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Title: "Tangled Wires in the Head": Older Chinese migrants' Perception of Mental Illness in Britain

Introduction

The aims of this article are to: a) explore older Chinese migrants' views on what mental illness means to them, their expectations and attitudes towards mental illness, b) identify which mental illnesses are the major issues for older Chinese migrants, c) identify cultural, socio-economic factors which may contribute to a failure of the older Chinese migrants to present themselves as suffering from mental illness, and a failure to access and/or take up mental health services, d) gain deeper insight into the special mental health needs and issues within a single population, and (e) identify pertinent issues for future research in this area. In the following sections, the authors will first carry out a cross-cultural literature review on the Chinese culture of stigma and mental illness. Second, they will examine the experiences of mental illness in local Chinese communities in the British context. Third, they will discuss ethical issues and methodologies. Fourth, they will present results which will then be followed by a discussion and conclusion.

Chinese Culture of Stigma and Mental Illness: A Cross Cultural Perspective

Culture refers to an inherited system of shared values and beliefs. Culture is transmitted from one generation to the next (Helman, 1990; Prior, Chun & Huat, 2000). It determines what is an appropriate, acceptable and normal display of behaviour. Culture shapes responses to an illness and what constitutes illness (Helman, 1990; Olafsdottir & Pescosolido, 2011; Prior, Chun & Huat, 2000). It also reveals what the cultural taboos involved are particularly related to mental illness and the stigma attached to them.

In cross-cultural psychiatry, a number of research studies showed that certain Western psychiatric diagnosis (for example: dementia, Alzheimer's disease or depression) was considered in non-western societies as a normal part of life. These illnesses were considered the inevitable consequences of stress from worries, frustrations and the pressures of life (Helman, 1990; Prior, Chun & Huat, 2000; Jones, Chow & Gatz, 2006; Olafsdottir & Pescosolido, 2011). In non-western cultures, mental illness was thought to be caused by an unhappy life (CMHA, 2009), imbalance of Yin (too much cold) and Yang (too much heat) (Zhang, 2007; Cretchley, Gallois, Cheneny & Smith, 2010), and aloofness (Littlewood, 1988). Elsewhere, mental illness was thought to be caused by bad family (Liu, Hinton, Tran, Hinton & Barker, 2008), thinking too much (Liu, Hinton, Tran, Hinton & Barker, 2008), 'excessive thinking' or 'thinking too hard' (Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010, p. 836). Dementia was identified as a 'mind stealer' (Ikels, 1998, p. 257). It was perceived as a result of not being open-minded enough (Chan, 2010). According to Chan (2012), Alzheimer's disease was considered by some people in Hong Kong as the destiny of heaven (tien ming) (p. 472). The result of such conceptualizations of different types of mental illness was that they did not require psychiatric intervention (Helman, 1990; Prior, Chun & Huat, 2000; Jones, Chow, & Gatz, M., 2006; Naeem, Ayub, Kingdon & Gobbi, 2012).

In Chinese communities across the world, mental illness per se was considered a taboo. It carried deep stigma of fear and shame for the sufferers and their families (Littlewood, 1988; Ikels, 1998; Burr & Chapman, 2004; Lee, Lee, Chiu & Kleinman, 2005; Collins, Johnston, Fang, Fung, Kwan & Lo, 2006; Zhan, 2006; Yang, 2007; Liu, Hinton, Tran, Hinton & Barker, 2008; Blignault, Ponzio, Rong & Eisebruch, 2008; Yang & Kleinman, 2008; CMHA, 2009; Gallois, Cheneny & Smith, 2010; Chan, 2010; Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010; Olafsdottir & Pescosolido, 2011; Liu, Ma & Zhao, 2012). For example, mental illness was purported to be caused by bad nerves and bad

genes in the family (Blignault, Ponzio, Rong & Eisebruch, 2008). The hereditary nature of mental illness was an 'inborn stigma' (Goffman, 1968, p. 45), which implicated the family as incompetent for carrying bad genes. This stigma contaminated the whole family and rendered it a bad family (Liu, Hinton, Tran, Hinton, & Barker, 2008). In the context of schizophrenia, Yang, Phillips, Lo, Chou, Zhang & Hopper (2010) reported that it was regarded as a 'mind-split-disease' (qing shen fen lie zheng) (p. 836), and as a result of 'taking things too hard' or 'excessive thinking' (xiang bu kai). Yang and colleagues (2010) reported that schizophrenia was also attributed to the 'narrow-mindedness' (xiao xin yan) of a person (p. 838). This meant that the person was unable to open up their mind to release blocked feelings (Zhang, 2007). Traditional Chinese beliefs suggested that the loss of control in feelings and the unpredictability of schizophrenia sufferer deeply disrupted the principles of harmony and balance vested in Confucianism (Cretchley, Gallois, Cheneny & Smith, 2010; Lee, Lee, Chiu & Kleinman, 2005; Yang & Kleinman, 2008; Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010). Moreover, the behavior of a person with dementia was thought to threaten the Confucius notions of harmony, unity and survival of the family. It was thought to bring shame to families and communities alike (Koehn, McCleary, Garcia, Spence, Jarvis, & Drummond, 2012).

Preservation and protection of face were also central to Confucius philosophy of equilibrium. The stigma attached to a diagnosis of mental illness threatened one's reputation called 'face' ('lien' or 'mian zi') (Yang, 2007, p. 47; Zhang, 2007, p. 56). Face represented a person's social and moral status (Zhang, 2007). Maintaining face in social interaction was very important for the Chinese in their local communities. This could explain why Asian communities (including Chinese) preferably attributed illnesses such as Alzheimer's disease to biomedical etiology. They preferred not to think of it as a mental illness (Jones, Chow, & Gatz, 2006, p. 15).

Vested in Confucianism also were virtues of self-control, self-help and the capacity to endure environmental stressors (Ikels, 1998; Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010). A diagnosis of depression (Burr & Chapman, 2004; Liang, Gong, Wen, Guan, Li, Yin & Wang, 2012), and dementia (Ikels, 1998; Liu, Hinton, Tran, Hinton, & Barker, J.2008; Chan, 2010), often implied a weak will in a person's constitution. Goffman (1968) called this weakness 'abomination of the body' (p. 14). People who suffered from it would be deemed 'faceless'. They would be regarded as 'moral defects' within their social circles (Yang, 2007, p. 43). Thus the sufferers and their families would be deemed as 'discredited' people (Goffman, 1968, p. 14).Their social identities would be 'spoilt' (Goffman, 1968, p. 31).

Chinese families would then build a 'protective capsule' around their loved one with mental health problems (Goffman, 1968, p. 46), or an invisible barrier to protect and shield their family members from shame and loss of face associated with such illness (Chan, 2010; Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010; Liu, Ma & Zhao, 2012). Since social interaction in Chinese groups was organized by a strict network of social relations (Yang & Kleinman, 2008; CMHA, 2009; Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010), the loss of face would lead to discrimination and social isolation of the sufferers and their close associates. The stigma attached to mental illness would therefore become a major barrier to the social acceptance of such a diagnosis (Blignault, Ponzio, Rong & Eisebruch, 2008).

The British context

Migration affected the nature of the wider Chinese communities in Britain. Li, Lee, Mackenzie, Jones & Lam (2009) revealed that experiences of ageing were strongly shaped by migration, traditional Chinese family values, gender and social class inequalities. They also found that long years of residence in Britain did not change the residents' traditional cultural

values. In fact, they appeared to hold on to them steadfastly. Sources of psychosocial distress and mental illness (depression, loneliness, isolation, and family tension) were identified.

Studies on Chinese migrants had reported issues of stigma, language barriers, inadequate support from their family and poor social networks (Yu, 2000; Blignault, Ponzio, Rong & Eisebruch, 2008; CMHA, 2009; Li, Lee, Mackenzie, Jones & Lam, 2009; CMHA, 2009) highlighted unmet mental health needs of this migrant group. The unmet needs included a lack of professional interpreting services on one hand, and on the other, an unwillingness to seek medical attention or a lack of mental health awareness. These issues led to, among other things, frustration, stress and inequalities of access to mental health professionals such as General Practitioners and support from social services. Tran and colleagues (Tran, Wong, Yung, Lam, 2008) explored the perception of 'mental health' in older Chinese people (aged 55-94) (Tran, Wong, Yung & Lam, 2008). They found that participants did not have any knowledge of mental illness. Their understanding of it was framed within physical well-being (for example, good sleep was linked to good mental health). Participants were unlikely to recognize mental health problems and subsequently. They were reluctant to seek help from the National Health Service. They were unlikely to perceive mental health problems as illness which required a visit to their doctors. Tran and colleagues also found that older Chinese people were underrepresented in specialist mental health services (Tran, Wong, Yung & Lam, 2008).

The unmet mental health needs and under-representation of ethnic minority population revealed in the empirical literature above reflected the concerns of the British Government. In March 2007, the Department of Health launched a policy initiative: 'Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England'. This policy document highlighted the Government's firm commitment in tackling issues of fear in seeking help, prevention, early detection and access to culturally sensitive

mental health services. The Government acknowledged that the ethnic agenda had been marginalized or ignored. It also acknowledged that there was an acute lack of national strategy and policy specifically intended to improve the mental health of minority groups.

Our present study

The review of literature above indicated that older Chinese migrants have particular cultural understandings of mental illness and specific ways of dealing with it. Culture may also determine how they talk about mental illness (Helman, 1990). A review of cross-cultural psychiatry revealed that the use of cultural idioms, albeit scant, was found in insightful studies of schizophrenia (Yang, 2007; Yang & Kleinman, 2008; Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010); dementia (Ikels, 1998) and Alzheimer's disease (Chan, 2010). Yang and colleagues (2010) reported that cultural idioms were functional in helping participants to express culturally relevant feelings and recognize culturally abnormal behaviors.

The Annual Population Survey showed that the total number of Chinese living in England and Wales in 2011 had increased from 71,083 (January-March) to 219,05800 (April to December) in the same year (ONS, 2011). This increase was hardly surprising. In the last five years, trading and business ventures between Britain and China were encouraged by the British Government (Foreign and Commonwealth Office, 2009). This had led to an influx of businessmen and students from mainland China (Uddin, 2013; Latham & Wu, 2013). The speed of immigration was accelerated by the urgent initiatives of the British Government to streamline and simplify the visa application process for Chinese visitors (Uddin, 2013). Despite this increase however, there was little research exploring Chinese migrants' experiences and health in Britain. Therefore there was a need to explore this under-researched ethnic group and the group's cultural responses to mental illness (Koo, 2012). Stigma was a multi-dimensional concept which needed to be understood within the contexts

of immigrants living in host societies (Chan, 2010; Helman, 1990; Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010). The purpose of this article was to provide a useful perspective in area with limited understanding and knowledge at present.

Our research questions were (a) what do you think the term mental illness means to you? (b) Have you come across anyone who suffered from mental illness? (c) How would you describe someone who you think is mentally ill? (d) Can you please name some mental illnesses you know of and their main symptoms? (e) How do you think society treats people who suffer from mental illness? (f) What do you think healthcare professionals should do to help people with mental illness? We purposively avoided mentioning specific diagnostic categories to participants because we did not want to impose our categories on them (Silverman, 1998).

In this article, we used the terms 'mental illness' or 'jìng sáhn *pehn' throughout* the text because this was the only term known and used by our Cantonese-speaking participants during the interviews. They understood the term as a non-organic concept, and as such, a sickness of mind and spirit. In contemporary Chinese medicine, the word 'jìng' represented the 'mind', and 'sáhn', represented the 'spirit' of a person (Zhang, 2007, p. 36). Thus 'mind and spirit' were the 'root of life' in traditional and contemporary Chinese medicine (Zhang, 2007, p. 36)'.

Methods

Research design

This article was based on a small-scale qualitative study of older Chinese migrants' perceptions of mental illness in Cantonese-speaking communities in Britain. The main aim of our study was to provide a greater insight into the knowledge and attitudes of Cantonese-speaking older people towards mental illness. We wanted to identify their basic knowledge of

mental illness through examining the cultural idioms used by these participants, and the role of cultural stigma in shaping participants' experiences. We adopted a Grounded Theory approach (Glaser & Strauss, 1967). This meant that theories were grounded in and generated from a natural environment. This approach allowed for comprehensive data treatment (Silverman, 2000). It included methods of triangulation, content analysis, constant comparative analysis and identification of deviant cases. This method of data treatment allowed for theoretical saturation (Seale, 1999) which the authors achieved by examining 'every piece of data collected which needed to be used until it was accounted for' (Silverman, 2000, p. 181). It was inductive, and it was useful for generating new concepts and categories in the process of data analysis.

The research context

Participants were recruited from one local Chinese Community Centre (LCCC) and one local Church community to which the first author had access. The LCCC was a charity organization which received limited funding from the Government. It provided a central meeting place for older and younger Chinese people to organize their activities for festival times (Chinese New Year and Christmas celebrations), and for learning new skills (Yu, 2000). The church was family-centred. It provided home visits to older Chinese people. It was in the LCCC and the local church community that older Chinese people were most visible. We selected these two community sites because they represented a cross-section of the older Chinese migrant population living in Britain.

Gaining access

We recruited participants with the help of the church community and the LCCC leaders as they were able to access the older Chinese people, and they understood their specific cultural concerns and needs (Rugkåsa & Canvin, 2011). By adopting this recruitment

strategy we were allowed to enter the 'heart of a culture' (Ochieng, 2010, p. 1725). We discussed the aims of the project and the research procedure with the community leaders and older Chinese people in a series of introductory meetings. These meetings helped us to establish and develop good research relationships (Ochieng, 2010). During these meetings, we had the opportunity to talk about our project and to answer any queries. Those that showed interest in the project were given information sheets (written in both English and Chinese) which contained the aims of the project, the research procedure and the option to opt in or out of our project. We gave potential participants time and space to think about the issues and to decide whether or not to take part in the project. As a result, eight older Chinese migrants came forward. Previous research indicated that older Chinese people were suspicious of outsiders (Chan, 2010; Chau & Yu, 2000; CMHA, 2009; LCCA, 2002; Yu, 2000), therefore it was important to establish a trusting relationship with them.

Participant characteristics

We recruited a convenience sample of eight migrants of Chinese origin who (a) attended local community centers where the first author had access, and (b) were Cantonese-speaking. (c) Did not suffer from known mental illness, and (d) were aged 60 and above. We selected Cantonese-speaking participants because the majority of people who attended their local community centres were from Hong Kong and Quangdong Province. Also the first author was a native Cantonese-speaker who had lived in Quangdong (China) and Hong Kong before migrating to Britain. We also felt that focusing on one dialect would simplify the process of translation. We recruited eight older Chinese people who had migrated to Britain from China and Hong Kong. We acknowledged that this sample was small. However, following Baruch (1981), Morse (2000) and Seale (2012), representativeness of the sample in our study was less important than the insights it would yield. We wanted to explore how

participants described mental illness and what mental illness looked like to them. The quality and richness of the data obtained enabled us to achieve this task.

The majority of our participants lived with their adult children. The shortest length of residence in Britain was 11 years and the longest 66 years (mean: 38.5 years). The youngest participant was 61 years and the oldest 92 years (mean: 76.5 years of age). Despite the wide range in years of residence, we did not observe any disparity in their descriptions of mental illness experiences. In terms of educational background, one participant attended primary school for one year, two had completed primary education, four had completed secondary education and one did not disclose this information. Apart from one participant who was a housewife, the remaining seven were retired workers in a variety of clerical and service occupations. We observed a level of informality within the colloquial Cantonese (Bourgerie, Tong & James, 2007) spoken by the participants in our study, which may reflect the low level of educational attainment of the participants. As far as health status was concerned, most participants self-reported that they were reasonably healthy with some age-related physical difficulties. Although we made an effort to exclude people with current diagnosis of mental illness, during the conduct of the fieldwork, one man disclosed ambiguously that he was treated for Chìhng séuih dái lohk (moods low and down) in Hong Kong in the past. Another man said that he had 'spent half a day being happy and half a day being worried', and one woman declared that she had been treated in the past by 'mental health doctors'. This ambiguous disclosure was interesting but not surprising, given the characteristics of keeping negative personal information from outsiders (Chau & Yu, 2000; Yu, 2000; CMHA, 2009). We did not exclude participants who disclosed vague symptoms of mental illness during the course of the interview. The disclosure of vague mental illness was very significant. It raised an important issue of the possibility of undetected (hidden) mental illness (Li, Lee,

Mackenzie, Jones and Lam, 2009; Ng, Hiew & Lok, 2007). Table 1 below displays a

summary of participant characteristics.

Table 1: Participant Characteristics

Participant	Gender	Age	Ethnicity	Marital status	Occupation	Education	Religion	No. of children	Country of residence	Years in UK	History of mental illness	Present health
E1	F	76	Chinese	Widowed	Housewife	Primary school	Catholic	'several'	CH/HK/UK	18	None	Walked with aids
E2	M	92	Anglo-Chinese	Re-married	Retired, self-employed	'Matriculation'	Atheist	10 (2 died)	CH/HK/UK	66	Treated for Chìhng séuih dái lohk (moods low and down)	'Good'
E3	F	83	Chinese	Re-married	Retired seamstress	1 year in primary school	Christian	3	CH/HK/UK	55	None	Walked with aids
E4	F	76	Chinese	Widowed	Retired waitress	Primary school	Buddhist	3	HK/UK	45	Treated by 'mental health doctors'	Pain in legs and hips
E5	M	77	Chinese	'Estranged from his wife'	Retired civil servant (HK)	Undisclosed	Christian	3	HK/UK	11	''Half a day being happy, half a day being worried'	'No good now', anemia
E6	F	66	Chinese	Married	Retired sewing machinist (HK/CH) Retired mental health nurse	Year 2 Middle school (CH) Evening school-English) (HK)	Christian	3	CH/HK/UK	52	None	Chronic sleep problems Brain tumor

| E7 | F | 61 | Chinese | Married. Husband spends most time in HK | Retired fish & chips owner. Carer for her grand-children | 3rd year secondary school | Buddhist | 3 | HK/ Holland/ UK | 43 | none | 'Generally ok' 'some knee problems ' |
| E8 | F | 83 | Chinese | Widow | Retired bank worker (HK) | Completed secondary school (HK) | Christian | 1 | Singapore/ HK/ UK | 25 | none | 'It's good as long as the bones or joints won't cause me any problems' |

Note. E = Elder; UK = United Kingdom; HK = Hong Kong; CH = China; F = female; M = male

Ethical considerations

We obtained ethical approval from our Faculty Research Ethics Committee. We also obtained permission from LCCC and church leaders to access their members. We reimbursed participants for travel expenses, and we made a small donation to LCCC after we completed our fieldwork to thank them for their assistance. We offered payment to the participants drawn from the church community but they declined, saying that 'you are doing a good thing for the Chinese community so why should I be paid for it, it is yìng goì dīk' (it is my obligation to reciprocate). In Chinese culture, the principle of reciprocity of gift-giving formed an important basis for social relations (Yang & Kleinman, 2008). Rewarding participants was for mutual benefit, and a matter of social justice (Rugkåsa & Canvin, 2011). It would be regarded as recognition of equal social status and exchange of good-will (Yang & Kleinman, 2008). A person who failed to reciprocate would be regarded as discourteous and impolite (Yang, 2007). We obtained verbal and signed consent from all participants. At the beginning of each interview, we reiterated their right to withdraw at any time and our obligation to keep information confidential and anonymous. All participants agreed to be audio-recorded. We informed them how long the interview would take. We would destroy all records of the interview upon completion of data analysis. To all participants, we gave an information sheet which contained details of the study, our names, contact numbers, and a copy of the interview guide with Chinese translations.

Data collection

The first author who was bilingual (Cantonese and English) conducted the interview in Cantonese. It is beyond the scope of this article to discuss the benefits and disadvantages of a bilingual researcher. Ochieng (2010) and Shklarov (2007) have discussed the issues of being a bilingual researcher extensively. The first author felt that she was readily trusted because she shared the same ethnicity with the Cantonese-speaking participants. This identity

of an 'insider' helped to obtain detailed and rich data which an 'outsider' would otherwise not

have been able to do so (Ochieng, 2010, p. 1729). Finally, we tried to reduce searcher bias by

maintaining a 'conscious partiality' (Ochieng, 2010, p. 1729) in both data collection and

analysis.

We collected the data in two stages. Stage 1: consisted of semi-structured interviews:

We structured the interview questions in two parts. The first part involved demographic data

(age, ethnic background, religion, and current health status). The second part concerned

questions about mental illness. Stage 2: We conducted a ten-minute exercise immediately

after the interview. The aim of this exercise was also to obtain basic knowledge of mental

illness categories. We presented participants with an official list of diagnostic categories with

Chinese translations (CMHA, 2010b). We asked them whether they had heard of these

illnesses or recognized these terms. If they had heard of them, we asked where they heard of

them from. We also asked them to give examples of what a person might look like with

mental illness. We marked their responses on a list for each participant immediately. A cross

(X) indicated that they had not heard of the illnesses and a tick (V) indicated that they had

heard of it but had not known what that illness meant. A question mark (?) indicated that they

were 'not sure'. (Results are shown in Table 2 below).

Table 2: Types of Mental Illness and Participant Responses

Diagnostic categories	Recognition of types of mental illness	N
Bipolar Disorder	Don't know	6
	Not sure	2
Alcohol and Depression	Don't know	6
	Not sure	2
Depression	Serious but not mental illness	6
	Not sure	2
Depression in Older Adults	Not mental illness	8
	Not sure	-

Depression in people with learning disability	Not mental illness	8
	Not sure	-
Learning disability	Not mental illness	8
	Not sure	-
Depression in the workplace	Not mental illness	8
	Not sure	-
Post-natal depression	Heard of it but don't know anything about it	5
	Not sure	3
Anxiety disorder	Not mental illness	8
	Not sure	
Phobias	Heard of it but don't know anything about it	5
	Not sure	3
Bereavement	Not mental illness	8
	Not sure	-
Schizophrenia	Very serious mental illness	8
	Not sure	-
Sleep disturbance	Not mental illness	8
	Not sure	-
Social phobia	Heard of it but don't know anything about it	5
	Not sure	3
Surviving adolescence	Not mental illness	8
	Not sure	-
Memory and senile dementia	Not mental illness	8
	Not sure	-
Physical illness and mental health	Heard of it but don't know anything about it	5
Post traumatic stress disorder	Not sure	3
Learning disability and mental health	Heard of it but don't know anything about it	5
	Not sure	3
Anxiety and phobias	Heard of it but don't know anything about it	5
	Not sure	3
Eating disorders	Not mental illness	8
	Not sure	-
Anorexia	Not mental illness	8
	Not sure	-
Bulimia	Not mental illness	8
	Not sure	-
Parkinsonism	Don't know	5
	Not sure	3
Severe mental illness (psychosis)	Heard of it but don't know anything about it	5
	Not sure	3
Delusional disorder	Very serious mental illness	6
	Not sure	2
Personality disorder	Heard of it but don't know anything about it	5

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Note. Adapted from the Royal College of Psychiatry website (http://www.rcpsych.ac.uk) in conjunction with The Chinese Mental Health Association

Data analysis

We took the following steps to analyze the data. First, a Chinese researcher who was experienced and skilled at translations translated all eight transcripts from Cantonese to English. Second, the first author re-listened to the audio-tapes. She then checked through the translated transcripts to identify discrepancies in cultural meanings. We then sent the translated transcripts to a professional translator for proof-reading who worked at LCCC. If there were discrepancies, we resolved them through discussions. Third, all authors read the translated English transcripts separately to sense the data for emerging themes. Fourth, we all discussed and agreed on the categories and themes that emerged from the first transcript. Fifth, the third author imported all data into the NVivo qualitative data management software program (Bazeley, 2007). She coded data from the first transcript according to four categories, (a) demography, (b) definition and causes of mental illness, (c) attitudes, and (d) expectations. She then repeated the process for the remaining seven transcripts until data saturation was attained (Seale, 2004). Sixth, the first author examined the coded data and identified patterns of cultural idioms (in English translation) of words and phrases spoken by participants. Next, she listened to all eight transcripts repeatedly for participants' expressions

of mental illness in colloquial Cantonese. Our participants as discussed earlier spoke informal colloquial Cantonese. This informal style was common among Cantonese native speakers in Hong Kong and Quangdong Province in China. The first author identified the idioms in the participants' verbatim accounts. She adopted the Yale system which helped to standardize the sounds of spoken Cantonese (Kwan, Lo, Lo Tam, Mak, Man, Miu Wong & Ng, 1991;

Bourgerie, Tong & James, 2007; Chik & Ng, 2010). She translated Cantonese idioms into English and then assigned a category to the idioms. For example, when a participant described mental illness as chì sin (tangled wires in the head), she would assign it as an idiom of nerves and so on. Throughout the process, she ensured that original source language was not lost, and that cultural relevance was maintained. She took care to avoid preconceived ideas seeping into the analysis (Yu & Lee, 2004; Larkin, Casterle & Schotsmans, 2007; Shklarov, 2007). Finally she asked another Cantonese-speaking researcher to review the translated version and cross-check for cultural relevance in the meanings of words. This was a method called backward/forward translation (Yu & Lee, 2004). We named our participants as E1 (Elder 1) E2 (Elder 2) and so on. The seventh step in the data analysis process involved developing a theoretical insight (Seale, 2012). Figure 1 below shows the process of data analysis.
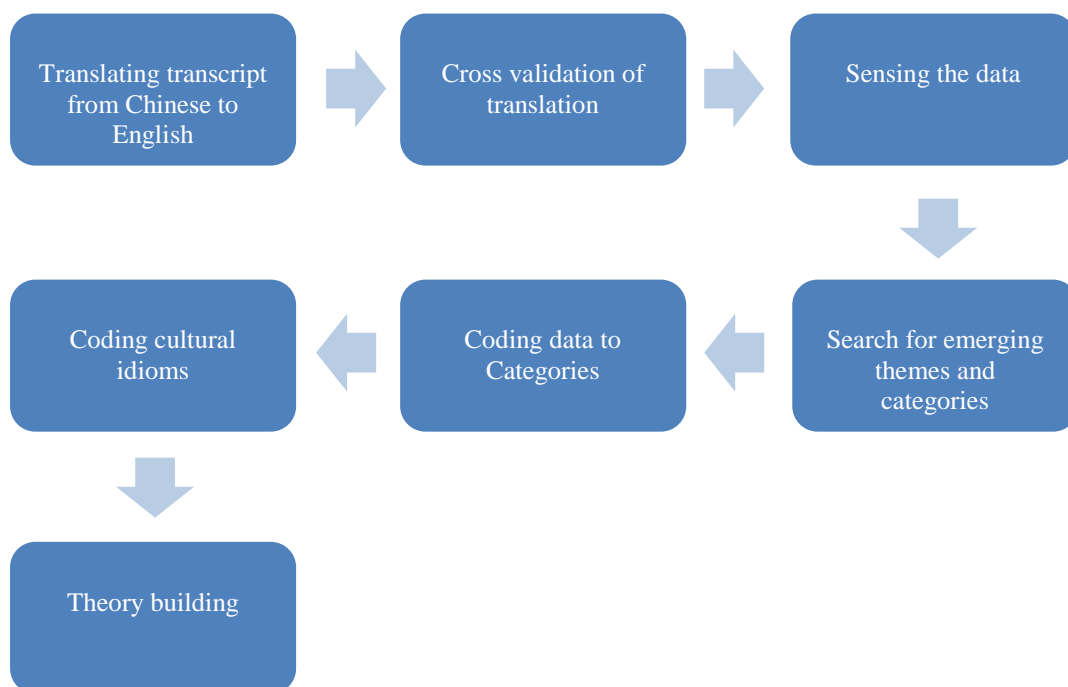

Figure 1: The process of data analysis

Results

In this study, we defined older Chinese migrants as those who had migrated from Hong Kong and China and who had lived in Britain for more than 10 years. We used verbatim words and phrases to give direct access to the participants' voices (Griffin & May, 2012) in relation to their experiences of mental illness within their own Chinese communities. We italicized cultural idioms spoken by participants. We wanted to present verbatim cultural idioms (colloquial Cantonese) first, followed by literal and cultural meanings in English in brackets. We did this because we did not want readers to confuse participants' voice (verbatim cultural idioms) with translators' voice (translations). We presented a table of idioms in colloquial Cantonese and interpretations to aid readers' understanding below in Table 3.

Table 3: Cultural idioms used by older Chinese migrants to describe mental illness

Abnormal constitution: abnormal nerves	faat sáhn gìng (sudden eruption of wild thoughts and nerves)
	jìng sáhn pehng (mind and spirit disease)
	chì sin (tangled wires in the head)
	sáhn gìng fahn liht jing (split, divided and fragmented nerves)
	sáhn gìng gán jèung (nerves tight and loose)
	mjing séuhng (not right and not normal)
	faat dìn yàhn (man with sudden eruption of wild thoughts and nerves)
	jàn chì sin yàhn (a real tangled wires in the head man)
	táai *chi gīk* (attacked by too many prickly thorns=frequent provocation)
	yàt go dīn yàhn (a crazy and mad man)
Abnormal constitution: bad genes	wáih chyùhn (passing on = inherited)
Abnormal behaviour	faat daaih kwòhng (sudden big eruption of frenzied behaviour)
	móhng daaih kwòhng (thinking large)

	kwòhng chiu pehng (disease of agitation and frustration)
	tiu laùh (jump off the building, suicide)
	haahng loih haahng heui (pacing back and forth aimlessly)
	dá dá dau dau (fighting and combating with each other)
	moùh dyùn dyùn naauh yàhn (telling people off randomly)
	nihng jyuh bá leih dōu (holding a sharp knife)
Abnormal mood	Chìhng séuih dái lohk (moods low and down)
	mhòi sàm (cannot open the heart, cannot release pent- up emotions)
	hóu sáuh (very sad)
	sauh chi gīk (thorns and pricks inflicted pain=pressure)
	tái mhòi (cannot see openly=holding pent-up feelings in=inability to think problems through)
	jih saat (self=kill=suicide)
Abnormal personality	wàaih sì séung (bad thinking and feelings inside)
	táai fàahn náu (too troubled in mind)
	táai máhn gám (too sensitive)
	hóu gù duhk (very aloof and withdrawn)
	sò f*āt jih géi* (self-neglect)
	jih bai (self-seclude)
Hidden mental illness-normal and abnormal	wúh sì lyuhn séung (cloudy thinking and chaotic desires in the head)
	jing séuhng yàhn (right and normal people)
Normal life illness idioms	lóuh yàhn gé sih (old people's matter)
Attitudes=participants them and us divide	mhóu chói (not lucky)
	móuh dāk yì (no cure for it)
	mdong néih haih yàhn (treat you as a nobody)

yóuh sàm mòuh lihk (have the heart but no energy= want to help but can't)

hóu hoih pa (very scared)

béi hoì (stay away)

ngóhdeith (we)

ngóh (I, we, our)

yàhndeith (other people)

kéuihdeith (them, those, their)

kéui (he or she)

néih (you)

nī go (this, it)

yàhndeith (people)

Godī yàhn (those people)

Mue go yàhn (everyone)

tà (denotes either he or she)

tà mùhn (they, them, those),

yāt go yàhn (someone, a person, one)

Expectation: professionals - compassion	hóu yáhn sauh tà múhn (very patient and tolerant)
	yiu yóuh ngoi sàm (need a loving heart or kindness of the heart)
	dò dēih ngoi sàm (more love in the heart)
	mhóu siu kéuih (do not laugh at him/her)
	tùhng Chìhng tà múhn (sympathize with them)
	yóuh ngoi sàm (have love in the heart)
	mhóu tái siu tà múhn (don't make them look small= don't look down on them)
	yìng goì dīk (it is my obligation to reciprocate)

The analysis of data revealed three themes of participant's knowledge of mental

illness: (a) culturally-bound knowledge of mental illness, (b) normalizing of mental illness,

(c) attitudes and expectations-the alternative world of 'others' (kéuihdeith) and the real world

of 'us' (ngóhdeith).

Culturally-Bound Knowledge of Mental Illness

Participants' used idioms of abnormal nerves, behavior, mood, personality and

idioms of 'others' to demonstrate their understanding of the behaviors expected of a 'normal'

person. They used normal behaviors to judge abnormal behaviors and to mark the boundary

between the normal world and the abnormal world of 'others'. The construction of these two

worlds gave participants a space to bracket the stigma of mental illness.

Abnormal nerve idiom

When we asked what our participants' thought about mental illness, they used nerve

idioms to express mental illness as caused by an abnormal constitution in the brain. The

abnormality was manifested in chi sin (tangled wires in the head), faat sáhn gìng (sudden

eruption of wild thoughts and nerves), sáhn gìng fahn liht jing (split, divided and fragmented

nerves), sáhn gìng gán jèung (nerves tight and loose) and kwòhng chiu pehng (disease of

nerve agitation and frustration). These abnormal nerve idioms functioned to depict a brain

with uncontrolled and unrestrained nerves, a brain which was riddled with frenzied, jumbled

up nerves with lots of knots and crosses. For them, mental illness meant jìng sáhn pehng

(mind and spirit disease/mental illness). For example:

E1: Jìng sáhn pehng (mental illness) means chi sin, and faat sáhn gìng.

E4: Jìng sáhn pehng means schizophrenia and mjing séuhng (not normal)

E6: It's sáhn gìng fahn liht jing and kwòhng chiu pehng, the stage when someone is chi sin.

Nerve idioms enabled participants to paint graphic images of an over-active brain which had run amok. Only one participant attributed the causes of mental illness to bad genes. She used the idiom of wáih chyùhn (pass on) (E6) to demonstrate her understanding that bad genes could be passed onto members in the same family and future generations (Goffman, 1968; Helman, 1990).

Hidden mental illness

Use of abnormal nerve idioms:

Participants used abnormal nerve idiom such as wúh sì lyuhn séung (cloudy thinking and chaotic desires in the head) to express behaviors which they interpreted as bordering on the threshold of rationality and abnormality. For example, seeing things that were not there, or saying things that did not make sense to them. Goffman called this group of people 'discreditable' (Goffman, 1968, p. 123). Participants used idioms of relations such as tà (she or he), and kéuihdeith (they) to distance themselves from abnormal others. They would construct an alternative world of 'others' in which they could bracket oddly behaved people. The absence of the personal pronoun 'I' represented the notion that they did not belong to the world of 'others' who have mental illness. For example:

E2: Kéuihdeith (they) wúh sì lyuhn séung (cloudy thinking and chaotic desires in the head), kéuihdeith are not logical, kéuihdeith have illogical behavior. Saying things that are not true.

E8: The sufferer may behave in a way or say things that jing séuhng yàhn (normal people) won't do or say, the way kéuihdeith (they) talk, or the things kéuihdeith do may be something that jing séuhng yàhn don't do.

For the participants, a jing séuhng yàhn (normal person) would not have thoughts of wúh sì lyuhn séung. The use of idioms of 'others' (kéuihdeith ,tà) served to express odd behaviors as belonging to the world of 'others'. They served to bracket discreditable stigma (Goffman, 1968).

Idioms of abnormal behavior

In the following extracts, fear of mental illness was evident in participants' accounts. They used abnormal behavior idioms to construct an image of a person who appeared to be *mdāk jing séuhng* (not right and not normal), who was a jàn chì sin yàhn (really crazy with too many tangled wires in the head). This person was a wild, unpredictable and a dangerous person who had gone hay-wire; for example, faat dìn yàhn (people with sudden eruption of wild thoughts and nerves). For our participants, chi sin (tangled wires in the head) was synonymous with schizophrenia (sáhn gìng fahn liht jing). It represented a bunch of split, divided and fragmented nerves. It was what Yang, Phillips, Lo, Chou, Zhang & Hopper (2010, p. 836) called a 'mind-split-disease. Chi sin in our study was also synonymous with delusional disorder (móhng daaih kwòhng - thinking large). Participants described abnormal behaviors of restlessness and aimlessness which they saw in a person. For example, haahng

loih haahng heui (pacing back and forth aimlessly), moùh dyùn dyùn naauh yàhn (telling

people off without reason), and dá dá dau dau (fighting and combating with each other).

E4: Chi sin (tangled wires in the head) is schizophrenia. Kéuihdeith (they) are md$\bar{a}k$

jing séuhng (not normal). N$\bar{\imath}$ go (this) also means if someone has got it, it's very

serious. Sometimes kéuihdeith (they) may zi bait (self-seclude), it means that

kéuihdeith hide kéuihdeith away. Kéuihdeith can be violent like hitting yàhndeith

(people), shouting at yàhndeith (other people).

In our participants' accounts, people who suffered from schizophrenia were dangerous,

irrational and unpredictable (Cretchley, Gallois, Cheneny & Smith, 2010; Yang, Phillips, Lo,

Chou, Zhang & Hopper, 2010). An image of a violent person who could kill was displayed in

the following extracts:

E1: God$\bar{\imath}$ yàhn (those people) who are chopping yàhn (people) are the real chi sin

ones. Kéuihdeith (they) fight. Kéuihdeith chop yàhn (people) with a knife.

E6: When yàt go yàhn (someone) is chi sin, néih (you) have to cushion the walls

with soft stuff, otherwise kéuihdeith (they) may hurt kéuihdeith (themselves) when

kéuihdeith hit the wall. Kéuihdeith also need medication to keep kéuihdeith (them)

under control.

E7: Kéui (he) stabbed the boy for no apparent reason.

Participants regarded people who suffered from delusional disorder as those who:

E5: May hurt néih (you) any time. Néih may be stabbed for no reason. Kéuihdeith

(they) need medication. Psychiatrists will have to deal with such cases.

E6: Kéuihdeith (they) want to be like Hitler and want to kill many people… And

kéuihdeith will cause disasters. Kéuihdeith need medication and hospitalization.

The analysis above demonstrated that participants drew on idioms of 'others' (kéuihdeith, néih) to express extreme abhorrent behaviors as abnormal and dangerous. We named these idioms as idioms of relations. The idioms served to bracket such behaviors in the alternative world of 'others' to contain the stigma and fear of mental illness.

Idioms of abnormal moods.

Participants used mood idioms to interpret abnormal and negative thoughts of someone who was *mdāk jing séuhng* (not right and not normal) and who exhibited abnormality of moods (Liang et al., 2012). For example, Chìhng séuih dái lohk (moods low and down), hóu sáuh (very sad), mhòi sàm (cannot open the heart). For the participants, a healthy and happy person would not suffer from jìng sáhn pehng (mental illness) if he/she was able to open his heart and release pent-up feelings- hòi sàm. This kind of blocked feelings (hei) (air breath) as a result of mhòi sàm caused both mental and physical problems (Zhang, 2007). However, the older Chinese migrants seemed to distinguish mental suffering from physical suffering. Blocked feelings were the result of a person's life-style choices. For example:

> E1: Well if néih (you) are hòi sàm (open your heart), if néih are enjoying life, néih shouldn't have jìng sáhn pehng (mood and thought disease).

> E5: If yàt go yàhn (someone) is not outgoing, if yàt go yàhn is not sociable, kéuihdeith (they) are more likely to get jìng sáhn pehng .

Use of personality idioms

Participants used personality idioms to interpret illnesses like depression as a symptom of inadequate personality but not as a symptom of mental illness. It meant that a person who suffered from depression had difficulty solving problems. An inability to solve

problem would be thought of as undermining the fundamental principles of balance and harmony vested in the doctrines of Confucianism (Liang, Gong, Wen, Guan, Li, Yin & Wang, 2012). A person who suffered from abnormal moods would be táai máhn gám (too sensitive), hóu gù duhk (very aloof and withdrawn), mhòi sàm (cannot open the heart), and Chìhng séuih dái lohk (moods low and down). Post-traumatic stress disorder was 'the problem that yàt go yàhn (one) can't accept something that has changed kéuihdeith (their) lives'. They also used idioms of 'others' such as kéuihdeith (they, them and those); néih (you); yàhn (people) to distance themselves from the abnormal people. For example:

E3: A person who tái mhòi (cannot see openly). If néih (you) worry too much, néih get depressed...When kéui (he) can't solve a problem, kéui would feel down.

E5: People often find kéuihdeith (themselves) mhòi sàm (cannot open the heart) at work.

E6: Néih (you) can tell that kéuihdeith (they) are mhòi sàm. Kéuihdeith (their) minds are fàahn náu (trouble in the mind) ...Kéuihdeith can't release wàaih sì séung (bad thinking and feelings) inside, and eventually when it becomes too much, it explodes in a way to let out those feelings.

One participant acknowledged that depression could have fatal consequences (suicide) if a person worried too much, or, as Yang and colleagues, (Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010) put it, 'narrow-minded' (p. 844). The person could not see beyond the problems because of restricted thinking. This meant that he/she could not think outside of a narrow range of possibilities. For example,

E5: Kéuihdeith (they) worry about everything… Having kéuihdeith (their) minds

occupied with such worries. My husband even wanted to jih saat (self-kill: Suicide)

by throwing Kéui (himself) in front of a bus.

Normalizing of Mental Illness

Normal Life Idiom

Participants used normal life idioms to interpret some types of mental illness as

normal life stresses and pressures associated with job loss, for example,

E2: Kéui (he) had a period of mhòi sàm (cannot open the heart) when kéui first

arrived in England kéui lost kéui (his) job.

E3: When kéui (he) came here kéui had a nice job. But 6 months down the road the

company closed down. As kéui had been a boss before, kéui found it hard to be a

mdong néih haih yàhn (treat you as a nobody). Kéui had to support his first wife too.

His wife and his eldest son had jìng sáhn pehng (mind and spirit disease). Because

of all these kéui suffered lots of chi *gīk* (attacked by prickly thorns or frequent

provocation).

Participants construed reading too much as normal pressure and a lack of ngoi

(love) in the family which caused fàahn náu (worries in the brain), for example:

E4: Some get it because kéuihdeith (they) read too much. The chi gīk (attacked by prickly thorns or frequent provocation) is too much for kéuihdeith (them); in that way kéuihdeith ruin kéuihdeith ge (their) health. The kids lacked ngoi (love).

The above analysis demonstrated that job loss, reading too much and lack of love in the family were regarded as general problems or normal setbacks in one's life and were therefore not seen as mental illness (Helman, 1990).

Normal ageing idioms

Participants did not construe dementia and Alzheimer's disease as mental illnesses but as a lóuh yàhn gé sih (old people's matter). Here they were happy to associate themselves to these diseases. The evidence for this observation can be located in their use of 'ngóh' ('I'), and 'ngóh ge' (my). As in the other cultures, the diseases were associated with normal ageing (Chan, 2010; Ikels, 1998; Jones, Chow, & Gatz, 2006; Liu, Hinton, Tran, Hinton, & Barker, 2008). For example:

E6: Dementia... ngóh ge (my) memory is fading. The older ngóh (I) become, the poorer memory ngóh have.

E7: Its lóuh yàhn gé sih (old people's matter) it is related to age…It's not a mental health issue. When néih (you) get old néih ge (your) memory will fade.

E8: That is my condition, lóuh yàhn gé sih, seriously. I tend to forget things often. It is not mental illness.

Attitudes and Expectations

The alternative world of 'others' (kéuihdeith -them) and the real world of 'us' (ngóhdeith)

In participants' accounts, they used idioms of 'us' such as ngóhdeith (we, us) and 'them' tà mùhn (they, them, those), yàhn (people), kéuihdeith (they), and néih (you) to indicate the untenable relations between the normal and abnormal world (Helman, 1990). They also drew on idioms of compassion to express a desire to be helpful, available, supportive, caring, loving and tolerant. For example:

E2: Néih (you) should mhóu siu kéuih (do not laugh at them), talk to kéuihdeith (them) to find out where kéuihdeith have gone wrong.

E4: Ngóhdeith (we) can't help kéuihdeith (them) much. Ngóh (I) feel yóuh sàm mòuh lihk (have the heart but no energy).

E6: Ngóh (I) feel sorry for kéuihdeith. Mue go yàhn (everyone) needs to be hóu yáhn sauh tà múhn (be very patient and tolerant towards them),tà múhn (they) should give kéuihdeith (them) a little more care, a bit more ngoi sàm (love in the heart), more time and don't isolate kéuihdeith (them).

There was also a desire to avoid meeting them or approaching them because of fear of dangers. For example:

E1: Ngóh (I) feel hóu hoih pa (very scared), because just in case kéuihdeith (they) stab néih (you), kéuihdeith don't do it knowingly, that is why ngóh feel scared. Ngóh don't know what to do.

E5: If ngóh saw kéuihdeith (them), ngóh would be afraid. Nì go haih (this is) alright to have a chat as long as kéuihdeith (they) don't nihng jyuh bá *leih dōu* (holding a sharp knife).

E8: Ngóh (I) try not to be too close. Ngóh would béi hoì (stay away) a little.

Expectations of Professional Help

Idioms of compassion

Participants said that carers yiu yóuh ngoi sàm (need a loving heart or kindness of the heart) to help them and be 'tolerant and understanding' towards them. It was 'important to interact with them' and keep an eye on them. Carers need yóuh ngoi sàm (have love in their hearts). They should mhóu tái siu tà múhn (don't look down on them and don't make them look small).

Discussion

Our empirical evidence demonstrated that participants did not have a Western vocabulary for describing mental illness categories (CMHA, 2010a). They had heard of them from Chinese television channels, newspapers and what their friends had told them, but had not known about them (see Table 2). For example, E8 said: 'I heard about them from watching Chinese TV', and E5: 'my friend's children had mental illness'. For those who had heard of these diagnostic categories, they considered schizophrenia and delusional disorder as the most serious, and depression was not serious. Like the participants in cross-cultural studies (Helman, 1990; Prior, Chun & Huat, 2000; Jones, Chow, & Gatz, 2006; Olafsdottir & Pescosolido 2011), our participants also shared the view that Alzheimer's disease, depression

and dementia were not mental illnesses. These diseases were considered an inevitable part and parcel of life. Therefore they were happy to relate themselves to this group of illnesses. Our findings confirmed previous findings that a lack of mental health awareness, unmet needs and under-representation of ethnic minority groups (Yu, 2000; Tran, Wong, Yung, Lam,, 2008; CMHA 2009) in the British context was strongly influenced by the traditional Chinese beliefs of balance, harmony, self-control, self-help and face-preservation embedded in Confucianism (Lee, Lee, Chiu & Kleinman, 2005; Yang & Kleinman 2008; Cretchley, Gallois, Cheneny & Smith, 2010; Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010). We demonstrated that the process of recognition, description and seeking professional help may well be hampered by a) a lack of culturally-specific language, b) fear of mental illness and c) the stigma attached to it.

Knowledge of Mental Illness

A review of available cross-cultural literature revealed scant yet insightful research on the use of cultural idioms which were applied to specific categories of schizophrenia (Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010), dementia and Alzheimer's disease (Chan, 2010). Our empirical evidence shed greater insight and added more depth to this small body of knowledge. We demonstrated that our participants had a culturally-specific way of describing mental illness within Cantonese-speaking communities. Our findings revealed that participants drew on cultural idioms of 'nerves', 'mood', 'behavior', 'personality', 'normal life' and idioms of 'others' and 'us' to demonstrate their understanding of mental illness. Cultural idioms served as an important medium through which participants could access an alternative world of 'others' from the position of the real world of 'us'. The construction of an

'alternative world' enabled them to express shared knowledge and beliefs regarding mental illness from a safe distance.

Furthermore, our analysis demonstrated that participants' concept of mental illness was shaped by Confucianism embedded in Chinese culture (Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010). Participants used nerve idioms to construct graphic images of a malfunctioning brain which was riddled with frenzied and unrestrained activities. Graphic brain imagery gave participants direct access to brain activities which they interpreted as abnormal and bad. Bad nerves (Blignault, Ponzio, Rong & Eisebruch, 2008) constituted an abnormal person. Bad genes were wáih chyùhn (passed on) and 'inborn stigmas' (Goffman, 1968, p. 45). This idiom demonstrated participants' awareness of mental illness as a hereditary disease which carried risks of infecting family members and future generations. Goffman (1968) called mental illness a 'courtesy stigma' or 'tribal stigma' (p. 14). Bad genes associated with mental illness stigmatized all family members. Abnormal nerves and genes disturbed the equilibrium between the physiological and mental constitution of an individual (Helman, 1990). An abnormal brain represented the stigma of an 'abomination of the body' (Goffman, 1968, p. 13). The person, who possessed abnormal nerves and genes, was discredited in the eyes of society and his/her social identity was spoiled (Goffman, 1968). This biomedical causation described in the data concurred with the views of the majority of people in Europe (Helman, 1990; Olafsdottir & Pescosolido, 2011).

Participants were aware of a group of people who displayed behaviors that were odd which would not be seen in jing séuhng yàhn (normal people) or the 'normals' (Goffman, 1968, p. 15). The illness as far as possible was managed and hidden from view until this hiding was no longer possible. When odd behaviors became known and visible to people during social interaction, the person became socially stigmatized. Our analysis showed that

participants drew on idioms of relations to construct the alternative world of 'others' (tà, tà mùhn - he, she and they); kéuihdeith (they, them and those) to express behaviors which they interpreted as bordering on the threshold of rationality and abnormality. They bracketed the stigmatized individuals in the alternative world of 'others' to reduce the risk of contamination (Goffman, 1968).

Participants reported a repertoire of dangerous and unpredictable behaviors which they interpreted as md*āk jing séuhng* (not right or normal). People who displayed these behaviors required treatment and incarceration. Schizophrenia and delusional disorder were regarded as major issues because of the unpredictability of the illness and the propensity for violence (Littlewood, 1988; Lee, Lee, Chiu & Kleinman, 2005; Gallois, Yang, 2007; Yang & Kleinman, 2008; Yang, Phillips, Lo, Chou, Zhang & Hopper,2010; Cheneny & Smith, 2010;). The instability and unpredictability involved in schizophrenia disrupted the holistic balance and harmony of mind and body embedded in Confucianism (Liu, Hinton, Tran, Hinton, & Barker, 2008; CMHA, 2009). A deviation from this holistic balance and harmony was a source of deep stigma and a loss of face for the individuals and their families (Yang & Kleinman 2008; Yang, Phillips, Lo, Chou, Zhang & Hopper,2010). The person who suffered from this type of serious mental illness would be treated as a deeply 'discredited' person (Goffman, 1968, p. 14).

Perception of a violent and dangerous person resonated with the views of participants who lived in Trinidad (Littlewood, 1988). Participants who lived in Beijing also shared this view (Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010). However, the image of a violent schizophrenic was not pervasive across all cultures in available literature. Violence was not reported to be a problem in people who suffered from schizophrenia in European countries (Blignault, Ponzio, Rong & Eisebruch, 2008).

The Chinese in Beijing interpreted schizophrenia as the result of 'excessive thinking' or, according to Yang and colleagues, 'xiang bu kai' (can't think openly) (Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010, p. 838). However, our participants used extreme nerve idioms (represented by táai or jàn which meant too much or really) to construct graphic imageries of a brain which was overloaded with broken and chaotic nerves. These nerves in turn caused unrestrained and unpredictable behavior. A person could not be cured of this illness (móuh *dāk yì)*. Participants used extreme abnormal mood and extreme abnormal behavior idioms to construct images of a wild and dangerous man. These distinctive cultural idioms enabled participants to recognize abhorrent behavior as culturally abnormal (Helman, 1990). Graphic images served to give the effect of a person being there to witness such events. The use of extreme mood and behavior idioms allowed participants to gauge the interactional distance or proximity between themselves and 'others' (kéuihdeith). Our participants created an alternative world of 'others'. In this alternative world, they were able to bracket extremely abnormal people and the stigma associated with mental illness.

Participants used abnormal mood idioms (mhòi sàm-cannot open the heart) to construct a downward-spiral imagery of an individual who had descended into the dark world of mental illness. Participants likened the heart to a room with a door which could be open and shut. This observation concurred with the Western view of the body as a machine (Burr & Chapman, 2004; Helman, 1990). An open heart indicated that a person was able to release his/her pent-up feelings, but when these feelings or hei (Zhang, 2007) were shut in or blocked the person would suffer from abnormal moods (Zhang, 2007). Our participants recognized that the freeing and unblocking of such feelings required a person to change their life-style. However, our analysis showed that older Chinese migrants did not appear to connect mood and thought disorders to how these emotions might affect their physical health. Our analysis also showed that they regarded depression as only requiring medication and psychosocial

support from their family members. They did not see any need for medical interventions or visits to the doctor (Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010).

The South Asian participants (Burr & Chapman, 2004) and the Chinese (Tran, Wong, Yung & Lam, 2008) in Britain somatized their feelings and presented depression as an embodied experience. However, our participants understood depression as an illness rooted in a person's personality, a person who was unable to endure environmental stresses (Burr & Chapman, 2004; Liang, Gong, Wen, Guan, Li, Yin & Wang, 2012). Worrying and thinking too much were stigmatizing. This meant that people who experienced these emotions were unable to free or unblock them (Zhang, 2007), instead, they held the thoughts in. An inability to control emotions would imply the existence of a weak will (Ikels, 1998; Burr & Chapman, 2004; Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010; Liang, Gong, Wen, Guan, Li, Yin & Wang, 2012). Having a weak will and the inability to control emotions blemished an individual's character (Goffman, 1968). Such a person would lose face (Yang & Kleinman, 2008). There was no place for weak will in the Confucius virtues of self-help and self-control (Burr & Chapman, 2004; Yang & Kleinman, 2008; Liang, Gong, Wen, Guan, Li, Yin & Wang, 2012). Our participants used idioms of 'others' to mark the boundary between the alternative world of 'them' and the real word of 'us'. The absence of the use of 'I' suggested that participants removed personal involvement (Drew & Heritage, 1992) but at the same time they could talk freely about their experiences of mental illness from a safe distance (Burr & Chapman, 2004).

Our empirical evidence demonstrated that older Chinese migrants tried to normalize patterns of the undisciplined behaviors that they described. They tried to frame mental illness as a normal and acceptable part of everyday life within the context of their cultural backgrounds. Causes of mental illness were the result of the normal stresses of life. The

normalizing strategy served to lessen social stigma and social distance. For example, participants perceived Alzheimer's disease and dementia as relating to normal ageing. It was therefore an old people's matter (lóuh yàhn gé sih). This perception was found to be pervasive in Chinese communities across the world (Ikels, 1998; Jones, Chow, & Gatz, 2006; Liu, Hinton, Tran, Hinton, & Barker, 2008; CMHA, 2009; Chan, 2010; Siu, Chow, Lam, Chau, Tang & Chui, 2012). This normalization process was called 'cultural camouflage' (Helman, 1990, p. 244). It was a form of 'social healing' for healing stresses, and by extension, stigma. The normalizing strategy was also pervasive in Chinese communities across the world (Ikels, 1998; Yang, 2007; Blignault, Ponzio, Rong & Eisebruch, 2008; Liu, Hinton, Tran, Hinton, & Barker, 2008; Yang & Kleinman, 2008; Chan, 2010; Yang, Phillips, Lo, Chou, Zhang & Hopper, 2010; Liang, Gong, Wen, Guan, Li, Yin & Wang, 2012; Siu, Chow, Lam, Chau, Tang & Chui 2012). However, the use of a normalizing strategy was less evident in Western cultures (Olafsdottir & Pescosolido, 2011). Our findings demonstrated that our participants were happy to relate this group of normalized mental illness to themselves and their family. They did not bracket these sufferers to the alternative world of 'others'. This observation could be seen in the use of personal identity markers ' ngóh ',('my and 'I') (Drew & Heritage, 1992).

Attitude

Our analysis showed that the most visible moment when participants made a clear demarcation between 'them' and 'us' was when we asked them how they felt about people with mental illness. They used idioms such as 'others' to express the difference between 'us' and 'them'. For the participants, mental illness belonged to the alternative world of 'others'. It was not a problem for the normal world. Nevertheless, the alternative world of 'others' had a permeable wall through which the 'normals' (Goffman, 1968, p. 15) could access. It meant that they could have a social but not a personal relationship with them. This observation

concurred with the findings of Siu and colleagues (2012**).** The permeable barrier functioned as a 'protective capsule (p. 46)', to keep 'undesired differentness' out (Goffman, 1968, p. 15). In terms of support for this group of 'others', participant reported that it was beyond their physical ability to help even if they had wanted to. Others drew on compassion idioms to display their sympathy towards this group of 'others'.

Conclusions

The older Chinese migrants who took part in our study resorted to a repertoire of Chinese cultural idioms to construct a specific way of knowing about mental illness. In our analysis of their accounts, we demonstrated that cultural idioms helped them to construct an alternative world of 'others' to manage the stigma of mental illness. The use of cultural idioms gave them a set of shared culturally-specific vocabularies to speak of the untouchable topic of mental illness in a single Cantonese-speaking community in Britain. Our findings show how the fear and stigma associated with mental illness could prevent older Chinese people from seeking professional support. It might also play a major role in the prevention, recognition, detection, diagnosis and access to mental health services.

There were limitations in this study. We employed a small, convenience sample which did not reflect the diversity of experiences of all older Chinese migrants in Britain. However, our small sample was not intended to be representative; rather we wished to provide a useful perspective in an area with limited understanding and knowledge. Future research with larger and more diverse samples will provide a more comprehensive understanding of the issue. Also, the level of participants' education may have affected their understanding of Western categories of medicine. However, all of them were literate in Chinese translations and were able to read from the list of types of mental illness shown to

them. We showed that acculturation did not seem to impact participants' view about mental illness. Their understanding of mental illness was shaped by traditional Chinese culture of Confucianism.

However, our study flagged up a number of potential issues for future research. We focussed on a particular ethnic group of older migrants. It was not possible to know how this group compared to indigenous older people's views. We need to explore further the perceptions of mental illness of other ethnic groups in Britain and the implications for cultural understandings when seeking and receiving mental health care. Therefore, it would be interesting to compare older Chinese migrants and older lay British people in terms of their cultural beliefs and meanings of mental illness. Our study raised issues of undetected and undiagnosed mental illness among older Chinese people. A follow-up study, using the same methodological tools presented in this article, would be useful to explore how other ethnic groups of older Chinese migrants in Britain understand Western psychiatric diagnoses and their attitudes towards seeking help for these problems. Future research should also take into account the need to stratify Chinese migrant communities in Britain and elsewhere according to a) their place of origin and ethnic group (e.g. Vietnam Chinese, Taiwan Chinese, China Chinese, Hong Kong Chinese and other), b) whether they migrated young, aged in Britain or migrated at an older age, and c) whether they are first, second generation migrants, d) whether they are born in Britain. Such differences may have a significant impact on the experiences, needs and access to health and social care services of older migrants (Hatzidimitriadou, 2010; Zhou, 2012).

Finally, there are implications of our study for mental health practice and support offered to older migrant groups. The finding that older Chinese people were reluctant to seek help from mental health services could have significant implications with regards to early diagnosis and treatment of debilitating long-term mental health problems such as clinical

depression and dementia. We argued that the reluctance of older Chinese migrants to seek help may be compounded by the vulnerable psychological well-being of Chinese caregivers (Zhan, 2006). It may be exacerbated by the decisional conflict which affected caregivers with regard to nursing home placement of their relatives, for example, those who suffered from dementia (Chang, Schneider, & Sessanna, 2011). This observation had prompted Chang and colleagues to call for early diagnosis and intervention before the symptoms of long-term clinical conditions (such as depression or dementia) became severe.

We want to acknowledge that perhaps a reluctance to access or seek Western medical treatment may reflect the older Chinese migrants' views that some forms of Western psychiatric diagnostic categories of mental illness would be best treated by traditional Chinese doctors (Zhang, 2007). As previous research suggested (Siu, Chow, Lam, Chau, Tang & Chui, 2012), personal contact with mental illness between mental health professionals and the older Chinese people may help to improve knowledge and acceptance. The intention of our article was not to get the Chinese people to accept the Western concepts, but to accept at least in part that Chinese conceptions about mental illness might require different treatment and a specific group of shared culturally-specific vocabularies. We recommend that cultural competence training for both community carers and older Chinese migrants should be incorporated into nursing and medical training programmes and a repertoire of Chinese cultural idioms developed as resources for training. This type of awareness raising could be provided through short videos, culturally appropriate leaflets about mental illness, seminars and talks at community sites. Such a proactive approach would increase understanding and awareness of mental health cultural meanings among older Chinese, community support workers and mental health professionals.

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