher on Chinese cross-cultural studies to review the interview transcripts (both original and translated) and the

data analysed to give her perspectives on the themes that emerged, especially relating to Chinese cultural perspectives (Cutcliffe & McKenna, 1999). Given the quantity of the information generated, only three participants' transcripts were reviewed by a peer. All names and identifying details were changed to further protect the participants' identities for confidentially purposes. This process helped to further guard against research bias and provided additional insights into the theme (Andrews, Lyne, & Riley, 1996).

3.6 Reflexivity

Rigorous and reflexive self-awareness were substituted for objectivity (Gasson, 2004) in this study. The only way to account for this subjectivity was through constant and explicit processes of reflexivity (Smith, 1999). Reflexivity concerns the process of critical self-reflection on my own biases and theoretical predispositions (Schwandt, 1997). Klein and Myers (1999) offered four principles for research conducted interpretively, which can be used to understand reflexivity in regard to this study:

1. The principle of interaction between the researcher and the subject (which tries to understand how the researcher impacts the data). It was inevitable that my own experiences and background would impact the study. The subject is personal to me and there was potential for me to become dangerously over-involved. Charmaz (2000) has suggested that researchers openly acknowledge the influence of prior work or experiences. Memo writing helped make me more aware of my own potential effect on the data.

2. The principle of dialogical reasoning (which focuses on contradictions between theory and data). With grounded theory it is important to give a voice to participants and let the theory emerge rather than force the study in certain directions. The constant writing and reviewing of the memos in grounded theory helped me to be vigilant and self-reflective during the course of the study.

3. The principle of multiple interpretations (which means one single incident could have many different interpretations). While my own understanding was an inter-connected part of the process from which categories emerge, those categories had to be inductively derived from the data with constant comparison and reflective memo writing.

4. The principle of suspicion (which means potential biases and distortion could be present). Certain biases and distortion would arise during the course of this study due to my own background and experiences. Finding a way to overcome this while at the same time maintaining an emotionally sensitive position was a challenge for me during this research, which I addressed through personal therapy and guidance from my supervisor.

Even with all these reflective procedures in place and a personal commitment to reflexivity, it would still have been naive of me to think that reflexivity would be easily achieved throughout the process. Therefore, I also kept a reflective log throughout the study. The log enabled me see a clear separation between my own thoughts as a Chinese counselling psychologist in training and those of my participants. The log also documented my own feelings and experiences in the research process and helped me make sense of some of the analytic decisions I made. As a counselling psychologist, reflective practice is part of my responsibilities and obligations to myself and society (BPS, Professional Practice Guidelines, 2008). Given the importance of reflexivity (and in addition to the reflective log which I kept throughout), I also conducted a reflective interview with myself where I asked myself a series of questions regarding the interview and data analysis process. A reflective interview with the interviewer was a critical turning point where I turned the investigative lens on myself, which helped me to be more aware of my assumptions on the researched topic, as well as my emotional responses in interviews with participants (Blee, 1998; Wasserfall, 1993). An overall reflection for the research process is included in Chapter 5.

An excerpt of the reflective interview is presented here:

Q: Do you think the cultural similarity between the interviewer and the participants is beneficial for the interview process?

A: Interviewing participants from a similar cultural background created an unexpected paradox during the interview process. On the one hand, our shared Chinese background allowed the participants and I to form a good rapport at the beginning of the interview, which was crucial to the success of the interviews. However, a different set of challenges emerged when interviewing ethnically matching participants, such as “assumed similarity” (Raja, 2015) and the difficulty of maintaining my own private frame and boundaries during interviews.

Q: How does "assumed similarity" affect the interview process?

A: When interviewing participants, I felt it was easy for me to understand their cultural values and personal histories because of our similar cultural backgrounds. At the same time, it was important for me to be vigilant about my own cultural assumptions throughout the interviews and data analysis process, as each participant tells a unique story. Cultural perspectives can be viewed differently, even within the same culture. This "assumed similarity" could also occur on the participant's side, where they would "assume" that I understood their viewpoints because I was also a Chinese immigrant. I would make additional efforts to clarify their specific experiences and the meaning attached to them when issues of "assumed similarity" arose during interviews.

Q: Why was maintaining your private frame and boundaries during interviews important?

A: As a collective society, the word "privacy" means something very different in Chinese culture. In fact, there is not a single Chinese word that incorporates all the meanings attached to "privacy", ranging from the inner, the personal and the concept that family life can be separate from the public (Zarrow, 2002). Purnell (2012) further suggested that "privacy" has negative connotations in Chinese culture which suggests "*underhand, secretive and furtive*" emotions (p. 184). Traditionally, Chinese people grow, work and socialise closely within the community, so social relationships and support are considered more important than "privacy". Therefore, Chinese people often ask each other personal questions about age, salary, marital status and so on (Purnell, 2012), which means my participants would often ask me these questions. If I did not respond to these questions, I would appear to be trying to be distance myself from my participants. I am aware of the power dynamic in the interview process and I wanted to be personable to my participants; but at the same time, I also wanted the interviews to be clearly focused on their experiences, rather than diluted by my own narratives. Balancing the interview/interviewee relationship was a major challenge. I decided to utilise the debriefing section of the interview to share some of my own personal experiences with participants (if they were interested), which ensured the interview was solely focused on the participant's experience, while at the same time addressing some of the power dynamic issues between myself and the participants.

Q: What do you think you excelled at during the research process?

A: Being empathetic and emotionally engaging with all my participants, which my training as a counselling psychologist enabled me to do. I did not only care about what kind of data my participants gave me; I also cared greatly about the participants' personal journeys. The interviews were not a pragmatic means to "scoop up the data and be done with it" but also were a means to understand their experiences. I hope the result of my research can benefit mental health practitioners in better understanding the Chinese immigrant community.

Q: What do you think the potential drawbacks might be?

A: As the research subject is personally connected with myself, I often worry that I might be overly involved in the research process. Critical self-examination is the key to preventing this problem. My own assumptions, beliefs, values, thoughts, feelings, experiences and unconscious agenda were constantly examined, using various methods like discussions with my peers, meetings with my research supervisor and personal therapy, which were all instrumental in the research process.

CHAPTER FOUR: ANALYSIS AND RESULTS

Look to find the forest, not just a few trees

- *Chinese proverb*

4. 1 Introduction

This chapter demonstrates how constructivist grounded theory methodology was used to generate a theoretical model on the research question. As previously mentioned in Chapter 3, this research was conducted with the guiding principle of constructivist grounded theory, not only as a way to learn about the world, but also as a method for developing theories to understand them (Charmaz & McMullen, 2011). Charmaz (2001) in particular highlights the importance of evoking the experiences of the participants in the final analysis stage. As suggested by Charmaz (2001), this current study focuses on making meaning from the data, and rendering participants' experiences into comprehensible theoretical interpretations, presented in the form of working model.

This study is interested in the Chinese mental health service users' experiences, specifically focusing on mental health beliefs and mental health treatment expectations in the context of Chinese cultural perspectives, which is the basis for generating a theoretical model. After identifying four main categories from the collected data and linking them together, the theoretical model emerged through "*the integration of concepts that aims at an increased understanding of the area of enquiry through the novel contribution it provides*" (Charmaz, 2006, p. 200; Clarke, 2005). A theoretical model can provide a "working theory" of action for the specific context (Dwivedi, 2009) of mental health services. As previously mentioned, this study represents a rare opportunity to examine mental health beliefs and mental health treatment expectations in the context of cultural perspectives by analysing the Chinese immigrants' own voices. This is the focus of this chapter and the researcher's comments aim to help the integration of categories and their properties, while also providing a comparative literature review from the conceptual framework discussed in Chapter 2. The chapter is presented in the order of the process as it emerged.

4.2 Four main categories

The four main categories identified are: experiences in the context of cultural perspectives, changing mental health beliefs, evaluations of the current mental health service and the review of treatment expectations. Category one accounts for the ways in which participants construct and perceive the meanings of their experiences, viewpoints, emotions, and attitudes in relation to Chinese cultural perspectives surrounding the subject of mental health. Category two explores the ways these experiences shape mental health beliefs, both before accessing mental health services and after. These experiences of accessing the service led to accounts about how the current mental health service is evaluated, which forms category three. Mental health expectations are reviewed in category four. These four categories all began to form early on in the data collection and analysis processes and emerged through continuous theoretical sampling and theoretical saturation, developing into main categories as Charmaz suggested (2006). After translating the transcripts into English and through constant comparative analysis of the initial and focused codes, subcategories emerged which elucidated aspects of each category. To help illustrate each category, a diagram for each category is provided, which also includes subcategories and themes.

The next section of this chapter introduces an overview of the process through which the four main categories emerged from the analysis. Each category is presented with subcategories and themes which are supported by the extracts from the translated transcripts. In particular, a comparison between the main themes that emerged from the analysis and the existing literature in the field is provided throughout, as is advised by the constructivist grounded theory approach (Charmaz, 2006).

4.3 Category one: Experiences in the context of cultural perspectives

This category primarily accounts for the ways in which the participants understand and construct their viewpoints, emotions, and attitudes in relation to the Chinese cultural perspectives surrounding the subject of mental health. Participants were asked how Chinese cultural perspectives are related to mental health. The narratives from the participants led me to introduce the subcategories of societal, gender and mental health, while showing how all three sub-categories intersect and shed light on how Chinese cultural perspectives are perceived in relation to understanding mental health.

Several aspects were common amongst all participants within the societal subcategory. An issue voiced by all participants was the difficulty they experienced when trying to share their feelings. They talked about this experience through the context of Chinese cultural perspectives:

P1 Rose:

"We (Chinese) are always educated not to reveal our emotions and not to express them… To be honest, it's too difficult for people in such (a) culture to frankly express their mood and emotions"

P2 Stone:

"Because I couldn't share my feelings with anybody"

Lily (P3) talked about how sharing feelings is difficult for Chinese people, even within her own family:

P3 Lily:

"As Chinese, we are reluctant to share inner feelings, even with family members".

April (P4) made a similar comment about how Chinese people do not feel comfortable talking about personal affairs and how it was difficult for her to share her feelings.

P4 April:

"Chinese people are more cautious and they are not comfortable in telling others their personal affairs… it's really not an easy thing for me to talk about my private issues.

The difficulty of talking about feelings is closely linked with the wider Chinese culture according to participants May (P5), June (P6), Wood (P7), Max (P8) and Jay (P11).

P5 May:

"(Being) born in a Chinese family, (means) we also don't talk about feelings much"

P6 June:

"We Chinese are not good at expressing our feelings or what's on our mind"

P7 Wood:

"Maybe because I am a Chinese, I am reluctant to share my feelings with others".

P8 Max:

"Personally I think the Chinese culture will make you shut up yourself, know not how to express yourself, and sometimes become pessimistic or keep all the feelings to yourself."

P11 Jay:

"It's very difficult for Chinese people to express their feelings, especially. We are not trained in feelings and emotions"

A common aspect expressed by all of these participants was their awareness about the discouragement towards expressing their emotions in Chinese society, regardless of their background and gender. Another common aspect discussed by the participants was the influence of enmeshed family dynamics. Minuchin's (1974) concept of the enmeshed family explains how "diffuse, sub-systems undifferentiated, and over-concern for others leads to a loss of autonomous development" (p. 244). In the context of Chinese culture, the enmeshed family can be described as "overly close" (Rothbaum, Rosen, Ujiie, & Uchida, 2002), and the dynamic can represent itself in different ways. Common examples include how children in Chinese families are not expected to leave home until they are married, or that a child's autonomy is not respected or will only be acceptable to the family when it is culturally congruent, or that Chinese parents may consider it perfectly acceptable to enquire into their children's affairs (Lam, Chan, & Leff, 1995). This concept is elaborated here by the participants' experiences. Rose (P1) talked about how her family lacks a sense of equality and how her family members are interdependent on each other.

P1 Rose:

"And to be honest, my family doesn't have democracy".

"Mutual interdependency! Very amazing. I want to escape from it, but an invisible thread leads and connects me".

Stone (P2) talked about how marriage arrangements in Chinese society occur.

P2 Stone:

"For example, I tell him (the mental health professional) that in China marriage is decided by parents".

May (P5) expressed her feelings about how being too close to her mother can cause arguments.

P5 May:

"we also quarrelled with each other because we were too close to each other."

This view is shared by June (P6) that the Chinese parent-child relationship can be too close.

P6 June:

"Chinese parents and children are too close to each other".

Max (P8) discussed the "over attentiveness" that Chinese parents have for their children.

P8 Max:

"the Chinese are very attentive to the children… Sometimes I think I'm too attentive too, and I think we should learn to let it be because everyone has his or her own personality."

August (P9) talked about how she feels the need to make her parents happy and how she works very hard to meet their high expectations.

P9 August:

"But at that time, I always thought that I should have great grades for that would make my parents happy and I would work hard to meet their expectation".

Henry (P12) talked about his parent's dependency on him and the expectations that they have about being cared for by Henry when they are old.

P12 Henry:

"I also find my parents are the most dependent on me… they cared much about me being with them, like all the time!"

> "They wish for a very interdependent relationship with me... They also wish to depend on me when they are old; I suppose (they want me) to be the one that looks after them in their old age."
>
> "Chinese culture values family much. I also care much about my family's view towards me".
>
> "Looking back, I think Chinese parents lack understanding and respect towards their children. I know they love me, but it's very different (for) western parents, I think."

Enmeshed family dynamics, expressed here by the participants, is one of the most important aspects in understanding the participants' experiences in the context of Chinese cultural perspectives. Participants also talked about the importance of face (or "mian zi") within the societal subcategory. In Chinese culture, mian zi represents one's dignity, prestige and status in the eyes of others (Bond & Hwang, 1986). It is a concept that is dynamic and can change with one's circumstances. It can be earned, given, taken away or lost due to one's behaviour. (Bond et al., 2010; Bond & Hwang, 1986). Fear of reflecting poorly on the self and the family or losing respect in public is referred to as the loss of mian zi (Zhang, Conwell, Zhou, & Jiang, 2004). The participants expressed their views on this issue:

> P2 Stone:
>
> "There are circles in Chinese culture and the mian zi matters much".
>
> P4 April:
>
> "For businessmen, mian zi is everything … Chinese give great regard to mian zi…"

Wood (P7) explained the emphasis on mian zi in traditional Chinese culture:

> P7 Wood:
>
> "As a Chinese, I have been influenced by traditional Chinese culture more or less, including the heavy weight of mian zi and pressure from social relations."

P8 Max:

"We Chinese are indeed very concerned about mian zi saving. It's out of vanity perhaps. We don't like to be looked down upon."

P9 August:

"Perhaps to look good in front of others, more or less, you know, to have mian zi. If your child does very well at school, you would look great in front of others".

Mian zi featured a few times in Poppy's (P10) narrative:

P10 Poppy:

"Also, there was the mian zi issue which is deeply rooted in Chinese culture".

"Chinese parents encourage their children to value their mian zi the first thing upon birth before teaching them anything else!"

"In such a social and family environment, everyone learns to care about mian zi naturally."

Henry (P12) believes mian zi influences how people view him.

P12 Henry:

"It's about mian zi as well. How would other see me and see them? What would other people say about me?"

Of the main themes that emerged in the societal subcategory, the difficulty of sharing feelings, enmeshed family dynamics and mian zi are the most imperative. These insights shared by the participants contribute to our understanding of their experiences in the context of cultural perspectives on a societal level.

Gender is the second subcategory within the context of cultural perspectives. This subcategory emerged after the process of theoretical sampling. The subject of how female and male gender roles are perceived as unequal by the participants recurred after translating and coding two interviews from female participants. According to research conducted by the World Health Organization (WHO, 2004), gender influences how much control men and women have over key aspects of their lives and can affect mental health. It is important that any researcher takes gender into account when considering mental treatments and outcomes (WHO, 2004), which is why I decided to explore the

subject in more depth. Given that both participants' accounts were from a female perspective, I subsequently recruited more male participants to help present a more dynamic and balanced viewpoint. When interviewing both male and female participants, the subcategory of gender and the theme of gender inequality emerged. Below are some of the extracts demonstrating the participant's experiences. Rose (P1) talked about how she experienced gender inequality as she was growing up:

> P1 Rose:
>
> "Men are praised for physical strength and literacy is not so valued… They should be good at drinking alcohol and eating large pieces of meat. As women, men are often very chauvinistic."

April (P4) talked about gender inequality in relation to her husband's traditional Chinese upbringing:

> P4 April:
>
> "My husband is a very traditional Chinese. His dad is the master of family".

May (P5) talked about the difference in gender roles within Chinese society, which was echoed by Wood (P7):

> P5 May:
>
> "It's also a kind of gender inequality in China. As a whole, according to the dominant culture, males stand at the heart of the society, while females possibly serve as good wives, just acting a helping role so they don't have so much pressure".
>
> P7 Wood:
>
> "Also in China, boys are expected have a very successful careers and girls are expected to have a good marriage or to look perfect".

Max (P8) elaborated on this gender inequality in more detail, suggesting the parental preference for boys is caused by the cultural concept of males continuing the family name. He also attributed gender inequality in traditional Chinese society to the influence of agricultural ways of living. Max further acknowledged gender inequality in the context of Chinese culture, but also expressed that men face higher expectations as a result of gender inequality, which Jay (P11) also mentioned.

P8 Max:

"I think Chinese parents still prefer boys to girls and they are not as aware of gender equality as western parents. They think that daughters will marry others eventually and only sons can carry on the family name".

"I think this is part of Chinese culture too. You see, the Chinese character "Nan (Man)" consists of "Tian" (field) and "Li" (manpower), implying the dominant role of the male. In the agricultural society, the field and the manpower were the most important production factors. Though it's no longer the case, yet it's hard to change some deeply-rooted ideas. On one hand, the male shoulders a lot of responsibilities, and on the other, he is expected to be steady"

P11 Jay:

"Maybe the expectations on boys are different. Also, boys are told to achieve more, be more successful and have more responsibility".

As the only boy in the family with two sisters, Henry (P12) experienced preferential treatment when compared to his sisters, which highlights gender inequality within Chinese families.

P12 Henry:

"I think my parents treated me and my sister very differently… I think I can say that my parents favoured me. For example, I always got the best food at the family table and my sisters were told to not to fight with me".

The next subcategory explored the participants' experiences of mental health in the context of cultural perspectives. Most of the participants had very limited knowledge about mental health. Rose talked about how she feels her cultural background is related to her lack of understanding of mental health, a view also shared by Stone (P2).

P1 Rose:

"I feel my understanding of mental health was very limited because of my cultural background".

P2 Stone:

"No, I didn't have much understanding. Well, in the background of Chinese culture, they'd rather ask for advice from a fortune teller than visit a psychologist or a Western-style doctor".

April (P4), Wood (P7), Max (P8), August (P9) and Poppy (P10) all mentioned that they knew very little about mental health.

P4 April:

"I knew nothing at all!"

P7 Wood:

"We just don't know much about mental health."

P8 Max:

"No, actually. I knew little about it."

P9 August:

"At that time, I didn't quite understand what mental health was".

P10 Poppy:

"I knew nothing about this field…"

Jay (P11) mentioned he had some basic ideas about mental health, but overall had access to a very limited amount of knowledge, which was echoed by Henry (P12):

P11 Jay:

"I had some idea, but I wouldn't say I know about it."

P12 Henry:

"I had some basic understanding of it… like depression".

The next theme that emerged in the subcategory of mental health was that mental health issues are perceived to be stigmatised and discriminated against. In particular, mental illness is closely linked with the term "psycho" (Shen Jing Bing), a derogatory way of implying a "non-human status" or that of a "lunatic" (Yang et al., 2010). All participants expressed this view in their narratives. Rose (P1) recalls how the reporting

of a psychotic patient killing his roommates in 2007 fused the attitude of social stigma towards mental health:

P1 Rose:

"One year earlier (2007), there was a murder by Ma Jiajue (a university student who killed his roommates) and since then everyone had such negative association since the murder and everyone thinks if you have mental health issues, you might start hurting people… Yes, there's so much stigma in general…"

Stone (P2) talked about the consequences of being labelled as a "psycho" in the context of Chinese culture:

P2 Stone:

"I don't tell my family when I am in trouble, afraid that they might think of me as a psycho… when others call you a psycho, they forget all your advantages and merits. You are just a psycho to them… Once you are labelled, people are afraid of you whatever you do… Afraid of you, your behaviours and all things related to you. Once you are labelled, it might be hard to find a wife or even talk with others because they don't trust you as they did in the past. They will think of you as an unreliable person that can't be counted on".

Lily (P3) and April (P4) talked about the negative connotations attached to the term "psycho":

P3 Lily:

"Moreover, in Chinese culture, people will think of you as a psycho once you go to a psychologist."

"People with mental disorder are psychos. Maybe you are not totally insane; doing foolish things like getting naked in the street, but it's of the same nature."

P4 April:

"In their mind, depression equals to psycho…I have encountered lots of misunderstandings since then and it feels horrible."

May (P5), Wood (P7) and August (P9) all discussed the discrimination and prejudice directed towards people suffering from mental illnesses, whilst Max (P8) made comments about how people are fearful of "psychos".

P5 May:

"I know that Chinese (people) somewhat discriminate against people suffering from mental problems… People would look down upon the patients, thinking there was something wrong with their mind".

P7 Wood:

"Chinese culture, traditional Chinese culture in particular, tends to have prejudices over mental diseases. If someone has the tendency of depression or autism, others will take him as a psycho and stay away from him".

P8 Max:

"In China, if one has mental illness, he will be regarded as a psycho and despised because everyone else is afraid of him".

P9 August:

"What's worse, if someone was said to have psychological problems, he or she might be discriminated against a little bit. We used to call such a person psycho".

Again, this narrative of discrimination was consistent with all participants; a final extract from Poppy's account emphasised this shared understanding.

P10 Poppy:

"I even thought only those psychos needed psychologists… In Chinese culture, psychos are total nuts who can't control their own behaviour. They become nuts because they are out of control. Their behaviour makes normal people think of them as mad men. This is the Chinese concept about mental diseases".

The final theme that emerged from the subcategory of mental health was that mental health problems are attributed to physical symptoms and somatised. The term "somatisation" can be described as a tendency to experience and communicate psychological distress in the form of physical symptoms (Lipowski, 1988). Given that the participants interviewed had limited knowledge about mental health issues which

develop in a society with a high level of stigmatisation and discrimination towards these issues, many participants attribute their psychological concerns to physical symptoms and somatise their mental health difficulties (Tseng, 1975; Kleinman, 1977; Nguyen, 1982; Gaw, 1993; Chun et al., 1996). Stone (P2) talked about how he initially went to seek help because of his problems sleeping and later received CBT treatment for anger issues:

P2 Stone:

"I went to my GP to talk about my poor sleep... I now realise that I am an angry person who has control issues."

April (P4) shared similar experiences when she initially noticed her overeating and sleeping problems and was recommend to a counsellor after talking with her GP.

P4 April:

"The initial symptoms were probably over eating and sleeping problems".

May (P5) first reported her problems with disrupted sleep patterns before undergoing inpatient psychiatric treatment:

P5 May:

"I slept a lot and ate a lot as well. I was somewhat different from normal people. It seemed that people always suffered from insomnia while I was always sleepy".

Max (P8) talked about his lack of sleep and appetite that made him seek help from his GP and was later recommended to take therapy services.

P8 Max:

"I was not able to eat or sleep…"

August suffered from insomnia and was later diagnosed with postnatal depression; she talked about her decision to seek help:

P9 August:

"I just couldn't sleep at night for a couple of months. I didn't think I could hold on any longer. I couldn't get any sleep, so I went to the GP for help."

Poppy (P10) talked about how she suffered from a poor appetite and sleep problems after her husband passed away. Later she accessed local bereavement services through a recommendation from her GP.

P10 Poppy

> "I wasn't eating and sleeping properly, and I also lost interest in all things and was barely looking after myself and my daughter. After six months, my GP told me that he would find a therapist for me".

4.3.1 Overview of Category One – Experiences in the context of cultural perspectives

Participants portrayed their experiences in the context of cultural perspectives in the subcategories of societal, gender and mental health aspects. The main themes within this category included the difficulty of sharing feelings, enmeshed family dynamics, the imperativeness of mian zi, gender inequality, that views of mental health had developed in a society where mental health issues are stigmatised and discriminated against and that mental health is a hidden subject (Figure 1). Kashima and Gelfand (2012) suggested culture means a set of "meanings or information that is non-genetically transmitted from one individual to another, which is more or less shared within a population (or a group) and endures for some generations" (p. 3). I believe this concept is reflected in category one.

The narratives of the participants in this category are consistent with the literature on Chinese culture, which was cited in Chapter 2. According to Tseng, Lin, and Yeh (1995), traditional Chinese culture promotes individual conformity, emotional restraint and the collective values of a society and family, which could explain the difficulty participants had sharing their feelings and the enmeshed family dynamics. In a survey conducted on Asian-American adults (Pew Research Centre, 2012.), it was found that 68% of Asian-Americans adults felt that their parents should have some influence on their career decisions and 66% felt that parents should have some influence on their child's choice of spouse, which was reflected in Stone's (P2) narratives. Evelyn Lee (2000) also stated that many Chinese young adults in America struggle with the dilemma of how to be differentiated and individuated within an extended family that is unusually enmeshed by the standards of their host nation. Although not specifically

focused on Chinese immigrants in the UK, the above studies have shown that the interdependence of family members in Chinese culture is a common phenomenon.

Gender is a critical determinant of mental health and mental illness (WHO, 2004), and the gender inequality experienced by the participants is possibly explained by the fact that men have more social status than women in traditional Chinese society (Pek & Leong, 2003; Marshall, 2008; Lai & Bond, 1997). From the sensitising concept of the dynamism of Chinese philosophies researched in Chapter 2, it was suggested that Confucianism believes women should behave in a submissive way, and "three obedience and four virtues" (San Cong Si De) were imposed on women. Labour divisions are very much based on gender in a traditional Chinese household, with the men in the family making major decisions while the women are responsible for taking care of family members (Wong, 1972; Chan & Lee, 1995). The view of men being the "master of the family" is reflected both in April (P4) and Max's (P8) narratives.

The phenomena of face (mian zi) has also been illustrated in many previous Chinese studies within the dynamism of Chinese philosophies. In the view of Confucianism, an individual's achievement mainly depends on moral effort and a negative outcome is solely due to moral failure (Lam et al., 2010). An individual's mian zi can be seen as a perceived position in a social network; it can also be drawn from personal wealth, physical appearance, professional career background, educational level and family background (Ho, 1976). Mian zi is at the core of the Confucian doctrine that sees the individual as a "person in relation" rather than a free standing agent (Hwang & Han, 2010; Chin, 2005). Fundamentally speaking, mian zi (in Chinese terms) encompasses social reputation and has enormous social importance in Chinese culture (Hwang & Han, 2010). Traditional Confucian values have a great impact on modern Chinese culture, including the medical and health care sectors (Guo, 1995). Therefore, the concept of mian zi hugely influences mental health beliefs and treatment seeking behaviours.

The lack of knowledge about the concept of mental health is also supported by existing literature. Previous studies (Sproston et al., 2001; Chen & Kazanjian 2005) argue that the underutilisation of the mental health services within the Chinese community suggests that the amount of knowledge about mental health is very limited amongst Chinese immigrants. Studies have also found the stigma and discrimination surrounding mental illness is particularity pervasive and problematic within the Chinese community (Yang & Kleinman, 2008). Various studies (Ng, 1997; Phillips & Gao, 1999) have

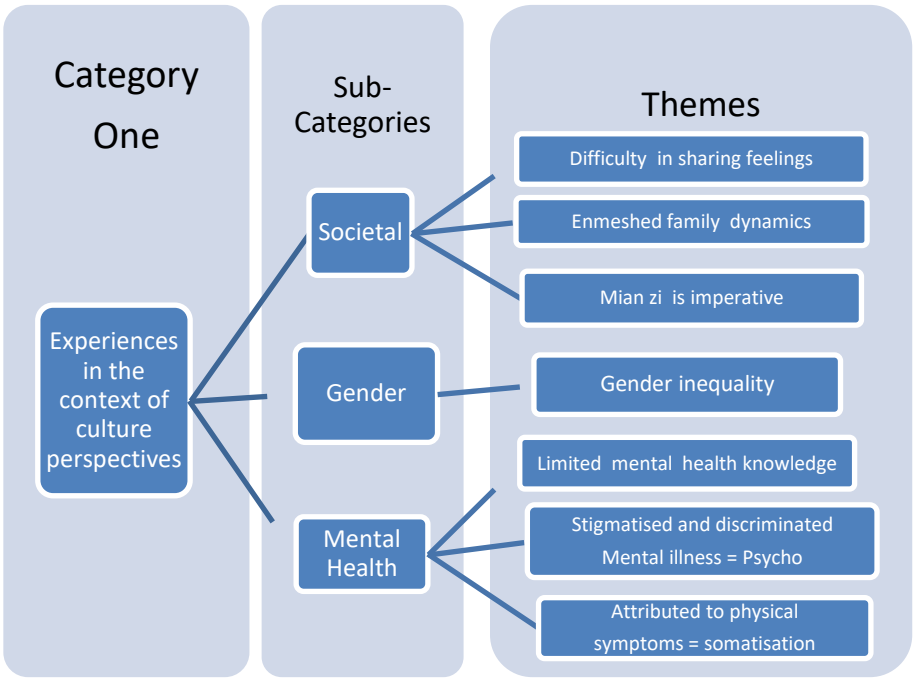
suggested that in Chinese culture people with mental illness are often perceived as dangerous and disruptive by society, which is reflected in the narratives. A study conducted by Tsang and colleagues, (Tsang, Tam, Chan, & Cheung, 2003) found almost 30% of 1,007 community respondents described people with mental illnesses as "quick-tempered" and agreed to comments that "people who had been mentally ill are dangerous no matter what." This perceived view of unpredictable behaviour being linked to mental illness is also reflected in the participants' narratives when they associate mental illness with the term "psycho". The adverse effect of stigma on mental health across all cultures is well documented (Markowitz, 1998; Perlick et al., 2001; Phillips, Pearson, Li, Xu & Yang, 2002). For mental health service users, mental health stigma can negatively impact their personal and professional relationships; subsequently mental health related stigma will significantly limit their views of self-worth, aspirations and capabilities (Thornicroft, 2006). Early studies suggested that simply being known as a psychiatric patient has adverse effects on an individual's reputation (Goffman, 1963, 1968; Gove & Fain, 1973) which is reflected in many participants' comments.

When conducting a review on understanding this stigma within the Chinese community, I found the symbolic interaction approach was the most appropriate method to explain mental health stigma. Symbolic interaction focuses on the concept that an individuals' knowledge and understanding of the world occurs through social interactions (James, 1907); therefore, an individual's 'self' is a product of social interaction, something that is in constant development through every social interaction and other experiences (Mead, 1938). The symbolic interaction model of stigma places emphasis on the interactions of individuals who are labelled 'mentally ill' and their social environment (Roe, Joseph, & Middleton, 2010). This framework invests in understanding the meanings generated in such interactions, which validates perspectives from the mental health service users (Clifford et al., 1991). Early literature on the symbolic interaction model of stigma saw Szasz (1960) argue that the label of 'mentally ill' is a socially constructed phenomenon arising within the institutionalised settings of mental health services. This argument is still very relevant in understanding mental health stigma in the Chinese community. As noted in Chapter 2, mental health systems in China (Liu et al., 2011) are primarily hospital-based care systems. This institutionalised setting of mental health services in China could facilitate our understanding about the stigma surrounding mental health within the Chinese community.

The somatisation of mental health issues could be related to Chinese cultural perspectives, as various research has suggested that different cultures can influence the expression of somatisation (Katz, 2014; Kleinman 1986). According to Katz (2014), individuals believe that they can seek treatment in a non-stigmatised and blameless way by expressing emotional distress through physical symptoms (Katz, 2014). Kleinman (1986) further explored the concept of somatisation as a "cultural idiom of distress" (p. 277), resulting from a negotiation between social and personal requirements. A study conducted by Kleinman (1986) in a Chinese psychiatric clinic observed the phenomena of neurasthenia (Shen Jing Shui Ruo), a term that encompasses a wide range of physical symptoms like insomnia, fatigue, dizziness, and headaches. The study found that 30% of patients would seek help for the symptoms of "Shen Jing Shui Ruo" whilst only 1% reported depressive symptoms (Kleinman, 1986). The study also found that although somatic complaints were central to the patients' reported distress in the Chinese psychiatric clinic, over 80% of the patients could be re-diagnosed as having some form of depression based on criteria in the Diagnostic and Statistical Manual of Mental Disorders during that time (American Psychiatric Association, 1980). Many later studies supported Kleinman's findings and have suggested that emotional distress is often presented with somatic symptoms such as neurasthenia in Chinese culture (Kleinman, 1986; Farooq et al., 1995; Kirmayer, 2001; Mak & Zane, 2004). Insomnia is one of the most common physical symptoms (Yeung & Deguang, 2002), which is also reflected in the participants' narratives. Studies conducted outside of China also provided evidence for the somatisation of mental health issues. Lin & Cheung (1999) found that Asian patients are more likely to report their somatic symptoms, such as dizziness, while not reporting their emotional symptoms until further questioned. The participant's narratives in this study support the idea that Chinese immigrants tend to selectively express or present symptoms in culturally acceptable ways (Kleinman, 1977, 1988).

Another explanation about the somatisation of mental health issues could be the more holistic view of general health that is present in Chinese culture (Bond et al., 2010). This holistic view of body and mind is embedded in the history of China and still has a strong influence. The holistic approach shapes how Chinese culture views psychological distress and mental illness while explaining the somatisation of mental health.

Figure 4. 1. Category One



4.4 Category two: Changing mental health beliefs

As illustrated in category one, the participant's experiences in the context of cultural perspectives surrounding mental health have greatly shaped their beliefs about mental health. It was acknowledged by various studies (Corrigan, 2004; Wahl, 2003; Jorm et al., 1997) that mental health beliefs set the stage not only for how the individuals experience and express their own psychological distress, but also for how they interact with others who might be experiencing emotional problems. According to Ajzen & Fishbein (1980), understanding people's beliefs can help predict their behaviour. In the context of mental health, understanding Chinese immigrants' mental health beliefs can help us see how their help-seeking behaviours are shaped. Mental health beliefs are changeable (Kelly, Zyzanski, & Alemagno, 1991; Angermeyer, Matschinger, & Schomerus, 2013), which is consistent with category two's findings. Category two portrays a process of changing mental health beliefs within two subcategories: before accessing mental health services and after accessing mental health services.

Category one demonstrated that the concept of mental health is stigmatised and discriminated against in the context of Chinese cultural perspectives. This viewpoint is reflected in the first subcategory in category two: that mental health is a hidden subject.

Most of the participants held this belief prior to accessing a mental health service. Many have highlighted this experience:

P1 Rose:

"Going to the "mind doctor" is a negative thing and it should be (kept) under covered and hidden. It should not be exposed to the sun because it is only a dark and filthy secret".

P2 Stone:

"Right. For example, if you have a child with mental issues, and this is known by parents of other children…You may worry about many things, including his or her difficulty in finding a wife or husband. So you hope to cover it all up."

April (P4) remembered one of her friends who had mental illness and the way her parents treated her:

P4 April:

"They tried everything to cover the fact. Her parents had alleged that their child just had some learning disorders, not mental disorders at all".

August (P9) remembered her reluctance about talking to people about her mental health issues and trying to hide the problem, wanting to deal with the issue by herself:

P9 August:

"We refused to talk to parents or friends about things (mental health issues) like this. And I always thought that I could handle it myself".

Poppy (P10) attributed Chinese culture as the source of her reluctance to talk about her mental health problems by saying:

P10 Poppy:

"I was reluctant to talk about such things (mental health issues) as if they were bad things. Chinese culture definitely has such implications".

Henry (P12) expressed that the many people suffering from mental health issues would not seek help because the subject of mental health is taboo for Chinese people:

P12 Henry:

"Many people with mental problems may choose not to seek for help".

These quotes show that the participants believed that mental health is a subject that should be hidden before accessing a mental health service. Another theme in this subcategory is the loss of mian zi. In category one, the importance of mian zi was illustrated through the participants' narratives, which corresponded with the subcategory of before accessing mental health service. Participants viewed the accessing of mental health services as a course of action that would cause the loss of mian zi:

P1 Rose:

"Because for ordinary people, it loses mian zi …Going to the 'mind doctor' is losing mian zi".

Stone (P2) and April (P4) expressed similar views:

P2 Stone:

"if you have a child with mental issues, and this is known by parents of other children, then can be seen as a loss of mian zi".

P4 April:

"They become jittery at the mention of mental disorders and losing mian zi for the family."

Wood (P7) thinks this problem is more prevalent amongst older Chinese generations:

P7 Wood:

"I think local Chinese are surely anxious about losing mian zi, especially for the elderly when trying to access mental health services".

Finally, Poppy (P10) highlighted the connection between having mental health issues and the loss of mian zi:

P10 Poppy:

"Also, there was the mian zi issue, which is deeply rooted in Chinese culture, like (I) don't want to lose mian zi before I have mental health issues".

Accompanying the belief that accessing mental health services is linked to the loss of mian zi, there is also the belief of shamefulness. The shamefulness of seeking help was expressed by the majority of the participants.

P1 Rose:

"Going to a mental hospital is a shame".

Stone (P2) made a comment on the shamefulness of seeking help within Chinese culture:

P2 Stone:

"Even if you talk about your problems with the British, they will simply ask: why not see a doctor? However, we Chinese are shamed of sharing this with others. In Chinese culture, it is a shameful thing".

Whilst Lily (P3) mentioned having mental health problems made her feel shameful:

P3 Lily:

"I feel shameful and depressed".

April (P4) believed the shamefulness of seeking help is an issue that affects all levels of Chinese society:

P4 April:

"It seems to me that seeing a psychologist is a very shameful thing to all Chinese, no matter poor or rich".

June (P6) and Henry (P12) both mentioned it was a little shameful for them to seek help for their mental health problems:

P6 June:

"At first I might feel a little ashamed to talk about it".

P12 Henry:

"So seeking mental health was quite shameful for me".

It appears that before accessing a mental health service, most of the participants' mental health beliefs were that mental health is a hidden subject, that seeking help for mental health issues would cause the loss of mian zi and that mental health issues are shameful.

However, a process of change emerged in the participants' mental health beliefs after the participants actually accessed a mental health service. A change can be observed in the first theme in this subcategory, which is an understanding that it is normal to have mental health problems. Participants recalled this shift in their thinking clearly:

P4 April:

"What's helpful is that he made me believe that I was normal… I have realised that it's quite normal to have emotional issues. To some extent, everyone may come across these issues at certain stages".

P5 May:

"It's normal to have some minor mental issues."

P7 Wood:

"After talking with the therapist during the treatment, I realised that it's normal to have pressure. Everybody does!"

P8 Max:

"I have some new understanding about it (mental health), I think it's normal".

P9 August:

"Yes, it has. Now I know if you are under too much pressure, you might have mental illness, it's normal."

P10 Poppy:

"Now, I think it's normal. It is beneficial for everyone to know something about mental health, because no one can have a smooth sailing for their whole life."

P11 Jay:

"Umm, from my own experience, mental disorders are the same across all people".

Henry (P12) further acknowledged that it is common for many people to have experiences of some kind of mental health problems:

P12 Henry:

"And it makes me believe that mental diseases are common and may happen to everyone. Anyone of us might have such problems at a certain stage."

The above extracts demonstrate that the belief that having mental health problems is normal developed after accessing the mental health service. Another change that occurred is how the participants started to acknowledge the importance of mental health professionals:

P1 Rose:

"Mental issues are disorders too and need to be treated by professionals, just as any physical disorders.… You really need to seek help from professionals if you have a problem".

Stone (P2) compared these professionals to mechanics, and suggested that we all need specialised help when struggling with mental health issues:

P2 Stone:

"In other words, I sought professional psychological help. I will have a professional mechanic repair my car when it is broken and I should do the same thing with my mind as well."

April (P4) suggested that mental health professionals are needed by everyone:

P4 April:

"Yes, I think it's necessary. I even believe that perhaps everybody needs a psychologist who you can turn to when you fail to communicate your feelings with others."

After accessing specialised mental health care services, May's (P5) view on mental health professionals is one of trust:

P5 May:

"I trusted the mental health professionals."

Wood (P7), Max (P8) and Poppy (P10) all believed that mental health professionals helped them in their recovery:

P7 Wood:

"A professional's suggestions on psychology and emotion expression are rather beneficial to me".

P8 Max:

"(A) Psychological professional's help did help me in certain way."

P10 Poppy:

"(Mental health) is a very professional field, involving certain mental consultation or treatment."

Poppy (P10) further elaborated the comments by saying:

P10 Poppy:

"This is a very professional job!"

Jay (P11) expressed a more appreciative view about the work of mental health professionals, saying:

P11 Jay:

"I felt, I felt different to talk to someone. And I start to realise that talking to someone can be quite useful."

Whilst Henry (P12) emphasised that the early involvement of the mental health professional is important:

P12 Henry:

"We need professional psychological help at the beginning stage of mental health issues."

4.4.1 Overview of Category Two – The changing of mental health beliefs

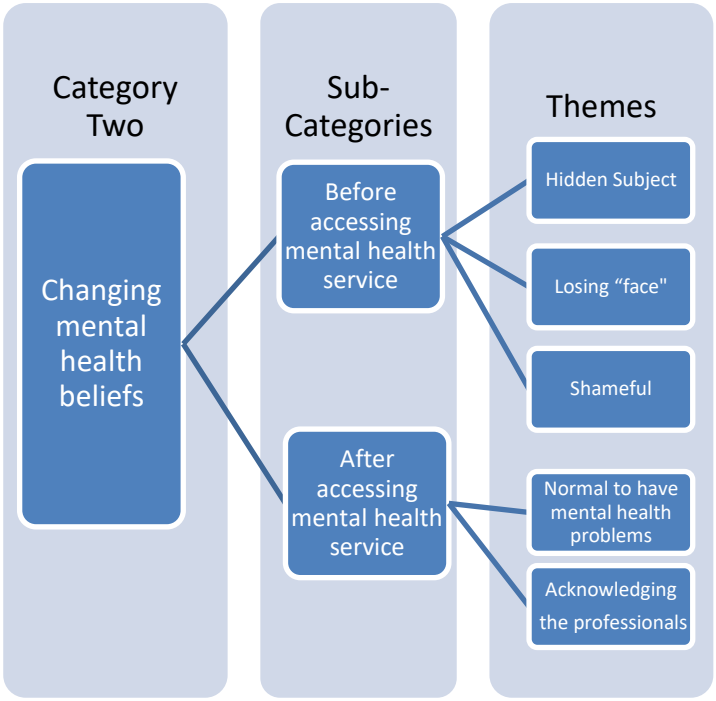
In this category, a process of change emerged in the participants' mental health beliefs after accessing a mental health service. Subcategory one illustrated the common mental health beliefs before accessing a mental health service (mental health is a hidden subject, accessing a mental health service means losing "mian zi" and it is shameful). However,

after accessing mental health services, the participants' beliefs towards mental health changed (mental health problems are normal and professional help is needed to treat mental health problems; see Figure 2).

Current literature on culture dimension theory (Hofstede, 1984; Hofstede & Bond, 1988; Hofstede, 1993) supports some of these findings. Chinese societies are viewed as "collective" and oriented toward enhancing in-group harmony (Leung & Bond, 1984). Some significant values in Chinese culture are identified such as the importance of the family or kinship groups, respect for elders, obligations towards friends and relatives, the avoidance of conflict, the need for harmony and the concept of face (mian zi) (Tan, 1990). Mental health is viewed as a family disgrace and should not be discussed with outsiders (jia chou bu ke wai yang) (Kwok & Wong 2000; Wu, Tang, & Kwok, 2004). This perspective supports the belief that mental health is a hidden subject, a common belief that participants held prior to accessing a mental health service. Mental illnesses are often seen as a source of shame (Abdullah & Brown, 2011), which was reflected in the narratives. A study conducted by Yang (2007) also supports this idea, as Chinese groups consistently demonstrate the use of more negative stereotypes and social restrictions towards people with mental illness (Yang, 2007). People with mental illness are seen as a "bad seed" or a "genetic taint" to their family in the traditional Chinese viewpoint (Sue & Morishima, 1982; Pearson & Chan, 1993). Sue (1994) and Uba (1994) both acknowledged mental health problems in Chinese society are often perceived as shameful for the whole family, and can cause the affected family to lose face and to have marriage prospects for all family members threatened (Kung, 2003). These viewpoints could further explain the loss of mian zi and shamefulness that underlie the participants' mental health beliefs. The process of change after accessing a mental health service is less observed in current literature when specifically addressing the Chinese community. However, the "contact hypothesis" suggested by Fischer and colleagues (Fischer & Turner, 1970; Fischer & Farina, 1995) might be able to explain this change in mental health beliefs. The hypothesis suggests that attitudes towards mental health treatment are more positive when linked with previous treatment or contact. The effect of "contact hypothesis" was observed in two studies on Hong Kong students' attitudes towards patients who suffer from mental illness that both reported positive changing of attitude after contact (Callaghan, Shan, Yu, Ching, & Kwan, 1997; Chung, Chen, & Liu, 2001). This could help explain the change in mental health beliefs after the participants accessed mental health services. In addition, as previously

discussed in Chapter 2 on the changing Chinese cultural context, in particular the generational subculture, a move to a more individualistic thinking framework for people who were born in the 1980s and 1990s could also have contributed to the change in mental health beliefs as demonstrated by Rose (P1), Stone (P2), April (P3), May (P5), Jay (P12) and Henry (P12). The category is consistent with studies that have suggested that mental health beliefs are changeable (Kelly, Zyzanski, & Alemagno, 1991; Angermeyer, Matschinger, & Schomerus, 2013). Before accessing services, participants believed that mental health was a hidden subject that causes the loss of mian zi and is shameful, but after accessing a service, the views of the participants changed: mental health issues are now viewed as normal and a cause for professional help. As Yip and colleagues suggested, the belief that mental health problems are normal is valued as a crucial concept when working with the Chinese community on mental health issues (Yip, Gee, & Takeuchi, 2008).

Figure 4. 2. Category Two



4.5 Category Three – Evaluation of the current service

We learned in category one about the participants' experiences in the context of cultural perspectives from societal, gender and mental health dimensions; we also learned that cultural perspectives shape the participant's mental health beliefs (which are changeable)

in category two. Following on from these insights, this category details how the current mental health service is evaluated from the perspective of the participants. There are two subcategories in category three: effectiveness and ineffectiveness.

In the effectiveness subcategory, the narratives represented discuss the aspects of the current mental health service evaluated to be effective in the view of the participants. The first main theme that emerged through analysis was an increased understanding and awareness about mental health issues. This aspect is evaluated to be particularly effective after accessing the current mental health service. Rose (P1) mentioned that accessing the mental health services had made her more aware of her mental health issues:

> P1 Rose:
>
> "But there was an opportunity that made me realise I need to be aware my own mental health issues and only thinking positively wouldn't help me".

Stone (P2), April (P4), May (P5) and Wood (P7) all believed the service was particularly effective in making them pay more attention to their mental health:

> P2 Stone:
>
> "I pay attention to my mental status every day… Now that I am aware of my problems, there is a hope that my life will turn back to normal… I gradually became aware of the conflicts between what I do and what I think and the thoughts I have tried to cover up. I desire to go deeper after telling my feelings during the treatment."
>
> P4 April:
>
> "It helped that I have been more aware of my emotional issues".
>
> P5 May:
>
> "I think people more or less will have psychological problems under pressure. It depends on your psychological endurance and psychological quality. I think I may pay more attention to it after this experience… Now I am more aware that I might have some mental difficulties."

P7 Wood:

"Learning to be aware of this has been of much help to me."

Max (P8) no longer saw mental health as a remote concept and believed the service was effective in promoting his awareness about his own mental health:

P8 Max:

"Now I am aware that mental illness is not a remote concept for I have mental problems myself".

For Poppy (P10), the service was evaluated to be effective, not only towards increasing her own awareness about the issue, but also about the mental health issues of others:

P10 Poppy:

"If everyone has the awareness of seeing a psychologist in the face of great pressure at certain life stages, it will be of much help. I really think so".

Jay (P11) believed the effectiveness of the service had made him more aware and willing to help other people experiencing mental health issues.

P11 Jay:

"So I'm more aware of the issue now… If I sense someone is suffering from depression or is anxious, I am more aware and want to help more. That's definitely changed."

Another aspect deemed to be effective was the increased ability of participants to deal with their symptoms. Participants expressed that they had managed to cope with their symptoms to various degrees of success after accessing a mental health service. Rose (P1) talked about her ability to cope with her symptoms of panic after accessing a mental health service:

P1 Rose:

"My symptom of panic was slightly released."

Stone (P2) said he might not be cured of his mental health problems, but treatment had helped him deal with some of his symptoms, both by using medication and talking therapy:

P2 Stone:

"I told my GP of these issues. He prescribed some medicine to me. I took the medicine and finally fell asleep…It might not cure me, but it is helpful to some degree".

April (P4) felt she was more calm when dealing with emotional stress:

P4 April:

"After that, the therapy calms me down whenever I encounter emotional problems."

May (P5) reported her hallucinations and anxiety symptoms were managed effectively with both medication and talking therapy:

P5 May:

"I became rational…"

Wood (P7) talked about how his depressive symptoms were effectively managed:

P7 Wood:

"I was in a depressive mood…After the treatment; I started to feel much more calm and peaceful"

Max (P8) believed both medication and talking therapy helped him with his anxiety symptoms:

P8 Max:

"Psychological professional help did help me in certain way, at least it could relax my mind in a certain way, so did the medication, I think".

Poppy's (P10) GP recommended her a therapist after her husband passed away. She found by accessing the service that she was able to slowly reconnect with society:

P10 Poppy:

"I found it really helpful… I felt that (the) psychologist's consultation was really helpful to me, even of great help. For an example, after my husband passed away, I didn't want to see anyone or do anything. But it made me feel pleasant or even happy to talk (during) the consultation."

Jay (P11) talked about his experiences in art therapy, which has helped him to manage his anxiety symptoms:

> P11 Jay:
>
> "It was like learning a new subject…helped a lot. I did some creative exercises in the therapy… I was also learning new ways to understand myself. And so that is helpful and interesting to take reflective view."

Henry (P12) also talked about how accessing mental health services had helped him to create a new framework of thinking which helped him deal with his depressive symptoms:

> P12 Henry:
>
> "He also helped me to build a framework and set goals. Actually, it is a process to build up a self-management mechanism."

However, there are aspects that the participants evaluated to be ineffective when accessing current mental health services. The ineffectiveness subcategory explores these relevant themes. The first theme of ineffectiveness in providing mental health services to the studied population was the language barriers in the current mental services. Lily (P3) talked about how language was a major obstacle for her in accessing mental health services and how she was discouraged by the language barrier:

> P3 Lily:
>
> "I couldn't understand much without an interpreter. Language was the biggest problem… English is not my mother tongue and I was discouraged by the language obstacle".

April (P4) talked about how language is a barrier in accessing the current mental services, despite having a relatively high level of education:

> P4 April:
>
> "Some of us have language barriers, too. I have received higher education and language is not a problem for me, but I still find it difficult".

May (P5) shared that language affected her treatment, as there was no Chinese psychologist present in the psychiatric unit where she was treated:

P5 May:

"I am not sure. Language probably is one thing. There is no Chinese psychologist psychiatric in the psychiatric unit, I didn't think I would be able to express myself properly using English..."

Max (P8) talked about how language could affect him expressing his feelings and this point was echoed by Poppy (P10):

P8 Max:

"Not to mention the difficulty to express your psychological problem in English. Sometimes I don't even know how to put it in Chinese, not to mention English…"

P10 Poppy:

"For me, a first generation Chinese immigrant, I had difficulties to expressing my feelings in Chinese, let alone in English."

Jay (P11) also highlighted the language barrier by saying:

P11 Jay:

"But I wasn't sure that I would be able to explain my feelings in English, I was worried for that. I can imagine for people (that) have worse English than me, they would really struggle. To explain or try to say how they feel. Yeah, that's what I think. That's the first difficulty."

Another aspect deemed to be ineffective while evaluating the current mental health services was the lack of access to mental health services for the studied population. Rose described her experience in searching for relevant services as difficult; this experience was echoed by April (P4):

P1 Rose:

"Such services are invisible now. I don't know where they are. I can't find them online or through advertisement. Right, no chance of accessing those services… it's really difficult to find a psychologist".

P4 April:

"So I actively looked for resources that provide psychological counselling services. However, I didn't know where to find it at all… As immigrants, it's very difficult for us to seek for help in case of mental health problem, as we don't know who to turn to… Though free counselling services are available, I only got to know it accidently."

Wood (P7) believed accessing mental health services could be particularly problematic for restaurant workers who have limited information resources:

P7 Wood:

"In addition to students, those running restaurants or the first-generation immigrants may also need such services, but their only information source is Chinese newspapers. They have no direct channel to get access to such an organisation".

Poppy (P10) found accessing mental health services difficult:

P10 Poppy:

"Extremely hard. Such services are rare…Many overseas Chinese know little about mental health and have no access to relevant services".

Jay (P11) echoed Poppy's (P10) view:

P11 Jay:

"So when I first searched for help, I couldn't find much information online, I only come across one Chinese specific organisation, so I think getting help is not easy".

Henry (P12) considered lack of access to mental health is one of the main problems in the current mental service by saying:

"Lack of access, definitely. They have no access to such services. I searched a long time before finding Chinese Mind[1]. Relatively speaking, there are inadequate channels and resources".

[1] Details of the organisation have been changed for confidentially reasons.

Another theme illustrating the ineffectiveness of the current service provided was a perceived lack of empathy or interest from the mental health professionals. Rose (P1) stated:

P1 Rose:

"The more we chatted, the more I felt his empathy for me was not authentic".

Lily (P3) expressed her experiences while receiving mental health treatment:

P3 Lily:

"I don't think it (treatment) works at all. I was passive because he was cold. I told him that I couldn't understand the questionnaire, but he didn't offer to explain it".

The therapist's interest in the participant's experience seems to be instrumental in the effectiveness of the mental health treatment. April (P4) admitted that the treatment was not as effective as the therapist looked exhausted and seemed like he did not want to be bothered with the session:

P4 April:

"The first treatment didn't last long…. he looked exhausted. It gave me the feeling that he hoped to end my treatment as soon as possible and meet the next patient… I think he should have listened more and let me express my feelings. Maybe I would feel better and didn't need specific treatment at all. That's my feeling at that time."

June (P6) expressed a lack of interest from the professional that she experienced:

"I mean he's not particularly interested, not interested in you."

August (P9) echoed this experience and elaborated that following the procedure seemed to be the most important concern for the professional:

P9 August:

"I don't think he truly wanted to solve my problem. He was just following procedures. I felt he was just muddling through. It seemed that was enough for him".

The final theme in the subcategory of ineffectiveness was the lack of understanding of Chinese culture from the mental health service professionals. The view was expressed by most of the participants:

> P1 Rose:
>
> "He was pretty professional and he knows how to listen. But since he lacks knowledge of the overall environment in China, when I talked to him about my family of origin, especially some very traditional stuff, I felt he could not totally understand."
>
> P2 Stone:
>
> "The British can't understand me due to difference in culture, background and everything."

Lily (P3) found the service provided was ineffective because she felt that the professional did not take cultural perspectives into consideration when working with her:

> P3 Lily:
>
> "I am just introverted and it is quite normal in Chinese culture. I guess he supposed I should be more active, instead of being silent. But there were also cultural differences".

June's (P6) narrative also reflected this point:

> P6 June:
>
> "First, the psychologist needs to understand the Chinese. He knows what you need. He knows culturally what you might think of and respond to the issue. At least he should be interested in it. I don't think many British people are interested in understanding your cultural background".

The importance of understanding Chinese culture when working with the studied population was emphasised by Max (P8):

> P8 Max:
>
> "But the GP didn't take your cultural background into account. He just saw the surface, without going deeper to understand your family background or your cultural background."

4.5.1 Overview of Category Three – Evaluation of the current service

Category three explored how the current mental health services were evaluated by the participants. Aspects deemed to be effective as a result of the services were the participants' increased awareness of mental health issues and their ability to manage their symptoms. However, language barriers, lack of professional empathy towards the participants and lack of understanding of Chinese culture were what is perceived to be ineffective by the participants (Figure 3).

The empirical data about the efficacy of accessing mental health services for the Chinese immigrant populations in the UK is very limited. However, in an evaluation of a Youth Counselling and Family Therapy Project, Chinese children and their parents were shown to respond well to therapy, showing a statistically significant reduction in psychological symptoms following a course of counselling (Howard & Thornicroft, 2006; Howard, 2006). Another study conducted in the USA saw a positive response rate in a group therapy setting for the treatment of depression to Chinese populations (Yeung et al., 2014). Kinzie's (1993) study on CBT and group therapy in treating Southeast Asian refugees suffering from PTSD saw major improvements in helping patients understand and manage their symptoms. This study suggests that the current mental health service is particularly effective in increasing the awareness of mental health issues among service users. The importance of raising awareness about mental health has long been acknowledged. In the World Health Assembly of 2001, WHO health ministers agreed that raising the level of mental health awareness was their first priority (WHO, 2001).

In terms of ineffectiveness, the main themes that emerged were the problems caused by language barriers in the current services, the lack of access to the current mental health services, the perceived lack of empathy from the mental health professionals and the lack of understanding of Chinese culture in the UK. Language is a key component of culture and can be a barrier for Chinese immigrants trying to access mental health services, as previously mentioned in Chapter 2. This is supported by many studies in both the UK and USA (Huang & Spurgeon, 2006; Chung & Lin, 1994; Takeuchi, Sue & Yeh, 1995; Ying & Miller, 1992). A quantitative study was conducted in the UK to identify some of the barriers causing problems for the mental health needs of the Chinese community (Li, Logan, Yee, & Ng, 1999). As previously mentioned, the relatively isolated work environment of the catering sector (which provides jobs for

most first generation Chinese immigrants) does not allow much development of English language skills (Akilli, 2003). This makes language a major barrier for this population when they try to access mental health services. A study conducted in the US (Tao, Zhou, Lau, & Liu, 2003) suggests that the vocabulary used in the English language to describe one's internal experiences and emotions are extensive, whilst in the Chinese language such descriptions might not translate easily (or even exist), which can often lead to misunderstanding. Mental health service providers can possibly expect a high level of verbal, emotional and behavioural expressiveness, as well as a clear awareness of the distinction between "physical" and "mental" well-being (Sue & Sue, 1977). This type of setting is particularly discouraging for Chinese populations seeking help. This challenge was also mentioned by Max (P8) and Jay (P11) when they mentioned that they find it difficult to express their psychological problems in English.

The lack of access to current mental health services for Chinese immigrants has been reflected in other research which suggests that first generation Chinese immigrants lack sufficient knowledge about mental care pathways in the UK (Li, Logan, Yee, & Ng, 1999). Lack of access to relevant mental health services is not just a problem facing the Chinese immigrant community in the UK; a recent report published by the Joint Commissioning Panel for Mental Health on "Guidance for commissioners of mental health services for people from Black and minority ethnic communities" pointed out that mental health services users from black and minority ethnic backgrounds face particular difficulties in accessing and using services compared with White counterparts (Joint Commissioning Panel for Mental Health, 2014). BME communities have little choice about the kind of services they can access at present, which leads to an underutilisation of the mental health services by these groups. The underutilisation of mental health services by black and minority ethnic groups is seen as a failure on the part of the service (Newbigging et al., 2012). Another explanation for the lack of access to the current mental health services in the UK is that there is a stark difference between the UK's healthcare system and the Chinese system, which means navigating through the NHS system could prove problematic for many first generation Chinese immigrants. A study conducted on the mental health system in China (Liu et al., 2011) revealed a primarily hospital-based care system where patients go directly to hospital for all their health needs, including mental health disorders, and bypass the primary and secondary health care. Mental health services in the UK are run very differently compared to their Chinese counterparts. NHS organisations, voluntary sector organisations (including

charities like Mind) and private companies that are commissioned by the NHS all run the mental health services in the UK. The organisations that run the mental health services are called "service providers" (Department of Health, 2013). Most people with mental health problems are cared for by their GP and the primary care team (NICE, 2011); there are also community-based services, early intervention services and services for children and young people, which all provide mental health support if needed. In 2010 the government launched the Improving Access to Psychological Therapies (IAPT) plan to make psychological therapies more available on the NHS. The IAPT program has allowed people to access psychological therapies through various avenues like their GP surgeries, universities, schools, work places (through the Employee Assistances Scheme) and other voluntary and charitable organisations (NHS, 2014). This multi-faceted service structure is confusing at times for local patients, let alone for immigrants who are unfamiliar with the system. This insufficient knowledge of mental health pathways could result in a lack of access to mental health by first generation Chinese immigrants and hinder them from using the services that are available (Lynch, Smith, Kaplan, & House, 2000). This viewpoint was reflected in April's (P4) narrative.

A perceived lack of empathy from mental health professionals is also viewed as one of the ineffective aspects. Empathy is regarded as the basic component of all helpful relationships (Reynolds & Scott, 1999) and research on empathy in primary care settings is abundant (Reynolds, 2000; Beckman & Frankel 1984; Mercer, Watt, & Reilly, 2001). Studies have suggested that showing empathy is related to improved outcomes in mental health services (Gateshill, Kucharska-Pietura, & Wattis 2011; Lawrence, Shaw, Baker, Baron-Cohen, & David, 2004; Di Blasi, Harkness, Ernst, Georgiou, & Kleijnen, 2001). According to Mercer and Reynolds, empathy involves an understanding of the patient's situation, perspective and feelings, combined with the ability to communicate that understanding and check its accuracy with patients and then to act on that understanding with the patient in a helpful way (Mercer & Reynolds, 2002). A further investigation into the concept of empathy in Chinese culture found that empathy is greatly appreciated in Chinese culture (Wang & Kim, 2010; Lei & Duan, 2014). As suggested by Hofstede's cultural dimensions theory (1980), Chinese societies are mostly collective. In Chinese culture, individuals tend to pay more attention to what other people think or feel in verbal and non-verbal exchanges during interpersonal communication. This type of interpersonal sensitivity in communication means that individuals often use their own feelings to guide their behaviour towards interpersonal

relationships to avoid conflict (Wang & Kim, 2010). This focus on "the other" during relationships is consistent with aspects of empathy (Duan & Hill, 1996). Further studies have revealed that empathy is embedded in Confucian teaching as an expected quality of individuals (Ham, 1993), as collectivistic cultures prioritise the needs and interests of others. A study conducted in the USA found that Asian (including Chinese) clients perceived a therapist's caring and nurturing non-verbal communication as signs of empathy towards them; so they tended to remain in treatment for longer and explore relationship issues when their therapist provided empathetic and culture-specific psycho-education for them (Roland, 1991). This viewpoint of empathy in relation to Chinese culture could help explain why a perceived lack of empathy from the mental health professional could be viewed as a cause of ineffective treatment within the current mental health service.

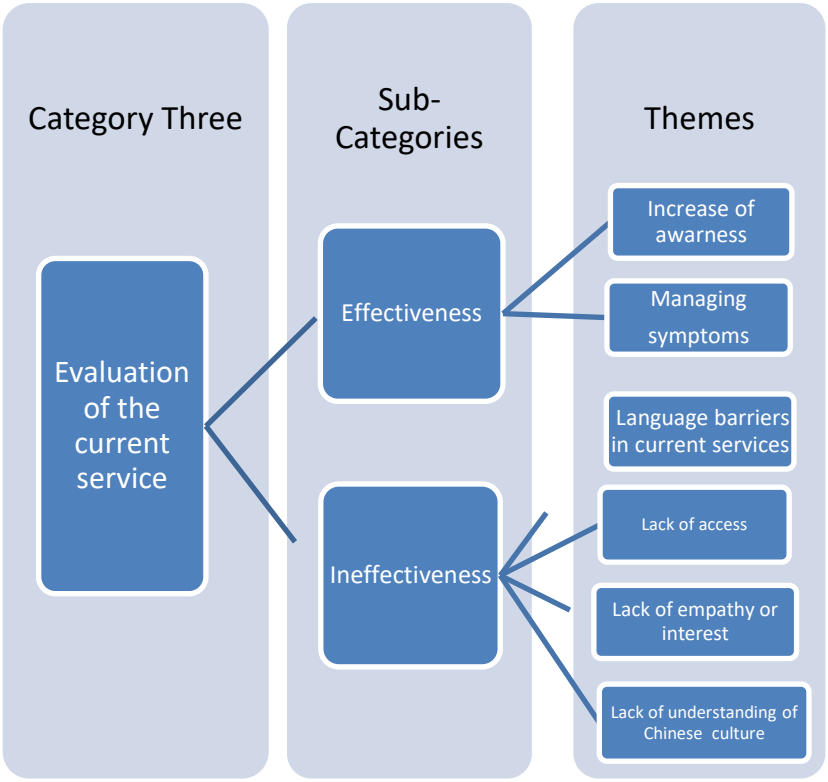
A lack of understanding about Chinese culture when working with Chinese immigrants is also perceived to be an ineffective aspect in the current mental health service. It was noted by Guarnaccia (1996) that mental illness and culture are interlinked and mental health professionals should be sensitive to this inter-connected phenomenon. As Lin (1981) reminds us:

> "most, if not all, of traditional Chinese health beliefs regarding mental illness are deeply rooted in the Chinese core culture and have evolved along with the historical development of that culture. Their content cannot be comprehended without adequate understanding of this cultural background." (p. 107).

A study conducted using the interpretative phenomenological analysis (IPA) method on culture and the therapeutic relationship from the perspective of Chinese clients by Jim and Pistrang (2007) suggests that the influence of Chinese culture enters into the therapeutic relationship in complex and diverse ways. Due to a lack of familiarity in Chinese culture, Blackwell (1997) identified common errors by Western psychiatrists when working with Chinese mental health services users as a normalisation of behaviour actually caused by mental illness. These misinterpretations of culturally derived behaviour as mental illness lead to the use of treatments unsuited to Chinese patients. Research has suggested that mental health care providers should pay attention to how Chinese culture values and shapes Chinese people's health needs and health seeking behaviours (Gervais & Jovchelovtich, 1998; Yu, 2000). The findings that emerged from the participants' narratives suggest the importance of cultural influence

that needs to be taken into consideration by mental health professionals when working with the Chinese immigrant population, which correlates with the current literature. It was noted by Alarcón (2009) that the patient's cultural background and identity must be thoroughly understood and evaluated by mental health professionals. To acknowledge and incorporate the importance of culture at all levels of the mental health service, the need to be aware of the dynamics resulting from cultural differences, the continued expansion of cultural knowledge and the adaptation of services to meet culturally unique needs are considered to denote a culturally competent service (Frey-Ridgway, 1997). The need to provide a culturally competent service to mental health service users has been recognised as an urgent topic by many mental health professionals (Pistole, 2004; Whaley & Davis 2007). There are frameworks to develop cultural competence in mental health services which were reviewed in Chapter 2. A further discussion of these issues in relation to the current study is explored in Chapter 5.

Figure 4. 3: Category Three



4. 6 Category Four – Review of the treatment expectations

Category three saw the participants evaluating the current mental health service through their narratives. In relation to these evaluations, category four presents a review of

treatment expectations through two subcategories: the individual's expectations and their expectations for the wider community. Several aspects were common amongst participants in regard to their treatment expectations. In the subcategory of the individuals' perspective, most of the participants expressed the expectation of being guided. Stone (P2) talked about his expectation of direction:

P2 Stone:

"I wanted there to be a guiding light, pointing out a direction for me."

April (P4) mentioned she did not expect to be cured, but she expected to be guided with professional techniques:

P4 April:

"I didn't expect to be cured once and for all, but hoped he could help me with his professional techniques. I expected him to guide me".

Given her limited knowledge about mental health before accessing the service, May (P5) was not sure what she expected, but had hoped for guidance.

P5 May:

"I don't know, some guidance maybe".

The expectation of guidance was also expressed by June (P6).

P6 June:

"I would expect some guidance from him".

Wood (P7) expected the mental health professional to guide him to find a way to deal with his emotional issues:

P7 Wood:

"Professionals can guide us to find the best ways."

Poppy (P10) also mentioned that she did not have a clear objective before accessing the service because of her limited knowledge about mental health, but she expected to get some guidance.

P10 Poppy:

"Well, with little knowledge about it, I didn't have a clear purpose or objective. It was a step-by-step process. I was just wondering whether I could get some guidance here."

Jay (P11) talked about how he was looking for a specific solution to solve his emotional problems by accessing the service:

P11 Jay:

"Yeah. That's right. A solution. So I think the Chinese tend to be very pragmatic, looking for a solution to solve a problem, and we tend to look for something that can help us fix things."

The expectation of guidance is finally illustrated in Henry's (P12) narrative:

"Maybe someone to guide me and tell me what to do."

Another theme within this subcategory is that participants expected that merely accessing a mental health service would enable them to discover deep rooted issues relating to their psychological distress. Rose (P1) expressed this view:

P1 Rose:

"I felt the core issue in my heart is still there and cannot be reached."

Stone (P2) explained that he expected the mental health professional could help him understand his deep-rooted problems:

P2 Stone:

"In other words, I wanted to seek professional psychological help to understand the deep rooted problem… I desire to go deeper after telling my feelings during the treatment."

June (P6) explained this expectation of discovering deep rooted issues by saying:

P6 June:

"Some psychological conflicts lie at the depth of the heart. If the inner conflict is not solved, superficial solutions could only cover it up for a while instead of truly solving the problem".

Max (P8) felt his symptoms were relieved, but his expectation of discovering deep-rooted problems was not met:

P8 Max:

"The medicine had some effect, but I felt the rooted problem was not solved."

In the subcategory of treatment expectations for the wider community, the call for ethnically matching mental health professionals and the need for more culturally tailored services for Chinese immigrants dominated the participants' narratives. "Ethnically matching" refers to the sharing of the same racial background between the patient and the mental health professional (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Most of the participants expressed the wish for an ethnically matching mental health professional to meet the community's language and cultural needs. April (P4) talked about how she felt communication could be improved by using a therapist from her own background:

P4 April:

"Firstly, language is a huge barrier; secondly, they just can't communicate their feelings with a foreigner, someone with blonde hair and green eyes. They only want to talk about it with Chinese people. Many of them told me so. Therefore, I really deem it necessary to cultivate Chinese psychologists with a second language ability."

June (P6) believed it was important to have ethnically matching mental health professionals because understanding Chinese culture is vital when working with Chinese immigrants:

P6 June:

"Yes. I think there should be more Chinese psychologists who understand the Chinese culture and background…. Yes, absolutely. I mean in particular when it comes to psychological consultation. First, the psychologist needs to understand the Chinese. He knows what you need. He knows culturally what you might think of and respond to the issue."

Wood emphasised that for mental health professionals to truly understand Chinese culture, they need to be Chinese:

P7 Wood:

"Even if he has some knowledge about Chinese culture, he is still not likely to understand deeper-rooted social issues, family relations or traditional legacies… It will be great if he can speak Chinese and there is no language barrier in mutual communication…"

Max (P8) felt ethnically matching mental health professionals would help him better express himself when seeking treatment:

P8 Max:

"What's even better is to recruit some Chinese-speaking psychologists or GPs with similar cultural background. That'll be even more helpful. At least it'll help with our expression and communication; otherwise the psychologist or GP might not understand the cultural background of new immigrants."

Poppy (P10) felt ethnically matching mental health professionals would enable better understanding of the Chinese cultural background. This view was echoed by Jay (P11) and Henry (P12):

P10 Poppy:

"I hope there can be more Chinese psychologists, as we have special cultural background"

P11 Jay:

"Also more counsellors from similar culture backgrounds would help because they understand the culture better.

P12 Henry:

"I find speaking to a Chinese therapist really helped, and I wish there are more Chinese mental health professionals available because culturally they can understand me much better."

The need for more culturally tailored mental health services is also apparent. There are various definitions of the term "cultural tailoring". Pasick et al. (1996) defined cultural tailoring as "the development of interventions, training practices and materials to conform to specific characteristics" (p. 145). Eyberg's (2005) definition of cultural

tailoring emphasised the "changes made in focus or delivery style of essential elements in an established treatment, based on the unique features of the individual case" (p. 199). Kreuter and colleagues (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003) further pointed out that although "culture" is a shared concept and "tailoring" only emphasises the singular, individuals within the culture still "have varying levels of the same cultural beliefs" (p. 137). Kreuter's viewpoint is reflected both in categories one and two of this chapter. There were common aspects when participants described their experiences in the context of cultural perspectives and in relation to their mental health beliefs. The need for the mental health services to understand and accommodate their beliefs, values, customs and language needs were expressed by the participants when discussing their treatment expectations for the wider community. Rose (P1) expressed her wish for mental health professionals to understand Chinese culture and for an integration of the Chinese traditional philosophical framework into the current mental health service:

> P1 Rose:
>
> "Because the Chinese community is growing, it is possible to have one or two psychologists that are familiar with western culture and are interested in the Chinese culture... It would be nice if Taoism and Confucianism could be included into psychological education. After all they are the bases for understanding the Chinese culture."

Stone (P2) also mentioned that he felt mental health professionals were confused by his cultural background and also called for a more specific service for the Chinese population:

> P2 Stone:
>
> "The British psychologist does not know the evolution of Chinese culture in the past 5,000 years, so he is confused at my mind-set… As more Chinese have come to Britain; I think more attention should be paid to this group. Mental health services should too, with more specific services to the Chinese population".

May (P5) believed that the mental health professional should understand the Chinese family structure:

P5 May:

"Yes, I think so, I think if the psychologist should know a bit about the Chinese family structure… it would help."

August (P9) talked about the need for a more culturally tailored service for Chinese immigrants:

P9 August:

"For us Chinese, I think more help should be offered and tailored to our unique cultural background".

Jay (P11) believed if the mental health professional has some knowledge about Chinese culture, it would help them explain the concept of mental health better to the Chinese immigrant population:

P11 Jay:

"I think especially if the counsellor tries to understand and explaining mental health problems in Chinese culture, Chinese people will understand it better."

Another theme that emerged in this subcategory was the participants' wish for easier access to mental health services, which was consistent with the narratives revealed in category three. Stone (P2) talked about how easier access to the service was needed:

P2 Stone:

"Yes. I think it will be better if this kind of help and more access is offered and accepted more widely."

April (P4) wished for more publicity about the services to be made available so it could help her access the service with greater ease:

P4 April:

"Yes. I think more publicity and more leaflets are needed so we can access the service."

Wood (P7) believed it is important for Chinese immigrants to know how to access mental health services:

P7 Wood:

"It's urgent to enable more Chinese people to know about mental health services so we can access them".

Max (P8) thought it would be helpful if there was more access to mental health services:

P8 Max:

"What's more, I think it'll be terrific to have more access, such as different agencies and departments to help us."

Poppy (P10) would also welcome more access channels:

P10 Poppy:

"Besides, I hope to see more publicity on the channel of access, especially for Chinese people".

Jay (P11) believed greater access to mental health services would lead to a change in help-seeking behaviour:

P11 (Jay):

"I also think counselling or talking therapist services for Chinese people should be more available, so people can talk to someone when they need, that will make people more acceptable and more likely to get help."

Finally, Henry (P12) emphasised the need for more access to mental health services:

P12 Henry:

"I think more publicity on the services available is needed so we know how to access them."

Rose (P1), Poppy (P10) and Jay P1 (P11) also mentioned that an extended service would be more suitable for the Chinese immigrant population as it is difficult for Chinese immigrants to express their emotions. Although this idea was expressed by only three participants, I believe that qualitative research should not focus just on the frequency of a concept but also on the demonstration of its importance in the qualitative paradigm; therefore, this viewpoint was included as a theme in this category. Rose (P1) expressed this viewpoint:

P1 Rose:

"I suggest the treatment can be extended for Eastern patients, especially Asians and Chinese. From minimum eight weeks, preferably to sixteen weeks, twice as much as for ordinary westerners. Because it's really difficult for Chinese people to open up to strangers. There must be a process in which the communication starts slowly and builds up to mutual understanding."

Poppy (P10) also talked about how an extended service is needed. It took a while before she felt she was able to share her feelings and she believed this was related to Chinese culture:

P10 Poppy:

"I had taken about 24 counselling sessions. Typically, 8 or 12 sessions are provided for one patient. But it is far from enough for me, as I am unable to share my inner feelings right at the beginning. A short-term treatment might be not satisfactorily effective, because most Chinese are introverted and need a slow and gradual process, so need longer treatment length. This is for sure in Chinese culture".

Jay (P11) felt that because his treatment plan was flexible, he was able to progress gradually instead of feeling rushed:

P11 Jay:

"If I had a concrete treatment plan, for example only 6 sessions, I would be stressing over it like I always do. But because I had more flexibility in the treatment plan, I was able to progress over the time and not feel like I was rushed".

4.6.1 Overview of Category Four – Review of the treatment expectations

In category three, we saw an evaluation of the current mental health service through the participant's narratives. This evaluation has helped the participants to review their expectations of the treatment provided by the current mental health services, which is illustrated here in category four. This category is divided into two subcategories: the individual aspect and the wider community aspect. It was found that when individuals

accessed the mental health services, the participants' expectations were that they would be guided and address deep rooted issues. The treatment expectation for the wider community focused on more ethnic matching with mental health professionals, better culturally tailored services for Chinese immigrants, better access to mental health services and extended treatment length (Figure 4).

As mentioned previously in Chapter 2, studies on mental health treatment expectation within the Chinese community are scarce and mostly conducted in the US. One earlier study conducted by Sue (1977) on Asian-Americans did suggest that Asian-Americans are likely to terminate counselling prematurely when compared to Western clients, potentially because their treatment expectations had not been met. An emphasis on education and self-cultivation in Chinese culture could partially explain the treatment expectation of being guided, as education is an important aspect for Chinese individuals to cultivate throughout their lifetime (Hsu & Wu, 2015). The concept of self-cultivation (xiu yang) means "rectifying one's mind and nurturing one's character with a particular art or philosophy" (Hwang & Chang, 2009, p. 1011). In the context of mental health treatment, this self-cultivation approach could suggest Chinese clients are more likely to adopt the role of students while the professionals are seen as teachers during treatment (Hwang & Chang, 2009). Other studies have suggested that advice giving could be appropriate when treating Chinese clients (Duan & Wang, 2000; Lau, 2000). As Duan and Wang (2000) explain: "clients may feel comfortable with getting what is expected from the expert" and "giving cultural appropriate advice ... can help the counselling to serve the role of promoting social and group interest as well as individual interest, which may gain the profession social and cultural acceptance" (pp. 14-15). Chong and Liu (2002) also suggested that counsellors could potentially take a more direct role when treating Chinese clients, especially during the early phase of treatment. This suggestion was further supported by Kim and Omizo's research (Kim & Omizo, 2003) that found Asian-American clients resonate better with counsellors that adopt a more "immediate resolution" approach. The findings from this study were linked with Sue and Zane's (1987) earlier research, which prioritised "the need for attaining some type of meaningful gain early in therapy" (p. 42) for American-Chinese clients. Studies conducted in China also found that patients are prone to accept a more didactic form of psychotherapy because they tend to value hierarchical organisations (Zhang et al., 2002) that prompt respectfulness and compliance with authority (Hsu, 2015).

Chinese clients' treatment expectations should be considered within their cultural framework. Most participants believed the current mental health services are effective in managing presenting symptoms of psychological distress (category three); however, a further exploration of the treatment expectations revealed a desire to address deep-rooted issues. The treatment expectation of addressing deep-rooted issues by the mental health services is somewhat contrary to Watt's (1961) study, which suggested that more explorative approaches might not be suitable for Chinese immigrants. However, the research on this specific subject is very limited and further studies are needed to explore the topic.

When discussing the treatment expectations for the wider community, a desire for ethnically matching mental health professionals was expressed by many participants. This need is supported by existing literature, as some evidence suggests that better treatment outcomes with lower drop-out rates occur when clients see therapists of the same ethnic or linguistic background (Sue, 1998; Sue et al., 1991). A study conducted by Sue et al. (1991) with 60,000 Asian-American clients found ethnically matching mental health professionals and clients increased the utilisation of mental health services and decreased the number of premature terminations among the clients. Amongst first generation Chinese immigrant clients who did not speak English, ethnic and language matching clients with therapists positively predicted the length and outcome of treatment. A call for a more culturally tailored mental health service for Chinese immigrants is illustrated in the subcategory of treatment expectations for the wider community. Studies on evidence-based treatments have suggested that mental health treatment disparities can be reduced through providing more culturally tailored services (Whaley & Davis, 2007; Yamada & Brekke, 2008). After reviewing 59 studies of cultural adaptations to mental health treatment, Griner and Smith (2006) argue that cultural tailoring works if it is progressively applied. Sue's study (1998) suggested that mental health services with bilingual staff and the incorporation of specific cultural needs see a better level of retention. Studies on Chinese immigrants have also demonstrated the benefit of culturally tailored mental health services in reducing service inequities, lower premature termination rates and treatment outcomes (Zane et al., 1994).

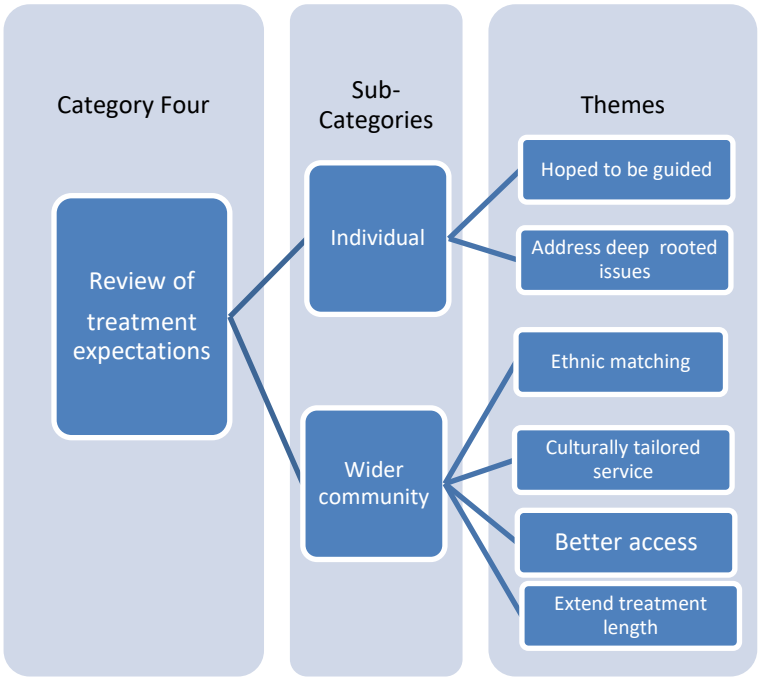
Despite being "heavily laden with Western beliefs and value systems (Jayasuriya, Sang, & Fielding, 1992, p. 194), there are have been developments towards incorporating Chinese values into psychotherapy treatment models to meet the demand for more

culturally tailored services. The Chinese Taoist Cognitive Psychotherapy (CTCP) model was developed as a modification of Rational Emotive Behavior Therapy (REBT) in 1992 by Dersen Young and Yalin Zhang (Zhang et al., 2002). As mentioned in Chapter 2, Taoism is one of the major branches of philosophy practised in China. Founded by Lao Tsu in the late Zhou dynasty, mental health in the view of Taoism represents a peace of mind and happiness in relating to the universe (Yip, 2004; Hansen, 2000; Yip, 2005). Based on this principle, Chinese Taoist Cognitive Psychotherapy (CTCP) was developed with eight Taoist teachings. The CTCP model applied the core Taoist teaching into the ABC framework of REBT (Ellis, 1957) and created its own ABCDE model: assessment of stress, belief system, conflict and coping system, doctrine direction and evaluate effect (Feng, Cao, Zhang, Wee, & Kua, 2011). The therapeutic model of CTCP (which incorporates Taoist philosophy) aims to regulate patients' negative affect, correct maladaptive behaviour and treat psychological problems by employing Taoist values (Feng et al., 2011). Since its development in the 1990s, the CTCP model has been widely accepted and studied in China (Mao & Zhao, 2011), especially with patients suffering from anxiety disorders and depression (Li & Jiang, 2011). The CTCP model is more directive when compared to some more explorative treatment approaches. During the course of treatment, patients can ask the therapist for explanations and guidelines (Zhang et al., 2002), which is consistent with the treatment expectation of being guided reflected in participant's narratives. However, the model has been criticised for its emphasis on "detachment", so may not be an appropriate treatment for adolescents or young adults as it might lower motivation (Li et al., 2008). Some other issues concerning CTCP treatment is that despite being widely researched, most of the findings are written in Chinese, which limit its presence at an international level (Blowers, 2010; Cheung, Leong, & Ben-Porath, 2003). Additionally, it is uncertain whether CTCP is compatible with Chinese people that are heavily exposed to other cultures (Ward & Lin, 2010). Further academic and clinical research studies are needed on the CTCP model; however, this model provides a possible solution to meeting the mental health treatment expectations within the Chinese community. Rose's (P1) desire for the incorporation of "Taoism and Confucianism… into psychological education" might be met with the development of the CTCP model.

The expectation of better access to mental health services is stated by the participants. This viewpoint is closely correlated with the theme that emerged in category three (the lack of access to mental health services). Studies conducted in America have found that

better access to mental health services is crucial in reducing disparity and improving utilisation when working with Chinese immigrants (Fang & Chen, 2004; Le Meyer, Zane, Cho & Takeuchi 2009; Yeung et al., 2004). Better access to mental health services is also listed as a priority for the NHS (NHS, 2014). While the need for ethnically matching mental health service professionals, more culturally tailored services and better access to mental health services were expressed by most of the participants as treatment expectations applicable to the wider community, the expectation of extended treatment length was only expressed by three participants. This viewpoint is less evident in the current literature; however, it still provides an insight into the participant's narratives. According to NICE guidelines (2011), mental health professionals should address cultural, ethnic, religious or other differences in treatment expectations and adherence. As with many issues relating to this population, current research on treatment expectations for the Chinese community is limited and further studies are urgently needed on the subject.

Figure 4.4. Category Four



4.7 Constructing the theoretical model

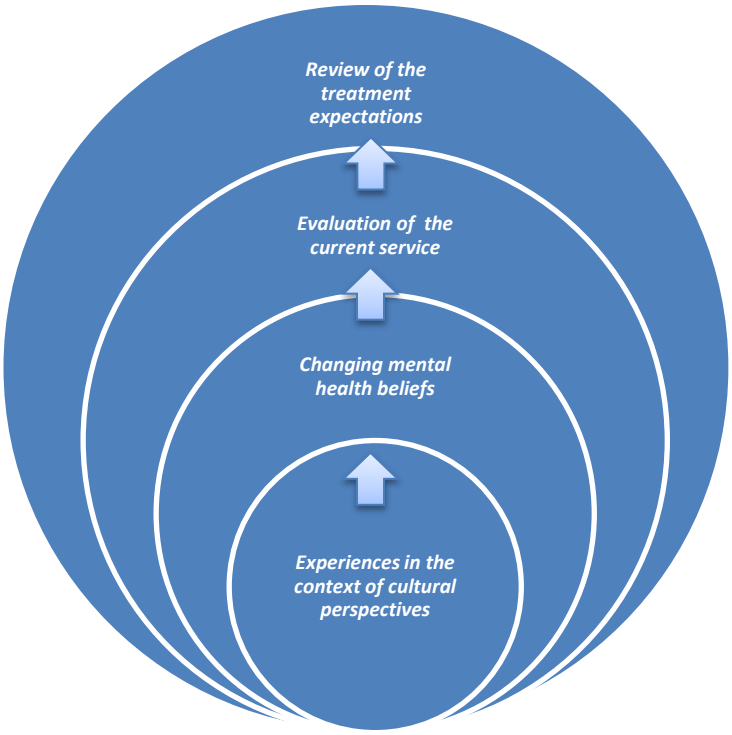
An evaluation of Chapter 3 saw the interview questions and recruitment of the participants adjusted for the purpose of theoretical saturation through an analytical process in order to answer the research question (cultural perspectives on mental health beliefs and mental health treatment expectations within the Chinese immigrant community). Four major categories were generated from the interviews and data (experiences in the context of cultural perspectives, changing mental health beliefs, evaluation of the service and the review of the treatment expectations). Each category has been discussed in detail with supporting extracts from the translated transcripts of the interviews. Furthermore, by continually comparing data, showing similarities, differences and the links across all four categories, this paper aims at theoretical integration resulting in the construct of the final theoretical model (Charmaz 2006; Charmaz & Byrant, 2007).

4. 7. 1 Theoretical Integration

Through a detailed analysis, four main categories emerged which signify the dominant themes that appeared to be present and interweaved in all the participants' narratives. As illustrated above (Figures 1, 2, 3 & 4), each main category comprises subcategories that facilitate an understanding of the overall process and allows the emergence of new perspectives when considering all the themes as a whole. The final theory aims to encompass the overall interrelation between the main categories, subcategories and themes to formulate them theoretically. Category one presents the ways in which the participants construct and perceive the meaning of their experiences in relation to their Chinese cultural perspectives on the subject of mental health. The societal, gender and mental health subcategories help us understand the participants' difficulty in expressing and sharing their feelings, enmeshed family dynamics, the imperativeness of mian zi, gender inequality, limited mental health knowledge that is developed in a society where the issue is stigmatised and discriminated against, and the attribution of mental health issues to physical symptoms. In light of these understandings, category two identified a process of change that emerged in the participants' mental health beliefs. The before and after accessing mental health service subcategories illustrated that beliefs changed from the notion that mental health is a hidden subject, that accessing a mental health service means losing mian zi and the associations of shame with mental health problems to the belief that mental health problems are normal and professional help is needed to

treat them. This change in mental health beliefs demonstrated in category two and the participants' experiences of accessing the service led to their accounts evaluating the current mental health service, which forms category three. In the subcategory of effectiveness, increased awareness of mental health issues and the participants' ability to successfully manage their symptoms are both perceived to be effective in the current mental health service. However, the ineffectiveness subcategory illustrated that language barriers, lack of access, a perceived lack of empathy or interest from mental health professionals and a lack of understanding about Chinese culture are perceived to be ineffective in the current mental health service. This evaluation of the current mental health service finally led to the participants reviewing their treatment expectations, both from an individual perspective and the perspective of the wider community, which formed the subcategories. This category found that individuals accessing mental health services expected to be guided and that their treatment would address deep-rooted issues. The treatment expectations for the wider community focused on more ethnic matching between clients and mental health professionals, better culturally tailored services for Chinese immigrants, better access to mental health services and extended treatment length. In examining all the categories, a layered interrelationship (Figure 5) emerged that helped to identify the basic social process underpinning most of the participants' behaviours, feelings and actions (Bryant & Charmaz, 2007).

Figure 4. 5. Layered interrelationship with categories



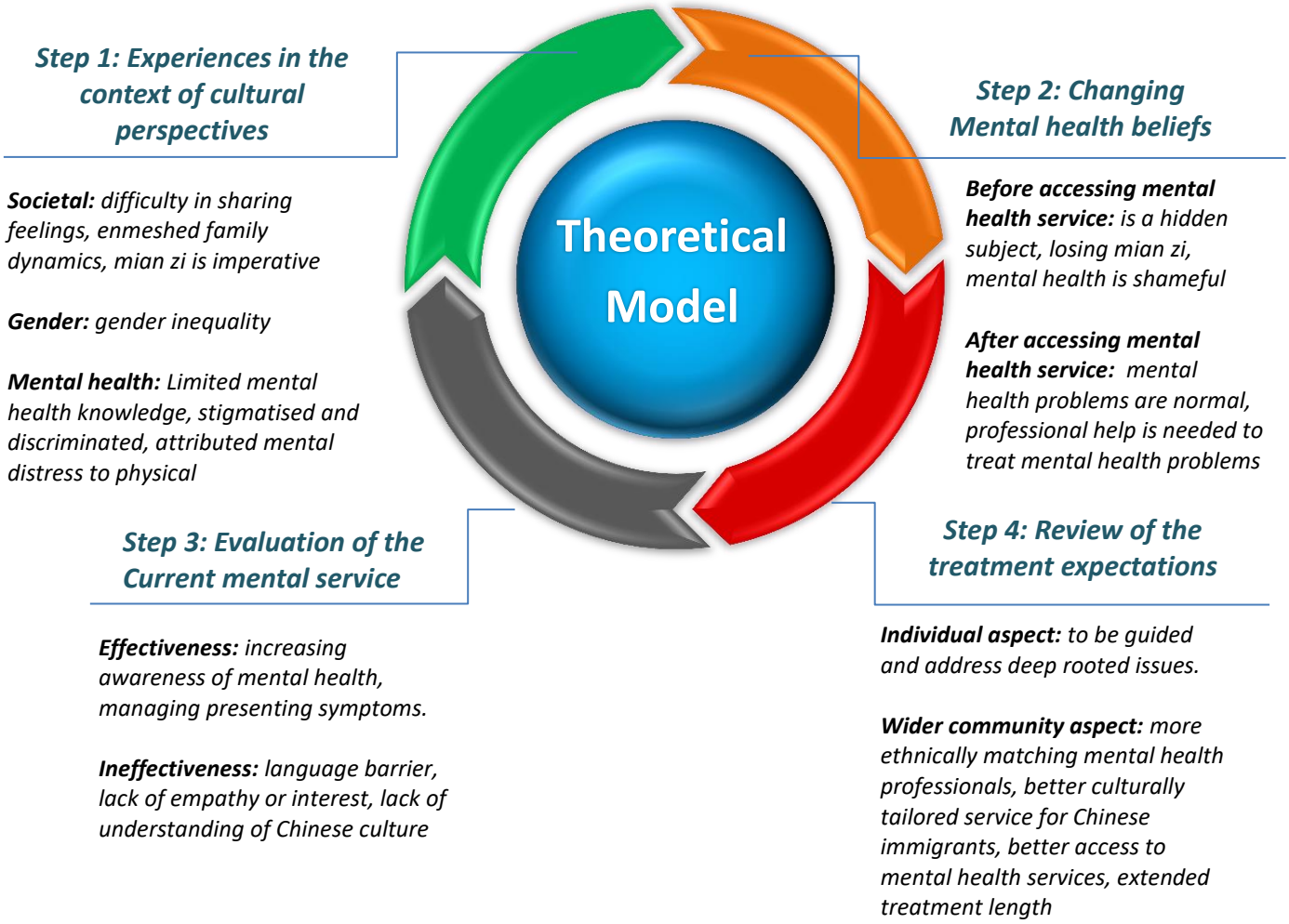
4.7.2 Presenting a working theoretical model

This study has looked thoroughly into the participants' narratives to construct a detailed, multi-faceted model of the process which explores Chinese immigrants' mental health beliefs and treatment expectations when accessing current mental health services. The model was constructed in the context of Chinese cultural perspectives to further explain all of the data and is expressed as a set of concepts that are related to one another in a cohesive way, which accounts adequately for all the data collected.

One of the aims of the current study was to utilise the knowledge gained to enhance the provision of a more sensitive, meaningful, effective and culturally competent service in the field of counselling psychology. I believed a theoretical model is the best way to present the knowledge gained as Jones and Donovan (2004) point out that the application of a theory into practice is often challenging. They further argue that health practitioners find using and implementing theory-based interventions difficult, and therefore often ignore theories during practice. However, if the theory was communicated as a theoretical model, it would help health practitioners to understand the theory more effectively and make a clear selection of outcome indicators to justify their intervention choices (Tones & Tilford, 1994). Furthermore, theoretical models help to provide a basis of best practice for health professionals (Corcoran, 2013). According to Trifiletti and colleagues (Trifiletti, Gielen, Sleet, & Hopkins, 2005), theoretical models are derived from a simplified version of a theory. Theories and models are "useful in planning, implementing and evaluating interventions" (Trifiletti et al., 2005, p. 299). Lewin (1951) further summarised by saying "there is nothing more practical than a good theory" (p. 169). To help implement the learning that emerged during this study, the 'Chinese immigrant's mental health beliefs and treatment expectations when accessing current mental health services constructed within the context of Chinese cultural perspectives model' has been developed. This 4-step circular model has four components: Step 1 of the model helps to understand the participants' experiences in the context of their cultural perspectives, Step 2 sheds lights on the participants' changing mental health beliefs, Step 3 details the participants' evaluation of the current mental health services and Step 4 provides a review of the participants' treatment expectations (Figure 6). All of these dimensions form the final theory for understanding how the cultural perspectives about mental health beliefs and mental health treatment influence expectations within the Chinese immigrant community. The

next chapter synthesises the overall findings in relation to the primary literature that was consulted and used as an interpretive lens in the analysis (Charmaz, 2006; Morse, 2007; Birks & Mills, 2011). A discussion about the application of the model and limitations of the study is presented together with the researcher's own reflection processes in Chapter 5.

Figure 4. 6: Chinese immigrant's mental health beliefs and treatment expectations when accessing current mental health service constructed within the context of Chinese cultural perspectives model



CHAPTER FIVE: SYNTHESIS, CRITIQUE, REFLECTION AND IMPLICATION

Only After Learning, Do You Know What You Do Not Know

\- *Book of Rites, Confucius*

The previous chapter detailed the analytic processes which resulted in the emergence of a theoretical model about Chinese immigrant's mental health beliefs and treatment expectations when accessing current mental health services, constructed within the context of Chinese cultural perspectives. A 4-step circular theoretical model was presented, along with its components: step 1 of the model helps to understand the participants' experiences in the context of their cultural perspectives, step 2 sheds lights on the participants' changing mental health beliefs, step 3 details the participants' evaluation of the current mental services and step 4 provides a review of the participants' treatment expectations (as illustrated in Figure 6 in Chapter 4). This chapter discusses the theoretical model in depth and also synthesises the key findings of the model. The limitations and critiques of the study are included in this chapter, together with the researcher's personal reflections about the overall research process. This chapter concludes with some wider implications for the practice of counselling psychology and suggestions for further research. To summarise, this chapter will "critically examine my findings in the light of the previous state of the subject as outlined in the background, and make judgments as to what has been learnt in my work" (Evans, Gruba, & Zobel, 2011, p. 12).

5.1 Synthesising the key findings of the theoretical model

The purpose of this study was to find a way to understand the mental health beliefs and mental health treatment expectations within the Chinese immigrant community in the context of their cultural perspectives. In order to answer the research question effectively, the following issues were explored: how the participants' experiences can be understood within their cultural context, how these experiences effect their mental health beliefs, how the current mental health service is evaluated given the participants' mental health beliefs and how their treatment expectations can be better met. By conducting the study using a qualitative approach within a theoretical framework of

relativist ontology, constructivist epistemology and perspective of symbolic interactionism, the study was able to explore the mental health beliefs and treatment expectations of Chinese immigrants accessing mental health services in the context of Chinese cultural perspectives. Furthermore, a theoretical model for the process was proposed in Chapter 4.

As previously mentioned in Chapter 4, the theoretical model generated from the current study aims "to demonstrate how the work adds a new dimension, an element that heretofore was unknown" (Stern, 2007, p. 123) to the existing literature. Therefore, a comparative literature review was conducted alongside the emergence of the theoretical model which is consistent with Charmaz's (2006) suggestion that the new learnings needs to be positioned in relation to the conceptual framework in order to clarify the contribution of the current study. The result of the constructivist grounded theory was presented in Chapter 4 during the participants' narratives, which indicated a layered conceptual relationship (Hallberg, 2006). Stern (1994) further suggested that the result of the constructivist grounded theory intends to discover processes; therefore, I presented a four step theoretical model that emerged in response to the research question. Within this process, it was apparent that the mental health beliefs and treatment expectations for the Chinese immigrant population cannot be viewed without an understanding of their cultural perspectives. To better meet the needs of Chinese mental health services users, an examination of their evaluations about the current mental health services also needs to be considered. A discussion about how each step fits in relation to the literature is presented here. It is worth noting that the relativist ontology, constructivist epistemology and symbolic interactionism theoretical perspective were adopted throughout in constructing the theoretical model. As with symbolic interactionism, society and social interactions are viewed as constantly changing and in flux (Blumer, 1969). Having identified the interrelated and interdependent categories that Chinese immigrants construct their mental health beliefs and treatment expectations from, it became clear that I needed to value the "continuously changing" aspect in these constructed experiences, which is reflected in the model.

5.1.1 Experiences in the context of cultural perspectives

Step one of the theoretical model focuses on the Chinese immigrants' experiences in the context of their cultural perspectives. The relationship between culture and mental health has been studied extensively. Culture is acknowledged as a source of beliefs about the origins and nature of mental health and influences attitudes, beliefs and ultimately affects the patients' readiness and willingness to seek and adhere to treatment (Nieuwsma, Pepper, Maack, & Birgenheir, 2011). Culturally speaking, Chinese society focuses mainly on achieving societal harmony and less on individual demands (Yang, 1986). Chinese culture is heavily laden with Confucian, Taoist and Buddhist philosophical concepts that promote different levels of harmony between people and nature, people and society, people and communities, and the mind and body (Bond et al., 2010). China has a highly collectivist culture (Hofstede, 1984; Hofstede & Bond, 1988; Hofstede, 1993), which places a high emphasis on social balance and harmony, which can cause the individual to "play down the concerns of self in favour of group consideration" (Bond & Hwang 1990, p. 236). Studies in the past have suggested that it is common for Chinese individuals to act in accordance with social expectations and social norms, rather than their own wishes or desires. The concept of the self in Chinese culture is very much related to an individual's family and social environment (Bond & Hwang, 1990; Bond et al, 2010; Yang, 1993b). Furthermore, as China is a traditional agricultural country (Zhang, LeGates, & Zhao, 2016), labour division is gender based, with men taking the lead about household decisions. Ancient Confucian teaching also considers women inferior to men (Brooks & Brooks, 1998). All these cultural perspectives are reflected in participant's narratives. It is important for mental health professionals to understand that Chinese immigrants can experience difficulty in expressing or sharing their feelings, that their family dynamics are often enmeshed, that face (mian zi) is imperative and they could have experienced gender inequality. Furthermore, Chinese immigrants tend to have limited knowledge about mental health, they are more likely to think mental health issues are stigmatised and express mental health issues through somatisation.

This study found that Chinese immigrants' mental health beliefs are embedded within Chinese cultural perspectives and that these mental health beliefs are changeable. The mental health beliefs of people are important, as such beliefs have been identified as key factors in health and illness behaviour and influence treatment expectations and

outcomes (Williams & Healy, 2001). Mental health beliefs are increasingly recognised in the "patient-centred" health care model (as discussed in Chapter 2), as the patient's own perspective of his or her mental illness is addressed in the overall care framework. The current research suggests that the mental health beliefs of the Chinese immigrant population cannot be understood without considering Chinese cultural perspectives. Furthermore, the individuals interviewed expressed how their beliefs about mental health changed before and after accessing a mental health service throughout the interview; therefore, mental health beliefs are characterised as changeable (Alarcón, 2009).

This research finding is informed by the current mental health services and helps incorporate Chinese cultural perspectives into the "patient-centred" approach when treating service users from a Chinese immigrant background. This process should include a culturally specific formulation and treatment approach that incorporates and acknowledges societal, gender, mental health stigma, and potential somatisation issues in all care steps of the mental health services. The emphasis towards emotional restraint in Chinese culture, the importance of "mian zi", interpersonal relationships and the holistic conceptualisation of mental health should all be taken into consideration when understanding the mental health beliefs held by the Chinese immigrant service users during the development of a "patient-centred" treatment approach. In relation to gender issues, traditional Chinese culture expects men to be "master of the family" and responsible for maintaining their family's social status and honour (Ho, 1991); meanwhile, women are expected to be the primary care providers for their husbands and children (Uba, 2003). An understanding of this cultural distinction about gender inequality could help mental health professionals to assess an individual's cultural expectations, which influences their mental health beliefs. The role of the family must be explored and understood, as this study has found that enmeshed Chinese family dynamics greatly influence the mental health beliefs of Chinese immigrants. The "micro-culture" of a Chinese service user's family history and structure are an important segment in the overall treatment assessment process (Alarcón, 2009). Local communities are also instrumental in developing culturally appropriate responses to address the Chinese immigrants' mental health needs, as this study observed social isolation as a major obstacle faced by Chinese immigrants in the UK. Local communities are also one of the main resources of social support. Therefore, work focusing on de-stigmatising mental health issues in these communities could be

productive when addressing the stigmatising and discriminating mental health beliefs of Chinese immigrants.

5.1.2 Changing mental health beliefs

Step two of the theoretical model focuses on the processes of how Chinese immigrants' mental health beliefs changed after accessing a mental health service. Step two revealed that common mental health beliefs before accessing a mental health service are that mental health is a hidden subject, that accessing mental health services means losing "mian zi" and that having mental health problems is shameful. This background information could help to explain some of the reasons why the Chinese immigrant community is currently underutilising the mental health services in the UK, as mentioned in Chapter 2. Chapter 2 also included a symbolic interactionist view about mental health stigma, which helps explain how mental health may be experienced by Chinese immigrants. The symbolic interaction approach could also be further incorporated into helping support mental health service users' autonomy and citizenship (Roe, Joseph, & Middleton, 2010). Recent NHS reports have indicated that there is a shift in focus towards alleviating and controlling the symptoms of mental health disorders to promote optimal levels of subjective and psychological well-being (Department of Health 1999; 2007; Linley & Joseph, 2004; Seligman & Csikszentmihalyi, 2000). This shift in focus could have implications for how mental health professionals conduct their practice, how the coping strategies for service users are developed, how creating an overall purpose and a sense of meaning for the service user is achieved and how developing support networks and relationships to achieve social inclusion is put into practice (Repper & Perkins, 2003). However, the prevalence of mental health stigma is a major challenge to accomplishing these goals. Stigma can cause difficulties relating to the mental health service user's personal and professional relationships and impact their view of self-worth, significantly limiting their aspirations and capabilities (Thornicroft, 2008). Studies in the past have recognised that simply being known as a psychiatric patient has adverse effects on an individual's reputation (Goffman, 1963; 1968; Gove & Fain, 1973). This was expressed by the Chinese immigrants in this study and many participants viewed mental health as a hidden subject, not to be publically acknowledged. Unlike the traditional medical model of mental health, the symbolic interactionist approach takes different cultural and social

experiences into consideration, while validating the service users' perspectives by studying meanings generated from their social and cultural interactions and identifying how individuals with a 'mentally ill' label may suffer as a result of stigma and how support can be provided to overcome it (Roe, Joseph, & Middleton, 2010). According to Halligan and Marchall (1996), the symbolic interactionist view of mental health could "bring to life the essence and character of a patient's experience and behaviour… and to reduce the discrepancy between formal presentations of the psychiatric illness and the experience of the actual patient struggling to make sense of the consequences of their illness" (Halligan & Marchall, 1996, p. vii). When investigating the experiences and needs of those caring for family members with mental health problems using the symbolic interaction approach, Muhlbauer (2008) found the mental health professionals' perceptions of their clients' social situation and needs could impact the quality of care they provide. Byrne and Heyman (1997) also suggest that symbolic interaction could be used as a theoretical framework to explore how service users exchange, perceive, create and interpret their social world whilst accessing health services. Kwok (2000, 2004) gave her account from a patient's perspective and suggested that mental health stigma in Chinese culture is related to the traditional concept that family disgraces should not be revealed to outsiders (jia chou bu ke wai yang). A family shame such as mental illness should be kept away and not be known by others (Kwok, 2000; 2004). Such social pressure and stigma often results in mental illnesses being undetected and untreated (Lin, 1983). Furthermore, Larsen (2007) also found that the symbolic interaction approach towards mental health provided a comprehensive insight into the socio-cultural processes that occur in an intervention and acknowledged the personal experiences of service users. This viewpoint, which recognises the services user's perspectives, is highly relevant and consistent with the current study.

Although the prevalence of stigma towards mental health issues is shown amongst Chinese immigrants, their mental health beliefs changed after accessing mental health services to recognising that mental health disorders are normal and that professional help is needed to treat mental health problems. The changes that occur are consistent with studies that have suggested that mental health beliefs are changeable (Kelly, Zyzanski, & Alemagno, 1991; Angermeyer, Matschinger, & Schomerus, 2013).

The largely negative mental health beliefs held by Chinese immigrants, along with language barriers, lack of knowledge and difficulty accessing current mental health

services can be viewed as barriers for Chinese immigrants accessing mental health services. However, mental health professionals should also understand that through providing a culturally appropriate service, the mental health beliefs of Chinese immigrants can be changed. This process of change is largely overlooked in the current literature on the Chinese community, but these changes could be seen as a result of the interactions of mental health professionals and service users forging a re-determined and re-negotiated meaning of mental health, as suggested by Larson (2007).

5.1.3 Evaluation of the current service

Step three of the theoretical model focuses on the evaluation of current mental health services by Chinese service users. This component provides an exploration of the interaction between mental health professionals and service users by including reflections upon such experiences as the service users see them. An increased awareness of mental health issues and an improving ability for the service users to better manage their presenting symptoms are deemed to be effective aspects in the evaluation of the current mental health services. On the other hand, language barriers, lack of access to mental health services, lack of perceived professional empathy and lack of understanding of Chinese culture are perceived as ineffective.

As mentioned in Chapter 2, empirical data on the evaluation of the current mental services by Chinese immigrants is very limited, especially from the user's perspectives. The research findings from this study suggest that Chinese immigrants found the mental health services are effective in increasing their awareness of mental health issues and improving their ability for the service users to better manage their presenting symptom. This research therefore offers a new way to help evaluate the current mental health services when working with Chinese users.

Other studies have suggested that language could be a major barrier to providing an effective service for Chinese immigrants (Huang & Spurgeon, 2006; Chung & Lin, 1994; Li, Logan, Yee, & Ng, 1999). A lack of access to mental health services seems to be a common problem facing black and minority ethnic communities, including the Chinese community (Hoang, 2008; Li et al., 1999; Joint Commissioning Panel for Mental Health, 2014). The multi-faceted service structure in the UK could be confusing

for first generation Chinese immigrants trying to access mental health services (Lynch, Smith, Kaplan, & House, 2000).

A perceived lack of empathy from mental health professionals is also viewed as an ineffective aspect. As mentioned earlier, empathy is rooted in Confucian teaching as an expected quality of individuals (Ham, 1993) and particularly emphasises the needs and interests of others. Chinese service users are more likely to consider what other people think or feel in verbal and non-verbal exchanges during interpersonal communication with mental health professionals. This focus on "the other" is consistent with aspects of empathy (Duan & Hill, 1996). Roland's (1991) study in the USA found Asian (including Chinese) clients valued therapists' caring and nurturing non-verbal communication as signs of empathy, which helped them to remain in therapy longer. This idea of empathy in the context of Chinese cultural perspectives could help explain why some of the studied population feels a perceived lack of empathy from mental health professionals. It is important for mental health professionals to understand that empathy and psycho-education need to be provided in a cultural-specific context for the service to be more effective (Roland, 1991) when working with Chinese service users.

Guarnaccia and Rodriguez (1996) suggested that mental illness and culture are interlinked and mental health professionals should be sensitive to this inter-connected phenomenon. Therefore, it is understandable why a lack of understanding about Chinese culture is perceived to be an ineffective aspect. Without any knowledge about Chinese culture, it is possible that mental health professionals could make errors when working with Chinese service users (Blackwell, 1997). As suggested by previous researchers, mental health professionals should pay attention to Chinese cultural values and how they can shape Chinese peoples' mental health needs and health seeking behaviours (Gervais & Jovchelovtich, 1998; Yu, 2000). Alarcón (2009) suggested that the patient's cultural background and identity must be thoroughly understood and evaluated by mental health professionals.

Given some of the cultural values explored in Chapters 2 and 4, mental health professionals should pay additional attention to the Chinese service user's enmeshed family dynamics, as Chinese immigrants are likely to experience a stronger sense of "family connectedness", which places an emphasis on family obligation (Hardway & Fuligni 2006). Some culturally appropriate responses could be developed to meet the mental health needs of Chinese immigrants by addressing these enmeshed family

dynamics. Grassroots activities such as support groups for family members of people with experiences of mental illness and de-stigmatisation work focusing on families could facilitate a better treatment experience for Chinese service users.

This investigation of the servicer users' experiences and how service users create and adjust social and cultural meanings from their interactions with mental health professionals is consistent with the symbolic interactionist theoretical perspective used in this study. Step three of the model hopefully draws attention to how mental health professionals interpret and reflect on their roles when working with the studied population. Mental health professionals are also influenced by the culture that defines their work and attitudes towards the service users (Roe, Joseph, & Middleton, 2010), so a reflection on how Chinese service users are perceived by individual professionals is critical for providing an appropriate and culturally sensitive service.

5.1.4 Review of the treatment expectations

The final step of the theoretical model reviews the service users' treatment expectations, both from the individual's perspective and the wider communities' perspective. Chinese immigrants who access mental health services expect to be guided and also hope to address deep rooted issues. Studies on the treatment expectations of the Chinese community accessing mental health care are scarce. However, an emphasis on education and self-cultivation in Chinese culture could be related to the treatment expectation of being guided. Education and self-cultivation in a Chinese cultural context means learning is a continual process and the individual should be "rectifying one's mind and nurturing one's character" throughout their entire lives (Hsu & Wu, 2015; Hwang & Chang, 2009, p. 1011). It is possible that Chinese clients are more likely to adopt a student role and treat mental health professionals as teachers (Hwang & Chang, 2009). Advice giving and a more directive approach during treatment might be appropriate with this studied population (Duan & Wang, 2000; Lau, 2000; Chong & Liu, 2002).

Chinese immigrants also expect mental health professionals to help them address deep rooted issues. The current literature is somewhat contrary to these findings, for example Watt (1961) suggested that an explorative approach might not be suitable for Chinese immigrants, though these conclusions may simply be outdated. However, I believe the treatment expectation of addressing deep rooted issues is consistent with the Confucian

idea of lifelong learning (Zhang, 2008), as continuous learning is perceived to be the "noblest of all human pursuits" (Chinese proverbs). Studies on learning styles (Oxford & Anderson, 1995) have revealed that the Chinese prefer inductive or collaborative learning and are more reflective throughout the learning process. The need to address deep rooted issues could be seen as a "slow, accurate and systematic approach" (Kennedy, 2002, p. 433) to understanding mental distress, which is in line with Chinese learning culture. However, further studies are needed to explore these treatment expectations from the Chinese immigrant community. This current study values the voice of Chinese service users and the information gained from their narratives about their treatment expectation provides a novel contribution to increasing understanding of this area of enquiry (Charmaz 2006).

The treatment expectations for the wider community focused on more ethnic matching with mental health professionals, better culturally tailored services for Chinese immigrants, better access to mental health services and extending treatment length. Studies in the US have suggested that ethnic matching between clients and therapist can lead to a better treatment outcome and lower dropout rates (Sue, 1998;Sue, Fujino, Hu, Takeuchi, & Zane, 1991). However, further studies are needed on mental health services in the UK. Other literature suggests that a more culturally tailored mental health service is positively associated with reducing mental health treatment disparities (Whaley & Davis, 2007; Yamada & Brekke, 2008), along with creating lower premature termination rates and better treatment outcomes (Zane et al., 1994). Better access to mental health is listed as a priority for the NHS (NHS, 2014) and also regarded as a crucial factor in reducing mental health disparity and improving utilisation for Chinese immigrants (Fang & Chen, 2004; Le Meyer, Zane, Cho, & Takeuchi 2009). The idea of extending the length of treatment for Chinese immigrants is less supported in the current literature. However, as Chinese culture places a high emphasis on emotional restriction, it might take longer for these service users to establish a trusting relationship with professionals (Leavitt, 2003).

These discoveries could help mental health professionals better assess the service users' needs and provide appropriate and responsive services to the Chinese immigrant community. Studies have revealed that services need to address cultural differences for an understanding of mental health, as well as establishing good collaborative links (Priebe et al., 2011). From the mental health professionals' perspective, further efforts

could be invested at a community level to promote mental health care awareness and reduce stigma with culturally appropriate approaches, as social isolation is a major problem facing Chinese immigrants. Chinese immigrants often rely on their local Chinese communities for accessing health related information (Chau, 2008), so involving local communities would be beneficial for providing a more effective service. Chinese mental health service users' treatment expectations should be considered within their cultural framework. Moreover, as with many mental health issues relating to the studied population, current research on the treatment expectations of the Chinese community is limited and further studies are urgently needed on the subject.

The purpose of the outlined theoretical model was to encourage more comprehensive thinking on the mental health needs of the Chinese immigrant community. As this study suggests, in order to better meet these needs, the mental health services must take account of the different values, morals and philosophies that drive the mental health beliefs and treatment expectation of Chinese immigrants.

5.2 Critique

The critique and limitation sections are divided into two parts: one examining the limitations of the constructivist grounded theory research methodology and the other critiquing the current research. I still believe the constructivist grounded theory was the most appropriate research method for my study. However, there are limitations within constructivist grounded theory, as with any research method. Bryant and Charmaz (2007) pointed out that many studies make use of the term grounded theory inappropriately, and due to its flexibility, the method can be appropriated to provide a justification for studies lacking in methodological strength.

The confusion between these methods is also presented in a number of grounded theory books, stating that researchers can commit "theory slurring" by making "non-systematic switching between references to Strauss/Corbin, Glaser and Charmaz… a rather diffuse method of skip and dip when collecting data" (Gynnild, 2011, p. 64). As mentioned previously in Chapter 3, the classic grounded theory developed by Glaser and Strauss was described as an inductive mode of analysis (Creswell, 1998). The title of their original work "The Discovery of Grounded Theory" (Glaser & Strauss 1967) suggested concepts were ''discovered'', which subscribes to naive realism, an epistemology that

is often associated with positivism (Guba & Lincoln, 1994). Therefore, despite Glaser and Strauss's sensitivities to the insights of symbolic interactionism (LaRossa, 2005), classic grounded theory is inconsistent with both the relativist ontological position and constructivist epistemological stance of this study.

Charmaz's work (2000, 2006) on the ''constructivist grounded theory'' approach recognizes that the categories, concepts, and theoretical level of an analysis emerge from the researcher's interactions within the field and questions about the data. (Charmaz, 2000, p. 522). As mentioned in Chapter 3, Charmaz further suggests an "emergence" of the theory, a "flip flop" of interplay between pre-existing ideas and the researcher's conceptualisation of the theory (Charmaz, 1990), which is much more suitable for my own theoretical framework.

To avoid the error described by Gynnild (2011), a constant reflection on my own theoretical framework was required. In this study, it was important to understand the impact of different research methodologies and how my own epistemological and ontological stances influenced the study and my conduct during the research process. As illustrated in Chapter 3, this study holds a relativist ontological stance and constructivist epistemological concerns with the theoretical perspective of symbolic interactionism. Particular attention was paid during the data analysis stage to ensure that themes and categories emerged through the research process, rather than being pre-selected, which is a key element to constructivist grounded theory. Engaging in peer to peer discussions about the research methodology allowed me to gain a clear understanding about the practicalities of achieving this goal.

It is worth noting that there are ontological and epistemological debates surrounding constructivist grounded theory. For example, Willig (2016) proposed that constructivist grounded theory combines a realist ontological stance and humility driven epistemological position. To further complicate matters, Charmaz (2000, 2006) also uses constructivism and social constructionism interchangeably in her own work. However, after reviewing the literature available on the research method, this study settled upon a relativistic ontological stance and a constructivist epistemology. In particular the viewpoint emphasised by Charmaz (2001) in being evocative of the experiences of the participants, as the study is hoping to honour the participants' subjective experiences about their mental health beliefs and treatment expectations which is shaped by the nature of the social and cultural world they live in.

The quality of the constructivist grounded theory relies heavily on the researcher's subjective interpretations, which can be critiqued from a validation aspect. From the early stages of this study, I understood that my own values and perceptions could skew the result of the study. Therefore, I paid particular attention to being vigilant and reflective during the overall process. Guidance from my supervisor was essential in achieving the project aims: his advice on keeping a reflective journal and conducting self-reflective interviews were instrumental to avoiding methodological pitfalls. Examining cultural perspectives about mental health beliefs and treatment expectations within the Chinese immigrant community could be particularly challenging because of my own background, which is further examined in the reflective section. I acknowledge my own input towards the mental construction of the world of experiences through my own cognitive processes (Young & Colin, 2004) on the subject matter. The co-construction of meaning is at the heart of this research. It is a balancing act to enable participants' accounts, to make connections between analytical findings and the data, and to also demonstrate the value the researcher places on the participant as a contributor to the construction of the theoretical model (Fossey, Harvey, McDermott, & Davidson, 2002). Furthermore, it was an immense task which required me to constantly reflect upon my own practices, to link my reflection to theories and to be committed to reflective writing throughout the study. By committing to the reflective process, my own voice need not "transcend experience but re-envis[age] it... bring[ing] fragments of fieldwork time, context and mood together in a colloquy of the author's several selves—reflecting, witnessing, wondering, accepting—all at once" (Charmaz & Mitchell, 1996, p. 299). However, with hindsight, I could have conducted a pilot study in the early stages of the research. Feedback from the pilot study could have helped me to better design the interview question and address any potential researcher's bias (Nunes, Martins, Zhou, Alajamy, & Al-Mamari, 2010).

Another critique of the method is that there have been legitimate questions raised about whether the product of constructivist grounded theory studies is really "theory" at all (Thomas & James, 2006). Thomas and James (2006) further argued a "theory" that has the power to explain and predict certain phenomena is rarely present in grounded theory studies. However, Charmaz (2006) recommended that researchers follow the definition of theory that emphasises "imaginative understanding" (p. 126) rather than explanation. Bryant (2002) made a similar suggestion by saying researchers should focus their goals on achieving adequate understanding for a specified context and purpose rather than

discovering a larger truth or establishing general theories with the power to explain and predict. Charmaz's (2006) and Bryant's (2002) work helped me to be more content and focused in developing a theoretical model "as the integration of concepts that aims at an increased understanding of the area of enquiry through the novel contribution it provides" (Charmaz, 2006; Clarke, 2005). I understood that I needed to reflect thoughtfully on my research goals and be aware of the limitations of my emerging theoretical model. Nonetheless, the interviews conducted yielded rich data and I believe I did capture the phenomenon through my analysis, with my research findings successfully providing a theoretical model of the mental health beliefs and treatment expectation from the perspective of the studied population. However, the immense amount of data collected was a limitation for the study, as it was easy to be swept away by the data and lose focus on the thesis. A balance was needed between considering a "large picture" to "small details" perspective when exploring the data, and peer reviews were immensely beneficial during this process. Peer reviews were conducted to improve the validity of the study, but the perspectives I gained from fellow researchers helped me to be more reflective and focus on the themes of the study. Furthermore, I intend to address the data that was beyond the scope of this thesis through future written work and publications. Pragmatically speaking, this methodology is noted to be complex and lengthy due to constant coding and memo-writing (Bryant, 2002). This was particularly true during this study, as all the data was recorded, transcribed, translated and manually coded in a very time-consuming way, which at times was particularly challenging.

Due to the time and resource constraints, I was not able to conduct generation specific studies on participants from a particular generation such as those born between the 1960s and 1990s. A further comparative study on different generation groups would be interesting as previously suggested by the literature that generation subculture is correlated to level of individualism, which is closed related to mental health beliefs and the experience of mental health issues. The sample size of this research is relatively small (12 participants) and is an obvious limitation of the study. However, constructivist grounded theorists have argued that quality of the data takes precedence over sample size in constructivist grounded theory studies (Morse, 2007). Although I believe the data was theoretically saturated through a process of constant comparison, defining theoretical saturation remains a debatable issue amongst grounded theorists (Dey, 2007). There is no definitive answer to whether this study has achieved saturation theoretically. Ideally, the process of data collection and data analysis in grounded theory continues

until no more new categories can be identified (Willig, 2013). Given the nature of the study, there are possibilities that further emergent perspectives will change and help develop the theory even after the thesis has been published, which I intend to address with future written work.

One of the limitations of using intensive interviews as the data collection method can be judging how honest the participants are. Given that mental health is a highly stigmatised subject in Chinese culture and a collective societal norm, there is no way to know for sure whether the participants were only sharing information they thought was socially acceptable with me or sharing their true feelings. The participants' potential reluctance to share their feelings could be seen as a vital aspect of the study, as it further demonstrates how mental health is stigmatised in Chinese culture. As the analysis suggested, many participants expressed a desire for ethnically matching mental health professionals, as they felt ethnically matching mental health professionals could have a better grasp of their culture and background. As a Chinese trainee counselling psychologist conducting a study on a Chinese immigrant population, I was aware that our shared language and cultural background could help me initiate a conversation on the subject of mental health with the participants. At the same time, it felt important for me to also acknowledge the emotions behind the experiences they were sharing. Being attentive to the participants' emotions during the interviews while being reflective on my own thoughts helped me to gain a better understanding of participants' agendas. All the participants wanted to help the Chinese community as a whole and this created a strong motivation to share their thoughts on the subject (hence the rich data). Given that the subject of mental health is highly personal and sensitive, even potentially traumatising, I was surprised and overwhelmed by their response. This observation led me to think that maybe a triangulation of sources should have been conducted in the form of respondent validation or member check (Mays & Pope, 1995), as I previously contemplated and rejected (see Chapter 3) for the reason that participants might change their mind and withdraw from the study. The lack of respondents' validation I now view as a limitation of this study and will include it in my future work.

The final theoretical model makes no claims at generalisation as the aim of this research was to achieve an interpretive understanding of the studied population. However, it is still important for me to consider the generalisability or transferability of the findings (Lewis & Ritchie, 2003). The current study dealt with a specific population: first

generation Chinese immigrants in the UK. It is possible that the findings that emerged could be applied to the Chinese immigrant population in general, but given the uniformity of the participants' backgrounds, the potential to generalise this study's findings to a wider population could be limited. Constructivist grounded theory has been criticised for its non-generalisability (Urquhart, Lehmann, & Myers, 2010), but does offer fresh insights based on the theory being drawn from the data (Corbin & Strauss, 1998). By conducting this study, I hope the theoretical model generated can bridge the different ideas about mental health between two different cultures (UK and China). The statements produced are not universal, but tentative generalisations (Byrant & Charmaz, 2007) for the Chinese community in the UK.

5. 3 Reflections

To take a reflexive stance is an obligation, both as a constructivist grounded theory researcher and as a counselling psychologist (BPS guideline, 2016; Charmaz, 2006). Throughout the research process, the researcher must constantly reflect on how meanings are generated and interpreted by both the researcher and the participants (Charmaz, 2006; Mruck & Mey, 2007). In Chapter 3, a self-reflective interview was included to demonstrate this reflective process in relation to the data collection process. In this section, a further reflection on the theoretical framework and data analysis is illustrated.

The purpose of reflexivity is described by Nightingale and Cromby (1999) as the exploration of the "ways in which a researcher's involvement with a particular study influences acts upon and informs such research" (p. 228). The constructivist epistemological stance and the symbolic interactionist theoretical perspective I took for this study both suggest that data generation is the result of interplaying knowledge between the researcher and participants (Birks & Mills, 2011). For the researcher, this is a personal and professional recognition that my own perspective is contributing to the construction of meaning while engaged in research (Munhall, 2007), as previously highlighted in Chapter 3.

My reasons for conducting research on the mental health beliefs and treatment expectations in the context of cultural perspectives for Chinese immigrants are both personal and professional. I wish to address the mental health needs of Chinese

immigrants using their own voices; however, the participants' experiences had a profound impact on me, which led me to revisit some of my own mental health beliefs.

The aspects of dynamism between the major Chinese philosophies explored in Chapters 2, 3 and 4 were apparent within me. Their emphasis on societal order and the importance of education give me "mian zi" as a trainee counselling psychologist. Being reflective about my own feelings allowed me to truly appreciate the importance of cultural perspectives and how meaning is constructed by individuals. This realisation also made me more sensitive to culturally related content when analysing the participant's narratives.

During my two years of training, I worked with a charity that specialises in providing mental health services to Chinese immigrants, which made me confident about my ability to build rapport with the participants. Most participants were keen to share their experience and discuss the subject, which was a huge encouragement to me; at the same time, I also felt very obliged to "describe the experiences of others in the most faithful way possible" (Munhall, 2001, p. 540) for my participants.

Preserving my own privacy was also a precarious issue, as the term privacy has negative connotations in Chinese society (Ess, 2006), with the concept representing ideas about the personal and the self instead of collective social values (Zarrow, 2002). It was very common that participants would ask personal questions about me. When such occasions arose, I found it challenging to strike a balance between preserving my own privacy and creating trust. What I tried was refocusing their interest onto the subject matter, engaging them by becoming their partner in a more general conversation about mental health. Many participants responded well to these methods. As a first generation Chinese immigrant, I often felt that I had some inside knowledge about the studied group; yet at the same time, to maintain neutrality in the research, I also had to remind myself that I was an outsider who was looking in as a researcher and/or as a mental health professional throughout the process. Ultimately, it is the participants' narratives that are most valuable to this study.

I was cautious that my own stances and feelings could influence the research findings unwittingly if they were left unchecked. When participants were dissatisfied with the current mental health services, I found myself trying to distance myself from the identity of a mental health professional and highlighted my identity as a first generation

Chinese immigrant instead to form an alliance with the participants. On realising those urges, I made an effort to contain my own emotions. I was also saddened and frustrated when I heard some participants speak about a perceived lack of empathy and interest in Chinese culture from mental health professionals. All these emotions had to be recognised and contained while I engaged in the data. A benefit of conducting research over a long period of time is that I had the reflective space during analysis and constant memo-writing to keep my own emotions in check. Being part of the community that I was studying did bring up complex emotions during the research process, but it was my belief that my research could help the wider community that motivated me. The process of conducting this research has also benefited my therapeutic work; it has allowed me to fully appreciate the complexity of culture, and further understand the intertwined relationship between culture and mental health. More efforts to investigate and examine an individual patient's cultural background will be practised in my future clinical work.

Reflexivity also serves as a means to promote validity, in particular when conducting qualitative research (Darawsheh, 2014). A detailed discussion on validity was included in Chapter 3; however, a further exploration of reflexivity and validity is needed in this section as I often wondered about the relationship between the concepts of validity and reflexivity throughout my research. It was acknowledged because patients and their safety represent such an important priority, that only findings (i.e. evidence) from high quality and rigorous research (i.e. quantitatively valid) should be included in healthcare practitioner guidelines (Shojania, Duncan, McDonald, & Wachter, 2002). Newton (2009) has suggested that quantitative research methods are now considered the gold standard in contemporary healthcare research and validity is a key factor in such a perspective. Because often in qualitative studies "input does not equal output" (Trueit, 2008, p. 36), as this study has demonstrated, there is no obvious, linear research progress that could dominate any evaluation of validity. Because of this, qualitative studies are sometimes overlooked or even dismissed as having too many validity threats to be incorporated into practice guidelines (Newton, 2009). However, qualitative studies are extremely valuable in representing patient perspectives, which is lacking in the current policy and guidelines (Newton, 2009), especially for the Chinese immigrant population in the UK. As mentioned earlier, participants in this study all expressed their wish to help the Chinese community as a whole, and this observation led me to wonder why the opportunity for Chinese mental health service users to share their experiences was not previously widely available; therefore it was imperative for me to respect and

honour this opportunity by presenting their narratives with the use of a qualitative method.

Stronach and MacLure (1997) requested a reconsideration of the traditional views of concepts such as validity and reflexivity by saying we should "resist closure…to find an opening in discourses, regimes, policies, theories or practices which tend to the inertia of closure and certainty" (Stronach & MacLure, p. 6). In recent years, Lather's transgressive validity (1994) has often been referred to by non-quantitative researchers (e.g. Fox, 2003). Lather (1994) describes her conceptualization of validity as "a dispersion, circulation and proliferation of counter, practices of authority" (p. 40) in which reflexivity, ethics and politics are integral parts of any research. Lather's concept of validity demands the researcher to be present and accounted for in research findings and evidence put forth as new knowledge which I believe I have demonstrated in this study.

I believe the study was successful in answering the research question (how to understand mental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community). The theoretical model that was generated when examining the Chinese immigrants' mental health beliefs and treatment expectations when accessing current mental health services sheds light on the Chinese immigrants' help seeking processes, which are important in the delivery of a patient-centred, culturally competent service. The unique contribution of this research centres around two areas: a study on a population that was not well researched before; and the provision of an overarching model to understand Chinese cultural perspectives in relation to mental health beliefs and treatment expectations.

The theoretical framework of this study assumes that an external, multi-faceted reality exists and our understanding of this reality is seen as relative. The points of view that are gathered from the participants' narratives offer a more thorough picture about how mental health beliefs and treatment expectations are constructed within the cultural perspectives of Chinese immigrants. The strength of this study primarily lies in the participants' knowledge and experiences, which provided the richness of the data gathered. By using a constructivist grounded theory approach, the research offered an understanding of the "tacit, the luminal, and the marginal that otherwise might remain unseen and ignored, such as latent sources of conflict" (Charmaz, 2011 p.362). The study has met one of its aims by contributing research to the field of counselling

psychology in an area where little research has been conducted. The theoretical model generated from this study does not make generalised claims, but by the co-construction of the participants' experiences and my analysis, a novel way of understanding the mental health beliefs and treatment expectations of Chinese immigrants is proposed.

5.4 Implications of the study

The findings of this study offer a unique insight into understanding Chinese cultural perspectives in the context of mental health beliefs and treatment expectations, which may provide a foundation for future research to develop theory-based interventions, mental health service users' family support groups, community de-stigmatisation programs and culturally competent policies of care for better mental health service provision for the Chinese immigrant population. In relation to the field of counselling psychology, the current study offers counselling psychologists and mental health professionals at large a framework and a source of awareness when working with Chinese immigrant clients and mental health services users (Charmaz, 2006).

The implications of this project are numerous and cross many different fields of study. Most important among them is that the perspectives of Chinese immigrants need to be taken into consideration during mental health policy making. Mental health promotion policies involving the Chinese community can be developed and further tested using this information. More collaborative care can be disseminated and employed in the current mental health services. As Chapter 4 suggested, the mental health beliefs and treatment expectations of Chinese immigrants are not static; they are fluid and changeable, therefore further research into the process of cultural change and its impact on the delivery of the mental health services is needed.

Chapter 2 discussed the importance of cultural competence in the provision of mental health services. It is important for mental health policy makers and professionals to adopt a set of integrated behaviours, attitudes and policies that enable them to work effectively in cross-cultural situations as suggested by Cross et al. (1989). Spencer-Rodgers and colleagues (Spencer-Rodgers, Williams, & Peng, 2010) acknowledge that translating cultural understanding into everyday practice is challenging; however, in light of this study's findings, it would help make mental health services more effective for the studied population. This study seeks to build on its uncovered knowledge and

look at its practical applicability in the field of mental health services in the UK. In this section, my role as a trainee counselling psychologist with experience of working with the Chinese community also provided insight into the current mental health services and helped contribute to the lessons learned on service provision.

5.4.1 Community and family focused mental health promotion and prevention

As Chapters 2 and 4 revealed, support from the families and communities of Chinese mental health service users in distress is paramount. In order to serve the Chinese community more effectively, mental health services need to understand Chinese cultural perspectives and develop both institutional and grassroots support networks for this community.

This study's results show that there is a limited understanding and awareness about mental health in the studied population. In addition, the study also found a high emphasis on collective values within the Chinese community. The lack of access to mental health services also poses a great challenge for this population; findings also revealed that health in general (including mental health) is viewed within a holistic framework. In light of these findings, it is important to develop mental health promotion and prevention programmes that are community and family focused. Attempts to de-stigmatise mental health within this population are more likely to be effective when focusing on the social dimensions of the mental health service users, which include community and family.

In a report presenting the key findings of the economic case for mental health promotion and prevention to the Department of Health (Knapp, McDaid, & Parsonage, 2011), early intervention was found to result in the successful prevention of mental illness. From my experience working with the Chinese community, I observe that this proactive stance is not fully reflected in the current services focused on the Chinese immigrant community, as interventions are mostly reactive. There are almost no support services for the family members of Chinese mental health service users and very limited family therapy services for Chinese families. NICE guidelines (2014) have highlighted the importance of helping family members who support someone who has experienced mental disorders; such services for Chinese families with culturally tailored messages

could be very beneficial for this population, given the common enmeshed family dynamic. Knowledge about cultural values is an important indicator when assessing a patient's strengths and weaknesses, so subsequent interventions can be more effectively tailored. For example, as maintaining a balance between body and mind is part of the traditional health views of the Chinese community, a focused intervention which looks at developing and promoting physical health in combination with mental health for this population would be helpful. Such mind-body workshops within the community could further help to decrease social isolation for Chinese immigrants. Another important health promotion intervention should create opportunities where the perspectives of Chinese service users are listened to and respected. Patient groups targeted at the Chinese community could be helpful in moving the service in a more patient-centred direction.

5.4.2 Linguistically and culturally accessible mental health services

It is important to take the dynamic aspects of the concept of culture into consideration when working with the Chinese community. This suggests that mental health services need to be both linguistically and culturally accessible. Kirmayer and colleagues (Kirmayer, Groleau, Guzder, Blake & Jarvis, 200) pointed out that there is an urgent need to expand the service base through cultural consultation services. It is important that the current mental health service systems work with the current understanding of the cultural implications of mental illness and treatment expectations for different populations and tailor their services accordingly. For example, when working on mental health de-stigmatisation, it is important to assess the current understanding about mental health within the Chinese community so that relative improvements can be recognised. One of the key findings of this study is the gender differences in relation to expressing and understanding mental health in context of Chinese culture. The gender specific element within the wider cultural understanding should facilitate the development of practice frameworks such as gender specific support groups.

Furthermore, the cultural sources of support such as "befriending" projects and "well-being" clubs should be integrated into the care plans for Chinese mental health service users. This means to first understand the cultural sources of individual support that the user is currently accessing and then to validate their function within the individual's support network. Such validation can lead to a sense of being understood and accepted, which can provide greater rapport and trust in the mental health service provision

(Beiser, Simich, & Pandalangat, 2003). In addition, local Chinese media (both print and online, such as the UK Times or Nee Hao magazine) should be used by mainstream organisations for health promotion and outreach work within the Chinese community.

5.4.3 Multiple services collaboration

This study suggests that the current mental health services need to work in collaboration with various services and charities for a better engagement with and service provision for the Chinese community. These should include local GP services, social care services, age UK and universities across the UK. Collaborative work should focus on educating all collaborators about Chinese cultural perspectives in relation to mental health and mental illness identification, as often they are the first point of contact for Chinese immigrants and can play a vital role in initiating help-seeking. Early intervention would be made possible by strengthening the capacity of these sectors, as suggested by previous studies (Durlak & DuPre, 2008; Taylor & Stanton, 2007).

This study clearly identifies that it is important to consider various Chinese cultural perspectives when working with Chinese immigrant populations, as these perspectives closely relate to how mental health beliefs and treatment expectations are constructed. This calls for mental health promotion, prevention and subsequent interventions to go beyond the existing frameworks to develop a culturally informed strategy for the mental health care of the Chinese community. Furthermore, the theoretical model will hopefully inform various agents like primary health care providers, Chinese communities and the social services sector.

5. 5 Suggestions for future research

This study adopted the constructivist grounded theory research method, which is consistent with the practice of counselling psychology aiming to integrate issues such as culture, gender, ethnicity and sexuality into its sphere of knowledge to understand humans (Strawbridge & Woolfe, 2010). The generated theoretical model from this research points to the importance of cultural and societal perspectives and presented a layered relationship framework to understand Chinese immigrants' mental health needs, which can contribute to the provision of culturally competent and patient-centred care. This study suggests the need for further research in several directions. A collaborative

care approach is required when working with the Chinese community, so further research is needed about the role of different services across all sectors, such as the role of GPs and social services when working with the studied population. The mental health providers' perspectives about working with Chinese immigrants should be examined to understand the current cultural awareness of this population amongst mental health professionals, which is considered a key competent for the provision of a culturally competent service (Gerrish & Papadopoulos 1999).

Throughout my research, I was constantly encouraged by the participants' feedback on the research subject. Their enthusiasm in sharing their experience, their curiosity about mental health as a subject and their view of me as being a representative of the Chinese community in mental health often moved me. I observed a greater participant involvement throughout the research process, both in the data collection stage and later on in the data analysis stage. This observation led me to believe that despite mental health being a highly stigmatised subject in Chinese culture, group studies such as a focus group are possible for further studies. Further studies could be conducted using different research approaches, such as quantitative or experimental methods, to further understand and determine cultural change and its impact on mental health service delivery for the Chinese immigrant population. Giving the complexity and heterogeneous nature of the Chinese immigrant community, specific studies on different generation groups, the length of immigration and level of acculturation could be conducted to further understand this community's mental health needs.

The future learning opportunities generated from this study are not limited to increasing awareness about the mental health needs of the Chinese immigrant community. Increasingly, counselling psychologists need to think of their role in a more global context, according to a recent article on "A Global Portrait of Counselling Psychologists' Characteristics, Perspectives, and Professional Behaviors" (Goodyear et al., 2016), there are between-country similarities and differences in how counselling psychology is practised. For example, CBT is endorsed by as few as 2.6% of the counselling psychologist in Taiwan, a country embedded with traditional Chinese cultural values (Fan, 2000), to as much as 20.1% in the United Kingdom (Goodyear et al., 2016). In understanding these similarities and differences, lessons can be applied from Eastern philosophy and projected onto the disciplines of Western psychology. For instance, mindful meditation is now widely considered a psychotherapeutic method for treating

various mental health disorders and the concept is deeply rooted in ancient Eastern philosophy (Walsh & Shapiro, 2006). Bolen (2005) suggested that the Chinese philosophy of Taoism can be used as the basis of specific counselling techniques. The Taoist concept of synchronicity (which connects two seemingly unrelated simultaneous events through their meaning (Aziz, 1990) was also observed and studied by Jung (Jung & Pauli, 1957). As the literature review revealed, traditional Chinese philosophies like Taoism and traditional Chinese medicine adopt a body-mind holistic approach to conceptualise health, including mental health. Studies (Chan, Ng, Ho, & Chow, 2006; Neimeyer, 2012) have found that adopting a body-mind-spirit integrated model shows promising results in a number of health conditions, psychosocial predicaments and bereavement treatment settings, which can be applied in Western healthcare settings.

This study has increased the understanding of cultural perspectives in the context of mental health beliefs and treatment expectation for Chinese immigrants and provided future research opportunities to further understand the growing Chinese community's mental health needs. In addition, this study also hopes that Western counselling psychologists can be more accepting and embrace a holistic view of mental health. As an ancient Chinese proverb puts it: "teaching and learning promote each other".

Reference

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review*, *31*(6), 934-948.

Agiomirgianakis, G., & Zervoyianni, A. (2001). Macroeconomic equilibrium with illegal immigration. *Economic Modelling*, *18*(2), 181-202.

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behaviour.* Englewood Cliffs, NJ: Prentice-Hall.

Akilli, S. (2003). Chinese immigration to Britain in the post-WWII period. Retrieved from http://www.postcolonialweb.org/uk/mo/sakilli10.html

Alarcón, R. D. (2009). Culture, cultural factors and psychiatric diagnosis: review and projections. *World psychiatry*, *8*(3), 131-139.

Alasuutari, P. (1996). Theorizing in qualitative research: A cultural studies perspective. *Qualitative Inquiry*, *2*(4), 371-384.

Allen, L. M. (2010). A critique of four grounded theory texts. *The Qualitative Report*, *15*(6), 1606-1620.

Alon, I. (2003). *Chinese culture, organizational behavior, and international business management*. Portsmouth: Greenwood Publishing Group.

Altarriba, J., & Santiago-Rivera, A. L. (1994). Current perspectives on using linguistic and cultural factors in counseling the Hispanic client. *Professional Psychology: Research and Practice*, *25*(4), 388-39.

American Psychiatric Association (Ed.). (1980). *Quick reference to the diagnostic criteria from DSM-III*. Washington, DC: The American Psychiatric Association.

Andersen, P. A., & Guerrero, L. K. (Eds.). (1997). *Handbook of communication and emotion: Research, theory, applications, and contexts*. Salt Lake City: Academic Press.

Anderson, L., & Bennett, N. (Eds.). (2003). *Developing educational leadership: using evidence for policy and practice*. London: SAGE.

Andrews, M., Lyne, P., & Riley, E. (1996). Validity in qualitative health care research: an exploration of the impact of individual researcher perspectives within collaborative enquiry. *Journal of Advanced Nursing, 23*(3), 441-447.

Angermeyer, M. C. Matschinger, H., & Schomerus, G. (2013). Attitudes towards psychiatric treatment and people with mental illness: changes over two decades. *The British Journal of Psychiatry, 203*(2), 146-151.

Angermeyer, M. C., Link, B. G., & Majcher-Angermeyer, A. (1987). Stigma perceived by patients attending modern treatment settings: Some unanticipated effects of community psychiatry reforms. *The Journal of Nervous and Mental Disease, 175*(1), 4-11.

Annells, M. (1997). Grounded theory method, part I: Within the five moments of qualitative research. *Nursing Inquiry, 4*(2), 120-129.

Appleton, J. V., & King, L. (1997). Constructivism: A naturalistic methodology for nursing inquiry. *Advances in Nursing Science, 20*(2), 13-22.

Atkinson, D. R., Kim, B. S., & Caldwell, R. (1998). Ratings of helper roles by multicultural psychologists and Asian American students: Initial support for the three-dimensional model of multicultural counseling. *Journal of Counseling Psychology, 45*(4), 414-423.

Aziz, R. (1990). *CG Jung's psychology of religion and synchronicity*. New York: SUNY Press.

Babcock, M. K., & Sabini, J. (1990). On differentiating embarrassment from shame. *European Journal of Social Psychology, 20*(2), 151-169.

Bajekal, M., Becher, H., Boreham, R., Brookes, M., Calderwood, L., Erens, R. & Korovessis, C. (2001). *Health Survey for England: The Health of Minority Ethnic Groups' 99*. London: Stationery Office.

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: a case of the tail wagging the dog? *British Medical Journal, 322*(7294), 1115-1117.

Baumeister, R. R. (1998). The self. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (Vol. 1, pp. 680–740). New York: McGraw-Hill.

Becker, H. S., & McCall, M. M. (Eds.). (2009). *Symbolic interaction and cultural studies*. Chicago: University of Chicago Press.

Becker, J. (2002). *The Chinese*. Oxford: Oxford University Press.

Beckman, H. B., & Frankel, R. M. (1984). The effect of physician behavior on the collection of data. *Annals of Internal Medicine, 101*(5), 692-696.

Bedford, O., & Hwang, K. K. (2003). Guilt and shame in Chinese culture: A cross-cultural framework from the perspective of morality and identity. *Journal for the Theory of Social Behaviour*, *33*(2), 127-144.

Beiser, M., Simich, L., & Pandalangat, N. (2003). Community in Distress: Mental Health Needs and Help-seeking in the Tamil Community in Toronto. *International Migration*, *41*(5), 233-245.

Bellah, R. N., Madsen, R., Sullivan, W. M., Swidler, A., & Tipton, S. M. (1985). *Habits of the heart: Individualism and commitment in American life*. Oakland: University of California Press.

Bennett, A. (2014, June 16). The rise of China: eight ways the middle kingdom is beating the United Kingdom. *The Huffington Post*. Retrieved from http://www.huffingtonpost.co.uk/2014/06/16/china-uk-11-ways-compare_n_5498793.html

Benoliel, J. Q. (1996). Grounded theory and nursing knowledge. *Qualitative Health Research, 6*(3), 406-428.

Benton, G., & Gomez, E. T. (2008). *The Chinese in Britain, 1800-present: economy, transnationalism, identity.* Basingstoke, Hampshire: Palgrave Macmillan.

Berger, D. (2008). Relational and Intrinsic Moral Roots: A Brief Contrast of Confucian and Hindu Concepts of Duty. *Dao, 7*, 157-163.

Berger, P. L., & Luckmann, T. (1991). *The social construction of reality: A treatise in the sociology of knowledge*. London: Penguin.

Bergiel, E. B., Bergiel, B. J., & Upson, J. W. (2012). Revisiting Hofstede's Dimensions: Examining the Cultural Convergence of the United States and Japan. *American Journal of Management, 12*(1), 69-79.

Berry, J. W. (1998). Acculturative stress. In P. B. Organista & K. M. Chun (Eds.), *Readings in ethnic psychology* (pp. 117-122). New York: Routledge.

Berry, J. W. (2003). Conceptual approaches to acculturation. In K. M. Chun, P. B. Organista, & G. Marin (Eds.), *Acculturation: Advances in theory, measurement, and applied research* (pp. 17–37). Washington, DC: American Psychological Association.

Berry, J. W. (2008). Globalization and acculturation. *International Journal of Intercultural Relations, 32*(4), 328–336.

Bhattacharya, R., Cross, S., & Bhugra, D. (2010). *Clinical topics in cultural psychiatry*. London: RCPsych Publications.

Bhugra, D. (2004). Migration, distress and cultural identity. *British Medical Bulletin, 69*(1), 129-141. doi: 10.1093/bmb/ldh007

Bhugra, D. (2003). Migration and depression. *Acta Psychiatrica Scandinavica, 108*(s418), 67-72. doi: 10.1034/j.1600-0447.108.s418.14.x

Bhugra, D., & Jones, P. (2001). Migration and mental illness. *Advances in Psychiatric Treatment, 7*(3), 216-222.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. *BMC Health Services Research, 7*(15), Published online Jan 31, 2007. doi: 10.1186/1472-6963-7-15

Birbili, M. (2000). Translating from one language to another. *Social Research Update, 31*(1), 1-7. Retrieved from http://sru.soc.surrey.ac.uk/SRU31.html

Birks, M., & Mills, J. (2011). *Grounded theory: a practical guide*. London: SAGE.

Blackwell, M. (1997). Psychiatrists and Chinese mental health. In L. Yee & S. Au (Eds.), *Chinese Mental Issues in Britain* (pp. 29–32). London: Mental Health Foundation.

Blee, K. M. (1998). White-knuckle research: Emotional dynamics in fieldwork with racist activists. *Qualitative Sociology*, *21*(4), 381-399.

Blowers, G. (2000). Learning from others: Japan's role in bringing psychology to China. *American Psychologist*, *55*(12), 1433-1436.

Blumer, H. (1954). What is wrong with social theory? *American sociological review*, *19*(1), 3-10.

Blumer, H. (1969). *Studies in social movements: A social psychological perspective*. New York: Free Press.

Bolen, J. S. (2005). *The Tao of psychology*. London: Harper Collins.

Bond, M. H. (1987*). Intergroup relations in Hong Kong: The Tao of stability*. Newbury Park, CA: Sage.

Bond, M. H. (2010). *The Oxford handbook of Chinese psychology*. Hong Kong: Oxford University Press.

Bond, M. H., & Hwang, K. K. (1986). *The psychology of the Chinese people*. Oxford: Oxford University Press.

Bowen, G. A. (2006). Grounded theory and sensitizing concepts. *International Journal of Qualitative Methods*, *5*(3), 12-23. doi: 10.1177/160940690600500304

Bowker, G., & Star, S. L. (1999). *Sorting things out: Classification and its consequences*. New Baskerville: MIT University Press.

Boyce, C., & Neale, P. (2006). *Conducting in-depth interviews: A guide for designing and conducting in-depth interviews for evaluation input*. Watertown, MA: Pathfinder International.

Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57*(4 suppl), 181-217.

Bradby, H. (2002). Translating culture and language: a research note on multilingual settings. *Sociology of Health & Illness, 24*(6), 842-855.

British Psychological Society (2008). *Code of ethics and conduct*. Retrieved from http://www.bps.org.uk/sites/default/files/.../generic_professional_practice_guidelines.pdf

British Psychological Society (2014). *Professional practice guidelines.* Retrieved from http://www.bps.org.uk/sites/default/files/documents/professional_practice_guidelines_-_division_of_counselling_psychology.pdf

British Psychological Society. (2009). *Code of ethics and conduct*. Retrieved from http://www.bps.org.uk/system/files/documents/code_of_ethics_and_conduct.pdf

Brooks, E. B., & Brooks, A. T. (1998). *The original analects: Sayings of Confucius and his successors*. New York: Columbia University Press.

Bryant, A. (2002). Re-grounding grounded theory. *JITTA: Journal of Information Technology Theory and Application, 4*(1), 25-42.

Bryant, A., & Charmaz, K. (Eds.). (2007). *The Sage handbook of grounded theory*. London: SAGE.

Byrne, G., & Heyman, R. (1997). Understanding nurses' communication with patients in accident & emergency departments using a symbolic interactionist perspective. *Journal of Advanced Nursing, 26*(1), 93-100.

Byrne-Armstrong, H., Higgs, J., & Horsfall, D. (2001). *Critical moments in qualitative research*. Oxford: Butterworth-Heinemann Medical.

Calderwood, L., & Tait, C. (1999). Self-reported health and psychosocial well-being. In B. Erens, P. Primatesta, & G. Prior (Eds.), *Health survey for England 1999: The health of minority ethnic groups.* The Stationery Office: London.

Caldwell-Harris, C. L., & Ayçiçeği-Dinn, A. (2009). Emotion and lying in a non-native language. *International Journal of Psychophysiology*, *71*(3), 193-204.

Callaghan, P., Shan, C. S., Yu, L. S., Ching, L. W., & Kwan, T. L. (1997). Attitudes towards mental illness: testing the contact hypothesis among Chinese student nurses in Hong Kong. *Journal of Advanced Nursing*, *26*(1), 33-40.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*, *38*(5), 203-207.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing*, *13*(3), 181-184.

Castillo, R. J. (1997). *Culture & mental illness: A client-centered approach*. London: Thomson Brooks/Cole Publishing Co.

Cattell, R. B. (1949). The dimensions of culture patterns by factorization of national characters. *The Journal of Abnormal and Social Psychology*, *44*(4), 443-469.

Chan, A. K. (2000). Confucian ethics and the critique of ideology. *Asian Philosophy*, *10*(3), 245-261.

Chan, C. L., Ng, S. M., Ho, R. T., & Chow, A. Y. (2006). East meets West: applying Eastern spirituality in clinical practice. *Journal of Clinical Nursing*, *15*(7), 822-832.

Chan, D. K. (1994). COLINDEX: A refinement of three collectivism measures. In U. E. Kim, H. C. Triandis, Ç. E. Kâğitçibaşi, S. C. E. Choi, & G. E. Yoon (Eds.), *Individualism and collectivism: Theory, method, and applications* (pp. 200-210). London: SAGE.

Chan, H., & Lee, R. P. (1995). Hong Kong families: At the crossroads of modernism and traditionalism. *Journal of Comparative Family Studies*, *26*(1), 83-99.

Chan, J. (1998). *Psychological adaptation of children and youth newly arrived in Hong Kong from mainland China: Research, theory and practice*. Hong Kong: Aberdeen Kai-fong Welfare Association Social Service Centre.

Chang, B. J., & Kemp, C. (2004). China. In C. Kemp & L. A. Rasbridge (Eds.*), Refugee and immigrant health: A handbook for health professionals* (pp. 132–141). Cambridge: Cambridge University Press.

Chang, S. C., & Dong-Shick, R. (2005). Buddhist teaching: Relation to healing. In W. Tseng, S.C. Chang, & M. Nishizono (Eds.), *Asian culture and psychotherapy: implications for East and West* (pp. 157-165). Honolulu: University of Hawaii Press.

Chang, W. C. (1985). A cross-cultural study of depressive symptomology. *Culture, Medicine and Psychiatry, 9*(3), 295-317.

Chao-lin, G. U., & Kesteloot, C. (1997). Social polarisation and segregation phenomenon in Beijing. *Acta Geographica Sinica*, *52*(5), 385-393.

Charmaz, K. (1991). *Good days, bad days: The self in chronic illness and time*. NJ: Rutgers University Press.

Charmaz, K. (1995a). Between positivism and postmodernism: Implications for methods. *Studies in Symbolic Interaction, 17*(2), 43-72.

Charmaz, K. (1995b). Grounded theory. In J. Smith et al. (Eds.), *Rethinking methods in psychology* (pp. 27-49). London: Sage.

Charmaz, K. (2000). Constructivist and objectivist grounded theory. In N. K. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509-536). Thousand Oaks, CA: Sage.

Charmaz, K. (2001). Grounded theory: Methodology and theory construction. *International Encyclopaedia of the Social and Behavioral Sciences*, Volume 1, 6396-6399.

Charmaz, K. (2003). Grounded theory. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 81-110). London: SAGE.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: SAGE.

Charmaz, K. (2012). The power and potential of grounded theory. *Medical Sociology Online*, *6*(3), 2-15.

Charmaz, K., & McMullen, L. M. (2011). *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry*. London: Guilford Press.

Charmaz, K., & Mitchell, R. G. (1996). The myth of silent authorship: Self, substance, and style in ethnographic writing. *Symbolic Interaction, 19*(4), 285-302.

Charon, R. (2001). Narrative medicine: a model for empathy, reflection, profession, and trust. *JAMA*, *286*(15), 1897-1902. doi:10.1001/jama.286.15.1897

Chau, C.M. & Yu, W.K. (1999). S*urvey Report on the Health and Social Needs of Chinese Women in Sheffield*. Sheffield: Lai Yin Association (in Chinese and English).

Chau, C.M. & Yu, W.K. (2002). Coping with social exclusion: experiences of Chinese women in three societies. *Asian Women*, *14*, 103–27.

Chau, R. C. M. (2008). *Health Experiences of Chinese People in the UK: A Race Equality Foundation Briefing Paper.* London: Race Equality Commission.

Chen, A. W., & Kazanjian, A. (2005). Rate of mental health service utilization by Chinese immigrants in British Columbia. *Canadian Journal of Public Health*, *96*(1), 49-51.

Chen, S., Sullivan, N. Y., Lu, Y. E., & Shibusawa, T. (2003). Asian Americans and mental health services: A study of utilization patterns in the 1990s. *Journal of Ethnic and Cultural Diversity in Social Work*, *12*(2), 19-42.

Chen, Y. C. (2001). Chinese values, health and nursing. *Journal of Advanced Nursing*, *36*(2), 270-273. doi: 10.1046/j.1365-2648.2001.01968.x

Cheng, C., Lo, B. C. Y., & Chio, J. H. M. (2010). The Tao (way) of Chinese coping. In M. H. Bond (Ed.), *The Oxford Handbook of Chinese Psychology* (pp. 399-419). Hong Kong: Oxford University Press.

Cheng, M.M., & Wong, S.L. (1997). Religious convictions and sentiments. In S.K. Lau et al. (Eds.), *Indicators of social development* (pp. 299-329). Hong Kong: The Chinese University of Hong Kong.

Chenitz, W. C., & Swanson, J. M. (1986). From Practice to Grounded Theory: Qualitative Research in Nursing Menlo Park, CA: Addison-Wesley. *Nursing Science Quarterly*, *2*(1), 53-54. doi: 10.1177/089431848900200113

Chepenik, L. G., & Mallory, M. N. S. (2013). *Behavioral Emergencies for the Emergency Physician*. Cambridge: Cambridge University Press.

Cheung, F. M. (1982). Psychological symptoms among Chinese in urban Hong Kong. *Social Science & Medicine*, *16*(14), 1339-1341. doi: 10.1016/0277-9536(82)90029-6

Cheung, F. M. (2009). *Mainstreaming gender in Hong Kong society*. Hong Kong: Chinese University Press.

Cheung, F. M., Leong, F. T., & Ben-Porath, Y. S. (2003). Psychological assessment in Asia: introduction to the special section. *Psychological Assessment*, *15*(3), 243-247.

Chin, P. (2005). Chinese. In J. G. Lipson & S. L. Dibble (Eds.), *Culture & clinical care* (pp. 98-108). San Francisco: UCSF Nursing Press.

Chinese Culture Connection (1987). Chinese values and the search for culture-free dimensions of culture. *International Journal of Psychology*, *18*, 143-164.

Chinese National Census (2014). Population data. Retrieved from http://www.stats.gov.cn/tjsj/ndsj/2014/indexeh.htm

Chong, F. H. H., & Liu, H. Y. (2002). Indigenous counseling in the Chinese cultural context: Experience transformed model. *Asian Journal of Counselling*, *9*(1), 49-68.

Chou, K. L., Mak, K. Y., Chung, P. K., Chan, D., & Ho, K. (1996). Attitudes towards mental patients in Hong Kong. *International Journal of Social Psychiatry*, *42*(3), 213-219.

Chun, C. A., Enomoto, K., & Sue, S. (1996). Health care issues among Asian Americans: Implications of somatization. In P. M. Kato & T. Mann (Eds.), *Handbook of diversity issues in health psychology* (pp. 347–366). New York: Plenum.

Chung, K. F., & Wong, M. C. (2004). Experience of stigma among Chinese mental health patients in Hong Kong. *The Psychiatrist*, *28*(12), 451-454.

Chung, K. F., Chen, E. Y., & Liu, C. S. (2001). University students' attitudes towards mental patients and psychiatric treatment. *International Journal of Social Psychiatry*, *47*(2), 63-72.

Chung, R. C. Y., & Lin, K. M. (1994). Help-seeking behavior among Southeast Asian refugees. *Journal of Community Psychology*, *22*(2), 109-120.

Claassen, D., Ascoli, M., Berhe, T., & Priebe, S. (2005). Research on mental disorders and their care in immigrant populations: a review of publications from Germany, Italy and the UK. *European Psychiatry*, *20*(8), 540-549.

Clark, K., & Drinkwater, S. (2006). Changing patterns of ethnic minority self-employment in Britain: Evidence from Census microdata. *Institute for the Study of Labor (IZA)*, Discussion Paper No. 2495. Retrieved from http://ssrn.com/abstract=955810

Clarke, D. M., Piterman, L., Byrne, C. J., & Austin, D. W. (2008). Somatic symptoms, hypochondriasis and psychological distress: a study of somatisation in Australian general practice. *Medical Journal of Australia*, *189*(10), 560-564.

Clarke, S. (2005). *Formative Assessment in action: weaving the elements together*. London: Hodder Murray.

Clifford, P., Charman, A., Webb, Y., Craig, T. J. K. and Cowan, D. (1991). Planning for community care: The Community Placement Questionnaire. *British Journal of Clinical Psychology, 30*, 193–211. doi: 10.1111/j.2044-8260.1991.tb00938.x

Cole, B., Adamson, S., Craig, G., Hussain, B., Smith, L., Law, I. & Cheung, T. (2009). Hidden from public view: racism against UK Chines in Locating ethnicity and health: exploring concepts and contexts. *Sociology of Health & Illness*, *29*, 795-810.

Constantine, M. G., Okazaki, S., & Utsey, S. O. (2004). Self-concealment, social self-efficacy, acculturative stress, and depression in African, Asian, and Latin American international college students. *American Journal of Orthopsychiatry*, *74*(3), 230-241.

Cook, S. (2000). Readjusting labour: Enterprise restructuring, social consequences and policy responses in urban China. In M. Warner (Ed.), *Changing workplace relations in the Chinese economy* (pp. 227-246). London: Palgrave Macmillan UK.

Cooley, C. H. (1902). The looking-glass self. In J. O'Brien (Ed.), *The production of reality: Essays and readings on social interaction*. Newbury Park: Pine Forge Press.

Corbet-Owen, C., & Kruger, L. M. (2001). The health system and emotional care: Validating the many meanings of spontaneous pregnancy loss. *Families, Systems, & Health*, *19*(4), 411-427.

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. London: SAGE.

Corcoran, N. (Ed.). (2013). *Communicating health: strategies for health promotion*. London: SAGE.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*(7), 614-625.

Corrigan, P. (2005). *On the stigma of mental illness*. Washington: American Psychological Association.

Corrigan, P. W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice*, *7*(1), 48-67.

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, *1*(1), 16-20.

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin*, *30*(3), 481-491.

Corrigan, P., & Matthews, A. (2003). Stigma and disclosure: Implications for coming out of the closet. *Journal of Mental Health*, *12*(3), 235-248.

Cowan, C. (2001). The mental health of Chinese people in Britain: An update on current literature. *Journal of Mental health*, *10*(5), 501-511.

Creswell, J. W. (1998). *Five qualitative traditions of inquiry. Qualitative inquiry and research design. Choosing among five traditions.* Thousand Oaks: Sage Publications.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, *39*(3), 124-130.

Crocker, J., Major, B., & Steele, C. M. (1998). Social stigma. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (pp. *5*04 –553). Oxford: Oxford University Press.

Crooks, D. L. (2001). The importance of symbolic interaction in grounded theory research on women's health. *Health Care for Women International*, *22*(1-2), 11-27.

Cross, T. L. (2008). Cultural competence. *Encyclopedia of Social Work*, *20*, 487-491.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care: Volume I.* Washington: Georgetown University.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London: SAGE.

Cull, W. L., O'Connor, K. G., Sharp, S., & Tang, S. F. S. (2005). Response rates and response bias for 50 surveys of pediatricians. *Health Services Research*, *40*(1), 213-226.

Cutcliffe, J. R., & McKenna, H. P. (1999). Establishing the credibility of qualitative research findings: the plot thickens. *Journal of Advanced Nursing*, *30*(2), 374-380.

Dai, Q. (2013). Social identity and self-esteem among Mainland Chinese, Hong Kong Chinese, British born Chinese and white Scottish children. (Doctoral dissertation). Retrieved from https://www.era.lib.ed.ac.uk/bitstream/handle/1842/8837/Dai2013.pdf?sequence=2

Damen, L. (1987). *Culture Learning: The Fifth Dimension on the Language Classroom*. Reading, MA: Addison-Wesley.

Darawsheh, W. (2014). Reflexivity in research: Promoting rigour, reliability and validity in qualitative research. *International Journal of Therapy & Rehabilitation*, *21*(12), 560-568.

Darwish, A. F. E., & Huber, G. L. (2003). Individualism vs collectivism in different cultures: a cross-cultural study. *Intercultural Education*, *14*(1), 47-56.

Davey, G., & Zhao, X. (2012). Counseling in China. *Therapy Today*, *23*(9), 12–17.

Davies, K. (2006). Addressing the needs of an ethnic minority diabetic population. *British Journal of Nursing*, *15*(9), 516-519.

Davies, S., Thornicroft, G., Leese, M., Higgingbotham, A., & Phelan, M. (1996). Ethnic differences in risk of compulsory psychiatric admission among representative cases of psychosis in London. *BMJ*, *312*(7030), 533-537.

De Laine, M. (1997). *Ethnography: Theory and applications in health research*. Sydney: MacLennan & Petty.

De Mente, B. (2000). *The Chinese have a word for it: The complete guide to Chinese thought and culture*. New York: McGraw Hill Professional.

de Pheils, P. B., & Saul, N. M. (2009). Communicating with Latino patients. *Journal of Nursing Education*, *48*(9), 515-518.

De Rivera, J. (1984). The structure of emotional relationships. *Review of Personality & Social Psychology*, *5*, 116-145.

Denzin, N. K., & Lincoln, Y. S. (2008). *Collecting and interpreting qualitative materials* (Vol. 3). London: SAGE.

Department of Health (2007). *Improving access to psychological therapies (IAPT): A practical approach to workforce development*. London: Department of Health.

Department of Health. (1999). *National service framework for mental health*. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf

Department of Health. (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages.* Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216871/Mental-Health-Implementation-Framework-Impact-Assessment-supplementary-note.pdf

Dewey, J. (1981). *The Philosophy of John Dewey: Volume 1. The Structure of Experience. Volume 2: The Lived Experience.* Chicago: University of Chicago Press.

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. Salt Lake City: Academic Press.

Dey, I. (2007). Grounding Categories. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp.167-190). London: SAGE.

Di Blasi, Z., Harkness, E., Ernst, E., Georgiou, A., & Kleijnen, J. (2001). Influence of context effects on health outcomes: a systematic review. *The Lancet*, *357*(9258), 757-762.

Dickerson, V. C., & Zimmerman, J. L. (1996). Myths, misconceptions, and a word or two about politics. *Journal of Systemic Therapies*, *15*(1), 79-88.

Dodson, L., & Dickert, J. (2004). Girls' family labor in low-income households: A decade of qualitative research. *Journal of Marriage and Family*, *66*(2), 318-332.

Dogra, N., & Carter-Pokras, O. (2005). Stakeholder views regarding cultural diversity teaching outcomes: a qualitative study. *BMC medical education*, *5*, 37-42

Douglas, M. (1973). *Symbolic orders in the use of domestic space*. Massachusetts: Warner Modular Publications, Incorporated.

Dovidio, J. F., Major, B., & Crocker, J. (2000). Stigma: Introduction and overview. In T. F. Heatherton, R. E. Neck, M. R. Hebl, & J. G. Hull (Eds.), *The social psychology of stigma* (pp. 1–28). New York: Guilford Press.

Downs, J. F. (1971). *Cultures in crisis*. California: Glencoe Press.

Duan, C., & Hill, C. E. (1996). The current state of empathy research. *Journal of Counseling Psychology*, *43*(3), 261-274.

Duan, C., & Wang, L. (2000). Counselling in the Chinese cultural context: Accommodating both individualistic and collectivistic values. *Asian Journal of Counselling*, *7*, 1-21.

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, *41*(3-4), 327-350.

Dustmann, C., & Frattini, T. (2011). *The socio-economic integration of migrants*. Department for Communities and Local Government, London. Retrieved from http://www.ucl.ac.uk/~uctpb21/reports/Final_report_CLG_06_2011.pdf.

Dwairy, M., & Van Sickle, T. D. (1996). Western psychotherapy in traditional Arabic societies. *Clinical Psychology Review*, *16*(3), 231-249.

Dwivedi, Y. K. (Ed.). (2009). *Handbook of research on contemporary theoretical models in information systems*. Hershey, PA: IGI Global.

Ehling, D. (2001). Oriental medicine: an introduction. *Alternative Therapies in Health and Medicine*, *7*(4), 71-82.

Ellis, A. (1957). Rational psychotherapy and individual psychology. *Journal of Individual Psychology*, *13*(1), 38-45.

Ernst, E., Rand, J. I., & Stevinson, C. (1998). Complementary therapies for depression: an overview. *Archives of General Psychiatry*, *55*(11), 1026-1032.

Ess, C. (2006). Ethical pluralism and global information ethics. *Ethics and Information Technology*, *8*(4), 215-226.

Evans, D., Gruba, P., & Zobel, J. (2011). *How to write a better thesis*. Melbourne: Melbourne University Publishing.

Eyberg, S. M. (2005). Tailoring and adapting parent-child interaction therapy to new populations. *Education and Treatment of Children*, *28*(2), 197-201.

Fabrega Jr, H. (1990). The concept of somatization as a cultural and historical product of Western medicine. *Psychosomatic Medicine*, *52*(6), 653-672.

Fabrega, H. (1995). Cultural challenges to the psychiatric enterprise. *Comprehensive Psychiatry*, *36*(5), 377-383.

Falk, G. (2001). *Stigma: How we treat outsiders*. New York: Prometheus Books.

Fan, Y. (2000). A classification of Chinese culture. *Cross Cultural Management: An International Journal*, 7(2), 3-10.

Fang, L., & Chen, T. (2004). Community Outreach and Education to Deal with Cultural Resistance to Mental Health Services. In N. Boyd (Ed.), *Mass trauma and violence: Helping families and children cope* (pp. 234-258). New York: Guilford Press.

Farooq, S., Gahir, M. S., Okyere, E., Sheikh, A. J., & Oyebode, F. (1995). Somatization: a transcultural study. *Journal of Psychosomatic Research*, *39*(7), 883-888.

Feng, L., Cao, Y., Zhang, Y., Wee, S. T., & Kua, E. H. (2011). Psychological therapy with Chinese patients. *Asia-Pacific Psychiatry*, *3*(4), 167-172.

Feng, Y., & Bodde, D. (1983). *A history of Chinese philosophy* (Vol. 1). New Jersey: Princeton University Press.

Filep, B. (2009). Interview and translation strategies: coping with multilingual settings and data. *Social Geography*, *4*(1), 59-70.

Fink, P. J. (1992). *Stigma and mental illness*. Washington: American Psychiatric Publication.

Fischer, A. R., Jome, L. M., & Atkinson, D. R. (1998). Back to the Future of Multicultural Psychotherapy with a Common Factors Approach. *Counseling Psychologist*, *26*(4), 602-6.

Fischer, E. H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *Journal of College Student Development*, *36*(4), 368-373.

Fischer, E. H., & Turner, J. I. (1970). Orientations to seeking professional help: development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology*, *35*(1), 79-90.

Fisher, M. H., Lahiri, S., & Thandi, S. S. (2007). *A South-Asian History of Britain*. California: Greenwood World Pub.

Fiske, A. P., Kitayama, S., MARKUS, H., & Nisbett, R. E. (1998). The cultural Matrix of Social Psychology. In S. T. Fiske, D. T. Gilbert, & G. Lindzey (Eds.), *The Handbook of Social Psychology*, (4th ed., Vol. 2, 915-981). Boston: McGraw-Hill.

Flick, U. (Ed.). (2013). *The SAGE handbook of qualitative data analysis*. London: SAGE.

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry*, *36*(6), 717-732.

Fox, N. J. (2003). Practice-Based Evidence Towards Collaborative and Transgressive Research. *Sociology*, *37*(1), 81-102.

Foyle, M. F., Beer, M. D., & Watson, J. P. (1998). Expatriate mental health. *Acta Psychiatrica Scandinavica*, *97*(4), 278-283.

Frey-Ridgway, S. (1997). The cultural dimension of international business. *Collection Building*, *16*(1), 12-23.

Fung, Y. L. (1948) *A Short History of China*. New York: Macmillan.

Furnham, A., & Bochner, S. (1986) *Culture shock. Psychological reactions to unfamiliar environments.* London: Methuen Publishing.

Furnham, A., & Li, Y. H. (1993). The psychological adjustment of the Chinese community in Britain. A study of two generations. *The British Journal of Psychiatry, 162*(1), 109-113.

Garfield, J. L., & Edelglass, W. (2011). *The Oxford handbook of world philosophy*. Oxford: Oxford University Press on Demand.

Gasson, S. (2004). Rigor in grounded theory research: An interpretive perspective on generating theory from qualitative field studies. In M. E. Whitman, & A. B. Woszczynski (Eds.), *The handbook of information systems research* (pp. 79–102). Hershey, PA: Idea Group.

Gateshill, G., Kucharska-Pietura, K., & Wattis, J. (2011). Attitudes towards mental disorders and emotional empathy in mental health and other healthcare professionals. *The Psychiatrist, 35*(3), 101-105.

Gavin, B. E., Kelly, B. D., Lane, A., & O'Callaghan, E. (2001). The mental health of migrants. *Irish Medical Journal*, *94*(8), 229-30.

Gaw, A. (1993). *Culture, ethnicity, and mental illness*. Washington: American Psychiatric Publication.

Gelfand, D., & Yee, B. W. (1991). Trends and forces: Influence of immigration, migration, and acculturation on the fabric of aging in America. *Generations*, *15*(4), 7-10.

Gergen, K. J. (1989). Warranting voice and the elaboration of self. In J. E. Shotter & K. J. Gergen (Eds.), *Texts of identity* (pp. 70-81). London: Sage Publications.

Gerrig, R. J., Zimbardo, P. G., Campbell, A. J., Cumming, S. R., & Wilkes, F. J. (2011). *Psychology and life*. Melbourne: Pearson Higher Education AU.

Gerrish, K., & Papadopoulos, I. (1999). Transcultural competence: the challenge for nurse education. *British Journal of Nursing, 8*(21), 1453-1457.

Gervais, M. C., & Jovchelovitch, S. (1998). Health and identity: the case of the Chinese community in England. *Social Science Information, 37*(4), 709-729.

Giddens, A., & Sutton, P. W. (2013). *Sociology* (7th ed.). Cambridge: Polity Press.

Giddens, A., Duneier, M., & Appelbaum, R. P. (2003). *Introduction to sociology*. New York: Norton.

Gilbert, P., & Irons, C. (2009). Shame, self-criticism and self-compassion in adolescence. In N. B. Allen, & L. B. Sheeber (Eds.), *Adolescent emotional development and the emergence of depressive disorders* (pp. 195-214). Cambridge: Cambridge University Press.

Gilgun, J. F. (2005). Qualitative research and family psychology. *Journal of Family Psychology, 19*(1), 40-50.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. California: Sociology Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. London: Weidenfeld and Nicholson.

Glaser, B.G. (1978). *Theoretical sensitivity*. California: The Sociology Press.

Gleize, L., Laudon, F., Sun, L. Y. K., Challeton-de Vathaire, C., Le Vu, B., & de Vathaire, F. (2000). Cancer registry of French Polynesia: results for the 1990–1995 period among native and immigrant population. *European Journal of Epidemiology, 16*(7), 661-667.

Goffman, E. (1963). *Stigma: Notes on a spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*. New York: Simon and Schuster.

Goldie, I. & McCulloch, A. (2010). *Public mental health today*. Brighton: Pavilion Publishing Ltd.

Goodyear, R., Lichtenberg, J., Hutman, H., Overland, E., Bedi, R., Christiani, K.& Grant, J. (2016). A global portrait of counselling psychologists' characteristics, perspectives, and professional behaviors. *Counselling Psychology Quarterly, 29(2),* 115-138.

Gordon, M. M. (1964). *Assimilation in American life: The role of race, religion, and national origins*. Oxford: Oxford University Press on Demand.

Goulding, C. (1999). *Grounded Theory: some reflections on paradigm, procedures and misconceptions*. Wolverhampton: University of Wolverhampton.

Gove, W. R., & Fain, T. (1973). The stigma of mental hospitalization: an attempt to evaluate its consequences. *Archives of General Psychiatry*, *28*(4), 494-500.

Graham, H. (2006). Socioeconomic inequalities in health: evidence on patterns and determinants. *Benefits*, *14*(2), 77-90.

Graue, M. E., & Walsh, D. J. (1998). *Studying children in context: Theories, methods, and ethics*. London: Sage Publications.

Green, G., Bradby, H., Chan, A., Lee, M., & Eldridge, K. (2002). Is the English National Health Service meeting the needs of mentally distressed Chinese women? *Journal of Health Services Research & Policy*, *7*(4), 216-221.

Griffin, E. (1997). *A First look at communication theory.* New York: The McGraw-Hill Companies.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, *43*(4), 531-548

Gu, D., Dupre, M. E., & Liu, G. (2007). Characteristics of the institutionalized and community-residing oldest-old in China. *Social Science & Medicine, 64*(4), 871-883.

Guarnaccia, P. J., & Rodriguez, O. (1996). Concepts of culture and their role in the development of culturally competent mental health services. *Hispanic Journal of Behavioral Sciences*, *18*(4), 419-443.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *ECTJ, 29*(2), 75-91.

Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. San-Francisco: Jossey-Bass.

Guba, E. G., & Lincoln, Y. S. (1982). Epistemological and methodological bases of naturalistic inquiry. *ECTJ, 30*(4), 233-252.

Guba, E. G., & Lincoln, Y. S. (1985). *Naturalistic inquiry* (Vol. 75). Beverly Hills, CA: Sage.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. London: SAGE.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). London: Sage.

Guo, Z. (1995). Chinese Confucian culture and the medical ethical tradition. *Journal of Medical Ethics, 21*(4), 239-246.

Gynnild, A. (2011). Book review: Grounded theory: A practical guide (Birks & Mills, 2011). *The Grounded Theory Review*, *10*(3), 63-65.

Hackley, C. A., & Dong, Q. (2001). American public relations networking encounters China's guanxi. *Public Relations Quarterly*, *46*(2), 16.

Hall, C.P., Hall, J.D., Pfriemer, J.T., Wimberley, P.D., & Jones, C. H. (2007). Effects of a culturally sensitive education program on the breast cancer knowledge and beliefs of Hispanic women. *Oncology Nursing Forum*, 34(6), 1195-1202.

Hall, J. A., Carter, J. D., & Horgan, T. G. (2000). Gender differences in nonverbal communication of emotion. In A. Fischer (Ed.), *Gender and emotion: Social psychological perspectives* (pp. 97-117). Cambridge: Cambridge University Press.

Hall, M. (1976). *The theory of groups* (Vol. 288). Providence, USA: American Mathematical Society.

Hall, S. (1990). Cultural identity and diaspora. In J. Rutherford (Ed.), *Identity: community, culture, difference* (pp. 222-37). London: Lawrence & Wishart.

Hallberg, L. R. (2006). The "core category" of grounded theory: Making constant comparisons. *International Journal of Qualitative Studies on Health and Well-being*, *1*(3), 141-148.

Halligan, P. W., & Marshall, J. C. (1996). The wise prophet makes sure of the event first: hallucinations, amnesia and delusions. In P.W. Halligan & J. C. Marshall (Eds.), *Method in madness: Case studies in cognitive neuropsychiatry* (pp. 237-66). Hove, UK: Psychology Press.

Ham, M. D. (1993). Empathy. In J. L. Chin (Ed.), *Transference and empathy in Asian American psychotherapy - Cultural values and treatment needs.* Portsmouth: Greenwood Publishing Group.

Han, E. (2013). *Contestation and adaptation: the politics of national identity in China*. Oxford: Oxford University Press.

Hansen, C. (2000) *A Daoist Theory of Chinese Thought: A Philosophical Interpretation.* New York: Oxford University Press.

Hardway, C., & Fuligni, A. J. (2006). Dimensions of family connectedness among adolescents with Mexican, Chinese, and European backgrounds. *Developmental Psychology*, *42*(6), 1246.

Harrison, G. (1990). Searching for the causes of schizophrenia: The role of migrant studies. *Schizophrenia Bulletin*, *16*(4), 663.

Hayes, N. (2013). *Doing qualitative analysis in psychology*. Hove, UK: Psychology Press.

Hays, P. A. (1995). Multicultural applications of cognitive-behavior therapy. *Professional Psychology: Research and practice*, *26*(3), 309.

Health Professions Council (2010). Standards of Proficiency. *Practitioner psychologists*. Retrieved from

http://www.hpcuk.org/assets/documents/10002E7FPsychologistsstandardsofproficencykeydecisionsdocumentFINAL.pdf

Heidari, A., Ketabi, S., & Zonoobi, R. (2014). The role of culture through the eyes of different approaches to and methods of foreign language teaching. *Journal of Intercultural Communication, 34*. Retrieved from http://www.immi.se/intercultural/nr34/heidari.html

Heinrichs, N., Rapee, R. M., Alden, L. A., Bögels, S., Hofmann, S. G., Oh, K. J., & Sakano, Y. (2006). Cultural differences in perceived social norms and social anxiety. *Behaviour Research and Therapy, 44*(8), 1187-1197.

Hermanns, H. (1995). Narratives interview. *Handbuch Qualitative Sozialforschung.* Munchen: Psychologie Verlags Union.

Hertz, K. H. (1973). Social science and human purpose. *Journal of Religion & Science, 8*(3-4), 341-357. doi: 10.1111/j.1467-9744.1973.tb00237

Hickey, G. (1997). The use of literature in grounded theory. *Nursing Times Research, 2*(5), 371-378.

Ho, D. Y. (1995). Selfhood and identity in Confucianism, Taoism, Buddhism, and Hinduism: contrasts with the West. *Journal for the Theory of Social Behaviour, 25*(2), 115-139.

Ho, D. Y. F. (1976). On the concept of face. *American Journal of Sociology, 81*(4), 867-884.

Ho, D. Y. F. (1991). The concept of "face" in Chinese-American interaction. In H. Wenzhong & C. L. Grove (Eds.), *Encountering the Chinese: A guide for Americans* (pp. 111–124). Yarmouth, Maine: Intercultural Press, Inc.

Ho, D. Y. F., & Chiu, C. Y. (1998). Collective representations as a metaconstruct: An analysis based on methodological relationalism. *Culture & Psychology, 4*(3), 349-369.

Ho, E., Au, S., Bedford, C., & Cooper, J. (2002). *Mental health issues for Asians in New Zealand: A literature review* (Commissioned by the Mental Health Commission). Waikato: University of Waikato.

Hoang, H. (2008). Language and cultural barriers of Asian migrants in accessing maternal care in Australia. *The International Journal of Language Society and Culture*, *26*, 55-61.

Hofstede, G. (1980). Motivation, leadership, and organization: do American theories apply abroad? *Organizational Dynamics*, *9*(1), 42-63.

Hofstede, G. (1983). National cultures in four dimensions: A research-based theory of cultural differences among nations. *International Studies of Management & Organization*, *13*(1/2), 46-74.

Hofstede, G. (1984). *Culture's consequences: International differences in work-related values* (Vol. 5). London: SAGE.

Hofstede, G. (1993). Cultural constraints in management theories. *The Academy of Management Executive*, *7*(1), 81-94. doi: 10.5465/AME.1993.9409142061

Hofstede, G. (2010). *National cultural dimensions*. Retrieved from http://www.academia.edu/download/37276065/Geert_Hofstede.docx

Hofstede, G. (2011). Dimensionalizing cultures: The Hofstede model in context. *Online Readings in Psychology and Culture*, *2*(1), 8-11. doi: 10.9707/2307-0919.1014

Hofstede, G., & Bond, M. H. (1984). Hofstede's culture dimensions an independent validation using Rokeach's value survey. *Journal of Cross-Cultural Psychology*, *15*(4), 417-433.

Hofstede, G., & Minkov, M. (2010). Long-versus short-term orientation: new perspectives. *Asia Pacific Business Review*, *16*(4), 493-504.

Howard C (2006) *Youth Counselling and Family Therapy Project – an evaluation report* London: Chinese Mental Health Association & Islington Chinese Community Association.

Howard, L., & Thornicroft, G. (2006). Patient preference randomised controlled trials in mental health research. *The British Journal of Psychiatry*, *188*(4), 303-304.

Hsiao, F. H., Klimidis, S., Minas, H., & Tan, E. S. (2006). Cultural attribution of mental health suffering in Chinese societies: the views of Chinese patients with mental illness and their caregivers. *Journal of Clinical Nursing*, *15*(8), 998-1006.

Hsu, F. L. (2015). *Americans and Chinese: Passages to differences*. Hawaii: University of Hawaii Press.

Hsu, L. G., & Folstein, M. F. (1997). Somatoform disorders in Caucasian and Chinese Americans. *The Journal of Nervous and Mental disease*, *185*(6), 382-387.

Hsu, S., & Wu, Y. Y. (Eds.). (2015). *Education as Cultivation in Chinese Culture*. New York: Springer.

Huang, S. L., & Spurgeon, A. (2006). The mental health of Chinese immigrants in Birmingham, UK. *Ethnicity and Health*, *11*(4), 365-387.

Huang, Y. H. (1997). *Public relations strategies, relational outcomes, and conflict management strategies*. Baltimore: University of Maryland.

Hudson, C. G. (2005). Socioeconomic status and mental illness: tests of the social causation and selection hypotheses. *American Journal of Orthopsychiatry*, *75*(1), 3-18.

Hui, C. H. (1988). Measurement of individualism-collectivism. *Journal of Research in Personality*, *22*(1), 17-36.

Hultberg, P. (1988). Shame-A Hidden Emotion. *Journal of Analytical Psychology*, *33*(2), 109-126.

Hwang, K. K. (1987). Face and favor: The Chinese power game. *American Journal of Sociology*, *92*, 944-974.

Hwang, K. K., & Chang, J. (2009). Self-cultivation culturally sensitive psychotherapies in Confucian societies. *The Counseling Psychologist*, *37*(7), 1010-1032.

Hwang, K. K., & Han, K. H. (2010). Face and morality in Confucian society. In M.H. Bond (Ed.), *The Oxford handbook of Chinese psychology* (pp. 479–498). Oxford: Oxford University Press.

IMF (2015). *China's Transition to Slower but Better - IMF Survey.* Retrieved from http://www.imf.org/external/pubs/ft/survey/so/2015/car081415b.html

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (2001). Community-based participatory research: policy recommendations for promoting a partnership approach in health research. *Education for Health, 14*(2), 182-197.

Ivanhoe, P. J. (2000). *Confucian moral self cultivation*. Indianapolis: Hackett Publishing.

Ivanov, L. L., & Buck, K. (2002). Health care utilization patterns of Russian-speaking immigrant women across age groups. *Journal of Immigrant Health, 4*(1), 17-27.

Jackson, R. (2010). The Aging of China. Critical Questions. *Center for Strategic and International Studies (CSIS)*. Retrieved from https://www.csis.org/analysis/aging-china-0

Jacob, K. S., Bhugra, D., Lloyd, K. R., & Mann, A. H. (1998). Common mental disorders, explanatory models and consultation behaviour among Indian women living in the UK. *Journal of the Royal Society of Medicine, 91*(2), 66-71.

James, W. (1907). Pragmatism's conception of truth. *The Journal of Philosophy, Psychology and Scientific Methods*, *4*(6), 141-155.

Jayasuriya, L., Sang, D., & Fielding, A. (1992). *Ethnicity, immigration and mental illness: A critical review of Australian research*. Melbourne: Bureau of Immigration Research.

Jim, J., & Pistrang, N. (2007). Culture and the therapeutic relationship: Perspectives from Chinese clients. *Psychotherapy Research, 17*(4), 461-473.

Joint Commissioning Panel for Mental Health (2014) *Guidance for commissioners of mental health services for people from black and minority ethnic communities.* Retrieved from http://www.jcpmh.info/wp-content/uploads/jcpmh-bme-guide.pdf

Jonassen, D. H. (1991). Objectivism versus constructivism: Do we need a new philosophical paradigm? *Educational Technology Research and Development*, *39*(3), 5-14.

Jones, D. (1979). The Chinese in Britain: origins and development of a community. *Journal of Ethnic and Migration Studies*, *7*(3), 397-402.

Jones, E. E. (1984). *Social stigma: The psychology of marked relationships*. New York: WH Freeman.

Jones, L. (2005). *The encyclopaedia of religion*. New York: Macmillan.

Jones, S. C., & Donovan, R. J. (2004). Does theory inform practice in health promotion in Australia?. *Health Education Research*, *19*(1), 1-14.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). Mental health literacy: a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, *166*(4), 182-186.

Jung, C. G., & Pauli, W. (1957). *The interpretation of Nature and Psyche*. California: Ishi Press

Kâğitçibaşi, Ç. (1994). A critical appraisal of individualism and collectivism: Toward a new formulation. In U. Kim, H. C. Triandis, C. Kagit-cibasi, S.C. Choi, & G. Yoon (Eds.), *Individualism and collectivism: Theory, method, and applications* (pp. 52–65). Thousand Oaks, CA: Sage.

Kashima, Y., Kashima, E. S., & Aldridge, J. (2001). Toward cultural dynamics of self-conceptions. In C. Sedikides & M. B. Brewer (Eds.), *Individual self, relational self, collective self* (pp. 277-298). Philadelphia: Psychology Press.

Kashima, Y., & Gelfand, M. J. (2012). 23 A history of culture in psychology. In A. W. Kruglanski & W. Stroebe (Eds.), *Handbook of the history of social psychology*. Hove, UK: Psychology Press.

Katz, I. (2014). *Stigma: A social psychological analysis*. Hove, UK: Psychology Press.

Kelly, R. B., Zyzanski, S. J., & Alemagno, S. A. (1991). Prediction of motivation and behavior change following health promotion: Role of health beliefs, social support, and self-efficacy. *Social Science & Medicine*, *32*(3), 311-320.

Kennedy, P. (2002). Learning cultures and learning styles: Myth-understandings about adult (Hong Kong) Chinese learners. *International journal of lifelong education*, *21*(5), 430-445.

Kim, B. S., & Atkinson, D. R. (2002). Asian American client adherence to Asian cultural values, counselor expression of cultural values, couselor ethnicity, and career counseling process. *Journal of Counseling Psychology*,*49*(1), 3-13.

Kim, B. S., & Omizo, M. M. (2003). Asian cultural values, attitudes toward seeking professional psychological help, and willingness to see a counselor. *The Counseling Psychologist*, *31*(3), 343-361.

Kim, B. S., Ng, G. F., & Ahn, A. J. (2005). Effects of client expectation for counseling success, client-counselor worldview match, and client adherence to Asian and European American cultural values on counseling process with Asian Americans. *Journal of Counseling Psychology*, *52*(1), 67-76.

Kim, U. (1984). *Psychological Acculturation of Korean Immigrants in Toronto: A Study of Modes of Acculturation, Identity, Language and Acculturative Stress*. (Unpublished M.A. Thesis). Ontario, Canada: Queen's University.

Kim, U. (1994). Introduction to individualism and collectivism: Conceptual clarification and elaboration. In U. Kim, H. C. Triandis, C. Kagiticibasi, S. C. Choi, & G. Yoon (Eds.), *Individualism and collectivism: Theory, method, and application* (pp. 19-40). Beverly Hills, CA: Sage.

Kim, U. E., Triandis, H. C., Kâğitçibaşi, Ç. E., Choi, S. C. E., & Yoon, G. E. (1994). *Individualism and collectivism: Theory, method, and application*. London: Sage Publications, Inc.

Kinderman, P., Schwannauer, M., Pontin, E., & Tai, S. (2011). The development and validation of a general measure of well-being: the BBC well-being scale. *Quality of Life Research*, *20*(7), 1035-1042.

King, M., Coker, E., Leavey, G., Hoare, A., & Johnson-Sabine, E. (1994). Incidence of psychotic illness in London: comparison of ethnic groups. *BMJ, 309*(6962), 1115-1119.

Kinzie, J. D. (1993). Posttraumatic effects and their treatment among Southeast Asian refugees. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 311-319). NewYork: Springer.

Kirby, S., & McKenna, K. (1989). *Experience research social change: Methods from the margins*. Toronto: Garamond Press.

Kirmayer, L. J. (2001). Cultural variations in the clinical presentation of depression and anxiety: Implications for diagnosis and treatment. *Journal of Clinical Psychiatry, 62*, 22-30.

Kirmayer, L. J., & Looper, K. J. (2006). Abnormal illness behaviour: physiological, psychological and social dimensions of coping with distress. *Current Opinion in Psychiatry, 19*(1), 54-60.

Kitayama, S., Markus, H. R., Matsumoto, H., & Norasakkunkit, V. (1997). Individual and collective processes in the construction of the self: self-enhancement in the United States and self-criticism in Japan. *Journal of Personality and Social Psychology*, *72*(6), 1245-1267.

Klein, H. K., & Myers, M. D. (1999). A set of principles for conducting and evaluating interpretive field studies in information systems. *MIS quarterly*, 67-93.

Kleinman, A (1977). Depression, somatization and the "new cross-cultural psychiatry". *Social Science & Medicine (1967), 11*(1), 3-9.

Kleinman, A. (1978). Culture and depression. *Culture, Medicine and Psychiatry*, *2*(4), 295-296.

Kleinman, A. (1986). *Social origins of distress and disease: Depression, neurasthenia, and pain in modern China*. New Haven: Yale University Press.

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books.

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: the problem of cultural competency and how to fix it. *PLoS Med, 3*(10), e294. doi: 10.1371/journal.pmed.0030294

Kluckhohn, C. (Ed.). (1962). *Culture and behavior: Collected essays* (Vol. 91745). Massachusetts: Free Press of Glencoe.

Knapp, M., McDaid, D., & Parsonage, M. (2011). *Mental health promotion and mental illness prevention: The economic case.* Retrieved from http://www.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf

Kreuter, M. W., Lukwago, S. N., Bucholtz, D. C., Clark, E. M., & Sanders-Thompson, V. (2003). Achieving cultural appropriateness in health promotion programs: targeted and tailored approaches. *Health Education & Behavior*, *30*(2), 133-146.

Kruzykowski, K. G. (2011). Reconciling two cultures: The experience of immigrants and first generation Americans from non-western countries. *Social Sciences Journal*, *7*(1), 11–22.

Kung, W. (2003). The illness, stigma, culture, or immigration? Burdens on Chinese American caregivers of patients with schizophrenia. *Families in Society: The Journal of Contemporary Social Services*, *84*(4), 547-557.

Kung, W. W. (2003). Chinese Americans' help seeking for emotional distress. *Social Service Review*, *77*(1), 110-134.

Kuo, J., & Porter, K. (1998). *Health status of Asian Americans: United States, 1992-94*. US Department of Health and Human Services, Centers for Disease Control and Prevention: National Center for Health Statistics.

Kvale, S., & Brinkmann, S. (2009). Interview: Learning the craft of qualitative research interviewing. *Det kvalitative forskningsintervju.* Oslo: Gyldendal akademisk.

Kwan, V. S., Bond, M. H., & Singelis, T. M. (1997). Pancultural explanations for life satisfaction: adding relationship harmony to self-esteem. *Journal of Personality and Social Psychology*, *73*(5), 1038-1051.

Kwok, C. F. Y. (2004). Personal accounts: a fragile China doll. *Psychiatric Services, 55*(2), 121-122. Retrieved from http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.55.2.121

Kwok, C. FY. (2000). *The tormented mind: A true story of manic depression*. Mattituck, NY: C & R Publisher.

Kwok, S., & Wong, D. (2000). Mental health of parents with young children in Hong Kong: The roles of parenting stress and parenting self- efficacy. *Child and Family Social Work, 5*, 57-65.

L. W., Liu, E. H., Zhou, J. L., & Wen, X. D. (2008). Analysis of Chinese herbal medicines with holistic approaches and integrated evaluation models. *TrAC Trends in Analytical Chemistry*, *27*(1), 66-77. doi: 10.1016/j.trac.2007.11.005

LaFrance, M., & Banaji, M. (1992). Toward a reconsideration of the gender-emotion relationship. *Emotion and Social Behavior*, *14*, 178-201.

Lam, C. S., Tsang, H. W., Corrigan, P. W., Lee, Y. T., Angell, B., Shi, K & Larson, J. E. (2010). Chinese lay theory and mental illness stigma: Implications for research and practices. *Journal of Rehabilitation*, *76*(1), 35-40.

Lam, D. H., Chan, N., & Leff, J. (1995). Family work for schizophrenia: Some issues for Chinese immigrant families. *Journal of Family Therapy*,*17*(3), 281-297.

Lam, T., Sales, R. A., D'Angelo, A., Lin, X., & Montagna, N. (2009). *The changing Chinese community in London: new migration, new needs.* London: Middlesex University Research.

LaRossa, R. (2005). Grounded theory methods and qualitative family research. *Journal of marriage and Family, 67*(4), 837-857.

Larsen, J. A. (2007). Symbolic healing of early psychosis: Psychoeducation and sociocultural processes of recovery. *Culture, Medicine and Psychiatry*, *31*(3), 283-306.

Latham, K., & Wu, B. (2013). *Chinese immigration into the EU: New trends, dynamics and implications*. Europe China Research and Advice Network. Retrieved from

https://eeas.europa.eu/china/docs/division_ecran/ecran_chinese_immigration_into_the_eu_kevin_latham_and_bin_wu_en.pdf

Lather, P. (1994). Fertile obsession: Validity after poststructuralism. In A. Gitlin (Ed.), *Power and method: Political activism and educational research* (pp. 36-60). London: Routledge.

Lau, P. S. (2000). Practicing counselling in Chinese communities: Some reflections on cultural competence and indigenisation. *Asian Journal of Counselling*, *7*(1), 43-52.

Laurence. C., Macha F., & Dhananjayan. S. (2005). S*electing Wisely: Making Managed Migration Work for Britain.* London: Institute for Public Policy Research.

Law, J. (2004). *After method: Mess in social science research*. London: Routledge.

Lawrence, E. J., Shaw, P., Baker, D., Baron-Cohen, S., & David, A. S. (2004). Measuring empathy: reliability and validity of the Empathy Quotient. *Psychological medicine*, *34*(05), 911-920.

Lawton-Smith, S., & McCulloch, A. (2015) A brief history of specialist mental health services, *Mental Health Foundation*, Retrieved from: http://www.mentalhealth.org.uk/content/assets/pdf/publications/starting-today-background-paper-1.pdf

Lay, C., Fairlie, P., Jackson, S., Ricci, T., Eisenberg, J., Sato, T., & Melamud, A. (1998). Domain-Specific Allocentrism-Idiocentrism A Measure of Family Connectedness. *Journal of Cross-Cultural Psychology*, *29*(3), 434-460.

Le Meyer, O., Zane, N., Cho, Y. I., & Takeuchi, D. T. (2009). Use of specialty mental health services by Asian Americans with psychiatric disorders. *Journal of Consulting and Clinical Psychology*, *77*(5), 1000-1005.

Leavitt, R. L. (2003). CEU: Developing cultural competence in a multicultural world (parts 1 & 2). Retrieved from http://www1.udel.edu/PT/current/PHYT600/2012/Lecture4Handouts/CES_25_Cultural Competence_012003%5B1%5D.pdf

Lee, E. (Ed.). (2000). *Working with Asian Americans: A guide for clinicians*. London: Guilford Press.

Lee, S. K., Sulaiman-Hill, C. R., & Thompson, S. C. (2014). Overcoming language barriers in community-based research with refugee and migrant populations: options for using bilingual workers. *BMC international health and human rights*, 11-14. Retrieved from https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/1472-698X-14-11#Abs1

Lee, S. Y., Martins, S. S., Keyes, K. M., & Lee, H. B. (2011). Mental health service use by persons of Asian ancestry with DSM-IV mental disorders in the United States. *Psychiatric Services*, *62*(10), 1180-1186.

Lee, Y. S., Kaplan, C. P., & Perez-Stable, E. J. (2014). Elder mistreatment among Chinese and Korean immigrants: The roles of sociocultural contexts on perceptions and help-seeking behaviors. *Journal of Aggression, Maltreatment & Trauma*, *23*(1), 20-44.

Lei, Y., & Duan, C. (2014). Relationship between therapist empathy and client-perceived working alliance in China: A multilevel modelling analysis. *Counselling Psychology Quarterly*, *27*(2), 200-215.

Leininger, M. (1994). Evaluation criteria and critique of qualitative research studies. *Critical Issues in Qualitative Research Methods*, 95-115.

Lennon, M. C., Link, B. G., Marbach, J. J., & Dohrenwend, B. P. (1989). The stigma of chronic facial pain and its impact on social relationships. *Social Problems*, *36*(2), 117-134.

Leong, F. T., & Lau, A. S. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research*, *3*(4), 201-214.

Leong, F. T., & Lee, S. H. (2006). A cultural accommodation model for cross-cultural psychotherapy: Illustrated with the case of Asian Americans. *Psychotherapy: Theory, Research, Practice, Training*, *43*(4), 410.

Leung, K. (2010). Beliefs in Chinese culture. In M. H. Bond (Ed.), *The Oxford handbook of Chinese psychology* (pp. 457-477). Hong Kong: Oxford University Press.

Leung, K., & Bond, M. H. (1984). The impact of cultural collectivism on reward allocation. *Journal of Personality and Social psychology*, *47*(4), 793.

Leung, K., & Bond, M. H. (1984). The impact of cultural collectivism on reward allocation. *Journal of Personality and Social Psychology*, *47*(4), 793.

Levkoff, S. E., Macarthur, I. W., & Bucknall, J. (1995). Elderly mental health in the developing world. *Social Science & Medicine, 41*(7), 983-1003.

Lewin, K. (1951). Field theory in social science: selected theoretical papers (Edited by Dorwin Cartwright.). New York: Harper & Brothers.

Lewin, S. A., Skea, Z. C., Entwistle, V., Zwarenstein, M., & Dick, J. (2001). Interventions for providers to promote a patient-centred approach in clinical consultations. *Cochrane Database Syst Rev*, *4*(10).

Lewis, J., & Ritchie, J. (2003). Generalising from qualitative research. *Qualitative research practice: A guide for social science students and researchers*

Lewis, J., & Ritchie, J. (2003). Generalising from qualitative research. In J. Ritchie & J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp. 263-286). London: SAGE.

Li, D. (1991). The experience of psychiatrists managing Chinese patients in Merseyside. *The Psychiatrist*, *15*(12), 727-728.

Li, D. (1991). The experience of psychiatrists managing Chinese patients in Merseyside. *The Psychiatrist*, *15*(12), 727-728.

Li, P. L., Logan, S., Yee, L., & Ng, S. (1999). Barriers to meeting the mental health needs of the Chinese community. *Journal of Public Health*, *21*(1), 74-80.

Li, P. L., Logan, S., Yee, L., & Ng, S. (1999). Barriers to meeting the mental health needs of the Chinese community. *Journal of Public Health*, *21*(1), 74-80.

Li, X., Stanton, B., Chen, X., Hong, Y., Fang, X., Lin, D. & Wang, J. (2006). Health indicators and geographic mobility among young rural-to-urban migrants in China. *World Health & Population*, *8*(2), 5-21.

Li. M. Z & Jiang. D. J (2011) Dao Jia Ren Zhi Liao Fa Xin Fa Zhan [The new development of Daoist Therapy] [*Medical Information*]. 24(3), 1474-1475.

Li. M. Z., Guo. T.S.; Wang. J. Ai., Tang. B. T., Long. H. W., Tan. M. J. & Wang. G. Q., (2008).Zhong Guo Dao Jiao Ren Zhi Liao Fa Dui Shen Jing Zheng Huan Zhe Xin Li Jian Kang De Yu Fang Gan Yu [The use to Daoist Therapy in psychological treatment care for family carers] [*Asia-Pacific Traditional Medicine*]. 4(8). 46-47.

Li-Howard, C. (1997). The community mental health nursing perspective. In L. Yee & S. Au (Eds.), *Chinese Mental Health Issues in Britain.* London: Mental Health Foundation.

Lim, R. F. (Ed.). (2015). *Clinical manual of cultural psychiatry*. Washington, DC: American Psychiatric Pub.

Lin, K. M. (1981). Traditional Chinese medical beliefs and their relevance for mental illness and psychiatry. In A. Kleinman & T. Y. Lin (Eds.), *Normal and abnormal behavior in Chinese culture* (pp. 95-111). Springer Netherlands.

Lin, K. M., & Cheung, F. (1999). Mental health issues for Asian Americans. *Psychiatric Services, 50*(6), 774-780.

Lin, T. Y. (1983). Psychiatry and Chinese culture. *Western Journal of Medicine, 139*(6), 862.

Lin, T. Y., Tseng, W. S., & Ye, Y. (1995). *Chinese societies and mental health*. Oxford University Press.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry* (Vol. 75). Sage.

Lincoln, Y. S., & Guba, E. G. (2013). *The constructivist credo*. California: Left Coast Press.

Lindsay-Hartz, J. (1984). Contrasting experiences of shame and guilt. *The American Behavioral Scientist (pre-1986), 27*(6), 689-704.

Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review*, *54*(3), 400-423.

Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress*, *17*(1), 11-21.

Lipowski, Z. J. (1988). Somatization: the concept and its clinical application. *The American Journal of Psychiatry*, *145*(11), 1358-1368.

Littleton, C. S. (1996). *Eastern wisdom: an illustrated guide to the religions and philosophies of the East.* London: Duncan Baird.

Littlewood, R., & Lipsedge, M. (1997). *Aliens and alienists: ethnic minorities and psychiatry.* London: Psychology Press.

Liu, J., Ma, H., He, Y. L., Xie, B., Xu, Y. F., Tang, H. Y & Ng, C. H. (2011). Mental health system in China: history, recent service reform and future challenges. *World Psychiatry*, *10*(3), 210-216.

Liu, W.-S., & Leung, P. W. L. (2010). Psychotherapy with the Chinese: an update of the work in the last decade. In M. H. Bond (Ed.), *The Oxford handbook of Chinese psychology* (pp. 457-477). Hong Kong: Oxford University Press.

Liu, Y. (2004). The self and li in Confucianism. *Journal of Chinese Philosophy*, *31*(3), 363-376.

Lo, H. T., & Fung, K. P. (2003). Culturally competent psychotherapy. *Canadian Journal of Psychiatry*, *48*(3), 161-170.

Lockett, M. (1988). Culture and the problems of Chinese management. *Organization Studies*, *9*(4), 475-496.

Long, T., & Johnson, M. (2000). Rigour, reliability and validity in qualitative research. *Clinical Effectiveness in Nursing*, *4*(1), 30-37.

Lopez, S. R., & Guarnaccia, P. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology*, *51*(1), 571-598.

Lueck, K., & Wilson, M. (2010). Acculturative stress in Asian immigrants: The impact of social and linguistic factors. *International Journal of Intercultural Relations, 34*(1), 47-57.

Lynch, J. W., Smith, G. D., Kaplan, G. A., & House, J. S. (2000). Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. *British Medical Journal, 320*(7243), 1200-1204.

Lynn, R. (1971). *Personality and national character.* Oxford, England: Pergamon Press

Lynn, R., & Hampson, S. L. (1975). National differences in extraversion and neuroticism. *British Journal of Social and Clinical Psychology, 14*(3), 223-240.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology, 91*(1), 1-20.

Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psychology, 56*, 393-421.

Mak, W. W., & Zane, N. W. (2004). The phenomenon of somatization among community Chinese Americans. *Social Psychiatry and Psychiatric Epidemiology, 39*(12), 967-974.

Mannheim, K. (1952). The problem of generations in: Karl Mannheim. *Essays in the sociology of knowledge.*

Mao, Z. H., & Zhao, X. D. (2011). Comprehensive analysis of articles on counseling and psychotherapy researches (2000- 2009) in *Chinese Mental Health Journal*. Chinese Mental Health Journal, 25, 4, 254-258.

Markowitz, F. E. (1998). The effects of stigma on the psychological well-being and life satisfaction of persons with mental illness. *Journal of Health and Social Behavior, 39*(4), 335-347.

Markowitz, F. E. (2005). Sociological Models of Mental Illness Stigma: Progress and Prospects. In C. D. Erickson (Ed.), *On the stigma of mental illness: Practical strategies*

for research and social change (pp. 129-144). Washington: American Psychological Association

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review*, *98*(2), 224-253.

Marshall, T. C. (2008). Cultural differences in intimacy: The influence of gender-role ideology and individualism—collectivism. *Journal of Social and Personal Relationships*, *25*(1), 143-168.

Martin, J. K., Pescosolido, B. A., & Tuch, S. A. (2000). Of fear and loathing: the role of 'disturbing behavior,' labels, and causal attributions in shaping public attitudes toward people with mental illness. *Journal of Health and Social Behavior*, *41*(2), 208-223.

Martin, V. B., & Gynnild, A. (2011). *Grounded theory: the philosophy, method, and work of Barney Glaser*. Boca Raton, Florida: Universal-Publishers.

Mason, Jennifer (1996). *Qualitative Researching*. London: SAGE.

Mau, A. (2013). *On not speaking 'much'Chinese: identities, cultures and languages of British Chinese pupils* (Unpublished doctoral thesis). London: University of Roehampton.

Mays, N., & Pope, C. (1995). Rigour and qualitative research. *BMJ: British Medical Journal*, *311*(6997), 109-112.

McCulloch, A., & Goldie, I. (2010). Introduction. In I. Goldie (Ed.), *Public Mental Health Today*. Brighton: Pavilion Publishing Ltd.

Mead, G. H. (1913). The social self. *The Journal of Philosophy, Psychology and Scientific Methods*, *10*(14), 374-380.

Mead, G. H. (1934). *Mind, self and society* (Vol. 111). Chicago: University of Chicago Press

Mercer, S. W., & Reynolds, W. J. (2002). Empathy and quality of care. *British Journal of General Practice.* 52(Supplement), 9-12.

Mercer, S. W., Watt, G. C., & Reilly, D. (2001). Empathy is important for enablement. *BMJ*, *322*(7290), 865-869.

Miles, M. B. H., Miles, A. M. M. B., & Huberman, A. M. (1994). *An expanded sourcebook qualitative data analysis*. London: SAGE.

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, *5*(1), 25-35.

Milner, L. M., Fodness, D., & Speece, M. W. (1993). Hofstede's research on cross-cultural work-related values: implications for consumer behavior. *European Advances in Consumer research*, *1*, 70-76.

Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. (1990). *In-depth interviewing: Researching people*. Melbourne: Longman Cheshire.

Minkov, M. (2007). *What makes us different and similar: A new interpretation of the World Values Survey and other cross-cultural data*. Bulgaria: Klasika i Stil Publishing House.

Minuchin, S. (1974). *Families and family therapy*. Massachusetts: Harvard University Press.

Mir, R., & Watson, A. (2000). Strategic management and the philosophy of science: The case for a constructivist methodology. *Strategic Management Journal*, *21*, 941-953.

Morrison, W. M. (2013). China's economic rise: history, trends, challenges, and implications for the United States. *Current Politics and Economics of Northern and Western Asia*, *22*(4), 461-506.

Morse, J. M. (2007). Ethics in action: ethical principles for doing qualitative health research. *Qualitative Health Research, 17*(8), 1003-1005.

Morse, J. M., & Field, P. A. (1995). *Nursing research: The application of qualitative approaches*. Cheltenham: Nelson Thornes.

Morse, J. M., Stern, P. N., Corbin, J., Bowers, B., Clarke, A. E., & Charmaz, K. (2009). *Developing grounded theory: The second generation.* Walnut Creek, California: Left Coast Press.

Mruck, K., & Mey, G. (2007). Grounded theory and reflexivity. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 515-538). London: SAGE.

Mu, Zong San (1997) *Zhong Guo Zhe Xue de Te Zhi* (Chinese Culture & Its Philosophie). Shanghai, Shanghai Classic Publishing House

Muhlbauer, S. (2008). Caregiver perceptions and needs regarding symptom attenuation in severe and persistent mental illness. *Perspectives in Psychiatric Care, 44*(2), 99-109.

Mui, A. C. (1999). Living alone and depression among older Chinese immigrants. *Journal of Gerontological Social Work, 30*(3-4), 147-166.

Munhall, P. L. (2001). Ethical considerations in qualitative research. In P. Munhall (Ed.), *Nursing research: A qualitative perspective* (pp. 501-514). Sudbury MA: Jones and Bartlett.

Munhall, P. L. (2007). The landscape of qualitative research in nursing. In P. L. Munhall (Ed.), *Nursing research: A qualitative perspective* (pp. 3-36). Sudbury MA: Jones and Bartlett.

Munro, D. J. (1985). *Individualism and holism: Studies in Confucian and Taoist values.* Michigan: University of Michigan

Munro, R. (2002). *Dangerous minds: political psychiatry in China today and its origins in the Mao era*. Belgium: Human Rights Watch.

Murphy, H. B. M. (1977). Migration, culture and mental health. *Psychological Medicine, 7*(04), 677-684.

Nazroo, J. Y. (1997). *Ethnicity and mental health: findings from a national community survey*. London: PSI.

Nazroo, J. Y. (Ed.). (2006). *Health and social research in multiethnic societies*. London: Routledge.

Neimeyer, R. A. (2012). *Techniques of grief therapy: Creative practices for counseling the bereaved*. London: Routledge.

Nerlich, B. (2004). Coming full (hermeneutic) circle. In Z. Todd (Ed.), *Mixing methods in psychology: The integration of qualitative and quantitative methods in theory and practice.* Hove, UK: Psychology Press.

Newbigging, K., Ridley, J., McKeown, M., Machin, K., Poursanidou, D., Able, L & Joseph, D. (2012). *The Right to be Heard: Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England* (Research Report). Lancashire: University of Central Lancashire,.

Newton, L. (2009). Reflexivity, validity and roses. *Complicity: An International Journal of Complexity and Education*, *6*(2), 104-112.

Ng, C. H. (1997). The stigma of mental illness in Asian cultures. *Australian and New Zealand Journal of Psychiatry*, *31*(3), 382-390.

Ngo-Metzger, Q., Telfair, J., Sorkin, D. H., Weidmer, B., Weech-Maldonado, R., Hurtado, M., & Hays, R. D. (2006). *Cultural Competency and Quality Care: Obtaining the Patient's Perspective*. The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org

Nguyen, S. D. (1982). The psycho-social adjustment and the mental health needs of Southeast Asian refugees. *Psychiatric Journal of the University of Ottawa, 7*(1), 26-35.

NHS Executive Mental Health Task Force (1994) *Black mental health – a dialogue for change*. London: Department of Health.

NHS Report (2014). *Improving access to psychological therapies: Measuring improvement and recovery adult services*. Retrieved from http://www.iapt.nhs.uk/silo/files/measuring-recovery-2014.pdf

NICE (2005) *Social value judgements – principles for the development of NICE guidelines*. London: National Institute for Health and Care Excellence.

NICE (2011) Common Mental Health Disorders: Identification and Pathways to Care. NICE clinical guideline 123. Retrieved from www.nice.org.uk/CG123 [NICE guideline]

NICE (2014) *An Inquiry into Patient Centred Care in the 21st Century.* Retrieved from http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Inquiry-into-Patient-Centred-Care-in-the-21st-Century.ashx

Niedenthal, P. M., Kruth-Gruber, S., & Ric, F. (2006). *Psychology and emotion - Principles of Social Psychology series.* New York: Psychology Press.

Nieuwsma, J. A., Pepper, C. M., Maack, D. J., & Birgenheir, D. G. (2011). Indigenous perspectives on depression in rural regions of India and the United States. *Transcultural psychiatry*, *48*(5), 539-568.

Nightingale, D., & Cromby, J. (1999). *Social constructionist psychology: A critical analysis of theory and practice*. London: McGraw-Hill Education

Nisbett, R. E., Peng, K., Choi, I., & Norenzayan, A. (2001). Culture and systems of thought: holistic versus analytic cognition. *Psychological Review*, *108*(2), 291-310.

Nisbett, R.E. (2003). *The geography of thought: How Asians and Westerners think differently and why*. New York: Free Press.

Nivison, D. S., & Van Norden, B. W. (1996). *The ways of Confucianism: Investigations in Chinese philosophy*. Illinois: Open Court Publishing.

Noh, S., & Kaspar, V. (2003). Perceived discrimination and depression: Moderating effects of coping, acculturation, and ethnic support. *American Journal of Public Health*, *93*(2), 232-238.

Nunes, J. M. B., Martins, J. T., Zhou, L., Alajamy, M., & Al-Mamari, S. (2010). Contextual sensitivity in grounded theory: the role of pilot studies. *The Electronic Journal of Business Research Methods*, *8*(2), 73-84.

Office for National Statistics. (2001) *Census 2001*. Retrieved from http://www.statistics.gov.uk/census/default.asp

Office for National Statistics. (2011). *Migration statistics quarterly report: November 2011* London: Office for National Statistics.

Office for National Statistics. (2013). *Migration statistics quarterly report: November 2013* London: Office for National Statistics.

Office for National Statistics. (2014). *Migration statistics quarterly report: November 2014* London: Office for National Statistics.

Office for National Statistics. (2015) *Population and migration*. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration

Office of the Surgeon General (2001). *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report of the surgeon general.* Retrieved from https://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS

Orlikowski, W. J., & Baroudi, J. J. (1991). Studying information technology in organizations: Research approaches and assumptions. *Information Systems Research, 2*(1), 1-28.

Oxford, R. L., & Anderson, N. J. (1995). A crosscultural view of learning styles. *Language Teaching, 28*(04), 201-215.

Oyserman, D. (1993). The lens of personhood: Viewing the self and others in a multicultural society. *Journal of Personality and Social Psychology, 65*(5), 993-1009.

Oyserman, D., & Markus, H. R. (1993). The sociocultural self. In J. M. Suls (Ed.), *Psychological Perspectives on the Self* (pp. 187-220). New York: Psychology Press.

Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin, 128*(1), 3-72.

Pandalangat, N. (2011). *Cultural Influences on Help-Seeking, Treatment and Support for Mental Health Problems–A Comparative Study using a Gender Perspective* (Doctoral dissertation). Toronto: University of Toronto.

Pang, M., & Lau, A. (1998). The Chinese in Britain: working towards success? *International Journal of Human Resource Management*, *9*(5), 862-874.

Papadopoulos, C. (2009). *Stigma towards people with mental health problems* (Doctoral dissertation). London: Middlesex University.

Papadopoulos, I. (2006). The Papadopoulos, Tilki and Taylor model of developing cultural competence. In I. Papadopoulos (Ed.), *Transcultural health and social care: Development of culturally competent practitioners* (pp. 7-24). London: Elsevier Health Sciences.

Papadopoulos, I., Tilki, M., & Taylor, G. (1998). *Transcultural care: a guide for health care professionals*. London: Quay Books.

Parker, G., Cheah, Y. C., & Roy, K. (2001). Do the Chinese somatize depression? A cross-cultural study. *Social Psychiatry and Psychiatric Epidemiology*, *36*(6), 287-293.

Pasick, R. J., D'Onofrio, C. N., & Otero-Sabogal, R. (1996). Similarities and differences across cultures: Questions to inform a third generation for health promotion research. *Health Education Quarterly*, *23*(suppl.), S142-S161.

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research*, *34*, 1189-1208.

Patton, M. Q. (2002). Two decades of developments in qualitative inquiry a personal, experiential perspective. *Qualitative Social Work*, *1*(3), 261-283.

Payne, S., Chapman, A., Holloway, M., Seymour, J. E., & Chau, R. (2005). Chinese community views: Promoting cultural competence in palliative care. *Journal of Palliative Care*, *21*(2), 111-116.

Pearson, V., & Chan, T. W. (1993). The relationship between parenting stress and social support in mothers of children with learning disabilities: A Chinese experience. *Social Science & Medicine*, *37*(2), 267-274.

Pei, M. (2006). *China's trapped transition: The limits of developmental autocracy.* Massachusetts: Harvard University Press.

Pek, J. C., & Leong, F. T. (2003). Sex–related self–concepts, cognitive styles and cultural values of traditionality–modernity as predictors of general and domain–specific sexism. *Asian Journal of Social Psychology*, *6*(1), 31-49.

Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salahi, J., Struening, E. L., & Link, B. G. (2001). Stigma as a barrier to recovery: adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services*, *52*(12), 1627-1632.

Pescosolido, B. A., Martin, J. K., Lang, A., & Olafsdottir, S. (2008). Rethinking theoretical approaches to stigma: A framework integrating normative influences on stigma (FINIS). *Social Science & Medicine*, *67*(3), 431-440.

Pew Research Centre (2012). *The Rise of Asian Americans.* Retrieved from http://www.pewsocialtrends.org/2012/06/19/the-rise-of-asian-americans/

Pharoah, R. and Lau, S. (2009). *Shaping the future for London's Chinese community: A research based policy briefing.* London: The Chinese in Britain Forum.

Phillips, M. R., & Gao, S. (1999). *Report on stigma and discrimination of the mentally ill and their family members in urban China*. Geneva: World Health Organization.

Phillips, M. R., Pearson, V., Li, F., Xu, M., & Yang, L. (2002). Stigma and expressed emotion: a study of people with schizophrenia and their family members in China. *The British Journal of Psychiatry*, *181*(6), 488-493.

Pieke, F. N., & Biao, X. (2009). Legality and labour: Chinese migration, neoliberalism and the state in the UK and China. *Geopolitics, History and International Relations*, *1*, 11-45.

Pistole, M. C. (2004). Editor's note on multicultural compentencies. *Journal of Mental Health Counseling*, *26*(1), 39-41.

Pitson, L., Whitfield, G., & Walker, E. (1999). *Health and lifestyles of the Chinese population in England*. London: Health Education Authority.

Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (2009). *Handbook of multicultural counseling*. London: Sage publications.

Ponterotto, J. G., Gretchen, D., Utsey, S. O., Rieger, B. P., & Austin, R. (2002). A revision of the multicultural counseling awareness scale. *Journal of Multicultural Counseling and Development, 30*(3), 153-159.

Potter, P. B. (1998). The Chinese legal system: Continuing tensions over norms and enforcement. *China Review*, 25-59.

Priebe, S., Sandhu, S., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E & Riera, R. P. (2011). Good practice in health care for migrants: views and experiences of care professionals in 16 European countries. *BMC public health*, 11:187. doi: 10.1186/1471-2458-11-187

Pui-Ling, L., & Logan, S. (1999). *The mental health needs of Chinese people in England: A report of a national survey*. London: Chinese National Healthy Living Centre.

Purnell, L. D. (2012). *Transcultural health care: A culturally competent approach*. Philadelphia: FA Davis.

Qu, Jin, Zhang,Yudong,Luo, Kereng & Li (2009) *Overseas Chinese Studies*. Beijing: Social Sciences Academic Press

Quah, S. R. (2003). Traditional healing systems and the ethos of science. *Social Science & Medicine, 57*(10), 1997-2012.

Raja, A. (2015). Ethical Considerations for Therapists Working with Demographically Similar Clients. *Ethics & Behavior*. Accepted author version posted online: 07 Dec 2015. doi: 10.1080/10508422.2015.1113133

Ralston, D. A., Egri, C. P., Stewart, S., Terpstra, R. H., & Kaicheng, Y. (1999). Doing business in the 21st century with the new generation of Chinese managers: A study of generational shifts in work values in China. *Journal of international business studies, 30(2),* 415-427.

Rathbone, J., Zhang, L., Zhang, M., Xia, J., Liu, X., & Yang, Y. (2005). *Chinese herbal medicine for schizophrenia*. London: The Cochrane Library.

Read, J., & Wallcraft, J. (1995). *Guidelines on equal opportunities and mental health*. London: UNISON.

Repper, J., & Perkins, R. (2003). *Social inclusion and recovery: A model for mental health practice*. London: Baillière Tindall.

Reynolds, C. L., & Leininger, M. M. (1993). *Madeleine Leininger cultural care diversity and universality theory.* NY: Cornell University Press

Reynolds, W. (2000). *The measurement and development of empathy in nursing*. Vermont: Ashgate.

Reynolds, W. J., & Scott, B. (1999). Empathy: a crucial component of the helping relationship. *Journal of Psychiatric and Mental Health Nursing*, *6*(5), 363-370.

Riessman, C. K. (1993). *Narrative analysis: Qualitative research methods series*. Boston: Sage Publications.

Robinson, C. (2002). *Real world research: a resource for social scientists and practitioner-researchers*. Oxford: Blackwell

Roe, J., Joseph, S., & Middleton, H. (2010). Symbolic interaction: A theoretical approach to understanding stigma and recovery. *Mental Health Review Journal*, *15*(1), 29-36.

Rohleder, P., & Lyons, A. C. (Eds.). (2014). *Qualitative research in clinical and health psychology*. Hampshire: Palgrave Macmillan.

Roland, A. (1991). *In search of self in India and Japan: Toward a cross-cultural psychology*. New Jersey: Princeton University Press.

Rosenfield, S. (1997). Labeling mental illness: The effects of received services and perceived stigma on life satisfaction. *American Sociological Review*, *62*(4), 660-672.

Rothbaum, F., Rosen, K., Ujiie, T., & Uchida, N. (2002). Family systems theory, attachment theory, and culture. *Family Process*, *41*(3), 328-350.

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, *123*(1), 346-352.

Sam, D., & Moreira, V. (2002). *The mutual embeddedness of culture and mental illness. Online readings in psychology and culture*. Western Washington University, Department of Psychology, Center for Cross-Cultural Research. Retrieved from http://www. wwu. edu/~ culture.

Sampson, E. E. (1977). Psychology and the American ideal. *Journal of Personality and Social Psychology*, *35*(11), 767-782.

Sarantakos, S. (2005). *Social Research* (3rd ed.). Hampshire: Palgrave Macmillan.

Savers, S. (2004). Huang Di Nei Jing Su We^ n: Nature, Knowledge, Imagery in an Ancient Chinese Medical Text. *The Journal of Alternative and Complementary Medicine*, *10*(1), 191-196.

Scheff, T. J. (1974). The labelling theory of mental illness. *American Sociological Review*, *39*(3), 444-452.

Scheff, T. J. (2007). A concept of social integration. *Philosophical Psychology*, *20*(5), 579-593.

Schwandt, T. A. (1997). *Qualitative inquiry: A dictionary of terms*. London: Sage Publications.

Schwartz, S. H., & Bilsky, W. (1990). Toward a theory of the universal content and structure of values: Extensions and cross-cultural replications. *Journal of Personality and Social Psychology*, *58*, 878-891.

Seibold, C. (2002). The place of theory and the development of a theoretical framework in a qualitative study. *Qualitative Research Journal*, *2*(3), 3-15.

Seligman, M. E., & Csikszentmihalyi, M. (2000). Special issue on happiness, excellence, and optimal human functioning. *American Psychologist*, *55*(1), 5-183.

Seto, K. C., Güneralp, B., & Hutyra, L. R. (2012). Global forecasts of urban expansion to 2030 and direct impacts on biodiversity and carbon pools. *Proceedings of the National Academy of Sciences*, *109*(40), 16083-16088.

Sévigny, R., Wenying, Y., Peiyan, Z., Marleau, J. D., Zhouyun, Y., Lin, S., & Haijun, W. (1999). Attitudes toward the mentally ill in a sample of professionals working in a psychiatric hospital in Beijing (China). *International Journal of Social Psychiatry*, *45*(1), 41-55.

Shen, B. J., & Takeuchi, D. T. (2001). A structural model of acculturation and mental health status among Chinese Americans. *American Journal of Community Psychology*, *29*(3), 387-418.

Shklarov, S. (2010). *Narratives of resilience in aging Soviet Jewish child survivors of the Holocaust*. Canada: Library and Archives Canada.

Shojania, K. G., Duncan, B. W., McDonald, K. M., & Wachter, R. M. (2002). Safe but sound: patient safety meets evidence-based medicine. *JAMA*, *288*(4), 508-513.

Shuai, P., Mi, S., & Zou, H. (2015). Individualism and Collectivism Transition in Chinese college students: Evidence from After 70's, 80's, and 90's. *International Conference on Advanced Information and Communication Technology for Education.*

Silove, D., Steel, Z., & Watters, C. (2000). Policies of deterrence and the mental health of asylum seekers. *JAMA*, *284*(5), 604-611.

Silverman, D. (2011). *Interpreting qualitative data: A guide to the principles of qualitative research.* London: SAGE.

Simmel, G., & Wolff, K. H. (1950). *The sociology of georg simmel* (Vol. 92892). New York: Simon and Schuster.

Singelis, T. M., Bond, M. H., Sharkey, W. F., & Lai, C. S. Y. (1999). Unpackaging culture's influence on self-esteem and embarrassability the role of self-construals. *Journal of Cross-Cultural Psychology*, *30*(3), 315-341.

Skapinakis, P., Weich, S., Lewis, G., Singleton, N., & Araya, R. (2006). Socio-economic position and common mental disorders Longitudinal study in the general population in the UK. *The British Journal of Psychiatry*, *189*(2), 109-117.

Smaje, C., & Le Grand, J. (1997). Ethnicity, equity and the use of health services in the British NHS. *Social Science & Medicine*, *45*(3), 485-496.

Smart, J. F., & Smart, D. W. (1995). Acculturative stress: The experience of the Hispanic immigrant. *Counseling Psychology*, *23*, 25–42.

Smith, G. (2008). Does gender influence online survey participation?: A record-linkage analysis of university faculty online survey response behavior. *ERIC Document Reproduction Service No. ED 501717*. Retrieved from http://files.eric.ed.gov/fulltext/ED501717.pdf

Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples*. London: Zed books.

Søndergaard, M. (1994). Research note: Hofstede's consequences: A study of reviews, citations and replications. *Organization Studies*, *15*(3), 447-456.

Song, L. Y., Chang, L. Y., Shih, C. Y., Lin, C. Y., & Yang, M. J. (2005). Community attitudes towards the mentally ill: The results of a national survey of the Taiwanese population. *International Journal of Social Psychiatry*, *51*(2), 162-176.

Song, M. (2015). The British Chinese: A Typical Trajectory of 'Integration'? In L. Baldassar, G. Johanson, N. McAuliffe, & M. Bressan (Eds.), *Chinese migration to Europe: Prato, Italy, and beyond* (pp. 65-80). London: Palgrave Macmillan.

Soobrayan, V. (2003). Ethics, truth and politics in constructivist qualitative research. *Westminster Studies in Education*, *26*(2), 107-123.

Spencer-Rodgers, J., Williams, M. J., & Peng, K. (2010). Cultural differences in expectations of change and tolerance for contradiction: A decade of empirical research. *Personality and Social Psychology Review, 14*(3), 296–312. doi: 10.1177/1088868310362982

Spielberger, C. D., & Sharma, S. (1976). *Cross-Cultural Anxiety.* New York: John Wiley & Sons.

Sproston, K. A., B. Pitson, L., & Walker, E. (2001). The use of primary care services by the Chinese population living in England: examining inequalities. *Ethnicity and Health*, *6*(3-4), 189-196.

Sproston, K., & Primatesta, P. (Eds.). (2004). *Health survey for England, 2003, Vol. 3: methodology and documentation*. London: TSO.

Squires, A. (2008). Language barriers and qualitative nursing research: methodological considerations. *International Nursing review*, *55*(3), 265-273.

Stern, P. N. (1994). Eroding grounded theory. In J.M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 212-23). Thousand Oaks, CA: Sage.

Stern, P. N. (2007). On solid ground: Essential properties for growing grounded theory. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 114-126). London: SAGE.

Stiglitz, J. E., Sen, A., & Fitoussi, J. P. (2010). *Report by the commission on the measurement of economic performance and social progress.* Paris: Commission on the Measurement of Economic Performance and Social Progress.

Stratton, P. (1997). Attributional coding of interview data: Meeting the needs of long-haul passengers. In N. Hayes (Ed.), *Doing qualitative analysis in psychology* (pp. 115-142). Hove, UK: Psychology Press/Erlbaum.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research Grounded theory procedures and techniques.* Newbury Park: Sage Publications.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research techniques and procedures for developing grounded theory Second edition*. Thousand Oaks, California: Sage Publications.

Strawbridge, S., & Woolfe, R. (2010). *Handbook of counselling psychology*. London: SAGE Publications.

Stronach, I., & MacLure, M. (1997). *Educational research undone: The postmodern embrace*. Philadelphia: Open University Press.

Sue, D. (1997). Counseling strategies for Chinese Americans. In C. C. Lee (Ed.), *Multicultural issues in counseling: New approaches to diversity* (2nd ed., pp. 173-187). Alexandria, VA, US: American Counseling Association.

Sue, D. W. (1994). Asian-American mental health and help-seeking behavior: Comment on Solberg et al. (1994), Tata and Leong (1994), and Lin (1994. *Journal of Counseling Psychology*, *4*(3), 292-295.

Sue, D. W., & Frank, A. C. (1973). A typological approach to the psychological study of Chinese and Japanese American college males. *Journal of Social Issues*, *29*(2), 129-148.

Sue, D. W., & Kirk, B. A. (1972). Psychological characteristics of Chinese-American students. *Journal of Counseling Psychology*, *19*(6), 471-478.

Sue, D. W., & Sue, D. (1977). Barriers to effective cross-cultural counseling. *Journal of Counseling Psychology*, *24*(5), 420-429.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, *53*(4), 440-448.

Sue, S. and Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist*, 42, 37-45.

Sue, S., & McKinney, H. (1975). Asian Americans in the community mental health care system. *American Journal of Orthopsychiatry*, *45*(1), 111-118.

Sue, S., & Morishima, J. K. (1982). *The mental health of Asian Americans: Contemporary issues in identifying and treating mental problems*. San-Francisco: Jossey-Bass.

Sue, S., & Zane, N. (2009). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *Asian American Journal of Psychology, 1*, 3-14.

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

Sue, S., Nakamura, C. Y., Chung, R. C. Y., & Yee-Bradbury, C. (1994). Mental health research on Asian Americans. *Journal of Community Psychology*, *22*, 61-61. http://dx.doi.org/10.1037/1948-1985.S.1.3

Suen, N.K. (1983). *The deep infrastructure of Chinese culture*, Taiwan: Yan San.

Sundararajan, L., & Averill, J. R. (2007). Creativity in the everyday: Culture, self, and emotions. In R. E. Richards (Ed.), *Everyday creativity and new views of human nature* (pp. 195-220). Washington: American Psychological Association.

Swinnen, S. G., & Selten, J. P. (2007). Mood disorders and migration. *The British Journal of Psychiatry, 190*(1), 6-10.

Szasz, T. S. (1960). The myth of mental illness. *American Psychologist*,*15*(2), 113-118.

Takeuchi, D. T., Sue, S., & Yeh, M. (1995). Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *American Journal of Public Health*, *85*(5), 638-643.

Talley, R. C., & Crews, J. E. (Eds.). (2012). *Multiple dimensions of caregiving and disability: Research, practice, policy*. New York: Springer Science & Business Media.

Tan, C. H. (1990). *Management concepts and Chinese culture. Advances in Chinese industrial studies, part A.* Greenwich, US: JAI Press.

Tang, C. S. K., Pun, S. H., & Cheung, F. M. C. (2002). Responsibility attribution for violence against women: A study of Chinese public service professionals. *Psychology of Women Quarterly*, *26*(3), 175-185.

Tao, A., Zhou, Q., Lau, N., & Liu, H. (2013). Chinese American immigrant mothers' discussion of emotion with children relations to cultural orientations. *Journal of Cross-Cultural Psychology*, *44*(3), 478-501.

Tarozzi, M. (2013). Translating and doing grounded theory methodology. Intercultural mediation as an analytic resource. *Forum: Qualitative Social Research*, *14*(2). Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/1429

Taylor, S. E., & Stanton, A. L. (2007). Coping resources, coping processes, and mental health. *Annual Review of Clinical Psychology*. *3*, 377-401.

Teiser, S. F. (1999). Religions of China in practice. In D.S. Lopez Jr. (Ed.), *Asian religions in practice. An introduction* (pp. 88-122).New Jersey: Princeton University Press.

Temple, B. (2002). Crossed wires: interpreters, translators, and bilingual workers in cross-language research. *Qualitative Health Research*, *12*(6), 844-854.

Thomas, G., & James, D. (2006). Reinventing grounded theory: Some questions about theory, ground and discovery. *British Educational Research Journal*, *32*(6), 767-795.

Thomas, M. (2006). Acculturative stress and social support among Korean and Indian immigrant adolescents in the United States. *Journal of Sociology and Social Welfare*, *23*, 123–143.

Thomson, N. (2005). Cultural respect and related concepts: a brief summary of the literature. In *Australian Indigenous Health Bulletin*. *5*(4), 1-11.

Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiologia e Psichiatria Sociale*, *17*(01), 14-19.

Thornicroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: ignorance, prejudice or discrimination? *The British Journal of Psychiatry*, *190*(3), 192-193.

Thrane, G. (1979). Shame and the construction of the self. *Annual of Psychoanalysis, 7*, 321-341.

Ting-Toomey, S., & Kurogi, A. (1998). Facework competence in intercultural conflict: An updated face-negotiation theory. *International journal of intercultural relations, 22*(2), 187-225.

Ting-Toomey, S., & Oetzel, J. G. (2002). Cross-cultural face concerns and conflict styles. In W. B. Gudykunst & B. Mody (Eds.), *Handbook of international and intercultural communication* (pp. 143-164). London: SAGE

Tones, K., & Tilford, S. (2001). *Health promotion: effectiveness, efficiency and equity*. Cheltenham: Nelson Thornes.

Tong, K.N. (1986) *Original Discussion of Chinese Philosophy*. Taiwan: Student Publisher

Toofany, S. (2007). Minority ethnic groups' experiences and expectations of nursing in primary care. *Primary Health Care*, *17*(2), 39- 42.

Torrey, E. F. (1987). Prevalence studies in schizophrenia. *The British Journal of Psychiatry, 150*(5), 598-608.

Trades Union Congress (2008), *Immigration Document Checks and Workplace Raids*, Retrieved from https://www.tuc.org.uk/sites/default/files/extras/idc&wrnegs.pdf

Tran, L. (2006). *Health needs of the Chinese in Shropshire County and Telford and Wrekin*. Shropshire: Chinese National Healthy Living Centre

Tran, L. (2009). *Evaluation of a Chinese Mental Health Advocacy and Support Project.*The Kings' Fund. Retrieved from: http://www.cnhlc.org.uk/pdf/mentalhealthadvocacy-finalreport.pdf

Triandis, H. C. (1995). *Individualism & collectivism*. Colorado: Westview press.

Triandis, H. C. (2007). *Culture and psychology: A history of the study of their relationship*. London: Guilford Press.

Trifiletti, L. B., Gielen, A. C., Sleet, D. A., & Hopkins, K. (2005). Behavioral and social sciences theories and models: are they used in unintentional injury prevention research? *Health Education Research*, *20*(3), 298-307.

Trueit, D. (2008). Beyond simple order: Complexity and postmodern politics. *Journal of the Canadian Association for Curriculum Studies*, *6*(1), 25-43.

Tsai, J. L. (2007). Ideal affect: Cultural causes and behavioral consequences. *Perspectives on Psychological Science*, *2*(3), 242-259.

Tsang, H. W., Fung, K. M., Chan, A. S., Lee, G., & Chan, F. (2006). Effect of a qigong exercise programme on elderly with depression. *International Journal of Geriatric Psychiatry*, *21*(9), 890-897.

Tsang, H. W., Tam, P. K., Chan, F., & Cheung, W. M. (2003). Stigmatizing attitudes towards individuals with mental illness in Hong Kong: Implications for their recovery. *Journal of Community Psychology*, *31*(4), 383-396.

Tse, S. (2005). *Asian mental health workforce development feasibility project*. New Zealand: Health Research Council of New Zealand.

Tseng, W. S., & McDermott, J. F. (1975). Psychotherapy: Historical roots, universal elements, and cultural variations. *American Journal of Psychiatry*, *132*(4), 378-384.

Tu, W. (1994). *China in transformation*. Massachusetts: Harvard University Press.

Tung, R. L. (1996). Managing in Asia: Cross-cultural dimensions. *Managing across cultures: Issues and perspectives*, 233-245.

Tylor, E. B. (1920). *Primitive culture: Research into the development of mythology, philosophy, religion, language, art, and custom*. London: SAGE.

Tzu, L. (2012). *Lao-tzu's Tao teaching: With selected commentaries from the past 2,000 years*. Washington: Copper Canyon Press.

U.S. Department of Health and Human Services (1999). *The Reports of the Surgeon General*, Retrieved from: https://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS

Uba, L. (2003). *Asian Americans: Personality patterns, identity, and mental health*. London: Guilford Press.

UK Council for International Student Affairs (2013-2014). *International student statistics: UK higher education.* Retrieved from http://institutions.ukcisa.org.uk/Info-for-universities-colleges--schools/Policy-research--statistics/Research--statistics/International-students-in-UK-HE/

UN Dept. of Economic and Social Affairs (2010). China's rapidly aging population. *Today's Research on Aging,* (20). Retrieved from http://www.prb.org/pdf10/todaysresearchaging20.pdf

University of Nottingham (2011) *Investigation into the mental health support needs of international students with particular reference to Chinese and Malaysian students*. Retrieved from: https://www.nottingham.ac.uk/studentservices/documents/investigation-into-the-mental-health-support--needs-of-international-students-with-particular-reference-to-chinese-and-malaysian-students.pdf

Urquhart, C. (2013). *Grounded Theory for Qualitative Research: A Practical Guide*. London: SAGE

Urquhart, C., Lehmann, H., & Myers, M. D. (2010). Putting the 'theory' back into grounded theory: guidelines for grounded theory studies in information systems. *Information Systems Journal, 20*(4), 357-381.

Varner, I., & Beamer, L. (2005). *International communication in the global workplace*. London: McGraw-Hill.

Vigotsky, L. S. (1987). *Thinking and speech. The collected works of LS Vygotsky. Vol. 1. Problems of General Psychology.* New York, Plenum Press

Von Glasersfeld, E. (1988). Constructivism as a Scientific Method. *Scientific Reasoning Research Institute Newsletter, 3*(2), 8-9.

Von Glasersfeld, E. (2001). Radical constructivism and teaching. *Prospects*, *31*(2), 161-173.

Wahl, O. F. (2003). News media portrayal of mental illness implications for public policy. *American Behavioral Scientist*, *46*(12), 1594-1600.

Waley, A. (2005). *The analects of Confucius* (Vol. 28). Hove, UK: Psychology Press.

Walsh, R., & Shapiro, S. L. (2006). The meeting of meditative disciplines and Western psychology: a mutually enriching dialogue. *American Psychologist*, *61*(3), 227-239.

Wang, J., Wang, G. G., Ruona, W. E., & Rojewski, J. W. (2005). Confucian values and the implications for international HRD. *Human Resource Development International*, *8*(3), 311-326.

Wang, S., & Kim, B. S. (2010). Therapist multicultural competence, Asian American participants' cultural values, and counseling process. *Journal of Counseling Psychology*, *57*(4), 394-401.

Wang, Y. P. (2004). *Urban poverty, housing and social change in China*. London: Routledge.

Ward, C., & Lin, E. Y. (2010). There are homes at the four corners of the seas: Acculturation and adaptation of overseas Chinese. In M. H. Bond (Ed.), *The Oxford Handbook of Chinese Psychology* (pp.657-678). Hong Kong: Oxford University Press.

Warren, C. A. (2002). Qualitative interviewing. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 83-99). London: SAGE.

Wasserfall, R. (1993). Reflexivity, feminism and difference. *Qualitative Sociology*, *16*(1), 23-41.

Watson, J. L. (1977). Chinese emigrant ties to the home community. *Journal of Ethnic and Migration Studies*, *5*(4), 343-352.

Watts, A. (1961). *Psychotherapy, east and west*. New York: Pantheon Books.

Watzlawick, P. (Ed.). (1984). *The invented reality: how do we know what we believe we know? Contributions to constructivism*. New York: Norton.

Wei, L. (1994). *Three generations, two languages, one family: Language choice and language shift in a Chinese community in Britain* (Vol. 104). Avon, UK: Multilingual Matters.

Weissman, M. M., Bland, R. C., Canino, G. J., Faravelli, C., Greenwald, S., Hwu, H. G. & Lépine, J. P. (1996). Cross-national epidemiology of major depression and bipolar disorder. *JAMA*, *276*(4), 293-299.

Welsh, E. (2002). Dealing with data: Using NVivo in the qualitative data analysis process. *Forum: Qualitative Social Research*, *3*(2). Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/865/1880%26q%3Dnvivo%2Bmanual%26sa%3DX%26ei%3DZAH_T5PQOYuBhQfe9sWGBQ%26ved%3D0CC4QFjAJ

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: a complementary perspective. *American Psychologist*, *62*(6), 563-574.

WHO (2001) *Advocacy for Mental Health*. World Health Organization. Retrieved from: http://www.who.int/mental_health/resources/en/Advocacy.pdf

WHO (2004) *Gender in Mental Health Research.* World Health Organization. Retrieved from: http://apps.who.int/iris/bitstream/10665/43084/1/9241592532.pdf

WHO (2011) *Standards and Operational Guidance for Ethics Review of Health-Related Research with Human Participants*. World Health Organization. Retrieved from: http://apps.who.int/iris/bitstream/10665/44783/1/9789241502948_eng.pdf?ua=1&ua=1

Wiles, R., Charles, V., Crow, G., & Heath, S. (2006). Researching researchers: lessons for research ethics. *Qualitative Research*, *6*(3), 283-299.

Williams, B., & Healy, D. (2001). Perceptions of illness causation among new referrals to a community mental health team: “explanatory model” or “exploratory map”? *Social Science & Medicine*, *53*(4), 465-476.

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: findings from community studies. *American Journal of Public Health*, *93*(2), 200-208.

Willig, C. (2001). *Qualitative research in psychology: A practical guide to theory and method.* Oxford: Oxford University Press.

Willig, C. (2013). *Introducing qualitative research in psychology*. London: McGraw-Hill Education.

Willig, C. (2016) Constructivism and 'The Real World': Can they co-exist? *Qualitative Research in Psychology Bulletin*. Manuscript in preparation.

Wills, J., Datta, K., Evans, Y., Herbert, J., May, J., & McIlwaine, C. (2010). *Global cities at work. New migrant divisions of labour.* London: Pluto.

Wong, F. M. (1972). Modern ideology, industrialization, and conjugalism: The Hong Kong case. *International Journal of Sociology of the Family*, *2*(2), 139-150.

Wong, G., & Cochrane, R. (1989). Generation and assimilation as predictors of psychological well-being in British-Chinese. *Social Behaviour*, *4(*1), 1-14.

World Bank (2011) *China's Urbanization and Land: A Framework for Reform.* Retrieved from https://www.worldbank.org/content/dam/Worldbank/.../China/WEB-Urban-China.pdf

World Health Organization (2009). *Mental health: a state of well-being*. Retrieved from http://www.wpro.who.int/countries/2009/chn/health_situation.htm

Wu, A. M. S., Tang, C. K. K., & Kwok, T. C. Y. (2004). Self-efficacy, health locus of control, and psychological distress in elderly Chinese women with chronic illnesses. *Aging & Mental Health*, *8*(1), 21-28.

Wu, D. Y. H. (1991). The construction of Chinese and non-Chinese identities. *Daedalus*, *120*(2), 159-179.

Wu, K. M. (1985). *Chuang Tzu: World philosopher at play*. New York: Crossroad.

Xiang, Y. T., Yu, X., Sartorius, N., Ungvari, G. S., & Chiu, H. F. (2012). Mental health in China: challenges and progress. *The Lancet*, *380*(9855), 1715-1716.

Xu, J., & Yang, Y. (2009). Traditional Chinese medicine in the Chinese health care system. *Health Policy*, *90*(2), 133-139.

Yamada, A. M., & Brekke, J. S. (2008). Addressing mental health disparities through clinical competence not just cultural competence: The need for assessment of sociocultural issues in the delivery of evidence-based psychosocial rehabilitation services. *Clinical Psychology Review*, *28*(8), 1386-1399.

Yamaguchi, S. (1994). Collectivism among the Japanese: A perspective from the self. In U. E. Kim, H. C. Triandis, Ç. E. Kâğitçibaşi, S. C. E. Choi, & G. E. Yoon (Eds.), *Individualism and collectivism: Theory, method, and applications* (pp. 175-188). London: Sage Publications, Inc.

Yan, H. (2005). Confucian thought: Implications for psychotherapy. In W. S. Tseng, S. C. Chang, & M. Nishizono (Eds.), *Asian culture and psychotherapy* (pp. 129-141). Honolulu: University of Hawaii Press.

Yang, K. S. (1986). Chinese personality and its change. In M. H. Bond (Ed.), *The psychology of the Chinese people* (pp. 106-170). Oxford: Oxford University Press.

Yang, L. H. (2007). Application of mental illness stigma theory to Chinese societies: synthesis and new direction. *Singapore Medical Journal*, *48*(11), 977-982.

Yang, L. H., & Kleinman, A. (2008). 'Face' and the embodiment of stigma in China: The cases of schizophrenia and AIDS. *Social Science & Medicine*, *67*(3), 398-408.

Yang, L. H., Phillips, M. R., Lo, G., Chou, Y., Zhang, X., & Hopper, K. (2010). "Excessive thinking" as explanatory model for schizophrenia: impacts on stigma and "moral" status in Mainland China. *Schizophrenia Bulletin*, *36*(4), 836-845.

Yang, S. Y., & Sternberg, R. J. (1997). Conceptions of intelligence in ancient Chinese philosophy. *Journal of Theoretical and Philosophical Psychology*, *17*(2), 101-119.

Yang, K.S. (1995). Chinese social orientation: An integrative analysis. In K. S. Yang (Ed.), *Chinese value: A social science viewpoint* (pp. 65-120). Taipei: Kwai Kuan.

Yao, X. (2000). *An introduction to Confucianism*. Cambridge: Cambridge University Press.

Yee, L., & Au, S. (Eds.). (1997). *Chinese mental health issues in Britain: Perspectives from the Chinese mental health association.* London: Mental Health Foundation.

Yeung, A., Howarth, S., Chan, R., Sonawalla, S., Nierenberg, A. A., & Fava, M. (2002). Use of the Chinese version of the Beck Depression Inventory for screening depression in primary care. *The Journal of Nervous and Mental Disease*, *190*(2), 94-99.

Yeung, A., Kung, W. W., Chung, H., Rubenstein, G., Roffi, P., Mischoulon, D., & Fava, M. (2004). Integrating psychiatry and primary care improves acceptability to mental health services among Chinese Americans. *General Hospital Psychiatry*, *26*(4), 256-260.

Yeung, A., Slipp, L. E., Niles, H., Jacquart, J., Chow, C. L., Fava, M.,& Fricchione, G. L. (2014). Effectiveness of the relaxation response-based group intervention for treating depressed Chinese American immigrants: a pilot study. *International Journal of Environmental Research and Public Health*, *11*(9), 9186-9201.

Yeung, I. Y., & Tung, R. L. (1996). Achieving business success in Confucian societies: The importance of guanxi (connections). *Organizational Dynamics*, *25*(2), 54-65.

Ying, Y. W., & Miller, L. S. (1992). Help-seeking behavior and attitude of Chinese Americans regarding psychological problems. *American Journal of Community Psychology*, *20*(4), 549-556.

Yip, K. S. (1999). Confucian, Taoistic and Medical Perspectives on Mental Health in the Pre-Chin'Period. *Asian Journal of Counselling, 6(1),* 35-55.

Yip, K. S. (2003). Traditional Confucian concepts of mental health: Its implications to social work practice with Chinese communities. *Asia Pacific Journal of Social Work and Development*, *13*(2), 65-89.

Yip, K. S. (2004). Taoism and its impact on mental health of the Chinese communities. *International Journal of Social Psychiatry*, *50*(1), 25-42.

Yip, K. S. (2005). Chinese concepts of mental health: Cultural implications for social work practice. *International Social Work*, *48*(4), 391-494.

Yip, K. S. (2005). Taoistic concepts of mental health: Implications for social work practice with Chinese communities. *Families in Society: The Journal of Contemporary Social Services*, *86*(1), 35-45.

Yip, T., Gee, G. C., & Takeuchi, D. T. (2008). Racial discrimination and psychological distress: the impact of ethnic identity and age among immigrant and United States-born Asian adults. *Developmental Psychology*, *44*(3), 787-800.

Young, D., Tseng, W., & Zhou, L. (2005). Daoist philosophy: Application in psychotherapy. In W.S. Tseng, S. C. Chang, & M. Nishizono (Eds.), *Asian culture and psychotherapy: Implications for East and West* (pp. 142–155). Honolulu: University of Hawaii Press.

Young, R. A., & Collin, A. (2004). Introduction: Constructivism and social constructionism in the career field. *Journal of Vocational Behavior*, *64*(3), 373-388.

Yu, W. K. (2000) '*Meeting the needs of Chinese older people'* JRF findings. New York: Joseph Rowntree Foundation.

Yu, W. K. S. (2006). Adaptation and tradition in the pursuit of good health Chinese people in the UK-the implications for ethnic-sensitive social work practice. *International Social Work*, *49*(6), 757-766.

Yubo, H., & Ying, Z. (2002). The effect of culture on thinking style of Chinese people. Journal of Chinese Psychology *Acta Psychologica Sinica, 34(1),* 106-111

Yutang (Ed.) (1958). *The wisdom of Confucius*. London: Michael Joseph.

Zane, N., Hall, G. C. N., Sue, S., Young, K., & Nunez, J. (2004). Research on psychotherapy with culturally diverse populations. In M. J. Lambert (Ed.), *Bergin and*

Garfield's handbook of psychotherapy and behavior change (5th ed., pp. 767-804). New York: John Wiley & Sons.

Zarrow, P. (2002). The origins of modern Chinese concepts of privacy: Notes on social structure and moral discourse. In A. Hansson (Ed.) *Chinese concepts of privacy* (pp. 121-146). Netherland: Brill Academic Pub.

Zhang, G. (2003). Migration of highly skilled Chinese to Europe: trends and perspective. *International Migration*, *41*(3), 73-97.

Zhang, J., Conwell, Y., Zhou, L., & Jiang, C. (2004). Culture, risk factors and suicide in rural China: a psychological autopsy case control study. *Acta Psychiatrica Scandinavica*, *110*(6), 430-437.

Zhang, L., LeGates, R., & Zhao, M. (2016). *Understanding China's urbanization: The great demographic, spatial, economic, and social transformation*. Massachusetts: Edward Elgar Publishing.

Zhang, W. (2008). Conceptions of lifelong learning in Confucian culture: their impact on adult learners. *International Journal of Lifelong Education*, *27*(5), 551-557.

Zhang, W., Li, X., Lin, Y., Zhang, X., Qu, Z., Wang, X. & Li, Y. (2013). Pathways to psychiatric care in urban north China: a general hospital based study. *International Journal of Mental Health Systems*. 7:22. DOI: 10.1186/1752-4458-7-2

Zhang, Y. (2012). *Transforming emotions with Chinese medicine: An ethnographic account from contemporary China*. New York: SUNY Press.

Zhang, Y., Young, D., Lee, S., Zhang, H., Xiao, Z., Hao, W., & Chang, D. F. (2002). Chinese Taoist cognitive psychotherapy in the treatment of generalized anxiety disorder in contemporary China. *Transcultural Psychiatry*, *39*(1), 115-129.

Zheng, H., & Yang, Y. (2009). *Chinese private sector development in the past 30 years: Retrospect and prospect.* Nottingham: International House University of Nottingham, China Policy Institute.

Zhou, L. Y., Dawson, M. L., Herr, C. L., & Stukas, S. K. (2004). American and Chinese college students' predictions of people's occupations, housework responsibilities, and hobbies as a function of cultural and gender influences. *Sex Roles*, *50*(7-8), 547-563.

Appendix 1 Consent Form in English

CITY UNIVERSITY LONDON

Title of Study: **Cultural perspectives on mental health beliefs and treatment expectations within the Chinese immigrant community in the UK**

Ethics approval code: [PSYCH(P/F) 14/15 128]

		Please initial box
1.	I agree to take part in the above City University London research project. I have had the project explained to me and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be audiotaped	
2.	This information will be held and processed for the following purpose(s): • Research I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____ _____ _____

Name of Participant Signature Date

_____ _____ _____

Name of Researcher Signature Date

When completed, 1 copy is kept by the participant and 1 copy by the researcher.

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

Appendix 2 Consent Form in Chinese

研究参与者同意书

研究课题

中国移民的文化背景对心理健康的认知以及治疗结果的影响

研究伦理委员会批准号码: [PSYCH(P/F) 14/15 128]

请阅读条例并签字

1.	我同意参加由伦敦城市大学发起的这项研究。我已经被告知过研究的大致内容并且阅读过并存有参与者资料手册。 我明白研究人员会对我进行大约 45-60 分钟的采访，访问内容会被录音。	
2.	所有我提供的资料仅被用来研究所有。采访过程与采访产生的数据将符合相关法律以及法规要求妥善保管并且加密，並承諾絕不洩露研究参与者身份之机密性。本研究结果数据除发表于科学性期刊之外，不会对外公开。所有刊登出来的文章，也不会出现任何可辨别研究参与者之咨询。	
3.	我明白如果我对参与本研究有所反悔，我有权退出此研究计划，不需任何理由，不會影响我的权益，亦不需负担任何法律道德責任。只要我在谈话进行之后 48 小时致电研究人员， 研究人员会确认我的意愿即可删除您的资料。 但如果超过这个时限，您的谈话内容可能还是会被收取到最终研究报告之中。	
4.	我同意参加这项由伦敦城市大学发起的研究并对我和研究员之间的谈话进行记录和进一步研究。我明白这些资料仅供学术研究所用， 伦敦城市大学将严格遵守相关法律(Data Protection Act 1998) 对我的资料进行保密。 在此条件下，我才会确认参加本项研究。	
5.	我确认参加本项研究	

_____ _____ _____

研究参与者 签名 日期

_____ _____ _____

研究人员 签名 日期

此分同意书一式两份， 分别由研究参与者和研究人员保存。

Appendix 3 Participant Information in English

Participant Information Sheet

Title of study: *Cultural perspectives on mental health beliefs and treatment expectations within the Chinese immigrant community in the UK*

We would like to invite you to take part in a research study. Before you decide whether you would like to take part, it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
In recent years there has been an unprecedented rise in the migration of Chinese citizens. This study hoping to address the intersection of culture in the field of mental health within Chinese immigrant populations, and also aiming to understand the experience of the mental health services users within the Chinese immigrant population. This study is taken as part of requirement for the Professional Doctorate in Counselling Psychology programme.

Why have I been invited?
All participants for this proposed study will be English or Chinese (Mandarin) speaking first generation immigrants (both male and female) who had used the mental health service in the UK. To ensure relevancy for the study, the treatment must received within the past five years. Total 12- 16 participants will be recruited.

Do I have to take part?
Participation in the project is completely voluntary, you may wish to withdraw at any stage, or avoid answering questions which are felt to be too personal or intrusive, and an assurance that this will not affect any future treatment or penalized if you choose to withdraw. All the information you decided to share with the researcher will be confidential, all the data we collect will be stored in locked equipments according to the Data Protection Act. Your identity will remain confidential and will not be revealed in any reports or publications arising from the study. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. If you decided to withdraw your consent from the stud after your participation, please contact me within 4 weeks, after which the data will be incorporated into the study.

What will happen if I take part?
If you are interested in taking part please take time to read this Participant Information Sheet and then sign the accompanying consent form. Following this:

- *An one to one semi-structured interview with the researcher for about 45- 60 mins*
- *The interview will be conducted at the location where is convenient for the participant*
- *The study will last over 6 month's period.*

What do I have to do?
To share your own experience regarding the current mental health service in the UK from a cultural perspective.

What are the possible disadvantages and risks of taking part?
Some potential risks are:

1. *Possible psychological disturbance for participants.*
2. *Communication errors*
3. *Confidentiality or inadequate attention to gender or privacy issues.*
4. *Overlook participant's traditional cultural values.*

However these risks are perceived to be very minimal.

What are the possible benefits of taking part?
With your participation, this study hoping to address the intersection of culture in the field of mental health within Chinese immigrant populations, and also aiming to understand the experience of the mental health services users within the Chinese immigrant population. Your participation is appreciated and will help counselling psychologists discover more ways of promoting better mental health care for the Chinese communities.

What will happen when the research study stops?
The audio and recordings of your activities made during this research will be used only for analysis and for illustration in the final research. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings. All data is handled and stored according to the Data Protection Act 1998. All information which is collected about you will be kept strictly confidential, and any information about you which leaves the university will have your name and address removed so that you cannot be recognised. The information collected as part of this study will be used only for the purposes described in this information sheet. Your consent is on the condition that we uphold our duties and obligations under the Data Protection Act 1998 for the storage, use and destruction of data and samples. If you do decide to take part your data will be stored for 3 years from when the study ends.

Will my taking part in the study be kept confidential?
Any information you provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. All the data we collect will be stored in locked equipments according to the Data Protection Act.

What will happen to the results of the research study?
In the future, the results of this study will be reported in study reports to the University Exam body as part of a Doctorate Thesis. Data will also be published in scientific journals and presented at scientific meetings. In either case you will only be identified by your anonymised participant code. If you would like to receive a results summary at the end of the research study, please let us now.

What will happen if I don't want to carry on with the study?
If you withdraw once the study has started, you do not need to give a reason. If you agree, we would like to keep data already collected, however it is up to you to decide whether we are allowed to do that, or not. In the unlikely event that you lose capacity to consent during the project, the research team will retain any data already collected and continue to use them confidentially in connection with the purposes of the current study, but no further data will be collected from you.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your question: Yiyi Yin, [redacted]

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone [redacted]*. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: Cultural Influences on mental health beliefs and treatment expectations within the Chinese immigrant community in the UK*

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [redacted]

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?
This study has been approved by City University London *[insert which committee here]* Research Ethics Committee, [*PSYCH(P/F) 14/15 128*].

Further information and contact details
Yiyi Yin
[redacted]

Thank you for taking the time to read this information sheet.

Appendix 4 Participant Information in Chinese

研究课题: 中国移民的文化背景对心理健康的认知以及治疗结果的影响

我们诚挚邀请您参加本研究。 此研究说明书主要是提供您有关本研究之相关咨询并保证您的相关权益，以便您决定是否参加本研究。研究人員将会为您說明研究內容並回答您可任何和此研究有关的问题。

此项研究的目的

近年来中国移民的数量大幅增加，如何为华人们更好的提供有关心理健康的医疗服务是重要课题。这项研究目的是为了解中国移民在心理健康上的认知， 以及在英国寻求心理健康有关方面帮助的感受。本次研究为伦敦城市大学心理咨询系博士论文的一部分。

参加本次研究参与的条件

如果您是定居在英国的华人，并在过去五年之内因为心理健康问寻求过医疗帮助， 都将符合参加本次研究的条件。

我一定需要参加本次研究吗？

本次研究为自愿参加。您可以自由决定是否參與本研究。 您如果对参与本研究有所反悔，您也有权退出此研究计划，不需任何理由，不會影响您的任何权益，亦不需负担任何法律道德責任。

参加研究后的具体步骤

如果您同意参加本次研究，请在仔细阅读本说明书之后签署参与研究同意书。即使在您同意后，您也可以随时退出本研究不需任何理由。签署同意书之后，研究人员将对您进行一次访谈（普通话或者英文），每次访谈大约 45 到 60 分钟。访谈地点可有您来选择。

我需要做什么?

访谈中将邀请您分享您的经历， 包括对移民文化的理解、对心理健康的认识， 以及在英国寻求心理健康帮助的经历，

參與研究預期的風險及處置方法

在研究中所讨论的某些问题可能会使您感到不适或困扰，但您随时可以拒绝回答任何问题或随时退出讨论。

参与研究的预期效益

您的参与能能够帮助英国各大医疗机构更一步了中国移民在心理健康方面的需要， 并为社区提供更高效的服务。

研究结束后资料的处理步骤

所有研究记录將妥善储存並保密，加锁保管在研究人员研究室中之档案柜，保存期限为研究結束后 3 年並在保存期限結束后销毁。在研究过程中，若有新资讯將可能影响您是否继续参与本项研究，研究人员將另行通知。

本项研究的机密性

本次研究将严格遵守相关法律(Data Protection Act 1998)对您在本次谈话中提供的所有资料进行保密。这些数据将仅作为毕业论文研究分析之用，并承诺对相关资料将严格保密。 研究所收集的资料将分别机密归档保存。

研究成果的发表

如果研究成果被发表或者出版， 您的身份仍将被保密， 您的谈话将加以编号，而连接您的姓名与此编号文件之编码将分别存储并保密。如果您希望得到一份研究成果的陈述，请事先告知研究人员。

研究之参与、中止及退出

若您对参与本研究有所反悔，您有权退出此研究计划，不需任何理由，不會影响您的权益，亦不需负担任何法律道德責任。只要您在谈话进行之后 4 周之内致电研究人员， 研究人员会确认您的意愿即可删除您的资料。但如果超过这个时限，您的谈话内容可能还是会被收取到最终研究报告之中。

其他问题

如果您对本项研究有任何問題，请与研究人员尹依依联络（电子邮件：yiyi.yin.1@city.ac.uk）。如果您对本项研究的的執行有任何不滿，或对于本研究所采取的程序、风险和利益或您作為研究参与者的权益有任何疑虑和申訴，請與伦敦城市大学联络， 联络方式为：

Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [redacted]

*伦敦城市大学对本项研究投有责任保险。

审查机构

这项研究已经被伦敦城市大学研究伦理委员会批准， 批准号码为：PSYCH(P/F) 14/15 128

如有任何问题，请联系：

尹依依
[redacted]

感谢您的阅读

PART TWO - Client study

Cultural sensitivity in an ethnically matching therapeutic relationship

A supportive expressive psychodynamic therapy client study

Submitted in partial fulfilment of the requirements for the degree of:
Professional Doctorate of Counselling Psychology
City University London
Department of Psychology

PART THREE - Empirical Article

International Journal of Culture and Mental Health

(Intend to submit)

Submitted in partial fulfilment of the requirements for the degree of:

Professional Doctorate of Counselling Psychology

City University London

Department of Psychology

Cultural perspectives of mental health beliefs and treatment expectations within the Chinese immigrant community

Yiyi Yin

School of Arts and Social Sciences, Department of Psychology, City University London, London, UK

Cultural perspectives of mental health beliefs and treatment expectations within the Chinese immigrant community

Chinese immigrants began to settle in the UK as early as the 19th century, and are also the fastest growing ethnic group today. However, the research interest and policy focus on the Chinese immigrant community does not reflect either their long-standing presence or these recent developments. There are also few studies that address the intersection of culture in the field of mental health within the Chinese immigrant population. This study explores the mental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community in the UK. Using a constructivist grounded theory methodology, intensive interviews were used to collect data from twelve participants. The data analysis resulted in the emergence of four categories: experiences in the context of cultural perspectives, changing mental health beliefs, evaluations of the service and a review of treatment expectations. From the data analysed, this study suggests a more comprehensive understanding ofmental health beliefs and mental health treatment expectations in the context of cultural perspectives within the Chinese immigrant community.

Keywords: Chinese immigrant; culture; mental health; treatment expectations

Introduction

The number of Chinese immigrants in the UK has continued to rise, especially in recent years. A recent figure released by the Office for National Statistics indicates that China now provides the largest number of new immigrants to the UK (ONS, 2014). An ECRAN report has also stated that the United Kingdom has the largest Chinese population in Europe (Latham & Wu, 2013).

Although there has been a reasonably long history of Chinese settlement in Britain while also being the fastest growing ethnic group in the UK (ONS, 2011), the research interest and policy focus on the Chinese immigrant community does not reflect either their long-standing presence or these recent developments. The purpose of this study is to understand the cultural perspectives of mental health beliefs and treatment expectations within the Chinese immigrant community. The study aims to focus on the exploration of social contexts and cultural processes surrounding the participants, while at the same time understanding their values and beliefs about mental health issues.