**Chinese people’s experiences of mental health:**

**A Review of Family Support Globally and an Analysis of Hong Kong Second-Generation Chinese Immigrants’ Lived Experiences in the UK**

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# **Thesis Abstract**

As part of a Professional Doctorate in Clinical Psychology, the author of this thesis was particularly interested in exploring Chinese people’s experiences of mental health difficulties. The investigation included a review of the literature to explore the experiences of family support for Chinese people with mental health issues globally, and an analysis of Hong Kong second-generation Chinese Immigrants’ lived experiences in the UK.

Paper one presents a comprehensive meta-ethnographic review of the literature exploring familial support for Chinese people with mental health difficulties globally. Fifteen papers were identified, and the findings were critically appraised, synthesised, and analysed. Seven key themes are discussed in relation to the lived experiences of mental health support from the perspectives of family caregivers’ and Chinese individuals.

Paper two presents a qualitative analysis of Hong Kong second-generation Chinese immigrants’ experiences of mental health support. Purposive sampling was used to identify seven participants from the UK who had lived experience of mental health difficulties. Semi-structured interviews provided data for an Interpretative Phenomenological Analysis and three main themes were identified.

Paper three presents an executive summary of the findings described in paper two, in an accessible format. The summary is aimed at Hong Kong second-generation Chinese immigrants and those interested in finding out more about Chinese people’s experiences of mental health and how they may obtain support for mental health difficulties.

**Word count:** 223

# **Paper 1: Literature Review**

**Exploring the experiences of family support in Chinese people with mental health difficulties: A Meta-Ethnographic Review**

**Target journal:** International Journal of Mental Health Nursing

**Word count:** 7999

# **Abstract**

**Objectives**: A literature review aiming to highlight the main themes associated with familial support for Chinese people experiencing mental health difficulties. It was hypothesised there would be factors unique to Chinese culture that would impact how mental health was conceptualised and how and what support was sought.

**Method**: A comprehensive literature search was conducted to explore sources relevant to the research in question. Fifteen papers (12 qualitative, three mixed methods) met the inclusion criteria, and findings were critically appraised and synthesised using a meta-ethnographic approach.

**Results**: This review included a range of international studies, five originating from China. The synthesis identified seven key themes relating to familial support for Chinese people with mental health difficulties.

**Conclusions**: Chinese families experience additional stigma and negative impacts on familial relationships due to different conceptualisations of mental health distress compared to Westernised understanding. Findings highlight the need for cultural awareness of Chinese values and concepts such as, “losing face” that contributes to fears around disclosure and perceived stigma associated with mental health issues that exacerbate social isolation experienced in this group. Shame is often experienced and can be a barrier to individuals and families help-seeking. Clinicians and services need to provide care that is sensitive to these cultural nuances, including psychoeducation and anti-stigma programmes and this should be supported by changes to mental health policy.

**Word count**: 222

**Key words**: family, mental health, meta-ethnographic, support, qualitative

# **Introduction**

In England and Wales, the Chinese diaspora is one of the fastest growing ethnic minority groups (ONS, 2018). Despite this, evidence suggests that mental health services are being underutilised by Chinese people in the UK (Care Quality Commission, 2011; Bignall et al., 2019). The reasons for this remain unclear but language and literacy difficulties have been cited as potential barriers to Chinese people accessing mental health services, with the 2011 UK Census stating just under 13% of Asian Chinese people “could not speak English well” (ONS, 2018). This has been highlighted as a probable barrier to seeking help (Yeh, 2003; Clough et al., 2013).

Large Chinese diasporas also exist across the globe, with immigrant communities in countries such as Canada and Australia, where a reluctance to consult professionals for mental health issues is evident (Kung, 2001; Lu et al., 2017). Chinese people are reluctant to seek professional help, or to recommend their parents or children do so, in the presence of mental health difficulties (Lu et al., 2017). This is supported by research suggesting Chinese populations may be less likely to approach professionals for mental health support due to families taking responsibility for the care of their relatives (Chu, 2004; Lee & Mock, 1996). However, a national survey conducted in the UK found that Chinese people with mental health difficulties (n=71) found their families to perceive mental illness as embarrassing and frightening and only five participants thought their families would be supportive (Li et al., 1999). This may undermine the argument that underrepresentation of Chinese people in mental health services is due to needs being met by familial support (Lee & Mock, 1996). Therefore, it is important to gain further understanding of how Chinese people with mental health difficulties might experience support from family and the experiences of people who may provide this care to relatives with mental health difficulties.

Chinese cultural concepts in relation to mental health may differ to those of Western European-based societies (Kuo & Kavanagh, 1994). Such differences can help explain why Chinese people seek other avenues to manage mental distress, such as via alternative healers and medicine (Lee & Mock, 1996; Yip, 2005). There is evidence to suggest that Chinese individuals can use somatisation to explain mental health symptoms (Li et al., 1999), rather than understanding them to be psychological in nature, which may explain choices to engage in more atypical and holistic approaches (Butt et al., 2015).

Cross-cultural research highlights how Chinese culture is significantly more collectivist than individualist where “maintaining group harmony” (Oyserman et al., 2002, p.21.) is vital. Confucianism plays an important role in determining the collectivist rules in which Chinese culture is founded, including how individuals must behave according to a social role hierarchy that typically restricts personal choice and action (Kuo & Kavanagh, 1994). For example, Chinese children typically have filial obligations to strive to honour parental expectations and contribute to family reputation and ‘face’ (Chu, 2004). Therefore, stigma around mental health issues is amplified due feeling obligated to maintain the ‘face’ of families (Shea & Yeh, 2008) and barriers to seeking mental health support may be quite significant, especially for those living in Western societies (Leung et al., 2012).

The impact of families on those experiencing mental health difficulties within ethnic minority groups is significant. Evidence suggests that within the culture of minority groups, family is of great importance (Kokanovic et al., 2006). Chinese people can rely on personal and family resources to manage what they believe to be a physical illness (Hsu & Folstein, 1997). Therefore, exploring individuals’ experiences of support for mental health difficulties will enable us to better provide culturally sensitive and appropriate support to a large ethnic minority group that continues to be neglected in research, particularly in the UK (Huang & Spurgeon, 2006).

# **Method**

# *A meta-ethnographic review*

This is an interpretive approach to research synthesis focused on analysing qualitative studies to enhance understanding (Noblit & Hare, 1988), which enables readers to concurrently understand how studies are related or different (see Figure 1 for further details).

*Search strategy*

A systematic literature search (carried out on 28th April 2020) of the following databases was conducted using EBSCO host: APA PsycInfo, APA PsycArticles, APA PsycBooks, CINAHL Plus with Full Text, Education Research Complete and MEDLINE, to explore sources relevant to the research in question.

Additionally, screening of reference lists of included studies was undertaken to ensure a comprehensive search of the literature.

Diagram

Description automatically generatedFigure 1: Diagram outlining meta-ethnographic review process, adapted from Noblit & Hare (1988). Note: double-ended areas represent overlap between the stages of synthesis, rather than a linear process.

*Search terms*

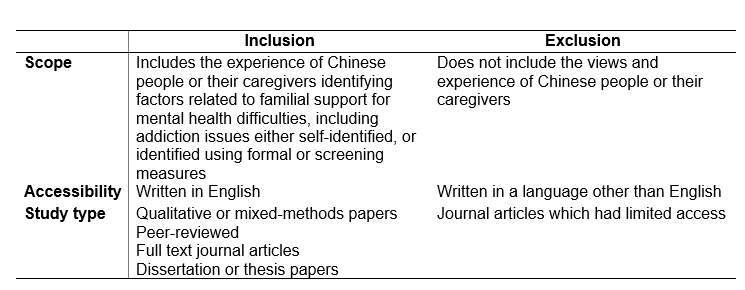
To ensure the most relevant papers were identified, these strategies were employed:

* Using Boolean operators “AND” and “OR” with search terms
* Asterisks to truncate words allowing associated terms to be included, for example Chin\*
* Use of DE (Database thesaurus descriptor) to try and ensure all studies relating to the relevant population were identified
* Quotation marks around key phrases to ensure relevant concepts were explored, for example “family relationships”.

Search terms were developed using pilot searches with keywords from qualitative studies exploring experiences of family support in Chinese people, with mental health issues. Based on the relevance of the returned references, terms were included or excluded. The following search terms were included in the final search strategy:

Culture, Chinese Ethnicity, China, Chin\*, Chinese, DE “Chinese cultural groups”, Hong Kong, Support, Care, “Mental health”, “Mental illness”, “family relations”, “family relationships”. Systematic searches combining these terms were completed to generate the most appropriate studies for inclusion in the review (see Appendix B).

Titles and abstracts of papers were screened in line with the inclusion and exclusion criteria to determine suitability. If there was any doubt about the relevance of the papers, a full text review was completed. No restrictions on publication dates were used in the search strategy. Mental health issues were defined not only using formal diagnostic labels, due to Westernised concepts not necessarily being relevant for this population.

****Table 1**: *Summary of inclusion and exclusion criteria*

# 

# *Search returns*

The systematic literature review returned 104 references. The Preferred Reporting Items for Systematic reviews and Meta-Analysis (PRISMA) framework (Moher et al., 2009) demonstrates the full systematic process of article selection utilised (see Figure 2, p. 19). After full text analysis, 15 papers were assessed as suitable for inclusion. The systematic process of identifying literature returned a relatively small number of papers exploring which highlights an under-researched area and population.

Grey literature was included for consideration, resulting in one study (Chan, 2009) being included in the final synthesis. Although this was published in a peer-reviewed journal article, the original thesis was also reviewed (Chan, 2007). Inclusion of grey literature is important as views and experiences may not be outlined in published research, due to the increasing trend of positive result studies published in the field of psychological research (Fanelli, 2012).

# **Results**

Findings were incorporated from 15 papers with a total of 393 participants. Two studies included some non-Chinese participants, but these were included as most participants were Chinese (Subramaniam et al., 2017), and non-Chinese controls were included in a mixed methods design (Chan, 2009). Most papers used semi-structured interviews, with only one using focus groups (Chan, 2009); and one using semi-structured “shared conversations” to facilitate interactive discussions (aided by interpreters), in addition to individual sessions (Chang & Horrocks, 2006, p. 437). All but one study used audio-recording to document participants’ perspectives. Kung (2003) summarised interviews in writing and the “actual wording of respondents was used” (p. 550), where possible.

Most studies explored caregiving for people with schizophrenia, or the broader defined “psychotic-spectrum disorder” (Chen et al., 2013, p.5), whilst remaining studies focused on people with ‘persistent mental illness’ (Bedi et al., 2015; Chang & Horrocks, 2006); depression and suicidality; post-partum depression, and older adults with self-reported experiences of problem gambling. Only five of 15 studies originated from China, but similar themes could be identified across studies. The discrepancy in reporting of demographics (e.g., age, duration of mental health difficulties) made it difficult to summarise them in any meaningful way. Whilst all studies reported findings relating to familial support for mental health difficulties, there was a variation in research questions. Characteristics of included studies are summarised in Table 2.

# *Data extraction*

Familiarisation with included studies was completed through reading and re-reading (Noblit & Hare, 1988). A data extraction tool (see Appendix C) was developed to ensure a consistent approach to synthesis across the studies. The tool was piloted with a few papers and any amendments made to ensure relevant information was extracted to complete the synthesis. This included the location, research questions, participant details such as, gender and age, recruitment strategy, method of data collection and analysis, whether reflexivity was employed, the validity of the findings, discussions and the author(s) main conclusions. These inclusions facilitated the quality appraisal of the included papers in relation to the Critical Appraisal Skills Programme (Public Health Resource Unit, 2018b) tool for qualitative research and the Mixed Methods Assessment Tool (MMAT) (Hong et al., 2018).

# *Critical appraisal*

Several studies formed part of a larger study (Chan, 2009, Subramaniam et al., 2017a, Zeng et al., 2012). In those where methodologies were not detailed, other related publications were searched for however, these were not always identifiable. Where broader studies were identified, these were accessed to accurately appraise the quality of the study (see Appendix D).

Methods for reviewing the rigour of studies have been widely discussed and there are many ways qualitative research could be appraised (Walsh & Downe, 2004). To review the quality and rigour of the literature, the CASP (Public Health Resource Unit, 2018b) tool for qualitative research was used; a checklist enabling thorough appraisal. As most articles included were purely qualitative, this tool was deemed suitable to evaluate research methodology. Although the CASP is commonly used, comparative to other tools such as, the Evaluation Tool for Qualitative studies (ETQS), it has been argued as being potentially less effective at evaluating the essential methodological quality of a study (Hannes et al., 2010).

For the three mixed methods papers (Chan, 2009; Kung, 2003; Zeng et al., 2013), the MMAT (Hong et al., 2018) was used to evaluate methodological rigour and quality in addition to the CASP. Whilst the qualitative MMAT (2018) criteria has been criticised for having quite generic criteria that requires further content validation and reliability testing, there are few other validated tools for appraising mixed method studies (Pace et al., 2012). The greatest methodological issues with the mixed methods papers were that themes presented alongside quantitative measures were not always clearly discussed (particularly in Kung, 2003), sometimes with a lack of information around the analysis process. Potential biases in the process of summarising the interviews was not outlined, highlighting a potential weakness in the methodology that contrasted with all other included studies, where audio-recording and verbatim transcription was used. Summarised critical appraisal of the included studies using the CASP and MMAT are in Appendix E and F respectively.

All studies had research questions which lent themselves to using qualitative methods. Seven studies had understanding the experiences of familial support as the main research question (see Table 2). Most studies utilised purposive sampling however, recruitment strategies were not always detailed and therefore, it was sometimes unclear how many participants were initially approached and the reasons for individuals not participating in studies.

Yardley (2008) highlights the importance of using reflexivity to enhance the credibility of qualitative research. Whilst two studies did not mention any potential bias or influence of the researchers on the data collection or analysis (Kung, 2003; Liu & Zhang, 2019), most studies discussed using reflexivity and critically examining interviewers’ roles in the research process, using triangulation and peer debriefing to improve rigour. Interpreters were used to overcome linguistic barriers however, potential influence and bias on data collection were often not discussed. Epistemological positions were not explicitly outlined but most studies did justify the use of qualitative methods to be able to accurately explore the lived experiences of familial support and mental health difficulties. Nevertheless, all studies made valuable contributions to research that recommended more culturally sensitive practice to aid understanding of mental health within Chinese populations.

Diagram

Description automatically generatedFigure 2: Process of data selection (Moher et al., 2009)

**Table 2** – *Characteristics of studies selected for inclusion*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Study number | Author(s), year of publication | Location | Mental health conditions/diagnoses | Participants | Community/  Inpatient | Data Analysis | Research questions |
| 1 | Bai et al., 2020 | China | Schizophrenia | 13 caregivers | Inpatient | Thematic | What are the challenges faced by parents caring for early-stage schizophrenia in children/adolescents in China? |
| 2 | Bedi et al., 2015 | Canada | Persistent mental illness | 10 caregivers and 9 clients | Community | Thematic/  Content | What are the experiences of Chinese family caregivers and what are their psychoeducational needs? |
| 3 | Chan, 2009 | Australia | Depression | 76 clients | Community | Thematic | What is the importance of social capital as a form of help for Chinese people experiencing depression? (How do Chinese people conceptualise their depressive episodes and mental illness? Chan, 2007) |
| 4 | Chang & Horrocks, 2006 | Malaysia | Severe and persistent mental illness | 19 caregivers | Community | Thematic | What are the lived experiences of Chinese family caregivers who were caring for relatives with severe and persistent mental illness? |
| 5 | Chen et al., 2006 | Taiwan | Post-partum depression | 23 women | Community | Constant comparative method | What is the psychosocial process by which PPD is alleviated? |
| 6 | Chen et al., 2013 | USA | Psychotic-spectrum disorder | 53 clients | Community- hospitalisation within 1 month of interview | Conventional content | How do Chinese immigrants decide to whom to disclose? What are the social consequences of mental illness disclosure? |
| 7 | Chen et al., 2019 | China | Schizophrenia | 20 caregivers | Community- GP practices | Thematic -Colaizzi’s method | What are the views of the Chinese family caregivers of people experiencing schizophrenia? |
| 8 | Huang et al., 2009 | Taiwan | Schizophrenia | 10 caregivers | Community | Thematic -Colaizzi’s method | What are the experiences of carers who live with someone with long-term schizophrenia? |
| 9 | Kung, 2003 | USA | Schizophrenia | 30 caregivers | Community | Unspecified | What are the sources and extent of burden in caregiving? |
| 10 | Liu & Zhang, 2019 | China | Schizophrenia | 16 caregivers | Inpatients | Inductive content | What are the experiences of caregivers living with people with schizophrenia? |
| 11 | Subramaniam et al., 2017a | Singapore | Gamblers | 16 (out of 25) | Community | Thematic network | What role do families play in the evolution of gambling behaviour? What are the effects on the family? What is the role that families play in help-seeking for gamblers? |
| 12 | Sun et al., 2008 | Taiwan | Suicidal ex-patients | 15 clients, 15 caregivers | Community | Grounded theory | What are family carers’ and suicidal ex-patients’ perceptions of the home environment and provision of care in the home? |
| 13 | Yeung et al., 2017 | UK | Schizophrenia,  Schizo-Affective Disorder, Bipolar Affective Disorder, Severe Depression | 16 clients, 16 caregivers | Community | Thematic | What are Chinese populations’ experiences of mental distress and how does this impact on their journey through mental health care? |
| 14 | Zeng et al., 2012 | Macau (China) | Depressed older adults | 31 older adults | Community | Thematic- Van Manen’s method | What are the factors associated with depression amongst older persons, relating to family and social aspects? |
| 15 | Zou et al., 2014 | China | Schizophrenia | 21 clients, 14 caregivers | Community-outpatients | Thematic-Colazzi’s method | What are the facilitators and barriers that inﬂuence self-management in Chinese people with schizophrenia and their caregivers? |

# **Reflexivity**

Wertz (2011) asserts that qualitative research is fundamentally “relational” (p.84) and therefore, impossible to have an absence of any bias or personal knowledge in relation to understanding a phenomenon. Yardley (2000) also highlights that knowledge and experience cannot consist of an objective appraisal and this is greatly influenced by our subjective and cultural perspective. Therefore, it is important to be transparent and reflexive as part of undertaking rigorous qualitative research (Yardley, 2008).

My interest in how familial support for Chinese people experiencing mental health issues has been developed as someone that identifies as British Chinese. Emotional expression is difficult within Chinese culture and may present those experiencing mental health difficulties with barriers to support (Kuo & Kavanagh, 1994). It was expected that individuals’ experiences would be influenced by Chinese culture which is not illuminated in research on mental health experiences of those from more Westernised backgrounds, where a biomedical model dominates (Bracken et al., 2012). During the synthesis, to reduce potential biases as a native researcher (Kanuha, 2000), reflexive discussions with an experienced researcher helped to explore the final themes that were outlined. These strategies intended to help the reader conduct an inductive synthesis of the literature. I hold an interpretivist epistemological position and believe there is no objective truth, but meaning is created from the researcher’s interaction with the researched (Gray, 2013).

# **Interpretation of findings**

A meta-ethnographic review was used to conduct an interpretative synthesis of the qualitative experiences of familial support. Noblit (2018) argues that meta-ethnography goes beyond interpretations of original studies which may help to generate new information and questions. Given the dominance of Euro-centric, Western understandings of mental health issues, this review aimed to identify how exploring Chinese families’ experiences can contribute to more culturally sensitive policy and practice recommendations.

Seven key themes will be outlined. The presence of each theme in the included studies is summarised in Table 3.

Four studies included other factors that supported people to manage mental health difficulties including peer support and maintaining a positive attitude. These are not discussed as they are beyond the scope of the focus of this review.

**Table 3**: *Themes identified from synthesis of the studies*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Theme** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| Mental health professionals & services | \* | \* |  | \* |  |  | \* | \* | \* | \* |  | \* | \* |  | \* |
| The burden of care | \* | \* |  | \* |  |  | \* | \* |  | \* |  | \* |  |  |  |
| Financial hardship | \* | \* |  |  |  |  | \* |  | \* |  | \* | \* |  | \* | \* |
| Spirituality & religion |  | \* | \* |  |  |  |  | \* |  | \* |  | \* | \* |  |  |
| Family conflict & relationships | \* |  |  |  | \* | \* |  | \* | \* | \* | \* | \* |  | \* | \* |
| Stigma & social isolation | \* | \* |  | \* |  | \* | \* | \* | \* | \* | \* | \* | \* |  | \* |
| Positive aspects of care |  |  |  | \* |  |  |  | \* |  | \* |  |  |  |  |  |

Note: \* indicates the presence of the theme within the studies included for synthesis.

# *Mental health professionals and services*

Whilst most studies were conducted with service users in community settings, two studies (Bai et al., 2020; Liu & Zhang, 2019) were conducted in psychiatric inpatient hospitals. Reciprocal translation found that whilst studies were conducted in many countries, the lack of continuity of care (due to poor communication between professionals and between professionals and caregivers) between inpatient settings and community settings was an issue across studies. It is troubling that community settings and support are increasingly relied upon when stigmatising attitudes remain a significant issue in Chinese populations (Chung & Wong, 2004; Yang et al., 2013).

Whilst caregivers proactively gathered information about mental health difficulties from the internet and other sources, they shared concerns about the validity of this information and desiring a more reliable source, such as a caseworker. Seven studies discussed the desire for more knowledge and skills from professionals. For example:

“For the Internet you got to be knowledgeable. And then there are so many [websites] and not everything is good.” (Bedi et al., 2015, p. 68).

In some cases, family caregivers normalised or rationalised unexpected changes in clients’ behaviours and personality, which contributed to a delay in help-seeking:

“I didn’t think it had anything to do with mental illness...She became very quiet. I thought it was her personality.” (Yeung et al., 2017, p. 594).

Caregivers often hoped for more opportunities to seek medical advice following relatives being discharged from hospital, particularly because caring responsibilities made it difficult to attend in-person appointments (e.g. Bai et al., 2020). Caregivers reported using professionals to aid in the provision of care, for example with medication adherence.

“My son has faith in his doctor. Whenever I want to increase the dose because his condition is not good, he will ask: ‘Did the doctor ask you to do that?’. I have to ask his doctor to call him, and then he will agree to increase the dose.” (Zou et al., 2014, p. 358).

On the other hand, some caregivers advised against medication regimes when the clients’ conditions stabilised (e.g. Zou et al., 2014), highlighting a lack of knowledge around mental health issues and the difficulties with treatment compliance.

Many studies underlined the importance of caregivers in the treatment process, to aid decision-making about care, with caregivers often needing to advocate for their relatives (Bedi et al., 2015). Caregivers were described as “service brokers” (Chang & Horrocks, 2006, p.438), particularly in important matters such as, psychiatric assessment, treatment and any legal issues (e.g. relating to the Mental Health Act). However, “cultural brokering” (Chu, 2004, p. 4) with services were viewed as a barrier to care, especially if there were any linguistic difficulties experienced by families, which is more applicable to Chinese immigrant populations (Bedi et al., 2015, Kung, 2003; Yeung et al. 2017), compared to participants from studies conducted in China.

# *The burden of care*

Using meta-ethnographic synthesis, the theme of burden of care was identiﬁed through reciprocal (similar studies being “‘added’ together”, p. 45) and refutational translation (where studies implicitly or explicitly refute each other) (Noblit & Hare, 1988).

Seven studies highlighted significant burdens and stress on caregivers, particularly following early stages of diagnosis (Bai et al., 2020; Liu & Zhang, 2019). Sadness and confusion surrounded diagnoses, particularly as caregivers came to learn more about conditions. For example, schizophrenia being recognised as a chronic condition requiring long-term care and, therefore, there was little hope of rehabilitation. This brought feelings of guilt for parent caregivers, as they felt they could have been more concerned and noticed early symptoms of schizophrenia (Bai et al., 2020). Nevertheless, it is not only Chinese parents that often blame themselves for the mental health difficulties experienced by their children (Corrigan & Miller, 2004). However, the significance of blame for Chinese families should be considered in the context of Confucianist values, and how interpersonal stress seems to be most acutely experienced when clients’ behaviours deviate from social and cultural norms, meaning they are unable to fulfil appropriate social roles (Bedford & Hwang, 2003) such as, that of a ‘good mother’. When these roles are not fulfilled, shame and guilt not only reflect negatively on the individual, but also lead to a loss of the family’s ‘face’ (Kuo & Kavanagh, 1994).

Caregivers worked hard to help maintain clients’ daily living skills to aid reintegration into society, with many caregivers asking for support for their family members in basic life skills and social skills training (e.g. Liu & Zhang, 2019). Despite this, many activities of daily living had to be completed by the caregiver as clients were no longer capable of doing these things:

“My wife has been sick for 26 years. She cannot do many things. She can’t cook, clean the house, take care of family” (Huang et al., 2009, p. 877).

There were clear examples of when family members’ influence had been positive on clients, such as family members that convinced or cajoled gamblers to seek help for their problems (Subramaniam et al., 2017a). However, Chinese families also played a significant role in the development and maintenance of gambling behaviour that was normalised during Chinese celebrations, such as Chinese New Year.

Furthermore, caregivers experienced a lot of frustration, particularly around the lack of communication or unwillingness of clients to discuss what was on their minds:

“I don’t understand what he needs. He doesn’t talk very much.” (Bedi et al., 2015, p. 69)

Caregivers often felt unsure how to help clients or that they lacked the skills to provide the best care. Positive thinking and seeking knowledge were often used by caregivers to overcome their difficulties (Huang et al., 2009). The more knowledge and skills acquired; the less burden that seemed to be perceived.

In Chen et al., (2019)’s study, most caregivers (14 of 20) experienced anxiety and depression, with seven receiving therapy, demonstrating the emotional toll on Chinese caregivers. Feelings of fear were also a predominant concern discussed by caregivers:

“I live with her now…I feel extremely insecure. She once suddenly broke into my father’s room with a knife at night when my father lived with her.” (Chen et al., 2019, p. 5).

Particularly for those clients with schizophrenia, caregivers looked out for bizarre behaviours and early relapse warning signs (e.g. Kung, 2003). For those caring for family members who had been hospitalised for suicide attempts, caregivers described a constant state of worry and vigilance of another attempt to end their lives. This was understandable given that some previous attempts had been carried out when caregivers were asleep.

“I really don’t know how to prevent her from committing suicide because I take all the knives away in my home but she buys knives by herself.” (Sun et al., 2008, p. 57).

For parent caregivers, there was a lot of worry around who would assume a primary caregiving role after they passed away (Bai et al., 2020; see also Chang & Horrocks, 2006, Kung, 2003). Caregivers sometimes expressed a sense of hopelessness and coping by lowering their expectations for their loved ones:

“Now I know more about the disease, and I know that the recovery rate is low. It doesn’t make sense for me to hope too much. Take one step at a time.” (Liu & Zhang, 2019, p. 208).

All these sources of fear and worry emphasise how stressful the experience of providing familial support for people with mental health difficulties is, particularly in the context of Chinese values where fears of ‘losing face’ and the desire to not bring shame to the family unit are so prominent (Lee & Mock, 1996; Jim & Pistrang, 2007).

From clients’ perspectives, familial support was highlighted as a vital part of their recovery and clients felt positive about their recovery process if this support continued (Sun et al., 2008).

“My husband’s very nice to me. I feel that someone else would have abandoned me. Others give up on people like me.” (p.57).

# *Financial hardship*

Nine studies discussed financial difficulties associated with caregiving. Some receipt of financial resources including medical insurance and free medication was highlighted by some caregivers in China (Bai et al., 2020; Chen et al., 2019). However, this support was not enough given the high costs of certain medication and the limited coverage of medical insurance policies.

Furthermore, rehabilitation institutions were a great source of respite care, enabling caregivers to recuperate and possibly engage in aspects of social life again, but this was an extremely costly service in China (Chen et al., 2019). Interestingly, none of the other caregivers participating in the four China-based studies mentioned these facilities, which may have demonstrated how inaccessible these services were. Only one other study (Kung, 2003) highlighted the desire of caregivers to have more options for respite care. Moreover, it was not uncommon for caregivers to give up employment or reduce their hours to care for their loved ones.

“We spend a lot of money per year on my daughter's illness and are tens of thousands of RMB [China’s currency] in debt. I closed my store and have no way to earn money” (Bai et al., 2020, p. 5).

# *Spirituality and Religion*

Six studies outlined beliefs that attributed symptoms of poor mental health to supernatural forces, such as ghosts:

“My neighbours also thought she was heavily scared, meaning that she must have been scared by a ghost, she needed to bring in monks.” (Bai et al., 2020, p.4)

Other religious practices involved attending temples, worshipping Buddha and completing incense burning (Liu & Zhang, 2019). Furthermore, families expressed concerns about the amalgamation of traditional and Western therapies- some thought it might enhance relatives’ compliance with Western treatments if combined with alternative treatments however, in Bedi et al.’s (2015) study, two of 10 families felt combining therapies might be confusing to clients.

# *Family conflict and relationships*

Reciprocal and refutational translation also highlighted this theme. Six studies discussed conflicts and disruptions to familial harmony because of caregiving. This included arguments between spouses due to conflicts over how to handle clients (Kung, 2003), and a general deterioration in martial relations (Liu & Zhang, 2019). Interestingly, cultural norms of filial piety were experienced differently across studies. In Zeng et al.’s (2012) study, older female clients experiencing depression described conflicts with their daughters-in-law, where their sons were unwilling to resolve this. Neglect from adult children and lack of contact with grandchildren even when living in the same household seemed to contribute significantly to clients’ experiences of depression. Contrastingly, clients experiencing post-partum depression (PPD) (Chen et al., 2006), highlighted feeling very distressed by traditional gender roles and expectations including:

“obeying parents-in-law, helping the husband and nurturing the children” (p.4).

Adherence to these social, cultural norms is in line with the Chinese concept of filial piety, where adult children are expected to

“honour their parents, serving parents’ needs in their old age” (Chu, 2004, p. 19).

In the case of older adult gamblers, conflicts centred around financial problems which directly and indirectly impacted on their families (Subramaniam et al., 2017). These ranged from short-term issues, such as not being able to pay rent, to having to borrow money from loan sharks. These conflicts led to a loss of trust and respect from family members. However, family members also played a significant role in encouraging gamblers to seek help for their issues (Subramaniam et al., 2017a):

“So she was not happy [with his gambling] ... My wife then chased after me to go to the National Addiction Management Services” (Subramaniam et al., 2017b).

Despite the negative impact of mental health difficulties on Chinese families, caregiving was also reported to bring family members closer together at times, for example with families having a shared goal of recovery for the client (Liu & Zhang, 2019). Caregivers generally reported being well supported by other relatives which is important considering that family and interpersonal harmony is highly valued in Chinese culture.

# *Stigma and social isolation*

Twelve studies discussed the impact of stigma and discrimination on clients and caregivers. Stigma was often experienced collectively by families; not solely by the individual experiencing mental health difficulties. This is unsurprising given the Chinese cultural context where duty and responsibility to family members is highly valued. Chu (2004) argued that Chinese families should be considered as more of a unit, rather than emphasis being just on the individual experiencing mental health issues (see also, Kung, 2003). This is supported by Chen et al.’s (2013) study highlighting how mental health disclosure is done strategically and often only to closest family members that are considered most understanding of mental health difficulties; and able to offer support. These family members and close friends were referred to as part of the “guanxi” network, defined as “a personalised network of social connections and representing individuals’ social capital and access to network resources” (Chen et al., 2013, p.24). Kung (2003) also discusses how mental health disclosures are privileged to the “inner circle” of clients’ social networks because of a fear of “face loss” (p.554). This Chinese social concept is discussed in other literature where Chinese people might present a picture of the family that is considered more socially acceptable, to prevent embarrassment and shame (Chu, 2004).

Caregivers admitted they would not reveal clients’ mental illness to others as they are unable to help, they feared stigma and refrained from inviting friends home (Huang et al., 2009; Kung, 2003). This is one example of how fear of stigma and discrimination contributed to the social isolation of clients and caregivers. Whilst stigma and the negative effects on social relationships is also experienced by typical Western families, the experience of stigma in Chinese families is amplified by trying to preserve “face” (Chen et al., 2013) and maintain interpersonal harmony.

Social isolation was discussed explicitly in eight papers. Clients actively avoided situations where they might meet people from the Chinese community and did not want to be the subject of any discrimination or gossip:

“They (neighbour and acquaintances) mostly all know about it. One [knows] and spreads [the news to] ten people and ten people spread it to one hundred people.” (Chen et al., 2013, p. 12)

Particularly for those older adults with gambling problems, there was fear that family members might find out, a sense of shame and a desire to hide their behaviours from family, which was then a barrier to help-seeking:

“I just have that comfort that my wife and my children are with me and hope that they are well, so I have to pretend forever until I die” (Subramaniam et al., 2017a, p.694).

Furthermore, for those experiencing depression and low mood, a lack of social relationships was connected to feelings of sadness:

“I have no friends. I seldom have social contact with others. There is little chance for me to know any friends…What is the use for you to share unhappiness with others?” (Zeng et al., 2013, p.304).

These experiences of social isolation rooted in fears of discrimination exacerbated the burden on caregivers and the isolation that clients experienced. However, as demonstrated by Chan (2009)’s study, utilising community resources (e.g. mother or migrant groups) to share experiences or engaging in volunteering, were recommended to help battle depression.

“I should come out more to this mother group. Then we get to talk to each other!” (Chan, 2009, p. 33).

Other caregivers also recognised the positive effects of sharing their experiences with other people with similar difficulties:

“It would be nice if children and parents like us can set up a group for communicating. A normal family can't understand us, we need an environment where we can…comfort each other” (Bai et al., 2020, p.5).

# *Positive aspects of care*

Despite the many aspects of caregiver burden discussed, there were still positive experiences that caregivers explicitly outlined in three studies. Some described having a closer relationship with the relative they cared for, and even experiencing a sense of worth and achievement in their caring role - “his son got a master’s degree and that after experiencing such hardships dealing with his son’s illness, he felt proud” (Huang et al., 2009, p. 878; Liu & Zhang, 2019).

For many caregivers, there was a sense of duty towards family members that experienced mental health issues (Huang et al., 2009), with caregivers saying if they did not take care of them, there would be nobody else to assume this role (Liu & Zhang, 2019). Some caregivers described growth in their process of caregiving, particularly when significant challenges and difficulties were faced, and they managed to gain new skills (e.g., at work to financially support the family, Liu & Zhang, 2019).

# **Lines of argument synthesis**

This synthesis identifies similarities and differences of studies to report a consensus of findings (Noblit, 2018). The synthesis of 15 papers revealed that most key themes were experienced by both Chinese and typical Western families in line with previous research underlining the predominantly negative and multidimensional impact of mental health difficulties on: families’ finances, stigma (Corrigan & Miller 2004), the mental wellbeing of caregivers and social relationships (Fekadu et al., 2019), as well as the need for informational support for families from mental health professionals (Sveinbjarnardottiq & de Casterlé, 1997). However, certain themes were particularly pertinent to Chinese families as represented in Figure 3 and the theme of spirituality and religion to understand and alleviate mental distress which is unique to Chinese culture.

Negative emotions were experienced by all caregivers offering familial support and the ability to provide adequate care was hampered by a lack of understanding between Chinese families, their cultural context, and formal mental health services. Even in the five studies conducted in China, participants highlighted the dominance of Westernised models of understanding (e.g., a “cure” for mental health issues) (Bai et al., 2020). Many key themes identified across studies were interdependent (see Figure 4).

Diagram

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Figure 3: The impact of familial support for typical Western and Chinese families, including overlapping and unique themes in Chinese families

Diagram

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Figure 4: A model of the pathway of mental health conceptualisations in Chinese culture, and how these factors impact on familial support

There is a disparity between how mental health difficulties are understood in Westernised mental health systems and within traditional Chinese culture (Figure 3). Whilst factors such as financial hardship, stigma and significant burden on caregivers is similarly experienced by families in other cultures (Fekadu et al., 2019), the impact of these factors on Chinese people is arguably more significant.

Interactions between Chinese families and mental health services compared to their Western counterparts are fundamentally underpinned by a lack of understanding and disparities in how mental health distress is understood. For example, Chinese culture ascribes mental health difficulties to ancestral misdeeds or current misconduct (Hsiao & Riper, 2010), or even the fault of parents (Tsang et al., 2003), which may act as barriers to help-seeking from formal services. Therefore, stigma and shame around mental health issues is much more significant due to concerns around “losing face” and bringing family shame. This is highlighted in the synthesis by situations where mental health crises were sometimes exacerbated by caregivers and clients help-seeking through religious or spiritual means (e.g., fortune telling, palm reading), delaying access to formal services (e.g. Yeung et al., 2017).

# **Discussion**

Despite significant hardships associated with the care provided, caregivers were determined and felt it was their duty. It is important to consider this within the context of Chinese culture that prioritises interpersonal harmony. Any disruption to family relationships resulting from caregiving, coupled with social isolation, exacerbated fears of stigma and discrimination. It is likely that the social responsibility for Chinese caregivers increased the stress and experience of caregiving. Given the collectivist nature of Chinese society, to experience social isolation from the guanxi network (Chen et al., 2013), goes against the grain of fundamental Chinese values and increases clients’ and caregivers’ risk of further societal alienation and associated mental distress (Yin et al., 2014). The stigma experienced by family members is pervasive and may include social devaluing and disapproval of families where mental health issues are experienced (Lauber & Rössler, 2007). Additionally, the limited value placed on caregiving by services contributes to poor coping (Hsiao & Riper, 2010). The burden of familial support in Chinese families must be recognised and reduced by new governmental policies, such as by ensuring the involvement of primary caregivers in clients’ pathways to care in China and internationally, to support families.

In China, there remains a heavily biological understanding of mental health difficulties and treatments where multi-disciplinary working is largely non-existent (Zhao, 2014). The first mental health law introduced in 2013 enabled psychiatrists to be able to provide psychotherapy however, there appeared little incentive for psychiatrists to do so given non-biological treatments were not recognised by insurance firms. This contributes to significant financial hardship as families struggle to afford medications, an issue not unique to China, but also highlighted in Taiwan (Huang et al., 2009) and America (Kung, 2003), where caregiving contributed to reduced earnings.

Having biologically based mental health conceptualisations underpinning services globally creates a tension with some traditional Chinese conceptualisations of mental health (such as, being due to ancestral misdeeds). The latter means Chinese mental health issues may be seen as more of a family issue, rather than contributed to by more systemic issues and thus, families living in traditionally Chinese families and societies may receive less support from the government and their community (with lack of financial support being one example. Whilst there is a tendency in Western society to categorise illness within a dichotomy of being either physical or mental, Eastern conceptualisations tend to merge mind and body. Hence, somatisation of mental health issues is common in Chinese culture and may help to avoid interpersonal explanations of mental health issues and potential disruptions to collective harmony (Kuo & Kavanagh, 1993).

Furthermore, spiritual and religious understandings of mental health issues may serve to delay help-seeking (Lefley, 2010), which can result in clients more often presenting to services when in crisis. Given these issues, there is clear need for more provision of psychoeducation for Chinese families worldwide, particularly for those providing community-based support, to facilitate understanding of mental health difficulties and reduce the treatment gap between Chinese families and services.

# **Clinical implications**

Chinese caregivers are very involved in clients’ care due to Chinese personal identity being intertwined with how one behaves relationally (Yip, 2005). Therefore, caregivers should be involved in psychoeducation and anti-stigma programmes to enhance their understanding of mental health conditions and the utility of accessing support formally, to alleviate the heavy burden on Chinese families. It is imperative clinicians and services in China and internationally are aware of the cultural issues that can be barriers to help-seeking and they offer culturally sensitive support to Chinese families such as, support with disclosure of mental health difficulties (Chen et al., 2013) and, importantly, helping families build “stigma resistance”, which is made easier by having positive relationships outside of mental health systems (Tew et al., 2011, p.7). People with high levels of social support have been shown to experience less stigma (Yin et al., 2014).

Views and attitudes towards people with mental health issues in Hong Kong demonstrated that whilst people see a need for greater mental health service provision; on a personal level, people remained suspicious that such individuals were dangerous, and preferred to maintain a distance from them (Tsang et al., 2003). This is significant in underpinning how mental health issues are experienced by Chinese people worldwide and leads to a number of potential difficulties in accessing support from services, due to a lack of understanding between Chinese culture and typical Westernised and biomedical concepts of what underpins mental distress (Bracken et al., 2012). This review highlights the need for further research examining the effects of implementing culturally appropriate psychoeducation and anti-stigma programmes as part of the mental health care package for Chinese people accessing services. This may help to reduce caregivers’ sense of helplessness and perception that they lack the skills needed to provide care to relatives.

As shame is a significant factor for Chinese families, there may be a role for compassion focussed approaches. According to Confucianism, Chinese people are led by a “duty-based morality” (Bedford & Hwang, 2003, p. 135) and if one fails to uphold one’s obligations and something negative happens to the individual who asked for help, one can suffer from feelings of shame. Therefore, the burden on Chinese caregivers is significant and, without adequate support, could lead to high levels of distress and psychological issues. Evidence suggests that self-compassionate attitudes and exercises can help to reduce feelings of shame and negative affect even in those who are more prone to experiencing shame (Johnson & O’Brien, 2013), as may be the case in Chinese culture. Future research should explore using self-compassion exercises (e.g. loving-kindness meditation), to reduce shame in Chinese people specifically as a possible intervention to improve psychological wellbeing for caregivers (Germer & Neff, 2013).

# **Limitations**

A potential limitation of this review is that studies were conducted in a variety of different international locations. Experiences of belonging to immigrant populations and levels of acculturation are likely to have impacted on the findings from studies completed in America, which might be difficult to compare to the findings in China. For example, language difficulties were cited as a barrier to accessing services by Kung (2003) which does not apply to Chinese people living in China. Most studies explored familial support for clients experiencing schizophrenia, whilst other studies covered a broad range of mental health difficulties, including formal diagnostic categories and others that merely recruited on the basis of ‘persistent’ mental health difficulties (Bedi et al., 2015; Chang & Horrocks, 2006). The broad range of participants included in these studies could be argued to be more inclusive of a wider range of experiences and conceptions of mental illness compared to Western diagnostic categories. However, this does make it difficult to determine whether other factors beyond the scope of this review may have impacted on the familial support of those participants included in these studies, and the conclusions that can be drawn from this review such as, clients’ attitudes to mental health and peer support.

Whilst many studies alluded to an epistemological stance and a view that qualitative research aimed to understand the lived experiences of participants, reflexivity and consideration of the researchers’ own potential bias and influence was not always evident and therefore, it is difficult to determine whether the findings were always an accurate depiction of participants’ experiences.

# **Quality of meta-ethnographic synthesis**

To assess the quality of this meta-ethnographic review, the CASP (Public Health Resource Unit, 2018a) checklist for systematic literature reviews was adapted to include important qualitative research factors, including reflexivity and transparency. The main areas were considered including: are the results from the review valid? What are the results? And will they help locally? It was felt this review has met 8 of the 10 standards outlined. This review had a broad research question which made it difficult to identify the most appropriate papers, with some papers cited more often in the discussion of the most applicable themes to consideration of familial support. However, all identified studies were critically appraised and most studies demonstrated good justification for qualitative methodologies; with researchers generally demonstrating awareness of reflexivity and transparency. Those using mixed methods were generally less robust in applying qualitative methods and did not discuss reflexivity relevant to qualitative components of studies. Despite these limitations, the review demonstrated considerable consensus about how familial support for mental health issues are experienced by Chinese people. The synthesis highlights findings that further understanding beyond the individual studies and discusses the implications for clinical practice and further research needed.

# **Conclusion**

This review aimed to identify, critically appraise and synthesise qualitative research to increase understanding of familial support for Chinese people experiencing mental health difficulties. The review highlighted the additional stigma and impact on familial relationships that can be experienced in Chinese families. Predominantly, findings highlight the need for cultural awareness of Chinese values and concepts such as, “losing face” that contributes to fears around disclosure and perceived stigma associated with mental health issues, that exacerbates the social isolation of this group. Chinese mental health conceptualisations are atypical compared to Westernised and biological understandings and are entangled in a social and moral context where shame is often experienced and, can be a barrier to individuals and families help-seeking. Clinicians and services should provide support sensitive to these cultural nuances, including psychoeducation and anti-stigma programmes. Finally, international mental health policy needs to provide more practical support to families such as financial sanctions for medication and services inclusive of cultural and social context in addition to Westernised understandings of mental wellbeing.

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# **Paper Two: Empirical Paper**

**Hong Kong Second-Generation Chinese Immigrants’ Experiences of Mental Health Support in the UK**

**Target journal:** International Journal of Mental Health Nursing

**Word count:** 7994

# **Abstract**

**Aim:** The following paper aimed to explore Hong Kong second-generation Chinese immigrants’ experiences of mental health support in the United Kingdom.

**Method:** Participants were recruited online via mental health support groups. Seven semi-structured interviews were conducted. Interviews were transcribed verbatim and Interpretative Phenomenological Analysis was used to select three superordinate themes.

**Results:** The themes identified were representations of mental health in Chinese community, sharing emotions in Chinese culture and striving to meet Chinese norms. This study suggests these factors contribute to second-generation Chinese immigrants’ unwillingness to seek support from family members and delays to pursuing formal mental health support such as, individual therapy.

**Conclusion:** The rich accounts of Hong Kong second-generation Chinese immigrants’ lived experiences of mental health contribute to the understanding around support-seeking. However, as interviews were not conducted in participants’ preferred language, some cultural aspects may have been missed. Future research should explore whether similar findings can be demonstrated in the wider population of second-generation Chinese immigrants in the UK. Service improvement projects should include direct consultation with the Chinese community to create culturally safe spaces to reduce stigma and improve understanding of mental health difficulties.

**Word count:** 189

**Key words:** Chinese, mental health, qualitative, services, support**Introduction**

Following the handover of Hong Kong to China in 1997 (Chan & Chan, 1997), the Chinese diaspora has been steadily growing, increasing from 0.4% to 0.7% of the population in England and Wales from 2001 to 2011 (ONS, 2018). Despite the growing Chinese population in England, Chinese individuals are underrepresented in psychiatric inpatient admission rates with little increase between 2005 to 2010 (Care Quality Commission, 2011). Although low admission rates may be attributable to a lack of consistency in ethnic grouping used across datasets (e.g., using Asian rather than Chinese, Bignall et al. (2019), other explanations should be considered. For example, literacy and language skills being a potentially significant barrier for the Chinese population in accessing mental health services (Kung, 2003; Tang 2016; Tran, 2009).

Cultural factors may also have a role. Research suggests that Chinese people are less likely to recommend their parents or children to seek professional help in the presence of mental health difficulties (Lu et al., 2017). Similarly, Chinese populations may be less likely to approach professionals for mental health support as families often take responsibility for caring for their relatives (Chu, 2004; Lee & Mock, 1996). Factors such as community support, holistic and atypical approaches to treatment (e.g., traditional Chinese medicine) may also contribute (Butt et al., 2015).

A national survey conducted with 401 Chinese people (Li et al., 1999) with mental health difficulties identified barriers to mental health services including: language; participants’ typically make somatic interpretations of symptoms; lack of knowledge of statutory services and lack of access to bilingual professionals. Significantly, over half (55.7%) did not find family supportive and half reported having no friends, refuting the argument that underrepresentation in services is due to needs being met by familial support (Lee & Mock, 1996). Later research highlights several barriers to mental health support including, a fear of stigma around mental health contributing to social isolation, and reluctance to seek support from outside of the family (likely exacerbated by a lack of familial support due to migration); language barriers and mistrusting officials (Kung, 2003). A need for community-based advocacy services with good inter-agency communication and linguistically-skilled workers to improve Chinese people’s engagement with mental health services, particularly among new migrants, has also been identified (Tran, 2009).

These studies suggest that assimilation into the host culture may have an impact on how Chinese immigrants interact with healthcare. Early work exploring barriers to accessing mental healthcare by Wong & Cochrane (1989) found higher assimilation scores amongst second-generation Chinese immigrants (SGCIs) compared to first-generation. Other studies also found SGCIs were more likely to report feeling part of the host community compared to first-generation individuals, and that there was a higher prevalence of psychological symptoms amongst the first-generation. (Furnham & Li, 1993).

Whilst there is a dearth of literature on this topic, the small number of qualitative studies have typically focused on exploring the needs of predominantly first-generation Chinese immigrants, from a range of Chinese diasporas accessing mental health services in the UK. Yin’s (2016) qualitative study exploring Chinese mental health service users’ experiences with 12 first-generation immigrants identified four main themes: experiences in the context of cultural perspectives; changing mental health beliefs; evaluations of the current mental health service and the review of treatment expectations.

Jim & Pistrang (2007) explored the role of culture specifically in therapeutic relationships from Chinese perspectives. Themes around clients’ and therapists’ awareness of culture and the impact on their working relationship highlighted the importance of working towards “cultural formulation” (p.26) by helping individuals reach an integrated understanding of their difficulties from their own cultural perspective and from the dominant culture. However, of eight participants, only one was second-generation and two Hong Kong Chinese and, therefore, it is impossible to say whether the same themes hold true for Hong Kong SGCIs.

In Yeung et al.’s (2017) qualitative study exploring how Chinese people understand mental distress and the impact of this on their mental health care journeys, it was unclear what generation participants were from, but it appeared that only four participants of the 32 were SGCIs and participants came from a range of Chinese diasporas including China, Vietnam and Hong Kong. Tang’s (2019) thematic analysis of 22 interviews also appeared to include participants across generations, where individuals settled in the UK ranging from the 1960s to 2010 from various countries similar to Yeung et al.’s (2017) sample.

Despite the Chinese diaspora rapidly growing in the UK, evidence suggests the reasons for underrepresentation within mental health services remain unclear.

Furthermore, as previous research exploring the psychological needs of Chinese people across generations is largely outdated, and recent research has mostly consisted of first-generation individuals from various Chinese diasporas, the current understanding of factors impacting on how Hong Kong SGCIs might access formal and informal support (e.g., friends, family, online) is extremely limited. Therefore, the aim of this study was to enhance understanding of Hong Kong SCGIs’ experiences of mental health support in the UK.

# **Method**

# *Design*

Semi-structured interviews with a purposive, homogenous sample of SGCIs living in the UK. Data were analysed using Interpretative Phenomenological Analysis (IPA) which is an idiographic approach aiming to understand particular phenomena and the contexts within which these exist. (Smith et al., 2009).

# *Sample size selection*

In order to detail the experiences of the phenomena being examined, small sample sizes are typically used in IPA (Smith et al., 2009). Data “saturation” is a problematic concept in IPA, as analysis aims to be iterative and evolve because of new insights from different sources which could be argued to continue infinitely (Brocki & Wearden, 2006). IPA does not aim to recruit a sample that is representative or generalisable, but rather a homogenous sample enabling in-depth analyses of similarities and differences within a group (Brocki & Wearden, 2006). IPA should convey patterns across the range of transcripts and capture the experiences of the individuals from which these patterns emerge. Therefore, it is more difficult to conduct a thorough IPA with a sample that is “too big” (Smith et al., 2009, p. 51), and the focus should be on quality and richness of the data rather than the quantity of participants (Larkin & Thompson, 2012). Therefore, this study aimed to recruit four to eight people. This sample size is consistent with other IPA studies (e.g. Holland et al., 2016), including those focusing on experiences of mental health (Beattie et al., 2019; Knight et al., 2003; Stockley, 2018).

# *Participants and recruitment*

Recruitment was conducted via social media. Invites were posted on general British-born Chinese (BBC) and specific BBC mental health support groups. Eligible participants had to be aged 18-30 years, SGCIs; individuals of Chinese ethnic origin but were either born in Britain or had left Hong Kong before the age of 10 (see Furnham & Li,1993) and self-identify as experiencing mental health difficulties. Based on literature outlining “emerging adulthood” as an important developmental period in young adults’ lives (Arnett, 2015), the age range was thought to enable recruitment of a relatively homogenous sample of people experiencing a similar stage of life, in line with IPA methodology. Therefore, findings may not be transferable to SGCIs of a different age. Furthermore, online recruitment via social media may impact on the findings as all participants are accessing online support already, which may not be the case for other SGCIs experiencing mental health difficulties. No formal diagnosis was required for participation in the study. Individuals who were too mentally or physically unwell to participate in the study, including those in inpatient care were excluded from the study.

# *Materials and procedure*

The study was approved by the university ethics committee (Appendix G). Participants were given information sheets (Appendix H) and the opportunity to ask questions before deciding to participate and completing the consent form (Appendix I). The right to withdraw from the study was also outlined.

Most interviews were conducted using a video-calling app (Skype or Facebook Messenger); one was conducted via telephone. The duration of interviews ranged from 73-109 minutes (mean: 84.3). All interviews were audio recorded and transcribed verbatim using Otter.ai (2021, v.2.1.30-2344 2021); data were deleted from the app after files were transferred to a secure device. Pseudonyms were used in all transcripts and analysis. The interviewer was female and of a similar age to participants. A schedule of broad, open-ended questions guided discussions about the participants’ lived experiences of mental health and obtaining support. The interview schedule was developed by consulting an individual who met the inclusion criteria (but did not participate) and was informed by existing research (Appendix J).

# *Data analysis*

IPA analysis was carried out as described by Smith (2009). Transcripts were read and re-read prior to line-by-line coding (Appendix K). Descriptive, linguistic, and conceptual comments were made alongside each transcript. Coding and themes were discussed with an experienced IPA researcher. The final selection of themes and subthemes were selected in line with Smith’s (2011) suggestions for high-quality IPA, including prevalence (occurrence of themes across all transcripts), representativeness of participants and variation (inclusive of a range of experiences).

# **Reflexivity**

Reflexivity is an important part of the IPA process therefore, a reflexive diary was kept, capturing my perceptions, and understanding (Appendix L). It also aided reflection on my emotions and how this may have influenced the analysis process. An interpretivist epistemological approach was taken which Gray (2013) outlines as being closely linked to constructivism. Constructivism suggests knowledge is “created in interaction among investigator and respondents” (Guba & Lincoln, 1994, p. 111). As I am also a Hong Kong SGCI, the potential impact on the research process is important to consider. Taking a constructivist approach, selecting an IPA methodology felt appropriate as the double hermeneutic could be utilised during analysis. From my lived experience, I felt that there would be culturally salient factors that might hinder SGCIs’ ability to seek support for their mental health issues. Therefore, it is likely that I was drawn to highlighting participants difficulties with obtaining mental health support. Perhaps being a novice IPA researcher helped reduce some difficulties outlined by Kanuha (2000) in being an ‘insider’ of the participant group. For example, I took special care to pursue the meaning of experiences stated by participants however, it is likely that some meanings were not clarified due to assumptions of shared understanding such as, assumed norms around cultural brokering for parents who experience language barriers to integrating into UK society. Despite this, I felt that appropriate distance between my own experiences and participants’ experiences was achieved via the reflexive process. This was highlighted by gaining further insight into my own experiences of being SGCI, such as how common it was from participants’ perspectives that emotions were expressed via actions rather than verbally or physically within Chinese culture. The native researcher as subject and object enabled meanings to be co-created, as the desire to understand participants’ experiences were motivated by curiosity and meaningfulness (Kanuha, 2000). Engaging reflexively enabled me to consider intersubjectivity, personal motivations and how this helped enhance understanding between mine and participants’ experiences. I believe being of a similar age and cultural background to participants facilitated a safe space for participants discussions about mental health experiences that they may otherwise not have comfortably shared, particularly with individuals of a different background who may be perceived as having less cultural understanding of topics discussed.

# **Results**

# *Participant demographics*

Twelve people showed interest in the study; seven agreed to an interview. One individual declined due to personal circumstances at the time of the study. It is unclear why others did not participate. Participant ages ranged from 20-28 (mean: 24.6) years old. Participant information is detailed in Table 4. Six of the participants identified as female and one as male, one participant was born in Hong Kong and moved to Britain aged one. Six participants had accessed some formal mental health support such as, individual or group therapy. The duration of mental health difficulties ranged from 1-14 years which is likely to have impacted on participants’ consideration of what mental health support they might seek and the opportunities to actively engage with support such as, speaking to family members or commencing individual therapy.

**Table 4**: *Basic participant information*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name\*** | **Age** | **Gender** | **Born in UK** | **Age moved to UK** | **Occupation** | **Diagnosis** | **Self-described MH difficulties** | **Duration of difficulties** | **MH support**  **(formal)** | **Support (friends/family etc.)** |
| Joyce | 26 | F | Y | NA | Admissions and Marketing Officer | None | Frequent lows | 4 years | Y- NHS, private | Cousin |
| Rebecca | 20 | F | Y | NA | Student | Generalised Anxiety Disorder | Anxiety, depressive symptoms, burnout | 3 years | Y-NHS, other | Social media groups |
| Fei | 27 | M | Y | NA | Office worker /professional | None | Anxiety, low self-esteem | 14 years | Y-NHS, private | Friends, Siblings |
| Piper | 22 | F | Y | NA | Independent Mental Health Advocate | None | Anxiety | 1 year | Y- university counselling | Family, friends |
| Mary | 26 | F | Y | NA | Office worker | None | Depressive phases | 12 years | N | (Online) Friends |
| Viv | 23 | F | Y | NA | Client Relationship Specialist | Y- generalised anxiety & mild depression | As diagnosed | 7 years | Y- NHS | Friends, partner |
| Noelle | 28 | F | N | 1 | Marketing Manger | None | Mild anxiety & depression | 12 years | Y- private | Partner |

\* = pseudonyms, Y = yes, N = no

# **Analysis**

The themes presented here centre on participant's identities as SGCIs and underpin how they view mental health difficulties and might access support for these. The following analysis presents three superordinate themes: representations of mental health in the Chinese community, sharing emotions in Chinese culture and, striving to meet Chinese norms (see Figure 5, p. 65). Each superordinate theme consists of three subordinate themes.

*Representations of mental health in the Chinese community*

This superordinate theme discusses how three interlinked subordinate themes influence how SGCIs seek support for mental health difficulties: representations of mental health in Chinese media, how this influenced family beliefs about mental health and the role of community in setting cultural norms.

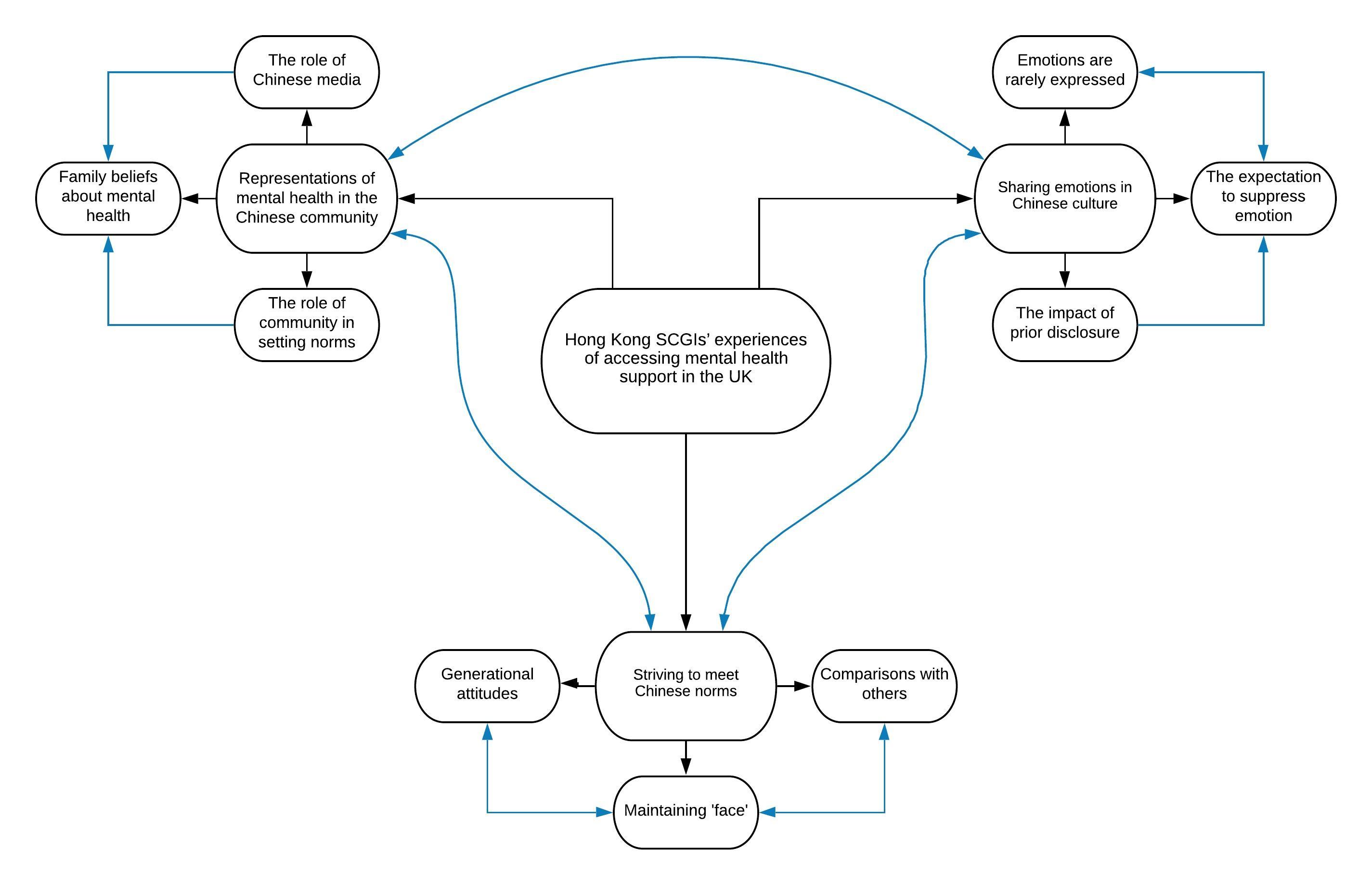
Participants described feeling that mental health difficulties were negatively perceived within Chinese culture and families, partly due to limited representations in Chinese media. One participant spoke about negative representations of mental health in Chinese news articles:

"What my mum said about them [people with mental health issues] being crazy, like those things she’s seen in news articles" (Rebecca, line 354)

Most participants discussed the role of Chinese television in setting cultural norms:

“I was growing up watching a lot of Chinese like television. So, even now I can kind of read and like just yeah, I can confuse the er, but I don’t really do it so much now but um, that's, fine for me, and it's kind of like a different side um to I guess like the Western world media and yeah, speaking with my parents on the phone” (Fei, L. 153).

The influence of Chinese television in Fei’s early life seemed to shape how he communicated with his family and impacted on the strength of his Chinese identity and potentially his acceptance of Chinese norms. The broken and hesitant speech used illuminates the confusing experience of growing up with Chinese and Western influences. For Fei, Western media brings a whole “different side” and perspective that Chinese television does not appear to.

Figure 5: A diagram to represent the different factors impacting on Hong Kong SGCIs’ experiences.

(Note: blue arrows show interlinking subordinate themes and double-ended arrows demonstrate a bidirectional influence).

Noelle described how Chinese television influenced her parents’ view of mental health:

“So if they [parents] ever see anything [mental health related] portrayed in the news or media it's always something really bad it's never like you know this is just a normal thing that happens, and people need um or, people use therapy for a variety of things it's, yeah it's like the language and the way they've talked about it, makes me think that there's no reason for them to understand it in a different way, because yeah in Western society, it's, it's like, you can see it in documentaries, you can see it on television and there are all sorts of things or just online media, but I don't think there's really - it's really the same in Chinese media at all” (Noelle, line 291).

Noelle discusses how the language around mental health is typically negative and that stereotypes on television are often extreme:

“You know like typical, um stereotypes you'd see on television of someone who goes into like a - a literal like asylum or something, that kind of thing, like it must be like, you know, multiple personalities and you know, that kind of thing, must be in a straitjacket to see a therapist” (Noelle, line 278)

Noelle believes that Chinese television presents mental health as a unidimensional (negative) concept, which contrasts with the differing perspectives of mental health issues presented in Western media. This contrast between Chinese and Western television discussed by both Fei and Noelle highlighted how SGCIs benefitted from a more diverse narrative around mental health in Western media. Joyce’s account offers a different view:

“Our parents’ generation look down on Western culture and see it as weak to be emotional because it's, it's unprofessional and it- you lose face if people know that you've got mental health issues- or if you can't control your emotions” (Joyce, line 211).

For Joyce, the views of Western culture held by first-generation Chinese immigrants are juxtaposed to the views of SGCIs. SCGIs see Western media as an opportunity to see varying narratives, whereas first-generation Chinese immigrants are perceived to view Western portrayals of mental health as depicting weakness and a lack of control.

The interplay between Chinese culture and the discussion and/or disclosure of mental health difficulties more broadly was discussed by some participants. For example, Rebecca talks about how the response to the disclosure of a mental health diagnoses to the wider Chinese community would have negative consequences for both herself and her family:

“For me within the family it could just be like, basically, like being, like having contact cut off so like I wouldn't be able to talk to them anymore, or like see them and then it would create like a conflict within the family so like if my, if my two brothers were both like really accepting, so then it'd be like the siblings versus the parents sort of, and then they could, they could be having like arguments with my parents and telling them to come see me and whatnot. Um, and then, like, within the community could be like that our family wouldn't get invited to like dinner parties and whatnot or like mahjong parties, or just generally not be accepted as part of the community anymore” (Rebecca, line 511)

Rebecca’s account demonstrates how the impact of a mental health diagnosis can be felt within and between generations, Chinese families, and the wider community. She speaks to the burden that someone with mental health issues may experience – the need to suppress their concerns about their health to protect their relationship with family members and their family’s reputation within the wider community. Despite this, Rebecca was compelled to take an active role in normalising difficulties with mental health and discussions about them:

“I like to talk to them [parents] about mental health but just not my own experiences of mental health so then, so then like I could use, like the general like talk about mental health to like bring them towards a more positive, opinion of mental health. So then like I would be able to disclose my erm, disorder if I had to” (Rebecca, line 470)

Therefore, Rebecca felt comfortable to discuss mental health generally, in a depersonalised way to protect herself from potential negative repercussions of disclosure. Central to her account is encouraging a more “positive opinion of mental health” in her parents and if this was achieved, would enable her to disclose her own mental health issues.

This superordinate theme describes how representations of mental health develop and are maintained in the Chinese community. Chinese television was the main source of information for parents in understanding mental health difficulties, and typically portrayed negative stereotypes. As a result, parental views of mental health were often seen as limited and predominantly negative. SGCIs’ awareness of negative stereotypes of mental health difficulties in Chinese culture was highlighted by broader representations of mental health in Western media. This contributed to SGCIs being reluctant to discuss their mental health issues with parents/family because of the negative stereotypes typically held. This reluctance went beyond the family unit and included negative repercussions within the wider Chinese community.

*Sharing emotions in Chinese culture*

This superordinate theme describes how the sharing of emotions in Chinese culture contribute to the delay in help-seeking. It draws on three subordinate themes, how emotions are rarely expressed, the expectation to supress emotions, and how the impact of prior disclosure discourages emotional discussions.

Participants described how the sharing of emotions impacted on their likelihood to seek informal support from family. The differences between how emotions are expressed in Western and Chinese families was central to this. Noelle discusses how this made her feel:

“Oh that you feel kind of like, just so different, and just unable to, um receive the same level of love and care, as, people - like people that surround you who would receive that every single day. Um but obviously like, in other ways, like in-in the back of my head I know that that's expressed- it's just expressed in a different way. But at the front, I-I kind of feel like, it's just kind of like almost unfair, in a way” (Noelle, line 112)

Noelle expressing how she does not feel able to receive “the same level” of affection as people in wider society speaks to a perceived inequity, where she is surrounded by people who receive and readily express emotion, providing contrast to her interactions with family. The “front” and “back” parts of her mind demonstrate the push and pull of various parts of her identity, wanting to receive affection whilst having difficulty accepting this in the way that first-generation parents typically express it. For Noelle, the cumulative impact of never hearing parents verbalise love or pride to her reinforces that more ‘difficult’ emotions, such as those often associated with mental health, could also not be shared.

The suppression of emotion due to a lack of ‘safe space’ was further impacted by the expectation to supress emotions in highly emotive circumstances, where sharing emotions might be expected, Joyce avoided engaging with the loss of her mother who had completed suicide:

“Like, just suck it up, you know um, and I feel like that, unfortunately- er not unfortunately - I feel like that's how I've grown up to feel that I shouldn't really be expressing those emotions, especially like if I'm sad, then it’ll make other people sad, and then you don't want to, you know, you don't want to affect other people.” (Joyce, line 229)

Joyce’s lack of opportunity to engage with the emotions of grief seemed to contribute to unprocessed grief and emotional difficulties even three years after losing her mother. This example typifies how participants avoid their emotions due to cultural norms about being perceived as weak or that this would be “inconveniencing” (Joyce, line 269) others.

Although the norm was not to share emotional difficulties, some participants described instances where they had tried engaging with family members. Participants described parents typically reacting in a dismissive nature, deterring them from speaking about their difficulties again and thus delaying help-seeking until they reached a crisis point. Viv spoke about how her parents only become aware of her mental health issues at the point of her being admitted to hospital following an overdose, despite previous attempts to discuss her difficulties with them:

“When I ended up in hospital my mum or well my parents were kind of, forced to acknowledge it somewhat at least um because they obviously – they had come to the hospital to get me but um, other than that, like, I think in the past, I tried to bring some stuff up with my mum, but she kind of just put it down to me being a teenager going through, you know, an emotional um mood swing part of my life. Um and once she kind of dismissed it almost, for me, I just thought, well, you know, she's obviously not taken seriously, there's no point in really trying to talk to her about it”. (Viv, line 182)

Viv’s parents being “kind of forced” to witness her mental health difficulties at the point of an inpatient admission indicates that open discussion around the hospitalisation was lacking. The broken language used to describe the process of having her emotions dismissed indicates how her resolve to reach out for help was reduced and minimised until she made the decision that talking about this further with her parents would be futile, stymying the support that she wanted from them.

In extreme cases, disclosures to family members were completely disregarded, leading participants to feel unable and/or unwilling to emotionally connect or maintain family relationships. In Fei’s experience, the disclosure of his sexuality to parents was met with confusion and a lack of cultural acceptance. This contributed to significant difficulties for Fei in maintaining a relationship with his parents.

“My relationship with them has changed in terms of before I would kind of fixate on, they’re still in denial about me and my sexuality and that was like the biggest thing and that was stopping me from connecting to them- with them, in any way. And now it's more – I kind of, I’ll ring them with almost no expectation of what we’ll talk about, even if it's kind of we’ll talk about, I don’t know like, food or what they’ve been doing day to day” (Fei, line 342)

Fei initially described anger and resentment towards his parents, particularly around their “denial” of his true self as a gay man. However, here he describes a significant shift in his thinking following accessing therapy, in being able to seek alternative ways of connecting emotionally, in ways that he and other participants described as being part of Chinese culture – in actions, such as, where food was used to communicate affection, and care was shown in asking about physical wellbeing. Until experiencing this shift in perspective, it was difficult for Fei to accept love or affection from his parents as he felt a significant part of him was being denied as his parents continued to ask if he had met a female romantic interest, for example.

This superordinate theme demonstrates that sharing positive emotions was not usual within Chinese families therefore, participants did not seek familial support for emotional difficulties. In addition, it was usual for emotions to be supressed even in extremely emotive situations. In instances when emotional difficulties were shared, this was either dismissed or disregarded by family members and support was not demonstrated. This negatively impacted on relationships and contributed to emotional distance within families. These factors illustrate why SGCIs may be reluctant to seek support for mental health difficulties, particularly from family members.

*Striving to meet Chinese norms*

This superordinate theme outlines how striving to meet Chinese norms delays support-seeking. Striving is influenced by the following subordinate themes: generational attitudes, the need to maintain ‘face’ of the family and comparisons with others as indicators of success.

Participants discussed how striving influenced how they managed their mental health difficulties. Participants inherited their striving attitude from previous generations. Knowledge about how their parents and grandparents struggled made them want to strive hard to make the most of the opportunities offered or presented to them:

“Having seen my parents work hard when they immigrated to the UK that kind of then reflects, in me um to do the best that I can, because they provided an environment in which we could have a better education in England than if we were to have one in Hong Kong” (Noelle, line 22).

The need to preserve the immigrant narrative provided pressure to succeed. Whilst some participants described direct pressure from older generations to achieve tangible outcomes (e.g., school grades), others discussed how responses from their parents reinforced the benefits of their striving behaviour:

“Even though they've never physically pushed me to achieve academic- achieve high grades academically, or in any sports or anything. I’ve set that goal and they’ve always, praised and reinforced, that kind of thinking, because all they see is the outcome - oh, she's doing really well obviously they’ll praise me but, they don't see the thinking behind it” (Piper, line 94).

Expectation around emotional perseverance was made explicit in Joyce’s family. When Joyce’s mother was unwell with depression prior to her suicide, there were expectations to meet:

“Like give my mum's generation or my grandma's generation, you feel sad, you deal with it, you’ve gotta [sic] get on with life, other people rely on you. And I would be like, I would inherit that kind of mentality and mindset too. So, when mum was really sad it was kind of like, you'll get over it”. (Joyce, line 171)

The short and punctuated sentences highlight Joyce’s emotional disconnection from the loss of her mother to suicide. The need to continue with life and manage is described in a somewhat matter-of-fact way, suggesting that mental health difficulties were seen as a barrier to performing the required role within the family, and were inconsistent with striving. Joyce’s experience is situated within the context of being the only unmarried child remaining in her immediate family and therefore, feeling it was her duty to organise her mother’s funeral. This fits with the wider traditionally Chinese concept of a social hierarchy within families. The importance of meeting Chinese social roles was discussed across participants. For example, Rebecca was told by her father that her role as a young adult was to study to secure a future successful career:

”My dad, he really wanted me to get into a high paying stable job. And to do that, like, he kept saying that I needed good grades to do that. And he used to tell me, well he, yeah he still does but he, he told me quite a lot that to, that my job as like as a child or, as I am now, to study. That my job at this age was to study. Yeah and then like, and then, like if he walked into my room and I wasn't studying he told me to, he told me like why aren’t I studying” (Rebecca, line 55)

Rebecca’s account speaks to traditions of Chinese culture. Within families there is a social hierarchy where the oldest male is the patriarch and commands authority over the family and younger members hold subordinate places (e.g., Rebecca and studying). Parents want to take pride in their children and children seek to hold this place in their parent’s esteem, to contribute to positive ‘face’ of the family:

“I think it comes from like Confucian, values and like and it's, it's kind of like about your reputation within the community. So, yeah, so like if something good happened in the family like, like your brother got into a good university -that- the parents would tell everyone and then everyone would think of your family as like, the family who has a son who went to a good university” (Rebecca, line 371).

The weight of this expectation felt by Rebecca to put the collective over herself appeared to affect how she experienced mental health difficulties, and such collectivist values may have prevented SGCIs from talking about such issues with their parents. The need to strive and contribute to ‘face’ and family reputation was perpetuated by a culture of comparison that was felt to be usual amongst participants.

“It's a bit different because you know in the Asian culture you sort of know we're getting compared, but at least in my family, I don't really know if other Asians are but you know you're compared so my dad will be like ‘oh so-and-so’s daughters just got a masters’ or ‘so-and-so is a doctor now’ and you’re like great, more pressure for me. So I think that kind of comes with the anxiety of- although not specifically said, you know people are looking at you, kind of an invisible ‘oh so-and-so’s doing that’ or ‘so-and-so’s failed’ (Piper, line 139)

Piper demonstrates how commonplace it was for achievements and failures to be openly discussed by parents. Comparisons between adult children and their peers was experienced as invasive, with no privacy of achievements or failures and feeling constantly observed. These comparisons may not only be made by parents but also by the wider community:

“My parents are actually, you know, they're quite chill about it like they're not necessarily like, oh, you know, you have to, kind of, you know like um, you know, have a career and, you know, buy a house or whatever like they're not like that. It's more kind of, I guess, external from maybe like, I’d say like friends and like external family members. Like, yeah like cousins or something like that”. (Mary, line 197)

Despite Mary and her family minimising their Chinese identity to being “just like an ethnic background” (Mary, line 5), she continues to experience pressure perpetuated by Chinese norms through wider interactions with relatives. This is further discussed by Noelle,

“parents can talk about this [success] with all their friends and family and just- just never ending topic of discussion” (line, 54).

The systems which contribute to striving norms are almost inescapable. In some cases, they are explicit, in others they are intangible nudges which feed into implicit expectations to succeed and contribute to ‘face’. Joyce describes how generational attitudes, the need to maintain ‘face’ and comparisons with others often coexist:

“I didn't care if I lost face because I'm younger it doesn’t matter, but my parents- it means that people think badly of them, it means their reputation drops and the way people view them- just, what I do would affect them and it's the same with my grandma. So, I feel like with face, there’s a lot of guilt because, like my- If my grandma came here 40 years ago and she's built up this lifetime reputation and then one day, I don't know- I do something very silly and I ended up getting like- I dunno, failing my university, it would look really bad on Grandma, because she's suffered so much (Joyce, line 70)

Despite the personal lack of importance, Joyce continues to buy into the concept of ‘face’ as it is important to others in her family. The possibility of failure seems to come with high stakes as this reflects negatively on previous generations, with Joyce’s own needs being deprioritised. This reveals how the need to strive is inherited from older generations: personal views are often subsumed within the collective consciousness, thereby maintaining the norm.

This superordinate theme describes how achievements and failures are commonly discussed by parents. There is a relationship between parents’ views of the child and the child’s view of themselves in comparison to their peers (friends or cousins from the same generation). This constant comparison was stressful, contributed to anxiety and led to burnout. Striving for success may prevent SGCIs from stopping to seek mental health support as this may lead to unwanted discussion and them becoming a source of shame and a loss of ‘face’.

**Discussion**

# *Key findings*

To the author’s knowledge, this is the first IPA study exploring Hong Kong SGCIs’ experiences of mental health support. Three interlinking themes describe how representations of mental health in Chinese community, sharing emotions in Chinese culture and striving to meet Chinese norms, enhance our understanding of SGCIs’ experiences of support, and why this population may underutilise mental health services.

The first superordinate theme, representations of mental health in Chinese community draws on how negative perceptions of mental health within Chinese families are influenced by negative and stereotypical portrayals in Chinese media, contributing to SGCIs’ reluctance to discuss mental health issues with parents/family. Chinese television was the main source of information for parents in understanding mental health, and typically portrayed negative stereotypes of people with mental health difficulties. For people in the UK, consumption of Chinese media facilitates a connection to Chinese culture (Shi, 2005). Although media representations of mental health are often negative globally (Ma, 2017), no research explores Chinese television representations of mental health specifically. However, participants’ exposure to Western media alongside Chinese media, highlight how stereotypical and negative representations in Chinese media are.

Negative representations of mental health in Chinese television and media contribute to views of mental health in this group being typically negative (Chung & Wong, 2004; Chen et al., 2013). Participants were reluctant to discuss mental health issues with parents/family due to negative stereotypes typically held, wanting to keep their mental health difficulties secret (Chung & Wong, 2004). Furthermore, feared rejection for help-seeking around mental health issues being considered a sign of weakness or incompetence (Link et al., 2001), contributed to stigmatising views in wider Chinese community and reluctance to seek informal and formal support (Chen et al., 2014).

The second superordinate theme, sharing emotions in Chinese culture describes how all emotions (positive and negative) are rarely expressed within Chinese families, the expectation to supress emotions, and how negative experiences of disclosure to family discourages emotional discussions.

Although previous research in first-generation Chinese immigrants portrays how not sharing emotions is common, the findings presented here indicate that SGCIs similarly have difficulties sharing their emotions, despite suggestions that they are potentially more culturally assimilated (Furnham & Li, 1993). SGCIs’ experiences support the concept of “segmented assimilation” where immigrant nationalities and identities vary (Portes & Rumbaut, 2005, p. 986).

Whilst familial support for mental health issues has been demonstrated for individuals with diagnoses globally (e.g., Bai et al., 2020; Bedi et al., 2015), research exploring whether familial support for emotional difficulties is typically sought by SGCIs in the UK, specifically, are lacking. Wei et al.’s (2013) study demonstrated a relationship between emotional suppression and interpersonal harmony, providing insight into the experiences of SGCIs and why they typically did not seek familial support for emotional difficulties. Moreover, disclosure of mental health issues within Chinese communities is complex and were only made to close family and friends, due to stigma around mental health and negative repercussions following disclosure (Chen et al., 2013).

The final superordinate theme, striving to meet Chinese norms describes how generational attitudes, the desire to maintain ‘face’ and comparisons made by parents contribute to mental health difficulties and SGCIs' reluctance to seek support. Findings from this study parallel previous research indicating how Chinese Canadian immigrant parents expect their children to strive for excellence, for example by securing successful careers (Li, 2001). Cross-cultural research highlights that Chinese culture is significantly more collectivist, rather than individualist (Oyserman et al., 2002). This is important to consider in line with traditional Chinese cultural concepts including, the need to maintain collective harmony (Kuo & Kavanagh, 1994), for example by upholding ‘face’, restraining emotions and avoiding conflict. Filial obligations are also central to the role of children as the desire to strive for success honours parental expectations (Chu, 2004). Contrastingly, Western parental expectations are more likely to be flexible and therefore, children typically feel less pressured to academically excel (Dandy & Nettelbeck, 2002). Part of SGCIs’ experiences of parental pressure to academically achieve included a culture of comparison where parents were felt to share achievements and failures within wider Chinese community. This is underlined by greater pride expressed for others’ accomplishments in Chinese college students compared to American students (Stipek, 1998). There appears to be no other current research exploring Chinese parental comparisons of achievements and therefore, it adds to our practical understanding of how striving norms are experienced by SGCIs specifically.

This superordinate theme describes how achievements and failures are commonly discussed by parents. These comparisons were stressful, contributed to anxiety and burnout. Striving for success is likely to prevent SGCIs from stopping to seek mental health support as this may lead to unwanted discussion, and them becoming a source of shame and a loss of ‘face’.

When comparing the results presented here with the existing literature, research on first-generation Chinese immigrants highlights literacy and language skills as a potential barrier for Chinese people accessing services (Kung, 2003; Tran, 2009), however these factors were not cited as barriers for SGCIs in accessing support. Whilst previous research suggests that less contact with mental health professionals could be due to families offering support to relatives (Chu, 2004; Lee & Mock, 1996), this was not the case for SGCIs. Earlier research indicated that SGCIs are more assimilated than first-generation individuals (Furnham & Li, 1993; Wong & Cochrane, 1989) however, findings suggest assimilation for SGCIs is not straightforward, and a concept of “segmented assimilation” may be more appropriate (Portes & Rumbaut, 2005, p.26). The findings around striving to meet Chinese norms support Jim & Pistrang’s (2007) concept of “cultural formulation” (p.26) emphasising the importance of developing an integrated understanding of mental health difficulties from a Chinese cultural perspective, as well as the dominant Westernised culture. Though Jim and Pistrang (2007) examined the role of culture in therapeutic relationships and found valuable insight around treatment, this study extends current knowledge by enhancing our understanding of informal mental health support and potential reasons for Chinese people being underrepresented in mental health services.

# **Strengths and limitations**

This is the first qualitative study exploring SGCIs’ experiences of mental health support in the UK. To further knowledge around potential reasons for Chinese people underutilising mental health services, participants with self-defined experiences of mental health difficulties were recruited. The researcher conducting the interviews was also a SGCI and this was conducive to building rapport and facilitating open discussion. Data were analysed using IPA which enabled rich, ideographic accounts of SGCIs’ lived experiences to be understood.

This study was only able to recruit participants proficient in English for the interviews. Unfortunately, the researcher did not have resources to offer bilingual study materials nor translation of any Chinese-spoken interviews as in previous research (Tang, 2016; Yeung et al., 2017). Whilst IPA studies aim for homogenous samples to explore similarities and differences in detail (Smith, 2009), participants history of mental health difficulties ranged from 1-14 years and support obtained varied. For example, one participant received brief individual counselling and others accessed longer-term therapy which likely impacted their experiences of mental health issues, and obtaining support for these, differently.

# **Implications**

To enhance understanding of Chinese people’s experiences of mental health support, further research should conduct interviews in participants’ preferred language. There is evidence that conducting qualitative research in non-native languages and using interpreters can complicate the research process and affect the findings, especially as language is used to express cultural nuances (Patton, 1990). To avoid difficulties associated with the use of translators, research with the Chinese community should be conducted by multicultural researchers who can speak Chinese. Future research needs to facilitate culturally safe spaces where Chinese people feel able to engage in research, accounting for gender, age, disability, and other social cultural factors (Tang & Pilgrim, 2017). This might be achieved by ensuring research is conducted by individuals with awareness of cultural factors that may influence mental health disclosure (Chen et al., 2009), such as the significant stigma around mental health issues in Chinese culture.

As this qualitative study explored the experiences of seven SGCIs, further quantitative research is required to explore whether the findings are generalisable to the wider Chinese population, particularly outside of the ‘emerging adulthood’ age range. Although there has been a wealth of research conducted with Chinese Americans (Chu & Sue, 2011; Kim et al., 2015), research on the British Chinese population is limited. Opportunities for service user consultation should be provided as this will help Chinese people feel empowered to engage in community participation and development, to help support and create spaces for meaningful social inclusion that facilitates change within and beyond Chinese communities (Tang, 2016).

As the British Chinese diaspora is geographically spread (Huang & Spurgeon, 2006), SGCIs typically find a sense of community online (Parker & Song, 2006). Therefore, online mental health champions within social media groups are recommended to facilitate open discussion of mental health issues and normalise accessing support (Chiu, 2002). Furthermore, mental health literacy within Chinese families is limited, due to stigma, the need to fulfil social roles and maintain ‘face’, whilst reinforcing the need for this population to keep striving. Therefore, it is likely that working directly with Chinese families and community to reduce stigma and contribute to mental health awareness will enhance SGCIs’ willingness to access support.

The ability to provide effective mental health support to these individuals goes beyond clinicians having “cultural sensitivity” (Butt et al., 2015, p. 11). To fully understand how culture impacts people who experience a mix of cultures, clinicians should be culturally curious and explore what culture means to individuals, how they make sense of their identity (e.g. third culture; Moore & Barker, 2012) and therefore, conceptualise mental health difficulties. Finally, there is evidence to suggest a lack of mental health literacy in Chinese communities globally (Australia, China, Hong Kong and Taiwan, Wong et al., 2017). For example, Chinese people may be more likely to deny having mental health issues and ascribe more socially acceptable labels to their experiences (e.g., stress, anxiety) as opposed to diagnostic labels. Therefore, a systemic approach to enhance knowledge of mental health amongst Chinese diasporas may be useful. Specifically, mental health promotion programmes may benefit from including information on signs and symptoms of mental health diagnoses, Eastern and more traditional understandings of mental health, in addition to Westernised conceptualisations and, the benefits and drawbacks of traditional medical and psychosocial treatments. Furthermore, mental health promotional materials for the Chinese population may benefit from production in Chinese to reduce barriers to accessing information. Other systemic approaches may include improving population health (e.g., the provision of mental health education in schools) to promote emotional health in the Chinese population and further prevent delays to help-seeking.

# **Conclusion**

This qualitative study suggests representations of mental health in the Chinese community, sharing emotions in Chinese culture and striving to meet Chinese norms impact on SGCIs’ experiences of mental health support in the UK. The rich and detailed accounts of SGCIs’ lived experiences of mental health contribute to the understanding around what helped or hindered their ability to seek support. However, as interviews were not conducted in participants’ preferred language due to not having resources to facilitate translation, some cultural aspects of SGCIs’ lived experiences may have been missed. Future research is required to explore whether similar findings can be demonstrated in the wider population of SGCIs in the UK. Service improvement projects should include working directly with the Chinese community to create culturally safe spaces to reduce stigma and improve understanding of mental health difficulties.

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# **Paper Three: Executive Summary**

**Hong Kong Second-Generation Chinese Immigrants’ Experiences of Mental Health Support in the UK**

**Word count:** 2041

**Target audience**: Hong Kong second-generation Chinese immigrants living in the UK.

This summary has been read by members of this audience and feedback taken to enhance its accessibility to this population.

Note: In this study, second-generation Chinese immigrants are individuals of Chinese ethnic origin but were either born in Britain or had left Hong Kong before the age of 10.

# **Background**

*This section summarises some relevant literature that helps to explain why this research study will add to existing knowledge.*

The Chinese population is one of the fastest growing ethnic minority groups in Britain, with an increase from 0.4% to 0.7% of the population in England and Wales from 2001 to 2011 (ONS, 2018). Despite this, there are still low numbers of Chinese people accessing inpatient mental health services (Care Quality Commission, 2010).

Several reasons for low representation of Chinese people using mental health services have been proposed. It has been suggested that Chinese immigrant populations are reported to make limited use of mental health services because:

* Inconsistent terms are being used to record demographic information (e.g. Asian rather than Chinese), resulting in Chinese service users being reported as Asian (Bignall et al., 2019)
* They experience literacy and/or language difficulties, combined with it being difficult to access bilingual professionals (Kung, 2003; Li et al., 1999. Tang, 2016)
* They may have a lack of knowledge of statutory services (Li et al., 1999)
* Resources other than formal mental health services are available such as, community support and/or holistic treatments (e.g. traditional Chinese medicine) (Butt et al., 2019)
* There is a fear of stigma associated with mental health issues (Kung, 2003)
* They may have positive experiences of assimilating into life in the UK, adopting the culture and values in the UK rather than those from their Chinese culture and therefore, may feel less need to access mental health support (Yeh, 2003)

Only a small number of studies have specifically explored Chinese people’s experiences of mental health difficulties and accessing support. Most of these studies have been completed with first-generation Chinese immigrants who may have different experiences (e.g. there may be more language barriers for first-generation Chinese immigrants’ access to services compared to the second-generation).

Previous studies have also been completed with Chinese immigrants from different countries such as, Vietnam and Singapore. This study specifically explores Hong Kong Chinese immigrants’ experiences, as this group immigrated to Britain in large numbers in the 20th century (Chan & Chan, 1997). With the growing population of Chinese people in the UK, exploration of Hong Kong second-generation Chinese immigrants’ experiences, provides valuable insight into why there are low numbers of Chinese people accessing formal mental health services, and what other support they may be utilising.

# **Aim**

The aim of this study was to explore Hong Kong second-generation Chinese immigrants’ lived experiences of mental health support in the UK and why this population may be underutilising mental health services.

**Methods**

*This section explains how this research study was carried out. This information also helps to provide transparency about how knowledge and understanding is generated.*

* Seven interviews were carried out online and audio-recorded, which were transcribed so that the contents were written out as text transcripts.
* The transcripts were analysed using a method that is suitable for exploring people’s experiences and tries to account for the researcher’s perspective (known as Interpretative Phenomenological Analysis).
* Participants were identified via social media. With permission of group administrators, invites were posted on general British-born Chinese and specific British-born Chinese mental health Facebook pages.
* Participants were second-generation Chinese immigrants who had experienced mental health difficulties and were aged 20-28 (recruitment was open to those aged 18- 30 years old).
* During the interviews, second-generation Chinese immigrants were asked about their experiences of mental health difficulties, if and how they sought support (informally – via friends, family or using online resources, or formally - accessing mental health services such as, individual therapy)
* During the analysis, similarities and differences were noted and patterns across participants’ experiences were identified.
* Three key themes were identified which describe the experiences that second-generation Chinese immigrants discussed. Quotes were then selected to illustrate each theme and are reported in publications. Pseudonyms were assigned to protect people’s confidentiality. Some example quotations are presented in Table 5.

# **Findings**

Figure 6: Diagram showing themes that contribute to Hong Kong second-generation Chinese immigrants’ experience of accessing mental health services and support in the UK

(Note: blue arrows show interlinking factors, double-ended arrows show how the factors impact on each other)

The diagram above summarises the main findings. The three main themes identified were: representations of mental health in the Chinese community; sharing emotions in Chinese culture and striving to meet Chinese norms. The other boxes highlight factors that contribute to and influence each of these main themes.

*Representations of mental health in the Chinese community*

Interviewees’ parents were influenced by negative representations of mental health in Chinese media, usually Chinese television. Therefore, parents and family members from older generations were felt to have limited and negative views of mental health.

Second-generation Chinese immigrants noticed differences to Western media portrayals of mental health, seeing more varied representations as a positive. However, they felt that first-generation Chinese immigrants saw Western media portrayals of mental health as depicting emotional weakness and a lack of control over emotions. Therefore, second-generation Chinese immigrants were typically less likely to discuss their mental health issues with parents and family due to the negative stereotypes held. Reluctance to share emotional difficulties went beyond the family and included potentially negative consequences within the wider Chinese community, such as being excluded from social activities.

*Sharing emotions in Chinese culture*

According to those interviewed, it was uncommon for Chinese families to share both positive (e.g., verbalising pride or love) and negative emotions. Therefore, second-generation Chinese immigrants did not seek support from family for their emotional difficulties. There was an awareness that perhaps emotions were expressed differently in Chinese culture and families compared to in Western families. For example, second-generation Chinese immigrants discussed how care and affection were expressed in more practical ways (e.g., making a relative food).

There was an expectation for second-generation Chinese immigrants to suppress their emotions, even in emotionally difficult situations such as grief. Showing emotions was often considered to be a weakness or an inconvenience to others.

On the occasions when second-generation Chinese immigrants did share their emotional difficulties, they were met with dismissal from family members, rather than receiving comfort or support. These factors all contributed to second-generation Chinese immigrants’ reluctance to seek support for their mental health difficulties, especially from family members.

*Striving to meet Chinese norms*

The second-generation Chinese immigrants in this study used striving to manage their mental health difficulties. They inherited their attitude to striving from previous generations. Knowledge of how their parents and grandparents struggled made second-generation Chinese immigrants want to strive hard to make the most of opportunities that previous generations did not have (e.g., education).

Mental health difficulties were perceived as barriers to performing traditional Chinese roles within the family (e.g., duties as the only unmarried child in the family). Parental expectations for their children to strive for success contributed to second-generation Chinese immigrants putting the collective needs of their family over their individual needs. Achievements and failures of second-generation Chinese immigrants were openly discussed by parents and contributed to further pressure to strive. Even for second-generation Chinese immigrants who felt more assimilated into the UK and no direct parental pressure, pressure to succeed was still experienced in interactions with extended family members. Parents’ views of second-generation Chinese immigrants and second-generation Chinese individuals’ views of themselves were linked. The comparisons made by parents, relatives or themselves was experienced by second-generation Chinese immigrants as stressful, anxiety-provoking and often led to burnout.

Striving to succeed is likely to prevent second-generation Chinese immigrants from stopping and seeking mental health support due to unwanted discussions about mental health, associated feelings of shame and loss of reputation or ‘face’.

# **Limitations**

Interviews were only offered in English rather than providing options for interviews to be completed in Chinese therefore, other second-generation Chinese immigrants not included in this study may well experience language difficulties as a barrier to accessing mental health support (in line with previous studies that highlight this is a significant issue for older Chinese adults).

There was a range of duration in the years that second-generation Chinese immigrants had experienced mental health difficulties (1-12 years) which may have impacted on their experiences of accessing mental health support.

This was a study aimed at understanding second-generation Chinese immigrants’ lived experiences using a small number of participants to obtain rich data and therefore, findings might not apply to other second-generation Chinese immigrants living in the UK with mental health difficulties.

**Table 5** - *Example participant quotations that highlight the themes found*

|  |  |
| --- | --- |
| **Themes** | **Participant quotations** |
| Representations of mental health in the Chinese community | “You know like typical, um stereotypes you'd see on television of someone who goes into like a - a literal like asylum or something, that kind of thing, like it must be like, you know, multiple personalities and you know, that kind of thing, must be in a straitjacket to see a therapist” (Noelle) |
| Sharing emotions in Chinese culture | “Like, just suck it up, you know um, and I feel like that, unfortunately- er not unfortunately - I feel like that's how I've grown up to feel that I shouldn't really be expressing those emotions, especially like if I'm sad, then it’ll make other people sad, and then you don't want to, you know, you don't want to affect other people.” (Joyce) |
| Striving to meet Chinese norms | “I think it comes from like Confucian, values and like and it's, it's kind of like about your reputation within the community. So, yeah, so like if something good happened in the family like, like your brother got into a good university -that- the parents would tell everyone and then everyone would think of your family as like, the family who has a son who went to a good university” (Rebecca) |

# **Conclusion**

* The findings help to explain why Chinese people may not be well represented within formal mental health services.
* Hong Kong second-generation Chinese immigrants in the UK may identify with experiences outlined in the findings
* Representations of mental health in the Chinese community; how emotions are shared in Chinese culture and striving to meet Chinese norms impact on second-generation Chinese immigrants’ experiences of accessing mental health services and support in the UK.
* The findings contribute to our understanding of what was helpful and unhelpful in second-generation Chinese immigrants’ experiences of seeking support from family and more formal mental health services.
* Future research should include more Hong Kong second-generation Chinese people in the UK to explore if the findings can be applied to them.

# **Recommendations**

* Findings should be used by professionals to develop mental health resources for second-generation Chinese immigrants, and to reduce stigma associated with mental health difficulties in the Chinese population in the UK.
* Second-generation Chinese immigrants should be consulted to directly contribute to mental health service design and projects within Chinese communities to increase access to mental health support (formal and informal).
* Due to second-generation Chinese immigrants commonly using Chinese social media groups, mental health champions should be used within these online communities to encourage more open discussion of mental health issues and normalise support seeking.
* Findings should be used to increase mental health professionals’ awareness of some of the cultural concepts that might impact on second-generation Chinese immigrants’ experiences of seeking support for their mental health difficulties in the UK.
* Further research should be completed with the wider Hong Kong second-generation Chinese immigrant population in the UK to explore if findings from this study can be applied to them.

# **Dissemination**

The findings will be published in an academic journal and shared with second-generation Chinese immigrants via the Facebook groups that participants were recruited from. It is expected that the findings will contribute to Hong Kong second-generation Chinese immigrants’ understanding of mental health difficulties and what influences the support they seek for these difficulties. Findings will also contribute to professionals’ knowledge around understanding why help-seeking for mental health difficulties in Hong Kong second-generation Chinese immigrants might be difficult, due to issues such as stigma and wanting to maintain ‘face’ and interpersonal harmony.

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Yeh, C. J. (2003). Age, acculturation, cultural adjustment, and mental health symptoms of Chinese, Korean, and Japanese immigrant youths. *Cultural Diversity and Ethnic Minority Psychology*, *9*(1), 34. <https://doi.org/10.1037/1099-9809.9.1.34>

# **Appendices**

# **Appendix A**

# **International Journal of Mental Health Nursing Journal submission guidelines**

Articles must have an unstructured abstract that states in 250 words or less the purpose, basic procedures, main findings and principal conclusions of the study. The abstract should not contain abbreviations or references. Five key words, for the purposes of indexing, should be supplied below the abstract, in alphabetical order, and should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list ([**http://www.nlm.nih.gov/mesh/meshhome.html**](http://www.nlm.nih.gov/mesh/meshhome.html)). Before you submit, you will need:

* Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. Manuscripts must:
  + Be blinded for peer review
  + Contain all required sections, based on the article type (e.g. abstract, introduction, methods, results, and conclusions)
  + Include legends for all figures and tables
  + Contain a reference list, but this may be presented in any style or format, as long as it is consistent throughout the manuscript
* Your title page must contain
  + Author details (name, affiliation, email address, ORCID ID [freely available at https://orcid.org]; see the journal’s authorship policy in the Editorial Policies and Ethical Considerations section for details)
  + A funding statement
  + An acknowledgments statement
  + A conflict of interest statement
  + An ethics approval statement (if relevant)
  + Patient consent for publication statement (if relevant)
  + Keywords (5 words, MeSH-compliant)

Submission guidelines link: <https://onlinelibrary.wiley.com/page/journal/14470349/homepage/forauthors.html>

# **Appendix B**

# **Combination of search terms**

|  |  |
| --- | --- |
| **Search** | **Terms** |
| **1** | Support OR Care |
| **2** | Culture OR cultural OR ethnicity |
| **3** | China OR Chin\* OR DE “Chinese cultural groups” OR “Hong Kong” |
| **4** | Family relations OR family relationships |
| **5** | “mental health” OR “mental illness” |
| **6** | Support OR Care  **AND**  Culture OR cultural OR ethnicity  **AND**  China OR Chin\* OR DE “Chinese cultural groups” OR “Hong Kong”  **AND**  Family relations OR family relationships  **AND**  “mental health” OR “mental illness” |

# **Appendix C**

# **Data Extraction Form**

|  |  |
| --- | --- |
| **Author(s), (year)** | |
| **Study details** | Location |
|  | Research question |
| **Participants** | Population |
|  | Age (range, mean) |
|  | Gender (%) |
|  | Other participant information |
|  | Recruitment/sampling method |
| **Data collection** | Method (interviews, focus groups, documents, etc.) |
|  | Who collected the data? |
|  | Were data translated or interpreted? |
|  | How were data prepared for analysis? (e.g. transcribed, documents grouped into categories, etc.) |
| **Analysis** | Method (thematic analysis, IPA, grounded theory, etc.) |
| **Epistemology** | If reported, what was study’s epistemological stance? |
| **Validity** | What validation methods used? (E.g. member validation, audit trail, field notes etc.) |
| **Reflexivity?** | Did the study report engaging in reflexivity? |
| **Findings** | How are the results presented? |
| Category 1  (title, description as given, verbatim extracts of data and/or author’s analysis of the data) | Title: |
| Category 2 |  |
| Category 3 |  |
| Category 4 |  |
| Category 5 |  |
| Category 6 |  |
| **Author’s conclusions** | Authors concluding remarks, key findings |
|  | Limitations identified by authors |
|  | Implications |
|  | Key references (not identified by search strategy) |
|  | Anything else worth noting |

# **Appendix D**

# **Citations of supplementary papers referred to as part of critical appraisal**

|  |  |
| --- | --- |
| **Included paper** | **Supplementary paper** |
| Chan, 2009 | Chan, 2007 |
| Zeng et al., 2012 | Zeng et al., 2013 |
| Subramaniam et al., (2017a) | Subramaniam et al., (2017b) |

# **Appendix E**

# **CASP critique of included papers in review**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Yes/No/Can’t Tell** | **Study number** | | | | | | | | | | | | | | | |  |
| **Focus** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **Comments** | |
| **SECTION A- Are the results valid?**  **Was there a clear statement of the aims of the research?**  Consider:  • what was the goal of the research  • why it was thought important  • its relevance |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | All studies had clear research goals and the relevance of studies was highlighted, including the need to understand the context of influencing factors on mental health difficulties in the Chinese population such as, migration, linguistic differences and discrimination; how the collectivist Chinese culture and social capital can be a protective factor for people and how better self-management likely contributes to better outcomes for individuals and caregivers. Additionally, the importance of exploring how care is provided within community settings was emphasised and familial support is more heavily relied upon. Issue that most research is conducted in Western cultures also highlighted. | |
| **Is a qualitative methodology appropriate?**  Consider:  • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants  • Is qualitative research the right methodology for addressing the research goal |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | All papers sought to illuminate the experiences of Chinese people with mental health difficulties and included themes to enhance the understanding of how family support was perceived.  Qualitative methodology was appropriate for all research goals outlined. A few studies also justified using mixed methods. | |
| **Was the research design appropriate to address the aims of the research?**  Consider  • if the researcher has justified the research design (e.g. have they discussed how they decided which method to use) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | In all but one paper, the researchers justified the qualitative designs to try and understand, the meaning, diversity and complexity for Chinese caregivers.  In the paper that did not justify the study design, focus groups and a questionnaire were used to explore the resources caregivers used to inform themselves of family members’ conditions. This still seemed an appropriate way of exploring familial support. | |
| **Was the recruitment strategy appropriate to the aims of the research?**  Consider:  • If the researcher has explained how the participants were selected  • If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study  • If there are any discussions around recruitment (e.g. why some people chose not to take part) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | In most cases, recruitment strategies were detailed, with most studies outlining topic guides to facilitate discussions in interviews, conversational sessions or focus groups.  Appropriate screening measures used for individuals with specific mental health conditions such as, post-partum depression. In most studies, purposive sampling was used. However, for those studies without detailed recruitment strategies, it was not always clear why certain groups were approached to provide access to the knowledge sought. For example, in Chang & Horrocks (2006), it was only stated that participants were part of the same speech group, spoke several different Chinese dialects and were “criterion-selected” (p.436). In those studies where it was rated “unclear”, the total number of participants approached was often not detailed, nor were the reasons for participants not taking part. Some papers reported being part of larger studies but not detailing which studies these were. | |
| **Was the data collected in a way that addressed the research issue?**  Consider:  • If the setting for the data collection was justified  • If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)  • If the researcher has justified the methods chosen  • If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)  • If methods were modified during the study. If so, has the researcher explained how and why  • If the form of data is clear (e.g. tape recordings, video material, notes etc.)  • If the researcher has discussed saturation of data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | All but two studies Kung, (2003) and Subramaniam et al. (2017) collected data to the point that saturation was felt to be reached. All studies detailed interview guides or the use of prompts to elicit more information from participants. The qualitative methods used were justified however, in Chan’s (2009) paper there was no justification of the theoretical/interpretative framework used to analyse the data from the focus groups. If the methods were modified during the study, this was described but generally there were not many modifications. | |
| **Has the relationship between researcher and participants been adequately considered?**  Consider:  • If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location  • How the researcher responded to events during the study and whether they considered the implications of any changes in the research design |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Two studies did not mention any potential bias or influence of the researchers on the data collection or analysis. Most studies were very thorough, using reflexivity and critically examining the interviewers’ roles in the data collection and analysis process. Adverse events were dealt with appropriately if they arose. In most studies, triangulation and peer debriefing were detailed to improve rigour during the data collection and analysis process. | |
| **SECTION B: What are the results?**  **Have ethical issues been taken into consideration?**  Consider:  • If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained  • If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)  • If approval has been sought from the ethics committee |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Most studies outlined that ethical approval had been granted and that informed consent was obtained from participants. Some studies detailed how ethical issues were accounted for in more detail than others, including explaining the potential benefits and risks of participating in the study to potential participants (e.g. Chang & Horrocks, 2006) or highlighting that participants did not need to answer any uncomfortable questions they encountered (Liu & Zhang, 2019). In those papers rated no (Kung, 2003; Subramaniam et al., 2017a), there was no mention of ethical approval sought or any discussion of any issues raised by the study such as, the impact on the caregivers interviewed nor the impact of completing the questionnaires. There was also no mention of how consent was obtained or how confidentiality was preserved etc. in these papers. Where it was unclear if this criterion was met, there was insufficient detail of how ethical standards were maintained. | |
| **Was the data analysis sufficiently rigorous?**  Consider:  • If there is an in-depth description of the analysis process  • If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data  • Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process  • If sufficient data are presented to support the findings  • To what extent contradictory data are taken into account  • Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Most studies detailed analysis processes, with reference to relevant literature. Generally, it was clear how themes were derived from the data and sufficient examples using quotations were given. However, a few studies did not discuss the potential impact of researchers’ biases, for example researchers screening electronic records to determine eligibility prior to conducting the interviews (Bai et al., 2020). The transparency and credibility of the data analysis was improved by peer debriefing, a reflective process (such as using reflective diaries) and consistency checks between researchers.  Some studies were rated as unsure due to the method of analysis being unclear (Bedi et al., 2015). In Kung’s (2003) mixed method paper, the themes were not clearly defined due to being reported alongside quantitative data. Other studies did not always have sufficient evidence of contradictory evidence from the data presented and one study in particular (Chang & Horrocks, 2006) seemed to have quite broad themes that could have been broken down further. Interpreters were also used to overcome linguistic barriers however, the potential influences and biases of their involvement were not discussed. | |
| **Is there a clear statement of findings?**  Consider:  • If the findings are explicit  • If there is adequate discussion of the evidence both for and against the researcher’s arguments  • If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)  • If the findings are discussed in relation to the original research question |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Generally, themes were clearly discussed so that findings were explicit and linked back to the original research question. Some studies used additional diagrams to describe the themes identified. Credibility was usually discussed, and most studies had several people involved in the analysis process. In such cases, consistency checks were performed and clearly described. Some studies also used respondent validation as part of their analysis process.  Mixed methods papers tended to be rated unclear, with Kung (2003) not having clearly defined themes due to these being presented alongside results from quantitative measures. In those studies rated unclear, researchers tended not to discuss the credibility of their findings at all and sometimes there was no information on how many researchers were involved in the analysis process. In one paper (Zeng et al., (2012) only one dominant category was discussed but from reviewing the relevant methodology paper, it seemed that other categories may also be relevant to the research question outlined. | |
| **Section C: Will the results help locally?**  **How valuable is the research?**  Consider:  • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature  • If they identify new areas where research is necessary  • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | All studies demonstrated valuable contributions to research. Recommendations for current practice were made including, family-based interventions and anti-stigma programmes, as well as health care policies. New areas for research were suggested such as development of more culturally sensitive measures and practice to aid the understanding of mental health difficulties in Chinese populations. Transferability of results was generally discussed with consideration of the impact of purposive sampling used – i.e. those that did not participate perhaps having different views to those participants included in studies or participants not necessarily being representative of other Chinese people in different geographical locations nationally and internationally due to different policies and practices being in place. Nevertheless, findings were discussed in the context of Chinese culture and important factors that should be considered when working with Chinese populations, regardless of location such as, awareness of mental health issues being understood using less traditional, Western frameworks. | |

# 

# **Appendix F**

# **Mixed Methods Assessment Tool critique of included studies**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Yes/No/Can’t Tell** | | **Study citation** | | | **Comments** |
| **Category of study designs** | **Methodological quality criteria** | **Chan, 2009** | **Kung, 2003** | **Zeng et al., 2012** |  |
| Screening questions (for all types) | Are there clear research questions? |  |  |  | All studies had clear research goals and the relevance of studies was highlighted, including the need to understand the context of influencing factors on mental health difficulties in the Chinese population such as, migration, linguistic differences and discrimination |
| Do the collected data allow us to address the research questions? |  |  |  | Quantitative measures and qualitative aims matched onto the outlined researched questions |
| Qualitative | Is the qualitative approach appropriate to answer the research question? |  |  |  | All studies adequately justified the use of qualitative approaches to explore how mental health issues and caregiver burden are experienced in Chinese populations |
| Are the qualitative data collection methods adequate to address the research question? |  |  |  | Two of three studies detailed rigorous qualitative data collection methods which adequately addressed research questions including for example, use of focus groups stratified by gender and age and grouped by Chinese dialects (Chan, 2009). However, one study only briefly outlined the use of open questions to collect narrative data and did not further detail the data collection process. |
| Are the findings adequately derived from the data? |  |  |  | Most studies used appropriate quotations from the data to demonstrate discussed themes however, short quotations were used to describe themes alongside quantitative data which made it difficult to ascertain if qualitative data was sufficient. |
| Is the interpretation of results sufficiently substantiated by data? |  |  |  | Two of three studies used diagrams and quotations to demonstrate the interpretation of qualitative data however, with one study, quotations used to demonstrate themes were limited and not presented very clearly due to discussion alongside quantitative data. |
| Is there coherence between qualitative data sources, collection, analysis and interpretation? |  |  |  | Coherence between qualitative data, collection, analysis and interpretation was clearly demonstrated in two of three studies. With the study where this was not coherent, it was difficult to know whether themes were highlighted by quantitative or qualitative data as these were reported together. |
| Quantitative descriptive | Is the sampling strategy relevant to address the research question? |  |  |  | All studies used purposive sampling from suitable populations in order to address research questions. Inclusion criterion were detailed with consideration of different degrees of caregiving relationships potentially impacting results. |
| Is the sample representative of the target population? |  |  |  | Studies either screened for mental health conditions relevant to the research question or purposefully designed focus groups to capture different groups relevant to the target population. Consideration was given to the inclusion of not only primary caregivers but other caregivers who were also heavily involved in providing care |
| Are the measurements appropriate? |  |  |  | Measures used are appropriately justified with variables clearly defined |
| Is the risk of nonresponse bias low? |  |  |  | Only one study (Chan, 2009) compared the demographics and depression variables between the excluded and retained participants and found there to be no significant differences.  Non-response bias was not detailed in the remaining two studies but Kung (2003) used stepwise regressions to detect significant predictors of caregiver burdens in the small sample used. |
| Is the statistical analysis appropriate to answer the research question? |  |  |  | All studies used appropriate statistical analyses that were clearly stated and justified. Appropriate limitations of interpretations were outlined, such as a small sample size. Full details of analysis for Chan (2009) were in the full thesis paper. |
| Mixed methods | Is there an adequate rationale for using a mixed method design to address the research question? |  |  |  | Studies justified the use of mixed methods to obtain quantitative data that allowed comparisons to be made to other Chinese populations or other control groups. Quantitative data was used to contextualise the qualitative findings. |
| Are the different components of the study effectively integrated to answer the research question? |  |  |  | Two studies effectively integrated quantitative and qualitive components of research with clearly defined phases to study design. However, one study did not clearly describe how quantitative and qualitative components were integrated – qualitative data analysis appeared to take place completely separate to the quantitative analysis however, results were reported alongside each other making it difficult to ascertain which themes were highlighted by which results. |
| Are the outputs of the integration of qualitative and quantitative components adequately interpreted? |  |  |  | Meta-inferences were successfully outlined and the value of conducting a mixed methods study was clearly demonstrated in two studies. However, the integration of Kung’s (2003) was not clearly described and it was felt two separate studies could have been conducted. |
| Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? |  |  |  | No specific strategies to explore divergences and inconsistencies were outlined however, one study did outline divergences between quantitative and qualitative findings in the explanation of different themes. As the two other mixed methods studies sought to use quantitative measures to inform qualitative findings, it appeared that there were no glaring inconsistencies for example, quantitative data indicating high risk of limited social support networks which was reinforced by themes outlining different contributory factors to older adults’ loneliness. Nevertheless, this was not clearly described by most studies and could have been reported more clearly. |
| Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? |  |  |  | Most studies detailed suitable quantitative measures and qualitative interview or focus groups. However, one study (Kung, 2003) only used written notes of interviews and did not audio-record and transcribe qualitative data as is usual good practice. |

# **Appendix G**

# **University ethical approval**



# **Appendix H**

# **Participant Information Sheet**

*Project Reference Number:* SU\_19\_34

**Title of study**

Exploring the experiences of second-generation Hong Kong Chinese immigrants’ access to mental health support and services in Britain.

**Invitation Paragraph**

I am Natalie Cheung, a Trainee Clinical Psychologist at Staffordshire University completing a Doctorate in Clinical Psychology.

I would like to invite you to participate in this research project which forms part of my Professional Doctorate in Clinical Psychology research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

**What is the purpose of the study?**

The study aims to gain an understanding of second-generation Hong Kong Chinese immigrants’ experiences of accessing mental health support and services.

**Why have I been invited to take part?**

You have been invited to take part in this research study because you are aged 18 to 30 years old; you self-identify as someone that has accessed any mental health services or organisations (such as, charities); and you are a second-generation Chinese immigrant, living in Britain. A second-generation Chinese immigrant is an individual of Chinese ethnic origin that was either born in Britain or had left Hong Kong to live in Britain before the age of 10.

To take part in the study, you will need be physically and mentally well (e.g. you do not have any terminal illnesses or chronic health conditions; you are not likely to experience further distress from participating, for example those in an acute phase of mental health episode) and are able to speak fluent English for the duration of the interview.

**What will happen if I take part?**

After reading this information sheet you will be able to ask the researcher any questions you have about taking part in the study. When you are happy with the answers to your questions you will be asked whether you would like to take part in the study or not. You will have at least 24 hours, or as much time as you need, to decide if you want to take part.

If you choose to take part in the study, you will be asked to sign a consent form to confirm that you are willing to take part.

You will then arrange a time to speak to the researcher to complete an interview to answer some questions about your experiences of accessing mental health support and services in Britain. This is not a formal interview as such, but a recorded conversation hoping to gain an understanding of your experiences. You may be asked questions such as, “how would you describe your experiences of mental health difficulties?”.

This will be an interview with the researcher by telephone or using video calling (e.g. Skype). If you complete an interview by telephone or using video calling, you will be asked for some extra information (your full name, your location and an emergency contact number) so that emergency services can be contacted if the researcher has serious concerns about your safety. This information will not be linked with what you say in the interview and will only be used if the researcher is very concerned for your safety.

When you speak to the researcher, they will ask you to complete a short questionnaire about yourself. This will include questions about your age, your gender and mental health support you have received. You do not have to answer all these questions if you do not want to. The information is used to try and tailor the interview questions to each participant. The researcher will then ask you some questions about your experiences. This can take up to 90 minutes, but it may take longer if you have a lot of experiences that you wish to share.

This conversation will be audio recorded (tape recorded) so the researcher can look back at what you say. Once the interview data has been transcribed, any identifiable information will be removed, and the initial recording destroyed. The information you provide when you talk to the researcher will be looked at with the information that other participants provide when they talk to the researcher.

Any electronic data collected will be password protected and stored on an encrypted device. This data will most likely be audio only but when using video chat software, video data may also be collected. This data will only be collected with the consent of each participant and the researcher will indicate the start and end of the recording. Any physically signed consent forms and demographic questionnaires will be stored in a locked cabinet by the researcher, either at their home or at the university.

**Do I have to take part?**

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact us if you have any questions that will help you decide about taking part. If you decide to take part, we will ask you to sign a consent form and you will be given a copy of this consent form to keep.

You do not have to take part in this study. If you choose to take part and then change your mind, you can stop taking part in the study (withdraw from the study) until 26th February. Unfortunately, we will not be able to remove your information from the study after this date as the researcher will have started to look at comparisons across different participants’ responses. Please let the researcher know if you wish to stop taking part.

**What are the possible risks of taking part?**

During the interviews, we may discuss or explore some sensitive issues that could be upsetting for you. If this occurs, the researcher will pause the interview and only continue with the interview, if and, when you are ready to do so. Participation in this study may cause emotional distress and anxiety in some individuals. Information will be provided about mental health support services and you will be signposted to appropriate services if further support is required.

**What are the possible benefits of taking part?**

There may be no direct benefit to you. However, speaking about your experiences may give other people a better understanding of what it is like for second-generation Hong Kong Chinese immigrants accessing mental health services and support in Britain. This will be helpful to service providers in understanding how to provide more culturally appropriate services to people from Hong Kong Chinese backgrounds in Britain.

**Data handling and confidentiality**

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

Signed consent forms will be kept in a locked cabinet at university or at the researcher’s home. Interview transcripts will be stored electronically once transcribed on a password-protected laptop with each transcript password encrypted. Each participant will be given a pseudonym and patient identifiers will be kept in a separate encrypted word document.

Staffordshire university regulations require research data to be stored for 10 years after the end of the research project, after which it is destroyed. Hard copies of data will be stored in a secure archive room until the 10 years has passed. Personal data such as names and addresses will be destroyed as soon as possible following the research being conducted.

Data will only be shared within the research team or on a transcription app for research use only, following removal of any identifiable information. This data would be password protected so that only the research team can access this. After the data is transcribed using the application, it would be saved securely and deleted off this application. This will only be done with the participant’s consent.

**Data Protection Statement**

The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a ‘task in the public interest.’ You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

**What if I change my mind about taking part?**

You are able to withdraw your data from the study without having to give a reason for a period of time following the interviews up until the point at which the data begins to be processed.Withdrawing from the study will not affect you in any way.

If you choose to withdraw from the study before the data being processed, we will destroy any information that you have provided us as a part of this study. If it is after this date, anonymised interview data will still be used in the analysis.

**What will happen to the results of the study?**

Data from the interview will be anonymised, with pseudonyms provided during analysis. Anonymised quotations will be used in the write up of my thesis and this will be publicly available via the British library in due course. Anonymised data may also be published in a peer reviewed journal article.

**Who should I contact for further information?**

If you have any questions or require more information about this study, please contact me using the following contact details:

Natalie Cheung – Principal Investigator

Email: n.cheung@student.staffs.ac.uk

**What if I have further questions, or if something goes wrong?**

If this study has caused harm to you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information.

**Study supervisor:**

Dr Susan Ledwith

Consultant Clinical Psychologist

Clinical and Research Tutor  
Professional Doctorate in Clinical Psychology  
School of Life Sciences and Education  
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**Thank you for reading this information sheet and for considering taking part in this research.**

# **Appendix I**

# **Participant consent form**

**CONSENT FORM**

Title of Project: Exploring the experiences of second-generation Chinese immigrants’ access to mental health services in Britain.

Name of Researcher: Natalie Cheung

Please initial box

1. I confirm that I have read the information sheet dated 17.09.2020 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw up until data

processing begins (date 26th February, 2021) without giving any reason, without my medical care or legal rights being affected.

1. I understand that the information collected about me will be used (e.g. anonymised quotations from my interview) to support other research in the future and may be shared anonymously with other researchers.

1. I agree to take part in the above study.

Name of Participant Date Signature

Name of Person Date Signature

taking consent

# **Appendix J**

# **Interview schedule**

**About the person**

One of the reasons you have been asked to participate in this study is because you are Hong Kong Chinese, can you tell me a bit about what this means to you?

Ethnicity, Family, Food, Superstition, Religion, Language, Profession

Is there anything that makes you feel more connected to your Chinese heritage?

**Mental health**

One of the reasons you have been invited to take part in this study is because you have experienced some mental health difficulties, so can you tell me a bit about your mental health and how it’s changed over time?

What impact has this/these had on your life?

Personal relationships – friends, family, (members of the wider Chinese community)

Work

Your activities/daily living

**Access to services**

Have you sought any help for your mental health?

If yes, can you tell me more about the help you sought and your experiences of this?

What led you to seek help?

How did you go about seeking help?

What help did you receive?

Who did you receive help from and how long did you receive this help for?

If no, can you tell me more about the reasons for this?

Have you done anything to change/improve your mental health?

What influenced your decision to do this?

How did you go about making these changes?

What impact have these decisions had on your life?

**Summing up**

Looking back now, is there anything about your experiences that you would have wanted to be different?

What do you think will help you be able to continue to maintain your mental wellbeing?

Is there anything you would like to add to what we have talked about today?

Note: indented lines = possible prompts to be used

# **Appendix K**

# **Example of line-by-line coding of transcript**

A picture containing text, newspaper, document, screenshot

Description automatically generated

# **Appendix L**

# **Reflective diary extract**

Text, letter

Description automatically generated