Improving Access to Mental Health Services among East Asian Immigrants

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Abstract

Studies have consistently found that East Asian immigrants in North America are less likely to utilize mental health services even when they experience levels of distress comparable to Euro-Americans. Although factors that may prevent East Asian immigrants from seeking mental health care have been identified, few studies have explored ways to foster appropriate help-seeking and use of mental health services. Recent work on mental health literacy (MHL) and acceptance and commitment therapy (ACT) provides a potential framework for interventions to promote appropriate service utilization. The current dissertation consists of three separate studies.

Study 1 reviews the literature on help-seeking for mental health problems among East Asian immigrants living in Western countries to critically assess the relevance of the MHL approach as a framework for interventions to improve appropriate use of services. Modifications needed to develop a culturally responsive framework for mental health literacy are identified.

Study 2 explores the lay conceptions, perceived community attitudes, and factors that influence attitudes toward mental illness among East Asian women in Canada. Using a focus group methodology (6 focus groups of 47 participants), thematic analysis revealed causal theories (i.e., situational, biogenic, constitutional), discussions surrounding the challenges and complexities of defining mental illness, and pathologizing beliefs that shape community attitudes toward mental illness. Moreover, East Asian women discussed the dynamic social and cultural processes that influence their understandings and attitudes toward mental illness. Guided by the intersectionality framework, the findings of the study are discussed in the context of the participants' multiple and overlapping social identities at the individual, community and societal levels.

Study 3 examines the applicability of a MHL and ACT intervention among East Asian Canadian women using a mixed-methods approach. East Asian Canadian women ($N = 91$) were randomly assigned to a MHL, ACT or no-intervention control. Participants were assessed for their levels of stigma toward mental illness and attitudes toward help-seeking at pre-intervention, post-intervention and at 3-month follow-up. Participants also took part in focus group discussions following the interventions. The quantitative results indicated that ACT and MHL reduced mental illness stigma and improved attitudes toward help-seeking compared to the control group, and some of the effects were maintained at 3-months. Qualitative findings captured the process mechanisms of change and nuanced differences between the two interventions.

Overall, findings suggest that public mental health interventions that aim to improve attitudes toward mental illness and help-seeking need to be culturally and contextually tailored to improve relevance for East Asian communities. Implications for mental health promotion initiatives in diverse communities and culturally responsive interventions are discussed.

Résumé

Plusieurs études démontrent que les immigrants de l'Asie de l'Est qui s'établissent en Amérique du Nord sont moins susceptibles d'utiliser les services de santé mentale, même lorsqu'ils éprouvent des niveaux de détresse comparables aux Euro-Américains. Alors que les facteurs qui empêchent les immigrants de l'Asie de l'Est d'accéder aux services de santé mentale ont été identifiés, il n'y a pas beaucoup de recherche qui porte sur les moyens d'encourager la recherche d'aide appropriée et l'utilisation des services de santé mentale. Les travaux récents sur les connaissances en santé mentale (CSM) et la thérapie d'acceptation et d'engagement (ACT) fournissent un cadre potentiel pour les interventions visant à promouvoir l'utilisation appropriée des services. Cette thèse se compose de trois études distinctes.

L'étude 1 examine la littérature sur la recherche d'aide pour les problèmes de santé mentale chez les immigrants de l'Asie de l'Est vivant dans les pays occidentaux, afin de faire une évaluation critique de la pertinence de l'approche CMS comme cadre pour les interventions visant à améliorer l'utilisation appropriée des services. Les modifications nécessaires pour développer un cadre adapté culturellement pour l'éducation en matière de santé mentale sont identifiées.

L'étude 2 explore les conceptions laïques, la perception d'attitudes communautaires et les facteurs qui portent une influence sur les attitudes à l'égard des maladies chez les femmes de l'Asie de l'Est au Canada. En utilisant une méthodologie de groupe de discussion (6 groupes de discussion de 47 participants), l'analyse thématique a révélé des théories causales (par exemple, situationnelles, biogéniques et constitutionnelles), des discussions sur les défis et les complexités qui rendent la définition de la maladie mentale difficile et des croyances problématiques qui façonnent les attitudes de la communauté envers les troubles de santé mental. De plus, les

femmes de l'Asie de l'Est ont discuté des processus sociaux et culturels dynamiques qui influencent leur compréhension et leurs attitudes à l'égard de la maladie mentale. Les résultats de cette étude, guidés par une perspective d'intersection d'identités, sont discutés dans le contexte des multiples identités sociales des participants qui se chevauchent au niveau individuel, communautaire et sociétal.

L'étude 3 examine l'applicabilité d'une intervention CMS et ACT chez les Canadiennes de l'Asie de l'Est en utilisant une méthodologie mixte. Les femmes canadiennes de l'Asie de l'Est ($N = 91$) ont été assignées au hasard à un groupe intervention ACT, un group intervention CMS, ou à un groupe contrôle sans intervention. Les niveaux de stigma envers la maladie mentale et les attitudes envers la recherche de soins de santé mentale des participants ont été évalués avant et après l'intervention, ainsi qu'au suivi de 3 mois. Les femmes ont aussi participé à des discussions de groupes à la suite des interventions. Les résultats quantitatifs indiquent que les interventions ACT et CMS ont réduit la stigmatisation de la maladie mentale et ont amélioré les attitudes à l'égard de la recherche d'aide par rapport au groupe qui n'a pas reçu d'intervention, avec certains effets maintenus à 3 mois. Les résultats qualitatifs ont permis de cibler les mécanismes de changement de processus et les différences nuancées entre les deux interventions.

Les résultats de ces études indiquent que les interventions publiques qui visent à améliorer les attitudes à l'égard de la maladie mentale et de la recherche de services doivent être adaptées à la culture et au contexte afin d'améliorer leur pertinence pour les communautés originaires de l'Asie de l'Est. La discussion comprend des implications pour les initiatives de promotion de la santé mentale dans les communautés diverses et pour les interventions adaptées à la culture.

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Preface and Contribution of Authors

This dissertation contains five chapters including three manuscripts, all of which I am the primary author. I was responsible for completing the literature reviews, conceptualization of the studies, data collection, analyses and write up of the manuscripts. I worked closely with my research supervisor, Dr. Laurence Kirmayer, who provided guidance on all steps of the research process, and members of the dissertation committee, Dr. Kenneth Fung, Dr. Andrew Ryder, and Dr. Josephine Wong.

Dr. Kirmayer provided feedback and consultation throughout all stages of the dissertation, including conception of research questions, study design, selection of instruments and development of focus group questions, data analysis and interpretation, and in-depth editorial comments. He is co-author in all three manuscripts presented in this dissertation.

Dr. Ryder provided consultation on the study design, data analysis and interpretation of the third manuscript. He also provided in-depth editorial comments and his expertise on acculturation on the first manuscript. He is co-author in the first and third manuscripts.

I worked closely with Dr. Fung and Dr. Wong for the second and third manuscripts They both provided feedback on the early conceptual ideas of the research study design. The intervention materials that was used for the third manuscript comes from their earlier work with Asian men. They both provided feedback on the qualitative data analysis on the second and third manuscripts. They also provided editorial comments on the second and third manuscripts. They are both co-authors in the second and third manuscripts.

Momoka Watanabe was involved in the qualitative analysis of the third manuscript, serving as a coder. She also conducted the focus groups for the third manuscript and co-facilitated some of the interventions. She is a co-author on the third manuscript.

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Introduction

Addressing the mental health disparities among immigrant, ethno-cultural and racialized groups is one of the top priorities set out by the Mental Health Commission of Canada (MHCC, 2012). Upon arrival, immigrants tend to have better health status than the Canadian-born population; however, over time, particularly among racialized immigrant groups, health outcomes, including mental health, decline to similar rates as the Canadian born population (Gushulak, Pottie, Roberts, Torres, & DesMeules, 2011; MHCC, 2016; Newbold, 2005). Despite similar rates of psychological distress and other mental health concerns as non-immigrants however, economic analysis in Ontario indicated that the average cost of mental health services among immigrants is 56 percent less than non-immigrant individuals, due to lower rates of use of the mental health system (MHCC, 2016). Thus, there is a critical need to better understand how to address mental health service use disparities among immigrant populations.

East Asian migrants (i.e., migrants from China, Korea, Japan) account for approximately a quarter of the ethnic minority population in Canada, and a majority are first-generation migrants (Statistics Canada, 2011). Consistent with the trend found by the MHCC (2016), even with universal health care in Canada, East Asian migrants are less likely to use mental health services than European Canadians (Gadalla, 2010; Tiwari & Wang, 2008), even when they experience severe and chronic mental illness (Chen & Kazanjian, 2005; Chen, Kazanjian, Wong, & Goldner, 2010). They may also delay using mental health services when needed. A large population study in Ontario reported that Chinese immigrants with schizophrenia were likely to present with more severe symptoms at initial hospitalization, compared to South Asians and the general population, suggesting delay in service use (Chiu, Lebenbaum, Newman, Zaheer, & Kurdyak, 2016).

Studies have identified various factors that may contribute to disparities in mental health service use, including mental health literacy (MHL), stigma and shame, and structural barriers (Thomson, Chaze, George, & Guruge, 2015). The literature suggests that East Asian migrants may be less likely to recognize symptoms of mental illness (Wong, Lam, & Poon, 2010), have diverse beliefs about the causes of mental health problems that diverge from the Western medical model (Tieu, Konnert, & Wang, 2010) and may be less familiar with how to access and navigate the mental health system (Kung, 2004). Although these factors can act as barriers to mental health services, the links between mental health related knowledge and help-seeking intentions and behaviours are more complex. Decision making about seeking treatment is often not only a rational, cognitive decision making process, but also a social process that involves community expectations, cultural scripts and negotiations about how to interpret and respond to symptoms and illness, so that many of the determinants of help-seeking are located in the social environment (Kirmayer, Gomez-Carrillo, & Veissière, 2017; Pescosolido & Boyer, 2010; Ramstead, Veissière, & Kirmayer, 2016).

The applicability of the mental health literacy framework for East Asian immigrants needs closer examination. Currently, the MHL model does not include diverse ways in which distress is experienced, interpreted and explained. Moreover, there is a need to integrate diverse treatment options and migrant specific barriers that challenge access to care. Thus, one of the objectives of this doctoral dissertation was to examine the relevance of the mental health literacy model for East Asian immigrants and to provide a culturally responsive framework.

Stigma and shame related to having mental illness has been highlighted as a critical barrier to mental health care among East Asian migrants (Abe-Kim et al., 2007; Sue, Cheng, Saad, & Chu, 2012). Attitudes toward mental illness are shaped by dynamic influences at the micro (e.g.,

illness characteristics), meso (e.g., social and media influences) and macro (e.g., laws and policies) levels (Pescosolido, Martin, Lang, & Olafsdottir, 2008). Moreover, lay conceptions or beliefs surrounding mental illness, including causal attributions, are closely tied to attitudes toward mental illness (Haslam, Ban, & Kaufmann, 2005). For instance, assigning biogenic causes of certain mental illnesses may actually increase stigmatizing attitudes compared to psychosocial causes (Kvaale, Gottdiener, & Haslam, 2013). Thus, the second objective of this dissertation was to examine lay conceptions and attitudes toward mental illness among East Asian immigrant women. Moreover, we aimed to explore the intersecting social processes and identities, involving aspects of gender, ethnicity and migration status, that shape and maintain community attitudes.

Finally, although studies have identified various barriers to mental health care among East Asian immigrants (e.g., Leong & Lau, 2001; Sue et al., 2012), there is dearth of evidence regarding the suitability of current intervention models to improve attitudes toward mental illness and help-seeking. Education or information-based interventions and psychotherapy-based interventions are two approaches that have garnered some evidence in studies with the general population (Thornicroft et al., 2016). The third objective of the dissertation was to examine the effectiveness and cultural relevance of an education-based mental health literacy internvention and an acceptance and commitment therapy intervention among East Asian immigrants. Each study is presented in its own chapter and the findings of the three studies are integrated in the final chapter, which also discusses overarching implications for addressing disparities in access to mental health care and steps toward culturally responsive community interventions.

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CHAPTER 1

Literature Review

Over the past two decades, despite having a better understanding of the structural and cultural factors that contribute to the underutilization or delay in mental health service use, little progress has been made in reducing mental health disparities among Asian migrants to Western countries (Okazaki, Kassem, & Tu, 2014; S. Sue, Cheng, Saad, & Chu, 2012). Understanding the process of help-seeking, including barriers to help-seeking, is needed to develop effective interventions. Barriers to mental health care can be broadly categorized into structural, cognitive and affective domains. This initial overview will provide a brief review of the barriers to help-seeking, with a focus on cognitive and affective domains that are relevant to the three studies presented in the following chapters.

Structural barriers to mental health care continue to be a critical factor contributing to mental health disparities among migrants. Cultural and linguistic incompatibility between the patient and the healthcare provider has been highlighted as a prominent deterrent to seeking mental health care for Asian migrants (Fung & Wong, 2007; S. Sue et al., 2012; Thomson, Chaze, George, & Guruge, 2015). Asian migrants may also experience discrimination within the health care system that leads to distrust in social institutions (Thomson et al., 2015). Using random-digit dialing method, telephone interviews of a nationally representative U.S. sample suggested that compared to European Americans, Asian Americans were less satisfied with their health care provider and reported that their health care provider was less likely to talk to them about mental health and lifestyle issues (Ngo-Metzger, Legedza, & Phillips, 2004). Moreover, economic challenges as a result of the settlement process can affect access to care, including the

lack of transportation to health services, lack of access to childcare, and long working hours (Leong & Lau, 2001; Thomson et al., 2015).

In addition to structural barriers to care, cognitive processes also affect help-seeking and access to services. These include, unfamiliarity with the healthcare system, knowledge of treatment options, and different ways of conceptualizing mental health issues (Leong & Lau, 2001). East Asian migrants, particularly newcomers, may be less familiar with how to navigate and access mental health services, including how and when to request interpreters and cultural brokers (Kung, 2004; Thomson et al., 2015). Moreover, they may use different ways to express and label their distress, and endorse more social and interpersonal causes for mental illness. Different causal explanations may lead to a preference for using informal support systems, religious or spiritual methods of coping and traditional medicines (Lee & Chan, 2009; Sin, Jordan, & Park, 2011). Causal attributions for mental illness are also closely tied to attitudes and affective responses that influence help-seeking behaviours (Haslam, Ban, & Kaufmann, 2005).

Social stigma and shame about mental illness can deter help-seeking among first- and second-generation East Asian migrants (Cheng, 2015; Fogel & Ford, 2005; Georg Hsu et al., 2008). The effects of stigma have more detrimental effects when an individual is labelled during treatment (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). Thus, stigma and shame influence help-seeking pathways, including delay to seek mental health services or preference for alternative or informal treatments. Among a community sample of Chinese Americans, for example, although traditional Chinese medicine was perceived as not as effective as Western psychiatric treatment, it was perceived as less stigmatizing (Yang, Phelan, & Link, 2008). Therefore, although knowledge of treatment options and perceived efficacy influence help-seeking behaviours, community attitudes and shame associated with accessing psychiatric

services also determine pathways to care (Yang et al., 2008). Together, the affective, cognitive and structural barriers illustrate that accessing mental health service is a complex social process that is tied to community attitudes, shared understandings and expected actions regarding mental illness.

Lay Conceptions of Mental Illness

Cultural dynamics and social meanings of illness can influence how distress is experienced, interpreted and explained (Kleinman, 1988). Explanatory models also shape how distress is communicated, beliefs about treatment, and pathways to diverse forms of care (Kirmayer & Bhugra, 2009; Kleinman, 1980). Furthermore, help-seeking and access to mental health services is not solely based on one's voluntary action, but also the influence of complex social ties and networks (Pescosolido, 2006). Labels, expectations and cultural scripts are an integral part of how people perceive the need for care and how they evaluate the sociocultural acceptability of available treatment options (Kirmayer, Gomez-Carrillo, & Veissière, 2017; Pescosolido & Boyer, 2010).

All cultures have their own explanations of abnormal behaviours and indigenous healing methods (D. W. Sue & Sue, 2012). Western medicine endorses a medical model of understanding mental illness, and seeing a physician, psychiatrist or psychologist are viewed as appropriate forms of treatment. However, traditional ways of understanding and healing persist in most cultures. For example, some Chinese migrants may view mental health issues as a lack of harmony in the energy flow of the body (Green, Bradby, Chan, & Lee, 2006), and indigenous healing in East Asian cultures often incorporates spiritual and religious traditions and may also involve herbs and acupuncture (Chung & Bemak, 2006; Yeh et al., 2004). East Asian immigrants to Western countries may be less likely to endorse biological causes (e.g., chemical

imbalance in the brain) for mental illness than the general population (Pang, 1996; Tieu, Konnert, & Wang, 2010).

Although biological causes for mental illness can be associated with support for treatment and help-seeking, it can also increase stigmatizing attitudes (Haslam & Kvaale, 2015; Pescosolido et al., 2010). Conversely, some indigenous causal beliefs may delay help-seeking but be less stigmatizing and serve to preserve the individual's moral standing in their community (Yang et al., 2010). In a study conducted in China with Chinese family members of outpatients with schizophrenia, the indigenous explanatory model of 'excessive thinking' was related to more social inclusion and less stigmatizing attitudes than being labelled as mentally ill (Yang et al., 2010). Similarly, East Asians may prefer social and interpersonal causes to explain their distress (Y. J. Wong, Tran, Kim, Van Horn Kerne, & Calfa, 2010; Yang et al., 2010; Yang & Wonpat-Borja, 2012). Studies have indicated that when provided with a vignette of a person experiencing symptoms consistent with depression, Chinese immigrants were more likely to report interpersonal conflict, situational causes and personality characteristics, such as "being a nervous person" as contributing to depression (Tieu et al., 2010). Among Korean immigrant seniors, depression was normalized, perceived as transitory, and was not necessarily considered an "illness" (Pang, 1996).

Over time, as part of the processes of acculturation, immigrants tend to integrate the beliefs, attitudes, and modes of presentations of mental health problems consistent with their host culture (S. X. Chen & Mak, 2008). Among Korean American seniors, for example, acculturation was positively associated with recognition of depressive symptoms and beliefs about the effectiveness of Western interventions (Jang, Gum, & Chiriboga, 2011). Other studies have indicated that acculturation is closely tied to biological causal beliefs and psychologizing beliefs

(i.e., understanding behaviour in terms of the person's environment or life history; Glovsky & Haslam, 2003; Jang et al., 2011; Parker, Chan, & Tully, 2006; D. Wong, Lam, Poon, & Chow, 2012). Although second-generation Asian migrants are more acculturated and do not face the same linguistic challenges as first-generation migrants, mental health disparities persist across generations. Using the Canadian Community Health Survey-1.1 data, Chen, Kazanjian, and Wong (2008), examined the rate of mental health service use among first-generation Chinese immigrants and Canadian-born Chinese Canadians in British Columbia. Both groups reported lower rates of service utilization, suggesting that cultural factors other than language barriers accounted for this discrepancy. Similar findings were reported in the U.S., using data from a national survey; first- and second-generation Asian Americans reported lower rates of all types of mental health related service use (Abe-Kim et al., 2007). This pattern was found even among those who had a probable DSM-IV diagnosis during 12-month period, indicating a need for services. In addition to different ways of conceptualizing mental health concerns, stigma and shame related to mental illness have been highlighted in the literature as possible barriers that maintain disparities in mental health service use (Abe-Kim et al., 2007; Ting & Hwang, 2009).

Stigma of Mental Illness

Stigma related to mental illness has been identified as one of the prominent barriers to mental health care among East Asian immigrants (Ihara, Chae, Cummings, & Lee, 2014; Leong & Lau, 2001). Following Erving Goffman's (1963) seminal work on stigma, substantial progress has been made in understanding the effects of stigma among those who live with mental illness. The conceptualization of stigma was furthered by Link and Phelan (2001) who defined stigma with several interrelated components that involves labeling, stereotyping, separating, status loss and discrimination (Link & Phelan, 2001). These stigmatizing processes are contingent upon the

existence of power (e.g., social, economic, and political), which constructs who is considered different and associated stereotypes (Link & Phelan, 2001).

Several studies have indicated that Asian Americans tend to endorse more stigmatizing attitudes toward mental illness than do European Americans (Cheng, 2015; Fogel & Ford, 2005; Georg Hsu et al., 2008). Cultural emphasis on social standing, saving 'face,' and reputation make stigma a particularly salient issue among individuals of East Asian descent (Li, 2001; Yang & Kleinman, 2008). Moreover, East Asian immigrants face marginalized status as an ethnic minority and thus, may experience 'double stigma' when they are labelled as having a mental illness (Gary, 2005). Studies have indicated that stigma of mental illness is negatively associated with help-seeking attitudes among Asian Americans (Clement et al., 2015; Shea & Yeh, 2008).

Interventions that aim to reduce stigma have garnered evidence for their effectiveness in fostering more positive views about mental illness and help-seeking (Thornicroft et al., 2016). A review of the literature suggests that information and contact-based interventions are effective in improving mental health knowledge and attitudes (Thornicroft et al., 2016). Psychotherapy-based interventions, such as acceptance and commitment therapy are also starting to gain empirical support in reducing stigma (Hayes et al., 2004; Masuda et al., 2007). This dissertation focuses on a knowledge-based intervention, using the mental health literacy framework, and a psychotherapy-based intervention, specifically, acceptance and commitment therapy, as potential intervention strategies for East Asian immigrant communities.

Mental Health Literacy

Mental health literacy (MHL) is one framework that has been used for knowledge-based interventions to reduce stigma and increase appropriate help-seeking. MHL assumes that people

can acquire basic knowledge about mental health problems and services that can guide their subsequent help-seeking behaviour. The MHL approach stems from the observation that while most of the general public has knowledge about how to prevent, recognize and access services for physical illnesses (e.g., knowing about the health consequences of smoking, recognizing symptoms of a stroke, or the need to eat a balanced diet), many populations have limited knowledge on recognizing and understanding causes of mental illness, and some are skeptical of certain interventions, including the use of medication (Jorm, 2012).

A large national study in the mid 1990's in Australia revealed that most individuals were unable to provide the correct psychiatric label to vignettes illustrating depression and schizophrenia (Jorm et al., 1997). Moreover, the study suggested that participants had mixed attitudes toward mental health professionals. When participants were asked to rate the helpfulness of various health care professionals for depression and schizophrenia, psychiatrists and psychologists were perceived to be less helpful compared to counsellors (a much less regulated profession in Australia) or general practitioners (Jorm et al., 1997).

Recognizing the need to increase the public knowledge and perceptions toward mental illness and mental health professionals, Jorm and colleagues (1997) coined the term 'mental health literacy' to capture, "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (p.182), with the aim of developing interventions to increase public knowledge and to encourage individuals to take more appropriate actions with respect to mental health. MHL is not only a broad and extensive framework that captures many components that influence help-seeking behaviours, it can be used as a tool to disseminate knowledge and raise awareness at the individual level and as a public health intervention.

According to Jorm (2012), MHL can be broken down into five components, including: (a) the knowledge of how to prevent mental disorders; (b) recognition of when a disorder is developing; (c) knowledge of help-seeking options and treatments available; (d) knowledge of effective self-help strategies for milder problems; and (e) mental health first aid skills to support others who are developing a mental disorder or are in a mental health crisis. Jorm (2012) emphasizes that MHL involves not only having knowledge about mental health, but having "knowledge that is linked to the possibility of action," (p. 1) including help-seeking behaviours.

In Canada, a MHL program focusing on understanding mental health and mental illness, different types of mental illness, impact of stigma and help-seeking led to improvements in knowledge and attitudes toward mental illness among secondary students. Moreover, gains were maintained at 2-month follow-up (Mcluckie, Kutcher, Wei, & Weaver, 2014). However, some researchers have questioned if improvements in MHL is effective in fostering less stigmatizing attitudes toward individuals with mental illness. For instance, a trend analysis using population surveys in Germany suggested that although MHL has increased in the general public, desire for social distance toward individuals with depression and schizophrenia persist (Angermeyer, Holzinger, & Matschinger, 2009). Similarly, biological explanations of mental disorders which frame it as 'a disease like any other' can reduce personal blame; however, it can also increase essentialist thinking, and implies that the disorder is a fixed trait, leading to more pessimistic views about recovery (Haslam & Kvaale, 2015; Pescosolido et al., 2010).

The applicability of the MHL model to East Asian migrants has yet to be determined. MHL is a Western framework that uses a scientific understanding of mental illness that may conflict with some traditional views of mental health (Jorm, 2012). Considering the diverse ways in which distress is conceptualized, experienced and expressed, and that help-seeking may

include various pathways that diverge from medication and psychotherapy (Kirmayer & Bhugra, 2009; Kleinman, 1980), there may be a need to modify the MHL model to increase its cultural adaptiveness.

Acceptance and Commitment Therapy

ACT is considered a 'third-wave' behavioural therapy that focuses on increasing psychological flexibility. Psychological flexibility as defined by ACT consists of six core processes, including: acceptance of internal experiences rather than avoidance; *defusion* or distancing from thoughts; increasing present moment awareness; understanding self as context; identifying values; and committing to behaviours that are consistent with one's values. The model of psychological flexibility was originally developed to understand psychopathology, and to change the impact of negative thoughts and feelings, and foster more adaptive behaviours (Hayes, Strosahl, & Wilson, 2011). More recently, ACT has been applied to reduce stigma and prejudice. Rather than a direct attempt to change stigmatizing thoughts, ACT aims to change how one relates to one's thoughts and choosing more pro-social behaviours (Masuda et al., 2012). Two studies have provided preliminary evidence that ACT may be an effective model to reduce stigma related to mental illness (Hayes et al., 2004; Masuda et al., 2012)

The ACT workshops to reduce stigma tend to focus on experiential and didactic exercises that build participants awareness to the automatic process of stigma, practicing mindfulness and acceptance skills, distancing oneself from stigmatizing thoughts, and getting participants to examine their values (Masuda et al., 2012). Among college students in the U.S., a 2.5-hour ACT intervention led to reduction in stigmatizing attitudes regardless of participant's level of psychological flexibility, whereas a mental health education comparison condition was only

effective among those with higher psychological flexibility (Masuda et al., 2007). At one-month follow-up, participants continued to report less stigmatizing attitudes than at pre-intervention (Masuda et al., 2007). Similarly, addictions counsellors were randomized to either a 6-hour ACT workshop, multicultural training, or education workshop about methamphetamine. Both ACT and multicultural training led to a significant reduction of stigmatizing attitudes among substance abuse counsellors (Hayes et al., 2004). However, at three-month follow-up, results were maintained only for the ACT condition. Moreover, ACT also decreased burnout at three-months following the workshop, suggesting that the workshop also promoted participant's mental health (Hayes, et al., 2004). Hence, preliminary findings suggest that compared to a knowledge-based intervention, an ACT workshop may be effective among even those who are not psychologically flexible at pre-intervention, and has the potential to have a longer-term impact than other interventions.

Current Gap and Research Objectives

The current literature suggests that lay conceptions and diverse explanatory models of illness shape attitudes and pathways to mental health care. There is a need to better understand community attitudes and conceptualization of mental health issues among East Asian immigrant communities. We specifically focus on East Asian women to better understand the intersections of gender, migrant status, and ethnicity on individuals' attitudes toward mental health. Gender hierarchy, male domination and gender roles may place immigrant women in more vulnerable positions that affect their mental health, and access to services (Donnelly et al., 2011; O'Mahony & Donnelly, 2007). Using qualitative focus groups, we aimed to capture diverse understandings

of mental health and mental illness, perceived community attitudes, and the role of multiple intersecting social identities in shaping these beliefs.

Although barriers that contribute to the underutilization of mental health services among East Asian migrants have been identified, there is a lack of literature on promoting appropriate service use. The MHL and ACT frameworks appear to be two promising models that may reduce stigma related to mental illness and foster help-seeking when needed. However, the applicability of these two models among East Asia migrants has yet to be established. One of the main barriers to mental health care among migrants is the lack of culturally and linguistically responsive options (Thomson et al., 2015). Similarly, many anti-stigma and mental health education initiatives do not consider cultural differences in conceptualizing mental health. Thus, the following studies aimed to critically assess the cultural relevance of MHL and ACT interventions. In the following chapters, we first examine the literature on MHL and help-seeking among East Asian migrants and propose a more culturally responsive model that integrates diverse ways of experiencing and conceptualizing mental illness, and pathways to care. Then, using a mixed-methods approach, we examine the effectiveness of a MHL and ACT intervention to reduce stigma of mental illness and improve attitudes toward mental health services.

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CHAPTER 2

Toward a Culturally Responsive Model of Mental Health Literacy:

Facilitating Help-Seeking among East Asian Immigrants to North America

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Abstract

Studies have consistently found that East Asian immigrants in North America are less likely to use mental health services even when they experience levels of distress comparable to Euro-Americans. Although cultural factors that may prevent East Asian immigrants from seeking mental health care have been identified, few studies have explored ways to foster appropriate help-seeking and use of mental health services. Recent work on mental health literacy provides a potential framework for strategies to increase appropriate help-seeking and use of services. This paper reviews the literature on help-seeking for mental health problems among East Asian immigrants living in Western countries to critically assess the relevance of the mental health literacy approach as a framework for interventions to improve appropriate use of services. Modifications needed to develop a culturally responsive framework for mental health literacy are identified.

Keywords: mental health literacy, help-seeking, East Asian immigrants, access to mental health services

Toward a Culturally Responsive Model of Mental Health Literacy: Facilitate Help-Seeking among East Asian Immigrants to North America

With increasing ethnocultural diversity in Canada and the U.S., significant disparities in mental health service utilization have become evident among many ethnocultural minority groups, including immigrants from Asian countries (Alegria et al., 2008; Tiwari & Wang, 2008). Strategies to address these disparities generally focus on promoting appropriate use of existing mental health services. Although progress has been made in understanding help-seeking pathways among East Asian immigrants in the past decade (Sue, Cheng, Saad, & Chu, 2012), mental health policies and practices tend to favour generic approaches that may not address the unique needs of Asian immigrants (e.g., Hall & Yee, 2012). In one common public health approach, mental health literacy (MHL) programs present information on common mental health problems, including their recognition, coping strategies, and appropriate help-seeking (Jorm, 2012). However, MHL generally adopts a "one-size-fits-all" approach that assumes that the health information needs and modes of reception are similar among diverse peoples. Yet there is a substantial literature on ethnocultural variations in illness explanations and help-seeking that raises doubts about the applicability of a generic approach (Alegria et al., 2010; Kirmayer & Bhugra, 2009). Integrating knowledge of ethnocultural variations in symptom attribution, coping and help-seeking into MHL programs could improve their uptake and effectiveness.

In this paper, we consider some cultural issues common among Asian immigrants that have implications for the design of MHL programs. Specifically, we focus on East Asian immigrants, defined as individuals whose society of origin is influenced in part by Confucian cultural values (i.e., China, Hong Kong, Taiwan, Korea and Japan; Ryder, Dere, Yang & Fung, 2012) to gather enough research evidence among a cultural group with some overlap in cultural

values and migration experiences. Immigrants from East Asia are among the fastest growing migrant groups in Canada and the U.S. (Statistics Canada, 2011; United States Census Bureau, 2012). Reports have indicated East Asian immigrants in North America tend to underutilize mental health services despite similar rates of distress to the general population (e.g., Tiwari & Wong, 2008; U.S. Department of Health and Human Services [DHHS], 2001). Moreover, East Asian immigrants who do use mental health services tend to report more severe symptoms compared to Euro-Americans (U.S. DHHS, 2001), suggesting that they may delay seeking mental health services or consider them only as a last resort for more severe conditions. The literature on mental health help-seeking among East Asian immigrants has identified several potential barriers to care, including: stigma of attending mental health services or receiving a psychiatric diagnostic label; limited knowledge of the types of services available; lack of availability culturally-sensitive services; and language barriers (Leong & Lau, 2001; Sin, Jordan, & Park, 2011). Some of these barriers could be addressed by a mental health literacy intervention.

Mental Health Literacy and Help-Seeking

MHL provides a framework to improve service use through public education (Jorm, 2012; Jorm et al., 1997). The MHL approach assumes that people can acquire basic knowledge about mental health problems and services that can guide their subsequent help-seeking behaviour. The interest in mental health literacy stems from the observation that while most of the general public has knowledge about how to prevent, recognize and access services for common physical health problems (e.g., knowing about the health consequences of smoking, recognizing symptoms of a stroke or the need to eat a balanced diet), many people have limited knowledge about the symptoms of mental illness and are unaware of, or skeptical about, the

effectiveness of biomedical, psychiatric or psychological interventions, including the use of medication (Jorm, 2012).

Jorm and colleagues (1997) coined the term "mental health literacy" to refer to the "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (p. 182). According to Jorm (2012), MHL can be broken down into five components, including: (a) recognition of symptoms of mental illness; (b) knowledge of risk factors of mental illness; (c) knowledge of help-seeking options and treatments available; (d) knowledge of effective self-help strategies for milder problems; and (e) mental health first aid skills to support others who are developing a mental illness or are in a mental health crisis. MHL involves not only having knowledge about mental health, but also having, "knowledge that is linked to the possibility of action" (p. 1; Jorm, 2012) including help-seeking behaviours. For instance, being able to recognize symptoms of mental illness and providing a psychiatric label can activate a schema about appropriate action that the individual should engage in, such as seeking professional help (Jorm, 2012). In a study of adolescents and young adults in Australia, being able to correctly provide the psychiatric label of either depression or schizophrenia to a vignette was associated with recommending that the person in the vignette seek professional help or take medication (Wright, Jorm, Harris, & McGorry, 2007). Correct labelling was also associated with less likelihood of endorsing potentially harmful self-help strategies (e.g., smoking marijuana, managing alone; Wright, et al., 2007), whereas giving a label other than depression (e.g., emotional problem) to a depression vignette was associated with the view that the person would be able to deal with the problem on his or her own (Jorm, et al., 2006).

Despite its potential relevance, the applicability and effectiveness of the MHL model for East Asian immigrants has yet to be determined. To examine the potential cultural fit and

relevance of the mental health literacy approach for East Asian immigrants, we conducted a literature review on knowledge and attitudes toward mental illness and help-seeking behaviours. Specifically, we examined the literature related to the following components of mental health literacy: (a) recognition of symptoms of mental illness; (b) beliefs about risk factors and causes of mental illness; (c) knowledge of help-seeking options and treatments available; and (d) knowledge of effective self-help strategies for milder problems. Based on this review, we propose a culturally responsive model of MHL for East Asian populations. The model can also guide adaptation of MHL for other ethnocultural groups.

Method

Search Strategy

We conducted a literature search using PsychINFO, PubMed, Medline, and Web of Science in consultation with a medical librarian to identify relevant references. Articles published in English from 1987-2016 were included in the search. Key search terms included: [mental health literacy] OR [barriers to mental health service use] OR [mental health knowledge] OR [self-care behaviors] OR [help-seeking] AND [Asian immigrant], including separate searches for [Chinese] OR [Korean] OR [Japanese] immigrant. Recent research articles in peer-reviewed journals were included and were supplemented based on the reference lists of the retrieved articles.

The search focused on research among East Asian immigrants (i.e., Chinese, Korean and Japanese) to Western countries (i.e., U.S., Canada, and Australia), but included papers that had South and Southeast Asian participants under the umbrella term “Asian American.” We included published papers that used the mental health literacy framework and methodology consistent with Jorm and colleagues (1997), in addition to papers that examined more broadly, beliefs,

knowledge, attitudes towards mental illness and its association with help-seeking among East Asian immigrants. We excluded dissertation abstracts, editorials, review papers, and studies that did not include East Asian participants. Figure 1 presents the search results according to the PRISMA guidelines (Moher, Liberati, Tetzlaff & Altman, 2009). The first author reviewed the articles and summaries were discussed among all of the authors to extract key issues related to the cultural fit or adaptation of the MHL dimensions.

Results

We identified 20 studies that included some aspect of mental health literacy, with most including more than one component of mental health literacy in the study: recognition and labelling (8 studies), beliefs about risk factors and causes (8), knowledge and attitudes toward help-seeking options (11), and self-help strategies (11).

Settings and Samples

All studies were conducted in metropolitan areas. The majority of the studies used convenience or purposive sampling, most often through community organizations. Most studies focused on the general adult population; however, we identified four studies that examined older immigrants, typically 60 years and older, and five studies that included participants who had a diagnosis of a mental illness. While not all studies provided information on the number years since immigration, only three studies focused on immigrants who had arrived within the past ten years, while 14 studies indicated that the participants' mean years since immigration was longer than ten years. Eleven studies took place in the U.S., six in Australia, and three in Canada. Thirteen studies pertained to Chinese immigrants, four studies with Korean immigrants, and three included individuals from diverse Asian backgrounds. Of those three studies, one study (Fan, 1999) consisted of primarily Vietnamese (42.5%), followed by Chinese (27.7%), Filipino

(12.8%) and Malaysian (8.5%). The second study (Wong, Tran, Kim, Van Horn Kerne & Calfa, 2010) consisted primarily of Chinese Americans (30.6%), followed by Indian (14.6%), Vietnamese (14.2%), Filipino/a (11.9%), Taiwanese (9.1%), Korean (4.1%) and "other Asian" (15.5%). The third paper (Zhang, Snowden & Sue, 1998), did not report specific ethnic group composition. Eleven studies were quantitative, five studies were qualitative, and four were mixed-methods.

Recognition of Symptoms and Labelling

Across the studies that examined recognition and knowledge of mental illness, all but one examined depression and/or psychosis. Four studies (Klimidis, Hsiao, & Minas, 2007; Tieu, Konnert, & Wang, 2010; Wong, Lam, & Poon, 2010; Wong, Lam, Poon, & Chow, 2012) examined MHL among Asian immigrants using adapted versions of vignettes from Jorm and colleagues (1997). In this method, participants are presented with vignettes of depression and/or schizophrenia, which are written to fit the diagnostic criteria of the DSM (American Psychiatric Association, 1994) and/or ICD-10 (World Health Organization, 1992). After each vignette, participants are asked, "What would you say, if anything, is wrong with the person?" and "How do you think this person would be best helped?" Three studies left this question open ended with responses being categorized and coded afterwards (Tieu et al., 2010; Wong, Lam et al., 2010 & 2012), while one study (Klimidis et al., 2007) provided options that participants could choose (e.g., "physical problem," "mental or emotional problem," "stress"). Participants are then asked their opinion on various types of professionals, non-professional help, medications and if they perceive them to be "helpful", "harmful" or "neither helpful nor harmful." In the adapted versions, the vignettes were translated to participants' native languages, and participants had the option to choose traditional/alternative treatment options (e.g., Tieu et al., 2010).

The four studies that used this method were community-based surveys with mainly first-generation Chinese immigrants, with all studies except one taking place in Australia. The studies generally found that East Asian immigrants were less likely to recognize symptoms of depression and schizophrenia compared to the general public; however, there was some variation in their perceptions toward help-seeking. For example, surveys of first-generation Chinese-speaking participants (n = 200) from Melbourne, Australia (Wong, Lam et al., 2010) and among older first-generation Chinese immigrants (n = 53) in Alberta, Canada (Tieu et al., 2010), found that Chinese immigrants were less likely to recognize depression compared to the general public (14% versus 65% in Australia and 11% versus 74% in Canada; Wong, Lam et al., 2010; Tieu et al., 2010). However, more participants reported that the person in the vignette was suffering from stress, anxiety, or another emotional disturbance (Tieu et al., 2010; Wong, Lam et al., 2010). When participants were cued to think about a "psychological disorder," about 21% of the participants, (compared to 11% prior to the cue) were able to label the vignette as depression (Tieu et al., 2010). Importantly, the great majority (91%) of Chinese Australian participants acknowledged that the person in the vignette needed help even when most did not label the vignette as depression (Wong, Lam et al., 2010). Thus, even though participants did not apply the "depression" label to the vignette, more individuals recognized that the person was suffering from emotional distress, and most acknowledged the need for help.

One study reported that Chinese immigrants (n = 418) were more likely than a representative Australian sample to provide a psychiatric label to depression and psychosis vignettes (Klimidis et al., 2007). About half of the participants chose the label "depression" and "schizophrenia" for the two vignettes. Noting that most participants also endorsed broader labels such as "stress" and "mental or emotional problems," the authors argued that these labels could

normalize depression and prevent individuals from taking appropriate action (Klimidis, et al., 2007). However, because the study used a multiple-choice format rather than the open-ended questionnaire used in the Australian general population survey (Jorm et al., 1997), the results cannot be directly compared (Wong, Lam et al., 2010). Moreover, when the multiple-choice method allows participants to choose as many options as they like, it is difficult to discern participants' primary knowledge or belief about the vignette.

Four other studies (Chen, Hung, Parkin, Fava, & Yeung, 2015; Jang, Gum & Chiriboga, 2011; Ho, Hunt, & Li, 2008; Sin, et al., 2011) examined recognition and knowledge among East Asian immigrants using alternative measures of mental health related beliefs. Findings from a qualitative study on perceptions of depression among Korean American adults (n = 28) living in Washington found that most participants recognized general symptoms and concepts of depression (e.g., mental illness, feeling down; Sin et al. 2011); however, participants used the term depression synonymously with stress and did not recognize any physical symptoms as signs of depression (e.g., change in appetite, fatigue).

There is mixed evidence to suggest that East Asian immigrants who do seek out professional help are able to provide a psychiatric label for their concern. In a community study of Chinese Australian immigrants in Sydney, researchers used the Chinese-bilingual structured clinical interview schedule for the DSM-IV to identify 49 participants who met criteria for an anxiety disorder (Ho, et al., 2008). Among the participants, the average length of delay for treatment was similar to the general Australian population (i.e., 7.04 years; Thompson, Issakidis, & Hunt, 2004). Notably, Chinese participants contacted health professionals before they recognized their problem as anxiety, while in the general population, recognizing the problem as

anxiety preceded contact with health professionals (Ho et al., 2008). The study suggests that help-seeking may not be dependent on one's ability to provide a specific label for their concern.

Chen and colleagues (2015) recruited 190 Chinese American immigrants seeking services at community health clinics in Boston; all participants met criteria for major depressive disorder but were not yet receiving services for depression. Using the Explanatory Model Interview Catalogue (EMIC; Weiss et al., 1992), participants were asked about their chief complaint and to provide a label for their problem. Approximately half of the participants (52.1%) reported depressed mood, unhappiness, or mood problems as their chief complaint, followed by psychosocial stressors (38.9%). The majority of the participants (67.9%) named their problem as depressed mood or depression, while 11.6% of the participants indicated they did not know.

Among East-Asian immigrants, the literature suggests that gender and acculturation may account for some differences in recognition and labelling. In a comparison of Chinese Australian men and women, Wong and colleagues (2012) found that women were significantly more likely to provide the label "depression" and "schizophrenia" in response to a vignette; however, women in the study were younger and had been living in Australia for longer than men, which may have accounted for the difference (Wong et al., 2012). Similarly, a survey in Florida of 675 Korean-speaking adults aged 60 and older indicated that acculturation and not education level was related to beliefs regarding depression (Jang, et al., 2011). Moreover, compared to non-Hispanic counterparts in previous studies (Pratt, Wilson, Benthin, & Schmall, 199; Zylstra & Steitz, 2000), findings indicated that Korean elders were less able to recognize symptoms of depression, tended to normalize depression among older adults, and believed that treatments for depression were ineffective. In addition, participants who reported higher levels of depressive symptoms

tended to normalize depression and believed that interventions would be ineffective (Jang et al., 2011).

Taken together, these studies suggest that East Asian immigrants are less likely to provide a psychiatric label of "depression" or "schizophrenia" for a vignette, although this labelling increases slightly when they are cued. Recognition and labelling may be associated with an increased tendency to seek professional help; however, this link appears to be more complex among East Asian immigrants. East Asian immigrants' understanding of basic aspects of depression is similar to that of the general population in Western countries and most acknowledge the need to seek help. Moreover, even when East Asian immigrants are not able to label their psychological distress, some do seek professional help. In addition, processes of acculturation appear to influence help-seeking intentions by normalizing depression and negative attitudes toward Western treatments for depression. However, current literature suggests that simply being able to provide a psychiatric label for symptoms or attribute them to a mental health or emotional problem may be insufficient to promote mental health services utilization. In particular, the assumption of mental health literacy programs that increased knowledge of symptoms and psychiatric labeling will lead to enhanced help-seeking behaviours may not be warranted for East Asian immigrants.

Beliefs about Risk Factors and Causes of Mental Illness

In addition to being able to recognize and label mental health issues, beliefs about the causes and risk factors of mental illness can also influence help-seeking behaviours. In a community sample of 200 Chinese Australian immigrants, Wong and colleagues (2010) used a Likert-scale to assess beliefs about causes of depression and perceived helpfulness of various interventions. Chinese immigrants viewed psychosocial problems, such as life stress, and interpersonal conflict, as causes of depression. Personality or inherent characteristics such as introversion and "thinking too much," were also perceived as causal factors. Overall, participants were less likely to endorse traditional beliefs such as, "bad *Fung Shui*" and "punishment for the misdeed conducted by ancestors" (Wong et al., 2010). Compared to females, male participants, who were older and had lived in Australia for shorter duration, were more likely to endorse traditional explanatory models of mental health (e.g., imbalance of *yin-yang*); importantly, male participants perceived "dealing with it alone" and traditional treatments (e.g., seeing a traditional Chinese medical doctor) to be more helpful. Chinese men were also more likely to endorse "psychiatric ward" and "electro-convulsive treatment" as helpful for depression and schizophrenia (Wong et al., 2012).

A qualitative study with a community sample of older Chinese immigrants (mean age = 62.56) in Alberta, Canada found that the majority of the participants attributed depression to day-to-day problems, and they were less likely to endorse biological factors (e.g., "chemical imbalance") and certain psychosocial risk factors (e.g., recent death and recent traumatic events) as causes of depression, compared to an age-matched sample from the general population (Tieu et al., 2010). Similar findings were reported among Chinese immigrants (N = 190) meeting criteria for depression living in Boston; most participants (68.4%) attributed their depressed

mood to stress (e.g., interpersonal stress) followed by biological causes (19.5%; e.g., physical-biochemical) and psychological causes (16.8%; e.g., thoughts, family upbringing) (Chen et al., 2015). Tieu and colleagues (2010) reported that Chinese participants were also likely to report personality characteristics, such as "being a nervous person" as contributing to depression, and two-thirds of the participants attributed depression to having a "weak character." Yet, participants were optimistic about complete or partial recovery without seeking professional help. Accordingly, participants viewed self-help strategies, such as physical activity, relaxation, stress management and getting out more often as being more helpful than other interventions, including antidepressants and traditional Chinese medicine (Tieu et al., 2010).

Similar findings were reported in two studies of older Korean American immigrants (i.e., 60 years and older). Pang (1996) conducted individual interviews with 70 older Korean American immigrants, with half of the participants having a diagnosis of depression. Participants, with or without a diagnosis, attributed depression to psychosocial problems rather than biological causes, and did not believe that medication could alleviate depression (Pang, 1996). Korean Americans tended to endorse stress due to immigration, introverted personality, and emotional stress as causes of depression, rather than biological causes (Sin et al., 2011). Many believed that depression was normal and transitory and not necessarily an "illness" (Pang, 1996). Consequently, participants believed that depression could be overcome with determination and the use of self-help strategies (Pang, 1996; Sin et al., 2011).

Biological or physical causal beliefs about depression were associated with endorsement of professional help-seeking. In a qualitative study, 40 recently emigrated Chinese American women were recruited from a public health clinic in San Francisco's Chinatown (Ying, 1990). Participants were provided with a translated vignette of someone experiencing depression, and

were asked questions about the cause of the illness. Twenty-three participants conceptualized depression as psychological (e.g., low mood, worry, psychiatric problem) and recommended that one seek support from family and friends, rather than seeking professional help (Ying, 1990). On the contrary, twelve participants who conceptualized depression as primarily physical (e.g., neurasthenia, physical illness, heart problem) recommended medical help for the individual in the depression vignette (Ying, 1990). Similarly, in a quantitative study consisting of 223 Asian American college students, endorsing biological (e.g., disease, hormonal imbalance) and situational causes (e.g., life transitions) of depression was associated with greater likelihood of endorsing professional help-seeking, whereas interpersonal causes, personal failures causes (e.g., failure to achieve one's goals, shame), and somatic consequences (e.g., poor appetite, health problems) were not (Wong, Tran et al., 2010).

In sum, East Asian immigrants tend to link the causes of depression to common psychosocial problems, interpersonal conflict and life stress, and also to personality characteristics such as having a weak character, being introverted and being a nervous person. In general, individuals were less likely to endorse biological causes of depression. Importantly, these beliefs about causes and risk factors of mental illness shaped the perceived helpfulness of different interventions and attitudes toward professional help-seeking, which is not reflected in the mental health literacy model. Because many viewed depression as a transitory state caused by common interpersonal or situational factors, they also viewed self-help strategies as a sufficient intervention, while those who believed in a more biological or physical cause of depression were more likely to seek professional services.

Knowledge of Help-Seeking Options and Treatments

A fundamental aspect of help-seeking involves knowing about the different treatment options available for mental health problems. Moreover, individuals' attitudes toward various interventions and health-professionals may facilitate or impede taking action by help-seeking. There is some evidence to suggest that East Asian immigrants, particularly recently arrived immigrants, are less knowledgeable than native-born groups about the mental health services locally available.

Among university students in Melbourne, for example, Asian immigrants ($N = 47$) who had been living in Australia for less than eight years had less knowledge about which local agencies provided mental health services, compared to Anglo-Australians and those who had been living in Australia for longer than eight years (Fan, 1999). Even among Chinese immigrants living with schizophrenia, depression or anxiety, a small qualitative study in Australia using individual interviews revealed that participants reported limited knowledge of the Australian healthcare system, the role of GPs in providing primary mental healthcare services, and the role of mental health specialists (Blignault, Ponzio, Rong & Eisenbruch, 2008). Similarly, Chinese immigrants in Sydney living with an anxiety disorder also indicated that one of the main reasons for their delay in help-seeking was not knowing where to seek help (Ho et al., 2008).

A survey of over 1,700 Chinese American immigrants conducted in the 1990s using probability sampling of Chinese American households residing in Los Angeles County indicated that half of the participants did not know where to seek help for mental health problems and 25 percent of the participants indicated scepticism regarding credibility of treatment (Kung, 2004). Similarly, in a mixed-methods study using focus groups with Chinese American immigrant women ($n = 86$) living in Los Angeles, in addition to reporting a lack of culturally sensitive

services, participants indicated that they lacked knowledge about the availability of mental health services in general (Tabora & Flaskerud, 1997).

Studies of East Asian immigrants have reported mixed attitudes and perceived helpfulness toward health professionals and various interventions for mental health problems. Among Chinese Australian immigrants, the majority of the participants rated GPs and psychiatrists as helpful for depression, more so than traditional Chinese doctors (Wong, Lam et al., 2010). Participants perceived counsellors as particularly helpful, with around 90% of Chinese Australians recommending a counsellor for a person in a vignette with depressive symptoms. Although Chinese Australian immigrants perceived antidepressants as helpful for the person in the depression vignette, they were uncertain about some medications that were rated as harmful by the general public, including sleeping pills, antipsychotics, and tranquilizers for depression. The findings suggest that Chinese immigrants may be less knowledgeable than the general population about the helpfulness or harmfulness of various psychiatric medications (Wong, Lam et al., 2010).

Similarly, Chinese seniors in Canada reported equivocal views of health and social service professionals (e.g., psychiatrist, social workers; Tieu et al., 2010). Most rated these professionals as "neither helpful nor harmful" rather than "helpful" when asked to rate the helpfulness of various professionals for a person in a depression vignette, which suggests either ambivalence or lack of knowledge. Furthermore, compared to the general population, older Chinese immigrants in Canada were significantly less likely to rate GPs, counsellors, clinical psychologists as helpful for depression; however, most perceived psychiatrists and psychotherapy to be helpful (Tieu et al, 2010). In addition to knowledge about where to seek help and the types of interventions available, previous negative encounters, including feeling

dismissed by physicians and reception staff affected attitudes toward health care professionals (Blingnault et al., 2008). Moreover, incongruent expectations of the treatment process can influence patients' experience of mental health services. For instance, cultural values of deference to authority led to expectations that psychotherapy would entail explicit directives on how to improve one's mood — expectations that are incongruent with many current forms of psychotherapy (Tabora et al., 1997). In addition to lack of trust of health professionals, incongruent expectations may lead to scepticism regarding the efficacy of treatment (Kung, 2004).

On the whole, the literature suggests that knowledge and attitudes toward mental health services and health professionals may affect access and willingness to seek professional help for mental health concerns among East Asian immigrants. Acculturation influences this process; whereas recent immigrants may be less aware of the types of services available for mental illness, ambivalence or negative attitudes toward mental health professionals or interventions may also stem from the lack of culturally and linguistically tailored interventions, and incongruent or negative expectations about the treatment process. There are mixed findings on whether East Asian immigrants perceive biomedical health professionals, including GPs and psychiatrists, as helpful in treating depression. Although some participants in the studies reported negative views on certain types of interventions, such as medication for depression, the majority viewed health care professionals positively; only a small proportion of participants endorsed traditional treatments and alternative services for the treatment of depression or schizophrenia.

Self-Help Strategies and Social Support

Across studies, East Asian immigrants frequently report the use of self-help strategies. In a community-based, exploratory survey of Korean Americans (n = 205), only 32% of participants reported that they would see a physician for mental health problems, whereas 89% of participants endorsed seeing a physician for a physical problem (Cheung, Leung, & Cheung 2011). Rather than seeing a professional for mental health issues, more than half of the participants reported that they would talk to friends or family (52%) or see a religious leader (40%). Similar findings were reported in a study of Chinese immigrants living in Montreal; when various personal/psychological or interpersonal/interactional problems arose (e.g., feeling worthless, problems sleeping, don't want to go on living, loneliness, worrying about future), the majority of participants chose immediate family as the preferred source of help even when they were aware of other resources, including those within the Chinese community (Christensen, 1987). Among Chinese American immigrants who met criteria for depression, participants (75.3%) also indicated that self-help such as exercise and talking to friends and relatives was the most important type of help sought, followed by spiritual help (9.5%; Chen et al., 2015).

However, there is also evidence to suggest that East Asian immigrants are less likely than Euro-Americans to discuss matters of mental health to friends and family. In the Epidemiological Catchment Area (ECA) Study in Los Angeles in the 1980's, not only were Asian Americans (N = 161) less likely to disclose mental health concerns to a psychiatrist or a physician, they were also less likely to discuss it with their friends and family (Zhang et al., 1998). As well, some East Asian immigrants may experience increased shame about disclosing their distress and personal failures because of the added pressures to fulfill family obligations post-migration. Chung (2010) conducted a qualitative study among 31 Chinese immigrants in

New York City who were in a treatment program after attempting suicide. In-depth interviews revealed that challenges associated with immigrant status prevented participants from seeking emotional support from their families; their reluctance to disclose their difficulties stemmed from the shame associated with not meeting family obligations (e.g., finding employment) and not wanting to be a burden to family members who were experiencing their own stresses due to immigration (Chung, 2010).

Other studies have also indicated that many East Asian immigrants use self-help strategies that do not involve others. Older Chinese immigrants in Canada and Chinese immigrants in Australia most commonly endorsed self-help strategies such as physical activity, relaxation, stress management and getting out more for depression (Tieu et al., 2010; Wong, Lam et al., 2010). Older Korean American and Chinese American immigrants reported strategies including having a positive attitude and trying to forget sad events, acceptance of challenging circumstances, forgiveness, eating lightly, and deep breathing (Lee & Chan, 2009; Pang, 1996). Older Chinese American immigrants and Korean American immigrants also endorsed religious and spiritual coping (Lee & Chan, 2009; Sin et al., 2011); some also used alternative medicine such as acupuncture and *qi-gong* to maintain health and well-being (Lee & Chan, 2009). Korean American immigrants also reported passive emotion-focused strategies, such as suppressing feelings and consuming alcohol to manage stress (Sin et al., 2011).

The literature suggests that East Asian immigrants commonly use self-help strategies to cope with psychological distress. It is likely that most East Asian immigrants experiencing distress use a combination of many self-help strategies. The use of self-help strategies appear to be closely tied to beliefs about the etiology of distress; in particular, because East Asian immigrants commonly endorse psychosocial and interpersonal etiologies of distress, they may

prefer to use self-help strategies and lay sources of help (Chen et al., 2015). However, given that many East Asian immigrants believe that mental health problems, such as depression, can be overcome through personal determination, there is concern that they will rely on self-help strategies even when these strategies are ineffective, and fail to seek mental health services when needed (Pang, 1996). Moreover, some immigrants experience loss of social networks and less access to culturally grounded self-help strategies as a result of the migration process (Groleau & Kirmayer, 2004; Chung, 2010), which needs to be considered in the mental health literacy model.

Toward a Culturally Responsive Model of Mental Health Literacy

Over the past two decades, MHL has been promoted as a way to frame knowledge about mental illness, and as a public health intervention to raise awareness and promote positive attitudes toward mental health and help-seeking. The present review of the literature suggests that compared to the general population in North America, East Asian immigrants may be less likely to recognize and label mental illness using psychiatric diagnoses, have different knowledge about the causes of mental health problems, have more negative views about mental health services, and are more likely to rely on self-help treatments. However, these findings must be interpreted carefully because these patterns of knowledge and attitudes may not necessarily be directly linked to help-seeking behaviors. While the current MHL literature on East Asian immigrants tends to assume that adopting the Western scientific understanding of mental health problem will necessarily lead to accessing appropriate mental health services for all populations, the determinants of help-seeking may be ecosocial, social structural, and affective rather than mainly cognitive or informational (Kirmayer, 2015).

Jorm (2012) acknowledges that MHL is a Western framework that uses a scientific understanding of mental illness that may conflict with some traditional views of mental health. Indeed, all cultures have their own explanations of abnormal behaviours and indigenous healing methods (Sue & Sue, 2012). Explanatory models of illness are shaped by personal, social and cultural influences, and they are strongly associated with beliefs about treatment, and different help-seeking behaviours (Kleinman, 1980). Whereas Western medicine endorses a bio-psycho-social model of understanding mental illness, and medication and/or psychotherapy are seen as common forms of treatment, traditional ways of understanding and healing persist in most cultures (Kirmayer & Bhugra, 2009). For example, some Chinese migrants may view mental health issues as a manifestation of lack of harmony or balance in the energy flow of the body (Green, Bradby, Chan, & Lee, 2006), and indigenous healing in Asian cultures often incorporates spiritual and religious traditions and may also involve herbs and acupuncture (Chung & Lin, 1994; Chung & Bemak, 2007; Yeh et al., 2004). Similarly, some Asian immigrants may view mental health services as less relevant to their concerns because Western interventions focus on symptom relief and lack a holistic perspective to health that integrates social, emotional and spiritual well-being (Kwong, Chung, Cheal, Chou, & Chen, 2012). Milder mental health problems, such as depression and anxiety are often regarded as moral or personal problems that are seen as more appropriate to be addressed by a family member, elder or spiritual leader, who are skilled at navigating social relationships (Abe-Kim, Gong, & Takeuchi, 2004; Gong, Gage, & Tacata, 2003; Phan, 2000).

Whatever the merits of current scientific understanding, persuasive explanations of mental health and illness have to make sense to people in terms of their own conceptual language, values and metaphors. For instance, some ethnocultural groups, including Asian

immigrants may refer to bodily distress as a culturally specific way of talking about distress (i.e., idioms of distress) that stems from interpersonal or psychological issues (Kirmayer, 2001; Groleau & Kirmayer, 2004; Park & Bernstein, 2008). Thus, knowledge and recognition of mental illness needs to encompass the use of alternative expressions, labels, idioms and explanations of mental health issues that differ from Western psychiatric constructs and presentations. Since expressions of distress, explanatory models of illness, and help-seeking behaviours are shaped by the cultural context (Kleinman, 1980; Kirmayer & Bhugra, 2009), simply providing the "correct" psychiatric diagnosis may not make sense to some immigrants, who may employ alternative understandings of illness and prefer alternative treatments and healing systems. Including alternative explanations of illness and beliefs about causes of mental illness that are reflective of diverse help-seeking pathways may be more fruitful in promoting help-seeking behaviors among East Asian immigrants. Similarly, examining specific knowledge, attitudes and practices that shape help-seeking of all forms may lead to more effective interventions for culturally diverse populations. To achieve this, MHL needs to shift its focus from promoting "correct labelling" to a more inclusive, contextual understanding of illness experience and explanation that considers the social embedding of cultural knowledge and practice (Kirmayer, 2015). Help-seeking may reflect cultural knowledge and practices that are embedded in particular social contexts that involve others in the patients' family or local community. Addressing this contextual shaping of illness behaviour and help-seeking requires an ecosocial approach.

Attention to the structural inequalities that act as determinants of mental health and help-seeking among immigrant communities is crucial (Metzl & Hanson, 2014). The assumption that a "correct" psychiatric label will lead to professional help-seeking may not be applicable for

populations facing such structural issues including: legal status; language; discrimination; and access to culturally appropriate services (Blignault et al., 2008; Kirmayer et al., 2007; Kung, 2004; Fung & Wong, 2007; Spencer & Chen, 2004). These barriers can act as critical social determinants that impede access to mental health services, independently of knowledge and attitudes. At the same time, the structure of the health care system itself may exert effects on local knowledge and attitudes and behaviors. Access to culturally and linguistically sensitive services has been found to be an important influence on attitudes toward help-seeking among Chinese, Korean and Vietnamese immigrant and refugee women in Toronto (Fung & Wong, 2007). Thus, when examining attitudes toward various health care professionals and their perceived helpfulness, the local availability of culturally and linguistically sensitive services must be considered. Immigrants also face specific risk factors that can increase mental health problems, such as unemployment, loss of social support, and loss in social status (Chung, 2010; Sin et al., 2011) that are not considered in the MHL model. Similarly, some immigrants may no longer have access to certain self-help strategies or social support networks used prior to migration (Chung, 2010; Sin et al., 2011). These contextual factors may warrant specific attention in MHL programs.

The MHL framework implies that mental health problems are similar to physical illness, and that the individual with a mental health concern has a disease. The assumption is that individuals who have basic knowledge about mental illness will approach it like a physical illness, and if they are able to recognize symptoms, they will seek appropriate health care services. Although this approach may provide a sense of urgency that motivates individuals to seek professional help, it is unclear if a medical model of mental illness will increase help-seeking (Angermeyer, Holzinger, Carta, & Schomerus 2011). A medical model of understanding

mental health concerns may not reduce stigma surrounding mental illness (Read, Sayce, & Davies, 2006; Kvaale, Haslam & Gottdiener, 2013), a critical and pertinent barrier that may prevent East Asian immigrants from seeking mental health services (Clement et al., 2015; Fogel & Ford, 2005; Georg Hsu et al., 2008; Ryder, Bean, & Dion, 2000). Knowledge-based or informational approaches to raising awareness regarding mental illness may not be able to diminish more affect-driven barriers, such as mental illness related stigma, fear of shaming the family, and "losing face" (Tabora et al., 1997). Many of the studies reviewed in this paper highlight stigma of mental illness as an important variable influencing help-seeking among East Asian immigrants (e.g., Blingnault et al., 2008; Chen et al., 2015; Chung, 2010; Pang, 1996; Tieu et al., 2010).

Interventions that aim to assess or to increase MHL among East Asian immigrants need to be critical of the underlying assumptions and limitations of the MHL model and to consider ways to address cultural diversity in illness knowledge, attitudes and help-seeking. MHL for East Asian immigrants —or for other ethnocultural communities — need not focus exclusively on transmitting knowledge consistent with the views of Western mental health care professionals. For a culturally responsive framework of MHL, modifications need to be made to account for the diverse beliefs, values and understandings of mental health concerns, and to include alternative help-seeking options that are perceived as useful in a community. Table 1 summarizes some of the areas that need to be addressed in the MHL framework to make it more culturally consonant as well as more specific issues for East Asian migrants. These include consideration of cultural variations in the expression, recognition and labelling of symptoms, notions of illness causality, patterns of help-seeking and strategies for self-help coping and social support.

Insert Table 1 about here

A culturally responsive approach to MHL would respect traditional explanatory models of illness, acknowledge diverse forms of help, and empower individuals to seek appropriate help based on their needs. To meet the mental health needs of diverse populations in a culturally responsive manner, adopting a more pluralistic understanding of mental health and advocating for a health care system that includes alternative interventions may be more effective than promoting a unidimensional, Western approach to understanding and treating mental illness. Although evidence-based practice has been an important approach to improve the quality of mental health care, evidence-based practice may have some limitations when applied to diverse populations (Kirmayer, 2012). Empirical studies, such as randomized controlled trials often do not represent the patient population in clinical settings (e.g., by focusing on individuals with a single diagnosis), do not represent culturally diverse service users (Sue & Zane, 2006; Whitley, Rousseau, Carpenter Song, & Kirmayer 2011), and use interventions based on an individualistic conceptualization of a person that may not be congruent with cultural notions of personhood and self-construal (Kirmayer, 2007). Having access to alternative treatments, particularly treatments that are recognized and have a long tradition in a community may increase the likelihood that immigrants will find an intervention that is effective for them. Hence, the current paper highlights the need to cautiously embrace alternative pathways and models of help-seeking and provided modifications for a culturally responsive framework of MHL.

Although only two of the studies reviewed in this paper (i.e., Jang et al., 2011; Wong et al. 2012) highlight the role of acculturation on attitudes toward help-seeking, the literature on

Asian Americans has consistently discussed acculturation as a critical variable that influences attitudes toward help-seeking (e.g., Liao, Rounds & Klein, 2005; Tata & Leong 1994). Newly arrived migrants need to learn the basics of how societal institutions function and how they can be effectively accessed. Importantly, contemporary research understands heritage and mainstream acculturation orientations as essentially independent, rather than as a one-way passage from the former to the latter (Dere, Ryder, & Kirmayer, 2010; Ryder, Alden, & Paulhus, 2000). Consistent with this view, research has demonstrated that the maintenance of traditional stigmatizing attitudes among East Asians can persist despite a general adaptation to life in the host culture, and this persistence can continue into the second and even the third generation (Abe-Kim et al., 2007; Chen, Kazanjian, & Wong, 2009). Moreover, help-seeking is often mediated by family members. Thus, persistent cultural knowledge and attitudes can contribute to delayed help-seeking across the generations (Ryder, Bean, & Dion, 2000).

In addition to influencing beliefs surrounding mental health and illness, acculturative experiences can contribute to distress (Kirmayer et al., 2011). The degree of adaptation to the host culture tends to be inversely associated with self-reported distress, although results are mixed on the contributions of heritage-culture maintenance (Ryder, Alden, & Paulhus, 2000; Ryder, Alden, Paulhus, & Dere, 2013). Other studies have indicated that the association between acculturation and mental health may be a complex one, with variables including SES, gender, perceived social support, discrimination and personality negativity having a mediating or moderating influence (Leu, Walton & Takeuchi, 2011; Shen & Takeuchi, 2001). Acculturative processes also may influence the symptom experience and clinical presentation. For example, a sample of Chinese migrants to Australia were less likely to emphasize somatic symptoms of depression as they gained more exposure to the Australian cultural context (Parker, Chan &

Eisenbruch, 2005). Since a 'psychologized' presentation of depression is normative in Western cultural contexts, such findings suggest that acculturative processes might involve shifts in symptom experience and expression that fit the assumptions of mental health literacy promotion efforts.

Finally, although the current paper focuses on East Asian immigrants, some of the barriers to help-seeking identified overlap with those encountered by most migrants as well as in the general population more broadly. First-generation immigrants, including those from the Middle East, Africa, Asia and Eastern Europe in the U.S. and Canada are more likely to report structural barriers such as cost, lack of services in their preferred language and not knowing where to seek help as barriers to mental health services (Kirmayer et al., 2007; Saechao, et al., 2012; Whitley, Kirmayer & Groleau, 2006); immigrants also report preferences for alternative treatments, stigma, and perceived dismissiveness of health care professionals as factors that deterred them from mental health services (Saechao et al., 2012; Whitley et al., 2006). In the general population in the U.S., Canada and the Netherlands, the belief that the problem will resolve on its own (Sareen et al., 2007) and doubts about the effectiveness of treatment (Wang, 2006) have been found to be prominent factors that prevent individuals from seeking mental health services. Although there is overlap between non-immigrant and immigrant groups, there are also culturally specific ways of thinking about mental health, expressing distress, and diverse ways of conceptualizing the self (Kirmayer, 2007; Kirmayer & Bhugra, 2009; Sue & Sue, 2012), which need to be considered when adapting mental health literacy interventions to specific ethnocultural groups.

Conclusion and Future Directions

Increasing MHL in a community has the potential not only to benefit mental health consumers and professionals, but also to increase the well-being of the general population through early interventions, prevention strategies, and promotion of mental health. Indeed, MHL is just as relevant for the general public as it is for immigrant communities. Efforts have been made to increase the MHL of the general population to promote prevention and early intervention in Australia (Australian Department of Health and Ageing, 2009), Scotland (The Scottish Government, 2003) and Canada (British Columbia Ministry of Health Services, 2003; Mcluckie, Kutcher, Wei & Weaver, 2014). However, the application of MHL to migrant populations raises specific issues. Although MHL intervention programs may encourage Western professional help-seeking, East Asian immigrants may be met with ineffective treatments that are not culturally sensitive or are incongruent with their illness beliefs. Hence, interventions that aim to increase MHL among East Asian immigrants need to be based on a more culturally informed framework. In addition to modifying the original intervention to improve cultural fit, mental health literacy programs could consider community initiated indigenous programs and those that more actively engage members from the cultural group (Barrera, Castro & Steiker, 2011). These interventions need to take into account not only cultural fit but also the ability to reach the intended population and how well the intervention is adopted and integrated by the community (Barrera, et al., 2011).

Further research is necessary to understand how recognition or recall of a psychiatric label influences help-seeking behaviours. The relationship between hypothetical responses to case vignettes and actual help-seeking behaviour requires critical study. Specifically, studies need to examine the potential difference between the action that survey respondents recommend

for a hypothetical person, and the decision that they would make for themselves. Similarly, it remains unclear to what extent being able to recognize symptoms of mental illness, having knowledge about causes of mental illness, and having positive attitudes toward mental health professionals are associated with actual help-seeking behaviours (Kirmayer & Ban, 2013). In particular, among East Asian immigrants, help-seeking may be largely determined by pragmatic barriers such as language, cost, and time (Ho et al., 2008; Kung, 2004), and it is unclear if MHL can surmount these practical barriers. Making mental health services more accessible for East Asian communities may require increasing the availability of culturally responsive services that can meet individuals' linguistic and cultural needs and expectations.

Furthermore, although self-recognition of a mental health issue is important, help-seeking is often not a solitary process. Help-seeking models have emphasized the role of social networks in service utilization (Thoits, 1985, 2011); however, the literature has largely neglected the role of the social context in shaping and influencing beliefs and actions toward mental health problems. Given the role of social ties and networks in determining whether and how people access services, there is a need for studies that examine if those in the community with more knowledge about mental health care actually facilitate access to care for others.

Although we have advocated pluralism in health care for ethical and pragmatic reasons, the availability of multiple sources of help raises many questions that deserve further study (Kirmayer, 2012). Key remaining questions in the domain of self-help strategies among East Asian immigrants include determining whether self-help methods, such as religious consultation or seeking support from family and friends—which are commonly endorsed among East Asian immigrants—are beneficial and if they lead to recovery. Moreover, researchers need to examine the patterns of transition from informal to formal help-seeking behaviours among East Asian

immigrants and how social networks influence their pathways to help-seeking. Ultimately, instead of pathologizing non-Western views and treatments for mental health, researchers, clinicians and policy makers can focus on increasing the service options available to immigrant communities so that consumers can make informed decisions based on their needs, whether that be accessing Western health professionals, traditional healers, or both. On the other hand, we also need to better understand the impact of specific beliefs about mental illness that may be associated with increased stigma or discrimination, and that may hinder help-seeking of all forms. Although traditional ways of understanding mental health issues may be important for communities because they are linked to particular cultural values and concepts of personhood, there obviously is a need to provide knowledge about treatable mental health problems so that individuals can seek appropriate help when necessary. Importantly, improving the quality of mental health care and enhancing MHL among Asian immigrants needs to involve collaboration with traditional healers and alternative service providers that may have initial contact with the individual.

Increasing the MHL of East Asian immigrants is one promising avenue to facilitate appropriate help-seeking behaviours and access to effective treatment. The goals of MHL can be advanced through a culturally responsive framework for MHL that gives careful considerations to the social and cultural context that shapes perceptions of mental health and health care providers. Understanding the cultural grounding and implications of mental health knowledge, beliefs and attitudes can empower East Asian immigrants to choose the best mental health care option available. The lessons learned from East Asian immigrants can inform culturally responsive frameworks for MHL to address other kinds of diversity.

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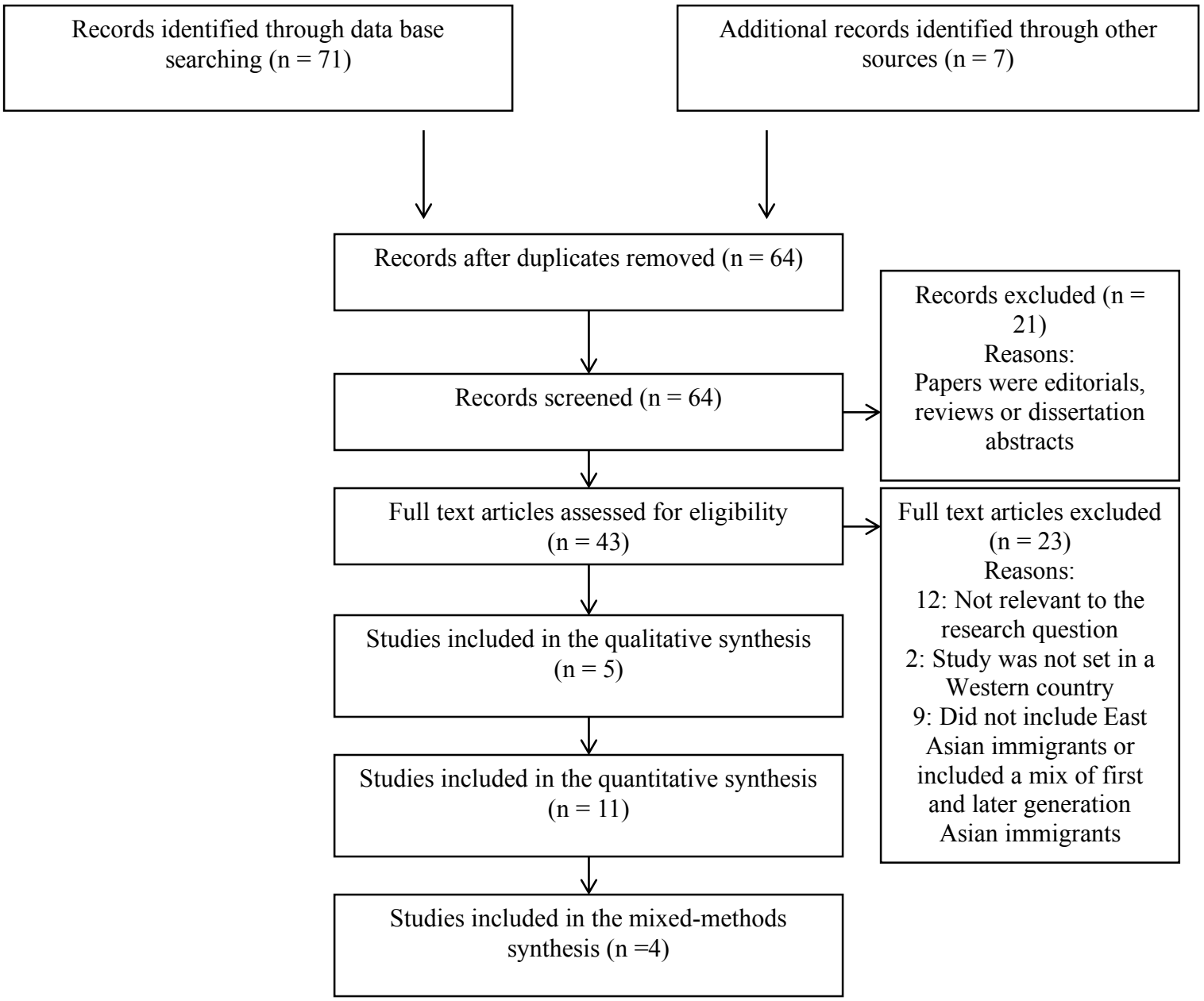

Figure 1. PRISMA Flow Diagram on East Asian immigrants, mental health literacy and help-seeking.

Table 1

Culturally Responsive Framework for Mental Health Literacy (MHL)

Components of MHL	Key Issues Based on Literature	Cultural Values and Migration Issues	Implications for MHL	Cultural Modifications for East Asian Migrants
Knowledge and recognition of mental illness (Symptoms, signs, modes of expression, thresholds of tolerance)	• Attitudes and behaviours towards help-seeking may not depend on symptom recognition and labelling	• Use of culturally specific terms to describe mental health problems • Symptoms and modes of expression of distress health issues that differ from Western models	• Move from conveying "correct" knowledge to more inclusive view of mental illness that allows for diverse cultural models • Tailoring assessment of knowledge and recognition of mental illness to capture culturally relevant actions	• Instead of 'depression' use terms such as, 'stress,' 'anxiety,' and 'emotional distress' which may be associated with acknowledgement of need to seek help (Wong et al., 2010) • Include somatic idioms of distress (Park & Bernstein, 2008)
Beliefs about risk factors and causes of mental illness (Causal attributions and explanatory models)	• Alternative explanatory models of illness influence diverse forms of help-seeking and pathways to care	• Explanatory models of illness identify causal factors that differ from those included in biopsychosocial models • Migrant specific risk factors affect mental health (e.g., stress due to migration, acculturation, discrimination)	• Include culturally salient explanatory models of illness, and risk and protective factors specific to migrants • Identify knowledge, attitudes, and practices that influence diverse forms of help-seeking	• Depression may be viewed as stress due to migration and social isolation rather than an biomedical illness (Sin et al., 2011) • Endorse psychosocial and personality characteristics as causes for depression (Sin et al., 2011) • Consider that milder mental health problems perceived as moral or personal problems may

				be more appropriately addressed by family member, elder or spiritual leader (Abe-Kim et al., 2004) • Include traditional explanatory models (e.g., imbalance of yin-yang) and traditional treatments (Wong et al., 2012) .
Knowledge about and attitudes toward help-seeking options	• Mental health services seen as appropriate only for most severe mental illness • Absence of culturally and linguistically appropriate services affect attitudes toward mental health services	• Culturally specific values, and concerns confer stigma and influence help-seeking • Preference for forms of help that are congruent with cultural beliefs about the causes of illness	• Attitudes toward health care professionals may reflect their perceived ability to provide culturally appropriate interventions • Help-seeking pathways must include alternative treatments valued by the community	• Address negative experiences with health professionals and incongruent expectations about treatment that contribute to negative attitudes (Blingnault et al., 2008; Tabora et al., 1997) • Preference for holistic approach to health that integrates social, emotional and spiritual well-being (Kwong et al., 2012) • Cultural values, including conformity to social norms and emotional restraint, may be closely related to help-seeking attitudes (Wong, Tran et al., 2010)

Self-help strategies and social support	• Cannot assume that individuals will seek professional help when self-help strategies are ineffective	• Use of alternative self-help strategies based on cultural practices • Loss of social networks and access to self-help strategies as a result of migration	• Self-help strategies and their effectiveness may differ from those found in the general population • Pathways to care may differ from the general population due to lack of culturally sensitive services or heightened stigma in some migrant communities • Consideration of accessibility of self-help strategies among migrant groups	• Loss of social networks through immigration process (Chung, 2010) • Include culture-specific self-help strategies, such as spiritual coping, *qi gong* or dietary changes (Lee & Chan, 2009) • Belief that depression can be overcome through personal determination may prevent individuals from seeking help even when self-help strategies are ineffective (Pang, 1996) • Need to examine both informal and formal help-seeking pathways

Bridging to Study 2

The mental health literacy (MHL; Jorm, 2012) framework has the potential to promote early interventions and foster appropriate help-seeking for mental health concerns. The first manuscript proposed a culturally responsive model of MHL that integrates diverse ways of conceptualizing, expressing, and treating mental health problems that may be more relevant for immigrant communities. The second manuscript more specifically explores East Asian immigrant's lay conceptions and attitudes toward mental illness. Understanding lay beliefs toward mental illness is critical in comprehending attitudes towards mental illness and help-seeking (Haslam, Ban, & Kaufmann, 2005). The folk psychiatry model (Haslam et al., 2005) broadly conceptualizes lay people's beliefs about mental illness in four dimensions (i.e., pathologizing, moralizing, medicalizing, and psychologizing). The findings of the second study are informed by the folk psychiatry model; the study explores overlapping dimensions of the folk psychiatry model among East Asian immigrant women. Moreover, the study examines more culturally nuanced lay beliefs in East Asian immigrant communities.

Attitudes toward mental illness and help-seeking are shaped at the individual, community and socio-political levels (Pescosolido, Martin, Lang, & Olafsdottir, 2008). Researchers have also highlighted the need to examine the role of multiple social identities on individual's perceptions toward mental illness to avoid essentializing cultural groups (Wong & Tsang, 2004). Guided by the intersectionality framework (Crenshaw, 1989; Davis, 2008), the second paper also aims to better understand the influences that shape mental health attitudes and beliefs among East Asian immigrant women, and situating the findings in their social and cultural context.

CHAPTER 3

Lay Conceptions and Attitudes Toward Mental Illness Among East Asian Canadian Women

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Abstract

This study explored the lay conceptions, perceived community attitudes and factors that influence attitudes toward mental illness among East Asian women in Canada. Using a focus group methodology (6 focus groups of 47 participants), thematic analysis revealed causal theories (i.e., situational, biogenic, constitutional) and discussions surrounding the challenges and complexity of defining mental illness. East Asian women in the study discussed beliefs about psychopathology that shape community attitudes toward mental illness. Moreover, focus group discussions captured the intricate and dynamic social and cultural processes that influenced participant's understandings and attitudes toward mental illness. These included discussions surrounding the role of family influence, sociocultural and gendered norms, and immigration related issues. The absence of dialogue on mental illness, normalization of common mental health problems, lack of awareness and knowledge on mental health issues, and not having contact and personal familiarity with individuals living with mental illness, exemplified additional social processes perceived as maintaining community attitudes. Guided by the intersectionality framework, the findings of the study are discussed in the context of participants' multiple and overlapping social identities at the individual, community and societal levels.

Keywords: lay conceptions, attitudes toward mental illness, East Asian immigrant women, sociocultural influences

Lay Conceptions and Attitudes Toward Mental Illness Among East Asian Canadian Women

Beliefs about mental illness are shaped in the context of culture, which then guide subsequent pathways to diverse forms of care (Kleinman, 1980, 1988). Understanding laypeople's conceptions about mental illness may provide insights to how individuals make help-seeking decisions and beliefs that are associated with stigmatizing attitudes (Haslam, Ban, & Kaufmann, 2005, 2007). In the present study, we explore lay theories about mental health concerns among East Asian Canadian women and the intersecting cultural contexts that shape their beliefs and attitudes toward mental illness.

With the growing ethnic diversity in Canada, it has become critical to better understand disparities of mental health among various ethnic communities, and to increase equitable access to effective mental health services. The Mental Health Commission of Canada (MHCC) identified the need to reduce disparities of mental health and improve mental health services for immigrant, ethno-cultural and racialized groups as one of their priorities (MHCC, 2012). However, immigrants have lower rates in using metal health service. In economic terms, the average cost of mental health services among immigrants is 56 percent less than non-immigrant individuals, despite similar rates of mental health concerns (MHCC, 2016). These trends are consistent among East Asian (i.e., Chinese, Korean, Japanese) immigrants in Canada, who comprise of one of the largest visible minority populations (Statistics Canada, 2011). Scholars have consistently indicated that East Asian immigrants are less likely to use mental health services than their European Canadian counterparts (Gadalla, 2010; Tiwari & Wang, 2008). Using the Canadian Community Health Survey Cycle 1.2, East Asian respondents who experienced a major depressive episode were 74 percent less likely than Euro Canadian respondents to seek services (Gadalla, 2010). Prominent reasons for not seeking services were:

deciding not to bother, preference for managing it themselves, and skepticism about the helpfulness of services, rather than financial or other accessibility barriers (Gadalla, 2010).

Research on barriers to care among Asian immigrants have broadly included the following categories: cognitive, affective, service, financial and practical barriers (Leong & Lau, 2001; Sue, Cheng, Saad, & Chu, 2012). Cognitive barriers include aspects of mental health literacy, including differences in understanding and recognizing mental health symptoms, and less familiarity about how to access the mental health system (Na, Ryder, & Kirmayer, 2016), whereas affective barriers consists of negative attitudes, particularly heightened stigma and shame associated with mental illness among Asian communities (Abe-Kim et al., 2007; Ting & Hwang, 2009). The lack of culturally and linguistically appropriate service options are also prominent reasons for mental health service use disparities (Fung & Wong, 2007; Leong & Lau, 2001). Issues of cost, lack of time and transportation have also been identified as potential barriers to care (Leong & Lau, 2001).

Lay Conceptions of Mental Illness

Understanding lay person's conceptions of mental health issues is essential in comprehending attitudes toward mental illness, including stigmatizing and help-seeking attitudes (Haslam et al., 2005). The "folk psychiatry" model proposed by Haslam and colleagues (2005 & 2007) outlines four dimensions with distinct cognitive foundations and processes that capture how lay people understand mental disorders: pathologizing, moralizing, medicalizing, and psychologizing. The pathologizing dimension reflects the initial judgement that the behaviour or experience is deviant from the norm, whether that may be because the behaviour is unfamiliar, infrequent or socially inappropriate. Pathologizing creates the need to explain the person's behaviour and consequently, lay people use the moralizing, medicalizing and or psychologizing

dimensions to understand the person's behaviour. The moralizing dimension places the responsibility and blame of the non-normative experience on the person. Individuals with mental health concerns may be perceived as lacking self-control, willpower or their behaviours may be interpreted as a sin or criminality. In the medicalizing dimension, laypersons may conceptualize symptoms or behaviours as signs of mental illness that is outside of the person's control, whether due to a chemical imbalance or a genetic cause. The psychologizing dimension explains behaviour through the person's environment or life history. Thus, behaviours are understood as not fully intentional but grounded in the person's past experience or life stressors (Haslam, 2003; Haslam et al., 2005, 2007).

The folk psychiatry model was tested among U.S. undergraduate students who rated various mental illnesses differentially along the four dimensions (Haslam & Giosan, 2002). For instance, major depression and panic disorder were closely associated with the psychologizing dimension, whereas, Alzheimer's dementia was strongly correlated with the medicalizing dimension (Haslam & Giosan, 2002). Studies also indicate that conceptions of mental illness vary across diverse cultures (Glovsky & Haslam, 2003; Robbins & Kirmayer, 1991) and is amenable to change as a result of the acculturation process (Glovsky & Haslam, 2003). Among Brazilians living in the U.S. for example, acculturation was associated with greater identification with the psychologizing dimension and a greater tendency to pathologize various conditions (Glovsky & Haslam, 2003). Similarly, among Asian immigrants, Western knowledge and understanding of mental illness, especially medicalizing and psychologizing were closely tied to the acculturation process (Glovsky & Haslam, 2003; Jang, Gum, & Chiriboga, 2011; Parker, Chan, & Tully, 2006; D. Wong, Lam, Poon, & Chow, 2012).

Several studies have examined lay beliefs or explanatory models of illness, particularly surrounding depression among East Asian immigrants. The findings suggest a tendency to conceptualize depression with psychologizing and moralizing dimensions, and less endorsement of the medicalizing dimension. For instance, among first-generation Chinese speaking immigrants in Melbourne, depression was perceived as being caused by psychosocial problems, including life stress and interpersonal conflicts (F. Wong, Lam, & Poon, 2010). Similarly, among older Chinese immigrants in Calgary, depression was less likely explained as biological (i.e., medicalizing), rather, most of the participants attributed depression to psychosocial risk factors (Tieu, Konnert, & Wang, 2010). Causal explanations that were consistent with the moralizing dimension included having an introverted personality and "thinking too much," which assumes control and responsibility on the person (Wong et al., 2010). Similar findings were reported among older Chinese immigrants in Canada, who endorsed personality characteristics such as "being a nervous person" and "weak character" as attributing to depression (Tieu et al, 2010). Consistent findings were reported among older Korean American immigrants who also tended to normalize depression and perceived it as transitory (Pang, 1996).

After migration, many East Asian immigrants begin to integrate beliefs and attitudes that are congruent with Western views of understanding mental health issues (S. X. Chen & Mak, 2008). However, scholars have suggested that disparities in mental health service use persist beyond first-generation East Asian immigrants, suggestion that the acculturative process may take multiple generations. Using the Canadian Community Health Survey Cycle 1.1 data, Chen, Kazanjian, and Wong (2009), examined the rate of mental health service use among first-generation Chinese immigrants and Canadian-born Chinese Canadians in British Columbia. Both groups reported lower rates of service utilization, suggesting that factors other than language

barrier account for lower service use. Similar findings were reported among Asian Americans in the U.S. Using the National Latino and Asian American Survey (NLAAS), Abe-Kim and colleagues (2007) reported that first- and second-generation Asian Americans reported lower rates of all types of mental health related service use (Abe-Kim et al., 2007).

Cultural factors other than language barriers, including the transmission of beliefs and attitudes within families may account for some of the discrepancy. Specifically, for Asian migrants, stigma and shame associated with mental illness may act as prominent barriers (Abe-Kim et al., 200). First- and second-generation Asian Americans tend to hold more stigmatizing views about mental illness than their European American counterparts (Fogel & Ford, 2005; Georg Hsu et al., 2008). A large national survey of Australians contacted by random-digit dialing indicated that young peoples' stigmatizing attitudes are associated with their parents' attitudes (Jorm & Wright, 2008). Similarly, in a study of primarily non-Hispanic White adolescents, that also included Black, Hispanic and Asian American adolescent participants, open family conversations about mental health were associated with more positive views toward mental health services, contrary to families who avoided or dismissed mental health related discussions (Chandra & Minkovitz, 2007). Thus, some beliefs and attitudes toward mental illness that influence help-seeking and stigmatization may be communicated and passed on within families.

Observing the lack of theoretical models that examine the process of how individual's attitudes toward mental illness are formed and maintained, Pescosolido, Martin, Lang, and Olafsdottir (2008) proposed the Framework Integrating Normative Influences on Stigma (FINIS). The FINIS integrates various theories (e.g., labelling theory, social network theory) and research from multiple disciplines to provide a broad theoretical foundation on how attitudes toward mental illness, particularly stigmatizing attitudes are formed. The FINIS examines micro

(e.g., individual attitudes), meso (e.g., social and media influences) and macro (e.g., laws and policies) levels of influence. Thus, the framework highlights not only interactions that shape attitudes at the individual level, but also at the larger social, cultural and political contexts. One of the aims of the study was to explore the factors that contribute to the shaping of mental health beliefs and attitudes among East Asian women.

Conceptions of Mental Health Among East Asian Immigrant Women

In addition to examining the diverse ways of understanding mental health in specific ethnocultural communities, the role of multiple social identities on individuals' perceptions toward mental illness needs to be explored. Some have argued that the literature on culture and mental health can at times essentialize or assume homogeneity within cultural groups, as well as overlooking diverse experiences stemming from several intersecting identities (Wong & Tsang, 2004). Rather than examining social identities in discrete categories, the intersectionality framework aims to understand how multiple social identities, including race/ethnicity, gender, SES, sexual orientation and ability status overlap within a system of power and oppression (Crenshaw, 1989; Davis, 2008). Assumptions about mental health and mental illness may differ as a result of one's gendered experience, coupled with one's ethnic identity and migration status. Intersectionality may be a useful framework in understanding East Asian women's experiences within a comprehensive cultural context.

Qualitative studies that have examined perceptions toward mental health among East Asian immigrant women suggest diverse perspectives that challenge stereotypical notions about East Asian sociocultural and gender norms. In a qualitative study among 102 East and Southeast Asian immigrant women living in Toronto, conceptualization of mental health and ways of maintaining mental health elicited multiple viewpoints that diverged from the simplified

frameworks of Confucianism and social harmony that are frequently presented in the literature (Wong & Tsang, 2004). East and Southeast Asian women in the study spoke of physical and mental health being closely interlaced. Mental health was understood differently among the participants. While some used spirituality and religious frames of understanding, others highlighted racial and political influences on their mental health, and some spoke of mental health as having their basic needs met, including food, clothing and shelter (Wong & Tsang, 2004). Some East Asian women also endorse more traditional views toward mental health. In a mixed-methods study among Chinese American immigrant women living in Los Angeles, participants spoke of imbalance of hot and cold elements in the body and modifying their diet to improve their distress (Tabora & Flaskerud, 1997).

One qualitative study examined the experiences of mental health care use among ten immigrant and refugee women from China and Sudan living in Canada. Participants discussed the need for culturally and linguistically appropriate services, issues of confidentiality due to stigma, and the need to raise awareness regarding mental health issues in their communities (Donnelly et al., 2011). Importantly, immigrant and refugee women actively engaged in self-care strategies and sought support to improve their mental health, a finding that contradicts stereotypes that immigrant and refugee women are passive, noncompliant, and do not take responsibility for their health (Donnelly et al., 2011). Thus, for a more nuanced contextual examination of perceptions and attitudes toward mental health, the present study applies the intersectionality frame in exploring East Asian immigrant women's perspectives and experiences that may be shaped by their multiple social identities and positioning.

The Present Study

The present study is a qualitative inquiry that examines perceptions and attitudes toward mental illness among 1st and 2nd generation East Asian young women in Canada. Young adult East Asian women may be an important population as they may frequently act as culture brokers for their immigrant parents and families in healthcare settings (Kim, Brenner, Liang, & Asay, 2003). Moreover, the initial onset of mental health problems often occurs among adolescents and young adults (Jones, 2013), a period in which making decisions regarding one's mental health is critical in prevention and early intervention. The study was guided by the following research questions:

1. What are East Asian women's beliefs about mental health and mental illness?
2. What are their perceived community attitudes?
3. What are some of the factors that influence their attitudes toward mental illness?

The intersectionality framework is a flexible approach that has been applied in diverse ways in women's health research (Hankivsky, Cormier, & De Merich, 2009; Hankivsky et al., 2010). In the present study, we applied the intersectionality framework in the following ways. First, consistent with most intersectionality scholars, the study begins with a social justice aim in addressing the disparities in access to mental health care among East Asian immigrant communities. Second, in line with the assumptions of the intersectionality framework, we focused on social inequalities and the role of power and oppression as central to understanding the research questions. Third, we intentionally recruited 1st and 2nd generation East Asian young adult women as participants and included explicit questions in the focus group discussions about the influence of their overlapping identities on participant's perceptions and attitudes toward mental health. Finally, in interpreting and presenting the data, we were careful to avoid

essentializing East Asian participants in terms of over-general categories; instead, we specify variation in relation to the social context. Thus, by applying the intersectionality framework in the present study, we aim to provide an in-depth understanding of how multiple identities, including ethnicity, gender and migration status, influence perceptions and attitudes toward mental illness.

Methods

The present study utilized a focus group methodology to explore, capture and document perceptions and attitudes toward mental illness among 1st and 2nd generation East Asian young adult women. We utilized a focus group approach, a commonly used qualitative research method in exploring attitudes and stigma related to mental illness (e.g., Schulze & Angermeyer, 2003; Sin, Jordan, & Park, 2011) and working with socially marginalized groups (Kitzinger, 1994; Madriz, 1998). Focus groups can stimulate discussions, capture group consensus and discrepancies in experiences, and balance power between participants and the researchers (Ekblad & Bäärnhielm, 2002). Moreover, focus groups have the potential to facilitate the discussion of nuanced information by creating a social context in which participants can discuss unique as well as shared experiences of a phenomena (Krueger & Casey, 2009).

Participants

Participants ($N = 47$) were undergraduate and graduate women at a large Canadian university located in a metropolitan city. Inclusion criteria for the study were: (i) self-identified East Asian (i.e., China, Korea, Taiwan, Hong Kong, Japan, Macau) woman between the ages of 18-25; (ii) immigrated to Canada from East Asia *or* have parents who are immigrants from an East Asian country; (iii) be able to read, write and converse in English. Individuals who were in Canada on an international student visa were excluded from the study to account for potential

discrepancies in the acculturation process, including different social networks that may influence attitudes and perceptions towards mental illness. Of the 47 participants, 36 identified as Chinese, 9 as Korean, and 2 participants as Taiwanese. Mean age of the participants was 21 years old (*SD* = 2.19) and on average, participants had been living in Canada for 13.3 years (*SD* = 6.13). Twenty-four participants (51%) had previously taken at least one psychology or mental health related course and seventeen participants (36%) disclosed having sought mental health services in the past.

Procedure

The study's sample was part of a larger intervention study to reduce mental illness related stigma among East Asian women. Participants were given the choice to attend this optional focus group prior to the intervention workshops. We used convenient sampling to recruit participants through student organizations, campus flyers and university listservs. Interested participants contacted the principal investigator by email. They were screened for eligibility by completing a brief screening questionnaire by email. Once they were screened for eligibility, we obtained informed consent and participants were asked to fill out a demographic questionnaire and their availabilities to attend the focus group online. Participants also completed questionnaires on stigma and attitudes toward psychological help-seeking that were part of the larger study on mental illness related stigma. Of the 61 participants who took part in the larger study, 47 participants agreed to attend the focus group.

The principal investigator (lead author) and a trained research assistant facilitated the focus group discussions. A total of six focus groups, consisting of 6-12 participants were conducted. The discussions took place at the university with an approximate duration of 85 to 95 minutes. At the beginning of each focus group, the facilitator described the purpose of the study

and the format of the discussion. The facilitator established group rules to foster a confidential and non-judgmental space, conducive to an open discussion (Krueger, 1994). Participants were asked to choose a pseudonym to maintain anonymity. The focus group discussions began with an "icebreaker" followed by a semi-structured question guide pertaining to the relevant topic developed by the research team (e.g., 'What does it mean when someone is experiencing a mental health problem?' 'What are some common attitudes or ways of looking at or responding to people with mental health problems?'). The facilitator made efforts to engage all participants to share their opinions to gather diverse opinions, group consensus and disagreement. At the end of the discussion, the primary facilitator provided a brief summary of the discussion and participants were provided with an opportunity to add any additional comments as they wished. Participants received a $20 honorarium for their attendance. All focus groups were audio recorded and a research assistant documented nonverbal expressions and summary of participants' comments.

Data Analysis

The principal investigator and research assistants transcribed the audio-recorded focus groups verbatim and they were then entered into ATLAS.ti (Version 1.0.50) qualitative analysis software. The focus group data was analyzed using the guidelines for thematic analysis (Braun & Clarke, 2006) to identify salient themes pertaining to the research questions. Researchers followed Braun and Clarke's (2006) six phases of thematic analysis: (a) become familiar with the data; (b) generate initial codes; (c) search for themes; (d) review themes; (e) define and name themes; and (f) produce a report. Three members of the research team were involved in the analysis of the data. Initially, the principal investigator listened to the audio recordings and reviewed the focus group transcripts to become familiar with the data. Using inductive coding, in

the second phase, the researcher generated initial codes grounded in the data and created a codebook. In phase three, the researcher searched for themes by examining the relationship between the codes and code co-occurrence. The two other members of the research team reviewed the codes and themes and the team met to seek agreement and negotiate differences. The frequency of codes was tallied and prevalent codes were grouped into themes. In phase four, the researcher reviewed initial themes by reading all the collated extracts from the transcripts for each theme across the six focus group transcripts. In phase five, overarching themes and sub-themes were explicitly defined and further refined through thematic mapping (creating a diagram of relationships between themes and subthemes). The research team reviewed the coded data and met regularly to discuss coding disagreement until consensus was reached. The principal investigator consulted and reviewed with the research team on the codebook, preliminary themes and refinement of themes.

Findings

We identified themes and subthemes that pertained to the conceptualization of mental health problems and mental illness, perceived community attitudes, and factors influencing attitudes toward mental illness. Below, we present themes, definitions, and illustrative quotations that exemplify each theme (see also Table 1). To protect participants' identities, we use self-selected pseudonyms throughout.

Conceptualization of Mental Health Problem and Mental Illness

Prominent themes concerning the conceptions of mental health problems and mental illness included discussions on *contributing factors* (39 participants), including three subthemes (*situational*, *biogenic* and *constitutional causes*) to mental health problems. Participants also discussed the *complexity and ambiguity* (18) of defining mental illness.

Most commonly, when asked to define mental health problems or mental illness, participants discussed perceived causes and contributing factors, including *situational* (17), *biogenic* (13) and *constitutional causes* (9). *Situational causes* were defined as external factors or events such as, difficult past experiences, interpersonal and environmental stressors that lead to distress. In particular, participants spoke of relevant stressors that affect their mental health, including parental expectations on career aspirations and academic performance, and societal pressures placed on young women pertaining to physical appearance. Participants in the study also endorsed *biogenic causes*, including "chemical imbalance" of the brain and having a genetic predisposition to develop mental illness. *Constitutional causes*, particularly having an "undesirable personality" or being "too sensitive" were also perceived to cause mental health issues. Participants commonly discussed constitutional causes as a belief that they observed more frequently within the East Asian community.

Eighteen women commented on the inherent *complexity and ambiguity* in defining mental health problem and mental illness. Some of the participants expressed that normal and abnormal behaviours are "socially constructed" and defined. Because common mental health concerns, especially depression and anxiety are considered normative experiences, participants voiced the challenge of defining and identifying when these experiences becomes an "illness." There was a general consensus that mental illness is on a continuum of severity. However, mental health problems were often defined differently than mental illness. Some participants stated that most individuals would experience some type of mental health problem in their lifetime. Thus, mental health problems were often perceived as a more normative reaction to situational factors that could be coped with self-help strategies such as exercise. On the contrary, mental illness was perceived as a more "chronic" and "severe" condition than a mental health

problem that requires treatment by a mental health care professional, the use of medication and a diagnosis or label.

Perceived Community and Personal Attitudes Toward Mental Illness

Stigmatizing beliefs (44) was a prominent theme discussed by women in the study on their perceived community attitudes toward mental illness. Subthemes included perceptions of: *fear and violence* (31), *weakness* (20), *person reduced to illness* (11), and *incompetence* (11). Fear and violence was the belief that persons with mental illness are "violent," "unpredictable" and "dangerous," a theme that was especially prominent for schizophrenia. Participants also discussed the need to "walk on eggshells" because they feared that the person with mental illness would become emotionally volatile or aggressive. For depression, individuals were perceived to be "fragile" and thus, some participants reported that they have refrained from discussing certain topics that may provoke a negative emotional reaction. Moreover, experiences of depression and anxiety were often normalized and were not necessarily perceived as an "illness" in the community; thus, these individuals were considered, "weak," "lazy" and "attention seeking." Participants also discussed that individuals with mental illness were perceived as "unproductive members of society" and "incompetent" in completing basic tasks and needing to rely on others for daily functioning. The reduction of a person to their illness - the illness becoming their "marker" or "identifier" and being categorized as "crazy" was also discussed by 11 of the participants. Although some acknowledged that stigmatizing beliefs were common across cultures and prevalent in Western societies, many women highlighted that stigma and negative attitudes toward mental illness were more prominent within East Asian communities.

Factors Influencing Attitudes Toward Mental Illness

We identified eight themes regarding the influences on attitudes toward mental illness: *lack of dialogue (33); family influence* (31); *normalization* (29); *socially defined gendered norms* (28); *awareness and knowledge* (16); *sociocultural norms* (15); *personal familiarity* (14); and *immigration related issues* (10).

A principal theme across the focus groups was the *lack of dialogue* regarding mental illness within the family and community. The absence of dialogue signified that the topic is "taboo," "not important," and "shameful." Participants recalled instances in which family members avoided discussions surrounding other family members affected by mental illness. One participant, Nina (Chinese, 15 years in Canada) described her experience regarding a cousin with mental health problems: "Whenever we talk about her, within the family context, it's always very um, it's very hush hush, like they don't bring her up very often."

Similarly, in all six focus groups, participants engaged in in-depth discussions on the role of *family influence*, predominantly parental influence on shaping their attitudes toward mental illness and mental health services. These included messages about distancing or avoiding contact with people living with mental illness, being discouraged to work or volunteer in mental health settings, conceptualizing mental health problems as not an "illness" but rather a temporary condition with personal control, and the lack of dialogue and personal disclosure surrounding mental health concerns that implied shame.

Nineteen participants disclosed either having a family member, knowing someone in the community or themselves experiencing mental health problems. These participants often recalled their experiences in the context of their parents' reactions. Chloe (Chinese, 25 years in Canada) stated,

> The way that my parents view um people with mental health problems is that- that- it's like their marker, their identifier. That whenever they would bring that person up they would be like 'oh by the way here she has depression.' And for a long time I think they kind of worded it like it was either extremely tragic, like they fell in to a chasm that there was no way of recovery or that they had chosen to be that way. And so um, when I um was diagnosed with an anxiety disorder and I told my parents, um, immediately they said, 'well don't tell anyone' because we don't want that stigma attached to you where everybody will look at you and just know that you have some sort of problem.

Consequently, participants discussed their familial attitudes continuing to affect their beliefs and attitudes surrounding individuals with mental illness, self-recognition, acknowledgement of mental health problems and self-stigma. Stella (Korean, 22 years in Canada) expressed,

> I think that kind of attitude … even though I'd like to think that I would be more open about, if I had a mental illness, or if my brother had an issue, I would be more open about it. But I think if I actually were in that situation, I probably would be, like, a lot like my mom. And I don't think ... maybe I'd tell like a really close friend maybe my mom? But I think outside of that, like if I needed ... I don't think I would extend my, like, support network, like it would be very very limited, and I wouldn't want anyone to know about it.

Some participants also discussed the discord between their preference toward Western mental health services (e.g., psychotherapy, going to see a physician) and their parents' reluctance and doubt toward seeking mental health services, which their parents considered as a "last resort." While some participants reported that their parents preferred traditional Chinese medicine and acupuncture for mental health related concerns, participants themselves expressed their hesitations regarding the effectiveness of alternative medicine. This incongruence led to

participants experiencing a lack of support from their parents when they wished to seek Western mental health services, while others stated their own reluctance to seek mental health services as a result. Grace (Chinese, 6 years in Canada) shared,

> I did have a period, back in high school, when I was quite depressed, um, and even then, like my counsellor was like, 'No, you should go see a doctor, like you should go get medicine,' or whatever, I was like, 'I could ... Or I could just suck it up and go to class ... um ... and I think a lot - a bit of that was shaped also by the fact that um ... my parents are also very against Western medicine ... because like my-my-my-my parents are very 'Oh you know, it's because you're not eating healthily enough or... you don't wear a jacket when you go outside' [people laugh and seem to collectively relate] ... Like, 'You got a cold because you went walking in the rain with *that* outfit. Or like... 'You didn't dry your hair' [people laugh in agreement] ... So like a lot of it to me was like ... even with sickness now to me it just seems like 'meh' I could take medicine or not.

Participants spoke of the process of negotiating and evaluating beliefs and attitudes about mental illness that stem from their family and forming their own attitudes and opinions. T.Y. (Chinese, 25 years in Canada) described,

> Knowledge and the education about mental illness is … has been there for a much longer time in Canada and the White—White Western community. It hasn't been in …uh, East-Asia and uh, we are first-generation, uh… or we are the first daughters of people who came to Canada. We still carry this background—this cultural background that—that our parents … um, so there's definitely, we—we—assuming all of us have had to… um… uh choose between …uh, what our parents beliefs are and …what the society here was…telling us to

> do. We've had to kind of evaluate all the signs and think 'you know, I—I think this one makes more sense.'

Being exposed to the Euro-Canadian culture that was perceived as more open to discussing about mental health issues, coming to university where there are more initiatives to raise awareness and knowledge about mental illness, having direct contact with people who have mental illness, and taking mental health related courses were some factors participants discussed that helped them cultivate less stigmatizing views.

Third, participants discussed the impact of *normalization* of common mental health concerns, particularly for depression and anxiety affecting their attitudes toward mental illness. Because mental health problems are not perceived as an "illness" per se, Robin (Chinese, 15 years in Canada) noted, "the burden of responsibility is on you, like maybe you caused it or maybe you're not strong enough for the situation that caused you to fall into this mental illness." Participants also expressed that mental health concerns are often "perceived less [important] than a physical problem" and thus, lead to a lack of support and sympathy from others.

Fourth, participants discussed the role of *socially defined gendered norms* in shaping attitudes and the experience of mental illness. There was a consensus among participants that it was more socially acceptable for women to experience, discuss and seek help for mental health problems because women are perceived as "weaker," whereas the fear of being "weak" discouraged men from talking about their mental health and accessing services. Participants also discussed being perceived as "emotional," "moody" and "overly dramatic and sentimental," which led to their mental health problems as being "invalidated" and "dismissed." Ashley stated that women's mental health concerns would be, "dismissed as being moody or being a girl or being on her period and wouldn't be taken as seriously," a sentiment that was shared by many

other women in the study. On the other hand, men with mental illness were perceived to be more "aggressive" and "violent." Some participants discussed the impact of migration and the role of women as caregivers on mental illness, particularly depression. These included dialogues about the shame that East Asian women experience if they are not able to meet family and childrearing responsibilities because of a mental illness, and the social isolation experienced by immigrant women in their community that contribute to depression. Isabel (Chinese, 5 years in Canada), described her mother's experience of depression since migrating from China.

> To me it's [depression] a very gendered thing, and I think it's almost… I know my—the reason my mom suffers from is because she…really feels trapped. Being alone in the family, my dad' always in China and he flies back—back and forth…uh, once per month or…once per two months to visit because he has to, you know, make living. So she feels trapped and she can't do much everyday, she… she has… the same life routine, raise my sisters, cooking uh…making them—packing them lunch, making breakfast, while…uh, she has a couple hours to, you know, get some sleep and then she goes home and cooks again, uh, prepares us dinner again, and send my sisters away… uh, for skating, comes back, uh, clean the house, go to bed at like 11, so her—everyday she's like…a laboured …you know, she doesn't really have time for herself, so to me it's um, it's almost like the men are…lucky that they can escape the possibility of *having* depression. Because to anyone, that kind of life could be quite depressed, without a community um, and not having any friends around you.

Another prominent theme was the perceived lack of *awareness and knowledge* regarding mental illness among the family and within their cultural community more broadly. Some participants expressed that the lack of knowledge and awareness regarding mental illness may

not be culturally specific, but rather tied to education level. However, the majority of participants believed that East Asian communities were less knowledgeable about mental illness, which leads to and perpetuates negative stereotypes. Participants noted that those with mental illness are often labelled as, “out of control” or “crazy” because community members do not recognize or understand the causes of a mental illness. Some participants described their family and community as, “narrow-minded,” “very conservative” and “uneducated” and some expressed disappointment and criticism for the lack of knowledge and awareness regarding mental health issues, and for lacking sensitivity toward other minorities including being “homophobic.” Participants also commented on the role of the media on perpetuating negative stereotypes and fear. This was coupled with a perceived absence of effort in their community to learn more about mental illness. Nozomi (Chinese, 4 years in Canada) stated,

> All the media coverage it's like schizophrenia people are crazy they're like hurting people. That's all the media they [my parents] get, and they don't quite understand how like mental illness are like what they are, what … how it can be treated, that sort of thing they don't … I think they don't care as much so they don't … they don't care to know. So they just say, 'oh he's crazy,' I'm just going to leave him alone. That's a simple solution for him.

Participants commented on the *sociocultural norms* including collectivism, filial piety (i.e., deference to parents, elders and ancestors) and the importance of maintaining ‘face’ as exacerbating mental illness stigma in their community. Women in the focus groups stated that the emphasis on “harmony,” “collectivism” and “blending in” lead to individuals in the community not wanting to “stand out in anyway,” including disclosing a mental health problem. Values of respecting one’s parents and elders lead to the understanding that mental illness would be perceived as “ungrateful,” “disrespectful” and “selfish” by one’s family and the community.

Similarly, women in the focus group discussed the emphasis placed on one's reputation (i.e., face) which extends to the family, and the shame that would be experienced by the entire family if one were to experience a mental illness. Lily (Chinese, 16 years in Canada) stated that if someone were to experience a mental illness, "that means that there's something wrong with that family or something wrong with the relationships in that family." If a child were to experience mental illness, "it might reflect on them as a parent. You know like, 'You didn't raise your child right they have mental illness'" (Nina). Consequently, this led to family conflicts about help-seeking. For instance, Isabel, who described her cousin as "suicidal" and "aggressive," stated:

> And we're trying to … we think … we're debating whether or not to tell my uncle and aunt about how she needs to go see a doctor regarding that. But we … we were … we were told by our grandma … she was very against the idea, she said, 'No you may not say that, because it's a shame to to-to-to-to even assume that you've got … a person with mental illness in the family, and … that my uncle would feel really … be ashamed and guilty because he might think it's his fault.

Another factor discussed as having an influence on one's attitudes was the *lack of personal familiarity* with those living with mental illness. Some women discussed not having had any contact with a person living with mental illness until they migrated to Canada. Participants discussed difficulties empathizing or relating to those who experience mental illness. For more common mental health concerns (e.g., depression, anxiety) the person's subjective distress could not be fully understood because they were common experiences experienced by most people. Connie (Chinese, 5 years in Canada) illustrated this with a metaphor,

> Imagine if your friend broke their foot and you've broken your foot before but you didn't feel any pain. And your friend is like, writhing in pain. You'd be like oh, it's no big deal;

> when I had my foot sprained I didn't have any pain at all. I think that's also really prevalent as like, kind of stigmatizing too. Um, so it's – it could be something that you have similar um, feel of what they're feeling and you didn't see it as an issue and then you'd also think that the other person is kind of ok.

Similarly, participants discussed the challenge of relating to experiences encountered by those with psychotic disorders. Katie (Chinese, 18 years in Canada) commented,

> That's even more difficult to understand than just maybe sympathizing or empathizing with feelings because um, illnesses that cause hallucinations you really, like, you, it's very difficult to put yourself in that person's shoes. You can't. Especially when it's something you've never experienced before it's very very difficult to imagine you in their place. And so it's even more difficult to understand that problem which … creates a larger stigma surrounding it.

The eighth theme, *immigration related issues* pertained to the role of living in small immigrant communities and marginalized status as an immigrant on affecting one's attitudes toward mental illness. This contributed to the lack of discussion and acknowledgement of mental illness in the community. Sophie (Korean,10 years in Canada) stated that living in a small immigrant community where everyone knows each other leads people to "try to keep it [mental health problems] really quiet." Marginalized status as an immigrant and ethnic minority was perceived as contributing to the dismissal and lack of acknowledgement of mental health problems in the community because of the additional layer of stigma and discrimination that one might experience. Robin stated,

> As an immigrant in Western society there's this perceived like, setback, that they're … like there's a stigma surrounding being a minority and an immigrant in itself so there's this

> perceived setback in trying to assimilate into Western society. So that adds like another burden in, or not burden but, like another barrier in wanting to um … like, uh … admit a mental illness in a way. Because you're already kind of marginalized and you're already seen as an immigrant in a way in that there's a stigma surrounding that so you don't want to make the situation worse on your own by admitting a mental illness in a way that sets you back even further and make you even more of an outcast in society because there's already a perceived "other-ing" by society.

Discussion

From the personal narratives and opinions shared by the focus group participants, we identified themes related to conceptions and attitudes toward mental illness that were consistent with the folk psychiatry model (Haslam et al., 2005). These included beliefs about causal factors and stigmatizing beliefs surrounding mental illness. Many also spoke of the complexity and ambiguity of understanding and defining mental health issues, including the notion that the absence or presence of a "mental illness" is socially defined. The findings also provide a more comprehensive snapshot of the social and cultural contexts that shape attitudes toward mental illness among East Asian women, at the micro-, meso-, and macro-levels (Pescosolido et al., 2008). These themes included: the absence of dialogue regarding mental illness within the family and community, direct and indirect parental influence on participants' attitudes toward mental illness, and the perceived lack of awareness and knowledge about mental health issues observed among participants' communities. Participants in the study also highlighted that normalization of common mental health problems and the lack of personal encounters with those who live with mental illness affect their attitudes toward mental illness. Moreover, participants discussed the role of intersecting social identities and positioning, including gender norms, sociocultural norms

of collectivism, filial piety and maintaining 'face,' and immigrant status as influencing their perceptions and attitudes toward mental illness.

East Asian Women's Conceptions of Mental Illness

The themes identified in East Asian women's narratives about psychological abnormality were congruent with the four dimensions of folk psychiatry (i.e., pathologizing, moralizing, medicalizing and psychologizing) and their underlying cognitive processes (Haslam, 2003; Haslam et al., 2005). While some women in our study defined mental illness by providing a label or category, most women focused on a plausible cause or reason for the person's distressing experience or behaviour. The folk psychiatry model posits that the perception that a condition defies normal experience drives the need for a plausible cause or explanation (i.e., pathologizing; Haslam et al., 2005). This tendency to provide a causal explanation when asked to define mental illness suggests an underlying assumption that mental illness is an abnormal, pathological experience.

Participants' etiological discussions on mental illness reflected the salience of stressors closely tied to East Asian women's social identities, as well as their exposure to the biomedical model and indigenous health beliefs. Participants most commonly reported understanding mental illness in terms of a person's life history, congruent with the folk psychiatry's psychologizing dimension. These included psychosocial stressors that are particularly pertinent to East Asian women's migrant status and gender; participants discussed academic stressors and heightened parental expectations on academic achievement because of their migrant status. Marginalized status as immigrants can lead to additional academic pressures from immigrant parents who view it as a way to cope with discrimination and disadvantages faced in employment (Li, 2001). Similarly, participants' discussion on issues of body image is closely tied to gender norms. Rigid

standards on physical appearance is used as a vehicle to marginalize women and undermine their competencies and resources, consequently affecting their mental health (Frederickson & Tomi-Ann, 1997).

Many of the participants in the study had been living in Canada for over ten years, and a significant portion of participants had exposure to Western mental health related courses and services. Biogenic causes for mental health problems are increasingly recognized in lay models of illness (Schomerus et al., 2012). The folk psychiatry model's medicalizing dimension (Haslam et al., 2005) is congruent with biogenic causes, and are more commonly endorsed in western societies (Karasz, 2005; Keyes, 1985). Western knowledge and understanding of mental illness, especially medicalizing is closely tied to the acculturation process (Glovsky & Haslam, 2003; Jang et al., 2011; Parker et al., 2006; D. Wong et al., 2012). Thus, the themes pertaining to biogenic causes appear to reflect participants' own level of acculturation and their exposure to, and integration of the medical model. In contrast, constitutional causes of mental illness, which attributed mental illness to personality and temperament, were more commonly related to attitudes within the East Asian community, including respondents' families, consistent with the literature (Lam et al., 2010; Sin et al., 2011; Tieu et al., 2010).

In addition to causal beliefs, participants discussed the complexities in defining mental health and mental illness. Participants expressed uncertainty and skepticism regarding the definition and labelling of psychological abnormalities and commented that these definitions are socially constructed. Some acknowledged the inherent challenge of defining and categorizing mental illness. Many defined mental illness and mental health problems differently, and perceived mental illness as a more chronic and severe condition. Understanding mental health and mental illness on a continuum, where the emphasis is on the quantitative difference of

distress severity, rather than a qualitative difference between individuals who have or do not have mental illness has been found to be more helpful in reducing stigmatizing beliefs (Schomerus et al., 2016). The effectiveness of similar interventions could be examined among East Asian women, in bridging the gap between how mental health, mental health problems and mental illness are defined and perceived.

The stigmatizing beliefs identified in the study surrounding mental illness were consistent with views commonly held among the general population in Western societies (Angermeyer & Dietrich, 2006; Parcesepe & Cabassa, 2013). These comprised of the belief that individuals with mental illness are violent, incompetent and weak, and placing responsibility and blame on the person. Themes of fear and violence, weakness and incompetence imply that the abnormal behaviour and experience is under the person's control (i.e., moralizing), which can provoke blame (Haslam et al., 2007).

Socio-Cultural Influences

Participants in the study discussed factors that shaped their personal attitudes and beliefs surrounding mental illness as well as those of others in their community. The themes highlight factors and forces at multiple levels, including at the individual, community and societal. Participants spoke of the roles of family, gendered norms, sociocultural norms and immigration related issues that shape their attitudes toward mental illness and mental health services. In light of the intersectionality framework, the findings indeed indicate that social identities are not independent of each other (Crenshaw, 1989; Davis, 2008). Rather, women's experiences and East Asian immigrants' experiences need to be considered within the individual's complex socio-cultural context.

First, the findings of the study emphasize the role of the intergenerational transmission within families and communities of attitudes toward mental illness and help-seeking. Most women in the study discussed receiving both implicit and explicit messages about social distancing from individuals with mental health problems, shame about such conditions, and skepticism toward Western conceptualizations and treatments of mental illness. The absence of dialogue about mental illness and the normalization of common mental health problems within the family and community conveyed a sense of shame and trivialized mental illness to participants in the study. Some participants reported that these experiences with family had an impact on their attitudes toward help-seeking and self-stigma.

Scholars have pointed to the influence of parents' attitudes toward mental illness on adolescents and young people (Chandra & Minkovitz, 2007; Jorm & Wright, 2008). The current literature suggests that second-generation Asian immigrants who generally do not experience the linguistic barriers to seeking mental health services that can affect first-generation immigrants, nevertheless continue to report lower rates of mental health service use than the general population (Abe-Kim et al., 2007; Chen, Kazanjian, & Wong, 2008) and more stigmatizing views about mental illness than their Euro-American counterparts (Georg Hsu et al., 2008). Discussions among participants in the study emphasize the important need to consider the family and social processes through which attitudes toward mental illness and treatments are transmitted and maintained. Some women reported beginning to negotiate their own beliefs surrounding mental illness based on exposure to mental health education at university, anti-stigma campaigns, and personal contact with those living with mental illness. The construction of attitudes toward mental illness and help-seeking is a complex social process, in which social networks, including family and peers, mental health services, and cultural background knowledge and values all

shape attitudes toward and recognition of mental illness and help-seeking (Pescosolido, Gardner, & Lubell, 1998; Pescosolido et al., 2008). The findings of the study provide insights to the intricate social process among East Asian women in Canada.

The ways that participants discussed family and community attitudes and beliefs also contribute a layer of complexity that is important when considering community psychoeducational interventions for East Asian immigrants. Many participants expressed criticism and disapproval of their community's conceptualization and treatment of mental illness. Some participants described the lack of awareness and knowledge surrounding mental illness within their family and community as an instance of being "narrow-minded" and "uneducated." Many also expressed skepticism toward traditional Asian medicine. A study among South Asian, Black African and Black Caribbean service users and laypersons in the UK, captured some participants' tendency to be highly critical of community attitudes and traditional treatments, and their preference toward a biomedical approach (Shefer et al., 2013). Participants discussed the lack of knowledge and the need to educate their communities about mental illness (Shefer et al., 2013), a theme that was also voiced in the present study.

These findings suggest that first, attitudes toward mental illness and treatments are diverse within East Asian immigrant populations or communities and within individual families; some may reject traditional ways of understanding and treating mental illness. Second, given that immigrants may be met with mental health services that are not culturally responsive to their needs (Kirmayer, 2012), over-identifying with Western conceptions of mental illness, particularly the biomedical model, could lead to disappointments by East Asian immigrants. For instance, they may experience discrimination within the health care system (Clough, Lee, & Chae, 2013) and services that do not cater to culturally relevant issues, for instance, shame,

stigma and family reputation (Wynaden et al., 2005). Moreover, they may also face broader systemic issues, such as long wait times and financial barriers (Blignault, Ponzio, Rong, & Eisenbruch, 2008). Some ethnic minorities adopt a pluralistic approach to mental health, embracing both traditional cultural and biomedical models, with the understanding that one may be more suitable for one individual than another or for one type of condition or aspect of a problem, and being open to trying both options (Shefer et al. 2013). A more pluralistic approach to mental health may maximize the service or treatment options available for East Asian immigrants. Intergenerational dialogue within families about the complexity of mental health issues and the role of culture in shaping the beliefs, attitudes and experiences of mental illness could lead to more flexible conceptions of mental health and openness to treatment options that meet the needs of the individual.

Intersections with Gender

Socially defined gendered norms, sociocultural norms, and immigration related issues were often intertwined and influential in shaping attitudes toward mental illness. Women in the study discussed several aspects of gender that affect attitudes in their communities. Although there was consensus that, as women, it is more acceptable to experience, discuss and seek mental health services, they were also dismissed because of gender stereotypes that view women as weak and more emotionally labile, which serve to discredit women's distress. These findings are consistent with a web-based study of primarily Euro-Americans; when participants were presented with a stereotypical disorder associated with each gender (i.e., depression for women and alcoholism for men) participants responded with less sympathy, inclination to help, and with more negative affect (Wirth & Bodenhausen, 2009). Disorders that are perceived as gender-typical may increase personal blame because their behaviours are perceived as more characteristic of their

gender and hence, imply more personal control or responsibility. On the other hand, disorders that are perceived as gender atypical (i.e., alcoholism for women and depression for men) may be associated with beliefs that their experience is more "genuine" with a biological cause (Wirth & Bodenhausen, 2009). Although findings of this study have not been replicated among East Asian individuals, participants in the present study also perceived depression as a more common experience among women compared to men. Moralizing and dismissing East Asian women's mental health concerns were discussed in the context of gender-typical symptoms, including being "moody" and "depressed."

This study highlights the way social identities at the individual level intersect with structural factors (i.e., loss of power and marginalization as women, ethnic minority and migrant status) to affect attitudes toward mental illness. Socially defined gender norms, expectations, and immigration/re-settlement challenges often converge to shape attitudes toward mental illness and reinforce social stigma. Gender role expectations may aggravate immigrant women's experience of loss of social support and marginalized status as an ethnic and racial minority. Participants noted that not being able to meet caregiving responsibilities for one's children and husband because of mental illness were concerns in the community. While the normalization or dismissal of depressive experiences may be a common experience among women in Western cultures as well (Wirth & Bodenhausen, 2009), specific norms and gender role expectations in East Asian communities, and loss of status and social support through the migration process, were identified as additional factors that contribute to increased stigma and shame regarding mental illness.

Moreover, participants spoke of the influence of sociocultural norms related to collectivism, filial piety and importance of maintaining 'face' on attitudes toward mental illness in their community. Previous literature has discussed the role of social harmony and the person

as relational rather than individualistic on influencing stigmatizing attitudes in Chinese society (Lam et al., 2010). Moreover, the concept of 'face,' or social or moral standing (Hwang, 2001; Kleinman & Kleinman, 1993, Qi, 2011), and the extension of shame and stigma to the family have also been discussed (Han, Cha, Lee, & Lee, 2017; Jenni, 1999). In Chinese and Korean societies, stigma and loss of 'face' are closely interconnected; loss of 'face' negatively affects access to social capital and a person's moral standing in society (Yang & Kleinman, 2008). In social interactions, individuals may want to not only maintain their own face but also the face of others (Qi, 2011), which may contribute to the lack of dialogue regarding mental illness. Moreover, having already lost social capital through the migration process, participants reported the critical need to maintain 'face' in their small immigrant communities, which contributed to stigmatizing attitudes and further discouraged dialogue regarding mental illness.

Together, findings suggest gendered experiences that may be shared more broadly by women in North America, and unique experiences of East Asian women in the study as a function of their socialized values and norms, migration status, and as a racial and ethnic minority. While the normalization and dismissal of depressive experiences may be a more generalizable experience of women, specific sociocultural norms, gender role expectations in East Asian communities, and loss of status and social support through the migration process, were additional layers that uniquely contributed to increased stigma and shame regarding mental illness. This study highlights the way social identities at the individual level intersect with structural factors (i.e., loss of power and marginalization as women, ethnic minority and migrant status) to impact attitudes toward mental illness.

Although the lack of knowledge and awareness was discussed as one of the factors contributing to negative attitudes toward mental illness, other deeply rooted socialized norms and

practices strongly impact attitudes toward mental illness. Thus, knowledge-based interventions to address stigma may be insufficient, when issues of stigma and conceptions of mental illness are closely intertwined with, and grounded in the social and cultural context. Although knowledge and contact-based interventions have found to be effective ways to transform public attitudes toward mental illness in Western contexts, it is unclear if the same approach applies to East Asian immigrants (Lam et al., 2010). Considering the complex and dynamic factors that influence and maintain attitudes and beliefs surrounding mental illness, interventions may need to be tailored to the unique cultural milieu of the community. Based on the findings of this study, these adaptations may include encouraging intergenerational dialogue about mental health, incorporating gender, ethnic and migration factors into the understanding of mental health issues, and emphasizing strengths and cultural values of the community that support individuals living with mental illness.

Limitations and Future Directions

There are several limitations to the study that must be noted. First, although the aim of the study was to examine the attitudes of first- and second-generation East Asian young women who may already be highly acculturated, we acknowledge that the participants in our study represented only a small subsection of the large and diverse East Asian population in Canada. Because the participants in the study were in the process of completing university education, many had been exposed to mental health related courses and mental health services; their attitudes and beliefs about mental illness are not representative of recently arrived or older East Asian immigrants. Future studies may benefit by including East Asian women of varying generations, acculturation and education levels to capture diverse perspectives. Similarly, the use of convenience sampling may have resulted in bias and self-selection of participants who are

more open to discussing mental illness. Moreover, although focus groups allow rapid identification of commonalities, they have the potential to promote "groupthink," or exaggerated consensus, which may minimize variations among participants' responses (Carey & Smith, 1994). Future investigations might incorporate in-depth individual interviews to supplement focus group findings.

Conclusion

The present study examined conceptions of mental illness among first and second-generation immigrant East Asian women in Canada and their understanding of socio-cultural factors that influence attitudes toward mental illness. The findings of the study provide a more comprehensive understanding of the varying sociocultural processes that shape understandings and attitudes toward mental illness. While East Asian women's conceptions on mental illness were reflective of the folk psychiatry model, these were shaped by a complex and dynamic process at the individual, community and societal levels. East Asian women's lay conceptions on mental illness consisted of various causal explanations including situational, biogenic and constitutional causes. Participants shared that as East Asian women, their mental health issues were often dismissed. In addition, sociocultural norms within the community and marginalized status as immigrants, increased feelings of shame surrounding the disclosure of mental health issues. The absence of dialogue on mental illness, normalization of common mental health problems, lack of awareness and knowledge on mental health issues, and not having contact and personal familiarity with individuals living with mental illness, illustrate additional social processes that maintain community attitudes. The study supports the critical need to examine

intersections of identities within East Asian immigrant groups to capture diverse perspectives and experiences, which can then be used for interventions that tailor to the community's needs.

The present study has implications for implementing interventions to improve attitudes toward mental illness, encouraging appropriate help-seeking, and promoting recovery. In particular, this study calls to consider the unique context and needs of East Asian communities. These may include bridging the generational gap on beliefs and attitudes toward mental illness by highlighting cultural values and strengths that support individuals living with mental illness. In addition to promoting cultural competency among mental health professionals, the mental health strategy for Canada for immigrant groups include assessing the mental health needs and strengths of diverse communities (MHCC, 2012). The present study illustrates the complexity in which perceptions towards mental illness are shaped and maintained, and the need to consider social and cultural processes, in addition to mental health related knowledge in community interventions.

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Table 1.

Theme	Subtheme	Definition	Illustrative Quotes
Meaning of Mental Health Problems and Mental Illness			
Contributing Factors	Situational Causes	External events and stressors, including societal, familial, interpersonal, environmental causes contribute to mental health problems. Includes academic and achievement related parental pressures tied to immigrant status and societal pressures placed on women on physical appearance.	I think that a lot of mental health issues may come from parental expectation … they have a lot of expectation for their child to be successful in their career to do well. Especially that to be successful in school equals being successful in life. (Marie, Chinese, 14 years in Canada)
	Biogenic Causes	Mental health problems are caused by imbalance of chemicals in the brain and have a biological or physical basis, like most other medical illnesses. Genetic predispositions can lead to mental illness.	Mental illness to me is more like a chemical imbalance in the brain. So it's an actual illness … a lot of people don't think it is. To me it's more like 'the illness of the brain.' (Blair, Chinese, 13 years in Canada)
	Constitutional Causes	Innate personality or temperament, particularly being introverted or sensitive. A more commonly observed belief within the East Asian community.	But I feel a lot of times maybe … uh, what I've—I think Asians will tie mental problems a lot with personality. I feel they might think oh, if it's mild or like… milder sym—symptoms, they will think, 'oh, this person just has some kind of personality issue,' or it's a matter of personality. (Sabrina, Chinese, 19 years in Canada)
Complexity and Ambiguity		Defining and identifying mental illness is challenging. Mental illness and what is considered normal or abnormal is defined by the society. Mental illness compared to a mental health problem is considered as more chronic and severe, requiring medical treatment.	I … I'm very skeptical of … sometimes, very ske—skeptical about mental illness because what you said— [referring to another participant who discussed about social anxiety] why can't someone just be themselves and be awkward and not be able to—to engage in those activities that we consider as normal, as … socially acceptable.

			I think it's very much um … uh … a societal con—kind of concept—socially constructed, that we need to socialize, we need to be able to really appear open and friendly and …. normal. (Isabel, Chinese, 5 years in Canada)
Perceived Community Attitudes Toward Mental Illness			
Stigmatizing Beliefs	Fear and Violence	Person with mental illness is erratic and dangerous. Includes fear of triggering the person to become violent or emotionally volatile.	I have some friends who were like depressed and like had trouble. But I um, I was really careful of my wording and everything else that you know when I was talking in front of her, I was afraid of … I might have triggered some you know unfavourable actions. (Nozomi, Chinese, 4 years in Canada)
	Weakness	Lack of emotional and personal control or willpower. Encompasses the belief that one should be capable of coping with distress on one's own. Some mental illnesses are associated with laziness or attention seeking.	I think there is just that thought associated with mental illness, like that it is a weakness and not like physical illness because people think that it is something that you can't control when you are physically ill. But mental illness people think that you couldn't cope with the pressure so its not something that people like, it not physical like, its out of your control, people think mental health like … you are not strong enough (Abby, Chinese, 7 years in Canada)
	Person reduced to illness	Person is identified solely by their mental illness and other qualities or characteristics are disregarded.	They wouldn't look at other characteristics of them [person with mental illness] as a whole human being. But instead, all they can see is that there's someone with a mental illness. (Grace, Chinese, 6 years in Canada)
	Incompetence	Perception of being incapable of taking care of oneself or contributing to the community. Needing to rely on others for daily tasks.	When people are diagnosed they are immediately deemed as unproductive members of society, they are unable to

			contribute when that may not be true. (Marie, Chinese, 14 years in Canada)
Factors Influencing Attitudes Toward Mental Illness			
Lack of Dialogue		Discussions surrounding mental illness are avoided and discouraged within the family and community, implying stigma, shame and trivializing mental illness.	Whenever we talk about her, within the family context, it's always very um it's very hush hush, like they don't bring her up very often. (Nina, Chinese, 15 years in Canada)
Family Influence		Family and parental shaping of attitudes toward mental illness including stigmatizing beliefs, direct and indirect messages about avoiding people with mental illness and related discussions. Family's skepticism toward Western medicine and incongruence with how mental illness is conceptualized shape participant's attitudes toward help-seeking. Negotiating family influence and Western influence (e.g., mental health awareness initiatives at university, taking mental health related course, direct contact with people who have mental illness) on attitudes toward mental illness.	I think that kind of attitude … even though I'd like to think that I would be more open about, if I had a mental illness, or if my brother had an issue, I would be more open about it. But I think if I actually were in that situation, I probably would be, like, a lot like my mom. And I don't think ... maybe I'd tell like a really close friend maybe my mom? But I think outside of that, like if I needed ... I don't think I would extend my, like, support network, like it would be very very limited, and I wouldn't want anyone to know about it. (Stella, Korean, 22 years in Canada) Knowledge and the education about mental illness is … has been there for a much longer time i—in Canada and the White-White Western community. It hasn't been in …uh, East-Asia and uh, we are first-generation, uh… or we are the first daughters of people who came to Canada …we still carry this background—this cultural background that-that our parents … um, so there's definitely, we—we—assuming all of us have had to…

			um… uh choose between …uh, what our parents beliefs are and …what the society here was…telling us to do. We've had to kind of evaluate all the signs and think 'you know, I—I think this one makes more sense.' (T.Y., Chinese, 25 years in Canada)
Normalization		Mental health problems are less important or concerning compared to physical illness. More common mental health concerns (i.e., depression and anxiety) are perceived as a temporary condition and thus, are either dismissed or personal responsibility and blame are placed on the person.	I know that for example, my mom, she sometimes comments on how… it' seems like so many White people are talking about having these anxiety and or depression issues and talking about like how she has gone through worse or has gone through more like mentally challenging situations and she doesn't like.. she talks about how she doesn't understand why um, if.. if she's gone through more and came through without having or getting these like mental health problems, than why can't other people do that too? And just like why would people just randomly put labels on feeling sad or whatever. And it's this lack of understanding of what exactly defines a mental illness problem versus just feeling unhappy for a brief period of time. So it's like that line makes it very blurry and makes it hard to talk about it too. (Natalie, Chinese, 15 years in Canada)
Socially Defined Gendered Norms		Gender shapes how mental health concerns are perceived. Women are perceived as more emotionally labile and thus, their mental health issues are dismissed. Expected gender roles	While men have to pretend they are all not feeling stuff and all manly I think that women are also like if they tell anyone they are dismissed as being moody or being a girl or

		lead to shame that women with mental health issues will not be able to fulfill their role as caregivers.	being on her period and wouldn't be taken as seriously. (Ashley, Chinese, 6 years in Canada)
Awareness and Knowledge		Lack of information about mental illness, including types of mental illness, causes, treatment options, and how to interact with someone living with mental illness perpetuate negative attitudes. Some participants were critical of their family and community that they lacked mental health knowledge and awareness and expressed criticism toward traditional treatments. The influence of the media in negatively perpetuating negative attitudes.	Like the older generation and the Asian generation. Like, they don't really know what is, like, what is portrayed as a mental illness. And they only know what they hear from the media, which is, you know aggressive, you know, attacking. So, and then they're more scared and more -- they, they withdraw themselves more. (Serena, Chinese, 20 years in Canada)
Sociocultural Norms		Collectivism, filial piety, and importance of maintaining 'face' heighten stigma towards mental illness. Emphasis on group harmony and conformity lead to increased shame about being different. Filial piety heightens the perception that the person with mental illness is self-centered, unappreciative and disrespectful towards their family. Importance of maintaining the family's reputation lead to added shame.	That [having mental illness] means that there's something wrong with that family or something wrong with the relationships in that family. (Lily, Chinese, 16 years in Canada)
Personal Familiarity		Belief that mental illness is uncommon and far removed from oneself and one's family. Not being able to relate or empathize with those who experience mental illness.	One thing I noticed was because well, because I used to live in Korea for a long … well, for quite a period when I was younger, but then when I was living in Korea I never really thought that um, physical, oh not physical, mental illnesses- in fact, psychiatric problems were so common. I thought it was um, a problem that a really small percentage of

			people go through. (Sophie, Korean, 10 years in Canada)
Immigration related Issues		Reluctance to disclose mental health problems and shame are exacerbated by living in a small immigrant community where individuals with mental illness and their families are more easily isolated. Marginalized status as an immigrant is an additional challenge that makes it difficult to accept and acknowledge mental health issues.	As an immigrant in Western society there's this perceived like, setback, that they're … like there's a stigma surrounding being a minority and an immigrant in itself so there's this perceived setback in trying to assimilate into Western society. So that adds like another burden in, or not burden but, like another barrier in wanting to um … like, uh … admit a mental illness in a way. Because you're already kind of marginalized and you're already seen as an immigrant in a way in that there's a stigma surrounding that so you don't want to make the situation worse on your own by admitting a mental illness in a way that sets you back even further and make you even more of an outcast in society because there's already a perceived "other-ing" by society. (Robin, Chinese, 15 years in Canada)

Bridging to Study 3

Lay conceptions of mental illness are closely associated with attitudes toward mental illness and help-seeking. Study 2 indicated that East Asian women have diverse ways of understanding mental health that are shaped at the micro, meso and macro levels. Mental health literacy (MHL) interventions or similar interventions that focus on mental health knowledge or information have been found to be effective in reducing stigmatizing attitudes toward mental illness and improving help-seeking in the general population (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Thornicroft et al., 2016). However, as suggested in Study 2, considering the cultural and contexual forces that shape attitudes and beliefs toward mental illness, it is unclear if such knowledge-based interventions will also be effective among East Asian immigrants. Moreover, although psychotherapy-based interventions, such as Acceptance and Commitment Therapy (ACT), have also shown promising results in improving attitudes toward mental illness in the general public (e.g., Masuda et al., 2007), their effectiveness among East Asian immigrant communities is unknown. Accordingly, the aim of Study 3 was to examine the impact of a MHL and ACT interventions on the mental health attitudes of East Asian immigrant women. Using a mixed-methods approach, the study captures intervention outcomes, process of change and barriers to change.

CHAPTER 4

The Impact of Mental Health Literacy and Acceptance and Commitment Therapy Interventions on the Mental Health Attitudes of East Asian Immigrant Women

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Abstract

Studies have consistently found large disparities in the use of mental health services by East Asian immigrants in North America. There is some evidence that interventions based on mental health literacy (MHL) or acceptance and commitment therapy (ACT) can improve attitudes toward mental illness and service utilization. However, the applicability of these interventions among East Asian immigrants remains unclear. The present mixed-methods study compared the impact of MHL and ACT-based interventions on the mental health attitudes of East Asian immigrant women. Participants (*N*=91) were randomly assigned to either a 3-hour MHL or ACT intervention or a no intervention control condition. Participants completed pre-, post-intervention, and 3-month follow-up questionnaires assessing mental illness related stigma and help-seeking attitudes. A post-intervention focus group was also conducted to capture outcomes, process of change, and feedback regarding the interventions. Findings suggest that both MHL and ACT improved attitudes toward mental illness and help-seeking short-term, and some gains were maintained at 3-month follow-up. Qualitative findings highlighted intervention-specific and non-specific factors that facilitated change, culture-specific barriers to change, and the need to tailor anti-stigma interventions for immigrant communities to ensure cultural relevance. Implications for working with East Asian immigrant communities are discussed.

Keywords: mental illness related stigma, attitudes toward help-seeking, mental health literacy, acceptance and commitment therapy, East Asian immigrant women

The Impact of Mental Health Literacy and Acceptance and Commitment Therapy Interventions on the Mental Health Attitudes of East Asian Immigrant Women

With Canada's growing ethnic diversity, it has become critical to understand mental health disparities among diverse ethnic communities, and to increase equitable access to effective mental health services. Migrants from Asia are one of the fastest growing populations in Canada (Statistics Canada, 2011). Although some progress has been made in understanding predictors that facilitate mental health service use among Asian immigrants (Sue, Cheng, Saad, & Chu, 2012), mental health policies have largely neglected providing culturally responsive care to meet Asian immigrants' unique needs (e.g., Hall & Yee, 2012).

Studies have consistently found underutilization of mental health services among Asian migrants in North America despite rates of distress similar to that of the general population (Gadalla, 2010; Kirmayer et al., 2007; Le Meyer, Zane, Cho, & Takeuchi, 2009; Tiwari & Wang, 2008). Even when they experience severe and chronic mental illness, studies have found that East Asian immigrants are less likely to use mental health services than European Canadians (Chen & Kazanjian, 2005; Chen, Kazanjian, Wong, & Goldner, 2010). Additionally, compared to the general population, Asian Americans are less likely to use alternative services (e.g., traditional medicine, spiritualist) for mental health concerns (Abe-Kim et al., 2007) and may also delay using mental health services when needed. Chinese immigrants with schizophrenia in Ontario presented with more severe symptoms at initial hospitalization, compared to South Asians and the general population, suggesting delay in service use (Chiu, Lebenbaum, Newman, Zaheer, & Kurdyak, 2016).

Potential barriers to mental health care include systemic issues, including the lack of culturally and linguistically appropriate service options (Fung & Wong, 2007; Leong & Lau,

2001), and financial and practical barriers (e.g., lack of time, transportation; Leong & Lau, 2001). Studies have also found that heightened mental illness related stigma contributes to mental health service use disparities among first- and second-generation Asian migrants (Abe-Kim et al., 2007; Ting & Hwang, 2009).

Stigma of Mental Illness

Stigma is a process that involves labeling, stereotyping, separating, status loss and discrimination and is commonly attached to people with mental health problems (Link & Phelan, 2001). These stigmatizing processes emerge from attitudes and anxieties about difference but become more pervasive, influential and entrenched through stereotypes and dominant discourse (Link & Phelan, 2001). Stigma may be a particularly salient variable among East Asian (i.e., Chinese, Korean, Japanese) immigrants because of the cultural emphasis on reputation, social standing, and saving 'face.' Specifically, having a mental illness may lead to loss of 'face,' which negatively affects access to social capital and a person's moral standing in society (Yang & Kleinman, 2008). Moreover, shame can extend to the entire family of the individual with mental illness. In a study with key-informants from the Korean-immigrant community in San Francisco, participants reported that mental illness can bring dishonor to the family and may be perceived as burdening the family and others in society (Han et al., 2017). Individuals who disclose having a mental illness can also experience rumors and gossip within the community which has social repercussions for the individual and the family (Han et al., 2017).

First- and second-generation Asian Americans may hold more stigmatizing views about mental illness than their European American counterparts (Fogel & Ford, 2005; Georg Hsu et al., 2008). A systematic review of 144 studies indicated that compared to individuals of European descent, Asian Americans present a more pronounced negative association between stigma of

mental illness and help-seeking attitudes, intentions, and behaviours (Clement et al., 2015). Although stigma of mental illness appears to be a potential target for interventions to improve appropriate use of mental health services among East Asian immigrants, there is limited research that examines the effectiveness and applicability of mainstream interventions to reduce stigma and improve attitudes toward help-seeking.

Mental Health Literacy

Mental health literacy (MHL) or information based interventions assume that people can acquire basic knowledge about mental health problems and services that can improve their attitudes and guide their subsequent help-seeking behavior (Jorm, 2012). MHL consists of: (a) recognition of symptoms of mental illness; (b) knowledge of risk factors of mental illness; (c) knowledge of help-seeking options and treatments available; (d) knowledge of effective self-help strategies for milder problems; and (e) mental health first aid skills to support others who are developing a mental illness or are in a mental health crisis. The extant literature suggests that although contact-based interventions appear to be superior, education or information based interventions can also be effective in improving attitudes and behavioural intentions towards people living with mental illness (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Thornicroft et al., 2016).

The type of mental health related content presented may affect the effectiveness of MHL interventions. Increasing the scientific knowledge on mental illness alone may be insufficient to reduce stigma associated with mental illness. For instance, although significantly more individuals in the U.S. endorsed a neurobiological understanding and need for treatment for mental illness in 2006, compared to 1996, high levels of stigma regarding mental illness persist (Pescosolido et al., 2010). Similarly, the effort to argue that “mental illness is like any other

illness" by emphasizing the biogenetic understanding of mental illness and corresponding diagnostic labels has been found to increase stigmatizing attitudes for certain mental illnesses (Read, Haslam, Sayce, & Davies, 2006). Moreover, knowledge-based interventions may be more effective in reducing stigma for those who already agree with the anti-stigma message (Rüsch, Angermeyer, & Corrigan, 2005).

A review of the literature suggests that East Asian immigrants to Western countries may be less likely than the general population to recognize and label mental illness, have different attributions for the causes of mental health problems, and have more negative views about mental health services (Na, Ryder, & Kirmayer, 2016). However, intervening only at the cognitive or informational level may be inadequate to address disparities in mental health service use, because it does not adequately address affective (i.e., stigma, shame), ecosocial, and social structural factors that determine help-seeking (Kirmayer, 2015; Na et al., 2016).

More recently, framing mental health and mental illness in terms of a continuum (i.e., conceptualizing mental health and mental illness as on a continuous spectrum from mild to severe distress) rather than as categorically different, has been identified as a potentially effective anti-stigma strategy that can address some of the affective barriers to service use. In an online experiment in Germany, participants ($N = 1679$) who were exposed to continuum beliefs reported decreased perceived difference and increased social acceptance for people with depression and schizophrenia, compared to those exposed to dichotomous categorical beliefs or no information (Schomerus et al., 2016). Further analysis revealed that the continuum intervention partially mediated the reduction of stigma by increasing continuity beliefs (Schomerus et al., 2016). Similarly, large cross-sectional online surveys in France (Angermeyer et al., 2015), Germany (Schomerus, Matschinger, & Angermeyer, 2013), and a multiethnic

sample in Singapore (Subramaniam et al., 2017) indicated that those who endorse continuum beliefs report less desire for social distance from individuals living with mental illness. Incorporating continuum beliefs in a knowledge-based MHL intervention may be a promising way to reduce stigma and improve attitudes toward help-seeking. The present study examines the effectiveness of a MHL approach that integrates continuum beliefs among East Asian immigrant women in Canada.

Acceptance and Commitment Therapy

Psychotherapy-based interventions, particularly cognitive therapy and acceptance and commitment therapy (ACT) approaches have also garnered some evidence in reducing stigma (Thornicroft et al., 2016). Psychotherapy interventions have been used to reduce self-stigma among individuals living with mental illness (Corrigan & Calabrese, 2005) and have also expanded to non-clinical populations (Masuda et al., 2007). Third wave behavior therapy interventions, such as ACT, that focus on mindfulness and acceptance, could be more effective in reducing stigma than approaches that aim to diminish or suppress stigmatizing thoughts, which may lead to harmful and paradoxical effects (Corrigan, River, Lundin, Penn, Uphoff-Wasowski, & Campion, 2001; Hayes et al., 2004). ACT aims to enhance 'psychological flexibility,' defined as present moment awareness (i.e., mindfulness) and engaging in patterns of behaviours that are consistent with one's chosen values (Hayes, Strosahl, & Wilson, 2011). Specifically, ACT workshops designed to reduce stigmatizing attitudes involve: (a) increasing present moment awareness of one's thoughts, including stigmatizing thoughts, (b) defusion from thoughts that are stigmatizing (e.g., thoughts are not truths but are just thoughts); (c) creating willingness to experience stigmatizing thoughts rather than avoiding them ineffectively (e.g., thought suppression, avoiding situations where stigmatizing thoughts occur); (d) identifying

values and patterns of activity in social interactions (e.g., values of compassion and kindness) and; (e) committing to patterns of valued activity with others, even when experiencing stigmatizing thoughts (Hayes, Niccolls, Masuda, & Rye, 2002; Levin et al., 2015; Lillis & Hayes, 2007).

In one study of college students in the U.S., participants were randomly assigned to either a 2.5-hour ACT or mental health education intervention. Results indicated that the ACT intervention led to a reduction in stigmatizing attitudes regardless of participant's level of psychological flexibility at pre-intervention, whereas an education comparison condition was only effective among those with higher levels of psychological flexibility (Masuda et al., 2007). At one-month follow-up, participants continued to report less stigmatizing attitudes than at pre-intervention (Masuda et al., 2007). Similarly, a one-day ACT workshop for substance abuse counsellors led to significant reduction in their stigmatizing attitudes toward their clients (Hayes et al., 2004). These results were maintained at 3-month follow-up, whereas for the multicultural training and education control conditions, the impact on stigma was not maintained (Hayes, et al., 2004).

Using ACT to Change Mental Health Attitudes of East Asian Women

It remains unclear if an ACT intervention designed to reduce mental illness stigma can be effectively applied among diverse ethnocultural groups. Accordingly, this study aimed to examine the applicability of an ACT intervention among East Asian migrants, who may have diverse attitudes and ways of conceptualizing mental health (e.g., Jang, Gum, & Chiriboga, 2011; Wong, Lam, Poon, & Chow, 2012). Moreover, the present study assessed whether an ACT intervention aiming to reduce mental illness stigma could also improve attitudes toward help-seeking, specifically among East Asian women.

Anti-stigma intervention studies have predominately examined their effectiveness among the general population, and thus, their applicability to diverse ethno-cultural communities are often not examined. *Strength in Unity* is a recent community-based research study in Canada that aims to reduce mental illness related stigma among Asian men. Preliminary findings from this multi-site project found ACT and knowledge-based interventions to be effective in reducing stigma and in engaging Asian men in mental health promotion behaviours (Fung et al., 2017). The present study utilized a modified, condensed version of the *Strength in Unity* intervention to examine its applicability among East Asian young women in Canada.

Social identities, including gender, ethnicity, and migrant status can shape conceptions and attitudes toward mental illness (author citation; Wong & Tsang, 2004). Specifically, young adult East Asian women may be an important population as they frequently act as culture brokers for their immigrant parents and families including in healthcare settings (Kim, Brenner, Liang, & Asay, 2003). Moreover, the initial onset of many mental health problems often occurs during adolescence and young adulthood (Jones, 2013), a period in which making decisions regarding one's mental health is critical in prevention and early intervention.

Design and Objectives

This study aimed to assess the effectiveness of MHL and ACT interventions to improve attitudes toward mental illness and help-seeking using a concurrent mixed-methods design (Creswell & Plano Clark, 2011). Using a randomized controlled trial (RCT), a mixed-methods approach was used for the purpose of complementarity, to expand on overlapping and distinct aspects of a phenomenon (Bryman, 2006; Greene, Caracelli, & Graham, 1989). Moreover, qualitative focus groups aimed to expand on the findings by documenting additional effects of the workshop that could not be assessed through the quantitative measures, the process of

change, potential barriers to change, and participants' recommendations for future interventions. There is potential value in mixed-methods designs, particularly in multicultural and social justice research (Doucerain, Vargas, & Ryder, 2015; Ponterotto, Mathew, & Raughley, 2013). Qualitative research is often more aligned with constructivist and critical-theory oriented approaches, paradigms that support the validity of multiple realities and worldviews of the participants that may not be fully presented in quantitative data. On the contrary, quantitative data allows researchers to examine specific hypotheses and to present results in the statistical tradition more aligned with positivist- and postpositivist paradigms (Doucerain et al., 2015; Ponterotto et al., 2013).

In the present study, quantitative and qualitative data were given equal priority and combined during the data analysis stage. Researchers aimed to address the following research questions:

(1) What are the intervention effects on attitudes toward mental illness and help-seeking compared to a control group with no intervention?
(2) What is the process of change, including barriers of change?
(3) How can the interventions be improved?

Method

Recruitment and Participants

Participants ($N = 91$) were recruited from a large Canadian university located in a metropolitan city. Inclusion criteria for the study were: (i) self-identified East Asian (i.e., China, Korea, Taiwan, Hong Kong, Japan, Macau) woman between the ages of 18-25; (ii) immigrated to Canada from East Asia *or* have parents who are immigrants from an East Asian country; and (iii) be able to read, write and converse in English. Individuals who were in Canada on an international student visa were excluded from the study to account for potential discrepancies in

acculturation that may influence attitudes and perceptions towards mental illness. Of the 91 participants 65 (71.4%) identified as Chinese, 20 (22%) as Korean, 5 (5.5%) as Taiwanese, and 1 (1.1%) as Japanese and Chinese. Seventy-seven participants (84.6%) identified as Canadian citizens and 14 (15.4%) as permanent resident status. On average, participants had been living in Canada for 13.43 years (*SD* = 5.79). Participants' mean age was 21.05 years (*SD* = 2.14). Of the 91 participants, 58 (63.74%) participants had taken at least one mental health related course and 28 (30.8%) reported having sought mental health services in the past.

Intervention Protocols

Mental Health Literacy (MHL). Participants in the mental health literacy group were asked to attend a 3-hour workshop on foundational knowledge of mental health and mental illness. The presentation started with an introduction of the presenter (principal investigator) and the participants. The presentation included information and discussion on the definition of mental health and mental illness and components of mental health (i.e., thinking, feeling, behaviours). The presenter reviewed conceptualizing mental health and mental illness on a continuum. Factors that affect mental health, including biological, psychological, social and spiritual influences and predisposing, precipitating, perpetuating and protective factors affecting mental health were discussed. Participants engaged in a group activity on recognizing common mental health problems (e.g., depression, anxiety), basic mental health first-aid (e.g., how to talk to someone experiencing depression) and treatment options. Treatment and recovery, including psychotherapy, medications and community rehabilitation were also discussed. At the end of the presentation, participants were provided with a list of local mental health resources.

Acceptance and Commitment Training (ACT). Participants in the ACT group were asked to attend a 3-hour ACT session focusing on experiential exercises that encompass the six

components of ACT. The protocol was drawn from a manual used in a previous study to reduce stigma of mental illness (Fung & Wong, 2014; Masuda et al., 2007). These two protocols focus on experiential, process-based group activities that aim to increase mindful awareness of one's thoughts, feelings and behaviours, identification of one's values, and engaging in value-driven behaviours despite having stigmatizing thoughts. The group started with an introduction of the facilitators (principal investigator and a research assistant) and participants. The facilitators provided a brief description of ACT and how it relates to mental illness related stigma. Participants then engaged in experiential group activities aimed to illustrate the six ACT components. The Inclusion Exclusion Circle (Fung & Wong 2014) is an activity designed to address internalized stigma and shame, promote empathy among participants and to illustrate the power of arbitrary rules. Participants also engaged in an exercise to clarify their values and value-driven behaviours and a guided mindfulness meditation to introduce the concept of mindfulness. The workshop included role-play exercises inspired by ACT metaphors (e.g., bus driver metaphor) to illustrate all six ACT processes. Each activity was followed by a group discussion where participants had an opportunity to share their reflections on the activity.

Control Group. Participants in the control group did not attend any workshops. They were asked to complete the pre- and post-intervention questionnaires approximately two weeks apart, which was a similar time frame as that of the intervention groups.

Procedure

Researchers used convenient sampling to recruit participants through student organizations, campus flyers and university listservs. Interested participants contacted the principal investigator by email. They were screened for eligibility by completing a brief screening questionnaire by email. Once they were screened for eligibility, researchers obtained

informed consent and participants were asked to fill out the demographic and pre-intervention questionnaires online.

The study used stratified randomization based on participant's age, their exposure to previous mental health related courses, and mental health services, to account for potential confounding variables that might influence the findings of the study. Once participants were stratified, they were randomized using computer generated numbers. Thirty-one participants were randomized to the MHL group, 30 to the ACT group, and 30 to the Control group. A subsample of participants in the intervention groups (n = 47) also participated in a separate study prior to the intervention workshops on attitudes toward mental illness among East Asian women. The three-hour intervention workshops consisting of 6-12 participants took place in one evening at the university. The workshops were run by a graduate student in counselling psychology with previous ACT training, and an undergraduate research assistant trained by the graduate student to co-facilitate the workshops. Participants were provided with the post-intervention questionnaires following their assigned interventions.

A post-intervention focus group with available participants (n = 46) took place a few days following the intervention to explore the effects of the workshop, process of change, and future recommendations. Three-month follow-up questionnaires were sent by email to all participants using an online survey. Participants were compensated $35 for the intervention session and $20 for the focus group session. The control group participants received $20 for completing the pre- and post-intervention questionnaires. For the 3-month follow-up questionnaires, participants were entered into a draw for one of two gift cards of $50.

Measures

Demographic Information. Participants completed a brief questionnaire regarding their age, place of birth, ethnicity, citizenship status, and length of residence in Canada. They were also asked if they had attended any previous courses on mental health and if they had received any mental health services in the past.

Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF; Fischer & Farina, 1995). Intentions for help-seeking was assessed using a modified version of the ATSPPH-SF. The ATSPPH-SF (Fischer & Farina, 1995) is a 10-item measure designed to assess participants' attitudes toward seeking help for mental health difficulties (e.g., "*If I believed I was having a mental breakdown, my first inclination would be to get professional attention*.") Participants rate each statement from 1 (*strongly disagree*) to 4 (*strongly agree*) and items are summed for a total score that ranges from 10 to 40. A high total score indicates inclination toward seeking professional help. The original ATSPPH-SF has a coefficient alpha of .84 and 1-month test-retest reliability coefficient of .80 (Fischer & Farina, 1995). Evidence of criterion-related validity and convergent validity were reported (Fischer & Farina, 1995). This scale has been used among Asian American college students (Kim & Omizo, 2003). In the present study, the scale had acceptable internal consistency (Cronbach's alpha = 0.75).

Social Distance Scale (SDS; Link, Cullen, James, & Wozniak, 1987). The SDS is a commonly used seven-item self-report measure to assess stigmatizing attitudes and desire for social distance from a person with mental illness. Participants rate their willingness to interact with persons with a mental illness in various circumstances (e.g., "*How would you feel about having a person with mental illness as a neighbour?*) on a scale from 0 (*definitely willing*) to 3 (*definitely unwilling*). The items are summed to yield a score from 0 to 21. Higher scores indicate a greater desire to distance oneself from individuals with mental illness. Previous research has

indicated excellent internal consistency (Cronbach's alpha = .92); authors established validity for this scale by its associations with perceived dangerousness (Link et al., 1987). The SDS has been used widely to assess stigmatizing attitudes toward mental illness and has been used among Asian Americans (Cheon & Chiao, 2012). The SDS had good internal consistency in the present study (Cronbach's alpha = 0.91).

Community Attitudes toward the Mentally Ill (CAMI; Taylor & Dear, 1981). The CAMI scale is a 40-item self-report questionnaire designed to assess attitudes toward individuals with mental illness. Participants are asked to rate each statement on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The CAMI has four subscales with 10 items per subscale: Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology. Items were modified to reflect more contemporary language (e.g., the term 'mental patient' was modified to 'individual with mental illness') and gender neutral phrasing (e.g., item 'Most women who were once patients in a mental hospital can be trusted as babysitters' was changed to 'Most individuals who were once patients in a mental hospital can be trusted as babysitters'). The Authoritarianism subscale assesses beliefs related to whether people with mental illness need coercive handling and obedience to authority (e.g., "A person with a mental illness needs the same kind of control and discipline as a young child"). The Benevolence subscale measures sympathetic and paternalistic views toward people with mental illness (e.g., "People with mental illness have for too long been the subject of ridicule"), while the Social Restrictiveness subscale measures the degree to which participants believe that people with mental illness are a threat to society (e.g., "People with mental illness should be isolated from the rest of the community"). Community Mental Health Ideology refers to the value of the community for recovery and de-institutionalized care. Items for each scale are summed to yield a

score from 10 to 50. Higher scores on the Authoritarianism and Social Restrictiveness and lower scores on the Benevolence and Community Mental Health Ideology indicate more stigmatizing attitudes. This scale has been used among diverse populations including Japanese college students (Masuda et al., 2011). Taylor and Dear (1981) reported adequate internal consistency for the subscales, with Cronbach's alpha ranging from .68 to .88. The authors also reported adequate internal, external, and construct validity for the CAMI scales (Taylor & Dear, 1981). Internal consistency for the present study was acceptable, with Cronbach's alpha ranging from .74 to .89.

Post-Intervention Focus Group. Two trained facilitators who were not involved in the delivery of the interventions led the focus group discussion. Of the 61 participants invited to partake in the post-intervention focus group, 46 participants were available (20 in MHL; 26 in ACT). Focus groups consisted of 4-12 participants and lasted approximately 85 to 98 minutes. All focus groups were audio recorded and participants were asked to choose a pseudonym to maintain anonymity. The research team developed a semi-structured question guide that examined outcome (e.g., "How has the workshop affected your attitudes toward people living with mental illness, if at all?"), process of change (e.g., "What information, if at all, changed what you thought about mental health?"), and recommendations ("What did you find least useful or interesting?"). The facilitator made efforts to engage all participants to share their views to gather diverse opinions, group consensus and disagreement. At the end of the discussion, the primary facilitator provided a brief summary of the discussion and participants were provided with an opportunity to add any additional comments they wished.

Analyses

Quantitative Data Analysis

All analyses were conducted using SPSS 23.0. Items were summed into total scores or subscale scores. Descriptive statistics including means, standard deviations, ranges, distributions, frequencies, and bivariate correlations were examined. For the outcome analysis, residualized change scores were calculated to account for baseline level differences. Using planned contrast *t*-tests, researchers examined if there were significant difference between the two intervention groups (MHL and ACT) and the control group for pre-intervention (T1) to post-intervention (T2), and for T1 to 3-month follow-up (T3). These differences were also examined between MHL and ACT.

Qualitative Analyses

The principal investigator and research assistants transcribed the audio-recorded focus groups verbatim. They were then entered into ATLAS.ti (Version 1.0.50) qualitative analysis software. The focus group data was analyzed following guidelines for thematic analysis (Braun & Clarke, 2006) to identify salient themes that were relevant to the a priori research questions. Researchers followed Braun and Clarke's (2006) six phases of thematic analysis: (a) become familiar with the data; (b) generate initial codes; (c) search for themes; (d) review themes; (e) define and name themes; and (f) produce a report. Using inductive coding grounded in the data, a codebook was created jointly by the first two authors, in consultation with the other members of the research team. The first two authors coded the first two transcripts together to ensure coding agreement and to make any modifications for the codes and their definitions. They then independently coded the remaining transcripts. The two authors met regularly to review their coding and to negotiate any differences. The primary author then identified emergent themes by examining the relationship between the codes and code co-occurrence. To maintain

trustworthiness, the research team worked collaboratively to discuss and confirm the emerging themes.

Results

Quantitative Results

All participants completed the T1 and T2 questionnaires. Thirteen participants (14.29%) did not complete the T3 questionnaires (T3). Of the thirteen, four were in MHL, four in ACT, and five in the Control group with no intervention. Baseline observation carried forward (BOCF) was used to account for missing data at T3. BOCF is considered a more conservative approach to deal with missing data and assumes that the participant did not benefit from the intervention (Shao, Jordan, & Pritchett, 2009).

Table 1 provides the means and standard deviations of the dependent measures for the three groups at three time points. First, we calculated residualized change scores to account for baseline level differences. The residualized change scores were used for subsequent analyses. In order to test whether there was a significant effect of group (MHL, ACT, Control) on the dependent variables (SDS; ATSPPH-SF; CAMI Subscales: Authoritarianism, Benevolence, Social Restrictiveness, Community Mental Health Ideology), we used planned contrasts to examine if there were significant differences between the two intervention groups (MHL and ACT) and the Control Group for the residualized change examined for T1 to T2. Being in either intervention group significantly decreased SDS $t(88) = -2.13$, $p = .036$, $d = .46$. Authoritarianism $t(88) = -2.14$, $p = .035$, $d = .46$, and Social Restrictiveness $t(88) = -2.53$, $p = .013$, $d = .55$ compared to the control group. Being in the intervention groups also significantly increased ATSPPH-SF $t(88) = 2.09$, $p = .039$, $d = .44$, and Community Mental Health Ideology $t(88) = 2.18$, $p = .032$, $d = .48$. An effect size of $d = 0.2$ is considered small, while a medium effect size is

d = 0.5 (Cohen, 1988). Thus, the effect sizes of the current analyses range between small and medium. The MHL and ACT Groups did not differ from the Control Group on Benevolence, $t(88) = 1.16$, $p = .25$, $d = .25$. Follow-up independent sample t-tests (see Table 2) revealed that for T1 to T2, there were significant differences between the two intervention groups (MHL and ACT) and the Control Group on SDS, ATSPPH-SF, Authoritarianism, Social Restrictiveness, and Community Mental Health Ideology. There were no significant differences between MHL and ACT from T1 to T2.

Planned contrasts comparing the two intervention groups with the control group for T1 to T3 revealed that being in the intervention groups significantly decreased Social Restrictiveness $t(88) = -2.85$, $p = .005$, $d = .62$, and increased Community Mental Health Ideology $t(88) = 2.40$, $p = .019$, $d = .55$ at T3, indicating medium effect sizes (Cohen, 1988). Independent t-tests comparing residualized change scores of T1 to T3 revealed significant differences between the two intervention groups and the control group on Social Restrictiveness and Community Mental Health Ideology (see Table 2). Between MHL and ACT, there were significant differences on ATSPPH-SF in that individuals in the ACT ($M = .28$, $SD = .86$) condition reported more positive views of help-seeking than those in the MHL ($M = -.24$, $SD = .91$). Post-hoc t-tests revealed no significant differences between the control group and ACT.

Qualitative Findings

Qualitative themes complemented and expanded on quantitative findings. The findings focus on: (a) intervention outcomes not measured through the quantitative measures; (b) process of change and barriers of change; and (c) participants' feedback on the interventions. To protect participants' identities, we use self-selected pseudonyms throughout.

Behavioural outcomes. East Asian women from both intervention groups (13 participants) reported having discussions about mental health with friends and family following the workshop. In some cases, the workshop acted as a catalyst that led to first-time conversations about mental health within the family. For example, Lily (22, Chinese, MHL), who stated that her father passed away several years ago, reported that the workshop promoted her to talk to her mother about her mental health since the death of her husband. She further commented, "Sometimes, I feel like we [children of immigrants] should be the ones who notice things that go wrong, even if that person is denying it. Because we know what's the best for them, we should probably encourage them to find ways to get better."

There were subtle differences in the content of discussions between the MHL and ACT groups. Among participants in the MHL group, participants spoke of having conversations around specific mental illnesses and the importance of mental health more broadly. For the ACT group, participants stated sharing the skills and experiential exercises that they learned from the workshop, and becoming more aware that it is their responsibility to speak up against stereotypes that target people with mental illness. Several participants in both groups also reported that they have become more "attentive," "compassionate," "understanding," and "patient" towards individuals in their lives who live with mental health issues.

Increased awareness of one's own mental health. Twenty-three participants in the MHL and ACT groups spoke of becoming generally more aware of the importance of maintaining good mental health following the workshop. Participants reported becoming cognizant that mental health applies to all, not just those who experience with mental illness. Participants in the ACT group spoke of practicing strategies learned during the workshop. For instance, Kathy (19, Korean, ACT), reported practicing mindfulness following the workshop. "I

actually started paying attention to what I'm thinking and what I'm feeling and eating. Because normally when we're busy, when we're eating, we don't pay attention to what we eat."

East Asian women in the MHL group discussed more general awareness regarding the importance of their mental health and taking action to take care of it. TY (25, Chinese, MHL) discussed making intentional decisions to engage in social activities for her mental health. This reminded her "that all these things that make me happy in life, it's actually very healthy for... It's a little bit like an investment for mental health."

Reflections on culture and mental health. Some participants (8) discussed becoming more aware of the influence of culture on mental health as a result of taking part in the study. Participants reported that before the workshop, they had not reflected on the ways in which their identity as East Asian and/or being a woman affected their perceptions on mental health. Specifically, through discussions held during the interventions, some participants reported becoming more cognizant of the barriers that prevent East Asian immigrants from receiving mental health services, including the lack of mental health services that meet their communities' needs and the role of stigma in their community. Some participants also noted that many of the mainstream workshops on mental health do not address intersectionality. Robin (19, Chinese, ACT) stated:

> It really did make me think about like a need of East Asians for mental health services. Often, if your—if your parents immigrate when they're in their 40's and they have to leave like their entire family, like everything they know behind and um, often like they're sort of socially isolated … and that's a source of mental health problems. There's the additional problem of there not being suitable services. First of all, there might be a language barrier and they're—they're probably not likely to be comfortable with opening up to um, like

someone of Caucasian descent or someone who doesn't understand their struggles. 'Cause it's so personal.

Process of change (MHL). In the MHL group, participants (13) commented that conceptualizing mental health and mental illness as a continuum was a new perspective that was memorable to them. When participants spoke of change in attitude toward mental illness, they most commonly reported that the continuum belief was the most helpful in shifting their perspectives. East Asian women stated being better able to relate to individuals with mental illness because they recognized that mental health affects everyone, including themselves. Some reported viewing mental illness as "very black and white" prior to the workshop, and that thinking of mental health and illness as on a continuum "makes people [with mental illness] more relatable and more approachable and easier to talk about." Similarly, other participants reported that continuum beliefs led participants to realize that individuals with mental illness are "more similar to us than we realize."

Process of change (ACT). Because the ACT workshop focused on experiential exercises that examined participants' thoughts, values and emotional difficulties, reflecting on one's own mental health allowed participants (13) to more easily relate to, and understand people living with mental illness. East Asian women in the study reported that reflecting on their own mental health struggles allowed them to become more aware that mental health affects all individuals. Some participants noticed their own challenges in coping with difficult thoughts and feelings, which allowed them to empathize with those who experience mental illness. Serena (21, Chinese, ACT) commented the following regarding a mindfulness exercise:

I think with the [mindfulness exercise] you really maybe relate to mental illness patients because, um you made me think about how hard it is to judge — like not judge my own

> thoughts but be present with them. And then to like let them go kind of. But um, at some point some of my worries I couldn't really let go. And so, I think that kind of relates to mental health patients as well. Some of their stressors, like they can't let go and that's hard for them too. And it made me realize that they have a hard time.

East Asian women also spoke of specific ACT exercises that facilitated change in their attitude toward mental illness. In particular, those in the ACT group spoke of connecting with their values (e.g., empathy, compassion) and becoming less attached to one's thoughts that are not congruent with their values. Stella (22, Korean, ACT),

> The most memorable thing for me was the [values exercise]… And I guess that activity made me think what kind of values I have. And then when I was doing that survey after … I noticed that my survey questions they weren't as extreme as before. Yeah, because I think one of the values that I always had is that I am very empathetic, but I realized after I did the first survey, I wasn't as empathetic as I thought as I'd be.

Non-specific intervention effects. East Asian women (16) stated that having an open discussion about mental illness during the workshop, and at the first focus group, facilitated reflections on mental illness, which fostered more positive attitudes. Participants reported that being in a non-judgmental space where they could openly converse about mental illness made the topic "less taboo." Hearing stories from other participants about their struggles with mental health issues or about their family/friends with mental illness allowed them to see that mental illness "affects most of us so closely." For one participant, these discussions "really shaped my views on mental health." Participants found it particularly meaningful to have a discussion on mental health with those who shared similar cultural identities. Because these topics were rarely discussed in their cultural communities, many participants found that the first focus group in

which they could openly talk about mental health issues was more relevant to East Asian women than the workshops themselves.

Barriers to change in help-seeking. Participants (11) reported that they would be hesitant to seek mental health services not necessarily because of stigma related to mental illness, but rather, due to skepticism towards their usefulness for them personally, previous disappointing experience, and aversion to the impersonal, judgmental mental health professionals and the medical system. Participants also identified the lack of cultural and linguistically responsive services, financial barriers (for psychotherapy), long wait times, and difficulties navigating the health care system to access mental health services as prominent barriers that prevent help-seeking.

Feedback on workshops. Participants (13) from both interventions commented that the workshops did not adequately address the relevant mental health issues of East Asian women. Participants suggested tailoring the interventions for East Asian women in several ways. Some suggested that the workshops need to incorporate ways of coping with stigma within their communities and interventions that would address stigma in families. Moreover, participants were interested in learning about types of mental health issues that impact East Asian women, and the influence of social and economic barriers on immigrant mental health and access to mental health services. Among individuals in the MHL intervention, most expressed their preference for interactive and experiential exercises, rather than a lecture-based didactic workshop. Participants in the ACT intervention suggested integrating information on different types of mental illness and where and how to seek services for mental health.

Discussion

The present study utilized a mixed-methods RCT to examine the effectiveness of an MHL and ACT intervention to improve attitudes toward mental illness and help-seeking among East Asian women in Canada. Findings of the study suggest that both MHL and ACT approaches can facilitate attitudinal and behavioural change that reflect more positive perceptions toward mental illness and help-seeking. By integrating quantitative and qualitative data, the study contributes to the literature by providing more depth on overlapping and distinct findings from the two approaches. Moreover, the study points toward the need to tailor anti-stigma interventions for immigrant communities to ensure cultural relevance.

Compared to participants in the control group, being in either intervention group reduced participants' social distance and various stigmatizing attitudes, including beliefs that those with mental illness need authoritative control and that they are a threat to society. The interventions also fostered beliefs in a community approach to recovery and more positive attitudes toward psychological help-seeking. These attitudinal changes were also reflected in some of the participant's behaviours following the intervention, in which they reported becoming more patient, compassionate and understanding towards those experiencing mental health concerns. Participants also stated they had more frequent discussions surrounding mental health with family and friends. This may be particularly meaningful considering the lack of dialogue on mental health in their community due to social stigma (Lee et al., 2009; author citation, 2017). Recent review of the literature on anti-stigma interventions emphasized the lack of behavioural outcome measures in intervention studies (Thornicroft et al., 2016). The qualitative findings of the current study provide insights to some of the behavioural changes elicited, including when

interacting with individuals with mental health issues, and in promoting dialogue about mental health in participants' communities.

Among some participants, taking part in the study facilitated awareness and reflections on the role of culture on East Asian women's access to mental health services and the role of stigma in their communities. Although participants reported that the two interventions did not adequately address the relevant mental health issues and ways of coping with barriers faced by East Asian women, discussions that were elicited during the interventions appeared to have prompted cultural reflections. The findings of the study demonstrate the indirect effects of intervention groups; conversations and sharing stories in a group setting was an important aspect of the interventions that fostered more positive attitudes toward mental health among participants. Being in a group with other women with shared cultural identities elicited discussions surrounding the challenges and barriers faced by East Asian immigrant women and immigrant communities more generally. Some participants reported that the focus group discussion on perceived attitudes toward mental illness prior to the workshop was more culturally relevant, and some indicated that these discussions had the most meaningful impact on shifting their perspectives on mental health. Participants discussed that being in a non-judgmental, open environment, where they could have a dialogue on mental health made the topic less taboo.

In the present study, approximately one-third of the participants disclosed having sought mental health services in the past. Some of these participants disclosed their mental health experiences in the group, and many others shared stories of family and close friends and their struggles with mental health issues. Contact-based interventions, in which participants come in contact with an individual with lived experience of mental illness, particularly when that person

disconfirms stereotypes associated with the mental illness, has been shown to be effective in reducing stigma (Reinke, Corrigan, Leonhard, Lundin, & Kubiak, 2004; Thornicroft et al., 2016). Discussions surrounding mental health issues experienced personally or by loved ones may have served to change attitudes in ways similar to a contact-based intervention.

Additional outcomes as a result of the interventions included an increased awareness of one's own mental health. Both MHL and ACT appear to make mental health more personally relevant, and subsequently reducing the separation between those with mental illness or those without, which is one of the principal aspects of stigma (Link & Phelan, 2001). Specifically, participants in the MHL group reported that continuum beliefs about mental health were important to their attitudinal shift. Rather than highlighting that individuals with mental illness are different from those who are not affected, continuum beliefs may reduce the separation between 'us' and 'them' (Schomerus et al., 2016).

A preliminary study on understanding the process mechanism of an ACT intervention to reduce stigma revealed that psychological flexibility (i.e., willingness to accept internal experiences and engaging in value-driven behaviours) predicted change in mental health stigma, suggesting that psychological flexibility may be an important process variable that facilitate change (Masuda et al., 2012). Some East Asian women in the study reported change in attitudes toward mental illness in the context of enhanced psychological flexibility, including becoming more aware of their stigmatizing thoughts, identifying with their values, and committing to behaviours that are consistent with their values. More frequently, however, participants reported that the ACT exercises allowed them to become more attentive in coping with their own distress. Thus, there may be several process variables that facilitate change, including psychological

flexibility and an ability to better relate to those with mental illness by acknowledging and coping with one's own distress.

Results from the study suggest that for the MHL and ACT interventions, only some of the effects were retained at 3-month follow-up. The long-term impact of brief knowledge-based interventions are mixed. One study found that although there were immediate effects of a reading-based education intervention, effects decreased at 6-month follow-up, whereas effects of an interactive computer-based intervention developed to induce an emotional response (e.g., incorporating the story of a person living with schizophrenia) were maintained. Thus, active engagement, affective content, and experiential learning in the education process appear to be important in producing lasting change (Finkelstein, Lapshin, & Wasserman, 2008; Pinfold et al., 2003). Moreover, there may be a need for a more in-depth, long-term intervention to change stereotypes and attitudes that are deeply ingrained in society. For instance, in a UK study of secondary school students, a two one-hour combined mental health education and contact-based intervention had an impact on mental health related knowledge but not on social distance attitudes (Pinfold et al., 2003).

Similarly, brief 3-hour ACT interventions may only have short-term impact. The previous study using a 2.5-hour ACT intervention to reduce mental illness related stigma among college students only conducted follow-up at 1-month (Masuda et al., 2007). Although one ACT study that aimed to reduce stigma among addictions counsellors reported that gains were maintained at 3-months post-intervention, the duration of the intervention was twice as long as the present study. Thus, an ACT intervention may have the potential to have long-term impact among East Asian women; however, it may need to be a longer more in-depth process to achieve this outcome.

Similarly, attitudes toward help-seeking improved immediately following the intervention; however, this change was not maintained at 3-months. Qualitative data gathered soon after the intervention provide some insights into the barriers to change. Participants most commonly reported that previous negative experiences, practical (time and financial) barriers, systemic barriers (i.e, long waits, lack of culturally/linguistically responsive services), and lack of perceived personal usefulness were reasons for not seeking mental health services. Factors that influence help-seeking intentions and behaviours are complex (Pescosolido & Boyer, 2010). Although stigma and shame related to seeking help is one barrier, East Asian women in the study reported the lack of perceived personal usefulness of mental health services as an additional reason. East Asian migrants may prefer ways of coping with distress that do not involve formal help-seeking (Tieu, Konnert, & Wang, 2010). Participants also reported previous negative experiences and mental health systems that did not meet their needs as additional deterrents to mental health services.

These sentiments were echoed in the feedback we received from participants about the study's interventions, particularly on the need to tailor the interventions to make them more relevant for East Asian women. Culturally responsive psychoeducation programs among East Asian immigrants living with mental illness and their families have improved mental health outcomes, reduce stigma, increase knowledge and service use (Kung, Tseng, Wang, Hsu, & Chen, 2012; Shin & Lukens, 2004). Particularly, integrating cultural lay beliefs and western concepts may aid in mental health related service use (Shin & Lukens, 2004) and reduce stigma related to a strictly biomedical perspective to mental illness (Yang et al., 2014). Incorporating family members, gaining trust in the community, and initiating mental health outreach programs in collaboration with the community are critical aspects that need to be considered when working

with East Asian immigrants (Weng & Spaulding-Givens, 2017). Moreover, combining the MHL and ACT interventions, might address some of the specific gaps in each intervention that were identified by participants, specifically, the need for more experiential exercises for the MHL intervention, and knowledge-based content for the ACT intervention.

Limitations and Future Directions

This study has several limitations. First, the sample was self-selected and the study's findings need to be interpreted in the context of the participants' distinctive characteristics. East Asian women in the study were in the process of receiving a university education, and most were highly acculturated. Moreover, more than half of the participants had exposure to at least one mental health related academic course, and approximately one-third of the participants identified as past or current mental health consumers. Thus, they might be expected to exhibit lower stigma levels and may be more prone to agree with an anti-stigma message. A ceiling effect on the benevolence subscale of the CAMI may also explain the lack of intervention effects for both groups. Future studies would benefit from examining a community sample with varying education and acculturation levels to assess the effectiveness of both intervention approaches.

There was no qualitative data collection at 3-month follow-up, limiting participant's qualitative outcomes to data collected shortly after the intervention. Moreover, we did not collect any qualitative data for participants in the control group. Assessing short- and long-term behavioural changes would benefit future studies. Some participants stated that being in the focus groups was an important experience that facilitated change in their attitudes, and because the control group participants did not attend any focus groups, it is difficult to discern if the change occurred in the intervention groups were because of intervention specific content or

indirect effects of being in the group. Nevertheless, participants did discuss specific elements of the intervention that they found helpful in changing their attitudes.

Moreover, only some of the participants (75.4%) attended the post-intervention focus group, potentially limiting our findings to those who were willing to return to the study. Although the post-intervention focus groups were facilitated by researchers who were not involved in delivering the interventions, participants responses may have partly resulted from a desire to please the interviewer, "groupthink," or exaggerated consensus, which can limit variations among participants' responses (Krueger & Casey, 2015).

Conclusion

Despite the limitations, the present study has important implications for community interventions and campaign strategies aimed at improving attitudes toward mental illness and help-seeking. Although MHL and ACT had short-term effects on fostering more positive views about mental illness and help-seeking, participants voiced the need to adapt the interventions to incorporate culturally relevant issues and information on mental health in the East Asian community. Thus, researchers need to work closely with community members to develop culturally responsive programs that meet their specific needs. Moreover, although attitudes and intentions are important, there is a need to assess meaningful behavioural change, whether that may be in how individuals interact with someone with mental health problems or behaviours related to informal or formal help-seeking. Importantly, although stigma reduction and improving attitudes toward mental health services are important initiatives, systemic and structural barriers need to be addressed, particularly in having more culturally and linguistically responsive service options available for East Asian immigrants.

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Table 1. Scores on Outcome Measures, Means (*SD*)

Group	Pre-Intervention	Post-Intervention	3-Month Follow-Up
ACT			
SDS	1.36 (0.65)	1.08 (0.64)	1.12 (0.60)
ATSPPH	2.73 (0.54)	3.06 (0.4)	3.08 (0.50)
CAMI Authoritarianism	2.04 (0.52)	1.87 (0.39)	1.87 (0.40)
CAMI Benevolence	4.11 (0.35)	4.2 (0.43)	4.14 (0.71)
CAMI Social Restrictiveness	2.05 (0.55)	1.82 (0.42)	1.82 (0.44)
CAMI Community Mental Health Ideology	3.62 (0.62)	3.98 (0.54)	3.9 (0.59)
MHL			
SDS	1.34 (0.72)	1.06 (0.66)	1.16 (0.62)
ATSPPH	2.85 (0.46)	3.04 (0.41)	2.96 (0.46)
CAMI Authoritarianism	2.02 (0.51)	1.86 (0.54)	1.98 (0.54)
CAMI Benevolence	3.99 (0.50)	4.13 (0.58)	4.01 (0.64)
CAMI Social Restrictiveness	2.02 (0.61)	1.8 (0.47)	1.87 (0.51)
CAMI Community Mental Health Ideology	3.73 (0.63)	4.05 (0.60)	3.96 (0.61)
Control			
SDS	1.39 (0.63)	1.31 (0.53)	1.31 (0.66)
ATSPPH	2.87 (0.42)	3.63 (0.49)	3.05 (0.55)
CAMI Authoritarianism	2.05 (0.42)	2.07 (0.49)	2.08 (0.42)
CAMI Benevolence	4.02 (0.44)	4.04 (0.46)	3.92 (0.73)
CAMI Social Restrictiveness	1.9 (0.41)	1.98 (0.47)	1.99 (0.46)
CAMI Community Mental Health Ideology	3.82 (0.52)	3.86 (0.58)	3.82 (0.56)

Table 2. Comparison of Intervention and Control Groups

T1 to T2 (Control vs. Interventions)

	M (Control)	*SD*	*M* (ACT & MHL)	*SD*	*t*
SDS	0.31	1.05	-0.15	0.94	2.14*
Help-Seeking	-0.3	1.14	0.15	0.89	-2.07*
Authoritative	0.31	1.1	-0.15	0.91	2.15*
Benevolence	-0.17	1.14	0.09	0.91	-1.17
Social Restrictiveness	0.37	1.12	-0.18	0.88	2.54*
Community Mental Health Ideology	-0.32	1.1	0.16	0.91	-2.20*

T1 to T2 (ACT vs. MHL)

	M (ACT)	*SD*	*M (MHL)*	*SD*	*t*
SDS	-.15	.91	-.16	.98	.05
Help-Seeking	.30	.90	0	.86	1.34
Authoritative	-.16	.89	-.14	.94	-.09
Benevolence	.08	.86	.09	.97	-.09
Social Restrictiveness	-.17	.79	-.19	.97	.11
Community Mental Health Ideology	.13	.74	.18	1.06	-.20

T1 to T3 (Control vs. Interventions)

	M (Control)	*SD*	*M* (ACT & MHL)	*SD*	*t*
SDS	.26	.92	-.13	1.0	1.76
Help-Seeking	-.03	1.15	.02	.92	-.23
Authoritative	.28	.94	-.14	1.0	1.94
Benevolence	-.15	1.16	.07	.90	-1.0
Social Restrictiveness	.41	1.05	-.2	.91	2.85**
Community Mental Health Ideology	-.35	.88	.17	1.0	-2.41*

T1 to T3 (ACT vs. MHL)

	M (ACT)	*SD*	*M (MHL)*	*SD*	*t*
SDS	-.21	1.02	-.05	1.0	-.61
Help-Seeking	.28	.86	-.24	.91	2.27*
Authoritative	-.34	1.10	.06	.86	-1.57
Benevolence	.09	1.17	.06	.56	.15
Social Restrictiveness	-.31	.90	-.09	.92	.93
Community Mental Health Ideology	.18	1.22	.17	.78	.03

CHAPTER 5

Conclusion

Interventions to improve mental health literacy (MHL) and reduce stigmatizing attitudes have been the focus of community campaigns in various nations, including in Canada (Rootman, 2013), Australia (Australian Department of Health and Ageing, 2009) and Germany (Dietrich, Mergl, Freudenberg, Althaus, & Hegerl, 2010). Considering the disparities in mental health service use in East Asian immigrant communities and the continued growth of ethnic diversity in Canada, examining the suitability of these interventions for diverse populations is an important task. The sequence of studies presented in this dissertation sought to build upon existing models that aim to foster more positive attitudes toward mental illness and help-seeking intentions.

The objectives of this dissertation were threefold: (1) to examine the literature on MHL and help-seeking among East Asian migrants and propose a culturally applicable MHL model; (2) to examine lay conceptions and attitudes toward mental illness among East Asian Canadian women; and (3) to assess the efficacy of a MHL and acceptance and commitment therapy (ACT) intervention to reduce stigma and improve help-seeking attitudes for East Asian Canadian women.

Study 1 presented a comprehensive literature review on MHL and help-seeking intentions among East Asian migrants. This review drew attention to the assumptions of the MHL framework that help-seeking is dependent on one's knowledge on mental health that involves symptom recognition and psychiatric labelling. As the literature and findings from Study 2 and 3 suggest, help-seeking is a more dynamic, socio-cultural and affective process. Particularly for diverse communities, including East Asian immigrants, there may be ways of experiencing, expressing and conceptualizing distress that are different from the Western

biomedical model of mental illness. The proposed culturally responsive model of MHL integrates culturally specific terms and symptoms, alternative explanatory models of illness, migrant specific risk factors, and culturally relevant actions and pathways to care that diverge from Western forms of treatment.

To further explore the meanings and attitudes toward mental health and mental illness in East Asian communities in Canada, Study 2 reported the findings of a qualitative study with 1st and 2nd generation East Asian young adult women. Participants' discussions of causal factors reflected the influence of indigenous beliefs in their communities as well as knowledge of biological causes that are consistent with how mental illness is currently conceptualized in many Western countries. In addition to characterizing East Asian immigrants' attitudes toward mental illness, this study contributed to the current approaches to understanding attitudes by situating the findings in participants' social and cultural context. The themes reflected the intersections of ethnicity, gender, and migrant status and the ways in which attitudes and beliefs surrounding mental illness are shaped at the individual, community and societal levels. The influence of family, gender roles, cultural values and immigration related factors emerged as important variables that shaped and maintained individual and community attitudes.

Study 3 used a mixed-methods design to evaluate MHL and ACT interventions to reduce stigma among East Asian young adult women. This study contributes to the literature by investigating the strengths and limitations of these approaches for an ethnic minority group. Both interventions were effective over the short-term compared to a no intervention control; however, participants voiced concerns about the lack of cultural relevance of these frameworks and the need to integrate more content that is pertinent to their community. Moreover, the findings of the study suggest that although MHL and ACT interventions were different in their content and

modes of delivery (i.e., didactic versus experiential respectively), the process that participants found most helpful in changing their attitudes were similar. Participants found it useful to have an open discussion about issues surrounding mental health and framing mental health as a relevant issue that affects everyone, not just specific populations who experience mental illness. Furthermore, participants articulated deterrents beyond stigmatizing attitudes that prevent them from seeking mental health services. Many of these factors were structural issues including, the lack of services that meet their cultural and linguistic needs, difficulties accessing or navigating services, and previous negative experiences with the health care system. To improve access to mental health services among East Asian immigrants, the study highlighted the importance of addressing systemic and structural issues in mental health care, in addition to fostering more positive community and individual attitudes.

Implications for Practice

The findings of the three studies have important implications for community based strategies that aim to improve attitudes toward mental health and help-seeking among East Asian immigrants. First, modifying and adapting current models for promoting mental health awareness may be important to effectively reach diverse communities. Community interventions that aim to improve mental health related knowledge need to be flexible in incorporating culturally relevant expressions, context specific risk factors, and diverse pathways to care. Integrating culturally specific syndromes, somatic expressions of distress, and recognizing and supporting stressors related to the settlement process, are some ways to enhance cultural relevance. Similarly, outlining the risks and benefits of Western mental health services and traditional treatments would allow individuals to make their own informed decisions based on their needs.

The findings of the study drew attention to the multiple layers of context at the micro, meso and macro levels that shape beliefs and attitudes toward mental health. Consistent with the current literature and conceptualizations on stigma, strategies to foster more positive attitudes toward mental illness need to occur not only at the individual level but in the broader community, and socio-political levels (Corrigan, Markowitz, & Watson, 2004; Link & Phelan, 2001). Participants discussed the role of family, gender, migration status and sociocultural norms having direct and indirect effects on their attitudes toward mental health. Community interventions could incorporate discussions on how these social forces uniquely contribute to community and individual attitudes. Moreover, interventions could also integrate ways of coping with systemic barriers and how to access culturally responsive mental health services that may be available in the community.

Findings from the studies suggest the need to consider the heterogeneity and diversity within the East Asian immigrant population. Even within a predominately acculturated and educated group, East Asian young adult women in the study expressed diverse ways of conceptualizing mental health; some discussed more indigenous beliefs while others identified with biological and psychosocial models. Similarly, research suggests that some immigrant women may prefer traditional and alternative forms of treatment, others may prefer Western approaches, or an integration of both (Green, Bradby, Chan, & Lee, 2006; Tabora & Flaskerud, 1997). Community interventions that integrate diverse ways of understanding and dealing with mental health concerns could increase service options for immigrants.

Partnerships between the community and mental health services can improve access to mental health services (Lee, Hanner, Cho, Han, & Kim, 2008; Sue, Cheng, Saad, & Chu, 2012). Involving informal sources of support including, community leaders, traditional healers and

religious leaders who may be the first point of contact when individuals are in distress are also important considerations. For instance, among Korean immigrants, Korean churches play a critical role in bringing the community together, and they serve not only a religious purpose but also a social, political and educational function (Lee et al., 2008). Hence, Korean clergy are important leaders in the community who can direct immigrants to formal mental health services when necessary (Lee et al., 2008). Programs that involve the family to address stigma related to mental illness may also be relevant because shame related to having a family member with mental illness is much more salient in Asian communities (Weng & Spaulding-Givens, 2017). Moreover, some may be reluctant to attend an education workshop that solely focuses on mental illness because the topic is considered sensitive and taboo (Han, Cha, Lee, & Lee, 2017). Taking a more indirect approach to mental health education by incorporating it with other community events or distributing information online are ways of delivering mental health related information that could reach more community members (Han et al., 2017).

Community based interventions can also build upon the previous literature that have adapted mental health education programs for East Asian caregivers (Kung, Tseng, Wang, Hsu, & Chen, 2012; Shin & Lukens, 2004; Yang et al., 2014). These studies suggest cultural lay beliefs and Western concepts of mental illness can be integrated. Considering that a biogenic approach can be stigmatizing (Haslam & Kvaale, 2015), particularly for East Asian immigrants who may view it as a shameful inherited trait in the family (Lee et al., 2008), incorporating indigenous beliefs may serve to reduce stigma that occur from a strictly biological perspective (Yang et al., 2014). Integrating indigenous and Western ways of understandings of mental health could also address the generational discrepancies in lay beliefs and criticism toward indigenous beliefs that were reported by some of the participants. Programs that acknowledge diverse ways

of conceptualizing and treating mental health may promote more intergenerational dialogue on mental health. However, there may also be indigenous beliefs that lead to more stigmatizing attitudes; beliefs that mental illness signifies weakness or lack of willpower can lead to shame for the individual and their family (Han et al., 2017). Identifying and addressing these nuances in traditional beliefs would be important for future interventions.

Importantly, it is unclear if interventions that attempt to address individual and community attitudes can surmount structural and practical barriers. To overcome mental health service use disparities in East Asian immigrants, structural change in the mental health care system needs to occur. Timely access to culturally appropriate services appears most promising in meeting the mental health needs of Asian immigrants (Chiu, Lebenbaum, Newman, Zaheer, & Kurdyak, 2016; Nguyen & Lee, 2012). Moreover, the perception that Asian immigrants are a "model minority" who experience little mental health problems can also reduce mental health resources (Okazaki, Kassem, & Tu, 2014). Addressing these societal stereotypes and advocating for the increase in availability of linguistically and culturally appropriate services appears to be crucial steps in addressing disparities in access to mental health services.

Directions for Future Research

The studies presented point to several directions for future research. First, studies could continue to examine the effectiveness of culturally adapted community based interventions. Although there is some research on reducing stigma for caregiver families, there is a dearth of evidence for raising awareness and addressing stigma in the community more broadly. Interventions that aim to foster mental health awareness and reduce stigma need to be developed in close collaboration with the community. Community based participatory action research (CBPR) is one avenue that would allow researchers and community participants as equal

partners. CBPR could increase cultural relevance, account for differences between immigrant communities and address inequities in mental health (Okazaki et al., 2014). Mixed-methods studies can also be particularly helpful in obtaining input and feedback from community partners (Doucerain, Vargas, & Ryder, 2015; Ponterotto, Mathew, & Raughley, 2013).

It is unclear if help-seeking intentions or more positive attitudes toward mental health services will in fact lead to changes in help-seeking behaviours. Future studies would benefit from assessing short- and long-term behavioural changes following the intervention. Although we were able to capture some of the short-term behavioural changes through the focus groups, assessing various dimensions of change (e.g., changes in how individuals interact with those living with mental illness, help-seeking behaviours, community involvement) in a systematic manner would provide a more comprehensive understanding of intervention effects.

Findings from our study suggest that with modifications, MHL and ACT are both promising frameworks for East Asian immigrants. Each approach has particular strengths, and a potential avenue for future research would be to integrate both approaches to bridge some of the gaps in the interventions; participants requested more information on mental health for ACT, and to incorporate more experiential exercises for MHL. Participants in our study suggested ways to increase cultural relevance of interventions, which could also be incorporated in future studies. Specifically, workshops could include ways to cope with stigma in the community and family, and discussing immigrant- and gender-specific mental health issues and barriers to care. Moreover, since a brief three-hour intervention may have limited long-term impact, a more in-depth approach that combines both MHL and ACT warrants further examination.

East Asian immigrants are a diverse group and studies would benefit from working with ethnic specific subgroups to better understand nuanced differences in lay conceptions and

attitudes toward mental illness. Moreover, social identities and positioning in terms of migration status, gender, age, and socioeconomic status affect attitudes, beliefs and risk factors surrounding mental health. For instance, Asian immigrant seniors may hold more traditional beliefs and negative attitudes toward mental health services (Jang, Chiriboga, & Okazaki, 2009) and may also be at higher risk for suicide (Sue et al., 2012). Moreover, linguistic challenges and knowledge of access barriers may be more salient issues among newly arrived immigrants (Fan, 1999). Better understanding of within group differences will allow researchers to tailor interventions that address the needs of specific target populations.

With the growing diversity of the population in Canada, increasing equitable access to services to meet the mental health needs of immigrant populations is critical. Strategies that aim to foster more positive attitudes toward mental health and help-seeking will be most effective when implemented at multiple levels of the individual, community, and in larger socio-political contexts. The studies presented in this dissertation suggests the value of adapting MHL and ACT interventions to increase cultural applicability for East Asian immigrants. By providing a more inclusive definition and conceptualization of mental health and help-seeking, these interventions can empower communities to make informed decisions on approaches to care.

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