Perceptions of mental health, help-seeking, and counselling among the Chinese community in Northern Ireland

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Thesis submitted for the degree of

Doctor of Philosophy

January 2021

I confirm that the word count of this thesis is less than 100,000 words, excluding the title page, contents, acknowledgements, summary or abstract, abbreviations, footnotes, diagrams, maps, illustrations, tables, appendices, and references or bibliography.

Dedication

To Keith, Tim, and David

Table of contents

List of tables

List of figures

Acknowledgements

I want to say thank you to Dr Anne Moorhead, who planted the seed of writing a PhD in my head, for her continuous support, feedback, and encouragement as my academic supervisor. My thanks also goes to Dr Maggie Long, for her support and constructive feedback as my academic supervisor. Further thanks go to Dr Karyn Stapleton who stepped in as academic supervisor for a brief period.

Thanks to the Chinese Welfare Association in NI who were willing to support this endeavour by bringing me into contact with many of the participants.

Thanks to my participants who were willing to share their stories and experiences. It was such a privilege to conduct these interviews and receiving your trust by being open and ready to talk about a still stigmatised topic.

Thanks to Ann and Roddy for their valuable comments and perspectives.

Thanks to my husband and sons for walking with me through the ups and downs of writing a PhD.

Abstract

Mental health services are often underused or not accessed by ethnic minority groups, although early prevention can make a real difference to individual lives. Further research is required in this area. The aim of this study was to explore the perceptions of mental health, help-seeking, and counselling among the Chinese community in Northern Ireland.

This research is a qualitative study employing an interpretative phenomenological analysis (IPA) approach. Data were collected, using in-depth interviews with 30 adult members of the Chinese community in NI.

Ten recurrent themes (RT) emerged through the findings and were grouped into three sections: Mental health, help-seeking, and counselling. Firstly, mental health comprised three RTs: '*It was kind of a taboo'* – ingrained associations and behaviours; '*A journey'* – shifts in perspective towards understanding and tolerance; Transformative influences – '*it can change your mind*'. Secondly, four RTs were identified in help-seeking: Paths of help-seeking – informal and formal ways; '*Shut the door, no one can see!'* – isolation through sociocultural and interpersonal issues; '*I did not know where to go'* – insights into the difficulties of accessing services; Language and communication – a barrier. Thirdly, counselling comprised three RTs: Impact of counselling within the Chinese community; An unfamiliar treatment method – '*what would you actually do?*'; Issues of trust – a barrier.

Recommendations include a call for culturally adequate, up-to-date, and locally relevant information supplied and distributed by health service providers to enhance de-stigmatisation of mental health issues, improve accessibility to help-seeking, and increase understanding of counselling among the Chinese community in NI.

In conclusion, this study found that information about mental health, help-seeking, and counselling must be tailored towards the Chinese community's cultural needs to enhance understanding of common mental health issues, overcome the complexity of accessing help, and clarify understanding and benefits of counselling for mental health issues and stressful life events.

Abbreviations

BACP	British Association of Counselling and Psychotherapy
BME	Black Minority Ethnicity
CANS	Counselling All Nations
CBT	Cognitive Behaviour Therapy
CRE	Ch'i Related Exercises
CSM	Common Sense Model
EMIC	Explanatory Model Interview Catalogue
GP	General Practitioner
IPA	Interpretative Phenomenological Analysis
MHL	Mental Health Literacy
NHS	National Health Service
NI	Northern Ireland
P	Participant
PIS	Participant Information Sheets
PRISMA	Preferred Reporting Items for Systematic Reviews & Meta-Analyses
RT	Recurrent Theme
SFBT	Solution Focused Brief Therapy
SJSR	Shenjing Shuairuo (weakness of nerves)
TCM	Traditional Chinese Medicine
WHO	World Health Organisation

Declaration

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Chapter 1: Introduction

This study explores perceptions of mental health, help-seeking, and counselling within the context of one ethnic minority, the Chinese community in Northern Ireland (NI). It is a qualitative study employing an Interpretative Phenomenological Analysis (IPA) approach. The introductory chapter begins with definitions of the four key terms contained in the title, to clarify their meaning for the current study: Chinese community, mental health, help-seeking, and counselling. These definitions are followed by an introduction to the background of the Chinese community in NI, including philosophical and moral influences within Chinese society. The introduction chapter closes with an account of the motivation for this study, the research question, and the outline of the thesis.

1.1 Definitions of key terms

The term 'Chinese community' describes Chinese people who live in a country, where Chinese people belong to an ethnic minority and are regarded as immigrants by the local population. According to the Oxford Advanced Learner's Dictionary, an immigrant is defined as: "*a person who comes to live permanently in a foreign country*." (Oxford Advanced Learner's Dictionary, 2015). The Chinese community is multifaceted with their members coming from different countries, different religions, speaking different Chinese languages and having varied reasons for their immigration into another country. The community consists of two major groups: Chinese immigrants, who work and live in their chosen country long-term and Chinese international students, who come for study and often stay short-term. In the current study, the Chinese community is represented by first or second-generation Chinese with long term residency in the United Kingdom (UK) and who originated in various Chinese speaking countries. Most participants were either born in mainland China, Hong Kong, Malaysia, Singapore, or Taiwan, except the second-generation Chinese who were born in the UK.

The term mental health is used in different senses, and that can be confusing. One meaning is defined by the World Health Organisation (WHO) as:

> "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." (WHO, 2014)

To equate mental health solely as a state of well-being was challenged by Galderisi et al. (2015) who questioned the idea of well-being as the key marker of mental health, for example, noting that people committing a crime could also experience well-being. An alternative understanding of mental health is in terms of mental illness, which ranges from minor to severe mental health issues. However, emphasis on strictly medical illness models has also been criticised (WHO, 2004). Among the general population, the term mental health is often understood in terms of mental health issues (Hinde, 2019). Thus, to describe a person's mental health is to describe how severely the individual is affected by mental health issues which interfere with the quality of their life. In the current study, the term mental health is applied in the sense of mental health issues.

Help-seeking can be understood as a process where a person decides to seek help for some perceived disturbances in their well-being or health (White et al., 1980). According to Rickwood et al. (2012), help-seeking can be differentiated into formal and informal help-seeking, and self-help. In the current study, help-seeking includes all these variations of help-seeking concerning mental health issues as opposed to seeking help for financial or other practical problems in daily life.

'Counselling' and 'psychotherapy' are defined by the British Association of Counselling and Psychotherapy (BACP) as:

> "… umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance their well-being." (BACP, 2015)

In the current study, counselling refers to counselling and psychotherapy for mental health issues, for example, depression, anxiety, or relationship issues executed by a trained professional.

1.2 Background of the Chinese community in Northern Ireland

In many countries, such as the United States of America (USA) and Canada, Chinese communities form the largest Asian immigrant subgroups (Statistics Canada, 2013; U.S. Census Bureau, 2006; Pew Research Center, 2012). Chinese immigrants to the UK were traditionally mainly from Hong Kong (Dubuc, 2016), however, in the last decades, the country of origin has changed from mainly Hong Kong Chinese to immigrants from mainland China (Pharaoh, 2009). This change has influenced the demographics of the Chinese community in Britain, with nearly 40% of their members now originating from mainland China (Groffman, 2018). Several organisations (China Direct, 2020; British-Chinese Project, 2020) claim that the Chinese are the third largest minority group in the UK. It is not clear where this claim originated, as the figures in the Census of 2011 do not provide an overall figure for the UK, as each country provides separate statistics.

According to the Office for National Statistics (ONS, 2011) in England and Wales, the Chinese community belongs to the largest ethnic group Asian/Asian-British and makes 0.7 percent of the population in Britain. Within this group, the Chinese are the fourth largest ethnic minority in Britain, preceded by Indians, Pakistani, and Bangladeshi (ONS, 2012). In Scotland's census, no differentiation was made between Asian and Chinese and therefore, the statistics only reveal that Asians are the largest ethnic community in Scotland (National Records of Scotland, 2018). In Northern Ireland (NI), a differentiation between Asian and Chinese was made (Northern Ireland Statistics and Research Agency, 2019). The latest figures regarding NI are from the 2011 Census (Russel, 2013) and show that the largest ethnic minority group in NI is Chinese with 6303 people. More recent figures will be available in the next census in 2021. The Chinese Welfare Association NI (2014) reported the population number to be even higher and estimated that the Chinese community represents 51% of the total ethnic minority population. Half of the population in the Chinese community is aged between 16 and 44 years, with a high proportion of school age children (Meredith, 2006).

Within the host nation Chinese people are typically regarded as homogenous (Yan, 2005; Lim et al., 2010), as they appear to stay together and not adapt to or merge with their host culture due to their strong sense of ethnicity (Shen, E. et al., 2006). However, this homogeneity is superficial as, due to the Chinese diverse immigration history, various countries of origin, different Chinese languages and cultural traditions, the Chinese community should be viewed as a heterogeneous community (Tang, 2017).

Heterogeneity is highlighted by the many different Chinese languages, for example, Mandarin, Cantonese, or Taiwanese, and by different cultural background among the Chinese (Hwang et al., 2006). Leung and Chen (2009) observed that while Taiwan's culture is rooted in ancient Chinese culture, it has its own characteristics. In addition, globalisation, industrialisation, and modernisation have also influenced values and further contributed to a more heterogeneous society (Leung and Chen, 2009). Heterogeneity also can influence the acculturation status of different Chinese groups (Hwang et al., 2006), for example, Hong Kong Chinese immigrants are often more knowledgeable of Western values and norms (Shen, E. et al., 2006) and might acculturate faster than Chinese coming from rural China.

The immigration history of the Chinese community in the UK also illustrates some of this heterogeneity. The first Chinese arrived in Northern Ireland from Hong Kong in the 1960s and established a Cantonese speaking community (Chinese Welfare Association NI, 1995), with most immigrants working in catering (Braid and Gadd, 1999). During the 1980s and 1990s immigrants also came from Taiwan and mainland China (Ginnety, 1998). Huang and Spurgeon (2006) noted the Chinese immigrants in the UK belong to one of the most scattered ethnic minority groups, due to their work in the catering industry spread over a wide area. The Chinese in the UK have one of the highest percentages of employment and achieve better exam results than any other ethnic group (ONS, 2005; UK Government, 2020), but they are not exempt from discrimination (Chan et al., 2004; Parker and Song, 2006). Discrimination is also reflected in a general increase of hate crimes over the last decade and the decrease of acceptance in the population in NI towards

Black Minority Ethnicity (BME) groups (Michael, 2017), including the Chinese community (Rolston and Shannon, 2002; Jarman, 2017). The Chinese Welfare Association NI was founded in 1986 with the aim of integrating the Chinese community into NI. The success of becoming part of the local community emerged when Anna Lo, a member of the Chinese Welfare Association, was elected as the first ethnic Chinese parliamentarian in 2007 (Simpson, 2019). Sadly, her position within the local community did not prevent her from becoming a victim of hate crime (Simpson, 2019).

Discrimination is not the only issue the Chinese community faces, in a study (Rochelle and Shardlow, 2013), the issue of isolation among the Chinese community due to a lack of social networks was raised. Close family ties are regarded as a hindrance in having a wider social network as needs are typically fulfilled within the family network (Rochelle and Shardlow, 2013). However, not all families have close ties, and Lane et al. (2010) highlighted the isolation of older Chinese women, who do not speak English and still depend on their family, financially and emotionally. These recent studies regarding isolation raise further concern about the well-being issues within the Chinese community, especially as Sproston et al. (2000) had already noted the fragile social support network among Chinese immigrants.

Despite the Chinese community being the largest ethnic minority in NI, little research is available about this ethnic minority (Magnet de Saissy, 2009; Health and Social Care in Northern Ireland, 2014; Radford et al., 2015) and the Mental Health Foundation (2016) identified an urgent need for research concerning prevention and early intervention for mental health issues. Research into mental health issues is important as research studies show that Chinese immigrants underuse health services and especially mental health services (Green et al., 2002; Chen and Kazanjian, 2005; Mental Health Foundation, 2016; UK Government, 2020). As contacting a psychologist carries stigma in China: "*Few dare to see a psychologist for fear of losing face or being branded sick*" (Doctoroff, 2012, p.26). Anecdotal evidence from NI confirmed that seeking a psychologist or a psychotherapist is rarely considered among the Chinese community and counselling services

in NI reported a lack of Chinese clients. Therefore, research among this ethnic minority contributes toward a better understanding of why the Chinese community is not seeking help for mental health issues.

1.3 Philosophical and moral influences in Chinese society

Chinese society is strongly influenced by Confucianism (Gabrenya and Hwang, 1996), Buddhism and Taoism (Chan et al., 2014) and over time their value systems have become interlinked (Huang et al., 2006). For example, Kolstad and Gjesvik (2014) pointed out that Confucianism is vital in contemporary China. Chinese society is a collectivistic and patriarchal society with the family at its centre (Goodwin and Tang, 1996; Wu et al., 2002) where family is understood as the "great self" (大我), to which the individual "small self" (小我) belongs (Bedford and Hwang, 2003). The priority of each family member is to contribute toward the functioning of the family (Ng and James, 2013) and to maintain harmony and unity (Leung, 1987; Leung, 1988). The three main principles of Chinese culture are patriarchy (Hamilton, 1990; Lee, 1999b; Bregnbæk, 2018), filial piety (Hartzell, 1988; Tzeng and Lipson, 2004) and saving face (Hartzell, 1988; Hwang and Han, 2010). These principles permeate Chinese society and influence people's attitudes and behaviours, both positively and negatively (Hsu and Wang, 2011). For example, maintaining harmony is one of the principles of Confucian philosophy and is often achieved by suppressing emotions (Han and Pong, 2015). However, patriarchy can have a negative influence, for example, women are often victims of sexual abuse (Wang and Heppner, 2011) and therefore, out of shame and fear, it is under-reported (Hsu et al., 1999).

Filial piety (孝) is highly regarded in Chinese culture as it controls relationships within the family, friends, and society at large (Hartzell, 1988; Tzeng and Lipson, 2004). Filial piety can be defined as social order which attributes a specific role to each member of the family or society, which they are obliged to fulfil (Hamilton, 1990). Filial piety also includes the concept of obedience towards parents or other seniors within the family. Although Confucius never demanded blind obedience towards elders, filial piety is

frequently understood as blind obedience (Upton-McLaughlin, 2013). The principle of filial piety can be used, for example, to convince a survivor of suicide that the family cares about them as filial piety is not only about the physical self, but also about the social self (Tzeng and Lipson, 2004). Filial piety can help the individual to understand ways of self, their relations with others and the world (Hsu and Wang, 2011). But filial piety can also demand the suppression of an individual's own wishes in relation to someone who has a higher social status, for example, a child to a parent or the wife to the husband (Yeh, 1997). Furthermore, it should be considered that the younger generation is also shaped by Western ideas and are eager to accept ideas of equality and individuality, which causes disagreement in relationship interactions (Compton, 2000). This is especially true of second-generation overseas Chinese who often must adjust to two different cultures.

The meaning of "face" is an essential and complex concept in any collectivistic society (Bond and Hwang, 1986; Bond, 1991; Gao et al., 1996; Hwang and Han, 2010). Face (面子) can be defined as the social image and worth an individual has within society or oneself (Hwang, 1997; Hwang, 1998; Choi and Lee, 2002). Ting-Toomey (2005) described face as multidimensional, as face is not only about saving one's own face, but also the face of others. Mak et al. (2009, p.242) also distinguished between 'self-face' and 'other-face'. 'Self-face', connecting to self-worth and social-worth, can induce great psychological stress as it is valued so highly within Chinese society (Mak et al., 2009).

The Chinese community can be regarded from both a heterogeneous and a homogenous viewpoint. Heterogeneity applies to their immigration history as members of the Chinese communities originate from various Chinese speaking countries. However, even if they originate from one country, for example, mainland China, the diversity of Chinese language, culture and different ethnic groups contributes to their heterogeneity. Homogeneity of the Chinese community is rooted in overarching philosophical and moral understandings based on Confucian, Buddhist and Daoist thoughts permeating society and providing a common concept for behaviour and

attitudes. To the outsider these common concepts underline the impression of a homogenous society, providing a sense of unity, which in the real world of the Chinese community, does not necessarily exist and can leave members of the Chinese community isolated and misunderstood.

1.4 Motivations for the study

My motivation in researching why the Chinese community underuses health services is rooted in my personal experiences with the Chinese community and my professional experiences as a counsellor. My personal experiences are grounded in having lived and worked for eight years in Taiwan. During this time, I have studied two Chinese languages and lived in various cities and villages in Taiwan and therefore experienced Chinese culture in both rural and urban environments. Living in Taiwan contributed to my awareness that Chinese culture is very much a heterogeneous culture, which manifests itself in the great variety of Chinese languages and customs. Living in Taiwan and building up friendships with the local Chinese people, allowed me to experience common grounds of humanity despite cultural differences.

Furthermore, based on my experiences of acculturation, I know first-hand the practical and emotional difficulties that living in another country can entail. My affiliation with the Chinese community has continued over the years, and I have continued to study Chinese to maintain my language skills and gain deeper insights into the current Chinese culture. On a professional level, I have observed few Chinese clients coming to counselling in more than 15 years of working as a counsellor in NI. This observation was confirmed to me by anecdotal evidence of other counsellors as few of the long-term residents of the Chinese community find their way to counselling, even if it is offered in Chinese language. Recent research (Mental health foundation, 2016) stated that in NI, mental health services were not frequented by BME communities, including the Chinese community. This raised my curiosity as I am also aware through my Chinese friends in NI that the Chinese community is not exempt from mental health issues. Due to my interest in Chinese culture and my professional interests in mental health, help-seeking, and counselling I therefore decided that it would be worthwhile to explore these issues in more

depths among the Chinese community in NI, in collaboration with the Chinese Welfare Association NI.

1.5 Research question, aim, and objectives

An initial literature search about mental health, help-seeking, and counselling in the context of the Chinese community led to the following research question, aim and objectives.

1.5.1 Research question

What are the perceptions of mental health, help-seeking, and counselling among the Chinese community in NI?

1.5.2 Aim

To explore perceptions of mental health, help-seeking, and counselling among the Chinese community in NI.

1.5.3 Objectives

To understand the perceptions of mental health among the Chinese community in NI.

To gain an understanding of the perceptions of help-seeking concerning mental health among the Chinese community in NI.

To gain insight into experiences of help-seeking concerning mental health among the Chinese community in NI.

To explore perceptions of counselling among the Chinese community in NI.

To gain insight into experiences of counselling among the Chinese community in NI.

To provide recommendations on mental health, help-seeking, and counselling to enhance mental health and well-being among the Chinese community in NI.

1.6 Outline of the thesis

Chapter one introduces the current study by defining the key terms of this study, explaining the background of the Chinese community including philosophical and moral values, describing the researcher's motivation,

stating the research question, aim and objectives and outlining the seven chapters of this thesis.

Chapter two presents the literature review starting with an explanation of the search strategy and an overview of the initial research papers. The literature review focuses on the extant research on the topics of mental health, help-seeking, and counselling, leading to the rationale of the current study and its research question, aim and objectives.

Chapter three provides the contextual framework to this study and is divided into two sections, one exploring theoretical frameworks of previous studies and the second explaining the development of the theoretical framework for the current study, which is posited in a multicultural humanistic framework.

Chapter four presents the methodology underlying the current study, explaining the research design, participants, sample size, recruitment, and data analysis. Ethical considerations are also detailed, and the issue of culturally sensitive research explored. Furthermore, in the spirit of an IPA approach, reflexive analysis was applied to ensure that the researcher was aware of her subjectivity in her role as a researcher and how it can influence data collection. The validity of the study was confirmed by examining sensitivity to context, commitment and rigour, transparency and coherence and impact and importance.

Chapter five presents the findings of the 30 semi-structured interviews starting with the demographics of the participants and is organised in three main subjects: mental health, help-seeking, and counselling. Each subject contains recurrent themes which are supported through subordinate themes and idiographic accounts to emphasise the participants' voices in the current study.

Chapter six provides the discussion of the key findings of the current study relating to mental health, help-seeking, and counselling. The themes of mental health stigma, mental health literacy and stigma reduction explored participant perceptions of mental health. Informal and formal pathways of help-seeking, barriers beyond language proficiency, as well as accessibility

and isolation, were the themes that examined participant perceptions of help-seeking. The mystery of counselling, encounters with counselling, and lack of trust – a barrier provided insight on how participants perceived counselling in their everyday life.

Chapter seven presents the conclusion and starts with a summary of the discussion chapter and connecting it to the research aim and objectives. Recommendations are aimed at health service providers, the Chinese community and counselling services as well as individual counsellors. Implications of this study for counselling policy and practices were considered. Limitations of this study were acknowledged, and suggestions for future research proposed. The contribution to literature within qualitative research created original research regarding, sample, topic, and the application of a methodology. The conclusion chapter ends with reflections of the researcher and a summary of this study.

1.7 Conclusion

This introduction chapter provided initial information about the Chinese community in Northern Ireland to gain an understanding of the participants' societal and cultural position. The motivation for the study demonstrates the cultural awareness of the researcher, but also the necessity of exploring the apparent underutilization of mental health services. Little research is conducted among this ethnic minority group, therefore an exploration regarding mental health, help-seeking, and counselling is a timely endeavour. Research question, aim and objectives are grounded in the literature review presented in the next chapter of this study with an exploration of the key terms: mental health, help-seeking, and counselling.

Chapter 2: Literature review

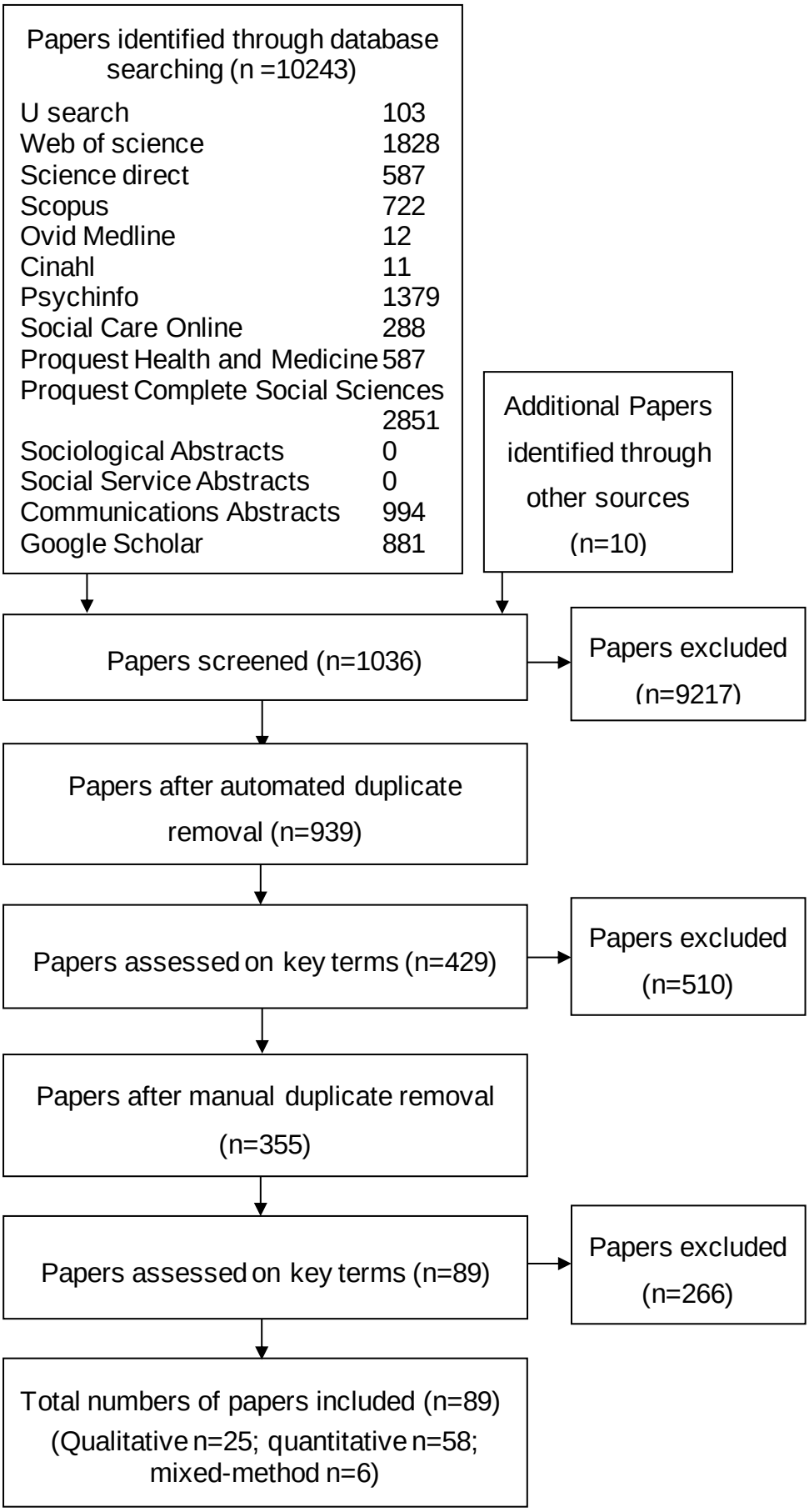
2.1 Introduction

Chapter two contains the literature review and is based on a literature search with a systematic approach conducted in 2014 and updated with additional searches between 2015 and 2019. The literature review starts with an explanation of the search strategy, which is demonstrated with a PRISMA flow diagram (Moher et al., 2009). An overview of the initial 89 papers yielded in 2014 is provided under the topics of mental health, help-seeking, and counselling. This overview is followed by a detailed exploration of how mental health, help-seeking, and counselling is perceived within a Chinese context. Research studies were drawn not only from the Chinese immigrant community but also included developments in Chinese speaking countries regarding mental health, help-seeking, and counselling, as attitudes and behaviour in the country of origin might also influence the Chinese community abroad. The literature review, with its diverse exploration into the extant literature provides the basis for the formulation of the study rationale and the research aim, question, and objectives.

2.2 Search strategy

The literature search was based on a systematic approach using 14 databases, which yielded 89 primary research papers following the PRISMA guidelines (Moher et al., 2009). **Figure 1** demonstrates the study selection procedure using a PRISMA flow diagram.

Figure 1: PRISMA flow diagram for literature selection (Moher et al., 2009)



The searches were performed using the following defined search terms: "Chinese" AND "Counselling" OR "Counseling" OR "Therapy" OR "Psychotherapy" AND "Mental health" OR "Emotional Well-being" AND" Help-seeking" OR "Seeking help". This search resulted in 10243 hits. The titles of the papers were screened for relevance which resulted in 1036 papers. An initial screening for duplication in RefWorks reduced it to 939. These 939 papers' abstracts were screened for the selection criteria shown in **Tables 1** and **2**.

Table 1: Inclusion criteria

Criteria	Reasoning
Chinese ethnicity	The word Chinese being in the title of studies in contrast to Asian, which is too broad a term
Adults 18+ years	No restriction on age widened the search
Mental health conditions, needs, issues & emotional well-being	The focus was on presenting issues in counselling, for example, depression.
Focusing on help-seeking	Seeking help regarding mental health issues
Counselling and / or Psychotherapy	Focus is on counselling and psychotherapy, but not psychological or psychiatric studies
All study designs are included	A systematic approach is used, which includes all study designs. The rationale for this is that this research is in an emerging area with a lot of exploring studies, therefore it reduces the likelihood of missing an important study
2004 – 2014	Newer studies will be included over time as appropriate
Original research studies with full text	
Studies written or published in English	

Table 2: Exclusion criteria

Criteria	Reasoning
Non-English studies	
Children and adolescents	Counselling children and adolescents requires different counselling approaches & ethical requirements
Medical subjects	Such as dementia, HIV, anorexia nervosa, or smoking and addictions such as gambling
Black Minority Ethnicity (BME)	The focus is on the Chinese community
Asian	The term 'Asian' is too broad and does not recognise the diversity of Asian culture. The term Asian encompasses approximately 40 ethnic groups (Sue and Sue, 2008).
Literature reviews, dissertation theses, review papers, reports, conference papers or abstracts, letters (to the editor) commentaries and feature articles.	

Applying these criteria resulted in 429 papers. However, as RefWorks search did not identify all duplicates, Excel was used to help identify a further 74 duplicates. These 355 papers were again screened using the above selection criteria, which resulted in 89 papers being selected for the literature review. An overview of the 89 studies of the literature search is provided by organising them in three themes: 'Mental health issues', 'help-seeking', and 'counselling'. As this was not a comparison study, no separate searches were conducted without the term 'Chinese', but when relevant literature emerged from the selected papers, it was incorporated in the literature review.

2.3 Overview of selected 89 studies

This overview summarises the numbers of studies considered for each of the three themes and provides an account of the broad topics they covered.

2.3.1 Mental health issues

The 67 studies that referred to mental health provided an insight into discerning different mental health issues among different Chinese population groups. Out of the 24 mental health studies conducted in China, Taiwan, Singapore, Malaysia, Hong Kong, the majority focused on depression. Anxiety (Chan et al., 2014) and bereavement issues (Burton et al., 2012; Kuo et al., 2011) were also considered. Two studies (Wang and Heppner, 2011; Yanqiu et al., 2011) explored abuse issues, which is an under-researched issue. Most of the studies situated in China made little distinction between different groups of the population. However, there are a few studies which dealt with different groups in the population such as the rural or urban setting (Qian et al., 2011; Chen, 2012; Wong and Li, 2014); the elderly (Witt et al., 2011; Chen et al., 2012) and victims of abuse (Wong et al., 2011; Yanqiu et al., 2011). The seven studies that originated in Taiwan explored a wider range of issues and therefore have a greater variety concerning different groups in society, such as, those bereaved by suicide (Tzeng and Lipson, 2004; Kuo et al., 2011) or survivors of childhood abuse, which is a taboo subject and hidden within a patriarchal society (Wang and Heppner, 2011). The 15 studies referring to college students considered beside depression (Chang, 2007a; Chang, 2007b; Li et al., 2008; Wu and Mak, 2012; Zhang and Cai, 2012; Zhang et al., 2013; Chang, 2014), relationship issues (Wang and Scalise, 2010; Hsu and Wang, 2011; Ng et al., 2012; Shen, 2014), the influence of acculturation stress (Li et al., 2008; Wu and Mak, 2012), anxiety (Chang, 2007b; Hsu & Alden, 2008) and face concern (Mak et al., 2009).

Of the 28 studies which referred to the Chinese community in the USA, Australia, Canada, New Zealand, and the UK, most were conducted in the USA (n=9) and Australia (n=6). Only six studies explored a particular section of the Chinese community: three studies referred to the elderly (Lai, 2004; Chu et al., 2012; Lee et al., 2014), one study to carers of dementia patients (Gallagher-Thompson et al., 2007) and two studies investigated relationship issues within the family (Hwang et al., 2006; Soo-Hoo, 2006). The other twenty-two studies dealt with the Chinese community in general, and the

main investigation issue was depression (n=13). This indicated a paucity of research about different groups of the Chinese community and their issues, for example, single mothers or men in midlife. Three studies considered the influence of psycho-education on mental health understanding (Hsiao et al., 2006; Lam et al., 2010; Yang et al., 2014). The only UK based study (Green et al., 2006) emphasised the connection of acculturation with a better use of western health services. Furthermore, studies referring to international students focused on acculturation stress (Lin and Betz, 2009; Wei et al., 2007; Wei et al., 2012; Wu and Mak, 2012) with most of those studies conducted in the USA.

2.3.2 Help-seeking

Of the 28 studies that referred to help-seeking, several studies in the USA (Kung, 2004; Kwong et al., 2012; Leung et al., 2012), Canada (Tieu and Konnert, 2014), Australia (Lu et al., 2014) and the UK (Yeung et al., 2013) confirmed reluctance of help-seeking among Chinese immigrants. Seven studies (Chiu, 2004; Mo et al., 2006; Mo and Mak, 2009; Witt et al., 2011; Chen, 2012; Liu et al., 2014; Mak et al., 2014; Wong and Li, 2014) conducted in China and Hong Kong examined attitudes towards help-seeking behaviour with varied results concerning preferences for formal or informal help-seeking behaviour. Four Taiwanese studies (Chang, 2007a; Chang, 2007b; Chang, 2014; Shen, 2014) with college students as participants also showed preference towards informal help-seeking, even when traumatic issues, such as dating violence, were addressed (Shen, 2014). However, one UK study (Tang et al., 2012) suggested that Chinese college students have a similar reluctance towards formal help-seeking than their British counterparts. Therefore, further research is needed to explore if there has been a shift in attitude towards help-seeking over the last decade.

2.3.3 Counselling

Fourteen of the 28 studies referring to counselling are based on Cognitive Behavioural Therapies (CBT) with several studies adapting CBT towards their Chinese clients' background (Hwang et al., 2006; Shen, E. et al., 2006;

Mak et al., 2011; Ng et al., 2012). Several studies about integrative (Ng et al., 2012; Chan et al., 2014) and multicultural counselling approaches (Hwang et al., 2006; Kuo et al., 2011; Wang and Heppner, 2011; Choi et al., 2012; Chan et al., 2014) reflected the diversity of counselling approaches used. However, none of the studies explored person-centred approaches exclusively. The main counselling issues presented were depression, followed by relationship issues, anxiety, and various other issues such as bereavement or abuse. Furthermore, the literature search did not reveal any studies about counselling interventions with the Chinese community in the UK.

2.3.4 Summary

The three themes provided a meaningful framework for the 89 studies. Mental health studies proved to be mainly focused on depression, with most research among the Chinese communities coming from the USA or Australia. The reluctance of seeking professional help was highlighted, yet a possible shift of help-seeking behaviour due to environmental influences also appeared. Counselling research often focused on CBT approaches with depression being the main presenting issue and person-centred approaches hardly considered. To gain a deeper understanding of how mental health, help-seeking or counselling is perceived in the Chinese population, the literature review included research studies from China and Taiwan. This search strategy underlined that there is a paucity of research in these areas in the UK.

The results of this first literature search conducted in November and December 2014 were periodically updated to include newly entered or published papers. The latest update was conducted in November 2019. The framework for the literature review is based on this search strategy and accordingly divided into three themes: ‘Mental health issues’, ‘help-seeking’, and ‘counselling’.

2.4 Mental health issues

The first theme of the literature review 'mental health issues' is divided into four topics: mental health issues within a Chinese context, tertiary students in China, tertiary students abroad and immigrants.

To restate an issue raised earlier, the term mental health and mental health issues are often used interchangeably in everyday language (Hinde, 2019). Therefore, it needs to be clarified that the focus of this section of the literature review is on mental health issues which can be addressed through counselling. The focus is not on psychotic illnesses, such as schizophrenia, which would require psychiatric treatment.

2.4.1 Mental health issues within a Chinese context

Mental health issues in China are also connected to developments in Western medicine. After Beard (1869) introduced the concept of neurasthenia, the idea spread to China, and although neurasthenia was endorsed only briefly in the West, in China, it became a culture-bound syndrome (Lee, 1999a; Davis, 2005). Neurasthenia is known in Chinese as Shenjing Shuairuo (神经衰弱) which refers to weakness of nerves and is abbreviated with the acronym SJSR (Lee, 1999a). Mak and Chen (2010) confirmed that according to previous studies (Zheng et al., 1997; Chang, D. et al., 2005) SJSR seemed to be a mental health issue specific to Chinese and did not necessarily correspond with Western diagnoses. SJSR is a convenient term because it emphasizes physical or chronic fatigue disorders, while helping avoid stigmatisation and mask mental illnesses such as anxiety, depression, or phobias (Lee and Wong, 1995). In the mid-1980s, it was still the major mental health diagnosis in China (Lee, 1999a) and Kleinman (1982) reported that up to 80% of psychiatric outpatients were diagnosed with SJSR.

Furthermore, common mental health problems are not as well-known and need to be better defined as for many Chinese, mental illness equates to psychotic illness (Hsiao et al., 2006). This view has also a historical background as under Mao psychiatric interventions were mainly used in prison hospitals (Zhang, 2014) or used as political reform (Chang et al.,

2005b). Research showed that mental illnesses are stigmatised (Lin and Lin, 1981; Ryder et al., 2000; Parker et al., 2001; Chan and Parker, 2004; Chung and Wong, 2004) and this often leads to secrecy, isolation and disregard of treatment (Lee et al., 2005).

Socio-economic changes, a weakening of social networks, and rising stress levels have contributed to mental health issues in China (Lim et al., 2010). Chen et al. (2012) reported that the government in China has started to recognise depression as a chronic disease. This recognition could contribute towards de-stigmatisation of depression, which is often underreported, yet highly prevalent among the older generation, especially among women over 60, with poor social support and deteriorating physical health (Chen et al., 2012). Due to commercialisation, mental health care in rural areas is basically non-existent and in urban areas often only available to the insured or the wealthy (Chen et al., 2012).

A recent study (Qiu et al., 2017), further underlined the lack of knowledge about mental health issues, especially in rural areas. The study noted that rural Chinese women had difficulties in recognising mental health issues and that they explained the causes of mental health issues with traditional beliefs, such as weakness of character (Qiu et al., 2017).

Previous research (Phillips et al., 2002) reported that China has one of the highest suicide rates in the world based on figures covering the years 1995-1999. According to Ji et al. (2001), the suicide rate was high among women and the elderly in rural areas. In a more recent study by Liu et al. (2017), based on the years 2002-2015, the suicide rate in China has decreased dramatically, to become the lowest in the world. Reasons contributing to this change are manifold, including social changes (Yip, 2005), economic development (Zhang et al., 2010) ageing and urbanization (Sha et al., 2017). In addition, lethal poison management reduced opportunities of suicide by poison (Page et al., 2017).

Despite an overall decrease in suicides, the suicide rates remain still higher in rural areas than in urban areas (Sun and Zhang, 2015; Liu et al., 2017)

and causes for this were sought in economic disadvantages or lack of medical resources (Chen et al., 2012; Wang et al., 2014). Furthermore, since 2006 male suicide rates have increased compared to female suicides and a more recent study by Sha et al. (2018) suggested a rise of the suicide rate among the male working population due to unstable employment conditions.

It is also important to understand the impact culture and language has on terms related to mental health. In Chinese, for example, “psychology” is translated to “the study of the logic of the heart”. The heart is considered the seat of the psyche (Shen, E. et al., 2006). Therefore, when Chinese talk about emotions, they often talk about the heart. This can lead to misunderstandings as it may be interpreted as somatization. While emotions are often expressed in somatic terms, for example, “heartache” equals sadness and “fatigue” can equal hurt or despair (Chang, 2007a), various studies (Cheung, 1995; Yeung et al., 2004) have shown that when participants were explicitly asked, emotional and social problems were expressed. Chang (2007a) found that Chinese college students described their psychological distress with cognitive-affective symptoms.

When the Chinese describe symptoms of depression, they often focus on more cognitive-behavioural symptoms, such as sleeplessness or distress about social disharmony (Lee et al., 2007; Ryder et al., 2008). However, caution should be taken to conclude that all Chinese express depression with somatic symptoms. Lai (2009) reported that there can be a difference in how Chinese report depressive symptoms depending on their ethnicity. The study examined elderly in Hong Kong, Guangzhou, and Taiwan and found that the elderly in Taiwan were most expressive about emotions as they reported negative mood while the elderly in Hong Kong and Guangzhou focused more on somatic and cognitive attributes.

In Chinese culture, emotional self-control is highly valued and a well-established behaviour (Markus and Kitayama, 1991; Soto et al., 2005; Butler et al., 2007) and contributes towards maintaining interpersonal harmony (Wei et al., 2013). Emotional self-control has a positive meaning and has shown no negative effect on psychological functioning among Chinese (Soto et al.,

2011). Several other studies support this as they claim that some cultures view the value of suppressing emotions as positive (Markus and Kitayama, 1991; Mesquita and Frijda, 1992; Wei et al., 2013), whereas in Western psychology suppressing emotions is traditionally associated with negative health outcomes (Gross and Levenson, 1993; Gross and John, 2003).

Overall, the awareness of mental health issues in China has risen in recent decades (Zhao et al., 2012). This increased awareness can be partially explained by Westernisation and changes in how mental health is viewed (Hsiao et al., 2006; Kolstad and Gjesvik, 2014). The passing of the first mental health law in China in 2012 also indicates a changed attitude towards mental health issues, as psychology was banned under Mao (Shao et al., 2015; The Guardian, 2014).

2.4.2 Tertiary students in China

Tertiary students in China can be divided into traditional and non-traditional students. Non-traditional students are those who had to repeat the entrance exams for university and therefore are a year older and under greater pressure to succeed (Chang, 2007b). Academic pressure that students experience is a major cause of psychological distress (Zeng and Le Tendre, 1998; Ang and Huan, 2006). Low self-esteem, high levels of maladaptive perfectionism, combined with negative coping styles such as denying problems and not seeking help, contribute to an increase in depression (Zhang and Cai, 2012). Furthermore, students who are dissatisfied with their subject choice also showed more mental health problems (Li et al., 2008). Despite the increase of mental health issues, Li et al. (2008) reported a paucity of research about tertiary students in Asian countries.

Five studies (Li et al., 2008; Hsu and Wang, 2011; Ng et al., 2012; Zhang, Y. et al., 2013; Shen, 2014) of the 13 mental health studies which recruited tertiary students as participants in this literature review, focused on the specific circumstances of students. Li et al. (2008) reported that among Chinese ethnic groups, Yi students had more serious mental health problems than Bai and Han students. This difference could be linked to language

issues because Yi students are less familiar with Mandarin Chinese, come from more remote areas and therefore have greater adjustment needs. No gender differences regarding mental health issues among Chinese students was noted by Zhang, Y. et al. (2013), however, Li et al. (2008) reported that gender has an impact on mental health. Li et al. (2008) suggested these differences may be related to different reporting styles between males and females. The use of different questionnaires in Zhang, Y. et al. (2013) and Li et al. (2008) might explain the differing results of the studies. Another of the five studies (Shen, 2014) focussed specifically on Intimate Partner Violence among Taiwanese college students. In Western literature, the link between Intimate Partner Violence and Post Traumatic Stress Disorder is well documented, but there are few studies concerning the Asian population (Chan et al., 2010). Cultural beliefs, for example, fatalism or traditional gender roles hinder victims from taking action (Shen, 2014). Another culture related psychological distress factor is filial piety, as feelings of shame, guilt and self-blame arise when students cannot fulfil their parents' expectations (Hsu and Wang, 2011).

The other eight studies with tertiary students as participants explored general themes such as attachment issues (Wang and Scalise, 2010) or emotional suppression (Wei et al., 2013) and applied findings to the general Chinese population. This generalization is open to debate as tertiary students only represent one part of society and are often vulnerable to psychological distress (Wu et al., 2006; Yan and Berliner, 2011). They are also in a transitional phase, for example, leaving home and adjusting to a new social and academic environment (Li et al., 2008) leading to high levels of stress and passivity in using coping techniques (Kim et al., 1997).

2.4.3 Tertiary students abroad

For international students, leaving their home country, adjusting to a new culture, communicating in a foreign language all add to stress and can influence their mental health (Constantine et al., 2004; Forbes-Mewett, 2019). Two studies suggested (Constantine et al., 2004; Hermann and Betz, 2006) that lower language proficiency, lower rates of social self-efficacy and

acculturation stresses were positively related to an increase in depression. However, in a later study, Lin and Betz (2009) found that international students' self-efficacy equalled native students' self-efficacy if they could converse in their mother tongue. Self-efficacy decreased only when non-native language was required.

Han et al. (2013) reported that depression and anxiety were mental health issues among students caused mainly by academic stress. However, as this study was done at an Ivy League institution, this might not be representative of all international students. Further reasons reported were poor current health, poor relationship with the tutor, no exercise and a quarter of students were unaware of existing counselling services (Han et al., 2013). Further research is needed as stigma and the concern that treatment for mental health issues might impact their studies and career prospects were not considered in this study.

Studies in the USA (Han et al., 2013) and Australia (Lu et al., 2014) found that Chinese international students had difficulties in accessing information about mental health issues and available services which contribute towards the underuse of these services.

The limited research in the UK referring to Chinese international students found that mental health issues among Chinese international students were stress, depression anxiety and relationship issues (The University of Nottingham, 2011). A more recent UK study highlighted that self-harm due to relationship issues is also prevalent among young, female students (Chang et al., 2015). Tang et al. (2012) also referred to Chinese international students in the UK, but the focus was on help-seeking attitudes and not the specifics of mental health issues. Nevertheless, the UK results confirm global results that international students are at high risk for psychological distress (Ying et al., 2007; Sherry et al., 2010; Yan and Berliner, 2011; Lu et al., 2014) and underuse the relevant health services (Forbes-Mewett and Sawyer, 2016).

2.4.4 Immigrants

Evidence suggests that immigrants, in general, have better mental health than local people (Breslau et al., 2007; Takeuchi et al., 2007; Barnes et al., 2008) and this is partially due to the "healthy immigrant effect" (Lee et al., 2013) where typically only healthy people immigrate as there are often legal barriers stopping people with mental health issues from immigrating (McDonald and Kennedy, 2004; Antecol and Bedard, 2006; Akresh and Frank, 2008). However, research among other ethnic groups found that the acculturation stress experienced by immigrants can lead to mental health issues (Pumariega et al., 2005; Riolo et al., 2005; Alegria et al., 2007).

Nielsen and Krasnik (2010) stated that the self-reported health of immigrants from various ethnic groups (not Chinese) was worse than that of their host country. In addition, there is strong evidence that immigrant health deteriorates the longer they stay (McDonald and Kennedy, 2004; Hernández-Quevedo and Jiménez-Rubio, 2009; Gushulak et al., 2011; Ng, 2011; Rechel et al., 2013). Possible reasons for this decline include a changed health-illness understanding (McDonald and Kennedy, 2004), socio-economic changes (Malmusi et al., 2010) and an increased uptake of health services due to better language skills (Furnham and Li, 1993; Sproston et al., 2000).

Regarding Chinese immigrants, Li and Browne (2000) found that that mental problems of Asian immigrants equal those of the native population. One factor for the increase in mental health issues could be the level of acculturation as it influences the view of mental illness and the use of mental health services (Kung, 2003). Hsiao et al. (2006) reported that Chinese-Australians were able to distinguish between various mental disorders by combining traditional knowledge with Western psychological approaches.

However, a more recent study showed that recognising depression among Chinese-Australians was still low (Wong et al., 2010). The difference in acculturation level could contribute to this as Mellor et al. (2012) showed Australian-born Chinese had fewer stigmatised attitudes toward mental health issues than Chinese immigrants or Taiwanese, but it was not as low

as Anglo-Australians. Interestingly, Australian born Chinese still held onto Chinese cultural practices, as much as Chinese immigrants. Yet, their exposure to Australian cultural values had influenced their attitude towards mental illness and decreased stigmatisation. Green et al. (2006) reported that Chinese immigrants in the UK also did not necessarily recognise symptoms such as insomnia as mental health issues.

Various studies among Chinese Canadians and Americans (Mok et al., 2003; Yeung et al., 2004; Shen, E. et al., 2006) showed that depression is the main mental health issue. Mok et al. (2003) reported major depressive episodes as the most common diagnosis among Canadian Chinese, followed by psychosis and post-traumatic stress disorder. Despite offering ethnically matched health professionals, the attrition rate among the Mandarin speaking Chinese Canadians was particularly high, while the Cantonese-speaking group and the Canadian born Chinese had the lowest attrition rate. Furthermore, Yeung et al. (2004) reported high depression rates among Chinese Americans contradicting a previous study (Takeuchi et al., 1998), which found low depression rates among Chinese Americans. However, Yeung et al. (2004) pointed out that demographic changes and a different immigrant generation, influenced by different traditional and socio-cultural values might have contributed to a change in results.

A study by Chong et al. (2012) in Singapore, reported a low depression rate among Chinese compared to other ethnic groups, confirming previous studies from China (Phillips et al., 2009), Taiwan (Chong et al., 2001) and America (González et al., 2010), which also suggested low rates of depression among Chinese. Nevertheless, Chong et al. (2012) implied that an underreporting of psychological symptoms could contribute to this lower rate. In addition, previous studies relating to mental illness (Furnham and Li, 1993; Sue, 1994) showed that Chinese immigrants prefer to express emotional distress with somatic symptoms as this is culturally more acceptable and fits their cultural understanding. Furthermore, the “Salmon effect” which occurs when seriously ill Chinese immigrants either return home so they can be treated within their paradigm or look for a practitioner

who is Chinese and understands their beliefs (Green et al., 2006), could further contribute to a lower rate of depression among Chinese immigrants.

Age is another factor which can influence mental health issues. However, results between studies varied, for example, Chong et al. (2012) reported high depression rates in those aged between 18-34 years old while Lee et al. (2013) reported the highest risk at age 60. Bartels et al. (2002) stated that elderly Chinese-American women have a high ideation rate of suicide. This high ideation rate is detrimental, as Tieu and Konnert (2014) showed that help-seeking decreased with age and the people who need help most are unwilling to seek it. However, age alone cannot be the only defining factor for the rise of mental health issues, as acculturation, age at immigration and financial issues all need to be considered. Lee et al. (2013) reported that there is a link between age and poverty with the younger and poor being more prone to mental health issues than those who were older and wealthy. However, retirement and loss of income can also affect the older immigrant generation (Burr et al., 2009), for example, Lane et al. (2010) reported that in the UK older widowed Chinese women found it difficult to access services and struggle with mental health issues due to isolation and financial difficulties.

Gender and marital status seemed also to contribute to the varied results in different studies. Lee et al. (2013) stated that gender and marital status have no significant influence on mental health among American Chinese immigrants. Whereas, Zhang, J. et al. (2013) stated that there was a gender difference with women more affected by mental health issues and marital status, contributing to a decrease in mental health issues. Both studies used the same questionnaire (The WHO World Mental Health Survey Consortium, 2004), however, the varied results could be explained by a difference in participants. Lee et al. (2013) included only foreign-born Chinese Americans, whereas Zhang, J. et al. (2013) surveyed both foreign-born and US-born Chinese immigrants, with the majority being born in China. More research is needed to clarify the influence of gender and marital status regarding mental health issues.

A general lack of research about mental health issues among Chinese immigrants becomes evident, not only in the UK (Tran et al., 2008; Chang et al., 2015) but also in other European countries, for example, in the Netherlands (Liu, C. et al., 2015) and further afield for example in the USA (Zhang, J., 2013). Further research is needed to explore the understanding of different mental health issues among Chinese immigrants.

2.4.5 Summary

The attitude towards mental health issues in China has changed from being ignored to being acknowledged, resulting in the Chinese government passing the first mental health law in 2012. However, stigmatisation of mental health issues continues, and education about the differentiation of mental health issues is still needed. Language plays a vital role in influencing understanding of mental health issues, and consideration is required on how best to translate psychological expressions and values. Tertiary students abroad and in China are highly stressed by academic pressure and underuse mental health related services. Although consensus exists that students are at high risk of psychological distress, their mental health issues are under-researched. Mental health issues of Chinese immigrants vary as does their level of distress. Chinese immigrants' mental health issues are influenced not only by acculturation level, but also by age, gender, and marital status.

2.5 Help-seeking

The second theme of this literature review 'help-seeking' is divided into five topics: attitudes, intentions, actual behaviour, barriers, and overcoming barriers. This division is partially based on three aspects of help-seeking identified in a systematic review by Gulliver et al. (2012) among the Australian population: attitudes toward help-seeking, intentions of help-seeking and actual behaviour of help-seeking. However, research findings about barriers toward help-seeking and overcoming those barriers were not considered in Gulliver et al.'s (2012) model and therefore were added as further topics to reflect the different issues of help-seeking better.

According to Rickwood et al. (2012), there is no agreed definition of the term help-seeking. One of the first definitions was supplied by Mechanic (1980), describing help-seeking as an adaptive form of coping, which is part of the illness behaviour process. Help-seeking can be understood as a process where a person decides to seek help for some perceived disturbances in their sense of well-being or health (White et al., 1980). Rickwood et al. defined help-seeking as a "behaviour of actively seeking help from other people." (Rickwood et al., 2005, p.10). Depending on whom a person is seeking help from or for what reasons, help-seeking is displayed in various forms: formal help-seeking, informal help-seeking, and self-help (Rickwood et al., 2012).

The extant literature showed that Chinese are reluctant to seek help (Snowden and Cheung, 1990; Hu et al., 1991; Sue et al., 1991; Chen and Kazanjian, 2005; Hwang et al., 2006; Foo and Kazantzis, 2007; Phillips et al., 2009; Chan et al., 2014; Liu et al., 2014). In a more recent study, Liu et al. (2014) still reported that 75% of participants diagnosed with a Major Depressive Episode did not seek help which is consistent with a study by Phillips et al. (2009), who reported that 87.1% of Chinese with mood disorders did not seek help.

2.5.1 Attitudes of help-seeking

Among many Chinese people, there is an assumption that mental health treatment is not credible (Kung, 2004; Kwong et al., 2012; Leung et al., 2012) and that counsellors or psychotherapists might not understand the cultural context of the individual (Ang and Liamputtong, 2008). In addition, the focus on working with emotions contrasts with the belief of suppressing emotions (Sue, 1994; Leong and Lau, 2001). Discussing personal issues with professionals is uncommon among Chinese (Chen and Mak, 2008; Grossman and Liang, 2008) as seeking help outside the family can be regarded as something shameful (Chang, 2014). Therefore, problems should be kept within the family to avoid dishonouring the family (Shea and Yeh, 2008). Self-reliance is highly valued and seeking help would be to admit that they could not be able to cope on their own and therefore lose face (Chiu,

2004). These findings are supported by Chang (2007b, 2014), who found that students with elevated depression scores were less likely to seek professional help or even help from family or friends. The extant literature concerning young people's help-seeking attitude showed a tendency not to seek help (Wilson and Deane, 2010; Gulliver et al., 2012; Chang, 2014). Among Chinese international students, help-seeking behaviours were broadly similar to their local peers, with two specific differences: Chinese international students were not willing to seek help for moderate mental health issues (Hsu and Alden, 2008) and had a greater reluctance to disclose difficulties to others (Tang et al., 2012).

Common mental health issues, such as depression and other forms of psychological distress are considered a weakness of character (Chung, 2010; Chang, 2014) and not regarded as a serious illness, but just part of life. Therefore, professional help is not required (Kung, 2003; Kwong et al., 2012) as mental health issues are expected to get better by themselves (Kung, 2004). These findings are supported by Wang and Mallinckrodt (2006), who stated that collectivistic societies connect mental health issues to internal and personal causes. If symptoms are not severe help is not sought (Lu et al., 2014; Liu, C. et al., 2015) and only when symptoms increase help will be sought (Cheung, 1995; Chang, 2014).

Although female Chinese participants expressed a more positive attitude toward help-seeking than their male counterparts, gender did not seem to play a significant role in help-seeking attitudes as both were still reluctant to seek help (Chang, 2014).Results from earlier studies about the influence of acculturation and gender to help-seeking (Gim et al., 1990; Atkinson et al., 1995) varied widely. A more recent study (Chen and Mak, 2008) found that westernisation in understanding the cause of mental illness and psycho-education influenced help-seeking attitudes, for example, Chinese Americans were more likely to seek help than Hong Kong and mainland Chinese.

Even within China different levels of help-seeking attitudes can be found, for example, Wong and Li (2014) stated that in Shanghai psycho-education and

a lower approval of Chinese beliefs and treatment methods had a positive influence on help-seeking. Mo and Mak (2009) found that in Hong Kong, socio-cognitive factors and the influence of significant others influenced help-seeking positively or negatively.

Age can also influence help-seeking attitudes as according to Tieu and Konnert (2014), positive help-seeking attitudes decrease with age. This is evidenced by an Australian study (Rickwood and Thomas, 2012) which showed a steep decline in help-seeking after the age of 55.

Help-seeking attitudes are also influenced by social networks. Yeung et al. (2013) and Tieu and Konnert (2014) reported that greater social support influenced positive help-seeking attitudes among Chinese, confirming an earlier study by Mo et al. (2006) among Hong Kong Chinese immigrants. However, not every social support network has a positive influence on help-seeking. Witt et al. (2011) showed in their study on older Chinese that a strong family support system is associated with increased fear of intimacy with mental health professionals and negatively impacts help-seeking attitudes.

These attitudes might explain the underutilization of mental health services by Chinese immigrants (U.S. Public Health Service, 2001; Chen and Kazanjian, 2005; Blignault et al., 2008), and in China (Boey, 1999; Chang, 2008; Chen, 2012). In conclusion, Chinese immigrants who were unfamiliar with using mental health and medical services in their home country (Chen, 2012), might be even more reluctant to use mental health and medical facilities in their adopted country.

2.5.2 Intentions to help-seeking

Chinese often express their mental distress with somatic complaints (Kleinman, 1986; Huang et al., 2006; Kwong et al., 2012) rather than cognitive-affective complaints (Chang, 2007a). They seek help to alleviate the symptoms, for example, anxiety, which is regarded as a somatic complaint, increases the likelihood of help-seeking (Chang, 2014). Chen (2012) found that in China, immediate family, friends or extended family are

usually trusted with disclosure of mental health issues. Thus, people with mental health issues need to find someone to trust and disclose their mental distress (Chan and Ritchie, 2011). Only a minority had the intention of seeking help from mental health professionals (Chen, 2012). These intentions did not change much among older Chinese immigrants because seeking help from a psychologist was their least likely intention (Tieu and Konnert, 2014). The majority wanted to take care of their problems themselves, but if this failed, they would consider seeking help from their General Practitioner (GP), before involving close friends or family (Tieu and Konnert, 2014).

Positive intentions towards help-seeking can be generated through contact with a health professional, such as a social worker (Mo et al., 2006). Also, as help is often sought within the family, the family might encourage the person to seek professional help and access mental health services (Wilson and Deane, 2010; Chan and Ritchie, 2011). Online services might be considered, yet Lu et al. (2014) reported that international students would prefer face-to-face treatment to Internet treatments.

Furthermore, in China, intentions of help-seeking might also be hampered by the inaccessibility of mental health services. Shen, Y. et al. (2006) reported that people diagnosed with a mental health issue did not receive any treatment within twelve months. In addition, the Chinese household registration system (Hukou) might also limit the intentions of help-seeking, as rural Chinese cannot use urban facilities, because they are not registered for urban areas (Liu, 2005; He and Wu, 2017). Gulliver et al. (2012) reported a paucity of research about intentions of help-seeking, which is also reflected in this literature review, indicating that further research is needed. Clarification of intentions of help-seeking might lead to a more defined picture of why the Chinese population is reluctant to seek help.

2.5.3 Actual behaviour of help-seeking

According to Kung (2004), few studies are looking into the behaviour of help-seeking among the Chinese. Often, when a Chinese person has a problem

they tend to try and handle the problem on their own (Bruffaerts et al., 2011; Qiu et al., 2017) before seeking informal help from family and friends (Chen, 2012). Ang and Liamputtong (2008) found that international students find solace in talking to other international students as they can share similar experiences. Although Kwong et al. (2012) found that just 10% of participants felt loved by family and friends, 55% of participants in his study still preferred talking to friends and family and participating in leisure and self-help activities rather than seeking general health services. However, it needs to be noted that help-seeking does not always use the pattern of preferring informal to formal help (Chiu, 2002). There can also be downsides in seeking help from friends, for example, advice can sometimes be overwhelming, or the person seeking help might not feel understood (Chan and Ritchie, 2011). Another hindrance may be that intimate issues or feelings of inadequacy towards the helper prevent disclosure to family and friends (Chiu, 2004).

Coping, which is regarded as a process and can be divided into problem-focused and emotion-focused strategies to deal with stressful events (Lazarus, 1993) is another form of actual help-seeking behaviour. Social interactions and social context also influence coping strategies (Dunahoo et al., 1998) and need to be especially considered in the context of different cultures, for example, Eastern versus Western cultures. Western coping strategies focus on individualism and independence (Kuo, 2011), while Eastern coping strategies also consider the impact of coping strategies on others (Hsu et al., 2008). Interpersonal harmony within a Chinese context is vital, and therefore Hsu et al. (2008) noted that a prosocial-antisocial coping strategy approach, which takes into account the effect of coping on others, can improve psychological well-being. This Eastern way of coping needs to be kept in mind by counsellors when they interact with their respective clients.

In recent years, the Internet has opened new avenues for help-seeking (Chen, 2012; Liu et al., 2014). According to Chen (2012), the most common users are young people, more educated people, or migrants from rural areas to cities. The advantages of the internet are accessibility, affordability, and

anonymity (Chen, 2012; Choi et al., 2012). Accessibility is of great value, as Chinese often work very unsocial hours and therefore find it difficult to attend during regular clinic hours (Ho et al., 2008). Affordability further contributes to the use of the Internet (Chen, 2012) as does its anonymity which is especially important regarding stigmatised illnesses. Health information and even communication with health professionals can be obtained without revealing identity (Berger et al., 2005). This anonymity can be especially useful in a Chinese context where loss of face is a real issue. In addition, language issues can be overcome more easily as the user can read instructions and guidelines in their language or listen to mental health professionals in their mother tongue (Blignault et al., 2008). Hence, the Internet is an ideal tool for people who seek self-help and want to obtain information about mental health issues or counselling approaches (Titov, 2007). Internet access to counselling information can be a gateway to face-to-face counselling (Choi et al., 2012). However, the disadvantages of obtaining counselling information on the Internet are that credibility can be an issue and that users might be falsely informed (Powell and Clarke, 2006).

Seeking professional help through the GP (Yen et al., 2000), traditional medicine (Foo and Kazantzis, 2007) or mental health services (Boey, 1999; Kung, 2003; Chang, 2007a), is usually only considered when informal options have failed and symptoms have become more severe (Lin and Lin, 1978; Durvasula and Sue, 1996; Lin and Cheung, 1999; Li and Browne, 2000). In the UK, this is noticeable because of higher than average admission rates through A & E for mental health issues among Chinese (Care Quality Commission, 2010). This indicates that professional help-seeking at an earlier stage is often postponed until no other options are available and that barriers to help-seeking might prevent people from seeking help.

2.5.4 Barriers to help-seeking

According to Kung (2004), cost, language, time, and knowledge of access are the most acknowledged barriers of help-seeking. Affordability of professional treatment (Kung, 2004; Bruffaerts et al., 2011; Chen, 2012;

Kwong et al., 2012; Lu et al., 2014) can be a problem in some countries. Kung (2004) stated that treatment costs for Chinese Americans are the biggest hindrance to seeking help for mental health issues. A similar situation is reported for China where the mental health service is commercialised, and those on low income often do not receive the help they would need (Shen, Y. et al., 2006; Chen, 2012). Chen et al. (2012) pointed out that despite attempts to improve access to mental health services in China, mostly rural areas are neglected. Language ability can also be a major barrier for Chinese immigrants and international students (Kung, 2004; Ang and Liamputtong, 2008; Leung et al., 2012; Lu et al., 2014). Experience of language-based discrimination (Spencer and Chen, 2004) and lack of bilingual health professionals hinders help-seeking behaviour (Takeuchi et al., 1995; U.S. Public Health Service, 2001; Ang and Liamputtong, 2008). Time is another factor, as long working hours leaves little time to seek help (Sue, 1994; Kwong et al., 2012). Lack of knowledge of existing services (Loo et al., 1989; Rosenthal et al., 2006; Ang and Liamputtong, 2008; Liu, C. et al., 2015), misconception about counselling services, counsellors being not regarded as part of their social network (Ang and Liamputtong, 2008) or lack of access (Chung, 2010; Lu et al., 2014) are additional barriers. Even a lack of transportation can be an issue (Bruffaerts et al., 2011).

In addition, if Chinese immigrants are in the country illegally, this makes seeking help even more difficult, for example, until 2019 UK health professionals were required to report illegal immigrants who came for treatment to authorities due to changes in the law in 2010 (Legido-Quigley et al., 2019). Although reporting is no longer required in the UK, it is doubtful if illegal immigrants are aware of this change and if trust in the care system among illegal immigrants has been re-established (Legido-Quigley et al., 2019).

Besides these practical barriers, there are also cultural, social, and psychological barriers affecting help-seeking. Cultural values, such as Confucian ideas of patriarchy, collectivism and self-reliance, emotional restraint, avoidance of shame and family ties (Kung, 2003; Chiu, 2004; Mo

and Mak, 2009; Spencer et al., 2010; Leung et al., 2012) contribute to a reluctance to disclose personal problems to outsiders (Chang, 2014) and diminish a positive attitude toward help-seeking outside the family (Tieu and Konnert, 2014; Wong and Li, 2014). Even within the family, disclosure might be difficult as burdening others can disturb the group harmony, and there is also a fear of being criticised by others (Kim et al., 2008).

Self-concealment by not expressing emotions, particularly negative emotions, is often regarded as maintaining harmony within the family (Shea and Yeh, 2008) but has an adverse effect on help-seeking attitudes adding to a lack of awareness of psychological distress (Chan and Ritchie, 2011; Leung et al., 2012; Lu et al., 2014). Withdrawal because of depression becomes another psychological barrier to seeking help (Kwong et al., 2012). In addition, help-seeking for mental health issues carries public stigma (Song et al., 2019). The stigma of mental illness and loss of face is not only attached to the person concerned (Kung, 2004; Chung, 2010; Chan and Ritchie, 2011; Chang, 2014; Cheang and Davis, 2014; Chiang et al., 2019) but also to the immediate family (Kung, 2003; Mak and Chen, 2006; Hsu and Alden, 2008; Shen, 2011; Leung et al., 2012). Public stigma becomes even more evident when taboo subjects, such as rape or abuse, are investigated (Shen, 2011). Chinese women do not want to be regarded as incompetent or inadequate and therefore, often do not seek help, but blame themselves over what happened (Chiu, 2004). A recent study by Kwong et al. (2012) seemed to contradict the influence of stigma on help-seeking, reporting that most participants did not feel ashamed or stigmatised in receiving mental health treatment in a primary care centre. However, nearly half the participants would have resented treatment if the treatment was offered in a mental health clinic. Therefore, consideration about where to provide mental health services is vital.

2.5.5 Overcoming barriers to help-seeking

Research suggests that mental health outreach is needed to overcome the assumption that therapy is not credible (Chung, 2010). Misconceptions such as ‘counselling is only for mentally ill people’ need to be overcome (Ang and

Liamputtong, 2008). Culturally adapted psycho-education is needed, which considers, for example, that the Chinese illness model is holistic and that Chinese people often express psychological distress through somatization, such as, sleep disorder (Kleinman, 1986; Kwong-Liem, 2009; Kwong et al., 2012). This holistic model is also expressed in the interchangeability of words like 'body' and 'heart/mind' within the Chinese illness concept (Chan and Ritchie, 2011), highlighting that the use of language within psycho-education can be complex and needs careful consideration.

Bilingual or culturally adjusted services could change help-seeking behaviour as existing services often lack cultural relevance, for example, a more directive approach where teaching and instructing are prioritised would be appreciated (Chan and Ritchie, 2011; Leung et al., 2012). Chinese often value the integration of Western and indigenous views; therefore, health talks could be more language sensitive and include Chinese concepts for example, 'nurturing life' or 'mental hygiene' (Chan and Ritchie, 2011, p.41). In addition, different socio-cultural circumstances among immigrant Chinese need to be considered when developing relevant help-seeking models (Takeuchi and Kim, 2000; Bhugra, 2004; Mo et al., 2006). Flexible opening hours, affordable services and shorter treatment approaches can positively influence help-seeking behaviour (Kung, 2004). These changes were already recommended in previous studies (Sue et al., 1991; Zane et al., 1994) but as more recent studies still find the same issues (Kung, 2004; Kwong et al., 2012) further research is needed to identify why change is slow and minimal.

2.5.6 Summary

Previous and recent studies showed that help-seeking for mental health issues is only reluctantly accepted among Chinese in China or overseas because common mental health issues were not regarded as an illness. Attitudes towards help-seeking for common mental health issues depended on the level of westernization, the influence of psycho-education or even the geographical location. Intentions of help-seeking indicated that trust was an influential factor in deciding to whom to disclose mental health issues. Help-seeking behaviour showed that self-reliance and informal help through family,

friends, or the Internet were the preferred choices before seeking formal help from mental health professionals. Besides well-known barriers of help-seeking, such as cost or language issues, barriers based on cultural values, for example, avoidance of shame, were also raised. Although suggestions of how to overcome help-seeking barriers, such as the promotion of culturally adjusted psycho-education, can be found in previous and recent studies, change is slow and minimal. Further research would be beneficial to identify the reason for this stagnation.

2.6 Counselling

The third theme of the literature review 'counselling' is divided into four topics: counselling history in China; multicultural counselling ("the fourth force"); counselling in action; and challenges in counselling.

2.6.1 Counselling history in China

Counselling in China has become increasingly common over the last two decades (Yip, 2005; Tang et al., 2012). China has undergone huge societal changes where not everyone has profited, and many have become lonelier as they have had to migrate to find work and leave their familiar social networks. In addition, man-made and natural disasters have led to an increased demand for professional help (Xu and Wu, 2011). Therefore, the need for meaningful exchange and advice in a safe environment has grown. However, in rural areas, mental health treatments are not readily available (Park et al., 2005; Yip, 2005) and in the cities, where counselling is more available, cost hinders many people from using it as it is often privatised (Zhang, 2014). In China, counselling is still strongly connected to medical science, and it is necessary to be a medical doctor to practise counselling (Zhang et al., 2001). In the Chinese medical system mental health issues are usually treated in general health care clinics (Chen, 2012) and the terms "psychological counsellors" (not qualified to give out prescriptions) and "psychotherapists" (who have the right to write prescriptions) are often used interchangeably or combined into the term "psychological doctor" (Zhao et al., 2012).

In 1988, the first Advanced Sino-German Psychotherapy Symposium was held in Kunming, which was regarded as the origin of the current counselling movement (Zhang, 2014). As a result of this symposium, a three-year training program was developed based on systemic family therapy, cognitive behavioural therapy, and psychodynamic therapy. This training course contributed to the development of another group of mental health professionals: the private counsellor practitioner. However, the growing need for psychological treatment demanded more training courses. In 2003, the Chinese government reacted to this need by starting a national examination program to certify counsellors and therapists. Although this short-term course (two to three months) does not equip participants sufficiently to practise as private counsellors, it is often useful as an additional skill to further one's career, for example, in teaching (Zhang, 2014). The growing popularity of counselling and psychology bears the danger that counselling and psychology training can become superficial and lack the depth needed to generate well trained mental health professionals (Zhang, 2014). Zhao (2014) reported a lack of counsellors, supervisors, regulation, and training. Also, Kleinberg and Thomas (2012) found a lack of psychiatrists for the estimated 16 million of the population affected by mental health issues. Sixteen million might be a more conservative number or refers to just the more severe cases because Fei (2006) and Moore (2009) suggested that there was a minimum of 100 million Chinese with mental health issues in China.

The Chinese Psychological Society reported a lack of funding from the government, which affects the expansion of their psychological services (Townsend, 2011). Psychology seems still not to be accepted as a scientific and trustworthy discipline within society, and this is a barrier to accessing services (Townsend, 2011). However, Zhang (2014) observed that in urban areas, psychology is regarded as a useful tool in dealing with social relationships or work-related issues. The growing popularity of psychology is demonstrated by an increase in published books, magazines, and websites with psychological content or offers of psychological and counselling training (Zhang, 2014).

2.6.2 Multicultural counselling ("the fourth force")

Multicultural counselling, which is also referred to as the "fourth force" (Ivey et al., 1997), developed in the 1970s in North America. Multicultural counselling challenges the western-based concepts of the three main counselling approaches, psychodynamic, humanistic, and cognitive-behavioural (Watson, 2011). The aim of multicultural counselling was to develop more culturally suitable counselling approaches and to take into consideration that the therapeutic relationship can be influenced by cultural diversity. Multicultural counselling recommends that clients' presenting issues, coping methods and treatment goals should be regarded within a multicultural context (Pedersen, 2001; Leong and Leach, 2007; Chen and Mak, 2008; Ng and James, 2013). D'Ardenne and Mahtani (1989) introduced transcultural counselling as a concept where counsellors accept that there is another world-view, accommodate the diverse needs of clients and develop appropriate counselling approaches. Lago and Thompson (1996) stated that the term multicultural is preferred in the USA, whereas the term transcultural is often used in UK literature.

Furthermore, Chen and Mak (2008) suggested that, as non-western populations were assessed for their psychological well-being, multiculturalism has moved toward internationalisation in North America. However, Ægisdóttir et al. (2007) pointed out that research using international populations concerning counselling issues in the USA are still scarce, and therefore, the research findings cannot be easily generalised to other countries. This paucity is further confirmed by the findings of Sutherland and Moodley (2011) who reported that there is a lack of research on how black and ethnic minority groups' experience counselling, leading to a lack of in-depth counselling approaches. Furthermore, the diverse cultures within racial groups were often not considered in research, which is criticised as being unethical (D'Andrea, 2005).

In addition, research often used Western measurements and models without considering their cross-cultural validity (Kim et al., 2006). Mak et al. (2011) investigated the connection between resilience, life satisfaction, depression,

and one's positive views towards self, the world, and the future, coined the term 'positive cognitive triad' which was based on the work of the cognitive triad (Abramson et al., 1978; Beck et al., 1979). The positive cognitive triad protects from depression by strengthening positive emotionality and life satisfaction. Mak et al. (2011) promoted psycho-education of the positive cognitive triad and teaching cognitive techniques, such as de-catastrophizing, to help combat negative thoughts. However, its cross-cultural applicability needs still to be tested (Mak et al., 2011). Therefore, adequate research is necessary to establish more culturally sensitive approaches (Flaskerud, 1986; Zane et al., 1994; Takeuchi et al., 1995; Hwang et al., 2006; Chen and Mak, 2008; Sue and Zane, 2009; Chan et al., 2014).

Leung and Chen (2009) regarded the search for culturally adapted counselling as following in the tradition of 'indigenous psychology' described by Ho as:

> "the study of human behaviour and mental processes within a cultural context that relies on values, concepts, belief systems, methodologies, and other resources indigenous to the specific cultural groups under investigation." (Ho, 1998, p.94)

In a Chinese context, such values and concepts can be collectivism or the hierarchy within society (Lin, 2004). Furthermore, indigenisation does not mean devaluing knowledge and practices which are used in other parts of the world, but rather integrating them within the local culture (Leung and Chen, 2009). According to Lin (2004), effective indigenisation can only occur, when a sound knowledge of general counselling values, for example, empathy, genuineness, unconditional positive regard is taught to health professionals. This training could provide the background for developing cultural practices of counselling among Chinese in Asian countries (So, 2005; Hwang, 2009; Hwang and Chang, 2009; Leung and Chen, 2009).

In China, health professionals have shown an increased interest in incorporating Western values, which have become more accessible through globalisation, within Chinese culture (Chen, 1999; Leung, 1999; Hou and Zhang, 2007; Leung et al., 2007) and recognise that indigenous forms of psychotherapy need to be developed (Duan et al., 2011; Zhang, 2014; Tsang,

2015). Culture-specific issues need to be considered to increase the effectiveness of counselling (Leung and Chen, 2009; Kuo et al., 2011), for example, gift-giving, in the sense of giving the client a sense of achievement through psycho-education and assertion of authority (Park, 2006; Sue and Zane, 2009) were suggested as culturally sensitive techniques. The next topic, 'Counselling in action' will examine in more detail how counselling approaches were applied with Chinese clients.

2.6.3 Counselling in action

This third topic within the theme of 'Counselling' examines how some of the main counselling approaches, psychodynamic, humanistic, cognitive-behavioural, and integrative were applied within a Chinese context. Counselling is grounded in Western theories and aims to reduce symptoms by exploring emotional issues through talking therapy (Chan et al., 2014). Eastern theories are often based on a holistic approach, for example, Traditional Chinese Medicine (TCM) is influenced by Daoist beliefs such as, '*jing*' (life essence), '*qi*' (life energy) and '*shen*' (mental well-being or spirit) and the interconnectedness of body and mind (He, 2019).

2.6.3.1 Cognitive-behavioural approaches

In the studies examined CBT was the most frequently mentioned counselling approach (Hwang et al., 2006; Shen, E. et al., 2006; Wong and Sun, 2006; Williams et al., 2006; Foo and Kazantzis, 2007; Gallagher-Thompson et al., 2007; Liu et al., 2009; Chu et al., 2012; Choi et al., 2012; Zhang, 2014) confirming previous studies (Leong, 1986; Lin, 2001; Li and Kim, 2004) that suggested CBT is well-suited to Asian culture and belief systems and can be adapted to deal with the specific issue of counselling Chinese clients.

Foo and Kazantzis (2007) noted that CBT is increasingly used worldwide, as its effectiveness in treating depression is well evidenced (Hopko et al., 2003; De Rubeis et al., 2005; Hollon et al., 2005). However, Iwamasa et al. (1995) and Iwamasa and Smith (1996) criticised CBT for not regarding cultural issues. Hwang et al. (2006) confirmed this by pointing out that stigma, shame, and loss of face are not considered within CBT. Furthermore, Shen, E. et al.

(2006) found that challenging Chinese beliefs which are connected to social and family responsibilities can be regarded by clients as betraying their culture. Despite this criticism, CBT can be adapted to Chinese culture (Hwang et al., 2006; Foo and Kazantzis, 2007; Gallagher-Thompson et al., 2007; Liu et al., 2009) as it is recognised to be structured, directive and symptom-focused (Hong and Ham, 2001; Hwang et al., 2006; Sue and Zane, 2009).

In particular, the method of psycho-education in CBT (Beck et al., 1979) is likely to be a familiar principle to many Chinese as they value education (Hwang et al., 2006; Foo and Kazantzis, 2007; Ng and James, 2013) and self-improvement (Chen and Stevenson, 1989; Dandy and Nettelbeck, 2002). Gallagher-Thompson et al., (2007), for example, developed an in-home behavioural management program for carers of dementia patients with the emphasis on psycho-education. Homework, as a form of psycho-education, is generally viewed as useful and enjoyable (Chen and Stevenson, 1989; Hong and Lee, 2000) and therefore, in CBT, Chinese clients often exceeded the therapist's expectations in fulfilling the homework assignments (Foo and Kazantzis, 2007). However, as Chinese parents often pressurize their children to achieve academic success (Chen and Stevenson, 1989; Sun, 2003), counsellors need to explain homework assignments in appropriate terms. Foo and Kazantzis (2007) suggested using J. Beck's (1995) individualised cognitive conceptualization framework to clarify thought patterns about homework. Only then can clients use homework assignments to explore their inner thoughts and coping behaviours, without fearing loss of face (Foo and Kazantzis, 2007). Homework should be understood as an opportunity to bring cognitive change and prevent relapse (Foo and Kazantzis 2007) rather than being done to please the therapist.

CBT allows for the integration of cultural issues, and this makes it useful for counselling among the Chinese (Iwamasa et al., 2006). Hwang et al. (2006) suggested that well known Chinese proverbs, could be used to teach CBT principles, for example, to fight depression the proverb "two brushes painting together" (*shuang guan ji xia*) could visualise the cognitive concept of

challenging negative thoughts and the behavioural concept of engaging in exercise. In a recent study by Hwang et al. (2015), culturally adapted CBT was found to contribute to a decrease in depression. Cultural adaption of counselling approaches is vital for their effectiveness (Rathod and Kingdon, 2009) and should consider, for example, clients' religion or language in therapy (Naeem et al., 2016).

However, CBT can also be used without cultural adjustments, for example, Liu et al. (2009) did not change examples used in cognitive bibliotherapy to Taiwanese culture. Furthermore, technology can also be used to extend the usefulness of CBT, for example, Liu et al. (2014) confirmed two earlier studies (Spijker et al., 2010; Spijker et al., 2012), showing that Internet cognitive-behavioural intervention could be a useful self-help tool to prevent suicide among Chinese suffering from depression.

Several studies (Lin, 2001; Li and Kim, 2004; Wei and Heppner, 2005; Kuo et al., 2011) suggested that Chinese clients prefer solution-focused and informative therapy, such as problem management or learning coping skills (Wei and Heppner, 2005), and often see task and goal setting in counselling as being the same (Zhu and Jiang, 2011; Lei and Duan, 2014). Chinese clients want to gain knowledge, have their thought patterns challenged and expect counselling to be short-term with quick results (Hwang et al., 2006; Foo and Kazantzis, 2007). Furthermore, therapy should be on a voluntary basis (Ng and James, 2013) as this will contribute to a better success rate (Chilvers et al., 2001).

2.6.3.2 Humanistic and psychodynamic approach

Therapists and clients seem to be comfortable with cognitive tasks but are more hesitant in working on emotional tasks (Kim-Goh et al., 2015). This preference could explain why humanistic and psychodynamic approaches are not as frequently used as cognitive-behavioural approaches. Only one paper (Ng et al., 2012) considered the Rogerian approach, albeit within an integrative approach. Ng et al. (2012) added a person-centred approach to Solution Focused Brief Therapy (SFBT). SFBT is well-matched to work with

Chinese clients (Yeung, 1999; Cheung, 2001) as it is a future-oriented, goal-directed approach that emphasises the searching for solutions rather than concentrating on problems (Trepper et al., 2006; Proudlock and Wellman, 2011). Counselling interventions, such as scaling questions, the miracle question and guided imagery are used to gain the client's collaboration (Ng et al., 2012). However, Ng et al. (2012) noted that SFBT was lacking in dealing with the emotional distress of the client and therefore integrated principles of the person-centred approach (Rogers, 1961) to enhance a sound working alliance which is essential for reaching goals set in the SFBT approach. None of the 89 studies retrieved addressed the psychodynamic approach. According to Corey (2001), psycho-dynamic approaches are not often found in multicultural contexts, as they are time-consuming and expensive.

2.6.3.3 Integrative approaches

Multicultural approaches benefit from an integrative approach as culturally specific issues can be integrated. Examples of multicultural approaches were found in five studies (Hwang et al., 2006; Kuo et al., 2011; Wang and Heppner, 2011; Choi et al., 2012; Chan et al., 2014). Hwang et al. (2006) who modified Cognitive Behavioural Therapy (CBT) to accommodate Chinese culture, considered not only cultural terms, such as beliefs and thought patterns from Confucianism, Taoism and Buddhism in the 18 therapeutic principles for counselling Chinese American clients, but also affiliations and status variables. Chan et al. (2014) developed an empowerment program which included thoughts and beliefs of Taoism, for example, resilience and therefore connecting western psychotherapy to well-known concepts of Chinese culture. A multicultural approach is also applied in Kuo et al. (2011), focusing on crisis intervention in a bereavement issue using indigenous counselling interventions based on Taiwanese and Chinese culture. Wang and Heppner (2011) investigated which counselling interventions were appropriate in a collectivistic society regarding childhood sexual abuse. Choi et al. (2012) adjusted an Internet-delivered CBT approach for Chinese Australians by making adjustments not only on a

linguistic level but also on a cultural and visual level, for example, cultural values of respect and interpersonal harmony were emphasised, and illustrations with Asian features were included in the psycho-educational material. These examples of multicultural approaches highlight that a great diversity of presenting issues can benefit from cultural adjustments.

Family therapy can also be regarded as an integrative approach and has been found to be valuable within a collectivistic society. Five studies (Soo-Hoo, 2006; Huang et al., 2006; Kuo et al., 2011; Sze et al., 2011; Zhang, 2014) provided insight how family therapy can be applied with Chinese clients. Western family therapy needed to be adjusted to the needs of Chinese Americans (Soo-Hoo, 1999) and a multicultural integrative family therapy approach was developed (Soo-Hoo, 2006). This approach was based on family systems therapy (Becvar and Becvar, 2003), brief strategic therapy (Fisch et al., 1982), solution focus therapy (O'Hanlon and Weiner-Davis, 1989) and narrative therapy (White and Epston, 1990) and proved to be beneficial in a Chinese-American context because it offers non-confrontational methods and techniques suitable to Chinese clients and their values (Soo-Hoo, 2006). Hwang et al. (2006) demonstrated in a case study how CBT adjusted to a Chinese context can be used as a therapy method in family therapy and achieve a positive outcome. 18 principles of adjustment were suggested, one of them (principle ten) refers specifically to the importance of family within Chinese culture and builds the basis for asking other family members to collaborate in the counselling treatment (Hwang et al., 2006)

In China, family therapy often focuses on problems with children and adolescents (Sze et al., 2011; Zhang, 2014). The willingness of the Chinese to seek family therapy as a family is based on the hope that the therapy will help the children or adolescents improve their academic results as presenting issues are often ‘lack of concentration, inefficiency’ and ‘adolescent dating’ (Sze et al., 2011). These issues can present a challenge to counsellors who are raised in that academic system, demanding self-awareness to differentiate between issues of academic pressure or other

mental health issues such as depression or anxiety (Sze et al., 2011). Zhang (2014) described a case study in which Satir family therapy was applied to improve communication skills and interactions among Chinese family members. The theory and methods of Satir family therapy seemed to fit well with the Chinese viewpoint that the family shapes the individual (Zhang, 2014). However, barriers in applying the theory arose referring to gender and financial issues (Zhang, 2014), for example, Chinese women are regarded as the primary caregiver of the family, and therefore men often are not willing to participate in the therapy process to improve family-related issues (Zhang, 2014). In addition, a therapy session can be expensive to the average Chinese and therefore not affordable over an extended period. These practical barriers hinder the full application of family therapy, and shortcuts need to be applied, for example, only one parent and child will receive treatment (Zhang, 2014). The term 'family therapy' was even applied when only one member of the family received counselling. Kuo et al. (2011) referred to the term family therapy in a case study about a bereaved Taiwanese family, explaining that values of a male-dominant social hierarchy motivated the rest of the family, which were all female, to consider counselling as beneficial, as it would support the only son of the family. Inclusion of collective and familial principles are necessary for counselling to be more effective (Kuo et al. 2011).

2.6.4 Challenges in counselling

The fourth topic 'challenges in counselling' is divided into five sub-topics exploring cultural differences in counselling, attrition rate, ethical concerns, language barriers and the therapeutic relationship.

2.6.4.1 Cultural differences in counselling

As counsellors in China are often regarded as authority figures (Kuo et al., 2011; Song et al., 2019) and experts (Mau and Jepsen, 1988), non-directive and insight-oriented counselling approaches are less understood. Song et al. (2019) suggested that directive guidance in counselling may be advantageous. Culture-specific issues also need to be understood (Iwamasa

et al., 2006) as the client's culture and values influence the therapeutic process. In China, counsellors are medically trained while in the Western model this is not regarded as necessary as the Western focus is on listening to clients, looking at thought patterns and enabling clients to become their own therapists.

Western therapeutic approaches also often focus on emotion or individualistic and independent behaviour, and this can cause misunderstandings as they do not consider Chinese thought patterns which emphasis self-control, aversion to conflict and social harmony (Huang, 2016) as part of a collectivistic society. Mak et al. (2009), for example, stated that counsellors need to be aware of the role face concern plays for Chinese clients and opt for a more directive counselling style. Counselling approaches also rarely consider using Daoist beliefs to gain resilience (Chan et al., 2014) as emotional suppression is often viewed in the West as something negative. However, emotional suppression can also be considered as positive as it aims to maintain interpersonal harmony (Wei et al., 2013). As interpersonal harmony is highly valued, counsellors need to reassure clients that counselling is a safe place to express emotions and even when clients need to express negative emotions that interpersonal harmony is not affected (Chiang, 2012).

In a collectivistic society, it is important to be part of the group, and when a counsellor builds up a sound therapeutic relationship, they are often regarded as part of the group or family. While this can be beneficial for the counselling process, it can also mean that the counsellor has obligations towards the family, for example, treating friends or relatives, which, in a Western context, would often be considered unethical (Zhao et al., 2012). Western practice may not always be appropriate in a Chinese environment, for example, the counsellor often needs to be flexible regarding the location of counselling as it can be more suitable to practice counselling at the client's home as this can show that the counsellor is genuinely interested in becoming involved in the client's life and family (Kuo et al., 2011). Studies have shown that involvement of the family in the counselling process can

make counselling more effective (Rea et al., 2003; Haine-Schlagel and Walsh, 2015) and Chen et al. (2012) suggested incorporating counselling into family services and family support.

Sze et al. (2011) found that family therapy is received well among the Chinese urban population, however, the counselling issues focus mainly on educational difficulties parents experience with their adolescent children. Furthermore, independence and individualisation, which are basic values in counselling, are not considered necessary to be explored by families, because they could contradict traditional Chinese values of a collectivistic society (Sze et al., 2011). However, a more recent study by Quek and Chen (2017) showed that the meaning of traditional Chinese values varies among generations depending on the socio-cultural context, for example, Chinese who have experienced the Cultural Revolution (1966-1976) display a more conflicted self in contrast to the more individualised self of the younger generation, who had more exposure to Western ideas. Therefore, counsellors need to keep their clients' socio-cultural context in mind to allow a better understanding of the values held by their clients (Quek and Chen, 2017).

Within a counselling context, the importance of the hierarchical relationships in Chinese society provides another challenge. Hierarchical relationships are based on Confucian philosophy and still influence Chinese society (Quek and Chen, 2017), as adhering to the principles of hierarchy contributes towards maintaining harmony within society (Chong and Liu, 2002). Counsellors need to be aware of the influence of this hierarchical thinking, as otherwise, individualisation could be misconstrued as negatively impacting the collective good.

Lei and Duan (2014) pointed out that focusing on the relationship at the start of counselling helped lower attrition rates. A sound therapeutic relationship makes a positive outcome more likely, no matter which counselling approach is used (Mallinckrodt, 1993; Norcross, 2002; Zhu et al., 2011). As a sound therapeutic relationship is also built on empathy (Rogers, 1957; Bohart et al., 2002), Western counsellors should be aware that the understanding of

empathy varies across cultures. For example, a collectivistic society expects that the individual gives priority to the needs and interests of others, rather than merely paying attention to them (Lei and Duan, 2014).

2.6.4.2 Attrition rate of attending counselling

Several studies have shown that Chinese clients have a high attrition rate (Sue et al., 1991; Mok et al., 2003; Sue and Zane, 2009). This high attrition rate can partially be explained by clients not wanting to confront their therapist and indirectly showing their displeasure by not coming back (Hong and Ham, 2001). Counsellors are regarded as more trustworthy and effective when their etiological beliefs are comparable to their clients (Atkinson et al., 1991; Worthington and Atkinson, 1996; Iselin and Addis, 2003), and therefore ethnic matching can help reduce attrition rates and achieve a better outcome (Flaskerud and Liu, 1991; Sue et al., 1991; Takeuchi et al., 1995). Without cultural insight (Hwang et al., 2006) the behaviour of clients might be misunderstood, the counsellor might use inappropriate interventions (Kleinman, 1978) and the therapeutic relationship deteriorates (Sue et al., 2009).

The attrition rate for immigrants will vary depending on their acculturation. Although ethnic and language matching for immigrants does not guarantee a successful therapy (Kim and Atkinson, 2002), cultural sensitivity and empathy can make a difference (Yeh et al., 1994; Takeuchi et al., 1995). Shen, E. et al. (2006) agreed with Sue et al. (1991) that matching leads to better outcomes in Chinese immigrants if English is their second language and Asian values were prioritized by the immigrants. This suggested that cultural and language-specific programs are important to reach out and offer psychological help to the Chinese (Shen, E. et al., 2006).

2.6.4.3 Ethical concerns

The illegality of Chinese immigrants makes counselling difficult as the counsellor is put in an ethical dilemma about whether they should report illegal immigrants, which can mean that those most in need of counselling may be kept away (Kwong et al., 2012). Another ethical issue to be

considered in a cross-cultural counselling setting is the therapeutic relationship. Zhao et al.'s (2012) research in China suggested that there can be boundary issues, for example, dual relationships as clients invite therapists to dinner or continue with the relationship after the counselling has ended. This kind of expectation could influence the understanding of Chinese immigrants in the counselling room, and it is, therefore, important to clarify with the client in advance the variations of the therapeutic relationships within a different cultural context. Furthermore, professional, and ethical guidelines need to be examined for their cultural appropriateness (Chen, 2003; Leung et al., 2003; Leung and Chen, 2009) and may need to be adjusted, so that they are relevant in a specific cultural or cross-cultural context (Mok, 2003). Working in a cross-cultural setting demands greater self-awareness of the counsellor's counselling practice, for example, clients will not always willingly show criticism towards the counsellor. Traditional Chinese culture, rooted in Confucianism, does not criticise authority and counsellors are regarded as an authority by clients (Zhao et al., 2012).

2.6.4.4 Language barriers to accessing counselling

The translation of Western concepts into Chinese presents another problem not easily solved, for example, Ng and James (2013) explained that there is no effective translation of 'directive approach', even though the methods of the directive approach seemed to be so highly regarded among Chinese counselling clients. Another example is 'empathy', where a direct translation is difficult even though the qualities that this word encompasses are well known in Chinese tradition and are still an important part of the socialization process in China (Lei and Duan, 2014). Chinese has words for psychological problems, for example, '*Yu*', which translates as "not flowing, entangled or clogged", and represents a low mood (Ng et al., 2006), but these terms are rarely integrated into counselling theories. Whenever counsellors have a different cultural and linguistic understanding from their clients' misunderstandings can easily arise (Ang and Liamputtong, 2008), and this contributes towards the thinking that counselling is cultural insensitive (Sue, 1998). In addition, key terms in assessment questionnaires not always

convey the exact meaning, for example, the term ‘hopelessness’ was translated to ‘friendless and no one understands or cares about me’ (Wong, et al., 2012). Another difficulty of translation is that translated words trigger various associations in different cultures (Jiang, 2000). Zhang (2014) pointed out that the real issue counsellors face is adapting Western-based counselling approaches, which claim to be scientific and universally applicable to anyone, within a Chinese context. The major difficulty is not the literal translation, but the translation of the concepts of counselling approaches (Zhang, 2014). Therefore, translation can be regarded as a continuous dialogue between Western therapeutic approaches and Chinese cultural values, which influence each other and help to develop new counselling approaches (Zhang, 2014). On a more pragmatic level, the researched studies in this literature review provided little evidence about interpreter services regarding counselling. Green et al. (2006) indicated that there is a need for translation and advocacy services within the National Health Service (NHS) regarding Chinese women as there can be significant communication problems depending on language ability. Often other family members were used as an interpreter in NHS consultations (Green et al., 2006), however, this would not be ethical within a counselling context.

2.6.4.5 Therapeutic relationship

Counselling studies often investigate the outcome of counselling approaches (Wei and Heppner, 2005; Kuo et al., 2011), but seldom examine the client’s counselling experience. Zhao et al. (2012) listed their study as being the first study to investigate counselling from the Chinese client’s point of view. Their findings showed that a large majority of clients regarded their counsellor as competent and trustworthy. However, Zhao et al. (2012) wondered if this result is realistic, as clients might not have enough knowledge to evaluate counsellors and many are influenced by a Confucian upbringing that does not question authority. Ethical issues involved mainly around minor boundary issues, for example, telephones were answered during sessions or dual relationships, defined as counselling friends and relatives. Two later studies (Ng and James, 2013; Lei and Duan, 2014) explored in more detail how

Chinese clients experienced psychotherapy. Ng and James (2013) reported that Chinese clients experienced counselling in three phases: understanding, analysis and information. An unexpected result was that clients felt they could be honest and direct with their therapist and not be concerned with saving face. Ng and James (2013) connected this to the therapist being regarded as family or as a close friend, and therefore, disclosure is possible. Lei and Duan (2014) also explored the client/counsellor relationship among Chinese using Bordin's (1979) theoretical framework of Bond, Goal and Task. They found that there was a therapist effect in Bond, but not a therapist effect in Goal and Task. This result confirmed an earlier study (Mallinckrodt and Nelson, 1991) that establishing emotional connection and attachment between counsellor and client is a skill that depends on the individual counsellor and their experience. In addition, time also played a factor as increased sessions equalled a growing working alliance (Lei and Duan, 2014). The importance of providing adequate time to clients refers not only to counselling sessions but also to helplines serving ethnic minorities. This was highlighted in a recent study by Dong (2016) stating that the length of a call helpline services provide should be measured on the complexity of the mental health issue presented and not on the internationally agreed time of 20 minutes per call. More flexibility is needed as callers who are culturally inhibited might not be able to disclose complex issues in a restricted timeframe (Dong, 2016).

2.6.5 Summary

Counselling has gained popularity in China due to societal and economic changes in recent decades and has increased especially in urban areas. Counselling approaches in China are mostly based on Western counselling approaches with CBT being a popular approach to use with Chinese clients due to its directive and structured principles. Multicultural counselling provided a theoretical framework to develop culture-sensitive counselling approaches contributing to positive outcomes in counselling. Consideration of cultural differences are important in understanding applications of counselling approaches, for example, the emphasis on independent

behaviour can be construed as an attempt to damage social harmony in a collectivistic society. Other challenges to counselling refer to ethical issues, language barriers and the therapeutic relationship. Constant adjustments of counselling approaches and skills development of the counsellor are required to maintain the relevance and accessibility of counselling.

2.7 Gaps in the literature / Study rationale

Based on this literature review it is known that attitudes towards mental health among the Chinese have changed over the last two decades and mental health issues have become a common occurrence in Chinese society (Lim et al., 2010). Previous research found that views on mental health issues in China were often not as differentiated as in the West and mostly equated with psychotic illness (Hsiao et al., 2006). In China, the concept of neurasthenia (Beard, 1869) was still widely used in the diagnosis of mental health issues and generally understood by the Chinese public as 'weakness of nerves' (Chang et al., 2005a). While more recent research linked the occurrence of mental health issues to socio-economic changes (Lim et al., 2010) such as unemployment (Liu et al., 2014; Sha et al., 2018) or location, for example, suicide rates in China are higher in rural areas than in urban areas (Sun and Zhang, 2015; Liu et al., 2017). As these changes were more recent, there is a lack of research as to how these changes might affect the attitude towards mental health in Chinese communities overseas. For example, Tran et al. (2008) and Chang et al. (2015) found that there is a lack of research about how the Chinese community in the UK is impacted by mental health issues.

The literature review showed that research into help-seeking has many facets, for example, attitudes toward help-seeking (Leung et al., 2012) or actual behaviour of help-seeking (Qiu et al., 2017) and also used a wide range of participants, such as college students, clinical or non-clinical community samples (Kung, 2004). This range of participants makes comparisons difficult as, for example, data on the influence of age on help-seeking is varied, further research is needed to better identify situations where age hinders help-seeking. But a common factor was that help-seeking

for mental health issues is sought only reluctantly (Chan et al., 2014; Liu, Z. et al., 2015), despite a growing awareness of mental health issues, expressed also by the implementation of a mental health law in China (Shao et al., 2015). The reluctance of seeking help is grounded in mistrusting mental health professionals (Chen, 2012) and enforced by an unwillingness of sharing personal issues (Chen and Mak, 2008). Actual behaviour of help-seeking matched intention of help-seeking, showing that Chinese prefer to solve problems by themselves before seeking help through informal or formal pathways (Wilson and Deane, 2010). Based on the literature review it is also known that recommendations of overcoming barriers were made in previous studies (Sue et al., 1991; Zane et al., 1994), but the same issues were found in more recent studies (Kung, 2004; Kwong et al., 2012).

Further research is needed to understand why change is slow and why health services are still underutilized by the Chinese immigrant population, especially in the UK, where health services are free of charge. In addition, the lack of a common framework of research concerning help-seeking, makes comparisons between different studies of help-seeking more difficult and research into the development of a common framework would be needed. Research about help-seeking among Chinese communities covered several countries, for example, the USA (Kwong et al., 2012) or Australia (Chan and Ritchie, 2011), yet, a paucity of research regarding help-seeking among the Chinese community in the UK became evident (Yeung et al., 2013).

The literature review on counselling revealed that although counselling with a range of theoretical approaches, such as family therapy (Kuo et al., 2011; Zhang, 2014), is known and applied in China, counselling is often difficult to access, especially in rural areas, due to a shortage of trained professionals (Zhao, 2014). Research on counselling among the Chinese showed that multicultural counselling needs to be further developed (Kuo et al., 2011; Tsang, 2015) and cultural differences acknowledged, for example, the preference of directive guidance in counselling among the Chinese (Song et al., 2019). Therefore, CBT is often used among Chinese clients, but the

influence of a client's cultural beliefs on CBT processes is under-researched (Foo and Kazantzis, 2007). In addition, little is known about using non-directive counselling approaches within the Chinese community (Ng and James, 2013). Research found that lack of cultural understanding, reflected in language barriers (Lei and Duan, 2014) or inadequate time frames for counselling sessions (Lei and Duan, 2014) or helpline services (Dong, 2016) can influence the attrition rate. Yet, counselling experiences within the Chinese community are seldom examined (Zhao et al., 2012), contributing to a lack of understanding of how counselling is perceived among the Chinese community.

Based on this literature review it is also known that few peer-reviewed studies are available concerning the Chinese community in the UK (Green et al., 2006; Tang et al., 2012; Yeung et al., 2013). Even though there are some articles and reports conducted by universities (Irwin and Dunn, 1997) or government organisations (Tran et al., 2008; Health and Social Care in Northern Ireland, 2014) none of the studies in Northern Ireland (Irwin and Dunn, 1997; Yeung, 2005; Olphert, 2007) examine mental health, help-seeking, and the use of counselling. The participant range is restricted (Olphert, 2007) and a study with a wider range of participants from the general Chinese community is missing. In addition, most of these studies are dated (Irwin and Dunn, 1997; Yeung, 2005; Olphert, 2007), therefore, recent changes in society are not included. An exploration of how these changes have influenced the mental well-being of the Chinese community would be timely, and a qualitative study could provide more specific information. Due to cultural, social, and linguistic differences, an exploration on the perceptions of mental health, help-seeking, and counselling among the Chinese community could contribute to a better understanding of this ethnic minority and help to make meaningful recommendations concerning their well-being. This led to the following research question, aim and objectives.

2.7.1 Research question, aim, and objectives

2.7.1.1 Research question

What are the perceptions of mental health, help-seeking, and counselling among the Chinese community in NI?

2.7.1.2 Aim

To explore perceptions of mental health, help-seeking, and counselling among the Chinese community in NI.

2.7.1.3 Objectives

To understand the perceptions of mental health among the Chinese community in NI.

To gain understanding of the perceptions of help-seeking concerning mental health among the Chinese community in NI.

To gain insight into experiences of help-seeking concerning mental health among the Chinese community in NI.

To explore perceptions of counselling among the Chinese community in NI.

To gain insight into experiences of counselling among the Chinese community in NI.

To provide recommendations on mental health, help-seeking, and counselling to enhance mental health and well-being among the Chinese community in NI.

2.8 Conclusion

This literature review provided insight into how mental health is viewed in Chinese society and that in the last two decades, awareness about mental health issues among the Chinese population has increased. Yet, increased awareness about mental health issues seemed not to have changed help-seeking behaviour, as Chinese society is still reluctant to seek help for common mental health issues. Although counselling is offered within Chinese speaking countries and Chinese communities abroad, a paucity of research on how counselling is beneficial and accepted among Chinese society emerged. The current study will contribute towards a more in-depth

view of how the Chinese community in Northern Ireland understood and experienced issues of mental health, help-seeking, and counselling.

This literature review is followed by the ‘Contextual framework’ chapter, which explains the wider framework in which the current study is posited.

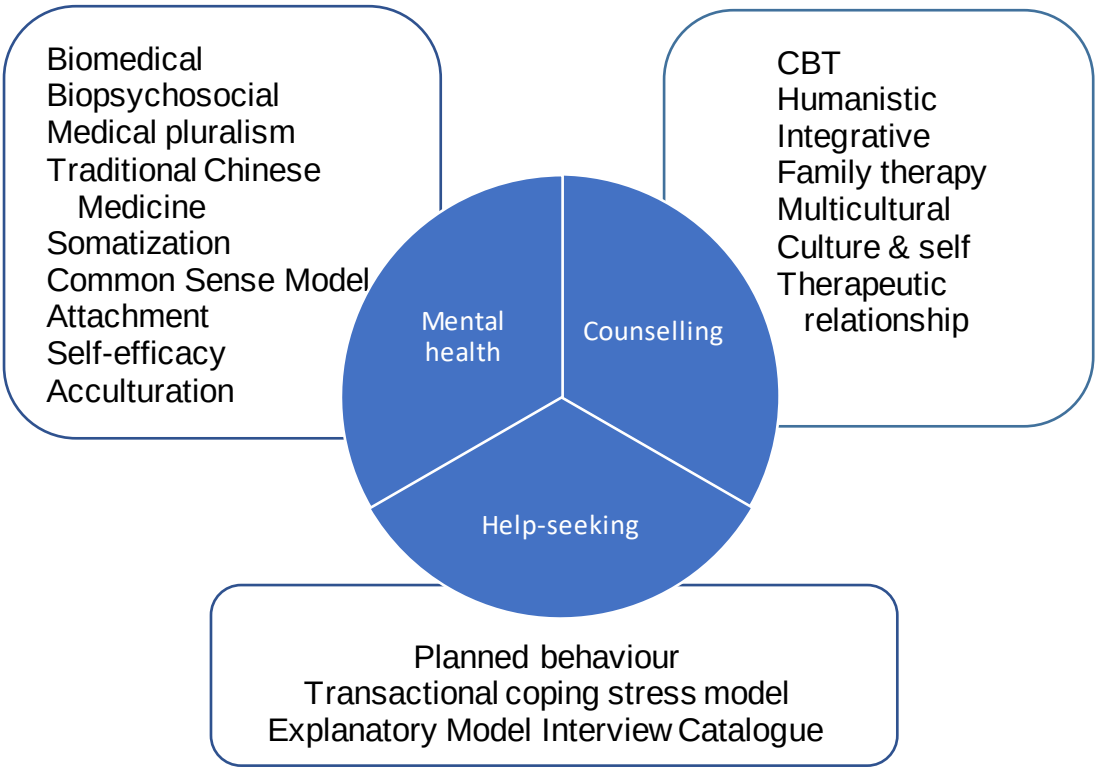
Chapter 3: Contextual framework

To develop a contextual framework, it is important to examine relevant theories regarding mental health, help-seeking, and counselling and how they are applied within a Chinese context. Thus, the first part of chapter three provides an overview of the theoretical frameworks of studies in the literature review. The second part demonstrates the necessity of a new theoretical framework to accommodate the research question, research aim and objectives of the current study.

3.1 An overview of the theoretical frameworks of previous studies

In the initial 89 studies used in the previous chapter of the literature review, 19 theoretical frameworks were explicitly mentioned. These 19 theoretical frameworks are grouped in **Figure 2** to provide an overview of the different theoretical frameworks with reference to the three main sections of the literature review: Mental health, Help-seeking, and Counselling.

Figure 2: Theoretical frameworks



Using the grouping in **Figure 2,** detailed explanations of the 19 theoretical frameworks are outlined in section 3.2 (mental health), section 3.3 (help-seeking), and section 3.4 (counselling).

3.2 Mental health – theoretical frameworks of previous studies

Of the initial 89 studies examined in the literature review, 67 referred to mental health issues among the Chinese population. Most of these 67 mental health studies referred to one of the three main theoretical frameworks: Biomedical, Biopsychosocial (holistic) or Somatic. Other theoretical frameworks mentioned were Medical Pluralism, which includes Traditional Chinese Medicine (Green et al., 2006); the Common Sense Model (Leventhal et al., 1992), also known as the Illness Perception Model, which was used by Mak et al. (2014). Attachment theory (Bowlby, 1969) applied in Wang and Scalise (2010), the Theory of Self-efficacy (Bandura, 1977) applied in Lin and Betz (2009), and Acculturation (Berry, 2005) used by Wei et al.(2012) provide further frameworks for understanding the root causes of mental health issues. A brief overview of these theoretical frameworks is provided below.

3.2.1 The Biomedical model

The Biomedical Model explains illness from a physical viewpoint, including anatomy, physiology, biochemistry, and pathology (Furze et al., 2008). Its four main principles are, firstly, that illness has an identifiable cause, for example, bacteria. Secondly, each illness can be defined by specific, overall agreed characteristics. Thirdly, illness is defined as a deviation from the norm, and the goal is to restore the patients' normal functions. Lastly, the Biomedical Model is defined as neutral because its diagnosis is based on rationality and objectivity (Blaxter, 2010).

There is a core of validity to the model which should not be denied. Some mental disorders do have direct physical causes. An obvious example might be brain lesions, which can cause mental disorders, such as depression or Alzheimer's disease (Bunevicius et al., 2008). However, there are strong reservations about over-reliance on the model, as it does not consider the

social, psychological, or behavioural factors of an illness (Farre and Rapley, 2017). Another common complaint is that the focus of the Biomedical Model is on the disease and not on the patient (Havelka et al. 2009). It leads practitioners to regard mental illness as brain diseases and use medication to treat biological abnormalities that are presumed, but not actually known (Deacon, 2013). Deacon (2013) criticises further that the Biomedical Model contributed to a paucity of clinical innovations and a low success rate in treating mental health issues.

The Biomedical Model can also lead to an overemphasis of the body (Thachuk, 2011). This is likely to explain the observation reported by Kleinman (1986) that Chinese have a preference for reporting somatic symptoms in connection with psychological distress and want these symptoms to be treated. The preference for reporting somatic symptoms was also found in a more recent study (Kwong et al., 2012), in which Chinese participants reported somatic symptoms (insomnia, tiredness) rather than psychological symptoms. Kwong et al. (2012) pointed out that a preference for the Biomedical Model might lead Chinese Americans to believe that only physical symptoms are worth mentioning and undervalue psychological symptoms.

Another criticism is that a pure Biomedical Model can lead to the dehumanisation of patients by health professionals (Havelka et al., 2009). For example, in Maoist China, psychiatric and behavioural interventions based on a Biomedical Model were used in prison-hospitals to gain political control (Zhang, 2014). In addition, the Biomedical Model refers to the paradigm that body and mind are regarded as two separate issues, and this contradicts research of how body and mind influence each other (Havelka et al., 2009). Similar points are made in a Chinese context. Zhang (2014) reported that Chinese therapists encourage a holistic approach, considering mind, body, and environment because the Biomedical Model cannot explain all the complexities of mental distress.

3.2.2 The Biopsychosocial model

The Biopsychosocial Model, which indicates that biological/pathological, psychological, and social/cultural processes have all an influence on illness (Engel, 1977) is based on the General Systems Theory (von Bertanlaffy, 1968). The focus of the Biopsychosocial Model is on the patient and not solely on the disease (Havelka et al., 2009). As with the Biomedical Model, the model has a clear core of validity. A UK government report concerning mental health in children (Sadler et al., 2017) reported that parent's mental health, adverse life events or social support and participation affect mental health in children. Their study's figures showed that 38.2% of children living in families with the least healthy functioning had a mental health disorder, compared to 8.3% of children in families with the healthiest functioning. Their results support the Biopsychosocial Model by underlining that social factors often play a crucial role in the occurrence of mental health issues.

However, the model can be overextended, for example, it is problematic if it deflects from treating conditions that do call for direct medical intervention (Bunevicius et al., 2008). Equally, Ghaemi (2011) regarded the Biopsychosocial Model critically as, in his view, it overemphasises the biological factor regarding mental health issues.

Yet, public reception of the model tends to be positive. McManus (2005) stated that the Biopsychosocial Model is more accepted by patients who have become dissatisfied with a pure medical model. Patients have become wary of purely pharmaceutical solutions and so alternative treatment has become more accepted (Allan et al., 2006). Acceptance of alternative treatment can also be observed in an increase of psychological self-help books in China (Liu et al., 2009). Self-help is highly regarded in Chinese culture (Sinclair, 2000), and therefore cognitive bibliotherapy can be an effective treatment for depressed adults (Liu et al., 2009).

Havelka et al. (2009) stated that the rise of chronic non-infectious diseases demands a Biopsychosocial Model rather than a pure medical approach as it supports team-work and an interdisciplinary approach. Wong and Li (2014)

suggested that the Biopsychosocial Model could also be useful for social workers assessing mental health among Chinese in Shanghai. The Biopsychosocial Model has also contributed to improved communication between health professionals and patients (Zolnierek and DiMatteo, 2009). However, Alvarez et al. (2012) noted that the Biopsychosocial Model is not a manual for mental health practice and therefore, challenging to implement.

Kwong et al. (2012) viewed the use of the Biopsychosocial Model as important in offering treatment to Chinese Americans, as it incorporates not only the medical causes of the illness but also considers social and cultural processes. Mak et al. (2014) shared a similar opinion concerning the Biopsychosocial Model in their study among Chinese in Hong Kong, showing that understanding psychosocial factors and cultural lay beliefs can influence how Chinese viewed mental illness.

3.2.3 Medical pluralism

Medical pluralism, also known as Conventional and Alternative Medicine, was developed in the UK in the late 20th century when individuals started seeking medical help outside the biomedical culture (Wahlberg, 2007). In 1986 the British Medical Association warned patients of possible risk from alternative medicines (BMA, 1986) and this led to osteopaths and chiropractors gaining recognition in 1993 and 1994 through parliamentary acts (Wahlberg, 2007). However, acupuncture, herbalists and Traditional Chinese Medicine have still not gained statutory regulation in the UK (Colquhoun, 2015). Green et al. (2006) explored how Chinese immigrant women use Western and Traditional Chinese Medicine in the UK for non-psychotic mental stress and found that they often supplemented treatment with complementary medicine. The tendency to mix Chinese and Western medication was also confirmed in a study among Chinese immigrants in the USA (Wade et al., 2007). Although results showed a preference towards Traditional Chinese Medicine, other complementary treatments were also used, such as, taking vitamins or using chiropractors (Wade et al., 2007).

3.2.4 Traditional Chinese Medicine

Traditional Chinese Medicine (TCM) is a medical system originated in China (ATCM, 2015) and can be considered as a holistic approach, integrating physiological and psychological factors with the aim of maintaining balance and the proper energy flow (Unschuld, 1987; Prior et al., 2000). TCM is based on its own diagnostic scheme and uses herbal medicine, acupuncture and a variety of mind and body practices, for example, “qi gong” (National Center for Complementary and Integrative Health, 2015). The humoral approach, which recognises the influence of certain foods on well-being, is also part of TCM and is often applied by Chinese immigrant women in daily life (Green et al., 2006). TCM’s philosophical background lies in Taoism and within TCM mental health issues are often regarded as the result of excessive emotions which can cause harm to the body and can present themselves through emotional, behavioural or somatic symptoms (Liu and Leung, 2010). In the UK, there are approximately 700 professionally qualified TCM practitioners (ATCM, 2015). Green et al. (2006) reported that although Chinese immigrants use TCM, they are nevertheless careful in selecting a TCM practitioner and often rely on recommendations from friends or family. Green et al. (2006) also found that TCM is commonly used when Western-based treatment is unsuccessful in treating health issues.

3.2.5 Somatization

Somatization is the process where psychological distress is expressed as physical symptoms. For decades somatic symptoms were regarded as a defence mechanism (Freud, 1936) and deemed as pathological (Furnham, 2015). However, more recently, Western psychotherapy has a renewed interest in the importance of the interrelatedness between body and mind (Young, 2006). Research in neurobiology further supports the interrelatedness of body and mind (Duros and Crowley, 2014) and Eastern mind-body traditions are becoming more integrated within Western psychotherapy (Mullan, 2014).

In a Chinese context, Kleinman (1979) regarded the practice of somatisation of mental health issues as "*a basic feature of the construction of illness in Chinese culture*" (Kleinman, 1979, p.146), for example, depression and anxiety disorders were not recognised as mental health issues in China before 1990 (Lee, 2011). Thus, mental health issues were, and continue to be, somatised in China (Mak and Zane, 2004). Ryder et al. (2008) suggested that one reason the Chinese prefer to describe their health issues with somatic symptoms is to avoid focusing on their emotional state. Zhang (2014) regarded the issue of somatisation critically, as it is grounded on Western thinking of the separation of body and mind. In Chinese tradition the separation of body and mind does not exist, for example, Traditional Chinese Medicine regards the "qi" flow as the connector between emotions, body, and mind (Scheid, 2013). Zhang (2014) stated further that Chinese mental health professionals seek to help clients express mental health issues beyond somatic symptoms, incorporating a holistic view.

3.2.6 Common sense model

The Common sense model (CSM), also known as Illness Perception Model or the Self-Regulatory Model, is based on the Parallel Process Model (cognitive and emotional) developed by Leventhal (1970) to investigate how individual beliefs and experiences influence illness behaviour (Leventhal et al., 1980). CSM can be divided into three stages: Interpretation (illness identity, cause, timeline, consequences, cure/controllability, illness coherence), Coping (how the individual copes with the perceived illness) and Appraisal of the coping strategies. However, Mak et al. (2014) only used the Interpretation stage of the CSM to investigate how Hong Kong Chinese understand mental illness and how the perception of mental illness influences acceptance or stigmatisation. Within interpretation, when looking at cause, results suggested that cultural lay beliefs (e.g. mental illness is a result of fate, a payback of past deeds or "feng shui") contributed to a lower rate of acceptance and higher stigmatisation. Within interpretation, controllability showed that the perception that individuals cannot control mental health issues decreased acceptance and increased stigmatisation

among Hong Kong Chinese. In addition, within interpretation, timeline and coherence revealed that if mental illness was regarded as a chronic condition and knowledge about mental illness was poor, acceptance was low, and stigmatisation increased. Mak et al. (2014) found that using CSM offered a wider-ranging framework to explore views about mental illness among Hong Kong Chinese and can contribute to developing specified psycho-education. Further research is needed to investigate all three stages of CSM and its applicability to other Chinese groups.

3.2.7 Attachment theory

Attachment theory was introduced by Bowlby (1969) and indicated that the development of attachment by an individual is connected to the quality of the relationship the person received as a child. Self-concept, emotional and social functioning as an adult can be directly related to a secure or insecure attachment style the person has experienced with their primary caregiver (Wang and Scalise, 2010). A secure attachment is connected to social competency and psychological well-being (Brennan et al., 1998; Cassidy and Shaver, 1999; Mallinckrodt, 2000). However, research has queried the uncritical transference of Western thought structures to non-Western individuals (Marsella, 2005). As a result, Wang and Scalise (2010) investigated if adult attachment research is applicable in a Taiwanese context concerning interpersonal problems and found some support for the cross-cultural applicability of adult attachment perspectives, but more research is needed concerning attachment assessment within a Chinese cultural context. Wang and Scalise (2010) caution that simply using Western attachment assessments in a Chinese context may contribute to misleading results.

3.2.8 Self-efficacy

Self-efficacy is the belief in oneself to be able to achieve something or to deal with a situation and is based on the social cognitive theory of Albert Bandura (1977). Self-efficacy can be influenced by behaviour, environment, personal and cognitive factors, and contributes to managing and mastering

tasks (Cherry, 2015). In the context of an individuals' capability of instigating and maintaining social contact, self-efficacy can be referred to as social self-efficacy (Sherer and Adams, 1983; Smith and Betz, 2000). Lin and Betz (2009) used the theory of social self-efficacy to explore how international Chinese students engage socially in their new environment. Findings showed that social self-efficacy was connected to being confident in using language skills. Social self-efficacy was high when used in a Chinese language context, but in an English language context, social self-efficacy varied depending on the confidence in communicating in a second language (Lin and Betz, 2009).

3.2.9 Acculturation

Acculturation describes the level of identity immigrants have with the host culture, and a low level of acculturation can indicate stress. Acculturation is defined as:

> "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (Berry, 2005, p.698)

Berry (2005) regards acculturation as a process to which everyone reacts differently and explains the variation by introducing the term of acculturation strategies. These strategies can be divided into two parts, attitude, and behaviour. Attitude encompasses the individual's preference of how to engage in acculturation, for example, to maintain or not maintain cultural heritage. Behaviour refers to the actual activity of the individual, for example, to engage or not engage with the host culture. However, the danger of maintaining cultural heritage and not engaging in the host culture is marginalisation (Berry, 2005). Acculturation was often used in the context of international students, for example, Wei et al. (2012) investigated 188 Chinese international students and found that there is a positive association between acculturative stress and psychological distress. However, the framework of acculturation was barely used in the context of Chinese immigrants. Therefore, more research is needed to differentiate in what way acculturation influences the life of the Chinese immigrants in the UK.

3.2.10 Summary

Mental health is a complex issue and can be understood from various viewpoints. Medical understanding of mental health is expressed in a variety of medical frameworks, for example, the Biomedical Model (Furze et al., 2008) and Somatization (Kleinman, 1979) both agree on the separation of body and mind to explain mental illness. In the Biopsychosocial Model (Engel, 1977), Medical Pluralism (Wahlberg, 2007), Traditional Chinese Medicine (ATCM, 2015) and the Common Sense Model (Leventhal et al., 1980) mental illness is conceptualised through the interrelatedness of body and mind. In comparison, Attachment theory (Bowlby, 1969), Self-Efficacy (Bandura, 1977), and Acculturation (Berry, 2005) link mental health issues to experiences in the social environment. Most of the above frameworks are general medical frameworks and apart from Acculturation theory, do not consider potential cross-cultural issues regarding mental health.

3.3 Help-seeking – theoretical frameworks of previous studies

In total, 16 out of 19 help-seeking studies reviewed, confirmed the view that help-seeking studies are often descriptive and theoretical frameworks are seldom applied (Rickwood and Thomas, 2012). Furthermore, Rickwood and Thomas noted that there is no unified help-seeking model, which is further confirmed by the wide variety of questionnaires used in the different studies. The remaining three studies (Mo et al., 2006; Mo and Mak, 2009; Kwong et al., 2012) used the following theoretical frameworks:

3.3.1 Planned behaviour theory

Mo and Mak (2009) used planned behaviour theory (Ajzen, 1991) to find out about help-seeking intentions of Chinese adults regarding mental health professionals. Results showed that, firstly, positive attitudes were strong and significant predictors for seeking help, and therefore the effectiveness of mental health services need to be promoted more (Mo and Mak, 2009). Secondly, subjective norm (how do significant others think about a person's behaviour) was another significant predictor of help-seeking intentions. This result emphasised that in collectivistic societies, where interpersonal

relatedness is highly valued, a person's help-seeking attitude is influenced by significant others in their life. Thirdly, against expectations, perceived behavioural control had limited influence on the intention of help-seeking. Mo and Mak (2009) extended the planned behaviour theory framework by exploring perceived practical barriers such as access to information, affordability, and suitability regarding mental health services. By extending the framework, an indication that social-cognitive factors influence help-seeking intentions was found.

3.3.2 Transactional stress-coping model

The transactional stress-coping model (Lazarus and Folkman, 1987) is a framework to appraise coping in stressful situations. First, the importance of a stressful situation is appraised, which is followed by an assessment of available coping resources and options (Lakey and Cohen, 2000). Mo et al. (2006) referred to this framework to examine the contribution of acculturation, enculturation, and acculturative stress relevant to help-seeking from formal and informal sources among mainland Chinese immigrants in Hong Kong. While the study did not use the terminology of the stress-coping model, the primary appraisal was that acculturative stress and general stress caused poor mental health (Mo et al., 2006). The secondary appraisal showed that seeking help from social workers were positively viewed, but informal sources were still used by most of the participants (Mo et al., 2006).

3.3.3 Explanatory model interview catalogue

The third theoretical framework is the Explanatory Model Interview Catalogue (EMIC), which is an empirical method to investigate the influence of culture regarding medical and psychiatric illnesses (Weiss, 1997). EMIC is advantageous because it has produced a database of several explanatory models, which enables comparisons in cross-cultural research (Raguram et al., 1996; Yeung et al., 2004; Okello and Neema, 2007). Kwong et al. (2012) used an adapted version to explore cultural barriers to mental health treatment among Chinese Americans and potential solutions. Results showed that somatisation and inconvenience and lack of time were the main

contributors for not seeking help from mental health professionals. Seeking informal help and the use of general health care were the preferred ways to overcome mental health issues.

3.3.4 Summary

The exploration of three different theoretical frameworks concerning help-seeking highlighted three ways to utilise theoretical frameworks in research: extending, applying or adapting. For example, Mo and Mak (2009) extended the Planned Behaviour framework to include barriers to help-seeking. Mo et al. (2006) applied the goal of the transactional stress-coping model to appraise coping in a stressful situation, without using the specific terminology of the transactional stress-coping model and Kwong et al. (2012) adapted the Explanatory Model Interview Catalogue as an interview guide to explore in Chinese Americans cultural barriers to help-seeking. Awareness of how different studies have used or adjusted theoretical frameworks has also helped to develop a suitable theoretical framework for the current study.

3.4 Counselling – theoretical frameworks of previous studies

Counselling can be categorised in three main counselling approaches: 'cognitive behavioural', 'humanistic' and 'psychodynamic'. Some of the 28 studies which focus on counselling issues can be categorised either in cognitive-behavioural approaches, for example, Cognitive Behaviour Therapy (Hwang et al., 2006; Shen, E. et al., 2006; Foo and Kazantzis, 2007; Gallagher-Thompson et al., 2007; Liu et al., 2009; Hwang et al., 2015) or humanistic approaches, for example, person-centred therapy (Ng et al., 2012). Psychodynamic approaches were not mentioned, however, various other counselling approaches were described, such as integrative approach (Ng et al., 2012), family therapy (Soo-Hoo, 2006; Huang et al., 2006; Kuo et al., 2011; Sze et al., 2011; Zhang, 2014) multicultural counselling (Kuo et al., 2011; Wang and Heppner, 2011; Choi et al., 2012; Chan et al., 2014). In addition, two more theories vital to the overall application to counselling were also identified, firstly, within a multicultural context, the theory of culture and self (Wei et al., 2013) and secondly, the therapeutic relationship (Ng and

James, 2013; Lei and Duan, 2014). Detailed below are descriptions of each of these counselling approaches and theories.

3.4.1 Cognitive behaviour therapy

Ellis (1996) and Beck (1976) are regarded as the founding fathers of Cognitive Behaviour Therapy (CBT). However, others such as Meichenbaum (1977), Lazarus (1971), Greenberger and Padesky (1995) and Young (1990) also influenced the development of CBT and contributed to the great diversity of CBT approaches (Corey, 2001). There are at least five common factors which unify the various CBT approaches: a collaborative relationship between client and therapist; the understanding that unbalanced cognitive processes cause psychological distress; changing negative thought patterns affects changes in mood and behaviour; time-limited treatment and psycho-education (Corey, 2001). The application of CBT within a Chinese context was previously discussed in the literature review (section 2.6.3.1).

3.4.2 Humanistic approach

The humanistic approach is defined by its capacity to include a great variety of concepts. Woolfe et al. (2003) state four central themes that define the humanistic approach. Firstly, it is not rooted only in psychology, but also develops approaches which can be linked to literature, the arts or philosophy. Secondly, the humanistic approach focuses on functioning and not on pathology. Thirdly, the individual 'self' is in the centre, and fourthly it does not claim one truth but relies on a '*loosely connected network of ideas'* (Woolfe et al., 2003, p.141). Humanistic counselling approaches include Gestalt Therapy (Perls et al., 2011), Emotion-Focused Therapy (Greenberg, 2001) and the Person-centred approach (Rogers, 1951). The Person-centred approach emphasises a non-directive approach, based on the core conditions of empathy, congruence, and unconditional positive regard (Rogers, 1951). Rogers' core conditions have become a vital element in any form of counselling approaches. Rogers regarded the client as trustworthy, capable of understanding themselves and being able to solve their problems without direct therapist advice (Corey, 2001). However, the therapist

supports the client indirectly through their non-judgemental attitude and so enables self-growth within the client to become "*the self that one truly is*" (Rogers, 1961, p.163). Therefore, the therapeutic relationship takes centre stage in this approach, where the client, not the therapist is the expert. The application of humanistic approaches within a Chinese context was previously discussed in the literature review (section 2.6.3.2).

3.4.3 Integrative approach

An integrative approach can be defined as a combination of different theories and techniques to have clients benefit from various approaches and perspectives (Arkowitz, 1991; Corey, 2001). Counsellors have become more open to an integrated approach as it is more and more recognised that one single counselling approach is often not adequate to support the diverse needs of clients and the multitude of counselling issues (Corey, 2001). Arkowitz (1997) described three different kinds of integration: technical eclecticism, theoretical integration, and common factors integration. Technical eclecticism uses different techniques and approaches without providing a theoretical context, whereas theoretical integration focuses on creating a new approach by combining two or more theories. Common factor integration emphasizes the uniting factors between different therapies and uses them to benefit therapeutic outcomes (Corey, 2001). Family therapy and multicultural approaches can be considered as integrative approaches and are examined in the following sub-sections.

3.4.3.1 Family therapy

Family therapy evolved from research in psychiatry in the 1950s as a treatment method regarding schizophrenia. In the 1960s, Satir (1964) and Ackerman (1966) were leading researchers to develop family therapy further and promoted that effective interventions in psychotherapy can only be achieved by acknowledging the family, group or community that the individual is connected to (Glick et al., 2000). In the 1970s, family therapy expanded further resulting in four major groups: affective-experiential (Satir, 1972; Satir, 1982), structural (Minuchin, 1974; Minuchin et al., 1978),

strategic (Haley, 1973; Haley, 1980; Haley, 1984) and Milan-style systemic family therapy (Selvini et al., 1980). By the 1980s, family therapy was no longer regarded as a major treatment for schizophrenia, as it was replaced by psychopharmacological treatment. Nevertheless, by that time family psycho-education was well established and expanded to include issues of gender and culture, which for the first time highlighted the diversity of family life in different ethnic groups (Glick et al., 2000). Zhang (2014) explored the importance of Satir family therapy within a Chinese context and concluded that it fits well to Chinese society as it focuses on improving family dynamics. The application of family therapy within a Chinese context was previously discussed in the literature review (section 2.6.3.3).

3.4.3.2 Multicultural approach

Multicultural counselling has numerous theoretical frameworks and definitions. Pedersen (1994) defined a multicultural counselling framework not just in cultural terms (ethnicity, nationality, religion, language), but also included demographic variables (age, gender, location), status variables (social, educational, economic) and affiliations (family, organisations, lifestyle). Furthermore, to Pedersen (1994), multiculturalism does not only exist outside a person but also inside a person. This insight links him to Sue et al. (1996) who proposed a theory of multicultural counselling and therapy, asking counsellors to challenge unacknowledged assumptions, which inform their counselling practice, for example, individualism as an ultimate core value instead of collectivism. Ivey et al. (1997) showed that all helping methods occur within a cultural framework, and therefore cultural concerns need to be considered in counselling practice.

The multicultural approach benefits from the integrative perspective as it can adapt cultural specifics to theoretical frameworks. Counselling cannot be effective without considering culture-specific issues (Leung and Chen, 2009; Kuo et al., 2011) and more culture-specific models need to be developed (Duan et al., 2011). The application of multicultural approaches within a Chinese context was previously discussed in the literature review (sections 2.6.2 and 2.6.3.3).

3.4.4 Culture and self

Markus and Kitayama's (1991) theory on culture and self explores the difference between independence and interdependence of the individual. The concept that the individual is independent of others and defines themselves according to their inner thoughts, feelings and actions is found in various degrees, mainly in Western cultures. In counselling, this is expressed in terms like "*self-actualisation*" or "*developing one's distinct potential*" (Markus and Kitayama, 1991, p.226). However, interdependence defines the individual according to the relationships they have to each other and is often found in Asian or other non-Western cultures. Interdependence is the building stone for a collectivistic society. These two different concepts can influence social behaviour. Wei et al. (2013) examined the relationship between suppression and interpersonal harmony in a cross-cultural context between Chinese and European American. The findings showed that emotional suppression was valued among the Chinese population as it contributed to maintaining interpersonal harmony, which is an important value in an interdependent society. Whereas the result among European Americans showed that suppression was still regarded as harmful and connected to negative behaviour and attitudes as interpersonal harmony is not necessarily highly regarded in an individualistic society (Wei et al., 2013).

3.4.5 The therapeutic relationship

There is consensus that irrespective of the counselling model, the therapeutic relationship plays a central role in achieving a positive outcome (Mallinckrodt, 1993; Assay and Lambert, 1999; Cooper, 2008). Lei and Duan (2014) explore the therapeutic relationship using Bordin's theoretical framework. Bordin (1979) offered a theoretical framework to explore the client-counsellor relationship by dividing the working alliance into three areas: Bond (client/therapist emotional connection and attachment), Goal (expected outcomes agreed by client and therapist) and Task (agreement between client and therapist how to achieve goals). Lei and Duan (2014) explore the therapeutic relationship using Bordin's theoretical framework to explore how intellectual and empathic emotion influences the working alliance in

counselling in China. Findings showed that the length of the therapy and Bond had the most effect on the working alliance, whereas Goal and Task did not show the same effect. Lei and Duan (2014) suggest that establishing an affective Bond is rooted in counsellors' personalities and cannot be as easily trained as Goal and Task. Emotional empathy was more important than intellectual empathy to establish Bond as emotional empathy influenced client willingness to accomplish Goal and Task. Among Chinese clients Goal and Task is often not differentiated but contributes as one element to the working alliance. However, Hsu et al. (2016) questioned the use of Bordin's theoretical framework of Bond, Goal and Task. Hsu et al. (2016) used the short form of the Working Alliance Inventory (WAI-S) by Tracey and Kokotovic (1989) to investigate its applicability to explore the therapeutic relationship in a Hong Kong setting. Confirmatory and exploratory factor analysis was applied to explore if Bond, Task and Goal are separate factors which influence the therapeutic relationship. They concluded that there is not enough evidence for a three-factor model because Bond, Goal and Task are too interdependent. Hsu et al. (2016) suggested a one-factor-model to explore the therapeutic relationship, based on nine relevant items from the WAI-S, which are meaningful in a Hong Kong context. Frameworks to measure the therapeutic relationship need to be adjusted to different cultural settings, and further studies are required to explore which kind of frameworks are most suitable to explore the therapeutic relationship.

3.4.6 Summary

The above theoretical frameworks are based on the main counselling theories found in the 89 studies examined in the literature review. Within a cross-cultural context, the various counselling theories such as cognitive behavioural theory (Beck et al.,1979), person-centred approach (Rogers, 1951), family therapy (Satir, 1964) all benefit from a multicultural framework (Pedersen,1994) and this highlighted the importance of using a multicultural framework for this study. The theory of culture and self (Markus and Kitayama, 1991) stresses the importance of applying cultural frameworks for a clearer understanding of clients' cultural roots. Acknowledging the value of

the therapeutic relationship also indicated that relational connections need to be included in the theoretical framework for this study.

3.5 Theoretical framework for the current research study

The background to this study was an observation that arose from professional experience that Chinese people seldom seek counselling. After completing a literature review with a systematic approach based on 89 papers, the research question, aim, and objectives were refined. The function of the theoretical framework review was to identify a framework in which to conduct this study. Initially, a multicultural framework was considered to allow mental health, help-seeking, and counselling theories, to be considered within different cultural contexts. The relevant theoretical frameworks from the 89 papers were discussed in sections 3.1.to 3.4. and provided important insights into the development of frameworks as each author extended, adapted, or integrated frameworks. The counselling frameworks in section 3.4 also highlighted the need to expand Western theories to include multicultural frameworks. However, in isolation, none of the frameworks from the 89 papers adequately reflected the aim and objectives of the current study, which intends to not only address counselling related issues but also explore perceptions of mental health and help-seeking among the Chinese community. This analysis indicated that a new theoretical framework was needed to provide a more comprehensive framing to the research question, aim, and objectives of the current study.

3.5.1 Multicultural humanistic framework

A theoretical framework has been developed, which draws on key concepts from multiculturalism and humanistic frameworks relevant to mental health, help-seeking, and counselling. A multicultural humanistic framework is suitable for the current study as it provides a broad framework to explore the perceptions of the Chinese community. An exploration of how multiculturalism and humanism are understood in the current study follows in the next two paragraphs.

Multiculturalism, defined as the co-existence of diverse cultures, has always existed as a societal phenomenon (Kymlicka, 2010). Multiculturalism can be defined by ethnicity, race, gender, religion or sexual orientation (Gutmann, 2001) and is frequently regarded as the opposite idea of the 'melting pot' because it proposes the integration of cultural and religious diversity rather than assimilation into the main culture of a country (Song, 2016). According to Lago (2011), issues relating to race and ethnicity are often neglected in counselling research and cross-cultural psychology emerged only in the late 1950s (Jahoda, 1970). In a counselling context, Pedersen (1994) defined a multicultural counselling framework not just in cultural terms (ethnicity, nationality, religion, language), but also included demographic variables (age, gender, location), status variables (social, educational, economic) and affiliations (family, organisations, lifestyle). To Pedersen (1994) multiculturalism not only exists outside a person but also inside a person. Therefore, within counselling, multiculturalism needs to be considered from both an interpersonal and an intra-personal viewpoint.

The term '*humanistic*' in this theoretical framework is derived from a wider philosophical viewpoint (Schafersman, 1998). Humanism is intended to be non-dogmatic and constantly adapting to the world (The Pluralism Project, 2016). In humanism, all people have equal moral worth and aim to work together for a better future. Ideas, based on the Enlightenment, are used to achieve these principles, for example, reason is the appropriate tool to achieve changes in society (The Pluralism Project, 2016). Different forms of humanism can be found, such as cultural humanism, modern humanism, and secular humanism (Edwords, 1989). Humanism can be defined as

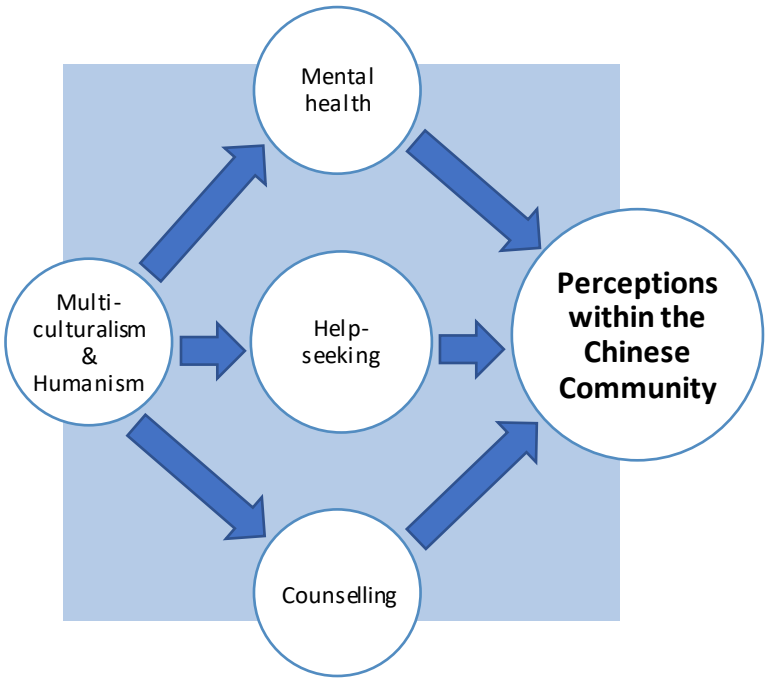
> "a progressive philosophy of life that, without supernaturalism, affirms our ability and responsibility to lead ethical lives of personal fulfilment that aspire to the greater good of humanity." (American Humanist Association, 2020).

Humanism is also expressed in psychology when it emphasizes the relationship human beings have to the world they live in (Spiers, 2001). The relationship human beings have with the world was explained by Buber (1923) in two terms: the I-Thou and the I-It relationship. The I-Thou

relationship can only be understood and experienced in the 'here and now' when one person encounters another person. It is in this encounter of two people, when "I" meet "you", that humans become human. This interpersonal relationship is expressed in words, looks, emotions and how one relates to each other. The I-It relationship refers to the relationship a person has with their environment and the objects of this environment. The I-It relationship is part of any person's life, but if this is the only relationship a person lives in, then the person cannot become truly human (Waldl, 2005). Thus, Buber extrapolated the concept of dialogue between I-Thou and I-It, which influenced and confirmed humanistic psychology and coined phrases and principles like, immediacy, dialogue, here and now, relationship skills and personal responsibility (Waldl, 2005).

This multicultural humanistic framework reflects the research aim and the research question of the current study and **Figure 3** provides a graphical presentation that multiculturalism and humanism relate to mental health, help-seeking, and counselling and influence the perceptions within the Chinese community. **Figure 3** is followed by an explanation of how multiculturalism and humanism are reflected in the current study.

Figure 3: Multicultural humanistic framework for the current study



Multiculturalism and humanism are both broad terms and are suitable to cover the aim and objectives of the current study. This multicultural humanistic framework covers the participants, the Chinese community in NI, and the dialogue of I-Thou and I-It through exploring how the Chinese community relates to mental health, help-seeking, and counselling.

Pedersen's (1994) definition of multiculturalism applies in cultural terms as the Chinese community in NI is itself a diverse community, originating from different countries, cultural backgrounds, and languages. The participants' countries of origin in my research study were mainland China, Hong Kong, Taiwan, Singapore, Malaysia, and the UK reflecting the diversity of this ethnic minority, with different cultures and languages. Pedersen's (1994) demographic variables of age, gender, and location is also reflected in a wide age range of participants, there were male and female participants, and participants came from different locations in NI. The status variable was not as varied, as most participants had tertiary education, but there was still a range of social and economic diversity. Pedersen's (1994) affiliation variable was reflected in various marital status and different lifestyle choices and took into consideration that family and friends can play a vital part on perceptions of mental health, help-seeking, and counselling. The Chinese community is part of the multicultural society in NI, but multiculturalism also plays a role in each Chinese person's perception.

Humanism brings into focus that human beings are always related, either to someone or something. This interrelatedness can be used to explore the different perceptions that individuals have within society or to achieve changes in society. In humanism, dialogue is the means of understanding oneself and others and allows connection to the world we live in. In the current study, this dialogue takes place on an I-Thou level, both between the researcher and the participants and between the participants and the Chinese community. Furthermore, the dialogue also takes place on an I-It level, as an exploration of how the Chinese community relates to their environment. This study aims to improve, albeit in a small way, the future of the Chinese immigrant population by exploring their perceptions of mental

health, help-seeking, and counselling. The knowledge of their perceptions could be then used as a foundation for further research, but also as a basis for recommendations how these perceptions could influence practical adjustments within the health services, for example, access and use of counselling services. Improving the Chinese community's position within the health service relates to one goal of humanism, which is to work together towards a better future.

3.6 Conclusion

The previous 89 studies of the literature review found a wide variety of theoretical frameworks and different ways of applying a theoretical framework to a study. However, the individual theoretical frameworks used in previous studies could not contain the aim and objectives of the current study, and therefore, a wider theoretical framework was needed. A multicultural humanistic framework seemed appropriate as the participant group is an ethnic minority (the Chinese community) which live in a Western society (NI). Multiculturalism is based on a definition by Pedersen (1994), which includes not only cultural terms but also demographic and status variables, as well as affiliations. Humanism with its wide range of definitions and understandings focuses in the current study on secular humanism with Buber's (1923) concept of dialogue between I-Thou and I-It to explain the relationship human beings have to the world they live in (Spiers, 2001). As Chinese society is a collectivistic society, a theoretical framework which also considers relational connections, such as humanism, is a suitable framework for the current study.

This multicultural humanistic framework provides the background for the qualitative research approach explored in the following methodology chapter of the current study.

Chapter 4: Methodology

This chapter presents the methodology for this study and is organised into ten sections. Section 4.1 explains the research design, including reasons for choosing qualitative research, providing a description of Interpretative Phenomenological Analysis (IPA) and explaining reasons for using an IPA approach. Section 4.2 provides an outline of the participants, including sampling method and sample size. Section 4.3 describes the recruitment process. Section 4.4 covers data collection tools and section 4.5 data-collection procedures. Section 4.6 describes the ethical considerations of the current study. Section 4.7 considers cross-cultural issues, such as cultural sensitivity and section 4.8 consist of a reflexive analysis statement of the researcher. Section 4.9 describes the data analysis process in eight steps, and section 4.10 examines the validity of the study, followed by conclusions.

4.1 Research design

In the social sciences, two main types of research methodologies are quantitative and qualitative. Quantitative research aims to test objective theories by comparing the relationship among variables by measuring numbered data analysed through statistical procedures and is often applied as an experimental or survey design (Creswell and Creswell, 2018). Qualitative research aims to generate theory out of research and has a strong interpretivist and constructivist stance (Bryman, 2015) and therefore emphasises the inclusion of the voices of participants, the reflexivity of the researcher and the application of hermeneutics (Creswell, 2013). Based on Braun and Clarke's (2013, p.4) differentiation of the two research methods, the main differences between quantitative and qualitative research in social sciences are listed in **Table 3**.

Table 3: Differences between qualitative and quantitative research in social science (Braun and Clarke, 2013, p.4)

Quantitative research	Qualitative research
Uses numbers	Uses written and spoken language
Identifies relationships between variables – aims to generalise results	Understands and interprets meaning, focuses on context. Generalising findings can happen but is not the first aim
Generates broad data from a larger participant number	Generates rich data from a smaller participant number
Seeks consensus, norms, or general patterns	Also seeks patterns, but highlights differences and divergences
Mostly deductive – theory testing	Mostly inductive – theory generating
Objective	Subjective and reflexive

Research uses numbers and categories in many ways. However, in social science, the distinction is commonly linked to different research paradigms. The differences between them are not simply a matter of the descriptions they use, quantitative and qualitative. The paradigms also differ with respect to epistemological and ontological positions (Bryman, 2015), where epistemology relates to how we seek to understand social phenomena in the world, while ontology relates to how we view the world. In social science, the major quantitative research paradigms focus on testing theory and being deductive, while the major qualitative paradigms are inductive, and aim to generate new theory.

The research aim and objectives of the current study required insights into the experiences and thoughts of the members of the Chinese community. Therefore, due to its inductive approach and epistemological and ontological positions, qualitative research was selected. An inductive approach allows new theories to be developed from research (Bryman, 2015), which is especially useful in under-researched areas, as it can better focus on individual experiences or circumstances and provide more opportunities to communicate sensitive issues (Davies et al., 2009). The literature review

showed that mental health, help-seeking, and counselling among the Chinese community is under-researched, and only 24 of the 89 studies in the literature review were qualitative. The inductive nature of qualitative research is also beneficial in a fast-changing world that is increasingly diverse and where local knowledge and practice need to be studied (Flick, 2002). This is particularly fitting for Chinese society, which has undergone significant social change in recent decades. These changes are reflected in the Chinese communities overseas, for example, in Northern Ireland (NI) the Chinese community, which consisted mainly of Hong Kong Chinese, has become more diverse, with more immigrants from mainland China, Taiwan and Malaysia.

The epistemological position emphasises understanding of the social world (Bryman, 2015), which, in the current study, focuses on the Chinese community. In qualitative research, understanding the social world is achieved by interviewing and observation (Denzin and Lincoln, 2012). As there are few studies about the Chinese community in NI, qualitative research was recognised to be instrumental in giving participants a voice. In addition, qualitative research can also be used to explore how participants interpret their experiences (Corti and Thompson, 2004). Padgett (2008) and Bryman (2015) suggested that qualitative research methods allow participants the space for deeper communication about their situation and its significance for them. Furthermore, qualitative research not only focuses on the participants but also considers

> "the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry" (Denzin and Lincoln, 2012, p.17).

Thus, qualitative research focuses on the processes, meaning and context in which participants' experiences occurred (Denzin and Lincoln, 2012).

The ontological position considers that interactions between individuals influence social behaviour (Bryman, 2015). Qualitative research also provides theories of positivist views, whereby reality can be fully understood, and post-positivist views, whereby reality can never be fully understood

(Guba, 1990). This is important because the current study is also a cross-cultural study where reality is experienced from different backgrounds and understandings. In addition, qualitative research studies are often emic, which means that behaviour is seen from the perspective of cultural insiders (Morris et al., 1999) thus tying in with the aim of this study which is to explore the perceptions of mental health, help-seeking, and counselling of the Chinese community in NI.

From the literature review, additional reasons for using a qualitative approach were identified, for example, Liamputtong (2010a) stated that qualitative research is ideal for exploring experiences of specific groups in society as participants can express themselves freely. Sproston et al. (1999) viewed qualitative research as flexible and adjustable to the complex belief systems about health and mental health of the Chinese population. Tang et al. (2012) regarded qualitative research as enabling a more in-depth analysis and a deeper understanding of cross-cultural viewpoints concerning mental health issues. These reasons aligned with the objectives of the current study and underlined that qualitative research could be used to gain new insights into the experiences and perceptions of the Chinese community in NI.

During the process of selecting a suitable qualitative approach for the current study, the researcher also considered what tools to use for data processing, for example, NVivo or Microsoft Word. The researcher decided to use Microsoft Word as she had previous experience of using it and could use it to develop an individual audit trail of the data analysis (section 4.9).

Qualitative research offers a variety of paradigms and criteria, leading to different qualitative research approaches (Creswell, 2007; Tracy, 2010). The main qualitative research approaches used in psychotherapy and counselling studies were categorised by Dallos and Vetere (2005) as interpretive theme analyses, discursive methods, narrative analysis, qualitative observation, and case study. A modified summary of these five qualitative approaches is provided in **Table 4**:

Table 4: Five approaches of qualitative research (modified from Dallos and Vetere, 2005)

Approach	Aims	Types
Interpretative theme analysis	Understanding and representing participants' point of view. Extraction of major themes and issues of participant data	Grounded Theory Thematic Analysis Interpretative Phenomenological Analysis
Discursive methods	Exploring the discursive position of participant and researcher Language is regarded as constitutive and constructive Researcher interested in all forms of talk and text	Discourse analysis Rhetorical analysis
Narrative analysis	Exploration of meaning in participants' lives through stories and accounts Focus on feelings and experiences Provide ideas of causal events	
Qualitative observation	Focus on social behaviour through verbal and non-verbal interactions	
Case study	Focus on clinical work to investigate the process of clinical change and intervention	

This summary of aims of the various qualitative research approaches highlights that discursive methods (Whetherell et al., 2001), narrative analysis (Mishler, 1986; Riessman, 2008), qualitative observation (Dallos and Vetere, 2005) or case study (Stake, 2006) would not have been suitable for the current study. The underlying concepts of discursive methods, for example,

> "to claim an identity as an individual, and to explain or account for one's action" (McLeod, 2011, p.181)

would not meet the research aim of the current study. Narrative analysis, with its emphasis on the participant's story, would have ethical implications, as it would be challenging to retain participant anonymity. As qualitative observations and case study are typically longitudinal, these approaches were ruled out as the current study was cross-sectional. Therefore, interpretative theme analyses, with its stance on understanding and representing the participant's point of view, was selected and grounded theory, thematic analysis and interpretative phenomenological analysis investigated.

Grounded theory, originally developed by Glaser and Strauss (1967), is an inductive approach which builds theory rooted in the data. Grounded theory is sometimes regarded as the grandparent of most qualitative research methods (Watts, 2019) and in its beginnings had positivist overtones as Glaser and Strauss (1967) argued for a

> "straightforward relationship between objects in the world and our perceptions of them." (Denicolo et al., 2016, p.145).

In its original form grounded theory aims to collect data in at least two phases, an inductive process used as a discovery phase and a deductive process to clarify themes discovered in the first phase (Timonen et al., 2018). Different versions of grounded theory have since developed, for example, Charmaz (2000; 2006) changed the epistemological position by extending grounded theory with a constructivist viewpoint, acknowledging the researcher's influence on how data is understood and adding an interpretative angle.

Due to its versatile epistemological position, grounded theory was initially considered as a possible research method for the current study but was ruled out as the two-phase data collection method required an extended data collection process, which was not practical within the time constraints of the participants and this study. Furthermore, the aim of this study is not to derive a model or a theory but is intended to be exploratory and gain an

understanding of participants' perceptions of mental health, help-seeking, and counselling.

Thematic analysis is applied for categorising qualitative data and theme identification and occurs in multiple forms, for example, as template analysis (King, 2004). Thematic analysis gained new momentum when Braun and Clarke (2006) clarified each step of thematic analysis and added an ontological approach by acknowledging the interpretivist position of the researcher (Denicolo et al., 2016). Although thematic analysis is a valuable method for analysing qualitative data Braun and Clarke (2013) identified possible limitations of thematic analysis, for example, not offering continuity and contradictions within individual accounts and therefore not highlighting individual participant voices. As the current study wanted to ensure that the individual participant voices were clearly expressed this led the researcher to Interpretative Phenomenological Analysis (IPA), described below.

4.1.1 Interpretative phenomenological analysis

IPA is a qualitative research design developed by Smith (1996). The centre of any IPA study is to focus on how participants engage with the world. IPA aims to understand the lived experience of the individual and how the individual makes sense of their experience. IPA contains epistemological views that are how we seek to understand social phenomena in the world, and ontological views, relating to how we view the world. IPA is underpinned by three major areas of philosophy: phenomenology, hermeneutics, and idiography (Wagstaff et al., 2014).

4.1.1.1 Phenomenology

Phenomenology describes the experience of everyday life for the individual. At first glance, this sounds straightforward, however, there are various approaches to understand the description and meaning-making of any experience.

Husserl (1859-1938) promoted a transcendental phenomenology which focused on the essence of an individual experience which would not be

distorted by the researcher's own experiences or judgements and would allow the true phenomena to emerge (Moustakas, 1994; Smith et al., 2009). He also emphasised the epistemological side of phenomenology, for example, perception, awareness, or consciousness (Smith et al., 2009).

In contrast, Heidegger (1889-1976) underlined the ontological view (van Manen, 2011), acknowledging that the individual is a relational being and always involved in the world and thus can only be understood if the context they live in is also taken into consideration. Heidegger's understanding of phenomenology is described as existential phenomenology as he examines phenomena as it appears but remains aware that there is a deeper meaning to the obvious appearance of the phenomena which can be further revealed using hermeneutics.

Another existential phenomenologist Merleau-Ponty (1908-1961) focused on embodiment, emphasising that behaviour and conduct are expressed through the body of the individual. He also observed that no matter how much empathy one shows another person, there would never be a complete understanding, as there is a difference of experience between the one who lived through the experience and the researcher who observed or listened to the experience (Merleau-Ponty, 1962).

Sartre (1905-1980) expanded the understanding of existential phenomenology by emphasizing that the individual is not a finished project to be discovered, but rather someone who constantly develops (Sartre, 1948). Furthermore, the individual is not only defined by the social context in which they live, but also by what is missing from their social context (Sartre, 1956).

Husserl, Heidegger, Merleau-Ponty and Sartre are the core contributors to phenomenology and thus provide the theoretical basis for the phenomenological aspect of IPA, for example, the focus on experience and its perception (Husserl), the relatedness-to-the-world (Heidegger), the importance of the body as a vital part in experiences (Merleau-Ponty) and Sartre's view that personal and social relationships influence our experiences (Smith et al., 2009).

IPA has adapted some of these phenomenological approaches, for example, the emphasis on reflexivity is based on Husserl's idea of bracketing one's presumptions. The importance of contextualising during data analysis can be connected to Heidegger's understanding that the individual is always in context to someone or something. Merleau-Ponty's focus on embodiment provides the background for idiographic accounts to give voice to the participants, while Sartre's view of the constantly developing individual reflects the iterative nature of the analysis process within IPA.

4.1.1.2 Hermeneutics

Hermeneutics can be defined as the theory of interpretation of texts, human actions or other meaningful material and their meaning (Mantzavinos, 2016). Hermeneutics became mainly known through Schleiermacher (1768-1834), a theologian and philosopher, who applied it to biblical texts. Heidegger and Gadamer widened the use of hermeneutics by applying it to non-biblical texts. Hermeneutics is an essential part of IPA as phenomenological research also aims to

> "construct a possible interpretation of the nature of a certain human experience." (van Manen, 1990, p.41)

According to Smith et al. (2009), Schleiermacher's understanding of interpretation is relevant to IPA as it offers a holistic view, linking linguistic analysis with psychological analysis (Cassidy et al., 2011). Schleiermacher's understanding not only enables an interpretation of a text but also discloses a deeper meaning of which the originator of the text might have been unaware. As a phenomenologist, Heidegger realised that phenomenology and hermeneutics work together as the hidden meaning of phenomena could be found through interpretation of the text (Moran, 2000).

As an interpreter, the researcher needs to consider that, according to Heidegger, interpretation cannot be totally unbiased because interpretation is always influenced by the past experiences and presumptions of the interpreter (Heidegger, 1962), which can be described as fore-conceptions. At the same time, by engaging with a text, new fore-conceptions can be

revealed to the researcher. Gadamer, a student and colleague of Heidegger, explained that the researcher, who wants to identify meaning from the text, does not deal with only one fore-conception. For Gadamer, fore-conceptions can replace each other, contradict each other, or change during the process of examining a text to find its meaning. "*A person, who is trying to understand a text is always projecting*" (Gadamer, 1960, p.267) and therefore, the researcher needs to be aware of their bias so they can be receptive of the meaning of the text (Gadamer, 1960). If the researcher is aware of the cyclical process of their fore-conceptions, they can make clearer interpretations by considering how and if their fore-conceptions have influenced data or where the data has revealed their unknown fore-conceptions. In the context of an IPA study, this also highlights the importance of reflexive practice while interpreting data.

4.1.1.3 Idiography

Idiography focuses on specific cases, experiences, or events. An idiographic approach pays attention to the uniqueness of an experience and is not interested in empirical measurements. Idiography is not concerned with constructing generalisations but is about finding the deeper meaning of each case, experience, or event through analysis. Idiography supports IPA's main goal of capturing specific experiences encountered by individuals and is useful for the small sample sizes often found in IPA studies.

IPA gives voice to the participant by capturing and reflecting what the participant has disclosed. IPA is written as a descriptive narrative but can be developed into an interpretative narrative by making sense of the participants' experiences through the researcher's interpretation, evidenced by the data and by applying psychological theories (Larkin et al., 2006; Smith et al., 2009). Furthermore, Larkin and Thompson (2012) emphasise that balancing giving voice and making sense will aid an explanatory narration. Researchers are aware that subjectivity plays a role in how data is analysed and interpreted, and so IPA studies are frequently written in a first-person account.

4.1.1.4 Reason for using an IPA approach in the current study

The current study is a cross-sectional, qualitative research study, which employs an Interpretative Phenomenological Analysis (IPA) approach. IPA, with its focus on participants' experiences, allows the research aim and objectives of the current study to be met. IPA offers a holistic approach to data analysis, which Smith et al. (2009) divided into three steps. Firstly, a systematic and detailed analysis of the text, secondly, an examination of a larger data set to reveal new connections and finally applying psychological theory to gain further insights or perspectives (Smith et al., 2009). Initially, IPA was mainly used in UK health psychology, but it has since been applied to various disciplines and cultures (Smith, 2011; Wagstaff et al., 2014) and therefore can also be applied within a Chinese community context. IPA is increasingly used in counselling and psychotherapy research and is useful in describing the different experiences among participants (McLeod, 2011).

As the current study uses a qualitative approach IPA, which is underpinned by phenomenology, hermeneutics, and idiography, it reflects the epistemological and ontological positions of qualitative research. Phenomenology allows that participants can share new and unanticipated experiences and contributes toward an inductive approach where new themes can emerge. Through its descriptive character, IPA produces thoughtful accounts of the participants and gives a "*faithful account*" (Smith et al., 2009, p.135). This is especially useful in under-researched areas as it gives voice to specific experiences.

The hermeneutic character of IPA enables the researcher to uncover the deeper meaning of the data by not only describing the participants' experiences, but also considering their understanding of the data and, where applicable, applying psychological theories. Heidegger's ontological viewpoint, which acknowledges that the interpreter's experiences influence how phenomena are understood (Bradbury-Jones et al., 2009), provides the theoretical underpinning for the researcher's awareness of bias. Furthermore, as the current study is cross-cultural, Merleau-Ponty's (1962) observation that there is never a complete understanding of the other person, contributes

toward the researcher's awareness that an understanding of another cultural view is only partially achievable and helps avoid rash generalisations based on the researcher's experiences.

The idiographic nature of IPA validates each participant's contribution, enabling the researcher to base findings on each participant's specific experiences. Furthermore, the researcher's role and continued development while conducting the research found expression in reflexive analysis (section 4.8). Reflexive analysis also builds on Sartre's observation that the individual is developing throughout their lifetime.

4.2 Participants and sample size

For the current study, 30 participants were recruited from the general population of the Chinese community in NI for face-to-face interviews. Participants were selected using purposive and snowball sampling (Bryman, 2015). The use of purposive sampling ensured that the research aim was in mind while choosing participants. Further, purposive sampling facilitated variety in the sample and adhering to the inclusion and exclusion criteria (**Table 5**).

Table 5: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Ethnic Chinese, including China, Hong Kong, Vietnam, Singapore, Malaysia & Taiwan 1st & 2nd generation immigrants Resident in NI for at least two years Conversational English Providing consent	Under 18 years of age Currently using psychiatric services

Purposive sampling is a non-probability sampling form to strategically select a diversity of participants within a certain characteristic, for example, ethnicity, which is pertinent to the research question and research goal. (Bryman, 2015; Creswell and Poth, 2018). Non-probability sampling approach does not allow generalisation (Bryman, 2015). Purposive sampling can be applied in

quantitative and qualitative research using various methods, for example, quota sampling in quantitative research, whereas theoretical or snowball sampling is applied in qualitative research (Bryman, 2015). In the current study, snowball sampling was applied, which is often used with populations which are difficult to approach (Matthews and Ross, 2010). Snowball sampling accumulates participants by valuing each participant as a source for a further participant (Baker, 1999) therefore, enabling a wider range of participants, allowing the researcher access to participants he might not have known. Noy (2008) regarded snowballing as a strategy that demonstrated that the researcher gained the trust of participants. In the current study, 17 of 30 participants were reached through snowballing, indicating that participants felt comfortable to engage in this study.

Although IPA studies are often conducted with small sample sizes (Larkin and Griffiths, 2002; Larkin and Thompson, 2012; Pietkiewicz and Smith, 2014; Harris et al., 2015) Smith et al. (2009) acknowledged that larger sample IPA studies are possible, depending on the aim, level and context of the research. For example, Xuereb et al. (2016) recruited a sample of 27 participants, and Flowers et al. (2000) used 37 participants. The aim of the current study was to explore perceptions of mental health, help-seeking, and counselling among the Chinese community in NI. To provide a more realistic representation of the Chinese community, it was important to recruit participants from a variety of ages, genders, countries of origin, education, and cultural backgrounds. Given that research on the Chinese community in the NI context is limited, a wide range of participants was imperative to help gain insight into the perceptions of this under-researched community. Thus, to ensure a broad range of participants, a sample of 30 participants was recruited (see Findings chapter: 5.2 Demographics of the participants).

In addition, as the Chinese community in NI is a close community and people are more easily identifiable, a larger participant group facilitated greater anonymity. With a larger sample size, recurrent themes are more likely. As a result, the idiographic nature of IPA is strengthened as individual experiences can even gain greater validity by highlighting recurrent themes.

Additionally, as the aim of the current study included three topics (mental health, help-seeking, and counselling) a larger sample size provided scope for a wider variety of in-depth-interviews as each participant had different experiences. The likelihood of finding inductive themes also increased.

4.3 Recruitment

Participants were primarily recruited through the Chinese Welfare Association NI, who supported this research study (Appendix 1: Chinese Welfare Association recruitment email) and gave permission to advertise this research (Appendix 2: Poster) Recruitment also took place through contacts with the Chinese Church, Chinese language class and with the Confucius Institute, Ulster University. Additional participants were generated through the snowball technique. This widened the range of participants and provided richer data as there was diversification of social background.

All participants received Participant Information Sheets (PIS) on the study with the researcher's contact details (Appendix 3: PIS) before the actual interview. The PIS was either sent by email or given as a printed copy to prospective participants. This meant that prospective participants had time to read the PIS and the opportunity to ask any questions that they had concerning participation. Some people who received the PIS subsequently declined to take part in the research. Reasons for not participating were that people either did not want to contribute towards this study or due to the inclusion / exclusion criteria. The PIS also contained an option to participate in a focus group, but none of the participants showed an interest in a focus group.

Before any data collection took place, each participant was asked if they had read the PIS. If they affirmed this, they were then asked if they had any further questions. If they had questions, for example, the length of the interview, the researcher answered them. Most participants had no additional questions.

The researcher also provided each participant with an additional information sheet with contact numbers of some counselling services, including

Counselling All Nations (CANS) (Appendix 4: Contact numbers). The researcher further explained that participants could, if needed, contact CANS, with whom the researcher had a specific agreement for offering counselling (Appendix 5: Confirmation e-mail from CANS). As this was offered as a confidential service, the researcher does not know whether any of the participants made use of it. In addition, the researcher had become aware of a recent mental health program from the Public Health Agency, called 'The 1+1 Project', which included the Chinese population.

Following the discussion of information about the research, the researcher provided the participant with a consent form (Appendix 6: Consent form) and asked them to initial the designated boxes and then sign their full name in the box at the bottom of the consent form. Sufficient time was allocated to ensure the participant could read the consent form and discuss any queries. Only after the participant had signed the consent form did the face-to-face interview commence. Thus, all study participants provided written informed consent.

4.4 Data-collection tool: semi-structured face-to-face interviews

Within qualitative research, including IPA, semi-structured face-to-face interviews are often the common method to gain data (Bryman, 2015; Smith et al., 2009). Interviews are effective tools to explore perceptions of participants (Punch, 2005) and instrumental in discovering deeper thoughts, emotions, and reasoning of the participants (Denscombe, 2007). However, interviews are intricate interactions (Noy, 2008) and require preparation to be meaningful.

In a qualitative approach, the researcher has the choice of unstructured or semi-structured interviews. Although an unstructured interview has the advantage that the participant can speak freely about the given topic, it requires certain skills from the participant, such as the ability to articulate openly about a topic or being confident talking in front of a stranger. It also requires from the researcher a sound knowledge of how to conduct unstructured interviews (Smith et al., 2009). Semi-structured interviews were chosen as the best option for this study based on following considerations:

The researchers' experience with unstructured interviews was limited and therefore decided to follow Smith et al.'s (2009) advice for newcomers to IPA to conduct semi-structured interviews. Semi-structured interviews are often useful for inexperienced researchers because the questions are already formulated, and this helps avoid asking multiple questions, which are difficult for the participants to answer and time-consuming to analyse (Smith et al., 2009). In addition, as most participants spoke English as a second language, it was important that questions were clear and unambiguous to enable participants to understand and respond in keeping with their views and experiences. Semi-structured interviews helped to maintain the flow of the interview and provided a framework to move from general questions to more specific ones. Thus, developing in-depth conversations gaining rich data covering the relevant topics of the research (Matthews and Ross, 2010). The interview schedule was developed according to objectives based on the literature review and provided a useful framework to structure the interview and ensure it covered the three sections of the research aim: mental health, help-seeking, and counselling (**Table 6**). The semi-structured face-to-face interviews provided an opportunity for participants to state their viewpoints on relevant themes. Furthermore, the researcher employed a flexible approach to interviewing by encouraging participants to expand on relevant areas by using prompts from the interview schedule (Denscombe, 2007; Bryman, 2015).

Table 6: Interview schedule consisting of questions and prompts (in *italics*)

What is your first thought when you hear the term "mental health"?
What has influenced your thoughts on mental health? *What in your daily life influences your sense of mental health?* *In what ways has your upbringing influenced these thoughts?* *In what ways has your social class influenced these thoughts?* *In what ways has age influenced your thoughts?* *In what ways has gender influenced your thoughts?*
What differences, if any, do you see between the Chinese view on mental health and the Western view on mental health? *How do you think Traditional Chinese Medicine (TCM) regards mental health?* *In what ways do you think mental issues can appear as physical symptoms?* *How do you consider does the body, the mind and the social environment influence mental health?*
How would you describe your attitude towards mental health? *In what ways is mental health important in your life?* *In what ways is mental health important to society?* *In what ways, if at all, has your attitude towards mental health changed in recent years?* *Do you think mental health issues have a stigma attached? If so, how does this stigma show?*
What is your first thought when you hear the term "help-seeking" in connection with mental health? *Imagine you have a mental health issue and need to seek help from a health professional. Describe how you would feel about this.*

What would you consider as reasons for help-seeking regarding mental health?

In what ways could relationship issues lead to help-seeking?

In what ways could stress lead to help-seeking?

In what ways could dependency on alcohol or other substances lead to help-seeking?

If you were to experience a problem that was impacting your mental health and well-being where would you seek help?

Would you consider help-seeking from your family and friends?

Would you consider help-seeking outside your family and friends?

Would you use the internet to seek help?

Research suggests that the Chinese community does not seek help from health professionals for mental health issues and does not utilize existing provisions. What are your thoughts on this?

How should help-seeking be encouraged?

What is your first thought when you hear the word "counselling"?

How would you differentiate between psychiatric issues and counselling issues?

In your opinion, what differences, if any, are there between schizophrenia and depression (anxiety, bereavement, or relationship issues)?

How would you describe your attitude towards counselling?

What benefits, if any, might there be in going to a counsellor?

In what ways has society / media influenced your attitude?

In what ways has your family influenced this attitude?

In what ways have your friends influenced this attitude?

In what ways, if at all, has your attitude towards counselling changed over recent years?

Where would you look if you, your family or a friend needed counselling? *In what ways might face-to-face counselling be preferable to online counselling?* *In what ways might online counselling be preferable to face-to-face counselling?*
How well known do you feel counselling is among the Chinese community? *What effect, if any, do you feel counselling has had in the Chinese community?* *How do you think counselling might be better promoted among the Chinese community?*
What reasons might hinder someone from considering counselling? *How could cultural issues hinder considering counselling?* *How could financial issues hinder considering counselling?* *How could language have an impact on considering counselling?* *How could age have an impact on considering counselling?* *How could gender have an impact on considering counselling?*
Is there anything else you would like to add?

4.5 Data collection procedures

Data collection took place in Belfast, Newtownabbey, and Carrickfergus. Various locations were used, such as Ulster University campus, the Belfast University campus, the Chinese Welfare Centre, and coffee shops. The preferences of the participant when choosing a venue were always considered, and the researcher accommodated the needs and wishes of the participants. This ensured that participants felt comfortable and safe in their surrounding and contributed to a relaxed atmosphere.

Initially, it was also the intention to use focus groups in the study, however, early in the recruiting process it became evident, that focus groups were not suitable because of time constraints, various locations of the participants and

the hesitancy of participating in a focus group with the topic of mental health. This confirmed Smith et al.'s (2009) observation that participants might be less willing to share their own experiences in front of others.

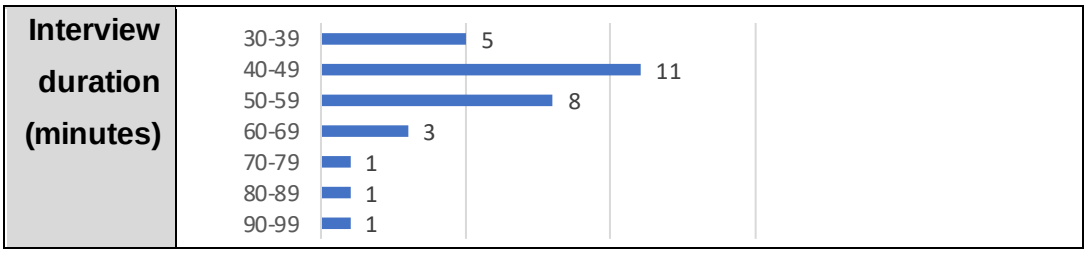
Before the face-to-face interview started, the participant was asked to complete the demographic information sheet (Appendix 7: Demographic information sheet). All participants were willing to fill out the demographic sheet and had no difficulties answering the questions. The use of a demographic sheet provided evidence for the diversity of the sample, by providing information, such as gender, age, country of origin or length of stay in NI. An accurate overview of the findings of the demographic information sheet is included in the Findings chapter of the current study (section 5.2, **Figure 5**).

Once the written consent was given, and the demographic sheet filled out, the actual interview could start. The researcher of the current study conducted all 30 face-to-face interviews. To show the participants that the researcher appreciated their willingness to give their time and thoughts to the research, the researcher often provided the participant with water or coffee and some fruit or Chinese snacks. This was well-received, as, in Chinese culture, this is regarded as being polite. The researcher disclosed that she was interested in Chinese culture and the Chinese community in NI and this helped establish a rapport with the participants. Participants who were recruited through snowballing had heard of the researcher through their friends and colleagues. This further contributed to a relaxed atmosphere, in which an interview on mental health, help-seeking, and counselling could be conducted.

Before the researcher started recording, the researcher double-checked with the participant that they had understood that the interview would be recorded and had agreed to it. Only after this reassurance did the researcher start recording. The researcher used two recorders to tape the interviews to allow for technical difficulties.

The researcher used the interview schedule (**Table 6**: interview schedule) as a rough framework for conducting the interview. Adhering to the interview schedule ensured that all the interviews could facilitate data collection focused on the three topics of the research: mental health, help-seeking, and counselling. Some of the participants talked very freely and effusively about the three topics, while others needed more prompts or explanations. In each interview, the researcher accommodated the individual needs of the participant and encouraged them to tell their viewpoint. The duration of the interviews varied between 30 and 99 minutes. Most of the interviews (n=22) lasted between 40 and 64 minutes. Five interviews were between 30 and 39 minutes. Three interviews were over 70 minutes, with one interview as long as 99 minutes. This provided an average time of 51 minutes for each interview. **Figure 4** provides an overview of the duration of the 30 interviews.

Figure 4: Duration of interviews



4.6 Ethical considerations

Prior to data collection, ethical approval from the Ulster University Research Ethics Committee had been obtained in June 2016 (section 9.1 of the Code of practice) as part of adherence to the Code of Practice for Professional Integrity in the Conduct of Research of Ulster University (2016) (Appendix 8: Ethics approval letter from Ulster University).

Participants' confidentiality and the right to privacy was paramount, and therefore various ethical issues had been considered and adhered to. The researcher also followed other relevant guidelines of the Code by successfully completing the 'Research integrity' course of Ulster University before conducting the interviews (section 1.3 of the Code of practice). The research process was supervised consistently by the allocated supervisors (section 6.2 of the Code of practice). Consent forms and data generated are

kept in a safe place in paper or electronic form (section 8.3 of the Code of practice). Personal identification and contact information were at all times kept separate (section 8.3 of the Code of practice) and informed consent had been sought by the researcher and given by the participants (section 9.3 of the Code of practice).

Ethical consideration was given to the recruitment process as self-selection was required as part of purposive and snowball sampling. Therefore, only participants who were adults were contacted because they could decide for themselves if they wanted to participate in the study or not. Participants were asked to give informed consent based on the Participation Information Sheet (PIS) about the research, which included details of the cooling-off period (Appendix 3: PIS) and a consent form (Appendix 6: Consent form). The researcher was aware that because of privacy issues participants could not be asked if they were currently undergoing psychiatric treatment. To ensure that this exclusion criteria was adhered to, the PIS stated clearly that no one in current psychiatric treatment was targeted. After reading this exclusion criteria, one prospective participant declined to participate and highlighted to the researcher that the PIS was beneficial for self-selection as it clearly stated the boundaries for participation. Furthermore, participants were only taken from the general population and were not recruited in hospitals, psychiatric units, or any NHS institution.

Conducting interviews as part of the research process required further ethical considerations. The researcher is a member of a professional body (British Association of Counselling and Psychotherapy) and adheres to work within the BACP Ethical Framework (BACP, 2016). The six ethical principles (BACP, 2016) which refer to counselling and psychotherapy are also appropriate to apply for face-to-face interviews and were applied in the current study see **Table 7.**

Table 7: Six ethical principles and their application in the current study (BACP, 2016)

Six ethical principals	Application in the current study
Being trustworthy – honouring the trust placed in the practitioner	The researcher did not disclose personal information of the participants to other people and made sure all data was anonymised and treated as confidential. The researcher adhered to the consent form and the Code of practice conducting research of Ulster University (2016). The researcher was always on time and at the agreed place before the participant arrived to be able to greet them and avoid any confusion on the participant's side that they would not be at the right place.
Autonomy – respect for the client's right to be self-governing	The participant had the right and opportunity at any stage of the interview to end the interview. The participants volunteered and were not forced to take part in the interview. The researcher never pressured a participant into disclosing an issue they did not want to disclose.
Beneficence – a commitment to promoting the client's well-being	The researcher had utmost concern that the participant experienced the interview as beneficial to them and that the interview was also an opportunity for the participant to talk about a topic, which could be relevant in their lives. Showing empathy to the participant whenever they started to share their personal thoughts or experiences was important to ensure that the participant felt understood and appreciated. The researcher valued that the participant had agreed to take part in the research and expressed this to them with words of thanks.
Non-maleficence – a commitment to avoiding harm to the client	The researcher explained to the participants the topic of the interview and provided them with an information sheet and consent form. If necessary, the researcher took the time to explain the information sheet to the participant. As the participant received the information sheet before the actual interview, the participant had time to read the information sheet and could decide if they wanted to take part or not without being influenced by the presence of the researcher.

Justice – the fair and impartial treatment of all clients and the provision of adequate services	The researcher treated all participants with the utmost courtesy and showed her appreciation that the participants had given their time and effort to take part in the research. The researcher also provided them with a contact sheet of possible relevant organisations for the participant if they had any mental health queries or issues.
Self-respect – fostering the practitioner's self-knowledge, integrity, and self-care	The researcher listened actively and attentively to the participant's knowledge about the issues of the current research. The researcher came prepared with working recorders, information sheet, contact sheet, demographic sheet and consent form, thus highlighting the validity of the interview. The face-to-face interviews were held in safe, protected places and conducted at suitable times. A distress protocol (Appendix 9: Distress protocol) was set in place which provided the researcher with clear guidelines on how to react if a distressing situation would occur.

The researcher was aware that the topic of mental health, help-seeking, and counselling could trigger distress in participants and, as a precaution, established with Counselling All Nations (CANS) to provide counselling (Appendix 5: Confirmation email from CANS) if necessary. As this was a confidential service, the researcher does not know if any participant availed of this service.

Participants were also provided with a list of confidential helplines (Appendix 4: Contact numbers) in case they wanted to contact an organisation independently. Sensitivity was required as the subject could become personal, and participants might become distressed. In cases of distress shown by the participant, the researcher could apply a distress protocol (Appendix 9: Distress protocol) detailing various stages of distress and offering appropriate actions by the researcher. The first step of the distress protocol was to have a time-out by stopping the recording, giving the participant time to settle. Depending on the level of the distress and its management, the interview could either be continued, or the participant could withdraw entirely from the research. Complete withdrawals from the interviews never happened during the conduct of interviews in the current study.

The researcher is a trained counsellor and is comfortable with managing distressed clients. While this is an important skillset, the researcher recognises the boundaries between her role as a counsellor and her role as a researcher. With one participant, it was necessary to facilitate a timeout during the interview. The researcher immediately stopped the recording, listened to the participant with empathy, and after some time, the participant was ready to resume the interview.

Participants' data remained anonymous in the current study by the application of the Data Protection Act (UK Government, 1998) in the handling and storing of data. All interactions remained confidential between researcher and participant. All data has been presented in a way that no individual can be identified and where a specific participant has been directly referenced a numeric identifier was used. The mapping between these identifiers and participant names is only known by the researcher and is password protected. Any data stored electronically was encrypted. The data will be stored for ten years, according to University guidelines. If requested, participants will be provided with access to their data and can also request a copy of the final summary. According to UK Government (2018a) the "*Data Protection Act 2018 is the UK's implementation of the General Data Protection Regulation (GDPR)*". Although this act did not exist at the time the data was collected, the handling of the data complies with the requirements of the Data Protection Act 2018 (UK Government, 2018b).

4.7 Culturally sensitive and cross-cultural research

Cross-cultural research is defined by Bryman as "*the collection and / or analysis of data from two or more nations*" (Bryman, 2015, p.66). According to Bryman's (2015) definition the current study cannot be classified as a cross-cultural study, however, the principles of cross-cultural research can still be applied as they provide a framework for conducting research with an ethnic minority group.

Cross-cultural research demands culturally competent researchers (Papadopoulos and Lees, 2002) to change the negative image earlier research created among ethnic minorities (Liamputtong, 2010b; Smith, 2008),

for example, the Maori in New Zealand were marginalised as people who cannot handle their problems (Walsh-Tapiata, 2003). Deloria implied cross-cultural research often "*bears the burden of researchers' past mistakes*" (Deloria, 1991, p.460) and therefore needs special attention. According to Papadopoulos and Lees (2002), culturally competent research can be achieved by applying four concepts: cultural awareness, cultural knowledge, cultural sensitivity, and cultural competence. These four concepts serve as a framework to explore the issue of culturally sensitive research in the current study.

4.7.1 Cultural awareness

Cultural awareness starts with the willingness of the researcher to be reflective about their personal value base and their social construct with participants (Papadopoulos and Lees, 2002). The social construct of the current study consisted of several layers: the participants, who are Chinese but came from different Chinese backgrounds, culture, language, and land of origin. The researcher, who is German, also has a different background concerning culture, language, and land of origin. Common factors between participants and researcher were, for example, coming from a different culture and experiencing cross-cultural living and this contributed to an emotional bond between researcher and participants which was beneficial for creating trust and understanding.

4.7.2 Cultural knowledge

Cultural knowledge of the participant group contributes to a better understanding of their similarities and differences and prevents the stereotyping of cultural groups (Papadopoulos and Lees, 2002). Cultural knowledge includes knowledge about "*social, familial, cultural, religious, historical and political backgrounds"* (Jackson and Niblo, 2003, p.24) and contributes to the rigour and trustworthiness of a study (Pelzang and Hutchinson, 2018). Without cultural knowledge, reflectiveness of the researcher regarding how their cultural knowledge and their insider/outsider position can influence the research process cannot be considered (Tillman,

2006). The insider/outsider position refers to categorisations of cross-cultural researchers into four categories developed by Banks (1998): indigenous insider, indigenous outsider, external insider and external outsider. Liamputtong (2010b) regarded the role of the external outsider critically because often, culture is only interpreted through the lens of the outsiders' culture and unfavourable comparisons conducted. The researcher of the current study is fully aware that she is not from the same ethnic group but regards herself as an external insider having lived overseas in Taiwan, contributing to an awareness that culture needs to be understood from a variety of perspectives. The researcher speaks Mandarin Chinese and had studied a second Chinese language (Hakka) which provides her with a more in-depth insight into the diversity of Chinese culture. The researcher also has Chinese friends who keep her up to date with issues of the Chinese community. In addition, the researcher enhances her cultural understanding by continuing studying Mandarin Chinese in a language class. Liamputtong (2010b) stressed that researchers need to have knowledge about the specific culture, otherwise they might not act in a culturally sensitive manner.

4.7.3 Cultural sensitivity

Cultural sensitivity is paramount in cross-cultural research (Papadopoulos and Lees, 2002; Liamputtong and Rumbold, 2008). According to Tillman (2002) recognising ethnicity and culture is vital in the research process and can be expressed towards participants by the researcher's care, humbleness, and sensitivity regarding cultural issues (Eide and Allen, 2005). In the current study, the researcher helped participants feel at ease by providing a small snack and water before starting the interviews – this follows the pattern of traditional Chinese culture. Papadopoulos and Lees (2002) claimed matching the ethnicity of researcher and participants as a way to achieve culturally sensitive research. Although there are advantages of having a common ethnicity between researcher and participants (Kauffman, 1994), sharing ethnicity can also be a disadvantage as participants may explain less as they assume the researcher already knows. Matching ethnicity alone is not a guarantor for cultural sensitivity as other factors need to be considered.

Burnette et al. (2014) in their research among indigenous communities, expanded the definition of cultural sensitivity by including historical context, cultural experiences, norms, values, and beliefs and developed a toolkit for culturally sensitive research. Wardale et al. (2015, p.40) condensed Burnette et al.'s guidelines into a 16-point strategy to be used with culturally diverse participants while conducting qualitative research (first two columns in **Table 8**). The current study was examined by applying these strategies, and examples of their application are presented in the third column of **Table 8.**

Table 8: 16-point Strategy for researcher(s) (Wardale et al., 2015, p.40) and examples of application to the current study

Strategy for researcher(s)	Description	Examples of application in the current study
Work with a cultural insider	A cultural insider ensures research is conducted within the culturally appropriate protocols and nuances of the participants.	Researcher talked to cultural insiders to ensure that the researcher's behaviour does not offend participants.
Become educated	Learn about the specific and broad history of the cultural group from written material and cultural insiders.	Researcher has knowledge acquired over many years through living in a Chinese culture and studying Chinese language.
Exhibit cultural humility	Approach interactions with the cultural group with positive intent, authenticity, and respect.	Researcher respected the participants.
Spend time in the cultural context	Where possible, spend time immersed in the culture, develop relationships, and build trust with members of the cultural group.	Researcher befriended members of the Chinese community and had also lived and worked overseas in a Chinese culture.
Collaborate	Become embedded in the cultural community and develop a network of people who conduct culturally sound research.	Researcher took part in conferences, and this contributed to being reflective about research methods.

Listen	Engage with culturally aware researchers or members of the cultural group by asking questions and learning from their experiences.	Being part of a Chinese language class provides a space to ask questions about culturally sensitive issues.
Build a positive reputation	Build a reputation for doing worthwhile research.	The current study will help provide a good reputation.
Commit long-term	Work with cultural groups over the long-term and foster lasting change and collaboration.	Not applicable
Use a memorandum of understanding	Outline important guidelines including who owns the data, how the research findings will be used and published and any intentions for follow-up activities.	This was covered in the information sheet given to the participants before interviews were conducted.
Use a cultural proof-reader	A cultural proof-reader can be used to review interview questions and processes prior to conducting interviews and publishing findings.	Two pilot studies were conducted, and feedback received from the two participants to ensure that interview questions were culturally sensitive.
Enable self-determination	Discuss the research methodology and framework with participants, incorporating their feedback in research design and implementation.	Researcher is in on-going contact with some participants to discuss the research.
Use a cultural lens	By adopting the perspective of the research participants, researchers avoid imposing culturally inappropriate frameworks.	The Chinese community in NI is small, and great care was taken to guarantee participant anonymity.

Use appropriate methodology	Use culturally congruent community-based, qualitative, quantitative, or mixed-method approaches based on what is deemed most appropriate by cultural insiders.	Qualitative research with an IPA approach research design provided a sound framework to highlight participant opinions.
Reinforce cultural strengths	Build on the strengths of the cultural group, for example, using a respect driven approach to encourage experience sharing.	The duration of the interviews and the willingness of participants to share, testify to the respect that the researcher gave participants.
Honour confidentiality	Always ensure that confidentiality is honoured based on what is initially agreed to between the researcher and participants.	Anonymization of data is guaranteed, and the researcher will not use data which might identify the participant, even if it would highlight a particular research point.
Allow for fluidity and flexibility	Balance rigour with culturally congruent research practises by adapting the research process to honour the community's natural rhythm and traditions.	Initially focus groups were planned, but as participant response to focus groups was low, only face-to-face interviews were conducted.

4.7.4 Cultural competence

Cultural competence is the accumulation of cultural awareness, knowledge and sensitivity and aims to prevent ethnocentric analysis (Papadopoulos and Lees, 2002). Cultural competence also provides the context in which the design and the analysis of the study are situated as socioeconomic or sociocultural contexts are considered to help prevent misinterpretation (Im et al., 2004). In the current study, cultural competence was achieved by showing cultural awareness, knowledge, and sensitivity. In addition, the researcher does not claim to generalise findings but has chosen a research design which emphasises an idiographic approach, highlighting the individuals' voice.

4.8 Reflexive analysis of data-collection

Awareness of how the researcher has used self within data collection and conducting face-to-face interviews is of interest within the IPA approach of the current study. Therefore, the researcher used self-reflection to examine how her personality and experiences might have influenced the conduct of the interviews. As mentioned earlier in this chapter, the researcher agreed with the Heideggerian view that every encounter is influenced by subjectivity (Heidegger, 1962; Smith et al., 2009), which is often enhanced by using a first-person account in an IPA methodology. The researcher decided to follow in this tradition by writing the self-reflection section in a first-person account, focusing on the researcher's personality, life experience, knowledge and skills, but also on how the surroundings where the interviews took place influenced data collection.

Reflecting on my personality, I would describe myself as a people person in the sense that I am truly interested in people's experience and life. Seidman (2013) regarded this as a vital characteristic for any person who plans to conduct interviews. I encountered my participants with warmth and openness as I enjoy meeting people. I believe this contributed to a positive and welcoming atmosphere at each encounter. I regard myself as a mature person, presenting myself in a calm and collected way in the role of the researcher. As a mature student, I have life experience and an understanding of different life situations, and this added to the trust participants had in me. During the interviews, I was relaxed and confident and was not intimidated by age, gender, or status of the participants.

When I encountered the participants, I showed my interest in what they told me by listening attentively. However, in some interviews, I realised during transcription that I had been too quick in providing the participant with information, for example, about counselling, instead of giving the participant space to talk. Once I realised this, I updated my notes to remind me not to get carried away with certain topics and lose my role as the researcher.

Being self-critical can sometimes be a negative characteristic, but it can also be used positively by developing self-reflective skills, for example, I

discovered that I had assumptions regarding the participant's reasons for living outside their home country. Through the interviews, I became aware that some participants did not choose to live in NI but came because of economic or educational reasons or because they were part of a family moving to NI.

Life experiences play a role in how we encounter other people. As a professional registered BACP counsellor, I have extensive experience in meeting people and making them feel welcome. In addition, I felt that I could also easily connect to my participants because I had lived abroad for many years and have an understanding what it means to live in a foreign country and experience different cultures. A subconscious bond was formed, which was with some participants deeper than with others. Sharing a similar social status, in the sense of belonging to a minority group within society added to a common understanding.

My knowledge of Chinese culture and life was beneficial as it contributed towards creating trust in the participants as they experienced that I was truly interested in their lives and experiences. I shared with my participants that I speak Mandarin Chinese, which was an ice breaker with participants I met for the first time. The participants were recruited from the general Chinese population, and only a few of them had experienced counselling themselves, and some had experienced counselling by observation through their work, such as interpreter services. Being a professional counsellor provided for me the background knowledge to answer some of the participants' questions regarding counselling. Participants could then follow up on the explanations and voice their opinions. I provided a secure place as participants felt free to also share critical opinions about counselling, although they knew I work as a counsellor. I think that my professional knowledge was beneficial, as participants did not need to explain the counselling process to me but could highlight specific problems in counselling, for example, the triad issue when an interpreter is part of the counselling session and the influence it has on the therapeutic relationship. I was aware that there are some areas of mental health which needed great care to explore, for example, psychiatric

treatment has a deep stigma attached. I respected participants' hesitation talking about treatment for severe psychiatric issues, as these were not the immediate research focus. I am also aware that censorship might influence behaviour, for example, recently, there were research papers with sensitive issues removed from online services in China (Badshah, 2017).

Most interviews could be conducted in a quiet area, such as the interview room in the university or a room in the Chinese Welcome centre and six were conducted in coffee shops. Although my preference was not towards coffee shops, I wanted to accommodate the wishes of the participants. Having experienced various locations for conducting the interviews, I felt that coffee shops posed challenges, as I had to make a conscious effort not to be distracted by the noise and activity of a coffee shop. Also, unexpected noise occasionally made it difficult to hear the participant and interrupted the flow of the interview.

The skills I have acquired through years of working as a counsellor were beneficial in creating a relaxed atmosphere, for example, maintaining eye contact, not invading their private space, having an open body language and being respectful and polite comes naturally to me and contributed towards establishing a good rapport with my participants. I felt comfortable meeting participants, and this reduced anxiety within myself and helped in providing a safe space to conduct an interview. I am used to face-to-face encounters within a specific time frame. I was also aware that a face-to-face interview could develop into a counselling session and, if this happened, I led the dialogue back to the research objectives by applying the interview schedule.

4.9 Data analysis

The data for the current study was analysed using an approach derived from IPA as working with a larger sample size brings its own challenges to the analysing process, and Smith et al. (2009) offer the following guidelines when working with a larger sample:

> "If one has a larger corpus, then almost inevitably the analysis of each case cannot be so detailed. In this case, the emphasis may shift more to assessing what were the key emergent themes for the whole group… As you can see a great variety is possible in terms of the detail of the particular analysis and the relative weighting to group and individual." (Smith et al., 2009, p.106)

The researcher interpreted these guidelines into an eight-step analysis process, keeping in mind that IPA guidelines are flexible and do not need to be considered as a rule book as Smith et al. states:

> "There is no clear right or wrong way of conducting this sort of analysis, and we encourage IPA researcher to be innovative in the ways they approach it." (Smith et al., 2009, p.80)

This data analysis process of the current study is detailed below.

4.9.1 Transcription

All 30 face-to-face interviews were audio-recorded by the researcher and then transcribed, which helped with the familiarisation of the data. Shortly after the researcher conducted an interview, she started the transcription. This meant that the interview was still fresh in the researcher's memory, which was useful, as occasionally, phrases or expression were difficult to understand because of pronunciation or noise. The researcher found that audio-recorded interviews proved valuable for transcriptions as they contributed to precise and rich data (Saunders et al., 2009). In addition, by transcribing the interviews shortly after they were conducted, the researcher could refine her interview technique, for example, not saying '*yes*' or '*mmh*' too quickly, as it interrupts the flow of the participant or overlaps with what the participant said.

During transcription, the researcher made reflective notes about the interview and these notes were used during the analysis of the data as, especially in an IPA context, they could show first interpretative thoughts.

4.9.2 First reading

According to McLeod (2011), coding can be achieved through sequential coding. This can be facilitated using three columns: notes, transcript, and

emerging themes. In the current study, a fourth column was added for references to conceptual points. The transcribed interview was copied into the second column, with a clear separation between the participant and researcher responses. During the first reading, notes were added in the notes column, the emerging themes column, and the conceptual point column. The references to conceptual points were labelled with a code and cross-referenced to an additional document which detailed each of the conceptual points, discussion points, references to literature and interpretative thoughts.

Reflections regarding the interviews were two-fold. Firstly, the researcher made notes regarding the uniqueness of each interview at the end of the coding process (Appendix 10: Example of a reflective summary of interview). Secondly, personal reflections were also noted while analysing the data, for example, emotions the researcher felt while a participant told her experience (Appendix 11: Example of researcher's personal reflection on interview).

4.9.3 Second reading

All 30 face-to-face interviews were re-read to fine-tune the themes, adding new points of analysis and, where appropriate, new conceptual points and new personal reflections – these points were highlighted to indicate that they were based on the second reading (Appendix 12: Example of coding after second reading of transcript).

4.9.4 Identify emerging themes

All the emerging themes of the 30 interviews needed to be sorted to identify common or similar themes. The objectives of the current study provided the structure to divide the emerging themes into the three major topics of mental health, help-seeking, and counselling. The emerging themes were initially sorted into these three major topics, and notes were made where participants provided suggestions for recommendations.

4.9.5 Organize emerging themes into themes and sub-themes

The emerging themes of the first five interviews analysed were compared to provide a more differentiated framework of emerging themes within each of the topics. This initial framework was then applied to the remaining interviews to establish which themes already existed and which themes emerged in each interview. The emerging themes were then organised into themes, for example, experience and further grouped into sub-themes, for example, personal experience, second-hand experience, and media experience.

4.9.6 Draw mind maps

Drawing mind map of each interview based on the emerging themes helped delve deeper into the data. This process achieved a greater familiarity with the data, provided an overview of all the emerging themes within each interview and allowed the researcher to organize the themes and sub-themes (see Appendix 13: Example of a paper mind map). In addition, all the emerging themes of each interview were related to extracts of the participants. These 30 mind maps and their emerging themes provided the basis for establishing recurrent themes.

4.9.7 Establish recurrent themes

Completing the 30 mind maps and the collation of the extracts according to the emerging themes provided the basis to investigate recurrent themes. This investigation was based on Smith et al. (2009), who suggested that in larger samples "*measuring recurrence across cases is important*" (p.106). The themes and sub-themes of the 30 interviews were collected in Excel and grouped under the topics of mental health, help-seeking, and counselling. Smith et al. (2009) used a table to identify recurrent themes by indicating a yes / no answer. For this study, the yes / no was replaced by numbers which indicate how many extracts support the theme in each interview. The results of the initially collated emerging themes are presented on an interactive webpage. (Appendix 14: Screenshot of emerging themes). The next step was to decide which themes recur and which do not. This decision was

helped by the interactive webpage of the emerging themes which provided the overview of participant participation and which of the emerging themes had a higher frequency than others. Although the frequency does not indicate a greater importance of the themes, it contributed towards a better understanding of which themes participants had raised more often and which topics were only raised by a few participants. In this process, themes were re-organized and combined to reflect the recurrent themes better. The results of the recurrent themes with their super-ordinate and ordinate themes are again summarised on an interactive webpage (Appendix 15: Screenshots of recurrent themes). Then the researcher again immersed herself into the data by collating all the extracts from the interviews which supported each recurrent theme with their super-ordinate and ordinate themes. (Appendix 16: Sample of collating extracts to super-ordinate themes – mental health).

4.9.8 Explore recurrent themes

The researcher chose the most suitable and expressive extracts to support the recurrent themes. This was an iterative process, reading and re-reading the interviews, the collated extracts and the notes made during the first and second reading of the interviews. This process led to re-organising of super-ordinate themes, re-naming headings of the recurrent themes and their super-ordinate and ordinate themes (Appendix 17: Mind maps of preliminary recurrent themes). Idiographic accounts were analysed using descriptive, linguistic, contextual, and hermeneutic comments to explore transcripts in greater depths (Appendix 18: Example of transcript and coding). This extensive collation of data was then consolidated and re-drafted into ten recurrent themes with their super-ordinate themes and wherever appropriate supported with idiographic accounts of participants, highlighting the richness of the data and the phenomenological character of the current study. Headings were again renamed to represent the contents of the recurrent themes better. These recurrent themes are presented in the Findings chapter (section 5.1 to section 5.6).

4.10 Validity of current study

To examine the validity of the current study, Yardley's (2000; 2015) criteria were applied, as Smith et al. (2009) recognised Yardley's criteria as suitable to examine IPA studies. Yardley (2000) named four principles of assessing a qualitative approach: sensitivity to context; commitment and rigour; transparency and coherence; impact and importance. In relation to the current study, these four principles were used as a framework to examine the validity of the study, which are detailed below:

4.10.1 Sensitivity to context

Sensitivity to context was examined considering the following four areas: choice of methodology; conducting interviews to gain rich data; the analysis process; the relation of the findings to existent literature and research. In the current study, the researcher chose IPA as the methodology because of its focus on the idiographic and the particular (Smith et al., 2009), which was expressed in purposive sampling of the non-clinical population of the Chinese community. Sensitivity to context was also expressed by conducting face-to-face interviews to gain rich and in-depth data, which required interview skills and compassion for the participants. In the current study, there were 30 semi-structured interviews, most of which lasted more than 40 minutes. These interviews contained rich data that reflected participants' levels of trust and comfort in discussing sensitive and taboo topics. Sensitivity to context was further demonstrated in the analysis process by providing space for participants' opinions and experiences using extracts from all the interviews. The current study, with its extensive literature review, the wider contextual framework, the theoretical underpinning of the methodology and relating the findings to relevant literature, also demonstrate a depth of sensitivity to context.

4.10.2 Commitment and rigour

In an IPA study commitment is measured in the attentiveness to the participants during data collection (Smith et al., 2009). In the current study, every effort was made to make participants feel welcome and the

interpersonal and soft skills of the researcher, acquired in her counselling profession, helped provide a warm and stress-free environment to conduct an interview. In addition, commitment to the participant was also safeguarded by working within ethical frameworks, for example, by having a distress protocol.

Rigour of a qualitative study can refer to the suitability of the sample to the research aim, the quality of interviews and the extensiveness of the analysis. In the current study, the choice of participants from the Chinese community matched the research aim of investigating the perceptions of the Chinese community in NI. The quality of the interviews was demonstrated, not only by the length of most interviews but also by the depth of the interviews shown by the participants' sharing deeply personal thoughts and issues. The extensiveness of the data analysis was illustrated by an eight-step data analysis process and by selecting appropriate quotes from the interviews.

4.10.3 Transparency and coherence

Transparency of a study relates to the write-up of the study and in particular to the findings and discussion chapter. The findings chapter of the current study is based on an eight-step data analysis process, described in the methodology chapter, which provides a transparent audit trail, for example, the interactive webpage presented all the emerging and recurrent themes in tables which can be traced back to the participants. The findings chapter also demonstrated commitment to phenomenological and hermeneutic sensibility, which found its continuation in the discussion chapter. Appendices 10 to 18 provide examples of each stage of the analysis process to demonstrate the audit trail.

4.10.4 Impact and importance

For Yardley (2000; 2015) the impact and importance of a qualitative study demonstrate its validity by contributing something interesting, important, or useful. The current study achieves this on both a phenomenological and hermeneutic level. It is interesting as it contributed towards perspectives of an ethnic minority group; examined a taboo and sensitive topic; applied IPA

to a larger number of participants and demonstrated a thorough audit trail of how to analyse a large data set within an IPA research design. The current study is important as it contributed to gaining insight into perceptions of a sample of the Chinese community and its findings could benefit health services and counselling agencies in their outreach to ethnic minority groups. The current study meets the four principles suggested by Yardley (2000), and on this basis, the validity of the study is ensured.

4.11 Conclusion

This was a cross-sectional, qualitative research study employing an Interpretative Phenomenological Analysis (IPA) approach as a theoretical underpinning to achieve the research aim of the current study which was to explore perceptions of mental health, help-seeking, and counselling among the Chinese community in NI.

This chapter provided the rationale and the theoretical underpinning for selecting an IPA approach. Data collection involved interviews with 30 participants who contributed a wide range of experiences and perceptions regarding the topics of mental health, help-seeking, and counselling. Ethical considerations were adhered to by applying ethical frameworks, and approval was received from the Ulster University's ethics committee. The application of cross-cultural guidelines confirmed the cultural sensitivity of the current study. In addition, the sensitivity of the researcher towards participants and the collected data was shown through reflexive analysis. The eight steps of the data analysis process provide a transparent audit trail and became the basis for applying the four principles of validating qualitative research, which in turn confirmed the validity of the findings.

This methodology chapter provides the roadmap for the emerging themes which are examined in the following Findings chapter.

Chapter 5: Findings

5.1 Introduction

The current study focused on the perceptions of mental health, help-seeking, and counselling among the Chinese community in Northern Ireland. Data drawn from 30 semi-structured interviews conducted between 2016 and 2017 were analysed using an approach derived from Interpretative Phenomenological Analysis (IPA). The findings are divided into three subjects: Mental health, help-seeking, and counselling. Each of the three subjects starts with a summary table, providing an overview of recurrent and super-ordinate themes.

In the findings, references to participants are displayed in two ways, firstly as superscripts listing multiple participants, for example, $^{p7, p8}$ references participants seven and eight. Secondly anonymised Chinese names are used for longer quotes and idiographic accounts, for example, Huang-ba.

The mapping between participant numbers and anonymised Chinese names are displayed in **Table 9.**

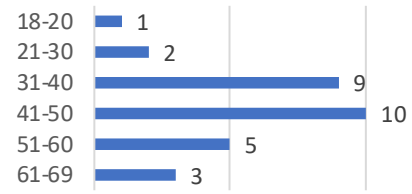
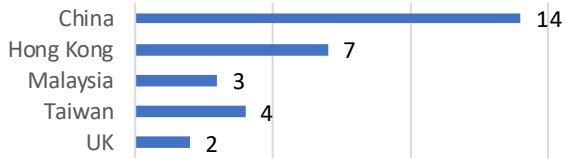
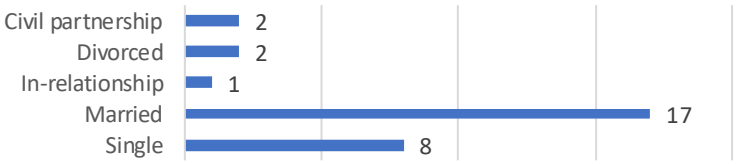
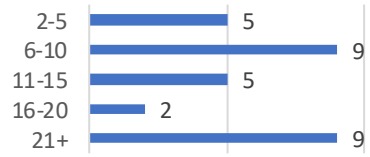
Table 9: Mapping of participants numbers and anonymised Chinese names (p=participant)

p1	Wang-yi	p11	Zhang-yi	p21	Chen-yi
p2	Wang-er	p12	Zhang-er	p22	Chen-er
p3	Wang-san	p13	Zhang-san	p23	Chen-san
p4	Wang-si	p14	Zhang-si	p24	Chen-si
p5	Wang-wu	p15	Zhang-wu	p25	Chen-wu
p6	Li-liu	p16	Huang-liu	p26	Wu-liu
p7	Li-qi	p17	Huang-qi	p27	Wu-qi
p8	Li-ba	p18	Huang-ba	p28	Wu-ba
p9	Li-jiu	p19	Huang-jiu	p29	Wu-jiu
p10	Li-shi	p20	Huang-shi	p30	Wu-shi

5.2 Demographics of the participants

There were 30 adult participants from the general population of the Chinese community in NI participating in this study. The participants were adults between the age of 18 and 69 years. The majority of participants were in the age groups 31-40 years (n=9) and 41-50 years (n=10), followed by ages 51-60 years (n=5) and 61-69 years (n=3). The smallest group was 21-30 years (n=2), and one person was 18-20 years (n=1). The gender distribution consisted of 21 females and nine males. All 30 participants were Chinese, but from various countries: Mainland China (n=14), Hong Kong (n=7), Malaysia (n=3), Taiwan (n=4) and the UK (n=2). Most participants were married (n=17), followed by being single (n=8), in a civil partnership (n=2), divorced (n=2) and one person in a relationship. Participants who lived more than 21 years (n=9) and between 6-10 years (n=9) in Northern Ireland constituted the biggest group. Five participants respectively lived 2-5 years (n=5) and 11-15 years (n=5) in Northern Ireland. The smallest group referred to participants who had lived 16-20 years (n=2) in Northern Ireland. The education level of most of the participants was university level (n=23), only four had college level and three secondary school. Most of the participants were employed (n=23), six were unemployed, and one participant was retired. For most participants (n=26), English was not their first language. **Figure 5** provides a summary of these demographic findings.

Figure 5: Demographic findings summary

Age (years)	
Gender	
Country of origin	
Marital status	
Lived in Northern Ireland (years)	
Education	
Work status	

5.3 Mental health

The mental health section explores how participants perceived mental health. Three recurrent themes were identified: '*It was kind of a taboo* – ingrained associations and behaviour'; '*A journey* – shifts in perspective towards understanding and tolerance'; 'Transformative influences – *It can change your mind'*. These recurrent themes are visualized, with their super-ordinate themes, in **Table 10**, followed by an exploration of each recurrent theme.

Table 10: Three recurrent themes of mental health

Recurrent theme 1	**Super-ordinate themes & idiographic account**
'It was kind of a taboo' – ingrained associations and behaviours	*'Negative associations'*
	Behaviour and feelings – '*you need to stay away'*
	'Scared' – childhood memories and personal development (idiographic account: Li-liu)
Recurrent theme 2	**Super-ordinate themes & idiographic account**
'*A journey*' – shifts in perspective towards understanding and tolerance	'*Quite a positive thing'*
	Understanding causes of mental health issues
	Perspectives on diagnosis and treatment
	'*Change of my perspective on mental health… a journey'* (idiographic account: Huang-liu)
Recurrent theme 3	**Super-ordinate themes & idiographic account**
Transformative influences – '*it can change your mind*'	Media – a source of psycho-education
	Being part of another culture
	Personal experiences
	'*People have some kind of problems*' – influences which contribute to a change of mind (idiographic account: Wu-shi)

5.3.1 Recurrent theme 1: '*It was kind of a taboo*' – ingrained associations and behaviour

Recurrent theme 1 includes two super-ordinate themes, '*negative associations*' and 'behaviour and feelings – *you need to stay away*'. An

idiographic account further describes how stigma and taboo have manifested itself in thoughts, behaviour, and feelings **(Table 11).**

Table 11: '*It was kind of a taboo*' – ingrained associations and behaviour

Recurrent theme 1	Super-ordinate themes & idiographic account
'It was kind of a taboo' – ingrained associations and behaviour	*'Negative associations'*
	Behaviour and feelings – '*you need to stay away'*
	'Scared' – childhood memories and personal development (idiographic account: Li-liu)

5.3.1.1 'Negative associations'

This super-ordinate theme shows that negative emotions, mental illnesses, and unusual behaviour were a common theme in participants' descriptions of mental health.

Although the words '*stigma'* or '*taboo'* were primarily used by participants connected to health services, it reflected the negativity which still surrounds the term mental health within society. Li-ba explained:

> "Mental health that terminology has a bit of a stigma still attached to it and people tend to have still negative associations with anyone who may have a mental health condition, and even talking about it is still a kind of taboo. It's not talked about with much positivity."

The term mental health was not regarded as a neutral term. Most participants *p1, p5, p6, p16, p19, p21, p22, p29* immediately connected it to a negative mental-state which ranged from '*unhappy'* to descriptions of severe cases of madness or insanity. Several participants *p13, p15, p19, p20, p22, p29* who connected the term mental health with severe mental health issues described how society labelled people with mental health issues as '*crazy*' or '*insane*' to make sense of behaviour which diverged from what society regarded as normal:

> "It is just two things, one is insane if anybody who have mental health is one is very serious in the hospital to be treated or is normal." [Wu-jiu]

Li-ba also acknowledged that people suffering from mental health conditions are still stigmatized. Li-ba expressed that the Chinese community and people

in Northern Ireland both view mental health negatively by not talking about mental health issues or shunning those affected by mental health problems:

> "Having said that, I think, I do see similarities how Chinese people and Irish people view mental health, in fact, it is negative, it is a stigma, it is not really talked about, people who are diagnosed with mental health conditions are kind of seen as pariahs, as people who have been not to engage with, to avoid."

Although there was a consensus that serious mental health issues need to be treated in hospital [p20, p29]:

> "People who have a really really big problem with mental health. They cannot manage their own life. They need to go to hospital, need doctor treatment." [Huang-shi]

There was also a reluctance to send family members with mental health issues to the hospital:

> "Sending to the hospital will be the last, the last thing they would want to do. They would just keep them at home." [Wu-shi]

In addition, a view that nobody wants to be embarrassed by a family member with a mental health issue was expressed:

> "For the Chinese culture, they are more conservative and also the face value, that you know, you wouldn't want anyone to know, that you are depressed, or your family member got mental health problem." [Wu-jiu]

Some participants [p2, p4, p8, p20, p24, p25] also explained that mental health is not a topic they had often thought about. For some [p2, p11, p25] it was only by participating in this research that they thought about the issue of mental health:

> "For me, I never think about it… like a few days ago you mentioned it and I thought what? Because I never, never to think about I need that." [Wang-er]

Mental health was also not considered in terms of well-being which needs to be nurtured:

> "So it is not very familiar with the public that we have to maintain a mental well-being." [Li-jiu]

Negative associations and a lack of awareness were linked by some participants [p9, p19, p30] to a lack of knowledge about mental health issues within society:

> "No education, they have no concept of mental problem." [Huang-jiu]

Li-jiu viewed a lack of education as a generational issue, as she thought that people over the age of 60 were not taught about mental health issues:

> "No much concept, because of our age you know, 60 people."

But for Wu-shi, the lack of knowledge about mental health issues was due to the education system in China and affected any age group:

> "I don't know about here, but in China, there is not enough education on that, not enough knowledge among people about mental health."

Participants were also aware that severe mental health issues could have legal implications, for example, Wang-wu stated:

> "In China, I think if a family has someone with a serious mental health, then that family is in big trouble as they have to report that person."

However, Wang-yi described a different legal situation in Taiwan:

> "According to our law, I mean in Taiwan, if you are hurt by people with a mental problem, they don't have to be responsible for their behaviour, even so, you might have suffered by their behaviour."

Wu-jiu noted that legal implications also occur in Northern Ireland and quoted an example of how governmental services in Northern Ireland stepped in when mental health issues negatively impacted children:

> "I mean there are a few cases I know, is because of the young children, you know, age between one to five. They will be seen by the health visitor and all that and sometimes they will pick up for that, and they will refer or social worker."

The term mental health was mainly experienced as a negative term, and this was linked to stigma, serious mental health issues, embarrassment and a general low level of education about mental health. Uneasiness regarding the legal issues surrounding mental health also enhanced the sense of negativity.

5.3.1.2 Behaviour and feelings

The second super-ordinate theme explores reactions to the term 'mental health' from both societal and personal viewpoints. Participants often used the third person to convey how society reacted to the topic of mental health. It could be inferred that by doing this, they unconsciously distanced themselves by not stating their opinion, but instead describing other peoples' reaction towards mental health. Some participants described self-protective behaviour, such as staying away from people with mental health issues *p1, p3, p8, p12*, while others recalled negative behaviour, such as, dismissing the issue *p30*, showing no respect *p3, p6* or using demeaning language *p6, p24*. Childhood memories relating to incidents where they encountered someone with a mental health issue were also evoked *p6, p11, p12, p16*. Li-liu recalled how mental health was a taboo, by labelling people with mental health issues as '*mad*' and children being told to stay away from them:

> "I was born in China and grew up in China. So, it was kind of taboo when I was young. So, when somebody have a mental problem, in China, they will say, oh, this is a crazy man or a crazy woman. This should stay in mental hospital, to protect us, so just don't get close to them for those people who called them "feng dz", that means like crazy men, but mom and dad always told me to stay away."

Zhang-er also recalled that her reaction as a child was to stay away from people with mental health issues:

> "When I was a child, if you heard something like that you always think, that is someone really scary, you need to stay away from them, to be safe."

But most participants described passive behaviour, such as, not talking about mental health issues *p2, p4, p5, p7, p8, p10, p11, p12, p15, p16, p17, p18, p19, p27, p28* and keeping it secret *p2, p3, p4, p16, p19, p20, p22, p24*:

> "They just want to sweep it under the carpet. There are not a lot of people who wants to face it." [Huang-liu]

Keeping mental health issues secret emphasised the stigma and the underlying feelings of shame:

> "But if the person has a mental problem, probably even is the worst shame in Chinese culture." [Huang-jiu]

Once the stigma is attached to the person with a mental health issue, further alienation can develop by making them responsible for anything bad that happens:

> "If anything would be happen in this area, first thing it would be linked to the person, whom they knew had a mental problem." [Chen-er]

This shame and scapegoat mentality is not only directed towards the person with the mental health issue but can extend to the family. For example, society might question whether the family did something to cause the mental health issues:

> "But Chinese people would say, people will get mental health… it must be some bother can bring to the family, people doing something bad, you know, that's why the result or consequences mental health." [Wu-ba]

Blaming people for their mental health issue deepens the stigma towards mental health, and these negative thoughts can be reinforced by media reports which often focus on violence and injury caused by mental health incidents. Some participants *p5, p6, p9, p12, p18, p22* were aware that mental health issues depicted in the media were often only sensational or severe, contributing to a negative image of mental health:

> "I think because whenever I came across mental health, it was from the news and something bad had happened – that's the association. Maybe someone has a mental ill-health and conduct something which is nasty to the public and then you know, it just has a negative image. Somebody crazy, or someone attack someone, things like that." [Li-jiu]

Chen-er had a similar view, explaining that often only severe mental health issues leading to hospitalization are reported, maintaining the negative image people have of mental health:

> "Because usually the cases we really knew about it is, it has already become a news. It is like, such and such in a house, has been taken to hospital, because he turned aggressive and crazy, and ended up in a mental health hospital."

Zhang-er suggested that movies and TV series also contribute to a negative image of mental health:

> "On the telly and on the dramas or movies, they always exaggerate about those people who suffer from mental health and say they are crazy."

Feelings of being scared or terrified were also expressed by participants when they remembered encounters with people who had mental health issues, for example, Zhang-wu described:

> "I did a two-week placement in the psychiatric centre in [UK city], and it was really terrifying some of the things they tell you."

Despite being trained to deal with mental health issues, for Zhang-wu being in contact with more severe cases was '*terrifying*'. On a personal level, Zhang-wu also disclosed that one of her parents suffered from mental health issues, and described her feelings of frustration:

> "I told her [parent], we just had the conversation yesterday, and now you are depressed again. I find it really frustrating, but I don't really know who can help her."

Participants who had experienced mental health issues also described their feelings about not being able to disclose their situation, for example:

> "Having had these issues myself, I think it is difficult for people, to come forward to admit." [Li-qi]

Huang-jiu connected the difficulty in admitting mental health issues to feelings of shame:

> "Even I was hiding, I didn't want people to know, so ashamed."

Feelings of shame are often at the root of secretive behaviour concerning mental health issues. Huang-jiu's example showed that his emotions of being ashamed led him to not talk about mental health issues and culminated in him hiding his mental health issues.

To stay away and to keep quiet were the most described behaviours, reflecting feelings of fear and shame. The sensationalism of mental health

issues by the media deepened these feelings of fear and shame and added to the negative image of mental health.

5.3.1.3 'Scared' – childhood memories & personal development – idiographic account: Li-liu

Li-liu's idiographic account supports the first super-ordinate theme by recalling how families in her village treated people with mental health issues. Her account provided insight into her feelings of being scared and the negative behaviour towards people with mental health issues, highlighting the isolation mental health issues can cause:

> "To be honest, I think when I was in China, I found that people were cruel to mental people, they are mistreat them, they are teasing them, they try to make them angry, do things. That was in the village – the village children would be teasing."

She also remembered how her parents talked about mental health:

> "That was one man. I heard my mummy and daddy saying that not to me, but to my daddy, that they are smelly, and that mental people would grab little child and eat them. Make me scared, so that I don't get close."

Li-liu's reaction of being scared and keeping away reflected other participant responses. Being labelled as '*mental*' in a village meant being isolated. Li-liu stressed the severity of the isolation by explaining that the man had even been abandoned by his family:

> "You'd be identified as mental, you don't have any friend, no anything you know. People don't want to have to do anything with you. They are, in that kind of social society, environment, that will be very isolating they are kind of very helpless and then people in China just get intended to just avoid them, not support them, their family even I think his own family didn't offer any support for this person, and he just lived his own life."

Li-liu also talked about how people made sense of mental health issues with spiritual explanations, for example, being demon-possessed:

> "Apart from if their family treated, they would probably go for those, ohh, send somebody to cast out demon, oh he is demon-possessed."

Her emotional reaction as a child was to be scared, but later in life, she reported how she asked her parents again about the person with the mental health issue. Li-liu wanted to find out what the reason was for the '*crazy*' behaviour and concluded that mental health issues were often caused by some traumatic incident. Li-liu remembered other cases of mental health issues in her village and expressed empathy '*I feel very sorry*' that they were not treated better:

> "When I grew up, I asked my mum and dad why that man was mental and that he may be, his wife left, and she took all the money, and then he start to be crazy like he had no children, no family, lonely. So it is always some sort of problems, like very very terrible things to make people to be mental. I feel very sorry for these mental problems because, in my village, we have some sort of mental people, they lived in our village, but they were not treated well."

Li-liu was able to move beyond her childhood experience. She used her curiosity to find out more about the person with the mental health issue and concluded that she now felt sorry for them, indicating that her feelings of being scared had been replaced by a greater understanding of the person's situation.

> "When I grew up, I more discovered that mental person they have like something they can't cope and then the person is very vulnerable."

In addition, Li-liu had experienced mental health problems herself, and this influenced her view on mental health issues in the present. Her life experiences enabled her to think more reflexively about her up-bringing and other people's suffering. This could represent a hermeneutic circle, in the sense that her recent experiences, retrospectively influenced her understanding of the situation in her village.

5.3.1.4 Summary

Recurrent theme 1 'It was kind of a taboo' – ingrained associations and behaviour' showed that mental health is still stigmatised within the Chinese community and this was expressed through linking mental health to '*negative associations*' and labelling people with mental health issues as '*crazy'* or '*insane'.* Connecting mental health to severe mental health issues has

repercussions on people's behaviour, and participants remembered being told to stay away from people with mental health issues. Feelings of being scared were often expressed by participants when they had encountered people with mental health issues, whereas people suffering from mental health issues often expressed feelings of shame. The idiographic account highlighted that thoughts, behaviour and feelings are never static and are influenced by life experiences, and this led to the second recurrent theme, which explores shifts in perspective towards mental health.

5.3.2 Recurrent theme 2: 'A journey' – shifts in perspective towards understanding and tolerance

Recurrent theme 2 shows alternative perspectives to the experiences in recurrent theme 1. This theme explores in three super-ordinate themes, how understanding and tolerance referring to mental health issues has grown in the consciousness of participants. An idiographic account adds further depth and highlights how encounters with mental health issues in different development stages of Huang-liu's life contributed to a shift of perspective concerning mental health issues **(Table 12).**

Table 12: 'A journey' – shifts in perspective towards understanding and tolerance

Recurrent theme 2	Super-ordinate themes & idiographic account
'*A journey*' – shifts of perspective towards understanding and tolerance	'*Quite a positive thing'*
	Understanding causes of mental health issues
	Perspectives on diagnosis and treatment
	'*Change of my perspective on mental health… a journey'* (idiographic account: Huang-liu)

5.3.2.1 'Quite a positive thing'

This super-ordinate theme shows that mental health was described in positive terms such as '*well-being* ', '*normal*', or '*positive*' by some participants[p3, p27, p8, p10]:

> "I know mental health is not always a negative thing. It can be quite a positive thing. Because if people realise that there is a problem, that there is an issue and then they would deal with it and then they would

> get the proper treatment and seek support and they would do something and then they have the chance to really turn it around and improve it." [Li-shi]

Mental health was equated with a state of being normal, being part of society and feeling good:

> "Mental health I think is a something is normal, keep you in a normal sense, and you feel good." [Wu-qi]

Li-ba recognised that the term mental health could sometimes be replaced by another term to indicate a shift of meaning:

> "What I notice is the move away from mental health and use term health and well-being." [Li-ba]

Li-qi also connected mental health to well-being. She considered well-being as something that can be lost and later regained. Her list of skills to maintain well-being included '*relaxation, anxiety management, good nutrition, lots of exercise and learning how to meditate*', providing a balance between psychological and physical needs. For Li-qi spirituality, in the form of meditation maintained her well-being:

> "From my perspective, I've had a Tibetan Buddhist monk teacher, who pretty much saved my life, because when I was 25, I would not say I was suicidal, but I was getting there and through him, and going to his spiritual retreats and doing spiritual practice, through the student-teacher relationship with him, I have completely transformed myself in my life, in a positive way."

Other participants [p7, p8, p10, p14, p23] acknowledged that good mental health provides strength to face daily life, for example, Zhang-si was aware that mental health is important, not only for her as an individual but also in how it influences those around her:

> "If I am not happy, it made you feel not happy. Especially for work, for family, I think it [mental health] is very important for myself."

Resilience was also regarded as part of mental health and contributing to well-being. Wang-wu linked building up resilience to education styles and compared the Chinese and Northern Irish style of education. Wang-wu explained that educators in China do not shy away from criticizing the

student, enabling students to deal with criticism and become more resilient to disappointment. Whereas the education system in Northern Ireland focuses more on encouragement which is not always beneficial in building up resilience:

> "When I was in school, and the schoolwork was not good, you might be criticised by the teacher and your mum and dad, because they expect you to get high scores, which somehow, I feel, yes it is reasonable. Over here I feel in the school, the student doesn't learn because we always encourage good, we don't really say your work is bad, we don't say that whenever somebody say you do bad, you feel angry. I mean that is the culture in the place where you live, I feel that makes a big difference in people to endure." [Wang-wu]

Positive associations of mental health, such as well-being, were primarily mentioned by participants who had training in mental health issues. Awareness that mental health can be nurtured was recognised, as was the importance of developing resilience to maintain mental health.

5.3.2.2 Understanding causes of mental health issues

The second super-ordinate theme of recurrent theme two explores how some participants explained causes for severe and common mental health issues indicating an understanding that mental health issues can occur. Some participants recognised that there are different levels of mental health issues and disclosed how severe mental health issues were sometimes explained with religion *p1, p3, p6, p16, p19, p22*, by an illness *p8, p19, p26*, an accident or trauma *p3, p6, p11, p16*, relationship issues *p4,p7,p10,p14* or pressures in society *p2,p8,p27,p25*.

Linking severe mental health issues to religion was expressed in various ways, for example, Chen-er explained that to her mental health was a spiritual issue:

> "It [mental health] is more like a spiritual thing, rather than a medical thing."

Being possessed by demons was an explanation for severe mental health issues as Huang-liu recounted how people tried to make sense of suicide:

> "I had people suicide, but they always related it to superstition. Superstitious thinking maybe possessed by demons. They always see things in that perspective."

Religious beliefs as the cause of severe mental health issues were reinforced by Wang-san who talked about the use of exorcisms, not only in traditional Chinese folk religion but also in Christian traditions:

> "In Taiwan, you know the most way traditional Chinese people act, they send them to the temple and some medium, and some frantic medium use the knife to cut them. They describe themselves as mediums, and they would try to expel the spirits, they thought they may have possessed the people. She was helped by the church people by exorcising her by using Christian power, and she got cured."

Severe mental illness was also simply linked to genetics or genes:

> "They are just madman, you know. But for that kind of people, nearly everyone around them know that they have this kind of problem. It passes from one generation to the next generation." [Wang-si]

Another way of showing understanding for people with severe mental health issues was for participants to find a rationale for unusual behaviour. Participants sometimes connected behaviour to traumatic incidents, for example, abuse, stress, or a life-changing accident *p3, p6, p11, p16*. Zhang-yi recalled a story from her childhood about a person who was regarded as crazy and explained that the behaviour of that person was rooted in a traumatic event during a war:

> "She well educated, all we know she well educated. Because the war, and when she was a child, and she talked all about the war and her family, and she had hiding under the table. That's how we talked about because she got a bomb in her house and that made her crazy."

Li-ba, who lived in NI during 'the Troubles' (a 40-year conflict in Northern Ireland), recognised 'the Troubles' as a cause for mental health issues:

> "They have been exposed to that kind of trauma and incidents which are related to sectarian divide, violence. We lived here from 1974. We did go through some very kind of difficult period of Northern Ireland's history."

Beside severe mental health issues, common mental health issues, such as depression or anxiety *p3, p6, p7, p16, p19, p23, p30* were also acknowledged and

participants shared how they viewed the causes of those. Some participants [p8, p14, p19, p26] understood common mental health issues as an illness which could affect anyone:

> "I think everybody, is kind of normal, for people to go through such a tough situation, like the mental issues, so I think it is sort of a disease." [Wu-liu]

Other participants [p4, p7, p10, p14] voiced that mental health issues can occur because of problematic family relationships, for example, Li-shi stated:

> "Mine would be coming from distress with family."

Social isolation was also regarded by some participants [p8, p13, p18] as a source of mental health issues, for example, Huang-ba described stress caused by loneliness:

> "If you are lonely, you, if you are too stressful, you can't really cope with things, then, of course, you might suffer from like depression or anxiety longer. It just become an issue."

Huang-shi touched on another aspect of social isolation as social media can leave people isolated:

> "So, they can say something, but also sometimes, because of everybody can totally assault someone, so your heart is not that strong to take all that thing. But some of the situation, even, you can't fight back – they are stronger than you. You are scared to talk about."

Adhering to societal pressure without considering health caused stress and was also described as a reason for physical and psychological damage:

> "The importance of working hard and earning money, and providing for your family, getting a better house, getting a better car, all that is that's the value which is prioritised. Your health is suffering, may it be physical or mental is collateral damage. It is not as important as the need to strive for these things. As with all societies where there is pressure to achieve in that way, there is obvious mental health side effects in the stress of trying to live your life in that way." [Li-ba]

Unrealistic expectations, based on gender and societal expectations, was suggested by Wu-qi as an additional cause of stress:

> "Men have much more responsibility to raise the family, they have much more responsibility, they have much more burden, pressure. But they

> will react very calmly to the pressure, and in fact, this will also cause much heavy load of pressure, work and responsibility will cause something to the mental health."

Another societal pressure is the responsibility to look after ageing parents which is applied no matter where the child lives and has become a greater burden due to the one-child policy:

> "And also have the work, especially one child policy you are the only child when you get married. So, you and your wife have four people to look after." [Chen-wu]

Financial difficulties can also influence mental health. Wang-er talked about how a difficult financial situation influenced her emotions: '*all day I worried*' and only when the issue was solved did her mood change.

Participants distinguished between severe mental health issues and common mental health issues and showed insight into causes for the occurrence of mental health issues, indicating a shift of perspective towards more understanding. Nevertheless, Chen-er was also aware that mental health was still a '*sensitive*' issue as anything connected to mental health would be labelled as '*crazy*':

> "But somehow, people do understand that it is the way of your thinking. But somehow, people doesn't want to link it with mental health, because it is quite sensitive. Because if you say mental health, people will think you are crazy."

Wu-jiu confirmed the sensitivity of the topic by pointing out the fear that admitting a mental health problem could negatively impact your profession:

> "It [mental health] will affect your career probably when you put a CV, and then you have to say, I have mental health issue is not a very great thing to put down."

Mental health was divided into severe and common mental health issues. Causes for severe mental health issues covered a wider range from spirituality to genetics to psychological trauma. Common mental health issues such as depression were regarded as illness or caused by life problems regarding relationships, finances, or stress. Despite showing an

understanding of mental health issues participants still regarded mental health issues as a sensitive topic.

5.3.2.3 Perspectives on diagnosis and treatment

The third super-ordinate theme examines the insecurities participants described in recognising common mental health issues in others and perspectives on the treatment of mental health issues.

Although awareness about mental health issues has risen, recognizing, or diagnosing them was still described as difficult. Some participants *p6, p9, p19, p20, p30* observed that the effects of mental health issues were recognised by the Chinese community, for example, sadness or relationship issues, but were often not linked to a mental health issue. Wu-shi recalled her experience of observing a person being very sad, but because she lacked knowledge, did not recognise it as a mental health issue:

> "Now I think he or she got depressed, but nobody knew anything about that at that time she was sad and you know unhappy, but didn't realise that at the time she was actually suffering from depression."

Wu-shi then generalised that within the Chinese community, even depression was not always recognised as it sometimes would just be observed as an emotional problem:

> "Many people, if they have, for example, very common depression, many people they actually don't know, that they have depression. They don't know and maybe their family and friends, they also don't know. They would just think, oh, she is unhappy."

Common mental health issues are not as obvious, and so it can be harder to diagnose the problem as a severe mental health issue:

> "I think it [mental health issue] is a bit not very clear, and everyone may have some sort of symptoms at some stage. You can't really judge from those." [Wang-wu]

Wang-wu reflected further on an encounter he had with someone who might have mental health issues, and admitted that it is difficult to judge mental health issues:

> "I can see he looks OK, but from looking at his face, maybe it is not good to judge, but from his look, I can guess he might be in a group of disability or mental health. I don't know, I cannot really tell that. Never stopped to talk to that person from that I think, I don't know."

Wang-wu's phrases: '*maybe it is not good to judge'; 'I guess'; 'I don't know'; 'I cannot really tell'; 'I think'* expressed uncertainty and emphasized the struggle of combining observations with existing knowledge.

Chen-er described a friend who suffered from stress and remembered that all her friends agreed that their friend was stressed, but none linked their observation to a mental health issue:

> "We never thought it has something to do with mental health. So like you say, it is quite a lot of things, but we never link it to mental health, because we do not think it has something to do with mental health."

Furthermore, common mental health issues are not immediately visible:

> "I mean, they don't look different from the normal people." [Huang-ba]

Li-qi had a similar view and described how a person could look perfectly happy, but no one knows they suffer inwardly. Again, this makes common mental health issues difficult to diagnose:

> "Because you cannot see it. You think a person is very happy and is getting on with their lives and all of it as well, but deep down they have thoughts of suicide and self-harm which can have massive detrimental effect on their work-life, their family life, their relationships, and it affects really every aspect of their lives really. If they can't hold down their regular job, that leads to money issues concerns and paying their bills, so all have a negative knock-on effect."

Although physical problems were recognised, Li-jiu thought that the link between physical and psychological problems is not always understood:

> "Maybe manifest onto the body. Symptoms, because our body can take the score, but maybe they are will be not aware, because the mental health is affecting their body function, so it is possible, maybe they don't recognise that they [physical aches] are symptoms and they don't know that it is originating from mental health."

People are not used to talking about their emotions and sometimes hide their emotional problems with physical complaints, contributing further to difficulties in diagnosing common mental health issues:

> "This is always you know, the expression of mental health among the Chinese community. They always complain about, you know, chest pain or you know, or you know headache and things like that. Rather than saying, oh, I am feeling really down, or feeling sad, or feeling something." [Wu-ba]

Emotional stress caused by the work environment was also recognised but not regarded as a mental health issue. Emotional stress is usually hidden from others, for example:

> "Because in our life, in reality, all those people around you, we all seem like act and pretend we are normal. Yes, we act like normal, but people won't tell how you think. You might very suffering from the inside. You think that life is so hard, and work is so hard and people around you, they seem unfriendly to you. You might get very frustrated or stressed, but you don't think that is mental issue." [Huang-shi]

Other participants *p7, p15, p18, p19*, especially those who had training around mental health issues, were more confident in judging mental health issues, for example, Li-qi clearly assessed her relatives' mental health issues and behaviour:

> "Both my parents have quite depressive symptoms, but they never sought medical help, or counselling help or any kind of help. So I think they just live in complete denial."

But distinguishing between character traits and symptoms of common mental health issues is not easy *p3, p5* and even health professionals do not always recognise the difference:

> "So, I would say sometimes if the psychiatrist sees someone if peoples personal personality or character. It could be just a variety of different peoples' personality. I don't think it is mentally ill." [Wang-san]

It can often be challenging for health professionals and the individuals affected to assess if a behaviour is a mental health issue, a character trait, normal stress factors or a physical problem. The difficulties in diagnosing mental health issues, also lead to various expectations of what kind of

treatment could be beneficial. Some participants were aware of medication [p12, p24] and treatment through the GP or counsellor [p12, p20, p24, p26]:

> "So, for those people, who may have a little bit of a mental health issue, it is better for them to seek for help, like from the, you know, the professionals." [Wu-liu]

But there was also an expectation that treatment of mental health depended on willpower, for example, Wang-san revealed his ability to deal with depression:

> "Sometimes, we have times when we feel very depressed, very down. Somebody, like myself, can stand it, but somebody could be quite weak at that point. So, I don't know."

Other participants [p7, p10, p14, p18, p23, p24] also shared the expectation that people with mental health issues can contribute to their healing if they have enough willpower to accept adversity in life:

> "But mental health problem, a lot of them, at least half of them is down to yourself. Things happen to us, we can't control, and we can somehow manage with a balanced mind, we've got into trouble because we can't accept it." [Chen-si]

Talking with friends about common mental health issues, such as feelings of being sad, nervous, stressed, or tired, was another way of dealing with mental health issues:

> "At best it is talked about as, you know, people talk about in terms of trying to solve a problem." [Li-ba]

Prayer as a treatment method was also suggested. Huang-jiu had the belief that being open towards people with mental health issues and showing them care could help them:

> "If you have a friend who would have a problem, bring them to the church, we can pray for them, comfort, and let them speak and see how this work."

Ambivalence about the treatment of mental health issues was expressed by Wu-ba, who doubted that all mental health issues could be healed:

> "Not sure totally cured, but you know, a lot of mental health can be conquered, and you know, and some can be cured as well, I think."

Diagnosis of common mental health issues, for example, depression or anxiety was viewed as difficult as symptoms are often not visible or are regarded as an emotional problem and therefore not linked to a mental health issue. Participants were aware of various solutions for mental health issues, including meditation, will-power or receiving help through friends. Still, some participants were unsure if mental health issues can be permanently healed.

5.3.2.4 'Change of my perspective on mental health… a journey' – idiographic account: Huang-liu

Huang-liu's idiographic account describes her journey towards a shift of perspective about mental health issues. Huang-liu started with an explanation that, in her country of origin, a mental health issue was defined as anything that differed from normality, for example:

> "Sometimes you see people hanging around without home or without like a normal daily routine and that person considered mad."

This understanding sets the scene to explain why her brother, who suffered from polio, was regarded as mentally ill as he did not fit in with what was considered to be the '*normal*' routine of everyday life:

> "My brother suffered from polio when he was born. Just because of his disability, my parents could not afford to send him to a special school, so he has to stay home without any education, but he has no learning disabilities that I know of. Only because of his physical disability he didn't get a chance to go to school, so people think he has mental health problems. But he has not, he is just compared to a normal person, he doesn't have a normal routine to go to."

Huang-liu talked about her upbringing and how she experienced that, within her family, physical disability was equated to mental disability. People with disabilities and their families were not supported, and people '*don't want to talk about it'.*

When Huang-liu came to live in Northern Ireland, her understanding of mental health changed as she encountered mental health issues with herself and her family and described this change as '*a journey*':

> "Change of my perspective of mental health since I came here is just a journey."

Initially, she believed that mental health issues had to do with not having a routine, but her perspective changed when she experienced post-natal depression:

> "It's like because I became a mother, I experienced a little bit of baby blues after my first child, and then I kind of become aware, as a human, we can have up and downtime."

Huang-liu described her post-natal depression as '*little bit of baby blues'* and how her experience contributed to the realisation that anyone can be affected by mental health issues. This realization deepened when she discovered that her husband struggled with anxiety and depression:

> "When my child born… we started to realise [the child] is autistic. I think that is the point that my husband realised the pressure on life and financial as well. But without any explanation, he started to get palpitations and then he became very depressed and then he had to see doctor and so this time we have to think about things like this. I think it is through all this experience that made me aware about mental health."

Huang-liu showed her awareness of the interconnectedness between mental health and life circumstances by linking the pressures in life with mental health issues. Further, she shows an understanding that physical symptoms, in this case, palpitations, can be connected to mental health issues, for example, anxiety. Mental health issues in her family raised her awareness, and she was able to apply her knowledge outside her family, for example, by not taking the behaviour of others personally:

> "So, it is not so shallow knowledge. It is like when you see people, they could answer you in different way, that could spark anger, but I realised we don't always have to take in that way. So, I started to think is it because he had a bad time, or something happened."

Huang-liu's idiographic account underlined how experiences of mental health issues in her own family changed her perspective. Huang-liu also realised that mental health issues can often be linked to stressful life events and are not rooted in the lack of a '*normal routine'*.

5.3.2.5 Summary

Recurrent theme 2 '*A journey* – shifts in perspective towards understanding and tolerance' revealed participants increased understanding of the causes of mental health issues and recognition that anyone could be affected and at any time. Environment and personal experiences were viewed as instrumental in changing perspectives on mental health issues, and participants also expressed that recognising common mental health issues can be difficult as symptoms are often less visible. Knowledge about treatment for mental health issues also reflected participants' level of understanding of the causes of mental health issues as possible treatment options ranged from medication to the suggestion that healing depression is a question of '*willpower*'.

5.3.3 Recurrent theme 3: Transformative influences – '*it can change your mind*'

Recurrent theme 3 explores in three super-ordinate themes that 'media – a source of psycho-education', 'being part of another culture', and 'personal experiences', further influenced how mental health is viewed. An idiographic account from Wu-shi adds further depth and highlights how encounters with mental health issues in different developmental life-stages contributed to a balanced view on mental health issues **(Table 13).**

Table 13: Transformative influences – '*it can change your mind*'

Recurrent theme 3	Super-ordinate themes & idiographic account
Transformative influences – '*it can change your mind*'	Media – a source of psycho-education
	Being part of another culture
	Personal experiences
	'*People have some kind of problems*' – influences which contribute to a change of mind (idiographic account: Wu-shi)

5.3.3.1 Media – a source of psycho-education

This super-ordinate theme shows that media exposure can contribute towards a shift of perspective, as many participants *p2, p4, p7, p9, p11, p16, p17, p22,*

[p26, p30] described TV, news, books and the internet as sources of psycho-education:

> "Papers and all those publications, media, they give you some information, and you can absorb that, and it can change your mind, and you get some knowledge about mental health." [Wu-shi]

Li-jiu used the internet to develop her knowledge about mental health and profited from being able also to access Chinese speaking webpages about mental health:

> "Because I go always to the [city in China] department of health and see any new things with regard to mental health, just for my perspective. Personally, I benefitted a lot from the internet."

Participants [p5, p15, p17, p20, p24] also voiced that mental health issues were more openly discussed in the media, for example, Chen-si observed more publicity of mental health issues in recent years:

> "If you think just recently, over the last 5 or 6 years, these mental health problem is more like in public domain – the medical or mental health people start broadcast it to the public domain, then we know, otherwise we don't know there are ways to help them."

Some participants [p5, p20, p24] suggested that there was a greater openness towards mental health because famous people openly admitted mental health issues. Wang-wu thought that this kind of psycho-education had an impact on the wider population:

> "A couple of years ago a very famous Chinese presenter, he left his post for a while and when he came back, he said he was depressed. I assume most people from that time know what depression is."

Participants made use of a variety of media sources to inform themselves about mental health issues. Participants also recognised that mental health had become a more visible topic in China due to the media and disclosure by public figures.

5.3.3.2 Being part of another culture

This second super-ordinate theme of recurrent theme three explores the influence exposure to a different culture can have on participants, for

example, living abroad and learning about other cultures also transforms views on what is regarded normal behaviour:

> "When I see some foreign custom, I will see the people not that normal. For example, I will take, for example, Taiwanese, they will see Scottish people, wearing a skirt, wearing a kilt, as people not being in good mental health, because they are not in normality." [Wang-san]

This example emphasised that mental health and acting within cultural norms are closely connected. Being exposed to a different culture can be the starting point of a growing awareness that personality and inner thoughts are not static. Wu-liu explained that living abroad changed his self-awareness:

> "I just myself may have a clearer or better picture of what the inner world or psychological world will be like. And that could be totally different, from what it was like several years ago when you were in a very familiar community so, that's why I mentioned, yes, of course, personally, my inner situation underwent a sort of change during the past several years. The only reason is, I, OK, one of the main reasons is, you are relocate yourself from a familiar community to a fresh new world."

Discussions about mental health issues also occurred at work. Zhang-er explained how, during a training course, she had experienced her local colleagues' reactions to the topic of suicide prevention and how '*they were in tears*'. She discovered she was emotionally not as strongly connected to the topic as her local colleagues:

> "I found it very easy to say because it is not in my own language. I don't feel the same. It just comes out like because the word doesn't mean the same. It works differently our brain."

Zhang-er's experience of not using her mother tongue when talking about a sensitive issue was revealing to her as she could better rationalize the problem. Zhang-er experienced freedom of expression in using another language as it did not evoke the same emotional response as it would in her mother tongue.

Among several participants [p1, p2, p10, p12, p28, p29] there was a sense that in Northern Ireland, mental health issues were more openly discussed:

> "I think the local culture here they are commonly are more easy to open up or chat. So, I think that's why the locals find it easier befriending group or peer group for mental well-being." [Li-shi]

Other participants thought that in Northern Ireland, mental health was more accepted as part of life:

> "But to local people, it [mental health] is a part of normal life." [Wu-ba]

However, Wang-er was also aware that only recently the attitude to mental health had changed and society becoming more open to discussing mental health issues:

> "So, and the doctor said to me, long, long time ago here, people don't want to mention here I am sad, I am depressed. They thought it is like a secret they don't want to say that, but recently people say oh I am so sad, I am depressed."

Some participants *p3, p6, p10, p25, p29, p30* suggested that more attention to mental health issues was paid in Northern Ireland and this was evident by the variety of services available to deal with mental health issues, for example, Li-liu stated:

> "Here [NI] you like more getting support from your GP, you can first talk to your GP you can go to the community public service area they will offer you hotline – you can choose like Lifeline, you know, all different kind of charity or government organization they offer help for the people who have problem."

Although participants were aware that such services were available in China, they still thought that more services were provided in the West:

> "Also, I think western countries definitely have done better than what they have done in China." [Wu-shi]

Zhang-er highlighted the kind of interventions which are more accessible in NI:

> "But Western way it is more things like counselling and other therapists."

While Wang-san emphasized that in NI, more care is provided to mentally disabled people:

> "I would say here, that here, for the disabled people, particularly mental disabled people, more care is given, than compared to China."

Chen-wu shared a similar view as she highlighted the support system in the West:

> "From the system and from the support I will say in Western country you have a better support system, and also I think in Western countries you have more training as well."

Chen-wu was not concerned about the local Chinese community not receiving treatment for mental health issues, as she regarded them as fully integrated within the whole local community and therefore having access to all their services:

> "Because they educated in here, so from the Chinese community points of view I don't see the difference, because they are born here and live in here."

Being exposed to a different culture broadened participants views, including their view on mental health. Participants also acknowledged that China and NI have some differences concerning mental health, for example, participants suggested that Northern Irish society is more open about discussing mental health issues and has a greater variety of services to support people with mental health issues.

5.3.3.3 Personal experiences

The third super-ordinate theme provides insight that personal experiences, either through indirect or personal exposure to mental health issues, can have a transformative influence on perceptions of mental health issues.

Indirect exposure refers to experiencing mental health issues suffered by colleagues, friends or family members and included depression *p2, p7, p15, p19, p23*, post-natal depression *p2, p4*, anxiety *p16, p20*, stress *p10, p22, p27* or behavioural issues *p4*. This form of indirect exposure raised participants' awareness of mental health issues. However, some participants also disclosed that they had personally suffered from mental health issues, such as depression *p3, p7, p16, p19, p23* or anxiety *p7*, for example, Wang-san disclosed:

> "In my life, I also for three or four years, I suffered depression for myself. I realised actually, every people have some kind of problems of mental health. They are just kind of lighter or severe."

Another participant, Huang-jiu, described how his exposure to depression changed his perception of mental health issues. He used the metaphor of a '*valley*' to describe both his feelings and how his problems had helped him gain empathy:

> "So honest, myself, in the past months, many valleys, so I have mercy, you know, the people with mental problem."

Other participants [p3, p5, p17, p23, p26] had also assessed their emotional state and connected it to mental health issues, for example, Huang-qi linked his emotions to a recent bereavement:

> "But the thing that would really influence me most is the personal experience myself. My mum passed away recently, and it has really affected me."

Some participants [p5, p23] were able to differentiate between mental health issues by describing their mental state, for example, Chen-san insisted he was depressed rather than stressed:

> "I am not stressed, I am depressed sometimes."

Wang-wu was able to self-assess anxiety, but had difficulties in self-assessing depression, as he admitted to a lack of knowledge about depression:

> "Until now, I still don't really know what depression is, all I know is that there is a really serious side of depression. I do have low anxiety sometimes, I don't feel like, I mean from my knowledge I don't see anybody mention that as depression."

Feelings of loneliness and helplessness due to acculturation were also regarded as influencing their mood and were regarded as a challenge:

> "I think one will go through a period of time, where one feel lonely, not so comfy. I think personally, I went through a period of time, you know, how to say, were challenging and helpless." [Wu-liu]

Another way of dealing with mental health issues was to normalise them, for example, Huang-ba had suffered a miscarriage and tried to make sense of

her situation by regarding her feelings as a normal reaction, generalising her experience within the wider context of women who had a similar experience:

> "Just that it is a normal process because just it is no exception, everybody feels the same."

The generalisation of her experience also infers an attempt to minimise her experience, maybe the hurt becomes then more bearable, and she is not alone in her pain.

Personal experiences illustrate an awareness of mental health issues as participants self-diagnosed mental well-being, including depression, anxiety, and various forms of loss, for example, bereavement.

5.3.3.4 'People have some kind of problems' – influences that led to a changed mindset (idiographic account: Wu-shi)

Wu-shi narrated in this idiographic account various perspectives on how, as a child, as a young adult and as a mature adult, she viewed mental health. Her narration reflected the experiences of other participants, such as fearing people with mental health issues or having a lack of knowledge about mental health issues. Wu-shi explained that when she thought of mental health, she immediately thought of people with severe mental health issues and her fear of them. She also explained that this fear was grounded in a childhood memory:

> "In the city where I was grown up, there was also a hospital, a mental hospital, so I remember clearly once when I travelled, that I met some of them and that really scared me."

However, fear was not her only emotion as Wu-shi also showed empathy when she used the verb '*suffer*' in connection with mental health and in how she described as '*terrible*' the fact that these people must stay in hospital:

> "Some of them they suffer lifelong illness and stay in the hospital for lifetime – very terrible."

She also described an experience from her time as a student at a Chinese university when a classmate suffered depression. Although Wu-shi described this incident as serious, she did not refer to it with the same emotional

response she showed when she was younger. Here, although neither she nor her classmates could make sense of the behaviour, she did not fear the person but instead thought she was strange:

> "She made very strange behaviour. Talk some very stupid words, so we just feel very funny and don't know what happened to her."

Her emotional response as a young adult was different from her response of '*fear*' as a child. Another reason for not showing fear could be that they had known the person before their illness. Wu-shi and her peers also tried to make sense of their classmate's emotional state:

> "She is just sad because she did not very well in her exam, and she just got separated from her boyfriend, and she was sad, and you know unhappy."

In addition, Wu-shi might have been influenced in her reflection of her classmate and how they had reacted to the person because she knew that her classmate had recovered:

> "But then you know, I think, it is four or five years ago, we had all classmates united together, and we saw her again. She was fine."

Witnessing both depression and healing in her classmate changed her understanding of mental health, and she recognised that not all mental health issues need long-term treatment in hospital:

> "So, at that time I know, OK, yes, mental health doesn't actually mean that we need to put her into hospital."

Her view on mental health issues expanded further as she herself experienced mental health issues:

> "I suffered depression for myself. I realise actually, every people have some kind of problems of mental health. They are just kind of lighter or severe."

Through her childhood encounter, her encounter at university and her personal life, Wu-shi understood that there are different levels of mental health issues. She recognised that anyone can have mental health issues and that there is still a lack of knowledge:

> “I don't know about here, but in China, there is not enough education on that, not enough knowledge among people about mental health.”

For her, the lack of understanding about mental health issues was confirmed in the reactions she experienced from her family who did not take her depression seriously:

> “I talked with my former sister-in-law, and she just said, 'What? Are you joking? Oh, you just have nothing to do. You just find something to do, you just so. She just couldn't understand. She just said, OK, you have a family, you have a beautiful child, you have good job, good salary. All your life is very good, so why are you depressed?”

Finding no understanding did not encourage her to disclose her mental health issue with her parents:

> “My parents, they still haven't gotten any knowledge about my period of suffering depression. They haven't.”

Wu-shi’s account can also be understood within a hermeneutic circle. Her observation as a child was the starting point for her knowledge about mental health. This informed her that mental health issues existed. Her student experience expanded her view on mental health issues, as she observed a different kind of mental health issues and realised that healing is possible. Her acquired knowledge enabled her to describe her mental health issues later in life as depression. Her experience contributed to a change in her outlook on mental health issues. But she also acknowledged that other people’s attitudes towards mental health issues had not changed, as she had experienced not being taken seriously by her wider family and this influenced her ability to share with her closest family.

5.3.3.5 Summary

Recurrent theme three ‘Transformative influences – *it can change your mind*’ underlines that psycho-education is a significant factor in increasing understanding of mental health issues. Psycho-education can be experienced in different ways, such as exposure to media or another culture or personal experiences, all leading to more understanding of mental health issues.

5.3.4 Section summary: mental health

The three recurrent themes of the mental health section, '*It was kind of a taboo* – ingrained associations and behaviour', '*A journey* – shifts in perspective towards understanding and tolerance' and 'Transformative influences – *it can change your mind*' all provide insight into how mental health is viewed within the Chinese community. It is evident that mental health issues are still stigmatised, and that mental health is still a sensitive topic. A shift of perspective was also detected, partially influenced by exposure to media and being part of another culture. Furthermore, experiencing mental health issues in self or others often led to feelings of empathy or normalisation in participants. It showed that stigma could be overcome by achieving a more accepting and open view on mental health issues.

5.4 Help-seeking

The help-seeking section examines in four recurrent themes how participants viewed help-seeking. An overview of these recurrent themes with their super-ordinate themes and idiographic accounts is provided **(Table 14).**

Table 14: Four recurrent themes of help-seeking

Recurrent theme 4	**Super-ordinate themes & idiographic accounts**
Paths of help-seeking – informal and formal ways	Informal paths – '*I will find a way*', self-reliance, friends and family
	'It makes you feel better just to talk to other people' – experiences of informal help-seeking (idiographic account: Zhang-er)
	Formal paths – *'the last straw'*, organisations, health professionals, and alternative methods
	'I received an invitation' – experiences of formal help-seeking (idiographic account: Huang-ba)
Recurrent theme 5	**Super-ordinate themes & idiographic account**
Shut the door, no one can see! – Isolation through sociocultural and interpersonal issues	Socio-cultural isolation
	Interpersonal isolation
	Changes in relationship while living abroad – '*sometimes you have to be alone*' (idiographic account: Huang-shi)
Recurrent theme 6	**Super-ordinate themes & idiographic account**
I did not know where to go – Insights into the difficulties of accessing services	Difficulties in accessing services – '*not familiar with the resources available*'
	Seeking help while grieving (idiographic account: Huang-qi)
	Lack of awareness
Recurrent theme 7	**Super-ordinate themes & idiographic accounts**
Language and Communication – a barrier	Language skills and resulting needs
	'*Refine it a bit'* – cultural adaption, a necessity in outreach (idiographic account: Li-shi)
	'I had no voice' – communication breakdown
	'*It was awful*' – an encounter with an insensitive health-professional (idiographic account: Zhang-er)

5.4.1 Recurrent theme 4: Paths of help-seeking – informal and formal ways

Recurrent theme four explores, with two super-ordinate themes, informal and formal help-seeking behaviour. Two idiographic accounts underline informal and formal help-seeking experiences of participants (**Table 15**).

Table 15: Paths of help-seeking – informal and formal ways

Recurrent theme 4	Super-ordinate themes & idiographic accounts
Paths of help-seeking – informal and formal ways	'*I will find a way*' – informal paths: self-reliance, friends, and family
	'It makes you feel better just to talk to other people' – experiences of informal help-seeking (idiographic account: Zhang-er)
	'The last straw' – formal paths: organisations, health-professionals, and alternative methods
	'I received an invitation' – experiences of formal help-seeking (idiographic account: Huang-ba)

5.4.1.1 'I will find a way*' – informal paths: self-reliance, friends, and family*

This super-ordinate theme explored informal paths of help-seeking, including self-reliance, talking to friends, and finding help within the family. Trusting in one's abilities to deal with problems was named by many participants *p1, p2, p3, p7, p11, p12, p18, p20, p22, p26, p29* as a form of help-seeking. This belief in their strength to solve problems was described by Zhang-yi:

> "After we moving here, only myself to deal with the problems. If I have problems, I can call home, but there is nothing they can do; they are so far away. So, anything I had to deal with the problem myself, I will find a way, I always think I can manage right away. I always think I believe in myself and do it."

Self-reliance was also regarded as part of the resilience Chinese display in everyday life:

> "Maybe they just get on, they are resilient. They just get on life." [Wu-jiu]

Self-reliance was described by participants as being proactive in dealing with the situation*p11, p12, p22, p26, p27, p29*. Zhang-yi explained that to her self-reliance also included learning new skills:

> "If I like to learn something, I can learn it. So, I can go on with my life. I think that's the way I survived here. Yes, to pay attention to the way here, pay attention to the TV news, to know the outside world, to know outside the family."

For Wu-liu self-help included self-reliance, based on reading books:

> "I tell you what, sometimes autobiographies, are very good. I read some of the books. Wow! What did those people used to go through in their lives actually happened a little bit in my life, and how they coped with such issues. Will give me some very good advice or tips on how to get those addressed. So, this is the process of internalisation. You think about it, and then you talk to yourself and then, just relax, take it easy. You try your best, to find ways to get those things sorted out – that's the main method I use when I wanna get rid of not so positive things in my mind. So that's what I do, really is a process of self-healing."

Wu-liu also highlighted the importance of exercise to deal with negative emotions as self-reliance:

> "It [exercise] is a very very important way to get those, and it also works very efficiently, it works very well. So whenever, I feel not that motivated, not that comfortable, or sometimes you feel quite low, or lonely, or anxiety, depressed, something like that. OK, leave everything at home and get out and do something and sweat, and then go and take a shower and then you feel fine."

Wu-liu then prioritized his methods of self-reliance and added communication, showing openness that health professionals could also be part of the help-seeking process:

> "So, I think you know, if I want to make big choices, number one comes sporting, number two reading and number three communicating with the people around. I think the fourth choice you mentioned today. I think it is a very good idea to talk to the professionals, even GPs if they are available."

Most participants *p1, p2, p3, p6, p9, p14, p15, p16, p17, p18, p21, p23, p26, p27, p28, p30* also considered using the internet as a form of self-reliance. Wu-liu regarded the internet as the '*first source of information*', and Chen-er even viewed it as part of Chinese culture:

> "Oh yes, the Chinese like to do that. Everything just google, and then at the end, they know more than you – I think that is the habit. That is the culture of the Chinese."

Talking to friends was another option for help-seeking for most participants [p1, p2, p4, p6, p12, p13, p14, p15, p16, p17, p18, p20, p21, p22, p23, p25, p26, p27, p28, p29, p30]. The term '*friend*' was understood by participants in different ways, for example, some used the term loosely as Wang-yi stated:

> "I think it can be extended to your friends, like even they are not your family, even though they are someone you know or your friends' friends. It is OK to ask help from them."

Other participants [p14, p15, p17, p22, p26, p30] were more specific and would only seek help from close friends, where experiences are shared, and trust is paramount:

> "Mostly their best friend I think for the people who really need to confide to someone they call their best friend. Someone they could really trust. They know that their secret won't be spread out to others. We don't know the person, we don't have the confidence, or feel the closeness – this is why we always go back to our best friend first." [Chen-er]

Seeking-help from family was mentioned by many participants [p2, p4, p5, p6, p8, p11, p12, p16, p19, p20, p22, p26, p27]:

> "I think I would prefer my family. Some problems, have some pressure, a lot of pressure, depressed, I would talk to my wife. I will have a pleasant chat with my daughter. I think, if I can talk with them, my pressure will go." [Wu-qi]

Dealing with problems inside the family is deeply ingrained in Chinese culture [p3, p4, p5, p11, p27], for example, Wang-si stated:

> "Because you know Chinese culture, we will solve this by ourselves or our families, we never are brought this out to public."

For Wang-wu, being listened to by his spouse helped him deal with his emotions and living abroad:

> "The first year I felt a bit lonely, but after that, when my wife joined, I think you can make a big difference with family. If I had something which made me happy or sad, I would speak to my wife. You get someone to listen to you."

When a good relationship between parents and children exists, parents often seek help from their children as they regard them as being more familiar with Western society:

> "Some of the old people I know, they have very good connection with their families, and their children are grown up here, and they are more knowledgeable, know more about things like that." [Zhang-er]

Living in a foreign country can lead parents to seek help from their children, using them as a bridge between two cultures:

> "Having to take on the responsibility in terms of being their cultural bridge between the biological family and the wider community. And there are many examples of young people being used as interpreters." [Li-ba]

Chen-er expanded on how a family can be supportive, creating a sound basis to deal with life's problems. To her, support meant establishing harmonious family relationships, for example, that her children show respect by behaving:

> "Family support is very, very important. Even though they do not know my problem, the support is like, for example, for myself, I have children, right, if the children, didn't really give much trouble to you. Like, they would do their homework, and they get good results in their tests, or exams or whatever, and they don't fight each other all the time, or they don't fight about silly things, and when you tell them to do something, they would say okay mama, rather than complain."

To Chen-er family support did not involve sharing her problems with her children, but as long as her children conformed to her standards, she was less '*troubled*' by her children misbehaving and was better able to deal with her problems.

Informal paths of help-seeking emphasised that self-reliance was the preferred way to deal with difficult situations. Self-reliance included developing resilience, for example, using the internet and books to improve their knowledge or using exercise to fight depression. Talking to friends and family was also considered as an appropriate way of help-seeking. However, it should be noted that participants had different levels of expectations concerning the relational depths of relationships to be able to disclose issues. Therefore, having friends or family did not always equate to having a trusted person to whom problems could be disclosed.

5.4.1.2 'It makes you feel better just to talk to other people' – *experiences of informal help-seeking (idiographic account: Zhang-er)*

Zhang-er's idiographic account supported the first super-ordinate theme 'informal ways of help-seeking' by underlining that having the support and help of friends is advantageous for well-being as it can reduce self-critical thoughts by gaining new perspectives. Zhang-er shared her relief after talking to friends:

> "Sometimes I think I am not a very good mother and then I just lost my temper, and then you have to tell yourself, everybody does that. It's really difficult, and then you talk to other moms, and then you realise your child is not the only one behaving like that. And you are not the only mom shouting at the child. So, it makes you feel better just to talk to other people."

Zhang-er judged herself as '*being not a good mother'* at times. This judgement was based on her self-awareness that she sometimes '*loses her temper*', and when this happens, she shouts at her child. By talking to other mothers, she discovered that she is not the only one who shouts at their children. She started to normalise her behaviour by saying '*everybody does that*' and used self-talk to reinforce this message. Zhang-er began to accept that '*shouting at the child*' can happen at times and sharing her experience with other parents helped her '*feel better'*.

Zhang-er's experience highlighted that help-seeking could occur in steps: identifying the problem ('*it's really difficult'),* sharing the problem ('*talk to other moms'*), coming to a conclusion ('*not the only mom shouting'*) and using self-talk to enforce the new awareness ('*you have to tell yourself…').* Zhang-er recognised that '*talk to other people*' changed negative emotions and helped deal with self-critical thoughts, therefore, positively influencing self-awareness and conditions of worth.

5.4.1.3 'The last straw' – *formal paths: organisations, health-professionals, and alternative methods*

The second super-ordinate theme of the fourth recurrent theme 'formal paths of help-seeking' describes participants' awareness of organisations, health

professionals and alternative methods they could access if they needed help. Many participants [p1, p2, p5, p6, p7, p8, p10, p12, p16, p18] could name at least one organisation to seek help from, with several [p1, p2, p10, p16] suggesting the Chinese Welfare Association:

> "I think that most Chinese people in Northern Ireland if they really need help, they probably would just look for Chinese Welfare Association and seek help there." [Huang-liu]

Advocacy services which offer interpreter service are known among the Chinese community:

> "Thank God, there is an interpreting service, if they need to go to see a GP and make an appointment, there is always an interpreter there." [Chen-si]

Advocacy services also reach out into the Chinese community offering training, workshops, and general advice as noted by some participants [p10, p12, p18]. Li-shi pointed out that advocacy services also aim to provide help in a culturally sensitive manner:

> "We have to make it more like a health workshop and associate it with an exercise session or a healthy eating session. Just to lighten it up a bit, not just to focus only on mental health. We will do something about mental health in that session." [Li-shi]

From her experience, the advocacy services also want to win the trust of the members of the Chinese community and work with social services:

> "We are kind of familiar face in the community, so we hope give them some confidence and trust. So that they trust us that we can deal with the issues or the social service make a referral to me, and I work on the cases with the Social Services." [Li-shi]

Positive encounters with formal health services contribute towards a greater willingness of seeking help, for example, Wang-si's open attitude towards formal offers of help-seeking is rooted in positive experiences with health services:

> "I think for me, maybe just the best way to talk to somebody you don't know – but here it is quite common, and we trust here, as we know everything is trustable here. But in China, we don't know which organisation we can trust."

Although participants indicated that they would seek help from organisations, seeking help from a health professional was commonly regarded as the last option, especially if it referred to mental health issues and would often only considered if the mental health issue was severe [p5, p11, p16, p17] as Zhang-yi expressed:

> "In my mind, I only think about my GP, if really really need help, but I don't feel I am at that level yet, I am not really that bad, that low, when I had trouble, it is not yet down to the bottom."

Seeking help from health professionals, such as a counsellor was regarded as challenging because members of the local Chinese community still do not want to be seen to seek help for mental health issues:

> "If you, for example, walk to a counsellor's office there are chances that people on the opposite side of the street, spotted you of walking in there. Oh, that's it, he is going to the asylum to seek help. He is mental. It is such a small community, whatever happens to one people, gets to know almost the next minute – that is the main problem." [Chen-si]

Concerns of staying anonymous within a small community were considered a major reason why members of the Chinese community are reluctant to seek help. In addition, reluctance to seeking formal help can often be traced to the stigma surrounding mental health issues, which contributes to doubts and reluctance about consulting a health professional as it could be regarded as being '*crazy*':

> "For myself, for my own opinion, the professional help will be the last straw, and it means, I am crazy." [Chen-er]

The depths of stigma towards help-seeking regarding mental health issues is further emphasised by one participant's experience of offering mental health workshops to the Chinese community:

> "The Chinese community here is quite a closed community so people would be very sensitive about. So if you really say 'mental health awareness workshop'. People would think 'oh if I come to this workshop then other people might think that I have a mental health issue' so that will people kind of stop from going to that workshop." [Li-shi]

Chen-er's and Li-shi's observations underlined how deeply ingrained the stigma of mental health issues is, but Chen-si also expressed hope that attitudes are changing:

> "But nowadays, it is much much better, I think. People realise it is just a problem with that person, it is nothing wrong with it."

Alternative methods of formal help-seeking such as applying Traditional Chinese Medicine were only mentioned reluctantly. Some participants did not know anything about Traditional Chinese Medicine *p4, p13, p29, p30*:

> "Not that I have experienced it myself or that I know anybody who has, but I haven't been myself, so I can't give an opinion there." [Wu-jiu]

Other participants *p12, p13, p24* stressed that Traditional Chinese Medicine was a long-term and holistic approach and did not immediately eliminate symptoms:

> "From my experience with Chinese medicine, they can't do the things so quick. It's a long term improve, it's a long process to improve yourself, but Chinese medicine helps you to improve gradually, for a long time. If you want to look after yourself, it is not rely on medicine. It is also your lifestyle and how to build up." [Zhang-san]

Although Traditional Chinese Medicine is used to treat many illnesses, some participants *p6, p12* did not think it beneficial for mental health issues:

> "I don't think Chinese medicine will be very useful for mental health because it is not just the case of taking medication, it needs people to talk to, it needs care for more about mind, and that doesn't really work on that side." [Zhang-er]

Chen-si noted that, due to difficulties in importing raw ingredients, much Chinese medicine is only available in tablet form and therefore is weakened:

> "People don't trust Chinese medicine in tablets. It has to be the regional material, that you boil or whatever you treat it at home. You boil it in water for 2 hours, so that the ingredient gets merged into the water and then you drink it. So that kind of things, you do not trust Chinese tablets, because it is not the same – if you have Chinese medicine it is you buy, and then you take it home, you start boil it, and then once it is done, you drink it. So that's what you want."

For Wang-san Traditional Chinese Medicine was closely connected to temple worship as the ashes of burned incense are often used as ingredients:

> "Chinese people use traditional medicine which is actually the ash of the incense. People go to the temple, and they worship the god inside and they burn incense – the incense burns, they collect the ashes, bring it home, put it in a cup and stir it with water and drink that."

Spirituality as a method of help-seeking was recognised by several participants [p1, p3, p6, p7, p14, p16, p22, p28, p29], for example, Li-qi experienced meditation as beneficial:

> "You know when I seek help not through conventional services, because it didn't work for me, but through meditation, which does work for me."

Zhang-si voiced that religion can help with mental health issues:

> "Sometimes, I also believe that religion is also important. Also, help you out. If you have religion inside your heart, doesn't matter what it is, also help."

Wu-ba emphasized the support network that religion can bring:

> "I am lucky because I am a Christian, I have a church, and that church group, I can talk to my brother and sisters in that sense. Give me some support, pray for me."

Chen-er regarded spirituality as an option if no other help-seeking method was successful:

> "The first time I would phone my best friend, the second time will hesitate, and then third time, if it happens again, I won't be ringing my best friend anymore. I just come to the realisation, if the same issue is troubling you, and you have been already mentioning it to your best friend, or you have been seeking professional advice, but it is still not solved. It does seem not the need to mention it anymore, even though it would still trouble me. So, the next thing I would do is, I would try to get some spiritual help. So, myself, I am a Muslim, so I just do my prayer, and pray that I get strength from my God, to help me get through this."

Persistent problems which cannot be solved by oneself, friends or health-professionals require a different approach and Chen-er found strength in her faith where she could express herself in prayers and gain new strength to help her cope.

Formal ways of help-seeking revealed that participants knew that community services, such as the Chinese Welfare association or other public health services, could offer help. However, consulting a health professional was only considered if issues were severe, or no other solution was found. Participants also acknowledged that the issue of anonymity within a small community and stigma about mental health issues still contribute towards a reluctance to formal help-seeking. Although Traditional Chinese Medicine was rarely considered beneficial for mental health issues, other alternative methods, such as spirituality or meditation, were regarded as useful.

5.4.1.4 'I received an invitation' – *experiences of formal help-seeking (idiographic account: Huang-ba)*

The second idiographic account in the fourth recurrent theme underlines formal paths of help-seeking by exploring how Huang-ba's experience of a traumatic event influenced her perception of help-seeking as she was offered several ways of support, including counselling. The variety of ways that support services were promoted led her to the conclusion that help-seeking services are widely available:

> "There are many different ways to find out".

Huang-ba then disclosed her experiences with help-seeking, for example, being offered counselling through the hospital:

> "I was very sad, and so the hospital said I was up for counselling".

However, there was a discrepancy between her needs and what the hospital thought she needed. Huang-ba owned her emotions, stating, '*I was very sad',* but did not pathologize her emotions. She was knowledgeable about mental health issues but did not label her sadness as depression. Her description of the hospital's offer of counselling as '*the hospital said*' is objectified and impersonal – she did not accept this offer, explaining*:*

> "I just didn't go for it. Of course, if I really think I needed it, I would go".

Although she did not attend face-to-face counselling, she was still open to seeking help and described other events which offered help, for example:

> "I received the invitation from [name] hospital for an event they held."

Without the invitation, Huang-ba would not have attended and "*I received an invitation*" echoes that she was recognized as an individual, as a person and she, therefore, followed the invitation. Her reaction reflected the attitude of other participants, who also noted that personal invitations help promote help-seeking. Huang-ba was proactive and continued to look for workshops to help her. Meeting others who had experienced a similar situation confirmed that what had happened to her was '*quite common'*:

> "I received a leaflet too, and he showed me the leaflet, and so I met everyone else."

Huang-ba's account showed that her openness to help-seeking and being pro-active played a role in accessing mental health related events. It also highlighted that personal contact and personalized invitations are important in outreach.

5.4.1.5 Summary

Recurrent theme four 'Paths of help-seeking' described both informal and formal ways of help-seeking. Informal paths of help-seeking, such as self-reliance or talking to friends or family, were preferred to formal paths of help-seeking, especially if issues were not regarded as severe. Zhang-er's account demonstrated that sharing similar experiences can often diminish self-doubt and contribute towards a better understanding of self. Formal help-seeking referred not only to health services but also to organisations who help with acculturation issues. Acceptance of formal help-seeking for mental health issues depended on various factors including the severity of the illness, suitability of offers of help and the trust in the help-service.

5.4.2 Recurrent theme 5: *'Shut the door, no one can see!'* – isolation through sociocultural and interpersonal issues

Recurrent theme five explores in two super-ordinate themes the issue of isolation from a socio-cultural and an interpersonal perspective and how it contributes towards a lack of help-seeking. An idiographic account from Huang-shi illustrates how relationship changes influence feelings of isolation (**Table 16**).

Table 16: *'Shut the door, no one can see!'* – isolation through sociocultural and interpersonal issues

Recurrent theme 5	Super-ordinate themes & idiographic account
Shut the door, no one can see! Isolation through sociocultural and interpersonal issues	Socio-cultural isolation
	Interpersonal isolation
	Changes in relationship while living abroad – '*sometimes you have to be alone*' (idiographic account: Huang-shi)

5.4.2.1 Socio-cultural isolation

This super-ordinate theme explored social-cultural isolation including geographical, social, and cultural factors which were regarded by several participants [p8, p9, p10, p13, p14, p17, p20, p22] as reasons for not seeking help.

Geographical isolation exists because the Chinese community are scattered throughout Northern Ireland:

> "The catering industry is something where you don't want to compete with too many other local Chinese takeaway. So, you go further out into the villages and towns throughout Northern Ireland to build your business, and that means that you are often the only Chinese in that village." [Li-ba]

Geographical isolation can lead to social isolation, especially if no immediate family is close by:

> "There will be still a lot of people who are isolated, who have not a very good connection to the local or the Chinese community here. Newcomers can be more isolated. I can only say about the ones I have come across – a lot of them are isolated, and although they might have friends, but not to the level they can disclose." [Li-shi]

Social isolation can become evident in cross-cultural marriages because a support network is missing, as Wu-ba explained:

> "If they come and marry to somebody in here, and you know the stress of things come from her husband or spouse. You know, where can they turn too? Because you know, they come to join their spouse in here. Family, girlfriend they are all his family and then you know that make it more difficult is you don't have your immediate family."

Social isolation can also be caused by not having the necessary social skills to build a new social network in a new country, as Zhang-san explained:

> "Even if they have lived here 20 years or 40 years. It doesn't mean anything if they not get out of their room they have a fear to reach somebody."

Unfortunately, overcoming fear is especially difficult where mental health issues are involved, and so the vicious circle of isolation and mental health issues continues:

> "For the people who have depression, they don't want to meet anybody, maybe only in their home." [Chen-er]

Different cultural behaviours and understandings between locals and the Chinese community can lead to cultural isolation, for example, Zhang-er explained that after giving birth the Chinese tradition of confinement was not understood by her Northern Irish mother-in-law:

> "When I was having the baby, my mum came over to look after me, and she always told me to lie in bed and sleep, and my mother-in-law said, it is not healthy. You need to go out, but our culture is not the same."

Zhang-er also shared the burden she felt of having to raise sons – for her, sons are providers for the family and, as their mother, she felt responsible for raising them to fulfil their roles within Chinese culture:

> "When I found out I had boys, I thought oh dear me, he is going to be responsible for another family, he is going to be man of another family, he has to have his own children, he has to be head of his own family, oh dear me this is stress, to have a boy."

Cultural isolation is also rooted in upbringing, and some participants [p1, p5, p22] expressed hesitancy about seeking help because they were raised not to ask or demand anything, but to endure:

> "In China, when we are child, you are not allowed to say anything, I feel that is our culture, carried on for generations, I mean parents ask you to obey what they say. I mean that is the culture in the place where you live, I feel that makes a big difference in people to endure, endurance, I mean Chinese people endure more. I would say bad – I don't know." [Wang-wu]

Being able to endure or persevere was described by Zhang-san as a cultural trait:

> "Chinese people also just put their head down to earn money. That is another culture."

Socio-cultural isolation connects geographical and social isolation, highlighting that both location and social issues can bring division. Social issues such as being part of an ethnic minority or having different cultural values hinder integration into mainstream society and contribute to isolation. Upbringing and cultural values such as endurance can also hinder people from seeking help as they are used to rely on themselves.

5.4.2.2 Interpersonal isolation

The second super-ordinate theme in the fifth recurrent theme provided insight into interpersonal isolation, which is defined as a lack of interaction between people and where social commitment, such as love or solidarity, is missing. Cultural values can worsen interpersonal isolation, for example, help-seeking for mental health issues was regarded by some participants [p3, p10, p14, p17] as shameful in Chinese culture. Huang-qi described his emotional reaction when he recognised his need for help:

> "I think it has to do with one being ashamed, admit it: I don't know. I have to say, my first attitude was, oh my goodness, I am a bit ashamed to admit that I am in that situation."

The Chinese cultural principle of 'keeping face' permeates behaviour and understanding, contributing to interpersonal isolation as people do not like to

share their problems as they want to avoid losing face and being treated differently:

> "The Chinese community here are a very close community, so they worry that other people, you know, they do nothing to share very openly their issue or concern because they are very sensitive and they worry that other people may think differently about them. They know they have problems, but they are too worried to speak up." [Li-shi]

Negative interpersonal experiences, such as not being taken seriously also reduce confidence and raise stress levels, contributing to a sense of isolation:

> "You can make friends, but to have true friend, friend is not like friend. So, you talk to them maybe they laugh at you. You are shy, and maybe you are not talk to them anymore, you just keep it to yourself, meaning you feel stressed, stressed, stressed. You are isolated from them." [Huang-shi]

Issues in trusting others were expressed by several participants *p2, p7, p11, p22* and Zhang-san generalized this to the wider Chinese community:

> "People don't want other people to know about themselves. Chinese people may be not so willing to talk about themselves. Shut the door, no one can see."

Keeping issues private can also be driven by a fear that institutions might interfere, for example, Li-qi described her fears when dealing with post-natal depression:

> "Whenever I had my child, I suffered from postnatal depression, but I knew I could get help from the health visitor etc. However, for me I did not want help from the health visitor, because I was so paranoid, about them going, oh she is a shit mother, she suffers from depression, I have the child taken off her. So, I was playing my post-natal depression down and trying not to have any interference from the state."

Although the fear that women with post-natal depression might lose guardianship of their child is also evident in the general population, this fear can be compounded for women from an ethnic minority.

Interpersonal isolation highlights cultural causes, such as shame or the fear of losing face, which hinder the development of interpersonal relationships. The question of trust is demonstrated on a micro-level, for example, can a friend be trusted, and on a macro-level where the trust of the wider

community is doubted. A lack of trust leads to an unwillingness to talk about issues and culminates in behaviour where mental health issues are hidden.

5.4.2.3 Changes in relationships while living abroad – 'sometimes you have to be alone' *(idiographic account: Huang-shi)*

Huang-shi's ideographical account provided additional insight into how isolation can develop by describing how her relationships changed while she lived abroad. Huang-shi experienced that her relationship with her parents had changed because she could not share her immediate problems as her parents had no understanding of living abroad:

> "How do you going to tell your parents about it? They won't understand about it. They don't understand even if you talked to them straight. I've got bullied by such kids but your family, they are in China, they cannot do anything about it. They will say, just talk to them or get over it, just tolerate it. You'll be fine."

Huang-shi did not think that the advice provided by her family was helpful. She did not feel that her family understood her situation, and she, therefore, turned to her friends to seek understanding, as they were in a similar position:

> "Then you maybe talk to your friends around you, talk to your friends, because they will have similar experiences."

However, how friendships are experienced is not always straightforward. Huang-shi reflected about the meaning and different level of friendships, distinguishing between '*play friends*' to whom you talk, but do not share your real thoughts or problems and '*true friends*'. She then reflected on her self-development and how her thinking and behaviour changed by using self-talk and depending on herself:

> "Sometimes I think in my mind, it is two people. And one talk to the other one. Two thinking sometimes. So, you have to learn how to say, how to live without people, without friends."

Huang-shi discovered that the feeling of loneliness was caused by not being able to communicate her true feelings:

> "Sometimes, you have to be alone. People are lonely. Why are they lonely? Because everybody in their heart they have their own thoughts. It is very hard to tell a different person, a second person to say what exactly I am thinking."

In the process of talking and conveying her thoughts, she realized that there was a difference between what she meant and what she said, increasing her feeling of loneliness.

Huang-shi's initial thinking was based on ideals of a collective society where family matters most, and problems are solved in the family. However, in her new environment, she experienced that her family's advice did not help her. She found some support with friends, but ultimately had to depend on herself, and this emphasised her feelings of having '*to live without people, without friends'.* Huang-shi described her experiences of an individualistic society which focuses on self, in contrast to the collective society where she grew up.

5.4.2.4 Summary

Recurrent theme 5 *'Shut the door, no one can see!* – isolation through sociocultural and interpersonal issues' highlighted how isolation could cascade. Geographical isolation leads to social isolation, which in turn can be reinforced by adhering to cultural values which can increase interpersonal isolation. Furthermore, acculturation processes influence relationships with self and others and can increase the feeling of interpersonal isolation. Thus, any form of isolation can decrease the likelihood of seeking formal or informal help.

5.4.3 Recurrent theme 6: '*I did not know where to go*' – insights into the difficulties in accessing services

Recurrent theme six explores in two super-ordinate themes the difficulties in accessing services. An idiographic account from Huang-qi adds further depth and highlights that help-seeking services are often not well promoted (**Table 17**).

Table 17: '*I did not know where to go*' – insights into the difficulties in accessing services

Recurrent theme 6	Super-ordinate themes & idiographic account
I did not know where to go – Insights into the difficulties of accessing services	Difficulties in accessing services – '*not familiar with the resources available*'
	Seeking help while grieving (idiographic account: Huang-qi)
	Lack of awareness

5.4.3.1 Difficulties in accessing services – 'not familiar with the resources available'

This super-ordinate theme explored difficulties in accessing services as several participants [p2, p14, p15, p21, p23, p26, p28, p30] explained that they did not know where to seek help for mental health issues, for example, accessing the GP for mental health issues had not occurred to them:

> "I did not know that. I thought if you have any physical problems you go to the GP and that's it." [Wu-shi]

Several participants [p4, p7, p9, p10, p15, p18, p21, p25] regarded unfamiliarity with the local health system a barrier to help-seeking:

> "They are not familiar with the resources available, they don't understand the health system here." [Li-shi]

Li-qi questioned that information about how to access health services is getting through to the Chinese community, especially to newcomers:

> "For other native Chinese, Hong Kong who come over here they probably don't have a clue where to go. I just think that the whole understanding the process – that you can access through the GP. I am not 100% certain that Chinese people will know that."

Coming from a different health system means members of the Chinese community might be unaware that treatment in Northern Ireland is free or that they need to register with a GP:

> "The health system is different here than it is in China. In China, we don't have a GP. People can go to any hospital in China." [Chen-wu]

Unfamiliarity with the local health system can lead to fears about treatment methods, as Zhang-wu described:

> "My mom has depression, and she said to me I think I have depression, but I don't want to go to anyone, because they might think arrest me, take me to a hospital or lock me up or something."

Being afraid of services based on a lack of information, and therefore not using them can easily lead to a bigger crisis. Some participants *p7, p8, p10, p17, p22* stated this lack of knowledge was due to a lack of outreach towards the Chinese community. Li-ba observed a lack of campaigns targeted at the Chinese community and a general lack of research into the mental health needs of the Chinese community:

> "I haven't necessarily seen many mental health campaigns within the Chinese community to raise awareness. I don't know of a specific report or study that is to assess the needs around mental health of the Chinese community specifically. And it's only that we have that pilot for BME and people in general, which is specifically addressing mental health issues, but that is for all minority groups, not specifically for the Chinese."

A lack of services for the Chinese community was also mentioned by several participants *p7, p8, p10, p16* as an issue:

> "Because there are very few services out there for people with those major issues, like post-traumatic stress and there are not enough services." [Li-qi]

It was also noted that some areas are better supplied than others, for example, Huang-liu explained that there was no help in her area:

> "She thought I am in the mid-Antrim area she thought I get help from here, but in fact, I am not. I think it is because of the area that Chinese people scatter a lot around the island. It is very hard for them, so I think for the mental health available to Chinese, I don't think it's good here."

The complexity of the help-seeking process was regarded as a further barrier by several participants [p1, p17, p21, p24, p29]. Chen-si described some of this complexity by indicating that the right amount of self-awareness, willingness to change and agreeing to a treatment method are all part of the help-seeking process:

> "You have to realise that you have a problem, and you are determined to be better. Now, it is up to you to decide which is the best for you."

Even if people know they can seek help for mental health issues through the GP, accessing services was regarded as difficult as awkward appointment systems were a hindrance:

> *"It is getting more difficult, and GP are really very busy, and then we book our appointment at least two weeks, you know to see a GP. By that time, your depression may be getting better, or you dealt with in some other ways. So that is not helping".* [Wu-ba]

There was a sense that too many obstacles exist and so people often give up on seeking help:

> "If there are too many barriers for you to seek help, you would just feel don't bother." [Wang-yi]

Participants were unfamiliar with the options the health services provide and did not know how to access them. There was also a sense that there were not enough services for ethnic minorities and a lack of outreach to the Chinese community to inform them about mental health services. The help-seeking process was also regarded as too complex and hindered people from seeking help.

5.4.3.2 Seeking help while grieving (idiographic account: Huang-qi)

Huang-qi's idiographic account adds to the first super-ordinate theme by focusing on the steps prior to seeking help. Huang-qi described his helplessness in deciding whom to talk to when trying to seek help after a bereavement:

> "I did not know where to go, who to talk to and sometimes talking to family members, you sometimes just feel you are burdening them, and they themselves are going through bereavement…You do need to talk to people, that is my thinking, and you do need to know where to go, and unfortunately these are all things you are not prepared."

Huang-qi was weighing his options of whom to talk to either family or someone outside the family and concluded that he was not prepared for this choice as he did not know where to go. He knew there were services available, but the number of services was overwhelming and added to confusion about whom to trust:

> "There are just too many organisations. How do you know what is the right one to go to? And what is actually a genuine organisation, who is there to help, or to use and abuse when you are vulnerable?"

Based on his experiences, Huang-qi stated that services were not well advertised as he found it challenging to find the right services for his issue:

> "The question is, are we not having the services out there in the open more to let people learn it is there or make it easier to find."

Huang-qi remembered an organisation from his youth but was unsure if they still existed:

> "I do know there is one: Cruse. But again, there is from when I was younger, during my education, we know that was available, but I don't hear about them. It is not well publicised – I don't know whether they still exist."

Huang-qi stated that organisations who could offer help are not advertised enough among the adult population:

> "As far as I know, there are a few organisations that are available, but there is not a lot of publicity for let's say for adults, who maybe seek help."

Huang-qi's experience highlighted that although he knew about services for mental health issues, he could not obtain enough information about the kind of services they offered and therefore stated that it was difficult to decide in favour of seeking professional help. Huang-qi suggested that to make mental health services easier to access, they need to advertise their services more clearly and cover all ages.

5.4.3.3 Lack of awareness

The second super-ordinate theme of recurrent theme six explored how a lack of awareness of mental health issues further influences help-seeking behaviour. Not seeking help can be rooted in a lack of psycho-education, which was evident in the lack of awareness of mental health issues many participants [p2, p3, p4, p6, p8, p10, p12, p17, p22, p24, p25] described. Chen-er, for example, observed that Chinese parents often do not consider that mental health issues might affect their children's behaviour:

> "I think, for the early stage, they don't think it will lead to a very, very serious situation [refers to difficult behaviour of students] the parent doesn't seem to see that that is a mental health problem. And that it might be linked to a mental health problem. You see, it doesn't really see the link, but in reality, it has the link."

Not connecting physical and mental health issues suggested that people sometimes miss out on receiving help:

> "A lot of my clients like I said before they don't realise that their physical problems in relationship to mental health. So, if they don't realise that how do they seek help? So sometimes they don't see that there is a link between the physical health and the mental health… but if the root of the problem is a mental health issue if they don't realise that, how are they gonna deal with that?" [Li-shi]

A slow deterioration of mental health can also hinder the recognition of a need for help-seeking:

> "Mental health can happen sometimes very slowly, and the person might not be aware that they need help." [Zhang-er]

Huang-qi painted a picture of despair when someone who needs help, cannot find help due to lack of awareness or support:

> "Sometimes you have been blinded, just going down the spiral not knowing that you are actually need help. The risk of getting deeper and deeper into it, rather than get out of it."

Some participants [p4, p7, p9, p17, p24] also suggested that age, gender and education influence awareness towards mental health and help-seeking. Chen-si expressed the importance of raising awareness about existing services among older members in the Chinese community and stated:

> "What we are trying to raise awareness for is among the older generation, that that age can access this kind of services that is free and that is there to help."

Findings also showed that help was often only sought when mental health issues had escalated to a critical point. Many participants *p1, p3, p6, p7, p11, p15, p18, p20, p23, p25* explained they would only seek help when the situation became so severe that they could not deal with it anymore:

> "If something to do with my family and I cannot solve it by myself, then I will definitely ask for help." [Wang-yi]

Withdrawal from society was a sign that help-seeking is needed and going to seek help is then accepted and even encouraged as some participants *p1, p16, p20, p23, p25* explained.

> "Unless you are very, really, really, serious. You cannot go to work, you cannot meet friends, then people have this companionship to you. They will think, oh, yeah, yeah, yeah, go to the doctor is fine." [Huang-shi]

Lack of awareness was caused by a lack of psycho-education, as participants described that they did not link physical and psychological problems. Often help-seeking was only encouraged and accepted when psychological problems became more visible, for example, when people withdrew from society and could not cope with daily life.

5.4.3.4 Summary

Recurrent theme six '*I did not know where to go* – insights into the difficulties in accessing services' illustrated that unfamiliarity about existing health services is exacerbated by a lack of advertised services for the adult population and limited awareness of mental health issues in self and others.

5.4.4 Recurrent theme 7: Language and communication – a barrier

This recurrent theme explores in two super-ordinate themes how language and communication issues contribute to barriers in help-seeking. Two idiographic accounts from Li-shi and Zhang-er underline the importance of culture and sensitivity in communication (**Table 18**).

Table 18: Language and communication – a barrier

Recurrent theme 7	Super-ordinate themes & idiographic accounts
Language and communication issues – a barrier	Language skills and resulting needs
	'*Refine it a bit'* – cultural adaption, a necessity in outreach (idiographic account: Li-shi)
	'I had no voice' – communication breakdown
	'*It was awful*' – an encounter with an insensitive health-professional (idiographic account: Zhang-er)

5.4.4.1 Language skills and resulting needs

This super-ordinate theme highlighted that language skills are often an issue as several participants [p1, p9, p16, p21, p30] noted that some members of the Chinese community have difficulties with English which has consequences in daily life:

> "I noticed not everyone in the Chinese society can speak very good English. If they work in a Chinese takeaway, and in this case, they always stick with Chinese people, they don't need a very high level in language. That can be a situation for a lot. They need help, they don't know how to express themselves properly." [Wang-yi]

Participants also observed that limited language skills restricted knowledge on where to access help [p3, p28], hindered developing deeper relationships with local people [p15, p23] and led to them being more isolated [p1]. Insufficient English language skills were regarded by many participants [p2, p7, p9, p10, p17, p19, p21, p25, p26, p29] as a barrier to receiving help. Huang-qi voiced that the older generation or the first generation often does not have the necessary English skills to communicate well:

> "A lot of the older generation, or maybe the first generations that are here, English may be not their first language, or they may not use English that often or they may not interact with the locals as much."

But lack of basic language skills was also found across generations. Depending on their background, the younger generation can also experience language difficulties. Li-jiu referred to the new intake of Chinese immigrants from mainland China over the last decade. Although some are highly educated, not all have the same high level of education or opportunity to practice their English skills before coming to Northern Ireland:

> "The younger ones who come… if they have not used English in their hometown, yes, then, it is still difficult."

Li-shi identified asylum seekers and refugees among the Chinese population as being most vulnerable as they often have poor English:

> "For the Mandarin speakers from mainland China, some of them are very well educated. They are coming here as researcher or studying, but still, a lot of them are coming are refugees or asylum seekers and come for a job in the catering industry or even a large amount of them are undocumented so their English, of course, is not that good and then they are more vulnerable."

Not being able to communicate leaves people in need of help as they cannot use existing services without interpreters:

> "They say there is citizen advice bureau and other things, but you know there is no language support there, you know, how to use the service. Some people do come to Chinese Welfare Association, with a letter they cannot read. They do not know what it is. You need staff to do it. To help them to read their letters. Or benefit, it can be all, this kind of service should be available." [Wu-ba]

Talking about health issues with a health professional can be challenging, as Wu-liu stated:

> "It is very challengeable, for them to have a very thorough and detailed communication for the GPs to know, to have a very clear picture, what is there?"

Difficulties in adequately expressing themselves make it even more challenging to seek help:

> "Especially here in Northern Ireland a lot of Chinese people they have no English, or even they know English their English is not sufficient enough for them to describe their symptoms or go to see the doctor." [Wu-jiu]

Insufficient English language skills require the use of interpreters. However, this is often not desirable as people often do not trust interpreters to keep confidentiality:

> "Some Chinese person cannot understand, then they have to ask someone to translate for them, and they don't want to face some other person to know." [Wang-er]

Huang-jiu clearly expressed that he was not interested in using an interpreter:

> "I know I can have an interpreter, but I don't want an interpreter, no." [Huang-jiu]

Some participants who worked as interpreters for the Chinese community highlighted the difficulties of interpretation, such as the inaccuracy of translation, not having enough time to translate the full conversation and difficulties conveying issues of mental health:

> "It is very different, I mean, to express in a way to the psychiatrist when you are not using your own language, and then through the interpreter, it might not be so direct, and you don't really feel that way. Some people want to tell their story in one whole go, and then you in the short. I mean for physical illness it is already difficult, never mind for mental." [Wu-jiu]

Even if language skills are adequate worries about communicating still exist and each level of language skills has its challenges:

> "Even if we know there is a place for mental health counselling, we still worry about the language during communication. We have some difficulty to express ourselves to exactly what the problem is." [Wu-qi]

Huang-jiu confirmed Wu-qi's worries about imperfect communication as he was aware that accurate communication could be advantageous. Huang-jiu experienced his lack of language skills as a '*wall*', separating him from health professionals as his English was not good enough to truly express his state of mind:

> "But still, still, not enough to describe my heart, but that is the problem, the psychology won't understand, don't totally understand my heart, this is a wall, one that you don't see."

Communicating mental health issues was experienced as difficult, especially when insufficient language skills hinder precise communication.

A lack of English language skills depended on education level, and opportunities to speak or study English and spanned all generations. Having insufficient English skills has repercussions such as isolation, not being able to use existing services, and an inability to express themselves in case of illness. Although interpretation services exist, translation can never be completely accurate, as some issues get lost in translation and privacy is further compromised by involving another person in the help-seeking process.

5.4.4.2 'Refine it a bit' – cultural adaption, a necessity in outreach (idiographic account: Li-shi)

Although linguistic problems contribute to barriers in communication, these issues are not solved through translation alone as cultural aspects also need to be considered. The following idiographic account of Li-shi adds to the first super-ordinate theme, highlighting that a lack of cultural adaption prevents successful outreach to the Chinese community. Li-shi recognized differences between ethnic minorities and the local population and questioned if Health and Social Care had the same awareness regarding mental health issues:

> "They [Health and Social Care] must have tried it with the local community so they must think we expand it and reach out to other minority ethics, so they have it translated. But sometimes you know the campaign or activity event that might work well in the local community but does not necessarily work with the minority ethics completely."

To Li-shi proper cultural adaption means that services need to go further than just translating existing material, even if that material had previously been used successfully among the local community:

> "A lot of things work well in the local community, but they cannot use it directly on the minority ethics. They [Health and Social Care] have to refine it a bit or make some changes and do some research for the minority ethics to really find out exactly what the community is like and what they need."

Li-shi was aware of outreach towards the Chinese community concerning mental health but criticized it as not '*refined*', due to a lack of research into

what the Chinese community needed. Li-shi's experience was that if the local community is willing to attend a mental health workshop, it does not mean that it will also work for the Chinese community. Li-shi also experienced that local people had no problem with the term '*mental health*' whereas people from the Chinese community did:

> "They see program posters by organisations or even Health and Social Care in here. If they just say 'mental health awareness workshop' that is no problem at all [for the local community]. But I can mention if we would do exactly the same the same here, it would be a very different story [for the Chinese community]."

Li-shi reflected that, in her experience, sensitivity is needed to invite the Chinese community to mental health events and suggested using other terms to raise interest in psycho-education:

> "If we brand it like a distress day or something like that, we can have exercise trials, come for some information and then we have staff here to have a casual chat, and then people will come. Although at the end we still don't know how many people we will get, but we will know that it will work much better than just say 'mental health awareness workshop'."

Li-shi's account provided insight into how offers of help-seeking need to be better communicated to avoid misunderstandings. She stated that what worked for the local community often did not attract the Chinese community due to a lack of cultural adaption.

5.4.4.3 '*I had no voice' – communication breakdown*

The second super-ordinate theme of recurrent theme seven expands linguistic skills by exploring that communication also involves interpersonal skills, with participants sharing some experiences of communication breakdown. Breakdown in communication happened not only within the family but also with professionals in the health service. Many participants *p1, p4, p6, p11, p15, p17, p20, p21, p22, p26, p28, p29, p30* stated that they would not seek help from their families. However, the definition of what constitutes family varied. Some participants defined family as the family of origin, others referred to their spouse or children. Depending on their relationships, some would seek help from their spouse but not from their family of origin. The main reason for

participants [p4, p6, p20, p21, p26, p30] not seeking help from their family of origin was not wanting to burden or worry them, as Wu-shi declared:

> "I will not first contact my family. No, I will not, definitely, no. Because, you know, even though you know, back in China, I will not first talk with my parents, the first people I will talk with will be my friends, not my family. And also, after that with professionals, not with my parents. No, the thing is I do not want that they worry about me."

But it was not only children who did not want to share their problems with their parents as parents also did not like to share their problems with their adult children:

> "I mean for older generation, they probably don't want to let their children know because they don't their children to worry about than the other way round, that the children, don't want the parents to worry about them." [Wu-jiu]

Another reason for not sharing problems was the feeling of being misunderstood by the family:

> "I don't go to family really. Yeah, it is just, I think, I will kind of living in a different environment so they wouldn't like understand my situation." [Chen-san]

Being blamed instead of supported can leave the help-seeker in a worse emotional state, as Wang-yi explained:

> "If I talk to my family, I talk to my mum and say I lost my phone. My mum will blame me and say, oh, you are so careless. And I feel burdened, it is my fault, so I better don't talk to my mum, as I will feel bad and I won't get any better."

Up-bringing played a part in why participants did not want to seek help within their family. For Wu-ba, the reason why she did not seek help within her family of origin was that she had *'no voice'* in her family, and this experience impacted her, even as an adult:

> "You know, when I was young, I feel, I had no voice in my family, as I middle in the sibling and I shouldn't voice my opinion, we carry things you know."

Chen-er provided another example of how up-bringing influences communication between parents and children. In an Asian upbringing,

parents have a higher status than children and therefore, children need to listen to their elders. If the child decided not to follow the advice of their elders, this would be regarded as not respecting their elder:

> "I think the Asian, especially the Chinese, they expect much higher level of the respect from the youngest to the eldest compared to the Western countries. And, again the parents, or grandparents or the elderly, they wouldn't lower themselves down to be or as a friend to the children. They always act as parents. They are always higher, indirectly, that means, they will show the children have to follow the authority of the elder, which put a boundary for the communication."

Another area of communication break-down was also described when contacting health-professionals. Negative experiences with health professionals, including not being understood, feelings of being unworthy of the GP's time, and feeling intimidated were narrated by some participants *p12, p14, p15, p16, p26, p28.* Huang-liu expressed her experience of not being understood and stated her problem was not taken seriously:

> "When I was really stressed and things going on in my life, and then I share it with my GP. It was a problem to me, but they did not give very helpful advice. I have quite a few number of times a bad experience with my GP, because, for me, if I go to see a GP, it means I need help or assisting. But a lot of the time they made me feel, my problem is so minor and why I need to see them."

Some participants *p14, p24, p26* also had the perception that GPs had no time or interest to listen to their problems:

> "I don't think they want to spend a lot of time talking to them or communicating in very thoroughly, what you are going through, what sort of experience you might have had and whether as a GP, I can provide some help. My personal experience, as I already have mentioned, I only met my GP once, talked to him like 5 minutes. Everything is OK, so no problems, OK, you can go." [Wu-liu]

This brief encounter with the GP left no time for Wu-liu to discuss more sensitive issues, such as mental health issues:

> "While it may come to the mental issues, they need to communicate with you very thoroughly to talk to you in detail, to know what it is about your personal life, so I need to put aside language barriers, the culture barriers, which is very challenging for any GP to do that."

Some participants [p1, p17, p26] suggested that, even if problems are communicated, members of the Chinese community could not be sure they would be fully understood when seeking help from outside the Chinese community:

> "There may be also an element, where, let's say a non-Chinese speaker, doing an interview, that they may not appreciate the cultural background." [Huang-qi]

Communication breakdown was experienced with family as well as with professionals. The reasons for not communicating within family varied from not wanting to burden anyone to being afraid of being blamed. Also, the status of parents as authority figures contributed to a lack of communication. Difficulties in communicating with health professional underlined a lack of patient-centeredness and insufficient consultation time, reinforcing insecurities about language and cultural understanding.

5.4.4.4 'It was awful' – encounter with an insensitive health-professional (idiographic account: Zhang-er)

Zhang-er's idiographic account expands the second super-ordinate theme by disclosing how the insensitive behaviour of health professionals can present a barrier to help-seeking. While working as an interpreter Zhang-er was aware that a client was very reluctant to explain the reason for her depression, but the health professional pushed her client to disclose the reason:

> "She doesn't want to talk about it. I know, she doesn't want to talk about it. And then he forced her, you have to tell me."

Zhang-er described the conversation between doctor and patient as '*awful*' and wanted to complain about his attitude:

> "Oh, I nearly complained him, because it was so awful."

Although Zhang-er did not make a formal complaint, she tried to make sense of the insensitive behaviour by explaining it as a male-female power struggle:

> "I could tell that because he is a man and she is a woman, and she already felt intimidated."

In her role as interpreter Zhang-er also made sense of her client's hesitancy of disclosure:

> "Her problem, to tell a strange man, it is a difficult thing to talk about, and she didn't want to say it."

Zhang-er described her emotional state after this conversation, which she regarded as the same as her client: "*So I was really upset for her*". Zhang-er displayed empathy as she was upset on behalf of her client about this insensitive communication.

Zhang-er's account underlines that communication breakdown is often multifaceted, with different levels of miscommunication. In this account, there was a lack of communication between health professional and patient ('*he forced her*'), between health professional and interpreter ('*I nearly complained'),* and between patient and client ('*I was really upset for her*').

5.4.4.5 Summary

Recurrent theme seven 'Language and communication – a barrier' demonstrated that although language skills are essential in communicating, soft skills, such as conveying understanding, being non-judgemental and respecting others are also needed for meaningful communication. These soft skills are pivotal, not only in personal relationships but also in other areas of communication, for example, between health professionals and patients. Furthermore, if translations are required, cultural issues need also to be considered for translation of speech and printed material.

5.4.5 Section summary: help-seeking

The four recurrent themes 'Paths of help-seeking – informal and formal ways', *'Shut the door, no one can see!* – isolation through sociocultural and interpersonal issues', '*I did not know where to go* – insights into the difficulties in accessing services*'* and 'Language and communication – a barrier' showed that informal ways of help-seeking were often preferred to formal ways of help-seeking. This indicated not only the resilience of participants but also revealed doubt if formal help-seeking services could be

trusted. Isolation, limited awareness of mental health issues, restricted language skills, a lack of soft skills regarding communication and insufficient culturally adapted information material for the Chinese community presented barriers to both formal and informal paths of help-seeking.

5.5 Counselling

The counselling section consists of three recurrent themes: 'Impact of counselling within the Chinese community', 'An unfamiliar treatment method: *what would you actually do?*' and 'Issues of trust – a barrier'. These recurrent themes are listed, with their super-ordinate and idiographic accounts (**Table 19**).

Table 19: Three recurrent themes of counselling

Recurrent theme 8	**Super-ordinate themes & idiographic account**
Impact of counselling within the Chinese community	*'God knows what is out there'* – a critical view of counselling referrals, sessions, and approaches
	'By just talking you do not solve my problems' – counselling through the lens of an interpreter (idiographic account: Wu-jiu)
	'*It is a vital service*' – receptive impressions about counselling
Recurrent theme 9	**Super-ordinate themes & idiographic account**
An unfamiliar treatment method – '*what would you actually do?*'	Lack of information about accessing counselling
	'Too young to differentiate' – promotion of counselling, a call for sensitivity (idiographic account: Chen-er)
	Limited knowledge
	'*Not many places here for you to go for counselling'* – about finding a counsellor
Recurrent theme 10	**Super-ordinate themes & idiographic account**
Issues of trust – a barrier	'*Don't talk to strangers*' – lack of confidentiality
	'Nobody needs to know' – the importance of privacy (idiographic account: Zhang-yi)
	'*Not part of Chinese culture*' – counselling regarded as a Western idea
	'This person will know my business' – three's a crowd, the use of Interpreters

5.5.1 Recurrent theme 8: Impact of counselling within the Chinese community

This recurrent theme explores how encounters with counselling had influenced participants' views on counselling. Although only four participants [p6, p7, p8, p19] disclosed that they had experienced counselling, other participants had encountered counselling through family or work. Two super-ordinate themes were identified: '*God knows what is out there*' and '*It is a vital service'.* An idiographic account adds further depth by including the third-person perspective of an interpreter (**Table 20**).

Table 20: Impact of counselling within the Chinese community

Recurrent theme 8	Super-ordinate themes & idiographic account
Impact of counselling within the Chinese community	*'God knows what is out there'* – a critical view of counselling referrals, sessions, and approaches
	'By just talking you do not solve my problems' – counselling through the lens of an interpreter (idiographic account: Wu-jiu)
	'*It is a vital service*' – receptive impressions about counselling

5.5.1.1 '*God knows what is out there' – a critical view of counselling referrals, sessions, and approaches*

This super-ordinate theme examined critical views about counselling, regarding counselling referrals, sessions, and approaches.

The referral process is an important factor in accessing counselling, for example, Huang-jiu was offered counselling but experienced the referral process as insensitive, and this impacted his views on counselling:

> "They sent me to a counsellor, and then it is difficult, you know."

Huang-jiu said '*they sent me*' – he was '*sent*', not asked if he wanted to go or to whom he wanted to go. It seemed to him that his opinion did not matter, and this experience of the referral process negatively influenced his perception: '*and then you know it was difficult*'. As a result, he questioned the usefulness of this offer of counselling and the value of investing time in something he doubted would help:

> "You spend more time, and it won't guarantee you heal or any better. No guarantee, no faith, no confidence."

Zhang-wu described why the referral process could be pivotal in accessing counselling. She explained that before the actual referral, the client has often already been thinking about counselling for some time and so a referral with a long waiting list becomes a barrier to seeking counselling. The day before she took part in this research, Zhang-wu had phoned her GP to get a counselling appointment:

> "I just rang them yesterday [middle of October] – the only appointment they have is in December, which is kind of a long way off."

An appointment in December meant Zhang-wu would have to wait at least six weeks for counselling and this seemed '*a long way off*' to someone who wanted counselling. Zhang-wu also described her thought processes before actively seeking counselling:

> "I don't think people are very aware of it, of these options, you definitely have to look them up. I guess it is not just common knowledge. When you look them up, you have to think about whether you do want to contact them, and I think that is just the first step. And then after that, they actually have to go to the appointment they made. So, I think there are just a lot of steps where you decide not to."

Zhang-wu observed three steps before the actual counselling process starts. Firstly, making enquiries about counselling services, secondly, deciding whether to contact the counselling service and thirdly, actually going to the appointment. However, Zhang-wu described these steps as '*there are just a lot of steps*' – her perception of these three steps is '*a lot*' and, to her, these steps result in people deciding against counselling. Based on Zhang-wu's description, it becomes evident that by the time a person seeks counselling, they have already been through various thought processes. Therefore, having to wait for weeks or months presents a barrier to counselling and can lead to a change of mind:

> "There is enough time to change your mind." [Zhang-wu]

Li-qi disclosed that she had often been to counselling and indicated the intensity of this experience by exaggerating: "*I went through hundreds of*

counsellors". Although she acknowledged receiving counselling which was beneficial to her, she also complained that many counsellors had been not beneficial:

> "I would say in my own personal experience of counselling, at least 50% of those who I have met, were absolutely bloody awful and actually deeply damaging to me in different points in my life. So, I have actually met more shit counsellors than good ones." [Li-qi]

Li-qi's use of terms such as '*bloody awful*', '*deeply damaging*' and '*shit counsellors*' surprised the researcher, but also indicated that the participant felt safe to express her feelings in the interview, even though she knew the researcher was a counsellor. Li-qi further emphasised her critical view on counselling by doubting the availability of good counsellors:

> "If that's my own personal experience, God knows what's out there for other people."

Li-qi's negative counselling experience impacted her assumptions about counselling for other people, as she concluded that there might not be many good counsellors.

Wu-ba perceived counselling as a '*luxury*' as she was aware that other services address more immediate needs:

> "They haven't got any funding to do all this work [refers to immigration or benefit advice]. So, their day-to-day life, still haven't got you support, so counselling would be after all these things."

Exposure to counselling experiences through work, also contributed to a critical view on counselling, for example, Li-shi, who works in a managerial position, received feedback from a client that counselling was not beneficial. The client's interpreter confirmed this feedback by explaining to Li-shi that the counsellor addressed the interpreter rather than the client. Li-shi made sense of this by recognising that the interpretation was the underlying cause of the difficulties. Her experience highlighted the skills needed by a counsellor, especially when a third party is involved:

> "At that time, they need to arrange an interpreter for that GP session. And then the client gave me a feedback and said she doesn't feel that session is really helping her. And the interpreters gave me feedback

> and said that they felt the interpreter gets the therapy rather than the client. It's because of the interpretation." [Li-shi]

Ability to critically assess counselling approaches was also evident, for example, Li-ba concluded that directive approaches, which are often favoured by health services, do not always produce change as they do not focus on empathy, congruence, and unconditional positive regard:

> "Unfortunately, a lot of people might get into mental health services, which is a bit more directive, is more diagnostic and don't necessarily see it as always producing best outcomes for people."

Another criticism of counselling approaches was that they were sometimes regarded as being too abstract, too theoretical, and too removed from the reality of everyday life[p28, p29]:

> "Most type of theory, well most people think that is not any help for that." [Wu-jiu]

Wu-jiu explained that the CBT approach of challenging thought patterns is often experienced as something abstract and not applicable to the real world of the person who seeks help. Wu-jiu suggested counselling should also deal with practical issues, for example, financial problems and not just mental health issues.

Counselling referrals were sometimes criticized as they were experienced as insensitive or overly complicated. In addition, some counselling sessions were described as not beneficial and sometimes were even regarded as damaging. The focus on using mainly directive counselling approaches in the health services was regarded as limiting patient choices and as not always suitable to the needs of the Chinese community.

5.5.1.2 'By just talking you do not solve my problems '– counselling through the lens of an interpreter (idiographic account: Wu-jiu)

Wu-jiu's idiographic account adds to the first super-ordinate theme because her experience as an interpreter provided further insight into negative perceptions of counselling by some of the Chinese community. Wu-jiu used her understanding of counselling to explain the attitudes and behaviour of the

client and the counsellor, explaining that her clients do not '*believe by talking*' because '*by just talking you do not solve my problems*'. To emphasise her experience that clients give up on counselling, she described how a client experienced counselling as a meaningless exercise of filling out questionnaires:

> "Because there is a lot of questionnaire to ask and to fill in that is the first session, the second session also, maybe the third session also filling in a different kind of questionnaire, then they just, after finish the session."

Wu-jiu then made sense of her clients' reaction by explaining why the client did not regard the counselling session as useful:

> "They don't think there is any help, they don't have patience for this and thinking, by just talking, you don't solve my problem. You don't solve my immediate problem and things."

A sense of disappointment was emphasised by repeating the belief or attitude mentioned earlier by her clients that '*by just talking, you don't solve my problem*'. At the same time, she tried to understand the counsellor's behaviour, by justifying the many questions asked in the questionnaires, explaining that they '*need to get to know you first*' before helping. Wu-jiu then tried to make sense of this experience by comparing her understanding of counselling,

> "Counselling is something that need to take time to talk about and to open up yourself and ask you to think things differently maybe they don't understand."

Wu-jiu's explanation of counselling showed that although she had some understanding of person-centred and cognitive-behavioural counselling approaches her client did not have this background knowledge and therefore did not fully understand what was happening in counselling. The lack of knowledge among her clients ('*they don't understand*') contributed to their negative perceptions of counselling.

5.5.1.3 'It is a vital service' – receptive impressions about counselling

The second super-ordinate theme of recurrent theme eight balances the negative views about counselling by illustrating that counselling was also regarded as an opportunity to improve mental health issues, for example, Huang-qi stated:

> "My experience, my feeling, my thinking is it is a vital service."

Huang-qi based his perception on his reflections on counselling within a wider context – he talked about *'different forms of counselling*', including psycho-education he encountered through his work. Huang-qi also connected counselling with providing *'empowerment*' through information and knowledge:

> "A lot of different forms of counselling, not only for mental health, I have seen the benefit of it. Because people, you know, when you give them information… and also guidance where they keep going to seek more information and help. It gives them empowerment."

Using counselling for advice or guidance can be the start of establishing a sound therapeutic relationship, which is fundamental for discussing more sensitive topics. In addition, once contact is established, the person seeking counselling has a referral point to go back to:

> "Maybe chatting one-to-one, face-to-face, they can open up a bit more about things like mental health issues, so the counsellor can counsel. At least if you need to speak to me or talk to me in the future, I am here. So at least they know where to go." [Huang-qi]

Understanding that counselling is a voluntary decision and depends on one's own decision was emphasised by Li-liu. Although her choice of a counsellor was based on trusting a friend who knew about counselling, Li-liu was aware that ultimately it was her decision to go for counselling:

> "In my personal experience, I had post-natal depression. I go to this friend, and she told me that she was counselling about depression as well and she could tell me this one good or that one, but it is up to myself if I go there."

Huang-jiu showed a positive attitude towards counselling by expressing his confidence in a counsellor who matched his faith, cultural understanding and background:

> "I am a Christian, a Christian you want to see a Christian counsellor, and then, if I am Cantonese speaking, she is a Cantonese speaking counsellor, she is from [city in China]… this person, so this counsellor is a very good girl… and keeps secret." [Huang-jiu]

Wu-ba was also aware of a new counselling service in Northern Ireland for ethnic minorities and recognised that the Chinese community has become more open about counselling as the Chinese promoted this new service:

> "I can see people, you know, more open than before because from talking to the people, and some people already use the service before – word of mouth."

Having experienced counselling in and out of Northern Ireland Li-ba suggested that, in general, Chinese clients prefer direct counselling approaches, such as solution-focused counselling because they could be linked to values of Eastern culture where authority and expertise are highly regarded:

> "I would say a lot of Eastern culture, Chinese, Indian are even more used to the sense of authority and obedience and expertise and being told what to do. So, they might have the expectations that a counsellor is more like a doctor. So, in that sense, I think an average Chinese person might respond more to someone who is a bit more solution-focused, is a bit more medical model approach."

A directive approach was also preferred by Zhang-si who questioned if counsellors who do not respond indeed listen to their clients:

> "They seem to be listen to you, but I don't believe it. No. Because I don't know, do this guy listen to me or not. I would like two ways to communicate, not just 'mhmh'."

Other participants also expected the counsellor to have an active part in the counselling session, for example, to challenge the client *p8, p14, p22* and advise them *p8, p14, p12, p26, p30*:

> "The counsellor will give you some kind of solution, how to solve your problem and give you advice." [Wu-shi]

This active approach can also be linked to the view that the counsellor is an expert who guides and diagnoses the presenting issue to offer a treatment plan '*to make you feel better*'. But without collaboration between counsellor and client, a successful outcome cannot be achieved:

> "Now it is up to you to decide which is the best for you. Because the counsellor can't say, you must do this, this is the only way – you agree with the counsellor, there is one way of doing it." [Chen-si]

Person-centred counselling, which is non-judgemental and non-directive, providing benefit irrespective of cultural background, was favoured by Li-ba:

> "I think, people from all cultures might benefit from a person-centred non-directive approach – if they get any of that non-judgemental, non-directive environment, it can absolutely turn things around."

The concept of the person-centred approach, with its focus on listening to a client's issue and not to pathologize a client, was valued by Wu-ba:

> "Really some people have problem, they need to see a counsellor. They think they have psychological problem or whatever. If you say, you listen here, I am here to listen to you, not make judgement and things. Maybe they get more open to share."

A non-directive approach, with its focus of being non-judgmental, creates the conditions for a sound therapeutic relationship and enables the client to share issues.

Receptive impressions about counselling revealed the benefits counselling approaches could provide, for example, empowerment or guidance. Depending on the issue and preferences of the client, either directive or non-directive counselling approaches were perceived as beneficial.

5.5.1.4 Summary

Recurrent theme eight 'Impact of counselling within the Chinese community' revealed whether counselling was regarded as beneficial depended on participant knowledge and their experience with counselling referrals, sessions, and approaches. Participants who had negative experiences regarded counselling negatively. In addition, a lack of understanding of counselling approaches led to premature conclusions about the benefits of

counselling, for example, '*only talking does not help*'. Participants, who had knowledge and understanding of counselling approaches or had positive experiences perceived counselling as beneficial, indicating that psycho-education would contribute to a more positive view on counselling.

5.5.2 Recurrent theme 9: An unfamiliar treatment method – '*what would you actually do?*'

This recurrent theme explores why counselling was perceived as an unfamiliar treatment method. Three super-ordinate themes were identified: 'lack of information', 'limited knowledge' and 'difficulties of finding a counsellor' and an idiographic account adds further depth by recounting an issue with a counselling promotion (**Table 21**).

Table 21: An unfamiliar treatment method – '*what would you actually do?*''

Recurrent theme 9	Super-ordinate themes & idiographic account
An unfamiliar treatment method – '*what would you actually do?*'	Lack of information about accessing counselling
	'Too young to differentiate' – promotion of counselling, a call for sensitivity (idiographic account: Chen-er)
	'*They don't understand*' – limited knowledge
	'*Not many places here for you to go for counselling'* – difficulties of finding a counsellor

5.5.2.1 Lack of information about accessing counselling

This super-ordinate theme highlighted that lack of information about counselling and how to access counselling was the most common reason provided by participants *p1p3, p5, p7, p17, p19, p20, p22, p23, p24, p25, p29* for not seeking counselling:

> "People don't really know about counselling, but on the other hand where do we have counsellors? Where can I get that sort of help?." [Wang-wu]

'I don't know' was a common answer when participants were asked if they knew where to access counselling. Huang-shi's experience further highlighted the information gap in accessing counselling services. Huang-shi,

who is well educated, speaks English fluently and has studied and worked over five years in the UK, had never heard about options for counselling while at university. She then worked in a place which was emotionally demanding but was never informed about workplace counselling. Huang-shi also did not know that she could access counselling through her GP:

> "People believe I cannot access it [counselling]. I did not know that I need to talk to the GP. I didn't know. Only you talk to me and GP refer me to the counsellor. I only know it today."

Huang-shi was made aware by the researcher that counselling can be accessed through the GP. She was also unaware of counsellors in private practice:

> "Private counsellor? I am not sure I am not so sure."

Information directed at schools and university about counselling seems not to reach target groups as participants suggested that people are still left without any knowledge to access counselling services *p15, p20, p23*. Chen-san, who was a student, was unaware of sources for counselling through university or other services:

> "But here I don't know much about that."

But lack of information about services does not only concern students. Some participants *p28, p5, p4, p9* mentioned that people from the community are not familiar with the idea of counselling services and therefore do not consider counselling:

> "Maybe there is a lack of knowledge about counselling in the Chinese community. They might not be familiar what counselling is. It is difficult to seek help from something they don't know about it. Maybe awareness need to be raised." [Li-jiu]

Although attempts were made to inform ethnic minorities about counselling, it appeared that this information has not yet reached the community. Most participants who are involved with the Chinese community did not know about a recent mental health project aimed at several ethnic minorities, including the Chinese. The few participants who knew about it thought that it

was not well advertised and Wu-ba attributed this to a lack of resources to promote this project:

> "But whether you know, they have the energy, time to come here and leave all these leaflets, because you need manpower to do it."

Even if leaflets were distributed, the use of leaflets was questioned by other participants [p22, p25,] who stated that no attention is paid to leaflets. However, Chen-si noted that if even one person is helped, it would be worth the effort:

> "It is worth making the effort putting it on restaurants. If you have a hundred leaflets and you get two or three cases that is worth it. At least if you put the leaflets up… it is there. If it helps one of a hundred, it helps, but if it is not there, nobody will know."

Although the principle of counselling was known to some participants, they still did not know where to access counselling. Some knew that counselling was accessible through GPs, but if someone did not want to go through the GP, they would not know where to go. For example, Huang-qi knew about access to counselling through the GP but had no idea how to access a counsellor in private practice. This finding seems particularly significant because Huang-qi is a health professional:

> "I don't really know much, especially where to go and other than informally with your loved ones, but you may not want to go to your GP, you want to speak to somebody informally or just a chat. So where do you go?"

If health professionals have difficulties in accessing counselling, that suggests it would be much more difficult for lay-people to access. Li-qi pointed out that information about counselling does not reach the public. The lack of information flow about existing services was highlighted by the fact that she did not know about a recent counselling project initiated by the local health service and aimed at ethnic minorities, including the Chinese community:

> "I don't know by heart, but unless you are a practitioner working in these fields, it is very difficult to know what exist."

Findings indicated that information about accessing counselling was not obvious to the participants. This became even more evident as most

participants were unaware of private counsellors, accessing counselling through the GP or workplace counselling. Even participants who knew about healthcare services expressed having difficulties in finding suitable counselling services.

5.5.2.2 'Too young to differentiate'– promotion of counselling, a call for sensitivity (idiographic account: Chen-er)

Chen-er's idiographic account adds to the first super-ordinate theme (section 5.5.2.1) because her narration of how a counselling helpline was promoted in her children's school indicated how easily misconceptions of counselling could arise due to limited information. Chen-er voiced that parents were not sufficiently informed about how the helpline worked and was concerned about how the helpline was introduced. Chen-er and other parents described that children misunderstood the helpline as a tool against parental boundaries:

> "In their children's mind if anything happens at all at home where the parents get really angry, where they get shouted at because they did something wrong. The children will say, I will call the helpline, which is very difficult for the parent to try to keep the children right."

A lack of communication between school, children, parents, and the promoters of the helpline left parents concerned that the helpline could be used as a threat by the children and that it interfered with how they raised their children:

> "It is very difficult, also for the parents nowadays. It is a big challenge to keep your children on the right path, but then too many things are against it."

Chen-er was not opposed to counselling in general, as she affirmed the usefulness of counselling services for secondary school children, but could not appreciate the benefits of a helpline for primary school children:

> "But not the primary level. In the primary school, children are far too young to understand what it is. But not by giving the information directly to the children themselves. Because they are far too young to differentiate that and will do damage to the children's relationship with the family."

Chen-er's experience suggests that promotion of helplines for counselling needs to be considered carefully and that the information presented needs to take into account possible multicultural issues. Transparency is necessary to avoid misinformation and schools can also play a vital role in communicating with parents in culturally sensitive ways, providing a bridge between parents and outside services.

5.5.2.3 'They don't understand' – limited knowledge

The second super-ordinate theme of recurrent theme nine explored the lack of basic knowledge about counselling that several participants [p1, p4, p5, p7, p10, p12, p21, p26, p28] mentioned. Some participants [p4, p5, p12, p26] used the interview to inform themselves about counselling and asked the researcher about the length of counselling, counselling approaches, what issues counselling can consider, who can come and how to access the service. Their questions highlighted that basic information on counselling is missing:

> "What would you actually do? Do you just listen? What's your role? Do you have to give advice, or you just listen? Do you say things to make them feel better?" [Zhang-er]

Some of these participants who recognised the lack of knowledge about counselling based this on their experiences of working in the health services, for example, Li-shi described how she would need to explain counselling to encourage her clients to use the services:

> "A lot of people are not familiar with that… when I worked on the cases, I had to spend a lot of time to explain to them what counselling is, what is CBT? Kind of you know, what this treatment does, how it can help you. Because if they don't understand what that is, how do you encourage people to go?"

Lack of knowledge about counselling decreases the willingness to go for counselling:

> "Then you have to explain in a way they understand because if not they will refuse to do that. How does that help if I talk to a stranger? They will have this kind of preconception, because one counsellor if they have not met them before, is a total stranger." [Li-shi]

Experiences from their land of origin, for example, in the education system in China, also contributed to knowledge about counselling. Participants described that at every stage of the education system counselling was available to the students. Wu-shi explained how counselling is applied within the education system and used the term '*instructor*', indicating that the goal of counselling within education is focused more on behavioural issues:

> "As far as I know in middle school, in primary school they have an office or at least one instructor who is taking care of the mental health, to instruct the children to behave properly."

Universities in China are aware that students often struggle with mental health issues and provide support by employing '*assistants*':

> "In the university in China, we do value this kind of help – mental help for mental health. For every department, they have an assistant to take care of these kind of students. Their duty is to cope with this kind of work. I think for the university in China they attach more importance to this kind of problem." [Wu-qi]

Wu-qi then explained that '*assistants*' don't exclusively deal with mental health issues:

> "To pay attention to those problems… that's just one of their duties. The other duty is to organise the students in taking part in different activities. Their job is not specific to mental health."

How students sometimes received counselling was described by Chen-san, who suggested that counselling was not valued by students:

> "We do have counselling, like in China – in the school. Actually, no one goes there. No one really cares about it."

In China, the roles of teacher and counsellor overlap, and Chen-san indicated that this could cause a lack of boundaries, leading to bias as counsellors are not independent:

> "Maybe the people here are more professional. In China, it used to be the teacher, who is the counsellor. In the high school, the counsellor seems to be like a teacher in your class. It was not an independent counsellor."

Although universities in China offer counselling for students, this is not always an independent service because it is sometimes linked to the Communist party providing guidance to students, as Wu-qi stated:

> "China is led by the Communist Party, and they think to lead the students to develop in the right way, not only in academic way but also mentally. They should go into proper way, they should perform their own value, so they just allocate a teacher in every department from the very beginning to direct the student to go the direct way, in the correct way, to develop their own values."

Wu-qi regarded counselling as a service of the Chinese Communist Party, which is not only interested in the academic progress of students but also wants to influence their mental and behavioural development. Connecting counselling with political party guidance highlighted cultural differences in understanding the role of counselling.

Several misunderstandings about counselling were expressed by participants, for example, counselling was perceived as a place to share complaints:

> "The misconception is that people go to counselling just to offload and to moan about the problems." [Li-ba]

Li-ba was also aware that some members of the Chinese community regard counsellors as medical experts:

> "So, they might have the expectations, that a counsellor is more like a doctor, who will diagnose me and who will prescribe something for me, which will make me feel better."

In addition to professional skills, counsellors were also expected to have personal experience of mental health issues, be empathic and knowledgeable *p14, p19*:

> "I think it is the best counsellor who experienced [unclear] or they have been mental, I mean in person and then you can understand others." [Huang-jiu]

The description of the ideal client provided another glimpse of how counselling is perceived. Chen-si explained that a person who seeks

counselling needs to fulfil some preconditions regarding themselves and the counselling process before counselling can begin:

> "You have to see him because you want to feel better. You believe in him, you believe in yourself that you will be better, by going to see him. That's the belief, that's the trust, otherwise, what's the point in going to see him. That's the main problem if you are forced into seeing someone. You won't believe you won't trust it. It has to be on your own initiative. You have to see him because you want to feel better."

While the described attitudes (belief in the counsellor, self-belief and seeking counselling on their initiative) contribute to successful counselling, they also present barriers to prospective clients who do not yet believe in the counselling process and worry about trusting a stranger.

Many participants lacked basic knowledge about counselling and did not understand the value of sharing their issues with a stranger. Other participants had limited knowledge about counselling and were sometimes negatively influenced by encounters with counselling in the Chinese or NI education systems where counselling was often misunderstood as a pedagogical tool. Preconceived ideas about the role of the counsellor and the client further impacted participants' understanding of counselling.

5.5.2.4 '*Not many places here for you to go for counselling' – finding a counsellor*

The third super-ordinate theme underlined that although there are many English-speaking counsellors in Northern Ireland, Chinese speaking counsellors are lacking. At the time of the interviews, the researcher was aware of only one Chinese speaking counsellor in Northern Ireland. The reason for this lack of Chinese speaking counsellors needs to be explored in another study, but during the interview with Chen-yi a possible explanation was provided:

> "Oh my God, the future counsellor needs to take up at least three languages. Three different languages."

The three languages that were suggested as necessary to communicate with a diverse Chinese community were English, Mandarin, and Cantonese.

Other participants [p28, p19] also experienced that there are not enough Chinese speaking counsellors in NI and dealt with this shortage by referring clients to mainland UK counselling services:

> "I remember some people are looking for counselling. I have to refer them to on telephone counselling. And then it is from people in London organise it. Then I forward, refer to London. They can talk to somebody they don't know. And they feel more assured, you know, confidentiality for them." [Wu-ba]

Referring clients to counsellors outside of NI had the added advantage that there were fewer confidentiality issues. Wu-ba had experienced that some within the Chinese community went for counselling outside NI:

> "They are happy to talk about their problems and things like that."

Huang-jiu was also aware of the possibility of accessing counselling outside NI through telephone or online counselling but had not heard of anyone using it:

> "In London, there is some Chinese lady, but not here. And of course, in Hong Kong, there are many. But I don't think I haven't heard anyone used this way to sort out their problems."

The researcher has no data to confirm if the Chinese community took up opportunities to be counselled by someone outside NI. Telephone or online counselling was rarely mentioned by participants, indicating that this is not in the awareness of the broader community. Nevertheless, the accounts of Wu-ba and Huang-jiu underlined that access to counselling in Chinese in NI is restricted and the lack of qualified, multi-lingual counsellors leaves the impression in the community that there are few if any, options for counselling. Zhang-san stated:

> "Not many places here for you to go for counselling."

Furthermore, the location of counselling places needs also to be considered as the Chinese community is spread throughout NI:

> "I mean from the point of Chinese community; it has to be somewhere close by or it has to be somewhere very convenient to you to get help." [Wang-yi]

This super-ordinate theme emphasized that there is a scarcity of suitable counsellors for the Chinese community in NI. Although online or telephone counselling would be a possible alternative few of the participants mentioned this option, and there was also doubt if members of the Chinese community would use these services. The lack of Chinese speaking counsellors left the impression that there are not many places offering counselling to the Chinese community.

5.5.2.5 Summary

Recurrent theme nine 'An unfamiliar treatment method – '*what would you actually do?'* showed that there is a lack of information about how to access counselling and that even projects aimed at the Chinese community are not well promoted. When promoting counselling in an increasingly diverse society, multicultural issues need to be considered to avoid misunderstandings. Although a few participants were well informed about counselling, most did not have even a basic understanding of counselling.

5.5.3 Recurrent theme 10: Issues of trust – a barrier

The recurrent theme ten explores the issue of trust in accepting counselling within the Chinese community. Three super-ordinate themes were identified: 'lack of confidentiality', 'not part of Chinese culture' and 'three's a crowd'. An idiographic account emphasises issues of confidentiality within the wider family. (**Table 22**).

Table 22: Issues of trust – a barrier

Recurrent theme 10	Super-ordinate themes & idiographic account
Issues of trust – a barrier	'*Don't talk to strangers*' – lack of confidentiality
	'Nobody needs to know' – the importance of privacy (idiographic account: Zhang-yi)
	'*Not part of Chinese culture*'– counselling regarded as a Western idea
	'This person will know my business' – three's a crowd, the use of interpreters

5.5.3.1 'Don't talk to strangers' – lack of confidentiality

This super-ordinate theme revealed participants' view that the Chinese community did not want to talk about personal issues with strangers [p2, p8, p10, p14]. Privacy is highly valued among the Chinese, and comments were made about not being willing to talk or share personal issues with strangers. This ranged from an unwillingness to share, for example, '*don't want strangers to know their business*' to statements that it is totally unacceptable to talk to strangers:

> "Chinese people cannot disclose their family matters – they are not allowed to do that." [Wang-san]

The assumption that counselling has to do with sharing secrets was expressed by several participants and was often connected to the question of confidentiality:

> "If they know my secret – will it be safe with them?." [Chen-er]

Guidelines regarding confidentiality need to be clearly communicated, and counsellors should ensure that confidentiality is kept to prevent rumours about lack of confidentiality:

> "If they [counsellor] can instil confidentiality if they can instil the trust in the client that they will be looked after. And that everything inside the room is inside the room. Is not going to go out… It all depends on how much the client can trust the authorities." [Chen-si]

Huang-qi expected counsellors to be vetted to reassure clients of the counsellor's expertise and trustworthiness:

> "That they have vetting system information that this individual I am speaking to is actually, you know, doing their job properly and is trustworthy."

Multicultural counselling often follows the concept that counsellors and clients need to be from the same culture to achieve a sound therapeutic relationship. However, some participants disagreed and expressed that confidentiality can be enhanced by the counsellor not being Chinese as they would not talk about them in their community [p4, p20].

> "I think they will trust you because you are not Chinese people, you won't talk to other people." [Wang-si]

Huang-shi agreed that the race of the counsellor was not the main issue, noting that a non-Chinese counsellor might be advantageous as they might have different viewpoints and therefore widen her options:

> "Maybe I trust someone from here, someone local because you have different thoughts and also, I don't want to restrict myself with one idea so for me it doesn't matter, maybe local [non-Chinese] counsellor can give me better idea."

Some participants expressed that they would not trust a stranger, someone who is '*outside the circle',* while others thought that professionals who are from the Chinese community are not to be trusted, as they might not keep confidentiality. Experiences of broken confidentiality in other areas of the health service, such as the interpreter services, were known to participants as there had been complaints about lack of confidentiality. Huang-jiu stated:

> "Unfortunately, some of them expose the people confidentiality, confidential things, you know. People complain."

A breach of confidentiality within the interpreter service had repercussions for counselling as a lack of confidentiality was extended to other health professionals working with the Chinese community. Wang-san expressed some of these fears:

> "The Chinese will think the Chinese counsellor know other Chinese if they come to the Chinese counsellor what if the Chinese counsellor discloses my situation to others. They will have this concern or fear in their mind."

This presents a dilemma as it seems neither health professionals from inside or outside of the Chinese community could be trusted. Issues of confidentiality are reinforced as the Chinese community in Northern Ireland is comparatively small – participants suspected they might be recognised by someone from the community if they went to counselling or if a health worker talked carelessly about their work. This concern was echoed by Wu-ba's experiences as a health worker within the Chinese community:

> "Because of the close-knit community... the fear that if I talk to you, you know my situation and then about confidential whether my affairs or my things will be spelt out in my community. People will talk behind me, you know, about my thing. These kinds of things, people may be slightly worried if you are from the Chinese community and doing counselling. Even they say you know, in my conduct, in my core conduct as a counsellor, I promise to keep confidential. Sometime may not, it's passed to other people, so there is a worry about that."

Breaching confidentiality rarely stays undetected in a small community, and these breaches influence people's opinions about sharing personal information. Whom to trust also depends on individual experiences, for example, Zhang-wu questioned the independence and confidentiality of university counselling services, fearing repercussions at a later stage:

> "I am worried about talking to someone about it. If I talk to a university counsellor does that get back to me somehow. I think there are still a lot of people who worry about things like that."

Zhang-wu, who is second-generation Chinese, also expressed hesitancy in sharing personal matters with strangers when she talked about how counselling was promoted in her university:

> "In the intro week at Uni, they tell you about it – there is maybe one slide on it, saying, that's what you can do if you feel stressed and stuff, and they always say, if you feel stressed, any issue, email the head of the year. But why would you want to go and talk to them? You don't know them either."

Her question '*why would you want to go and talk to them? You don't know them either'* underlined that, for her, talking about stressful issues of her life is not conducted with a stranger. Zhang-wu's experience of how counselling was promoted also raised boundary issues, as her university head of year was named as the contact person for counselling.

The question of how confidentiality can be maintained within a population which highly values privacy needs to be considered. The importance of adhering to principles of confidentiality and maintaining boundaries in all areas of the health service are paramount, to gain people's trust and provide the confidence to consider counselling when needed.

5.5.3.2 'Nobody needs to know'– the importance of privacy (idiographic account: Zhang-yi)

This idiographic account supports the first super-ordinate theme 'lack of confidentiality' by providing insight into why confidentiality is vital. Zhang-yi explained why she does not like to talk about personal matters:

> "I would say I still feel I don't like to talk about my personal details. Nobody needs to know. I still feel I don't like it."

Zhang-yi emphasised her view on privacy by repeating '*I still feel I don't like*' and making sense of her feelings by explaining '*nobody needs to know*' – this runs like a thread through her life. She reflected in the interview how her upbringing contributed to this attitude, for example, her mother had taught her to be self-reliant, and Zhang-yi had applied this principle, especially after leaving home:

> "From our childhood, my mother always said to us, if you are not working to yourself, nobody can. You have to deal with things… Only you yourself can deal with things, so I think from the childhood in my mind it has influenced, yeah. And after we moving here, only myself to deal with the problems. If I have problems, I can call home, but there is nothing they can do; they are so far away. So, anything I had to deal with the problem myself. Inside the family, it is best."

Despite Zhang-yi explaining that she dealt with problems on her own she finished by saying '*inside the family is best*'. Her understanding of *'inside the family'* refers specifically to her children, not her family of origin and also not the family of her partner. She further explained that she keeps herself to herself and regarded anyone in the community to whom she was not connected as a stranger:

> "So, I don't know about those. Even those, long ago people are already here, I don't really connect with them. They don't know me, I don't know them. I just can't; just keep myself to myself. Stranger people."

Zhang-yi described the other Chinese as '*stranger people*' and then associated the word '*stranger*' with being strange herself. She explained that she is regarded as strange within the family of her partner. This is based on

her behaviour – that she is unwilling to share personal issues, even within the family, as personal matters can be turned into gossip:

> "I know myself I am strange person. At least my husband's family think I am a stranger person because I don't like gossip, they are just sitting there and gossip here and there, even their friends, talking, even behind their backs, I don't like it."

Her understanding of talking about personal matters is closely connected to her experience of gossip and influenced her attitude towards talking to others. She also presented a view of Chinese society where privacy is not kept, because they '*gossip here and there*', and this reinforced her desire to keep her issues private. This barrier of not wanting to talk to a stranger needs to be considered if counselling services are to engage with the Chinese community meaningfully. Sensitive approaches to promoting counselling need to be developed and are important in encouraging the Chinese community to access counselling.

5.5.3.3 'Not part of Chinese culture' – counselling regarded as a Western idea

The second super-ordinate theme of recurrent theme ten explores the view that counselling '*is not part of Chinese culture'* and is therefore not considered by participants [p1, p9, p17]. The term '*Chinese culture*' can be understood in different ways, for example, Wu-liu elaborated on Chinese culture, stating that culture is based on various life philosophies, making counselling, which is rooted in Western culture, incompatible with Chinese culture:

> "Because people from different areas, from different countries, from different culture backgrounds, obviously have a different philosophy of living, philosophy of talking, behaving, something like that. Although what you provide are perfect, are very, very good, but they are not the general rules to guide people's thinking, behaving."

Wu-liu knew that the researcher is a counsellor and acknowledged the counselling provided by the researcher: '*what you provide are perfect*'. This statement was not grounded on any experience the participant had with the researcher as a counsellor and perhaps was only being polite and softened

the impact of his statement that counselling and Chinese culture clash as the '*rules'* of counselling are not culturally appropriate. Despite expressing a positive impression of counselling Wu-liu viewed counselling as foreign to Chinese thoughts and behaviour and used the example of parenting to clarify his view:

> "For instance, the parenting issues – because in China, compared to the Western world, they have a different philosophy when it comes to the parenting relationship, to parenthood."

Another cultural divide that becomes an issue in conducting counselling among the Chinese community is the concept of 'face', which is complex and deeply ingrained in Chinese culture. Li-qi explained that keeping face is vital within Chinese society:

> "Without wanting to make generalization, it is all about keeping face. They are very, you know, very important to keep up a façade." [Li-qi]

Losing face has many facets and includes admitting having trouble, not being able to solve a problem or being looked down upon. Several participants *p3, p6, p7, p13, p23, p24, p30* connected going to counselling with losing face:

> "I would say Chinese are not so used to counselling. And also, they may think that we seek counselling, that would suggest we are in trouble, we have a problem. So, in order not to disclose my current situation, my current problem or anything. I would not to go counselling or seek counselling from others." [Wang-san]

Translation of the word 'counselling' into Chinese can add to a sense of losing face when seeking counselling. Wang-san explained that counselling is often translated in Chinese as 'fu-dao'. The term 'fu-dao' is often given to a person with a higher status as they provide guidance, mentoring, coaching or tutoring and concluded that if an adult sought counselling that could be conceived as a loss in social status:

> "The word 'counselling' in Chinese is 'fu-dao' – it is more like a child or a student get help from an adult. And when you are adult, you don't think you want to get help from adult to adult. People are in a kind of good social status; they don't think to lower themselves down to seek help." [Wang-san]

Losing face is also connected to feelings of shame, and people want to avoid this. Chen-san summarised this by stating:

> "They might be like ashamed having the mental problem."

Feelings of shame about mental health issues were perceived by Zhang-wu as a problem within the Chinese community in NI. Zhang -wu compared the Chinese community in England to the Chinese community in NI and concluded that the Chinese community in NI is more closed and less open to talking about mental health issues. Zhang-wu, who is second-generation Chinese, explained these differences by the fact that there were more mental health campaigns in England, impacting perceptions of mental health:

> "I guess that they [Chinese community in Northern Ireland] are more closed, I feel. It's general more conservative, compared to England. It's still not great in England, but I think there is a movement in England to say and target mental health and say it's ok to talk about mental health."

Counselling was regarded by several participants as a foreign concept, as participants felt that Chinese behaviour and values, such as the importance of keeping face, were not incorporated. Translation issues deepened misunderstandings about counselling and feelings of shame surrounding the topic of mental health issues, were not challenged as mental health campaigns aimed specifically at the Chinese community in NI were missing.

5.5.3.4 '*This person will know my business' – three's a crowd, the use of interpreters*

The third super-ordinate theme explores that counselling is also affected by a lack of bilingual counsellors and difficulties in organising suitable interpreters:

> "We can find you an interpreter. OK, fine. I don't know how confidential the interpreter is going to be." [Chen-si]

Patients who are offered interpreters need to decide if they want to proceed with counselling, without knowing how the interpreter will influence the counselling process. Using an interpreter in counselling requires additional skills from both the interpreter and the counsellor. Participants who had

insight into employing interpreters raised several issues, such as confidentiality, continuity and the skillsets of the professionals involved:

> "How does the client feel with counselling having a third person? This person is from the same community, and this person will know my business and whether the person keeps my confidentiality." [Li-jiu]

Li-jiu was sceptical about the use of interpreters in counselling sessions and raised the issue of confidentiality, especially as different interpreters may be employed for different counselling sessions:

> "Sometimes, the person not having the same interpreter for all series of sessions has created a difficulty."

If both the counsellor and interpreter are not adequately trained a sound therapeutic relationship cannot be developed and the interpreter could become the focus in the counselling session, as Li-shi's experience demonstrated:

> "There was no connection, there was no strong connection between the counsellor and the client because their communication was through the interpreter. That's why the interpreter felt that the counselling, the CBT is more for her, and the client doesn't feel the session has helped too much."

Zhang-er also expressed doubts about using interpreters during counselling as, to her, the interpreter presents a barrier to developing a sound therapeutic relationship:

> "I think counselling might not work as well, especially as we have clients here and they use interpreter, I would say it is a language thing, when there is someone in the middle or when someone telling you in a different language it doesn't work the same. I don't think counselling will work very well with interpreters."

A lack of suitable interpreters who have knowledge about counselling, keep confidentiality and can translate without disturbing the therapeutic relationship presents a significant barrier to the Chinese community in NI seeking counselling.

5.5.3.5 Summary

Recurrent theme 10 ‘Issues of trust – a barrier’ underlined that issues of trust present a challenge to accessing counselling. As counselling is rooted in the idea of talking to a stranger, any unwillingness to talk to strangers needs overcome, and the community needs assurance that confidentiality will be maintained. Trust is also linked to familiarity, and some participants regarded counselling as unfamiliar and alien to their culture. The issue of trust was further explored through the lens of language regarding the role of interpreters in counselling sessions which impacts the therapeutic relationship and demands specialised counselling skills to ensure confidentiality.

5.5.4 Section summary: counselling

The three recurrent themes ‘Impact of counselling within the Chinese community’, ‘An unfamiliar treatment method – *what would you actually do?’,* ‘Issues of trust – a barrier’ highlighted that counselling was not well established as a means of help-seeking for common mental health issues. Many participants lacked knowledge about counselling and therefore, did not consider it as a possible solution. Negative or positive experiences with counselling referrals or sessions influenced participant perceptions of counselling. A lack of cultural adaption in the pre-stages to counselling and in counselling sessions hindered a positive experience of counselling. Issues of trust concerning confidentiality, culture, and the use of interpreters in counselling sessions presented further challenges to acceptance of counselling within the Chinese community.

5.6 Overall summary of findings chapter

The findings of this study provide insight into how mental health, help-seeking, and counselling are perceived within the Chinese community.

The findings of the mental health section illustrated that mental health is still stigmatised within the Chinese community and affects both help-seeking behaviour and seeking counselling. However, a positive shift of perception about mental health became evident from participants who increasingly

normalised the issue of mental health. This change was influenced by personal experience, media, and exposure to a different culture.

The findings of the help-seeking section demonstrated that although both informal and formal paths of help-seeking were used, informal paths of help-seeking, and in particular self-help, were preferred. Formal paths of help-seeking, such as consulting a health professional, were only considered when there was no other solution available, or the situation was severe. Socio-cultural and interpersonal isolation, combined with a lack of information about accessing services, was often the reason for not seeking help. Lack of psycho-education, leading to a lack of self-awareness and not linking physiological with psychological symptoms, added to the reluctance in seeking help. An additional barrier to help-seeking was insufficient language skills which can hinder communication with health professionals. Furthermore, communication breakdown can also occur within the family, which suggests that it is not always a question of language skills but also connected to relational issues, such as finding understanding within the immediate family.

The findings of the counselling section showed that the impact of counselling is still relatively small within the Chinese community. Although some participants voiced clear views about counselling, most participants indicated that they did not know what counselling is. Findings showed that participants who had limited knowledge about counselling conveyed that suitable counsellors or services with an understanding of Chinese culture are difficult to find. A significant barrier which emerged was the issue of trust, as participants expressed the need for confidentiality and their fear that confidentiality is difficult to maintain within the Chinese community in NI.

The findings of the mental health, help-seeking, and counselling sections had several points in common. Firstly, a lack of knowledge and a lack of information meant that there was a lack of awareness of mental health issues, which in turn influenced help-seeking behaviour and led to participants not accessing counselling. Secondly, mental health, help-seeking, and counselling are still sensitive issues, as mental health is still

stigmatised, help-seeking is regarded as shameful as one can lose face by admitting needing help, and counselling is questionable because of the issue of confidentiality and not being part of Chinese culture. Thirdly, a positive shift of perspective on mental health, help-seeking, and counselling also became evident, for example, mental health was less stigmatised and described as just another illness which can affect anyone. Help-seeking from health professionals was regarded as an option, especially if the person concerned could not help themselves. Participants also showed curiosity about counselling, and some even disclosed that they had experienced counselling in the past and had found it beneficial.

These findings demonstrate the complexity of issues of mental health, help-seeking, and counselling within the Chinese community in NI and contribute towards a better understanding of this ethnic minority group.

Chapter 6: Discussion

6.1 Introduction

This research study explored the perceptions of mental health, help-seeking, and counselling among the Chinese community in NI, employing an IPA approach. The findings chapter provided multifaceted insights into how mental health, help-seeking, and counselling were perceived within the Chinese community in NI. The discussion chapter explores these findings and is divided into three sections: mental health, help-seeking, counselling. Each section examines the key findings in relation to previous literature and highlights new evidence to contribute to the body of knowledge. As an attribute to the IPA approach drawn upon for this study, background information is provided about the participants at the outset of this discussion chapter.

6.2 Background information on participants

The 30 participants in this research represent some of the more integrated members of the Chinese community, as most had no difficulties conversing in English, were well educated, and nearly all were in employment. This reflects statistical evidence that the Chinese in the UK have one of the highest percentages of employment and are high academic achievers among the ethnic groups (ONS, 2005). The gender distribution of two-thirds female and one-third male contributes towards a comparatively balanced group. Family is important within Chinese society, reflecting values of a collective society. Therefore, it was not surprising that most participants were in a relationship, with less than one-third of participants who were single, distributed across most age groups.

Although the Chinese community is frequently viewed as a homogenous group, the background information findings showed that participants originated from five countries, reflecting the diversity of the Chinese community represented in this study. Participant's length of stay in NI also reflects some of the immigration history of the Chinese community to the UK. Out of the 30 participants, nine had lived for more than 21 years in NI, and

five of those were from Hong Kong and only one from mainland China. This finding can be partially be explained by the fact that until 1997 Hong Kong was a British colony, making immigration to the UK easier, while more than 21 years ago mainland China was still closed to the west. This has changed in the last 15 years, and this was also reflected in the participants, as two-thirds of participants who immigrated to NI in the last ten years came from mainland China.

Most participants were mature adults aged between 31 and 50 years old and had rich life experiences, and this was reflected in the stories told during the interviews. A focus on the student population was deliberately avoided, as many research studies about the Chinese rely on international students as participants. To fulfil the goal of researching the wider Chinese community, some younger participants were also included, as were participants from the 51+ year group.

This introduction of the participants not only connects to the methodology of IPA by emphasising the idiographic character, which validates participants' contribution and gives them a voice. It also connects to the multicultural humanistic framework (section 3.5.1), in which the current study is positioned. Participants' background information underlines the multicultural framework as it presents a diverse community reflecting cultural, demographic and status variables (Pedersen, 1994). The humanistic framework is expressed by exploring how the Chinese community related to the topics of mental health, help-seeking, and counselling as the humanistic underpinning is ideal to understand how humans relate to the world in which they live (Spiers, 2001). This study did not focus on specific gender or age differentiation, as humanism describes all people having equal moral worth and does not depend on age or gender differentiation.

6.3 Mental health

The findings in this study relating to perceptions of mental health among the Chinese community in NI suggested that a stigmatised view about mental health exists, especially concerning severe mental illness. Stigma became visible in emotional and behavioural reactions towards people with mental

health issues, for example, fear, labelling or social distancing from people with mental health issues. However, the findings also related a shift of perspective on these stigmatised perceptions once participants differentiated between common and severe mental health issues. Nevertheless, a varied knowledge of recognising mental health issues was apparent. Findings further indicated that experiences of mental health issues in self or others, psycho-education through media or exposure to a culture where mental health is less stigmatised had transformative influences on the perception of mental health. Findings inferred that personal experiences increase compassion towards people with mental health issues, challenging ingrained associations and behaviour. These findings led the researcher to organise this section around three key themes: mental health stigma, mental health literacy, and stigma reduction.

6.3.1 Mental health stigma

Findings indicated that mental health stigma persists as an issue among the Chinese community represented in this study. This relates to existing literature, indicating that attaching stigma to mental health is a universal phenomenon (Dovidio et al., 2000; Link et al., 2004). The findings also reflect the observation that stigma tends to divide individuals from one another, due to societies rules on inclusion or exclusion (Pescosolido et al., 2008).

Experiencing mental health stigma in China does not only concern the stigmatised person but is often extended to the whole family (Yang and Pearson, 2002). Therefore, to hide mental health issues protects not only the person suffering from mental health issues but also their family from being excluded from society (Yang et al., 2007). Exclusion from society due to mental health issues has a detrimental effect, not only in China but also in the Chinese immigrant communities, for example, people will lose their employment (Yang et al., 2014). Lack of employment is linked to financial hardship most notably among disadvantaged Chinese immigrants, which has a negative effect on seeking help for mental health issues, particularly in a health system which does not provide free services (Yang et al., 2014). Although the issue of unemployment due to mental health issues was not a

finding in the current study, fears were expressed about being disadvantaged because of mental health issues.

Participants' comments revealed that stigma of mental health was expressed on a verbal '*crazy*', a behavioural '*stay away*', and an emotional '*so ashamed'* level indicating that stigma is multi-layered and relevant differentiations are present in the literature. Stigma is described as a societal construct (Goffman, 1963; Hunt, 1966; Nyblade et al., 2019), as self-stigma (Corrigan, 2004), and double stigma (Gary, 2005). These three differentiations of stigma are explored further and connected to the findings of the current study.

According to Goffman (1963), stigma is a societal construct which occurs on an interpersonal and intrapersonal level and is therefore relational. The interpersonal level refers to the relationship between 'normal' and 'stigmatised' people when people become stigmatised while interacting with others by being given '*an attribute that is deeply discrediting*' (Goffman, 1963, p.3). Stigma becomes enacted when 'normal' people in society judge others through looks, comments, or other forms of degrading treatment. The intrapersonal level occurs when the stigmatised person internalises that they are not regarded as normal by society and feel they are '*disqualified from full social acceptance*' (Goffman, 1963, preface). Goffman's definition of stigma as a societal construct can also be applied within a Chinese context regarding the context of 'face'. Whenever a person loses face, they lose status within society. This loss of face is often extended to the wider family as well, isolating the person and their family from the society they live in:

> "…people who are diagnosed with mental health conditions are kind of seen as pariahs, as people who have been not to engage with, to avoid." [Li-ba]

This finding that people with mental health issues and their family are isolated from society can be linked to the concept of 'distancing' (Goffman, 1963). Distancing tends to be understood in two ways, firstly as a form of stigma management with the purpose to express a 'we are not the same' mentality, emphasising the difference between 'normal' and 'stigmatised' people (Markowitz and Engelman, 2016). And secondly, distancing is also a

preventive measure to avoid spreading stigma from the affected to other members of society (Goffman, 1963). The findings of the current study relate to both forms of distancing. In relation to stigma management, verbal differentiation was employed by describing the other who has mental health issues as '*crazy*'. In relation to preventive measures, the most common behaviour employed was '*staying away*' from people with mental health issues to avoid losing face by being affected by stigma. Thus, these findings provide explicit examples of how distancing is applied within a Chinese context.

Previous literature (Weiner et al., 1988*;* Corrigan et al., 2000; Corrigan, 2004) inferred that mental health issues are more stigmatised than other health conditions. Further, according to Pescosolido et al. (1999), stigma increases according to the severity of mental health issues, for example, psychotic disorders are more stigmatised than depression. Link and Phelan (2001) suggested that stigmatisation is a step by step process, starting with labelling a person as different and especially in the context of mental health issues linking it to negative attributes. By doing this, the stigmatised person becomes disconnected from the general society and becomes the 'other'. This is followed by dehumanisation where the person becomes an object rather than a subject, which leads to loss of status, discrimination and finally exclusion (Glasby and Tew, 2015). This process of exclusion from society due to stigma was also described by participants in this study. Participants recalled how they had experienced the treatment of people with mental health issues in Chinese society, emphasising that when people behaved in an out of the ordinary manner, for example, not being able to follow a normal daily routine, mental health issues were suspected and people were labelled before finally being excluded from society:

> "You'd be identified as mental, you don't have any friend, no anything you know. People don't want to have to do anything with you." [Li-liu]

Kleinman (2009) examined the usage of the term 'stigma' and noted that 'stigma' does not hold great meaning to people because it has become a clinical term, to circumvent this Kleinman (2009) suggested to use the

metaphor of '*social death'* instead of stigma. Stigma understood as social death incorporates the experiences of people with mental health issues, for example, when people are unable to work because of their mental health issues and are no longer part of the workforce. According to an earlier study (Kwong, 2002), the term '*social death*' had a literal meaning where Chinese immigrants who fell ill and were unable to work, could not pay back their debts for being smuggled into a country and therefore were menaced with execution. As participants of the current study were not illegal immigrants, there were no findings to support Kwong's (2002) view. Nevertheless, participants raised concerns that admitting to mental health issues could cause difficulties when applying for a job, influencing university studies or even create difficulties with social services concerning parenting.

Self-stigma is internalised public stigma, which negatively influences self-esteem and self-worth within the individual (Corrigan and Rao, 2012). Research relating to self-stigma within the Chinese immigrant population (Wong, E. et al., 2017) underlined that Asian-Americans have higher levels of self-stigma compared to the white population, and this was expressed in feelings of inferiority when affected by mental health issues. Feelings of inferiority can also be linked to the persistent belief that people with mental health issues cannot make significant contributions to society (Wong, E. et al., 2017). This belief is detrimental in any society where high achievement is greatly valued as a determinant for self-worth. These findings contradict an earlier study which found that self-stigma is lower among Taiwanese people, compared to Americans or British (Vogel et al., 2013). A possible explanation for this lower level of self-stigma was that within a collectivistic society the focus is on others and not on self, and this leads to less self-stigma (Vogel et al., 2013). However, Vogel et al. (2013) were aware of the difficulty of measuring self-stigma based on Western concepts and not including collectivistic concepts. Therefore, Vogel et al. (2013) emphasised the importance of including collectivistic concepts when measuring self-stigma in a collectivistic society to gain a less biased result. The current study did not use any measurement scales regarding self-stigma but provides idiographic findings on self-stigma. Self-stigma on mental health was expressed by

participants of this study who felt '*so ashamed*' when they first admitted having mental health issues, and this suggests that self-stigma is not an issue of the past but also an issue of the present. Findings of the current study related a sense that self-stigma was also connected to a fear that admitting to any form of mental health issues could be detrimental, for example, it might lead to being institutionalised or other legal implications. Feelings of fear influence mental health and can further contribute to a deterioration of self-esteem and self-worth. Self-stigma can cause a downward spiral, leading to hopelessness and reluctance to seek treatment (Corrigan et al., 2009; Clement et al., 2015). Findings of the current study (see section 5.3.1) indicated that self-stigma influences people's behaviour negatively as they do not want to disclose mental health issues out of fear to be stigmatised:

> "But if the person has a mental problem, probably even is the worst shame in Chinese culture." [Huang-jiu]

Gary (2005) introduced the term double stigma to differentiate between public stigma, self-stigma and when public and self-stigma concerning mental health are combined with race or ethnicity as the individual is not only stigmatised through mental health issues but also through their race. The term double stigma is crucial concerning the findings of this study, as experiencing stigma refers not only to mental health issues, but also considers the position of the Chinese community as an ethnic minority. Studies in the USA showed that Chinese users in health services were discriminated against (Spencer and Chen, 2004; Chu and Sue, 2011) and that Chinese reported lower satisfaction of health service experiences (Clough et al., 2013). Although Grey et al. (2013) examined the issue of racial inequality concerning mental health issues in the UK and pointed to a gap between policies and implementation, their review did not specify whether racial inequality was experienced by the Chinese community. The findings of the current study provided insight that some participants were not satisfied with the mental health services they received, but participants did not connect it explicitly to racial differences. Therefore, further studies would

be needed to explore whether there is a racial side to stigma within the Chinese community in NI.

Stigma can also develop due to a lack of knowledge or information. Therefore, the second key theme of the mental health section explores the findings in the context of mental health literacy to examine the breadth of knowledge about mental health issues among the Chinese community.

6.3.2 Mental health literacy

Australian studies showed that improving mental health literacy (MHL) is advantageous as it contributes towards early diagnosis of mental health issues, reducing stigma, and increasing help-seeking behaviour (Reavley and Jorm, 2011; Reavley and Jorm, 2012). Therefore, aiming for a higher level of MHL is important as research has shown that MHL influences the use of mental health services (Wong et al., 2017; Huang et al., 2019). Research on MHL influences many interventions and policies (Furnham and Swami, 2018) and frequently focuses on two mental health issues, depression, and schizophrenia (Wong et al., 2010; Wong et al., 2017; Park et al., 2018). Lu et al. (2019) conducted a scoped review on MHL research in China including research papers in Chinese (n=313) and English (n=37) and showed that MHL research often focuses on survey findings and not on evaluation of mental health interventions. This indicates that mental health interventions are not yet as common, and this was reflected in the current study:

> “I don't know about here, but in China, there is not enough education on that, not enough knowledge among people about mental health.” [Wu-shi]

Mental health research in China further indicated that MHL was low among the Chinese (Gong and Furnham, 2014; Lui et al., 2016; Wong et al., 2017; Huang, D. et al., 2019). However, results on MHL need to be differentiated as they depend on the mental health issue and the geographical region. Identifying various severe mental health issues was not as easily achieved as identifying common mental health issues, such as depression (Gong and Furnham, 2014; Lui et al., 2016; Huang et al., 2019).MHL varied among

geographical regions, for example, Hong Kong Chinese, who historically were influenced by Western values and norms (Shen, E. et al., 2006), had a higher MHL than mainland Chinese (Gong and Furnham, 2014).

Geographical differences were also evident in a recent study by Wong et al. (2017) comparing four Chinese communities' MHL with Australians. Participants in Taiwan had a higher MHL concerning depression than mainland China's participants. Wong et al. (2017) linked this higher MHL of common mental health issues to various mental health campaigns on depression implemented since 1999 in Taiwan. Although the Taiwanese MHL was higher than other Chinese communities, in comparison to Australians, the Taiwanese MHL was still about two thirds lower. Among the four Chinese communities, Hong Kong scored highest in recognising schizophrenia. Mental health campaigns explaining schizophrenia and re-labelling the term to 'malfunctions of thoughts and sensations' which had started in 2001 in Hong Kong might have influenced this result. Recognition of depression was lowest among the Australian Chinese community (Wong et al., 2010; Wong et al., 2017). Lack of adequately culturally adapted mental health promotion material in Chinese language was considered a reason for the lower MHL rate (Wong et al., 2017).

The importance of using suitable terms to reach out to the public was also one of the findings in the current study. If mental health terminology is culturally adjusted to reflect the sensitivity surrounding the topic of mental health within Chinese culture, the Chinese community might respond more positively to psycho-educational endeavours. Therefore, previous research (Wong et al., 2017) and findings from the current study suggest that information about common mental health issues needs to be culturally adjusted and made more accessible.

Loo et al. (2012) conducted a cross-cultural study comparing MHL of British, Hong Kong and Malaysian participants and concluded that British participants had a higher level of MHL than the Hong Kong or Malaysian participants. However, this does not provide an indication for MHL among the Chinese communities in the UK, as the British sample was a mixed sample

consisting of various ethnicities. The findings in the current study focused on the Chinese community in NI and contribute towards a better understanding of how MHL is expressed within this ethnic minority. Although the current study excluded severe mental health issues, such as schizophrenia, findings provided meaningful insights about MHL among the Chinese community.

MHL varied among the participants of the current study and is explained by using a macro and micro level point of view. Lack of MHL was not immediately apparent because findings on a macro level indicated that differentiation into common and severe mental health issues was made. Moreover, causes of mental health issues were identified, such as genetic reasons or the experience of traumatic incidents in people's life. Findings in this study also suggested that treatment methods for mental health issues depended on individual's preferences, ranging from seeking help from health professionals to using alternative methods, for example, prayer to heal a mental health issue.

However, when the findings are explored on a micro-level, in the sense of how each participant understood mental health issues, a different picture emerged. MHL was still evident, but mostly to those with training about mental health issues, for example, through their workplace or personal interest. Causes of mental health issues were named, but findings inferred that doubts and insecurity existed about recognising mental health issues in others and self:

> "Many people they actually don't know that they have depression. They don't know and maybe their family and friends, they also don't know. They would just think, oh, she is unhappy." [Wu-shi]

The findings in the current study suggested that common mental health issues were also difficult to recognise. Many participants had only a limited knowledge about mental health and often described severe mental health issues with words like 'crazy', feelings of being scared or connected them to being locked away in an institution.

In addition, findings of the current study related a sense that MHL was measured by more than just understanding the differences between common

and severe mental health issues and their treatment methods. MHL was also displayed by understanding that external factors such as societal or cultural issues influence mental health, for example, cultural pressure was recognised as a contributor to an increase in mental health issues:

> "Men have much more responsibility to raise the family, they have much more responsibility, they have much more burden, pressure. But they will react very calmly to the pressure, and in fact, this will also cause much heavy load of pressure, work and responsibility will cause something to the mental health." [Wu-qi]

The finding that external factors need to be included when measuring MHL correlates with Kutcher et al. (2016) who emphasised that MHL is an '*evolving construct*' (p.4) that needs to continually develop contextual interventions, which can then be evaluated to influence mental health outcomes positively. Kutcher et al. (2016) critiqued that MHL cannot be based solely on the recognition of two vignettes, but needs to include other markers as well, for example, actively seeking to reduce stigma or enhancing help-seeking efficacy. Further research about MHL in the Chinese community would be advantageous as MHL also contributes towards stigma reduction, which will be explored in the third key theme of this section.

6.3.3 Stigma reduction

The findings of the current study suggested that although participants' MHL varied it still contributed towards a shift in perspective on mental health issues and consequently to stigma reduction. This became especially evident when participants narrated that external influences such as media and being part of a culture where mental health is less stigmatised had changed their perceptions. In addition, personal experiences, such as having a mental health issue themselves or having contact with people who suffered from mental health issues, led to more understanding and tolerance. Participants showed their change of attitude by accepting that mental health issues are a part of life and that they were no longer afraid or ashamed of them.

Findings of the current study indicated that social contact with people who suffered from mental health issues had a significant impact on understanding

as awareness increased that mental health issues can affect anyone at any time:

> "I realise actually, every people have some kind of problems of mental health. They are just kind of lighter or severe." [Wu-sh]

Change of perceptions due to personal experiences confirms research which indicated that personal contact to individuals with mental health issues reduced stigma (Penn and Martin, 1998; Swan, 1999). Furthermore, the findings of the current study correlate with research by Thornicroft et al. (2016) who reviewed research about stigma intervention and concluded that social contact improves stigma-related knowledge and attitudes at least on a short-term basis. Studies on the long-term effect of interventions on stigma reduction are missing. The current study contributes towards long-term effect studies, as findings provided a sense that social contact with people experiencing mental health issues had a long-term influence on stigma reduction. Idiographic accounts suggested that attitudes toward mental health issues had changed over time and due to various life experiences. Stigma reduction was expressed by being more empathic for people with mental health issues.

Nyblade et al. (2019) also agreed that stigma reduction is achieved by contact with the stigmatised group but extends this finding further by suggesting the provision of information and participatory learning also contribute to stigma reduction. Although Nyblade et al.'s (2019) research was directed towards stigma reduction among health professionals, their findings highlighted that providing information and participatory learning are a vital factor in stigma reduction. Psycho-education and Cognitive Behavioural Therapy (CBT) proved to have a positive effect on reducing stigma in China (Xu et al., 2017). The findings of the current study implied that less formal psycho-education interventions could also be effective, for example, media, living in another culture, and personal experiences with mental health issues contributed towards reducing stigma. This raises the hope that stigma of mental health can be overcome not only through formal psycho-educational measures but also through less formal interventions. This is especially

important for stigma reduction within the Chinese community as according to a more recent publication (Irvine et al., 2017) adequate formal psycho-education is difficult to attain within the Chinese community in the UK. According to Irvine et al. (2017), literature in Chinese on mental health issues was not available:

> "As there was no mental health literature written in Chinese in the UK, both Margaret and Mandy mobilized their overseas resources and asked friends and family to send them books from Hong Kong and mainland China, respectively." (Irvine et al., 2017, p.182).

Of course, one could argue that information can also be obtained through the internet or online, however, it can be difficult to obtain correct and valid information (Walsh et al.,2019). In addition, there is also the issue that literature obtained from China or Hong Kong will not consider the specific local services available in the UK. Therefore, even if members of the Chinese community could inform themselves about mental health issues, they are not necessarily informed about local services which could, in turn, have a detrimental effect on their help-seeking behaviour.

Findings of the current study also inferred that stigma of mental health issues still permeates society, for example, one participant disclosed that they wanted to talk with some of their extended family about their mental health issue but received no support or understanding. Based on this experience, a decision was made not to disclose anything, not even to their closest family. Therefore, stigma reduction cannot only be restricted to the individual but also needs to be applied in a wider context, such as family (Yang et al., 2014). Eliminating stigma of mental health issues is an ongoing process in any society needing support from government, education services, and health services to filter down to the individuals and their families. Stigma reduction can only happen in a supportive environment where rights and concerns of citizens are protected (Hemmens et al., 2002). Kleinman (2013) explained that the new mental health law in China helped to create an environment where the patient also has rights and cannot be hospitalised without consent. Prior to this law, people with mental illness in China were

declared as nonpersons, for whose deeds the family was responsible, and this often led to abuse and stigma for the people concerned.

Regarding how stigma of mental health permeates society in NI, findings of the current study suggested participants perceived a difference between the local and the Chinese community. Participants' comments revealed that the local people were often perceived as more open to talk about mental health issues than members of the Chinese community. Stigma reduction among the local population within NI could have been partially influenced by an anti-stigma campaign 'Time to Change', which had started in England in 2003. Although, an evaluation report (Borneo and Pinfold, 2007) showed that despite an anti-stigma campaign in NI a similar level of MHL remained than before the campaign with a lower level of MHL compared to a population in England. However, the survey's participants were recruited from the general population in NI, and the study did not focus on a comparison of mental health between local people and ethnic minorities. Therefore, Borneo and Pinfold (2007) provide insight that NI lags behind England, but do not provide insight about stigma reduction among ethnic minorities. Clement et al. (2011) also doubted if society really has changed their attitude towards mental health issues and people who suffer from mental health issues. Clement et al. (2011) examined stigma within a UK context and concluded that stigma is expressed by distrusting, hostile and sometimes violent behaviour towards people affected with mental health issues. However, in a more recent study (Evans-Lacko et al., 2014) anti-stigma campaigns such as 'Time to Change' was regarded more positive as research found that they might have a long-term effect on the reduction of stigma and discrimination (Evans-Lacko et al., 2014). Therefore, it is important to continue to educate the population about mental health issues and explore further what kind of stigma reduction interventions are most beneficial, not only for ethnic minorities but for society at large.

6.3.4 Section summary: mental health

Mental health stigma among the Chinese community was explored with the help of three theories: stigma as a societal construct, as self-stigma, and as

double stigma. Applying these theories to the findings emphasised the complexity of stigma in society and the difficulty in reducing stigma. The exploration of MHL highlighted that raising MHL contributes to a shift in the perception of mental health issues and can lead to stigma reduction. Findings of this study indicated that MHL could also be achieved by less formal interventions such as media. In addition, measurements for MHL should also be expanded to include external factors, for example, cultural issues, which are especially pertinent for ethnic minorities. Participants' narrations of personal experiences of mental health issues in self or with others provided insight within a Chinese context that contact between stigmatised and non-stigmatised also reduces stigma, confirming previous literature on stigma reduction.

6.4 Help-seeking

The findings in this research study on the perceptions of help-seeking for mental health issues among the Chinese community related the participants' sense that informal ways of help-seeking were preferred to formal ways of help-seeking, because of the sensitive topic of mental health issues. Seeking help from formal pathways was often only considered when all the informal pathways were exhausted, and mental health issues were severe. However, findings of the current study inferred that formal help-seeking was also considered even if mental health issues were not yet severe, especially around bereavement issues and if the service provider offered the patient help. Furthermore, the willingness of formal help-seeking depended on positive or negative experiences with the service provider. The findings on informal and formal help-seeking indicated the multi-layered aspect of help-seeking, which also includes the exploration of barriers which went beyond the lack of language proficiency and issues of accessibility and isolation. These findings led the researcher to organise the help-seeking section around four key themes: informal pathways of help-seeking; formal pathways of help-seeking; barriers beyond language proficiency; accessibility and isolation.

6.4.1 Informal pathways of help-seeking

The extant literature showed that Chinese people are reluctant to seek help (Snowden and Cheung, 1990; Hu et al., 1991; Sue et al., 1991; Chen and Kazanjian, 2005; Hwang et al., 2006; Foo and Kazantzis, 2007; Abe-Kim et al., 2007; Phillips et al., 2009; Yeung et al., 2012; Chan et al., 2014; Liu et al., 2014; Yeung et al., 2015). However, findings in the current study suggested a more positive attitude towards help-seeking, especially regarding informal help-seeking. A recent study by Zhou et al. (2019) also remarked on greater openness regarding help-seeking among Chinese college students. According to Xu et al. (2018), there is a paucity in English, German, and Chinese literature about which types of interventions or experiences influence informal help-seeking. The following section examines how, in the current study, participants viewed informal pathways of help-seeking and which experiences influenced their attitudes.

The findings of the current study inferred that the preferred coping strategy for many participants was self-help. The focus on self-help supports a more recent study by Zhou et al. (2019), which suggested that solving problems through one's own strengths was vital in Chinese culture. Research confirms that self-help is often based on obtaining psycho-education, either through educational material or by attending group sessions (Knight, 2006; Rickwood and Thomas, 2012), but also includes seeking help from friends and family (Chen et al., 2015). Self-help was described by participants of the current study as solving the problem themselves and was primarily understood as relying on oneself and might involve gaining information through the internet or other media. Personal determination to overcome mental health issues was also recognised in previous studies (Aroian et al., 2005; Chen et al., 2015) and therefore, self-help in context with the Chinese community cannot be separated from cultural values, such as resilience. Hong et al. (2014) noted that, within a Chinese context, resilience is strongly influenced by Confucianism and Taoism. Adversity is positively viewed as it creates a possibility for positive changes (Hu and Gan, 2008) and contributes to developing one's potential (Yan, 2005). Thus, encountering difficulties,

including mental health difficulties can, as one participant noted, be regarded as showing one's potential:

> "Sometimes, we have times when we feel very depressed, very down. Somebody, like myself, can stand it, but somebody could be quite weak at that point." [Wang-san]

Underlying values of Confucian teaching, such as self-determination, self-control, and self-reflection (Hong et al., 2014), influences resilience in the face of adversity, such as mental health problems. Yu et al. (2014) also noted that personal and family resilience has a positive effect on dealing with mental health issues.

When self-help, in the form of relying on one's strength, was not successful the findings of the current study indicated that other forms of seeking informal help for mental health issues, such as asking friends or family for help were considered. This finding is in line with more recent studies from Hong Kong (Sun et al., 2017; Chen et al., 2018) and China (Yin et al., 2019) which suggested that seeking help from family and friends was regarded as the most common informal way of help-seeking for mental health issues among Chinese patients. The term 'family and friends' can cover a wide range of people and the current study provided a more detailed insight into this term: participants differentiated between the family of origin, the nuclear family, and the family-in-law; they were selective in choosing whom they would trust with their problems within the family and seeking help often depended on the relationship participants had with family. If their relationship was strained, participants expressed hesitancy about seeking help from family and this finding correlates with a recent study which suggested that distrust in a spouse is not conducive to help-seeking (Schwank et al., 2020).

Findings of the current study indicated that seeking informal help from family referred mostly to spouses or siblings and conveyed trust in support of the nuclear family:

> "If I had something which made me happy or sad, I would speak to my wife. You get someone to listen to you." [Wang-wu]

These findings support a study by Yu et al. (2014) which suggested that family can offer emotional support. Family support is especially important for immigrants whose non-family social networks in the new environment have not yet been built up. Yet seeking help from the family can also be problematic, especially when cultural values add to the problem. Examples of how cultural values influence help-seeking within the extended family and the family of origin are explored below.

The Chinese family has a hierarchical structure rooted in Confucian philosophy, where filial piety informs behaviour between parents and children and the wider family. Filial piety's hierarchical structure is expressed linguistically in the detailed form of address of each family member which identifies the exact relationship within the family, for example, older or younger brother. These family idioms also offer insight into the status of women within the family relationships, as many idioms referring to women clearly mark them as coming from outside the family (Upton-McLaughlin, 2013). Female participants of the current study related this sense of being an outsider and voiced that they felt uncomfortable about seeking help from their family-in-law. This feeling of being an outsider was exacerbated when families came from different cultural backgrounds and had different cultural understandings, for example, one participant shared her experience after giving birth and relying on help and understanding:

> "When I was having the baby, my mum came over to look after me, and she always told me to lie in bed and sleep, and my mother-in-law said, it is not healthy. You need to go out, but our culture is not the same." [Zhang-er]

Mistrust against mothers-in-law is a universal phenomenon, for example, Schwank et al. (2020) suggested that in China mothers-in-law are the least trusted source of support and women in need of help often preferred online resources.

Another reason for not seeking help from the family was that many participants of this study did not want to burden their family of origin. This was expressed in two ways, as children did not want to burden their parents and parents did not want to burden their children. This attitude can be

partially explained with filial piety as when parents advise children, and the children ignore their advice, it could be construed as disregarding filial piety and upsetting family harmony. Hsu and Wang (2011) noted that filial piety could also contribute to psychological distress as feelings of shame, guilt and self-blame arise when students cannot fulfil their parents' expectations. Therefore, seeking help from the family of origin, often excluded participants' parents. Furthermore, if parents seek help from their children, they might lose face and authority and not receive filial piety, for example, respect from their children. Therefore, cultural values, such as saving face, not causing shame to the family and the significance of maintaining self-control all influence help-seeking behaviour (Kung, 2004; Kim, 2007).

The findings of the current study also highlighted that participants often preferred seeking help from friends instead of family. This indicated that participants who had lived in NI for many years had already built up a social network on which they could rely. For many participants seeking help from their friends depended on a trusting relationship:

> "Mostly their best friend I think for the people who really need to confide to someone they call their best friend. Someone they could really trust." [Chen-er]

This relates to a study by Chen et al. (2013), suggesting that close friends were the recipients of mental health disclosures. Findings of the current study also indicated that positive experiences in help-seeking among friends encouraged participants and influenced their mental well-being. Negative experiences in seeking help from friends or family led participants to rely on themselves again or influenced their intent in seeking formal help.

The findings of the current study about informal help-seeking indicated a clear preference for self-help and seeking help from friends. Help from family was considered with caution, and this reluctance was linked to the concept of face and hierarchical structures within Chinese society. Cultural and social issues influence not only informal help-seeking but also impact formal help-seeking, which will be further explored in the following section.

6.4.2 Formal pathways of help-seeking

The findings of the current study suggested that positive experiences with the health service encourage trust in the health service, which in turn leads to positive help-seeking intentions: "*and we trust here, as we know everything is trustable here".* Cultural sensitivity, empathy, and being listened to contributed towards positive experiences of the service provider. Communication is not just a matter of speaking the same language but is also conveyed through interactions such as non-verbal communication and cultural understanding. Not being understood by the service provider presents an issue to immigrants as Ali et al. (2006) found that even South-Asian fluent English speakers were not satisfied when the communication was reduced to just a diagnosis of the illness. According to Tang (2019), the focus on diagnosis reflects the pure biomedical approach of the service provider which disadvantages all service users, independent of ethnicity.

Service providers need to consider that involving users in treatment decisions can be empowering (Deegan and Drake, 2006). The findings of the current study indicated that users could be engaged through outreach from the service providers. In some instances, it took more than one offer of help for the patient to accept help, and this indicated that having a choice positively influenced help-seeking behaviour. It is well known in literature that interactions between the service provider and service user are important factors influencing communication. For example, Paternotte et al. (2015) noted in their review of ethnic minorities and health service providers that cultural and social differences, as well as the health professionals' assumptions, influence communication between the service provider and service user. Several UK studies were also included in their review (Wright, 1983; Moss and Roberts, 2005; Roberts et al., 2005; Ali et al., 2006; Neal et al., 2006; Chudley et al., 2007), providing insights into communication styles among ethnic minorities and service provider. Although the participants in the UK studies did not include members of the Chinese community, some of their findings echo findings of the current study. For example, Neal et al. (2006) found that South Asian patients fluent in English were given less GP

consultation time than white patients. The findings of the current study suggested that participants were also challenged by negative experiences with their service provider such as their GP, counsellor or psychiatrist and these experiences hindered formal help-seeking:

> "When I was really stressed and things going on in my life, and then I share it with my GP. It was a problem to me, but they did not give very helpful advice. I have quite a few number of times a bad experience with my GP, because, for me, if I go to see a GP, it means I need help or assisting. But a lot of the time they made me feel, my problem is so minor and why I need to see them." [Huang-liu]

The extant literature suggested that poor communication skills between service providers and service users often led to diminished patient satisfaction and poor psycho-education (Ferguson and Candib, 2002; Ngo-Metzger et al., 2007; Paternotte et al., 2015). Formal help-seeking depends on communication and the interaction skills of service providers and service users as these skills influence how health services are experienced. The findings of the current study provided insight that the Chinese community is not exempt from poor communication skills and insensitive interactions within the health service. Few participants had experienced that their GP had explained the role of the GP as a gatekeeper for mental health issues. These miscommunications were not only narrated by the service user, but also by other parties, for example, interpreters or health advocates. Thus, negative experiences not only influence the help-seeking intention and behaviour of the service user but also the helper creating a ripple effect and reducing the likelihood of formal help-seeking.

Documet and Sharma (2004) found that negative experiences in health care, for example, cultural incompatibility, led to an unwillingness to seek further help. Cultural incompatibility can be overcome through communication. Yet, communication depends on language proficiency. Lack of language proficiency is often mentioned in the extant literature as a barrier to formal help-seeking, for example, information on existing mental health services cannot be accessed due to the language gap (Li et al., 1999; Aroian et al., 2005; Lee, 2007; Koehn, 2009; Long et al., 2015; Yeung et al., 2015; Chan et al., 2016). Although findings of the current study indicated that lack of

language proficiency can contribute towards the lack of formal help-seeking within the Chinese community. Participants' comments went deeper than just acknowledging insufficient language skills as the cause of miscommunication. Findings of this study also suggested that there are barriers beyond language proficiency. These language related barriers are explored in the next key theme and provide further insights into how language and culture issues relate to formal help-seeking.

6.4.3 Barriers beyond language proficiency

Communication breakdown is not solely based on a lack of language proficiency. Findings in the current study related a sense that communication, despite high proficiency in a language, will always lack true understanding, especially concerning mental health issues:

> "Even if we know there is a place for mental health counselling, we still worry about the language during communication. We have some difficulty to express ourselves to exactly what the problem is." [Wu-qi]

This phenomena of not being truly understood connects to components of existential phenomenology discussed earlier in chapter 4. Merleau-Ponty (1962) observed that there is never a complete understanding between two human beings as there is a difference between the one who has lived through the experience and the other who listened to the experience. Merleau-Ponty's (1962) observation highlighted that complete understanding of another person is not achievable, even with perfect language skills. Cultural differences are an additional barrier and sometimes hinder full understanding, especially concerning the explanation of one's emotional state. For example, when Chinese talk about emotions, they often talk about the heart. This could easily be construed as somatization by someone who has no awareness, that in Chinese understanding, the heart is the seat of the psyche (Shen, E. et al., 2006).

Inadequate written information about mental health issues also contributes to the underutilization of mental health services. Cultural insensitivity by health care providers was already recognized as a serious barrier to help-seeking

among BME service users (Memon et al., 2016). Simply translating idioms from one language into another does not achieve true understanding. This was pointed out by some participants of the current study who had experienced that mental health literature targeted at the local population, was translated literally into Chinese. This translated information material did not convey the true meaning of the issue and alienated the very people at which it was targeted. Hamilton (1990) suggested that literal translations which do not convey or consider the true meaning of certain idioms distort the original text. Findings of the current study indicated the importance of considering cultural issues when translating material relating to mental health issues:

> "They [Health and Social Care] have to refine it a bit or make some changes and do some research for the minority ethics to really find out exactly what the community is like and what they need." [Li-shi]

Cultural adaptation relies on better knowledge about the Chinese community, for example, Tang (2018) criticized that the heterogeneity of the Chinese community is often not recognized by service providers. A homogenous view of the Chinese community can lead to miscommunication between the needs of the Chinese community and the information provided by the mental health services.

Cultural differences, inadequate written information due to a lack of cultural adaption, and the phenomenon of true understanding all contribute to a reluctance in seeking help among the Chinese community in NI. Inadequate information influences the accessibility of services which is explored further in the next key theme, along with the issue of isolation of the Chinese community.

6.4.4 Accessibility and isolation

Misunderstandings based on linguistic differences and a lack of written information leads to a lack of knowledge about mental health services and hinders accessibility on a local level, as findings of the current study highlighted:

> "For other native Chinese, Hong Kong who come over here they probably don't have a clue where to go. I just think that the whole understanding the process – that you can access through the GP. I am not 100% certain that Chinese people will know that." [Li-qi]

Not being informed about their rights and a lack of information which hindered Chinese immigrants seeking help was observed in studies in the Netherlands and the UK (Liu, C. et al., 2015; Yeung et al., 2015; Irvine et al., 2017). Although Yeung et al.'s study (2015) referred to health services for physical disabilities among the Chinese community, the study also underlined the chronic lack of local information available to the Chinese community in the UK. The lack of availability of information also becomes evident in a lack of specific mental health campaigns aimed at the Chinese community as findings of the current study inferred:

> "I haven't necessarily seen many mental health campaigns within the Chinese community to raise awareness. I don't know of a specific report or study that is to assess the needs around mental health of the Chinese community specifically. And it's only that we have that pilot for BME and people in general, which is specifically addressing mental health issues, but that is for all minority groups, not specifically for the Chinese." [Li-ba]

This is disconcerting as this participant's comment highlighted the lack of communication between the Chinese community and mental health services about the mental health needs of the Chinese community. Huang and Spurgeon (2006) reported in their study about the Chinese community in Birmingham that 60% of their participants experienced difficulties in using the health service.

Insecurities about deciding which services to use: "*How do you know what is the right one to go to?"* was another difficulty which hindered help-seeking, indicated in the findings of the current study. This insecurity about how to access beneficial services has some roots in the fact that the Chinese community is often isolated from the local community. Geographical and social isolation can influence help-seeking. Previous literature (Verma et al., 1999; Huang and Spurgeon, 2006) had suggested that geographical isolation is an issue among the Chinese community due to employment within the catering sector and findings of the current study indicated a similar view:

> "The catering industry is something where you don't want to compete with too many other local Chinese takeaways. So, you go further out into the villages and towns throughout Northern Ireland to build your business, and that means that you are often the only Chinese in that village." [Li-ba]

Research on geographical isolation suggested that accessing services becomes more problematic as it keeps the help-seeker not only away from information and resources, but also from accessing services or creating support networks (Lane et al., 2010; Wendt et al., 2015).

Research into social isolation implies that it has a negative impact, for example, it affects well-being (Zadro et al., 2004; Chou et al., 2011) and can be linked to depression (Cacioppo et al., 2010). Social isolation can be divided into three layers, interpersonal, intrapersonal, and existential (Yalom, 1980). Findings of the current study inferred that interpersonal isolation in the form of not seeking help for mental health issues emerged out of fear of being exposed to the community. This finding is in line with an earlier study by Clement et al. (2015), who identified that among Asian Americans, stigma had a disproportionate effect on help-seeking. Interpersonal isolation can lead to further struggles and is represented in statistics indicating that Chinese only seek help when issues are severe (Care Quality Commission, 2010). Furthermore, a finding of the current study suggested that intrapersonal isolation was experienced as existential isolation (Yalom, 1980) because one human being can never be fully understood by another human being:

> "People are lonely. Why are they lonely? Because everybody in their heart they have their own thoughts. It is very hard to tell a different person, a second person to say what exactly I am thinking." [Wu-shi]

The realisation of never being fully understood can be viewed negatively as people might get frustrated and give up on help-seeking. However, I suggest that existential isolation can also be viewed positively, as it includes collectivistic and individualistic experiences:

> "Each man is at once a part of all other men, and yet he is apart from all others" (Bugental, 1976, p.102).

Therefore, existential isolation can provide space for individuality within a collectivistic society, for example, willingness to seek help for mental health issues despite a collectivistic view that help-seeking for mental health issues is shameful. According to Pinel et al. (2017), research is needed on the impact of existential isolation. Further research is necessary to establish the link between existential isolation and the impact on help-seeking, also among ethnic minorities.

6.4.5 Section summary: help-seeking

Informal help-seeking was preferred and was mostly understood as self-help, which includes friends and family. Formal pathways of help-seeking were only reluctantly used and use often hinged on positive or negative experiences with health providers. Language barriers to help-seeking were examined from an existential phenomenological viewpoint, emphasising that true understanding is difficult to achieve, even with language proficiency. This was further exacerbated by inadequately translated information material and a lack of outreach to the Chinese community. This lack of quality information, combined with geographical and social isolation, contributed to a lack of knowledge about available mental health services.

6.5 Counselling

The findings in the current study relevant to perceptions of counselling for mental health issues among the Chinese community revealed the participants' sense that counselling was not well established in the Chinese community. Counselling was, for most participants, an unfamiliar treatment method. Despite this unfamiliarity, an openness towards counselling was apparent as participants wanted to find out what counselling is and does. Unfamiliarity with counselling links to the accessibility of counselling and the findings suggested that pathways of accessing counselling in the public health service or privately were not very well known. Findings also inferred that counselling was not regarded unanimously as beneficial, as critical voices were also raised. Furthermore, findings inferred that even when counselling as an option for treatment of mental health issues was in participants' awareness, the issue of trust and confidentiality as a barrier to seeking counselling was presented. These findings led to the organisation of this section around three key themes: the mystery of counselling; encounters with counselling; lack of trust – a barrier.

6.5.1 The mystery of counselling

Findings of the current study suggested that counselling was an unfamiliar treatment method for mental health issues among the Chinese participants. This unfamiliarity was expressed through findings that inferred a lack of knowledge of what counselling is and does, biased encounters with counselling in health or educational settings and "*not knowing where to go*".

Counselling as a treatment method is difficult to explain as the term '*counselling*' is complex and diverse, with more than 400 different counselling approaches (Palmer et al., 2006). Counselling is often understood as a treatment for the '*worried well*' (Freeth, 2020). Freeth (2020) argued that the nature of counselling needs to be more clearly defined with its goals and aims. Barkham et al. (2017) also stated that the definition of counselling is unclear and non-specific, and this has consequences in the health professional field, for example, in the National Institute for Health and Care Excellence (2009) clinical guidelines for Depression, CBT and counselling

are regarded as different treatment methods. If the medical profession cannot agree on a clear definition of counselling, it will be even more difficult to explain counselling to non-health professionals.

Another obstacle in understanding the role of counselling is rooted in the word itself. Counselling is not a protected term (Aldridge, 2014) and is applied in different areas, for example, guidance counsellor at schools (Reid and West, 2011; Wong and Dykeman, 2019); employment counsellors (Zhu, 2015) or used as a term for volunteers in summer camps and sometimes it is confused with councillor. The usage of the term in different areas dilutes the term and confuses people when they come across being offered counselling. Findings in the current study also related the sense of difficulties in translating the term counselling into Chinese. One possible translation is '*fu-dao*' (辅导)**,** which can be translated as providing guidance, mentoring, or coaching. This appears to an English speaker quite close to the meaning of counselling. However, as this term is often given to a person with a higher status, seeking counselling can be conceived as a loss in social status:

> "The word 'counselling' in Chinese is 'fu-dao' – it is more like a child or a student get help from an adult. And when you are adult, you don't think you want to get help from adult to adult. People are in a kind of good social status; they don't think to lower themselves down to seek help." [Wang-san]

Awareness of how terms are translated and what kind of images they provoke is vital in providing better explanations of counselling.

Lack of knowledge about counselling among the Chinese community was further underlined by findings of the current study, which related a sense that multicultural counselling was not known to participants because counselling was stereotyped as a western phenomenon. Extant literature confirmed that counselling is in its origin based on western ideas and concepts (Watson, 2011; Chan et al., 2014) with an emphasis on open dialogue, exploring intrapsychic conflicts and focusing on the individual (Sue and Sue, 2008). These concepts were often regarded as the '*standard approach to counseling and psychotherapy*' (Moodley et al., 2013, p.2). However, over

the last decades, multicultural counselling has been developed on a global level (Moodley et al., 2015) and contributed further to the diversity of counselling. Multicultural counselling with its basic idea of presenting the client's issues, coping methods and treatment goals within a multicultural context (Pedersen, 2001; Leong and Leach, 2007; Chen and Mak, 2008; Ng and James, 2013) has also developed into a multitude of different approaches (Hwang et al., 2006; Gallagher-Thompson et al., 2007). In a more recent study, Liou and Prior (2012) examined how ch'i related exercises (CRE) were incorporated into counselling practice, mainly as a form of self-care for the counsellor and having an impact on their counselling practice. Deciding to apply CRE within a counselling session is not as straightforward because it depended on individual counsellors' understanding of ch'i in Chinese culture (Liou and Prior, 2012). The definition of ch'i can range from a purely physical and biological meaning to a much more complex meaning of spiritual beliefs, which were not necessarily regarded as suitable to counselling (Liou and Prior, 2012). Therefore, incorporating CRE within counselling depended on the individual counsellor's' perspective and experience of CRE (Liou and Prior, 2012). This example emphasises that the development of multicultural counselling is complex because of the diversity of cultural concepts. Culturally adapted counselling approaches aim to reach out to clients from multicultural backgrounds. These adapted approaches might also be of benefit to the Chinese community as they can experience counselling as incorporating and reflecting Chinese culture and values.

Although participants in this study were not necessarily aware of multicultural counselling, they did comment on their encounters with counselling, in their country of origin and the UK. Their perceptions indicated a lack of understanding of counselling. This is consistent with previous research on the development of professional counselling in China, which found that although professional counselling has developed over the last two decades, counselling is still not fully understood among the Chinese public (Wong and Li, 2014; Deng et al., 2016). Several reasons contribute to this lack of understanding such as lack of well-trained mental health professionals (Zhao

et al., 2011; Zhang, 2014; Deng et al., 2016), a lack of funding for the expansion of psychological services (Townsend, 2011) and the strong connection of counselling to the medical science (Zhang et al., 2001), emphasised with the term 'psychological doctor' (Zhao et al., 2012). This perception of counselling as a medical intervention is captured in one of the findings in the current study:

> "So, they might have the expectations, that a counsellor is more like a doctor, who will diagnose me and who will prescribe something for me, which will make me feel better." [Li-ba]

Experiences of counselling in the country of origin of the immigrant community can also influence knowledge about counselling in the adopted country. Although counselling is also conducted within the Chinese educational system, this did not provide a comprehensive understanding of counselling. Counselling within education was mostly understood to focus on behavioural issues of students, with the goal of helping students achieve a better academic outcome. In addition, findings of the current study inferred that the purpose of counselling within the Chinese education system underlies a different value system, which is influenced by politics:

> "China is led by the Communist Party, and they think to lead the students to develop in the right way, not only in academic way but also mentally. They should go into proper way, they should perform their own value, so they just allocate a teacher in every department from the very beginning to direct the student to go the direct way, in the correct way, to develop their own values." [Wu-qi]

Counselling that is influenced by politics and focuses on guidance and behaviour has very little to do with the development of a self-actualization process (Maslow, 1943; Rogers, 1961), which is one of the central value beliefs of counselling in the West.

In addition, findings of the current study suggested that boundaries within the education system were blurred as the teacher sometimes incorporated both teacher and counsellor roles. The lack of boundaries meant that counselling was sometimes regarded as unapproachable, as one participant's comment revealed: "*Actually, no one goes there. No one really cares about it"*. The role of counselling within the education system is also explored by Tu and Jin

(2016) and provided insight that in the early days of counselling in Taiwan, counselling primarily existed within the education setting. Counselling focused on guidance, aiming to nurture students' mental health to help them with any adjustment issues concerning education, but was not concerned with intra-psychic issues of students (Tu and Jin, 2016). This also finds its expression in the employment of counsellors, for example, 28.2% of counsellors in Taiwan are employed in university counselling centres, whereas in the UK only 2.1% of counsellors are employed in university counselling centres (Goodyear at al., 2016). It is also remarkable that according to Goodyear et al. (2016), there were no self-employed or private counsellors in Taiwan, while in the UK, 32.3% reported being self-employed or in private practice. This provides context to the findings of the current study that private counsellors were not considered as an option, as counselling in private practice is not necessarily common or available in their country of origin, for example, Taiwan, and therefore not in the awareness of participants.

Access to counselling within the NHS was not well known, as findings in the current study indicated, for example, few participants regarded the GP as the first port of call for mental health issues: "*I did not know that I need to talk to the GP."* Similar difficulties in accessing services for the Chinese community within the UK was also found by Irvine et al. (2017), regarding access to social care services. One underlying reason for the lack of knowledge about access was the lack of information in Chinese. Findings of the current study suggested that information about counselling needs to be better publicised among the Chinese community in NI. Thus, members of the Chinese community would be able to make an informed decision about whether counselling would be a treatment option for mental health issues.

Even when the access pathway to counselling was known, findings of the current study indicated that the access pathway was experienced as complex, as several decision-making steps were involved. The complexity of accessibility and long waiting lists are counterproductive, for example, one participant was discouraged by the complexity of access and, as a result, no

longer considered counselling as a treatment option. Research found that administrative issues can have a negative impact on counselling (Goldman et al., 2016), for example, long waiting lists negatively influence the outcome (Reichert and Jacobs, 2018). Research on how to improve access to counselling in NI and make counselling more user-friendly for ethnic minorities is needed.

This first key theme of the counselling section emphasised the complexity of counselling. Translation issues, different experiences of counselling and difficulties in accessing counselling affected perceptions of counselling. Nevertheless, some participants had accessed counselling and shared their experiences, which will be further explored in the second key theme.

6.5.2 Encounters with counselling

Within the multitude of counselling approaches a common denominator to any successful counselling lies in establishing a sound therapeutic relationship based on unconditional positive regard (Jacob, 2013; Knox and Cooper, 2016). Findings of the current study suggested that when sound therapeutic relationships were created, counselling was perceived as vital and life-changing:

> "people from all cultures might benefit from a person-centred non-directive approach – if they get any of that non-judgemental, non-directive environment, it can absolutely turn things around." [Li-ba]

However, when there was no sound therapeutic relationship, findings inferred that counselling was regarded as harmful:

> "at least 50% of those who I have met, were absolutely bloody awful and actually deeply damaging to me in different points in my life." [Li-qi]

The extant literature agrees to the importance of establishing a sound therapeutic relationship (Bordin, 1979; Crits-Christoph et al., 2011; Noyce and Simpson, 2018; Nienhuis et al., 2018; Crits-Christoph et al., 2019) and the adherence to ethical frameworks to avoid harming the client (Bond, 2015).

The importance of sound interpersonal relationships between health professionals and patients was also highlighted in a study about mental

health provision in NI (Montgomery et al., 2018). Health professionals who listen and show empathy influence patients' views positively about mental health services and contribute towards the empowerment of patients (Montgomery et al., 2018). However, findings of the current study inferred that poor communication between health professional and client also contributed towards negative experiences and misunderstandings about counselling. Health professionals were perceived as not taking the time to explain counselling approaches, for example, filling in a multitude of questionnaires during the counselling process was not regarded as meaningful and left the client baffled about its purpose. When person-centred approaches were not explained, they were experienced as not beneficial: "*by just talking, you don't solve my problem".* Counselling as a talking therapy based on person-centred approaches seemed not to be in the awareness of most of the participants, which is in line with the extant literature that among Chinese, direct counselling approaches such as, solution-focused, or cognitive-behavioural counselling are preferred (Lin, 2001; Li and Kim, 2004; Wei and Heppner, 2005; Iwamasa et al., 2006; Kuo et al., 2011; Song et al., 2019).

Matching is a common concept in multicultural counselling (Chang and Yoon, 2011) and often expected to contribute to ideal conditions in counselling relationships. Matching the counsellor with the client's nationality often equates to sharing the same language. However, the Chinese community is a heterogeneous community with different languages, ethnicities, and cultures. Therefore, the availability of matching counsellors to clients will be restricted, as few mental health services will have access to the full range of languages clients need (Costa, 2017). According to Tan and Denson (2018), training in multicultural counselling is paramount as the lack of linguistic competence is apparent in the whole world. For example, the American Psychological Association (2010) reports that 76% of psychology PhD students are white, while only 5.2% are Asian. It is worth noting that, as of 2020, there are two Chinese speaking counsellors in NI.

Matching is not always regarded as the ideal way of conducting counselling. Findings of the current study inferred that talking to someone from the same culture was not necessarily wanted. One reason for this could be that most participants were fluent in English. Another reason was that input from another culture was welcomed:

> "Maybe I trust someone from here, someone local because you have different thoughts and also, I don't want to restrict myself with one idea so for me it doesn't matter, maybe local [non-Chinese] counsellor can give me better idea." [Huang-shi]

This finding is in line with previous research (Chang and Yoon, 2011) which also indicated that counsellors from different backgrounds were appreciated by ethnic minority clients. In addition, research on communication between South Asian people and their GP in the UK found that encounters within the same ethnicity do not necessarily improve outcome (Ali et al., 2006).

First encounters, for example, promotion of counselling or the referral process can influence the perception of counselling. This was illustrated through an idiographic account in this study which raised the issue that promotion of counselling needs collaboration between counselling agencies and potential clients otherwise misconceptions can arise. In this account, promotion of counselling at primary school level raised issues with the participant as they felt that their parental authority might be undermined. The idiographic account inferred that the service provider did not address the parents, provoking negative attitudes toward counselling in the parents, and therefore counselling was regarded with suspicion. Promotion of counselling by service providers needs to take place in collaboration with schools, students, and their parents to ensure that counselling is perceived as beneficial to the individual and society. Research also indicates that counselling is not well understood in a non-clinical population (Wong and Li, 2014; Deng et al., 2016) and service providers need to consider this when promoting counselling.

Furthermore, the referral process also influenced perceptions of counselling as findings of the current study inferred. Not being listened to during the referral and not being part of the decision-making process influenced

perception of the benefits of counselling: "*it won't guarantee you heal or any better. No guarantee, no faith, no confidence".* In the UK, the GP is the gate-keeper to mental health services (Haworth and Gallagher, 2015). It is therefore imperative that the referral process through the GP is conducted in an empathic way to ensure that the patient is not discouraged before they even start with the counselling process. Further research is needed about patient and health professional interactions during the referral process within an ethnic minority setting.

The second key theme of the counselling section confirmed that positive perceptions of counselling are based on having a sound relationship with the counsellor. Within a multicultural counselling setting matching counsellor with client was not viewed as critical, but instead being listened to and assured of confidentiality was vital in having a positive perception of counselling. Promoting counselling sensitively and a client-centred referral process are vital to improve client perceptions of counselling as a beneficial intervention. Trust also plays a vital role in perceptions of counselling and is examined in the third key-theme of this counselling section.

6.5.3 Lack of trust - a barrier

The findings of the current study inferred that a lack of trust in counselling acted as a barrier to seeking counselling. Lack of trust encompassed lack of trust in the counselling process, lack of trust in the counsellor, and issues with building a sound therapeutic relationship.

Lack of trust in the counselling process was rooted in the finding of the current study that counselling would not be compatible with Chinese culture and values:

> "Because people from different areas, from different countries, from different culture, backgrounds, obviously have a different philosophy of living, philosophy of talking, behaving." [Wu-liu]

In the extant literature, the issue of culture within counselling is well researched and explores how counselling rooted in Western concepts can be adapted to other cultures (D'Ardenne and Mahtani, 1989; Ivey et al., 1997;

D'Ardenne and Mahtani, 1999; Pedersen, 2001; Soo-Hoo, 2006; Leong and Leach, 2007; Chen and Mak, 2008; Watson, 2011). D'Ardenne and Mahtani (1989), were early advocates of multicultural counselling, recognising that the majority culture is often hostile towards ethnic minorities and pointed to the possibility of bias in the counselling room. The findings of the current study indicated that bias can also originate from clients. For example, participants were aware of cultural differences and did not expect from the counsellor understanding of Chinese value systems such as the authoritative role of the parent in Chinese culture. Client-based bias also contributes to a lack of trust in the counselling process.

These findings are in line with research from Mak and Shaw (2015), which also found that differences in cultural values, beliefs and social norms can be challenging for clients and health professionals alike. This challenge is experienced in different ways, for example, health professionals might be unaware of the assumptions the client might hold, whereas clients might experience that their expectations are not met (Mak and Shaw, 2015). Therefore, cultural awareness needs to be addressed by the counsellor and the client during sessions to build trust in the counselling process.

Trusting the counsellor is vital for a positive counselling experience (Saunders et al., 1989), as without trust between counsellor and client counselling cannot be conducted (Bond, 2015). However, the findings of the current study related a sense that counsellors, especially if part of the Chinese community, would not be trusted. There was concern that information could leak: "*If they know my secret – will it be safe with them?*". These findings inferred that trustworthiness of a counsellor is closely connected to their ability to keep a secret. Moller et al. (2016) found that South Asians felt uncomfortable going to a counsellor from the same ethnicity, but at the same time wanted a counsellor with the same ethnicity as they felt better understood. Moller et al.'s (2016) findings are reflected in the findings of the current study, which also suggested hesitancy about counselling when conducted by someone from the Chinese community:

> "The Chinese will think the Chinese counsellor know other Chinese if they come to the Chinese counsellor what if the Chinese counsellor discloses my situation to others. They will have this concern or fear in their mind." [Wang-san]

At the same time findings of the current study also inferred that due to language and cultural issues, a counsellor from the same ethnicity was preferred. Participants suggested a possible solution to this dichotomy by utilising a counsellor who shares the same ethnicity and culture but comes from outside NI. While the availability of online counselling services makes this solution more accessible to members of the Chinese community, the findings of the current study also suggested limited awareness of online counselling services among participants: "*I haven't heard anyone used this way to sort out their problems*". Therefore, awareness of online counselling services needs to be raised among the Chinese community as an alternative to local counselling.

The professionalism of the counsellor is a vital aspect of building trust and was another finding in the current study:

> "That they have vetting system information that this individual I am speaking to is actually, you know, doing their job properly and is trustworthy." [Huang-qi]

The importance of professionalism also links to Confucian principles which value expert authority highly and being treated by an expert generates trust that problems can be solved (Yeung and Ng, 2011). Mak and Shaw (2015) call for an intercultural sensitivity and skills training for psychologists, counsellors, and mental health professionals and emphasise that a lack of empathy and trust is counterproductive to the delivery of counselling services. Assurance of professionalism will contribute towards developing trust in the counsellor and the counselling process.

Confidentiality and trust are interrelated and, in counselling, form the foundation for a sound therapeutic relationship (Lamont-Mills et al., 2018). The findings of the current study inferred that trust and confidentiality provided by the counsellor were vital for seeking counselling:

> "If they [counsellor] can instil confidentiality if they can instil the trust in the client that they will be looked after. And that everything inside the room is inside the room. Is not going to go out… It all depends on how much the client can trust the authorities." [Chen-si]

Confidentiality is essential for a trusting professional relationship between doctor and patient (BMA, 2020), and between counsellor and client (Bond and Mitchels, 2008). Both Qian et al. (2011) and Zhao et al. (2012) reported that counsellors in China were able to maintain confidentiality. However, Zhao et al. (2012) questioned the ability of clients to understand the meaning of confidentiality and informed consent. In addition, in an earlier study, Zhao et al. (2011) stated that counsellors in China admitted that they had breached confidentiality by discussing cases with family or acquaintances. The issue of breaching confidentiality within multicultural counselling and the subsequent loss of trust is not only an issue among counsellors but can also involve others. Findings of the current study indicated that interpreters were perceived as not keeping confidentiality: *"Unfortunately, some of them expose the people confidentiality".* It is therefore paramount that the counsellor ensures that the interpreter understands the importance of confidentiality and for example, does not work with an interpreter who knows the client (Miletic et al., 2006).

When using an interpreter, counsellors also need to be aware that role exchange can influence the counselling process. This role exchange was illustrated by the experience of a participant where the interpreter involuntarily took on the role of the client:

> "There was no strong connection between the counsellor and the client because their communication was through the interpreter. That's why the interpreter felt that the counselling, the CBT is more for her, and the client doesn't feel the session has helped too much." [Li-shi]

This finding presents a new angle to the issue of role exchange while interpreting. Prior studies (Farooq and Fear, 2003; Paone and Malott, 2008) described a role exchange between the interpreter and mental health provider, whereas, in the current study, the role exchange took part between client and interpreter, making the client invisible. Role exchange can affect the therapy (Miller et al., 2005), and therefore, the therapeutic relationship

can suffer. Furthermore, the findings of the current study also indicated that clients did not always get the same interpreter for each session. Yet, research found that having consistency in the interpreter service has a positive impact on the building of trust and the establishing of a sound therapeutic relationship (Tribe and Lane, 2009; Bargreen, 2014; Jones-Smith, 2019). These findings highlighted the importance of skills training for counsellors concerning issues of confidentiality and how to deploy interpreter services beneficially to avoid a loss of trust in the therapeutic relationship. Therefore, maintaining trust is not only based on the relationship between counsellor and client, but expands to a triad, where the relationship between counsellor, client, and the third person in the room, the interpreter, also needs to be considered.

Keeping confidentiality is paramount in any counselling relationship. Within a multicultural counselling setting, issues such as respect of the client's cultural values, role exchange and safeguarding confidentialities while working with interpreters add additional challenges to maintaining trust in the counselling process.

6.5.4 Section summary: counselling

Counselling as an intervention for mental health issues was not well known among the participants of this study. Several reasons for this lack of understanding were explored: the lack of a clear definition of counselling; the mainly western roots of counselling; little awareness of the existence of multicultural counselling and experiences of a different focus on counselling in the country of origin. Participants' experiences with counselling, the referral process or promotion of counselling influenced their perceptions of counselling. The participants' lack of trust was often based on fears about confidentiality, questioning the professionalism of counsellors and issues of multicultural counselling such as the pros and cons of matching or the use of interpreters in counselling sessions. These challenges contribute to a reluctance in considering counselling as an intervention for mental health issues.

6.6 Conclusion

The common theme that runs through this discussion chapter is how the lack of accessible information surrounding the issue of mental health influences the Chinese community's perceptions of mental health, help-seeking, and counselling.

Lack of information on mental health influenced how mental health was perceived within the Chinese community in NI, as it generated stigma. Mental health as the '*worst shame in Chinese culture*' was further highlighted by research about low MHL among the Chinese immigrant population. Low MHL is also rooted in a lack of psycho-education and was exacerbated by a lack of culturally adapted terminology and difficulties in identifying mental health issues in self or others '*they actually don't know they have depression*'. The discussion underlined that MHL can be increased not only by formal interventions, but by less formal interventions, for example, encountering people who suffer from mental health issues. The discussion also highlighted that social contact is an effective tool in stigma reduction, which can be increased when a supportive environment exists, not only at a personal level, but also within a societal and legal context.

Lack of information on help-seeking influenced how help-seeking was perceived within the Chinese community in NI, with formal help-seeking rarely being considered and both social and geographical isolation contributing to the information gap of how to access services. The discussion also highlighted that communication skills and interactions between service provider and service user influence help-seeking. Poor communication skills of the service provider caused a barrier to formal help-seeking, '*they made me feel, my problem is so minor and why I need to see them'*. However, positive experiences with the service provider encouraged formal help-seeking. Nonetheless, informal ways of help-seeking, such as self-help were preferred by most participants and this can be linked to cultural values such as resilience, '*somebody, like myself, can stand it'*. Stereotypical ideas of help-seeking behaviour within a collectivistic society such as help is primarily sought within the family were not confirmed. Within the Chinese community,

friends were often the preferred choice, while the family of origin was rarely considered due to traditional cultural values and stigma regarding mental health issues.

Lack of information on counselling influenced how counselling was perceived with the Chinese community in NI. Participants' comments indicated that counselling was not well understood, '*by just talking, you don't solve my problems*'. The discussion highlighted that the variety of counselling approaches, terminology, and translation issues, together with limited knowledge about multicultural counselling further complicated comprehension of counselling. Participants fears around counsellors' cultural incomprehension, fears of confidentiality breaches, and questions around professionalism of counsellors were explored with relevant literature. These explorations underlined the importance of trust, '*if they can instil the trust in the client that they will be looked after*', when considering counselling as a help-seeking intervention.

This discussion chapter highlighted that perceptions of mental health, help-seeking, and counselling within the Chinese community are interlinked and would benefit from an information campaign. Health service providers need to reach out to the Chinese community to change perceptions by raising awareness that mental health issues no longer need to be stigmatised, explaining the accessibility of existing mental health services and emphasising the benefits of counselling not only for mental health issues but as an intervention to better deal with life's difficulties, especially within a multicultural environment.

Chapter 7: Conclusion

7.1 Introduction

This conclusion chapter provides a summary of the discussion of the key findings and links them to the research aim and objectives. The recommendations based on findings provide health care providers and service users with new insights into changes to improve mental health and well-being of the Chinese community. Findings also have implications for counselling practice and policies. Limitations of the current study were considered, but despite the limitations, the study contributed to new knowledge in the field and closed some of the gaps mentioned in the literature. The conclusion chapter ends with personal reflections of the researcher and a summary of this study.

7.2 Key findings

The aim of this study was to explore perceptions of mental health, help-seeking, and counselling among the Chinese community in NI and this is based on data collected from 30 adult participants, who are members of the Chinese community in NI. The key findings were examined in three sections, mental health, help-seeking, and counselling to address the aim and objectives of this research study.

The mental health section explored the findings by examining mental health stigma, mental health literacy, and stigma reduction to answer the first research objective: To understand the perceptions of mental health among the Chinese community in NI.

Mental health stigma highlighted multiple layers of stigma by examining its societal construct, self-stigma, and double stigma. The societal construct highlighted that the experience of stigma is still common in Chinese society. Stigma affects not only the individual but also the family and can be interpreted with 'social death' through isolation from mainstream society. Self-stigma was experienced through admitting to feelings of shame about having a mental health issue and through repeating society's belief that

mental health issues are shameful. Although double stigma was not explicitly mentioned, there were still experiences of dissatisfaction with mental health services. The issue of double stigma among ethnic minorities would need further research in NI.

Mental health literacy underlined that psycho-education in the form of mental health campaigns can have a positive effect on MHL as research indicated that regional differences of MHL, could be connected to regional mental health campaigns. Although MHL in the host country can be high, this does not always equate to a high MHL for immigrant communities. Adequate, culturally adapted mental health information is vital in reaching out to the Chinese community, as even common mental health issues were not well understood.

Stigma reduction suggested that social contact with people experiencing mental health problems reduces stigma and can have a long-term effect on stigma reduction. Psycho-education, in the form of continual professional development, online resources and personal experiences of mental health issues, proved to reduce stigma. However, a lack of adequate, up-to-date information about mental health issues and services in NI was a barrier to stigma reduction in the wider Chinese community. A supportive private and public environment is crucial to allow anti-stigma campaigns to flourish. Anti-stigma campaigns are often only aimed at the local population but should also be adapted to the specific needs of an ethnic minority.

The help-seeking section explored the findings by examining informal and formal pathways of help-seeking, barriers beyond language proficiency, accessibility and isolation to answer the second and third research objectives: To gain an understanding of the perceptions of help-seeking concerning mental health among the Chinese community in NI, and To gain insight into experiences of help-seeking concerning mental health among the Chinese community in NI.

Informal pathways of help-seeking underlined that self-help, grounded in Confucian and Daoist values, was the preferred way of seeking help. An

alternative to self-help was seeking help from friends and family, but only if the relationship was sound and trustworthy. Family can offer emotional support, however, a distinction needs to be made from whom help is sought as siblings and spouses were the preferred contacts. Cultural values, such as filial piety could cause issues while seeking help within the family and therefore, contacts outside the family were often preferred.

Formal pathways of help-seeking indicated that if the service provider becomes more active in offering help, this positively influenced the help-seeker. However, findings also inferred that negative experiences with the service provider did not encourage help-seeking in the future. It is therefore important that communication and interactions between service user and service provider are of a high standard to encourage help-seeking.

Barriers beyond language proficiency highlighted that barriers to understanding are more complex than just being based on insufficient language skills. The commonly recognised barrier to help-seeking, lack of language proficiency, was expanded on by applying existential phenomenology to raise awareness that full understanding between two human beings can never be achieved, even with language compatibility. Not being understood is exacerbated when service providers to not recognise cultural differences and heterogeneity of ethnic minorities. Additionally, the use of information material which is not linguistically and culturally adapted further alienates service users and hinders them from finding services that can benefit them.

Accessibility to existing health services is rooted in a lack of up-to-date knowledge, due to a lack of adequate information material, a lack of mental health campaigns specifically aimed at the Chinese community, and a lack of communication between service providers and users. In addition, geographical and social isolation exacerbate the lack of knowledge about the accessibility of health services. Social isolation was explored from an interpersonal and an intrapersonal perspective. Interpersonal isolation is grounded in the fear of being exposed to help-seeking, while intrapersonal isolation can have a positive effect by contributing to individualisation. Thus,

individualisation can develop into the freedom to seek help for mental health issues, despite the stigma surrounding help-seeking for mental health issues.

The counselling section explored the findings by examining them under the themes: the mystery of counselling; encounters with counselling; lack of trust – a barrier, to address the fourth and fifth objectives of the current study: To explore perceptions of counselling among the Chinese community in NI, and To gain insight into experiences of counselling among the Chinese community in NI.

The mystery of counselling is rooted in the difficulties of defining counselling due to the multitude of counselling approaches that are based on different value and belief systems. The difficulty in finding a commonly agreed definition has repercussions for finding appropriate terms for translations and contributes to insecurities in understanding what counselling is and does. Lack of knowledge about multicultural counselling approaches further deepened the perception that counselling is a western phenomenon. The limited understanding of counselling that existed was often based on experiences either in the health or education system in China and the UK. Experiences in the health system influenced an expectation of a more medical approach of counselling, for example, expecting to receive prescription drugs for mental health issues. Experiences of counselling within the education system left a sense of counselling only being used for behavioural reform with boundaries being blurred. Accessibility of counselling was hindered by a lack of information on how to access it and the perceived complexity of the access pathway.

Encounters with counselling highlighted that the therapeutic relationship, matching and first encounters all contribute towards how counselling is perceived. A sound therapeutic relationship is crucial in any counselling approach and influences if counselling is perceived as beneficial. Poor communication between counsellor and counsellee hinders the building of a sound therapeutic relationship. In multi-cultural counselling theory, matching the ethnicity of counsellor and client is often regarded as the ideal way to create a sound therapeutic relationship. However, findings indicated that

matching was not always preferred or needed. Therefore, client preferences need to be considered when allocating a counsellor within services. Perceptions of counselling were also influenced by first encounters outside the counselling room, such as the promotion of counselling or the referral process.

Lack of trust – a barrier, explored trust issues relating to the counselling process, the counsellor, and the therapeutic relationship. The counselling process was regarded critically as it was perceived not to address Chinese culture and value systems. Findings indicated that counselling was believed to be rooted in Western values and thus did not consider other cultural mindsets. Trusting a counsellor was linked by participants to strict adherence of confidentiality. However, the trustworthiness of counsellors was questioned, and a dichotomy revealed between being better understood by someone from the same race or ensuring greater confidentiality by finding a counsellor outside their ethnicity. Therefore, the professionalism of counsellors is vital as trust only develops when clients feel safe, accepted, and understood. Furthermore, the therapeutic relationship in multicultural counselling can also be influenced by the presence of the interpreter. Findings of the current study implied that interpreters were regarded as lacking understanding of confidentiality. Therefore, counsellors who work within a multicultural setting need to have adequate training to deal with specific issues, for example, the use of interpreters, to provide a safe environment for the client, the interpreter and themselves. Thus, protecting the therapeutic relationship and ensuring that counselling is perceived as beneficial when dealing with challenging life situations.

7.3 Recommendations

The recommendations were derived from the key findings examined in the discussion chapter and follow the discussion chapter's structure to answer the sixth and final objective of this research study: To provide recommendations on mental health, help-seeking, and counselling to enhance mental health and well-being among the Chinese community in NI. The recommendations target health service providers, the Chinese

community, and, as a representative for the Chinese community, the Chinese Welfare Association in NI, as well as counselling agencies and individual counsellors.

7.3.1 Mental health

The study has demonstrated that mental health issues are still stigmatised. To reduce stigma of mental health issues, it is therefore recommended that health providers launch a mental health anti-stigma campaign specifically designed for the Chinese community in collaboration with the Chinese Welfare Association in NI.

The exploration of the current study also revealed that MHL is lacking among the Chinese community. To improve MHL among the Chinese community, it is therefore recommended that health service providers promote and organise opportunities for psycho-education.

In addition, the findings of the current study revealed a lack of adequate, up-to-date information about mental health issues and services in the UK for the Chinese community. To access suitable information, it is therefore recommended that health service providers produce information about mental health issues and available services specifically aimed at the Chinese community, which is culturally adapted, up-to-date and locally relevant.

7.3.2 Help-seeking

The findings of the current study revealed that members of a collectivistic society, such as the Chinese community, do not necessarily seek help within the family and are often isolated. To raise accessibility to available services, it is therefore recommended that health service providers offer service users guidance on where to seek help.

The findings identified that formal ways of help-seeking are not well known. Therefore, it is recommended that GPs better explain their role to patients from ethnic minorities, for example, that they can also provide pathways for mental health issues.

The findings of the current study indicated that negative experiences with the health service provider decrease intent to seek help. To improve doctor / patient communication, it is therefore recommended to increase empathy toward the patient, for example, by listening carefully to the service user's narration.

The current findings underline that true understanding is difficult to achieve, even with language compatibility. To improve communication between the service provider and service user, it is therefore recommended that extended time windows are provided when dealing with members of an ethnic minority community.

7.3.3 Counselling

The findings inferred that counselling is not well understood among the Chinese community. To improve understanding of counselling as an intervention for mental health issues and other stressful life events, it is therefore recommended that counselling services and professional bodies for counselling acknowledge that counselling is not well understood among the Chinese community and work towards more accurate, transparent and appropriate explanations of counselling.

The current study indicated that multicultural counselling approaches are not well known among the Chinese community. To promote multicultural counselling among the Chinese community, it is therefore recommended to start a mental health campaign which focuses on multicultural counselling approaches.

The therapeutic relationship is crucial in any counselling approach. To achieve a sound therapeutic relationship, it is recommended that counsellors explore what kind of understanding of counselling clients from the Chinese community carry. This awareness will help prevent misunderstandings concerning the therapeutic relationship and enable counsellors to explain better the counselling approach that they use.

Findings indicated that matching client and counsellor ethnicities was not always desired by the clients. To adapt counselling to individual clients' needs, it is therefore recommended that counselling agencies consider a more flexible approach towards matching to accommodate the individual needs of clients better.

Promotion of counselling is undertaken in various places, for example, schools. To prevent mistrust of counselling, it is therefore recommended that when promoting counselling, the needs of a multicultural audience with various value and belief systems should be considered and approached sensitively.

Professionalism in counselling contributes towards maintaining confidentiality and a sound therapeutic relationship. To ensure confidentiality and a sound therapeutic relationship in counselling sessions, it is therefore recommended that counsellors undertake skills training for specific issues arising in a multicultural counselling setting.

7.4 Limitations

Several limitations can be observed concerning the current study. The current study does not claim to generalise the findings as participants did not include Chinese-only speaking members of the Chinese community in NI. Therefore, it does not represent the entire population of the Chinese community in NI. Nevertheless, this study still offers insight into the perceptions of members of one ethnic minority group, without claiming generalisation to other ethnic minority groups.

The research was conducted in English, which excludes the Chinese-only speaking population of the Chinese community in Northern Ireland and could be regarded as a drawback of this study. However, as this is an explanatory study, access to the English-speaking population of the Chinese community provided first insights into perceptions of mental health, help-seeking, and counselling. Interviewing the English-speaking members of the Chinese community reinforces some of the research findings because, despite their

English ability, information about mental health, help-seeking, and counselling was not easily obtained by participants.

It could be argued that semi-structured interviews guided the conduct of the interview and may have restricted participants. However, the structure used helped cover the main objectives of the study and comply with the Ulster University ethical regulations. In addition, the researcher was aware that she was an inexperienced IPA researcher and followed Smith et al.'s (2009) advice on using semi-structured interviews.

As this is a cross-sectional study, interviews were conducted at a single point in time. Longitudinal research would, through follow-up interviews, better allow recognition of developments and changes of perception. Nevertheless, the current study still provided insight into the evolution of participant understanding as they narrated their stories of development.

7.5 Implications

Several implications emerged from this study concerning practice and policies of health service providers.

7.5.1 For practice

The main implication of the present research is that lack of information about mental health, help-seeking, and counselling is the primary barrier to members of the Chinese community in NI accessing services to improve their mental health and well-being. Therefore, awareness needs to be raised among various professional groups:

In health service providers' practice, awareness needs to be raised that service users are not as well informed about pathways of accessing mental health services. Also, the lack of up-to-date, culturally adjusted and locally relevant information material needs to be addressed urgently.

In interpreter service providers' practice, awareness needs to be raised that interpreters need specific training when translating in mental health issues related areas, for example, issues of confidentiality need to be clarified. Also,

duty of care needs to be considered as interpreters could suffer secondary trauma when interpreting mental health issues.

In counselling practice, awareness needs to be raised that counselling is not well understood, or at best understood within a different framework, by the Chinese community. Counsellors and counselling agencies need to find innovative ways to reach out to ethnic minorities to explain the meaning and benefits of counselling. Counsellors need to include in their continuing professional development multicultural counselling training to become adept in counselling outside their cultural understanding and experiences.

In Chinese community practice, awareness needs to be raised for more collaboration and dialogue with health services and counselling agencies to introduce culturally adequate mental health campaigns to promote the existing mental health services and counselling agencies.

7.5.2 For policy

Regarding health service policy, it is essential that mental health campaigns will be developed in co-operation with local ethnic minority groups to address individual concerns of various ethnic groups. A one size fits all approach is not good enough as it cannot cover culture-specific issues of ethnic minorities.

Regarding counselling policy, it is vital that heterogeneity of ethnic communities is addressed, to avoid stereotyping by acknowledging, for example, the variety of cultural background and language which influences each human being. Clear and appropriate definitions of counselling need to be publicised by counselling agencies through media and mental health campaigns but also by reaching out to community centres with this information.

7.6 Future research

In the discussion of the findings, the need for further research emerged in three directions. Firstly, concerning mental health issues, an exploration if there is a racial side to stigma within the Chinese community would expand

knowledge about the influence of double stigma within ethnic communities. Further research about MHL in the Chinese community would be also advantageous as MHL also contributes towards stigma reduction, for example, do external factors, such as social issues or cultural pressures, influence MHL?

Secondly, future research relating to help-seeking could include an exploration of the needs regarding Chinese-only speaking members of the Chinese community in NI. This could be linked to more in-depth research about patient and health professional interactions during the referral process within an ethnic minority setting. Furthermore, the link between existential isolation and the impact on help-seeking would also be a worthwhile exploration as it would contribute towards a deeper understanding of the reluctance to seek help.

Thirdly, future research regarding counselling must include research on how to improve accessing counselling in NI and make it more user friendly for ethnic minorities. The issue of how experiences of counselling in the country of origin influences willingness to seek counselling among the Chinese community, would provide further insights into the reluctance to consider counselling as a mental health intervention. More research is also needed to explore how online counselling could be a solution to overcome the barrier of confidentiality and trust issues.

7.7 Contribution to literature

The key message of this study is that information about mental health, help-seeking, and counselling must be tailored towards the Chinese community's cultural needs to enhance understanding of common mental health issues, overcome the complexity of accessing help and clarify understanding and benefits of counselling regarding mental health issues and other stressful life events.

The importance of this research study lies in adding a qualitative research study to the literature that provides a more detailed view on the perceptions an ethnic minority (Chinese community) has of mental health, help-seeking,

and counselling. According to Denzin and Lincoln (2012), there is still a paucity of qualitative research concerning the Asian population, as quantitative research is often preferred in international social psychology publications.

The lack of research into the distinctions between different Asian ethnic groups (Hwang et al., 2006; Sue and Sue, 2008) can often lead to a generalization of results from one Asian immigrant group to another (Shen, E. et al., 2006). This study does not generalise Asians but explored one specific Asian group. In addition, the sample for the current study provides a good range of participants from the non-clinical population of the Chinese community. Also, this sample does not draw from a student population, which is often the case in research studies. Furthermore, this study incorporates the changing demographics of the Chinese community in NI, as approximately half of the participants were from mainland China, and this reflects the rising percentage of mainland Chinese within the NI Chinese community.

The literature review has also shown that there is a paucity of research about the health and well-being of the Chinese community in the UK (Yeung et al., 2013) and therefore this study contributes towards bridging this gap by providing a unique view on the non-clinical population of the Chinese community and their understanding of mental health, help-seeking, and counselling. This study, with its detailed exploration of perceptions of mental health, help-seeking, and counselling, expands on earlier studies about the Chinese community in NI (Irwin and Dunn, 1997; Yeung, 2005; Olphert, 2007) and therefore, contributes towards bridging a research gap of more than a decade. The current study allows a deeper understanding of the participants' experiences and provides insights into why the Chinese community are hesitant to use existing services. Furthermore, this study contributes toward a better understanding of the attitude-behaviour relationship concerning mental health, help-seeking, and counselling among an ethnic minority because it provided new insights into, for example, the lack of appropriately translated information.

In addition, this study contributes towards IPA research with a larger sample size, creating original research by interpreting IPA with a reversed hermeneutical approach (the whole explains the part, and the part explains the whole) and by recruiting a non-clinical population. Furthermore, a table was created to organise the larger sample size and provide clear evidence for the recurrent theme theory. IPA studies often deal with major health events in a person's life, however, there is a lack of IPA studies in preventative health behaviour and health promotion (Smith, 2011). Therefore, exploring the existing knowledge in the community contributes towards a better understanding of what preventative measures are needed.

Findings of the current study were presented at conferences and in more informal settings and are listed below.

7.7.1 Conference presentations

BACP Conference (2019) oral presentation: Perceptions and barriers of counselling among the Chinese community within Northern Ireland.

Ulster University Festival of PhD Research (2018) 3 Minute Thesis finalist.

IPA 2nd International Conference (2018) oral presentation: Perception of Mental health, Help-seeking, and Counselling among the Chinese community in NI.

BACP Conference (2017) poster presentation: Applied Counselling approaches within the Chinese community.

BACP Connect Conference (2016): Raising awareness of this study among counselling colleagues.

7.7.2 Professional knowledge exchange

Peer supervision group as a discussion forum for findings of the current study (2018; 2019)

Sharing of findings with ethnic minority counsellors (2016-2019)

Counselling supervision to inform supervisors about findings (2014-2019)

Chinese Welfare Association (2016; 2017; 2018)

7.7.3 Planned publications

Planning of publications in peer reviewed journals to contribute to the field, and it is anticipated that there will be three research papers:

Mental health and the Chinese community:

Target journal: *Journal of Immigrant and Minority Health (Springer)*

Help-seeking and the Chinese community:

Target journal: *International Journal of Intercultural Relations (Elsevier)*

Counselling and the Chinese community:

Target journal: *Counselling & Psychotherapy Research Journal (Wiley)*

7.8 Reflections of the researcher

Having the opportunity to study at PhD level can be described as an academic journey. I choose the word ‘journey’ because counsellors often use this metaphor to explain to clients that counselling is a process, and this is also true of a PhD study. This academic journey has a clearly defined goal: submitting a thesis. To reach this goal persistence is required as it involves many milestones, detours, unexpected roadblocks, and delays.

For me, the academic journey started with a leap from studying at degree level to studying at PhD level. Each chapter of the thesis is a milestone on that journey, starting with the literature review, followed by the contextual framework, and the decision-making process which methodology to apply, the data collection and analysis culminating into the findings and discussion chapters. Finally, writing the conclusion chapter brings the finishing line within sight.

The literature review laid the foundation for the research aim and objectives, providing insight into the existing literature. At this early stage of the PhD, continuous support from supervisors and librarians was very much

appreciated. The contextual framework chapter was like entering a new landscape with its various theoretical positions and the realisation that there is a multitude of research approaches and frameworks. The methodology chapter needed perseverance as it involved the final decision-making on which methodology to use, clearance by the ethics committee and the great adventure of data collection. I can say without a doubt that data collection was an absolute highlight. Talking to participants energized me and provided me with rich and meaningful data. The descent into data analysis was slow and included some detours to determine the best method to analyse this rich data. The findings chapter was a continuing decision-making process as findings emerged and needed to be summarised in meaningful themes and presented logically. The crucial point was to give voice to all 30 participants without becoming superficial and losing the depth of the interview data. The discussion chapter included many twists and turns before it became streamlined, but still captured the voices of the participants and their multifaceted perceptions. The conclusion chapter is written with the knowledge that the goal is in sight, which seems quite incredible after all this time. The challenge will now be to disseminate the findings to ensure that improvements are made in health services and counselling agencies to inform the Chinese community about mental health issues, help-seeking, and counselling.

7.9 Summary

This study has illustrated that lack of information, personal experiences and socio-environmental factors influence perceptions of mental health, help-seeking, and counselling within the Chinese community in NI. Cultural adapted, up-to-date, and locally relevant information about mental health issues is required and needs to be disseminated among the Chinese community in NI to encourage formal help-seeking and ensure that counselling is better understood and trusted.

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Appendices

Appendix 1: Chinese Welfare Association Recruitment Email

Dear Uli,

I am confirming that on behalf of Chinese Welfare Association NI (CWA) we are interested in your research:

> An Exploration into the Perspectives on Mental Health, Help-seeking and Counselling among the Chinese Community in NI

This research will help ascertain the current mental health and counselling needs of the Chinese community. The Chinese community in NI is very diverse, varying in age and also country of origin, including China, Hong Kong, Vietnam, Singapore, Malaysia and Taiwan. As a result of this increased diversity, the needs we encounter in our services are increasingly complex. This research is therefore timely as we see shifting trends of the Chinese community, not only in linguistic diversity (Mandarin and Cantonese) but also cultural diversity from different regions (e.g. Fujianese to locally born Chinese.)

CWA support this application and are willing to work with this research to enable better service provision and to identify the needs of the changing Chinese population in NI.

CWA are willing to help with the recruitment of participants for the focus groups and face-to-face interviews and, if necessary, provide access to a room where the focus groups and the face-to-face interviews could be conducted.

Yours sincerely,

Appendix 2: Poster

Ulster University

School of Communication

Your perspectives on mental health, help-seeking and counselling are needed

New research study is being conducted on the perspectives of mental health, help-seeking and counselling among the Chinese community in Northern Ireland.

The study will include focus groups and face-to-face interviews.

If you are a member of the Chinese community, over 18 years of age and would like more information or to participate in a focus group or a face-to-face interview, please contact the researcher below.

This study will be conducted by a PhD student from the School of Communication.

Contact details:

Uli Speers (PhD student)
E: speers-u@email.ulster.ac.uk

Dr Anne Moorhead (Academic supervisor, Ulster University)
E: a.moorhead@ulster.ac.uk
T: (028) 9036 8905

Dr Maggie Long
(Academic supervisor, Ulster University)
E: m.long@ulster.ac.uk
T: (028) 9036 6282

Appendix 3: Participant Information Sheets (PIS)

Information Sheet

School of Communication

An exploration on the perspectives on mental health, help-seeking and counselling among the Chinese community in NI

This research is part of a PhD within the School of Communication at Ulster University. The aim of the study is to explore perspectives on mental health, help-seeking and counselling among the Chinese community in NI. As a part of this study, I am inviting adults (18+ years) from the Chinese community to participate in a focus group or a face-to-face interview to explore their perspectives on mental health, help-seeking and counselling.

What is required?

If you participate you will be required to give written informed consent and confirm that you are not presently undergoing psychiatric treatment. You can choose to participate in a focus group or a face-to-face interview with the researcher – both will be in English.

What will happen in a focus group?

In the focus group, you will be asked to share and discuss your perspectives on mental health, help-seeking and counselling with the other participants. The focus group will consist of five to six people and will take at most 60 minutes.

What will happen in a face-to-face interview?

The interview will give you an opportunity to talk about your perspectives on mental health, help-seeking and counselling. Face-to-face interviews will take 30 to 60 minutes.

Confidentiality

All data will be anonymous and treated as confidential by the researcher. Your participation in a focus group or a face-to-face interview is voluntary, and you are free to withdraw at any time without giving a reason. Due to the group setting participants within a focus group will not be anonymous to each other. In addition, full confidentiality cannot be guaranteed as participants may potentially choose to talk outside the focus group, please be reassured that all participants in the focus group will be reminded not to disclose any information from the focus group.

What will happen to the data from the focus group or the face-to-face interview?

The focus group and face-to-face interviews will be audio recorded for analysis purposes and accessed only by the researchers. The findings will be used to write a research paper that will contribute to developing a better understanding on the perspectives of the Chinese community in NI with regard to mental health, help-seeking and counselling. The data will be kept for 10 years by the university.

What are the benefits for taking part in this research study?

You will be part of a study, which will contribute to new knowledge on the perspectives on mental health, help-seeking and counselling among the Chinese community, with the aim of improving existing provision and giving a voice to the Chinese community.

Contact details

Researcher:	Uli Speers	speers-u@email.ulster.ac.uk
Supervisors:	Dr Anne Moorhead	a.moorhead@ulster.ac.uk, 028 9036 8905
	Dr Maggie Long	m.long@ulster.ac.uk, 028 90366282

Appendix 4: Contact numbers of counselling services in NI

Listed below is a selection of counselling services in NI.

CANS (Counselling All Nations Services)

Service co-ordinator: Lekan Ojo-Okiji Abasi
Mobile: [removed]
Email: cansinfo@yahoo.co.uk

Samaritans of Belfast

5 Wellesley Ave, Belfast, BT9 6DG
Landline: 028 9066 4422

Lifeline

Freephone: 0808 808 8000

Relate NI

Locations: http://www.relateni.org/centres
Landline: 028 9032 3454

Other counselling services and counsellors can be found at
http://www.counselling-directory.org.uk/adv-search.html

Appendix 5: Confirmation e-mail from CANS

From: Counselling All Nations Services (CANS) [mailto: cansinfo@yahoo.co.uk]

Sent: 15 December 2015 17: 20

To: Ulrike Speers <Speers-U@email.ulster.ac.uk>

Subject: Re: PhD study - Chinese community - ethics

Dear Ulrike

We had our meeting, and I brought your request to my Management Committee. I was asked to check with you if you have funding provision in your application, even if not, we will not turn back anyone for counselling.

I hope I can be of help in the future.

Yours kindly,

Lekan Ojo-Okiji Abasi

Volunteer Clinical Coordinator Counselling All Nations Services (CANS)

Mobile: [removed]

Appendix 6: Consent form for face-to-face interviews

Consent Form Face-to-Face Interview

School of Communication

RESEARCH GOVERNANCE

Title of Study	An exploration on the perspectives on mental health, help-seeking and counselling among the Chinese community in NI
Chief Investigator	Dr. Anne Moorhead

Please confirm, by initialling the boxes provided, that you agree with the following statements:	*Initial below*
1. I have been given and have read and understood the information sheet for the above study and have asked and received answers to any questions raised.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my rights being affected in any way.	
3. I understand that the researchers will hold all information and data collected during the study securely and in confidence and that all efforts will be made to ensure that I cannot be identified as a participant in the study (except as might be required by law) and I give permission for the researchers to hold relevant personal data.	

4.	I agree to take part in the face-to-face interview for the above research study and give permission for the face-to-face interview to be audio recorded for analysis purposes only.
5.	I understand the requirements of this research study and freely volunteer to take part in the face-to-face interview.

Name of Participant (please print)	Signature	Date (dd/mm/yy)

Name of Researcher	Signature	

Appendix 7: Demographic information sheet

Private and confidential

Please complete the following which will provide a general overview on the background of the participants.

Please tick as appropriate

1. Age range (years) :
   - ☐ 18 – 20
   - ☐ 21 – 30
   - ☐ 31 – 40
   - ☐ 41 – 50
   - ☐ 51 – 60
   - ☐ 61 – 69
   - ☐ 70+
2. Gender:
   - ☐ Female
   - ☐ Male
   - ☐ Other
   - ☐ Do not like to say
3. Country of birth (please specify):

4. Marital Status:
   - ☐ Co-habiting
   - ☐ Civil partnership
   - ☐ Divorced
   - ☐ In relationship
   - ☐ Married
   - ☐ Separated
   - ☐ Single
   - ☐ Widowed

Continued on page 2

5. How long have you been living in NI?
   - ☐ 2 – 5 years
   - ☐ 6 – 10 years
   - ☐ 11 – 15 years
   - ☐ 16 – 20 years
   - ☐ 21+ years
6. Other than English which language (s) do you speak?
   - ☐ Cantonese
   - ☐ Hakka
   - ☐ Mandarin
   - ☐ Other (please specify):
7. Educational level:
   - ☐ Primary
   - ☐ Secondary
   - ☐ College
   - ☐ University
8. Employment:
   - ☐ Employed
   - ☐ Self-employed
   - ☐ Unemployed

Thank you for completing the demographic information sheet.

Appendix 8: Ethics approval letter

Ulster University
Shore Road
Newtownabbey
County Antrim
BT37 0QB
Northern Ireland
T: +44 (0)28 9036 6552/6518/6629
ulster.ac.uk

Our Ref: NC:GOV

10 June 2016

Dr A Moorhead
Room 17E12
School of Communication
Ulster University
Jordanstown Campus

Dear Dr Moorhead

Research Ethics Committee Application Number: REC/16/0042

Study Title: An exploration on the perspective on mental health, help-seeking and counselling among the Chinese community in Northern Ireland

Thank you for your recent response to matters raised by the committee. This has been considered and the decision of the committee is that the research should proceed.

Please also note the additional documentation relating to research governance and indemnity matters, including the requirements placed upon you as Chief Investigator.

The committee's decision is valid for a period of three years from today's date (this means that the study should be completed by that date). If you require this period to be extended, please contact the Research Governance section.

1. **Please complete and return the Chief Investigator Statement of Compliance prior to commencing the study and keep a copy for your file.**
2. **Please retain all other documents.**

Further details of the University's policy along with guidance notes, procedures, terms of reference and forms are available at the following web address:

http://research.ulster.ac.uk/office/rofficeeg.html

If you need any further information or clarification of any points, please do not hesitate to contact me.

Yours sincerely

Nick Curry
Senior Administrative Officer
Research Governance
028 9036 6629
n.curry@ulster.ac.uk

Appendix 9: Distress protocol

Protocol for managing distress in the context of a research focus group/interview

Distress

A participant indicates they are experiencing a high level of stress or emotional distress

OR

exhibit behaviours suggesting that the focus group/interview is too stressful

Stage 1 response

Stop the focus group/interview.

Offer the participant the opportunity to be accompanied by the researcher (who is a trained counsellor) to a quiet area where their situation can be dealt with in a safer environment.

Possible questions for the participant:

- Tell me what thoughts you are having?
- Tell me what you are feeling right now?
- Do you feel you are able to go on with the focus group/interview?

Review

If participant feels able to carry on then resume focus group/interview.

If participant feels unable to carry on continue to Stage 2.

Stage 2 response

Encourage the participant to contact their family, a friend, GP or one of the counselling resources listed on the information sheet. If further support is required, appropriate action will be taken.

Follow up

Subject to participant consent researcher follows up with courtesy call to participant.

Based on Draucker et al. (2009).

Appendix 10: Example of reflective summary of interview (p6)

Participant 6 is reflective of how her childhood outlook on people who experienced mental health issues changed when she was an adult. Participant 6 (p6-10) questioned her parent about the crazy man in the village – what were the real reasons for his behaviour? The parents tried to explain mental health to her by telling her to stay away as they wanted to keep her safe. They did not think that children would understand the real reasons for this man's behaviour.

Participant 6 is very open to the help-seeking and what is available. She is aware of services, like Lifeline or Women's aid. She regards life coaching as a worthy birthday gift for a friend. She knows that the GP is a pathway to counselling and is aware of various mental health services.

Also, she has awareness about herself – that she would not seek help at first, as this would be admitting that she is less than perfect, although she knows that she is not perfect (p6-25):

> "Yeah and then I do not want to admit that, that I have a problem first. Problem is the ego saying, you know, there is no perfect person." [Li-liu]

This participant brings lots of examples of second-hand experiences. Not only as mental health examples but also how she and other people seek help or avoid seeking help. Here the emerging themes are widened in the section of help-seeking – that second-hand experiences also influence the way we seek help.

Participant brings a lot of second-hand mental health experiences and examples, including some emotionally disturbing descriptions of how people with a mental health issue were treated. She also shows that she has compassion for people with mental health issues. This is a quite personal interview as she tells stories where she was personally affected by the behaviour of someone who appears to have a mental health issue.

Appendix 11: Example of researcher's reflection on interview (p6)

At times it is useful if the researcher knows some background of the participant to make sense. Maybe I should have asked the question is that person Chinese, but as I knew, I did not ask.

How I understand what a participant is saying is always connected to my knowledge as a researcher.

I am aware that sometimes I know what the participant wants to say, but it is not actually said. That puts me in the situation where I cannot actually use it in my write-up, as it was not expressed in words, even if it may have been what the participant wanted to say.

I realised that I did not follow up on some things the participants started to tell, for example, the participant began to compare counsellors with fortune tellers, meaning someone who predicts the future. Instead of following up on that, I switched topics (p6-31 and r6 following)

"*Their crying for help is very high"* (p6-40) – the way participant said this touched my heart. There is a need within the Chinese community, but how can help be given?

[r6 after p6-11] I introduced the word "stigma" which is leading and could be potentially confusing for the participant.

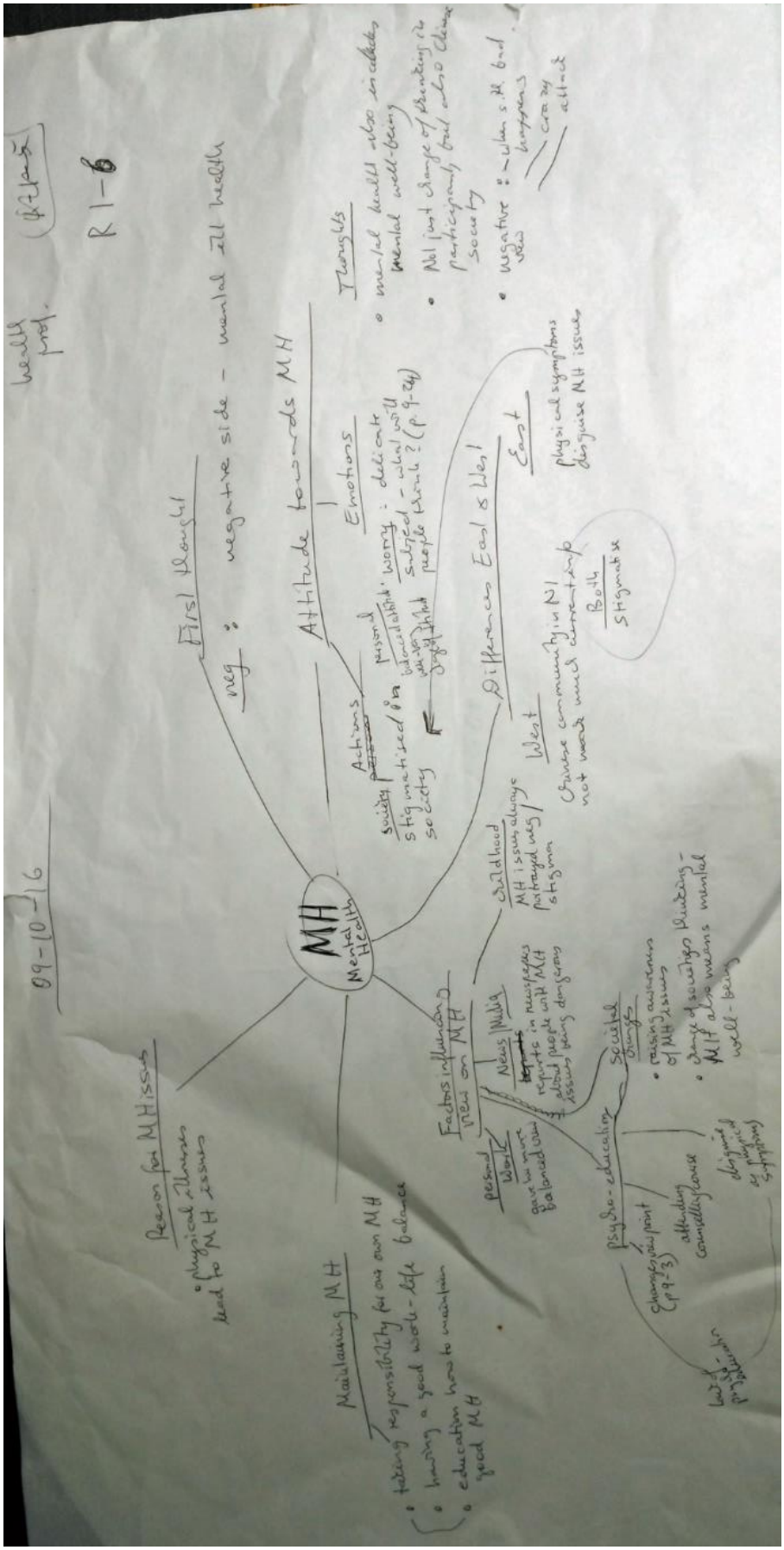
Appendix 12: Example of coding after 2nd reading of the transcript

(where highlighted text denotes additions from 2nd reading)

Notes	Transcription	Emerging themes	Code
	[r6] What is your first thought when you hear the term mental health?		
People who have a problem and need mentally support. Places to seek help: mental hospital, psychiatrist, special support services	[p6-1] First thought in my mind usually I would think of people who mentally need support or help, but they already have problem. That would come to my mind. Can be mental hospital, psychiatric doctor, or special support for people who have a mental problem.	Mental health: first thought Help-seeking	
	[r6] What do you think has influenced your thoughts on mental health? Where does this knowledge come from?		
Mental health is connected to craziness because that is the explanation given in childhood	[p6-2] Well, I was born in China and grown up in China. So, I kind of taboo when I was young. So, when somebody have a mental problem, in China, they will say, oh, this is a crazy man or a crazy woman. This should stay in mental hospital, to protect us, so just don't get close to them. When I was young, but when I grew up, I more discovered that mental person they have like something they can't cope and then the person is very vulnerable.	Mental health view – changes in view Factors influencing mental health view Childhood memory: crazy – taboo Adulthood: view changed: can't cope – vulnerable	D64
	[r6] Do you think that age, you know you said, when you were younger, they said stay away, but then when you got older you realised that.		
Traumatic	[p6-3] No, because behind the	Reasons for	

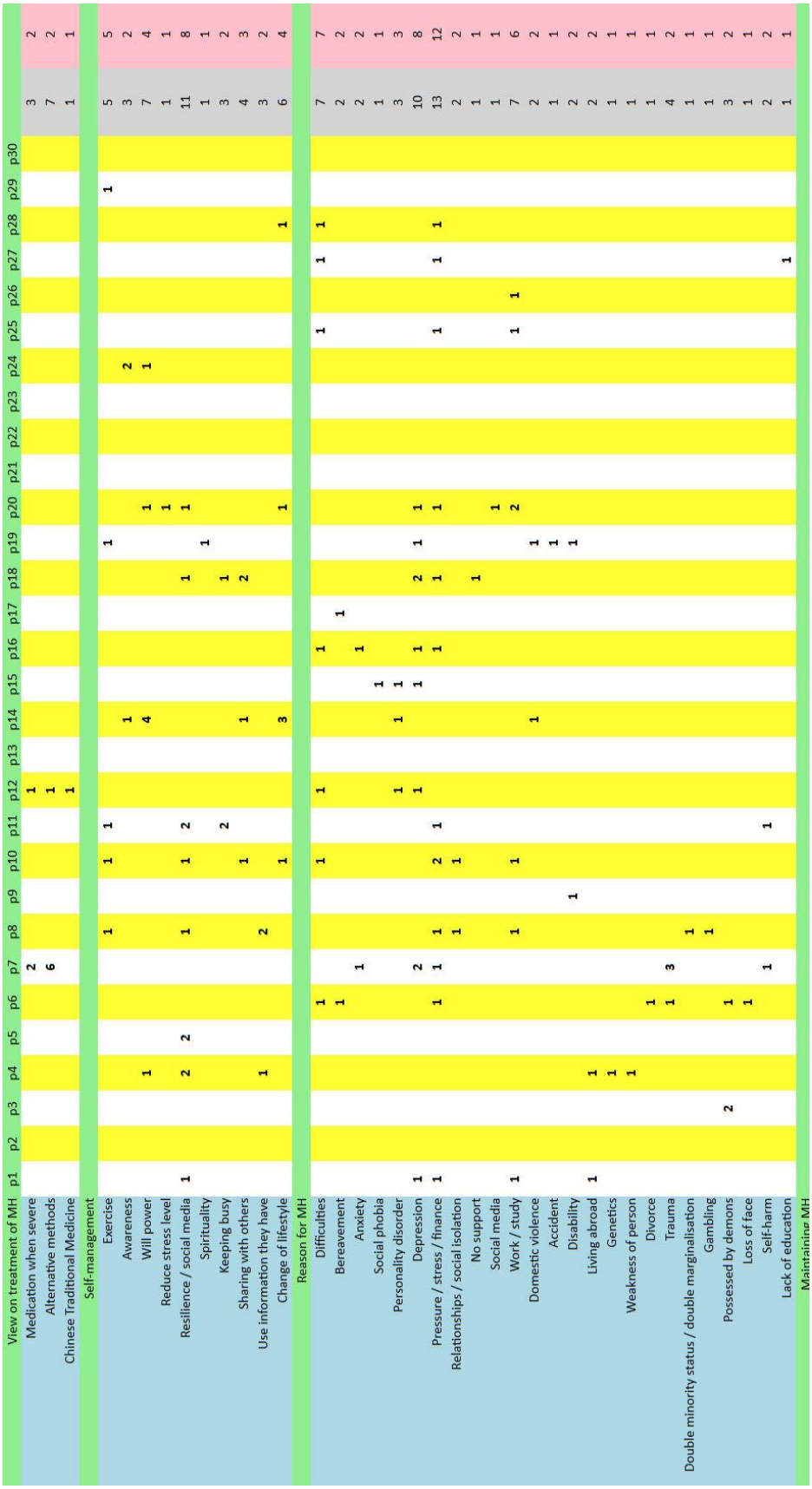
experiences, e.g. torture or mistreated. Participant remembers childhood experience of crazy person – advice: stay away	scene for those people who called them “feng dz”, that means like crazy men, they probably had very traumatic experience, they been tortured, or they been mistreated. Not sure. They always had some sort of background people know them. We had one “feng dz” in our village. But mom and dad always told me to stay away, because he lost his mind he not wash himself, and clean, he had a very crazy life. He eat dead animals…	mental health issues Personal experiences / second-hand experience	

Appendix 13: Example of a paper mind map

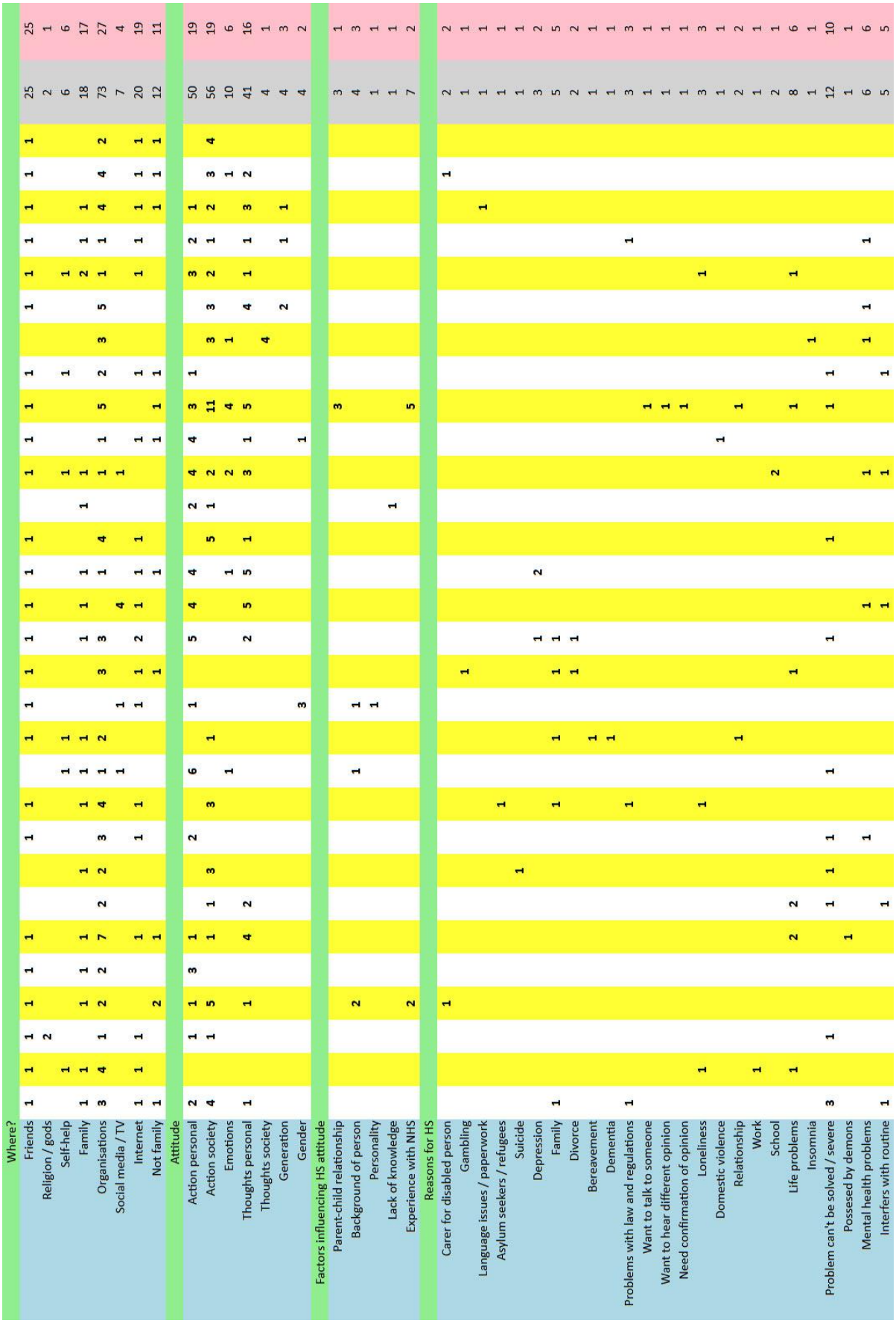


Appendix 14: Example screenshots of emerging themes

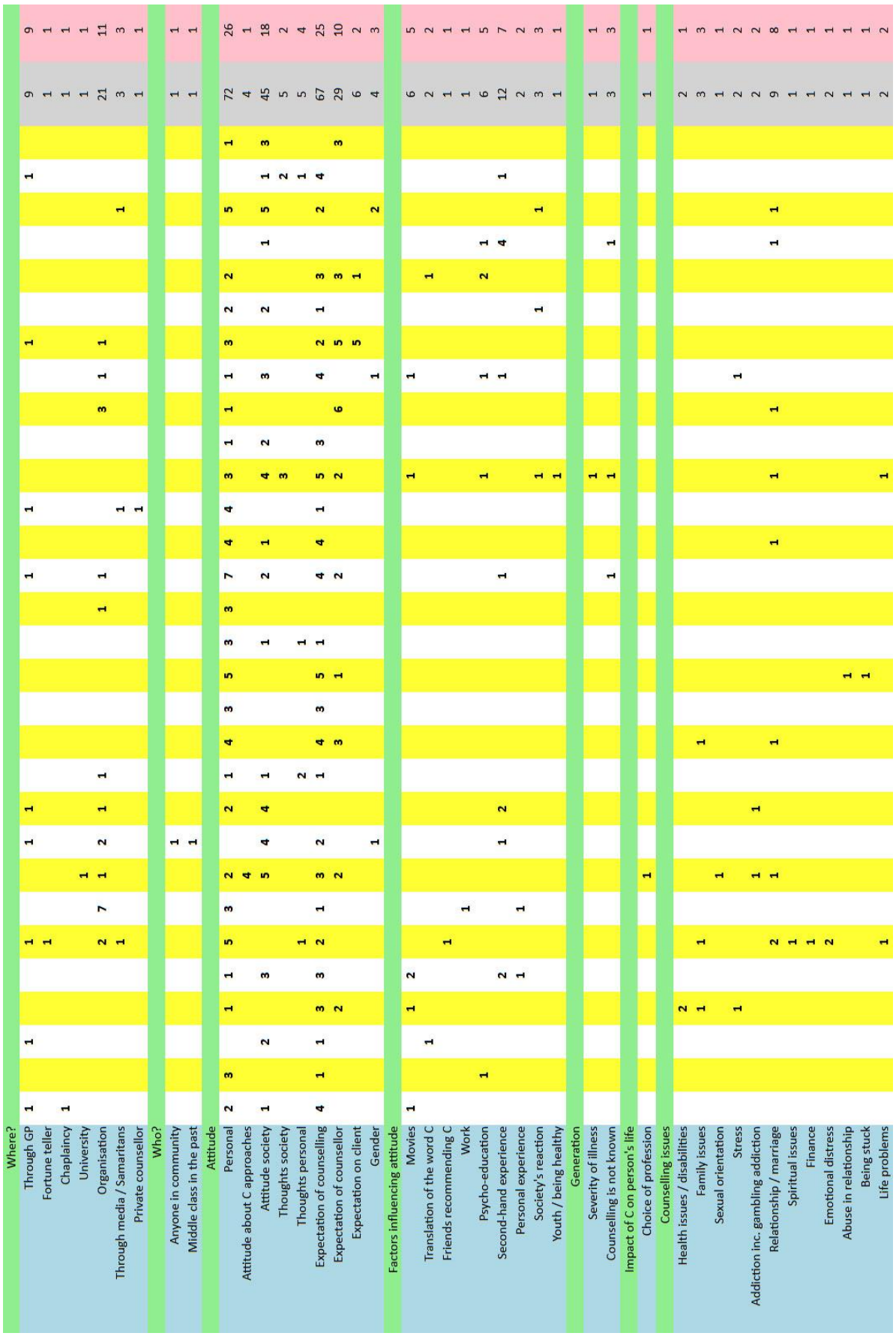
Mental health emerging themes



Help-seeking emerging themes

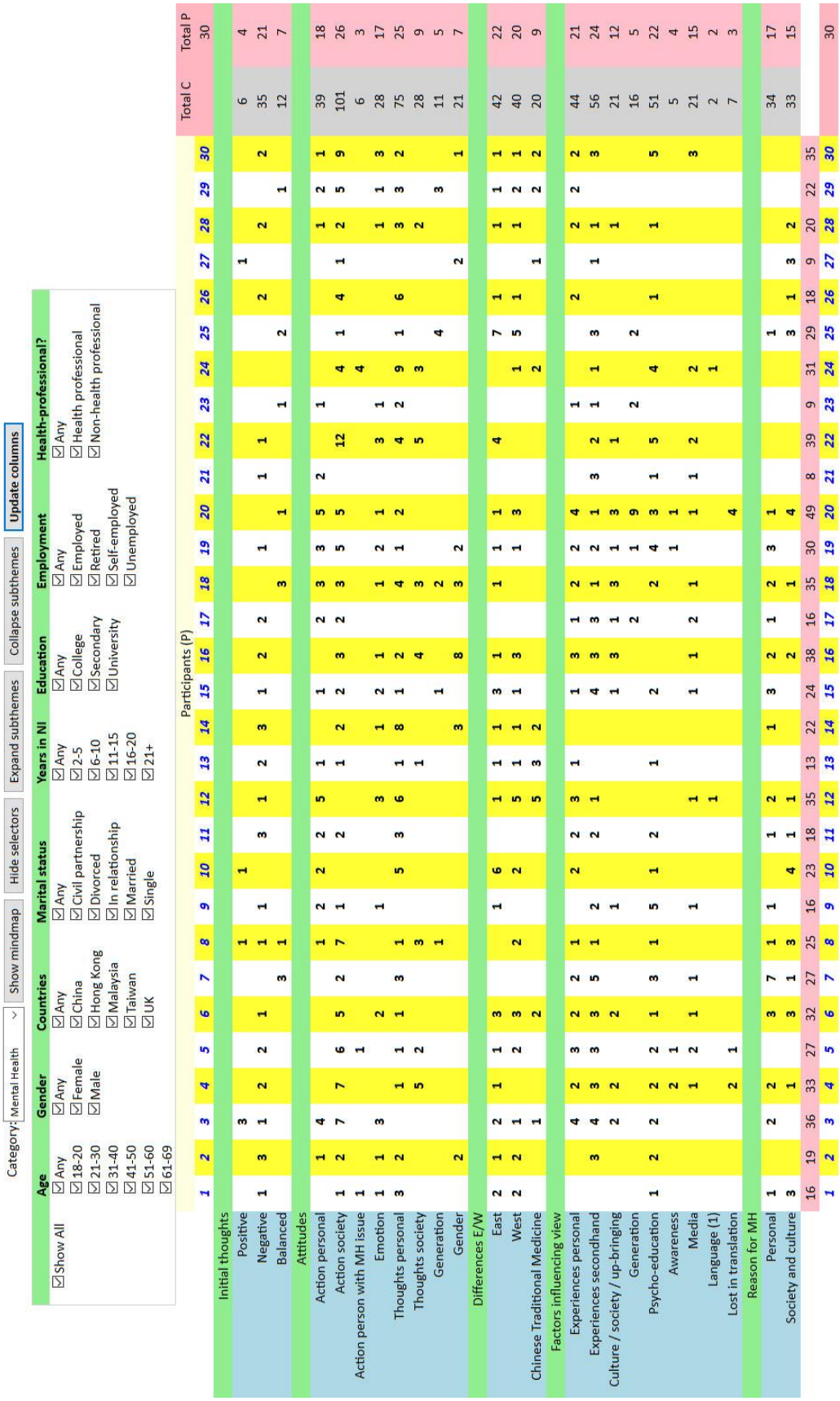


Counselling emerging themes



Appendix 15: Screenshots of recurrent themes

Mental health recurrent themes



Category: Help-Seeking | Show mindmap | Hide selectors | Expand subthemes | Collapse subthemes | **Update columns**

	Age	Gender	Countries	Marital status	Years in NI	Education	Employment	Health-professional?
☑ Show All	☑ Any	☑ Any	☑ Any	☑ Any	☑ Any	☑ Any	☑ Any	☑ Any
	☑ 18-20	☑ Female	☑ China	☑ Civil partnership	☑ 2-5	☑ College	☑ Employed	☑ Health professional
	☑ 21-30	☑ Male	☑ Hong Kong	☑ Divorced	☑ 6-10	☑ Secondary	☑ Retired	☑ Non-health professional
	☑ 31-40		☑ Malaysia	☑ In relationship	☑ 11-15	☑ University	☑ Self-employed	
	☑ 41-50		☑ Taiwan	☑ Married	☑ 16-20		☑ Unemployed	
	☑ 51-60		☑ UK	☑ Single	☑ 21+			
	☑ 61-69							

	Participants (P)																											Total C	Total P
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*19*	*20*	*21*	*22*	*23*	*24*	*25*	*26*	*27*	*28*	*29*	*30*		30
Resources																																
Personal contacts	2	3	1	2	2	2		1	1	2	2	3	1	1	2	2	2	1	1	3	1	1	2		1	4	2	2	1	1	49	28
Offical sources	4	5	4	2	2	8	2	2	4	5	2	2	2	4	5	5	2	5		2	2	5	3	3	5	2	2	5	5	3	102	29
Not family	1			2		1								1			1				1	1	1					1	1	1	12	11
Attitude																																
Action	6		3	6	3	2	1	3	2	3	6	1	1		5	4	4	5	3	6	4	14	1	3	3	5	3	3	3	4	107	28
Emotions											1						1			2		4		1					1		10	6
Thoughts	1			1		4	2								2	5	5	1		3	1	5		4	4	1	1	3	2		45	17
Reasons for HS																																
MH issues	4		1			1	2	2	2		1	2		1	2		2	1		2		1	2	2	1		1				30	18
Relationship issues	1									1		2		2	2						1	1									10	7
Society / Culture		2								1										2						1					6	4
Obstacles																																
Information			1	1		1	2	3		1				1	2	2	5				3	4	1		2	1		2	2	2	36	18
Culture / Society	4	1	2	2	1	1	2	3	4	7			3	2			4		1	1		1		8		2					49	18
Health service	1	1	1	2		1	3	2	1			6		1	4	4	2	1	2		1	3	1	13	1			3	2		56	22
Personal situation	1			2		3	1	1	1	2		1	4	2	3		2			1		3					2		2		31	16
Confidentiality		2		1			1				1	1	3						1	1				4		2			1		18	11
Language		1					1	1	1	1							1		3	2					2	1		1	4		19	12
Reasons not involving family / friends																																
Burden / worry				1							1				1		1			1	1					1		1	2		10	9
Problem longterm																						1				1					2	2
Family / spouse is the problem				1																											1	1
Will keep reminding you of issue				1																											1	1
Do not want to talk															1														1		2	2
Difficult to diagnose																													1		1	1
Family of origin																												1			1	1
Burdened with same issue															1		1														2	2
Not familiar with situation																				1						1					2	2
Self-management																																
Self-help	1		1				5				2	3		3	1	1	1	3		3			2		3	2	1	1	3		36	17
Network											1		3			1		3		3		4			3	2	1				21	9
	26	15	14	24	8	24	22	18	16	23	17	21	17	18	31	24	34	20	11	33	15	48	13	38	25	26	13	23	31	11		
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*19*	*20*	*21*	*22*	*23*	*24*	*25*	*26*	*27*	*28*	*29*	*30*		30

Category: Counselling | Show mindmap | Hide selectors | Expand subthemes | Collapse subthemes | **Update columns**

	Age	Gender	Countries	Marital status	Years in NI	Education	Employment	Health-professional?
☑ Show All	☑ Any	☑ Any	☑ Any	☑ Any	☑ Any	☑ Any	☑ Any	☑ Any
	☑ 18-20	☑ Female	☑ China	☑ Civil partnership	☑ 2-5	☑ College	☑ Employed	☑ Health professional
	☑ 21-30	☑ Male	☑ Hong Kong	☑ Divorced	☑ 6-10	☑ Secondary	☑ Retired	☑ Non-health professional
	☑ 31-40		☑ Malaysia	☑ In relationship	☑ 11-15	☑ University	☑ Self-employed	
	☑ 41-50		☑ Taiwan	☑ Married	☑ 16-20		☑ Unemployed	
	☑ 51-60		☑ UK	☑ Single	☑ 21+			
	☑ 61-69							

	Participants (P)																												Total C	Total P
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*19*	*20*	*21*	*22*	*23*	*24*	*25*	*26*	*27*	*28*	*29*	*30*		30
Sources																																
Organisation	1					3	7	2	2	1	1					1	1		1			3	1	1				1			26	14
Through GP	1		1			1			1	1							1		1					1					1		9	9
Private counsellor																			1												1	1
Perceptions																																
Personal Perceptions	2	3		1	1	6	3	2		2	3	4	3	5	4	3	7	4	4	3	1	1	1	3	2	2		5	1	1	77	27
Society Perceptions	1		2		3			5	4	4	1				1		2	1		7	2		3		2		1	5	3	3	50	18
Expectation of counselling	4	1	1	3	3	2	1	3	2		1	4	3	5	1		4	4	1	5	3		4	2	1	3		2	4		67	25
Expectation of counsellor				2				2				3		1			2			2		6		5		3				3	29	10
Factors influencing perceptions																																
Second-hand experience	1	1		1	4	1	1		1	2							1			3			3		1	2	5	1	1		29	16
Personal experience					1		1																								2	2
Counselling issues																																
Health issues				2				2		1								1													6	4
Mental-health issues				1		2												2				1	2				1				9	6
Life issues						3								1				1		2											7	4
Relationship issues				1		3		1				2		1				1		1		1					1	1			13	10
Barriers																																
Lack of Information	1	1		2	4		1	1	1	3		1	1	1	1		2		1	4	1	3	2	2	2	3		9	3	1	51	24
Culture / Society	5		1			1	1		6			1	1	1	1		2						1	1		2		2		2	28	15
Health service	1								1								1														3	3
Trust		1	1	1	5	1		2	3	1	1	2		2	1				1	2		3	1	8				3			39	18
Accessibility	4		1		1	2			1				1		4		2		3	5	3	1		3			1	3			35	15
Finance	1	1				1								3	1					1								2	1		11	8
Personal situation	1	2				3		1	2			1	3	1	2		5	4				1	1	3					1		31	15
Language	1		1						2	1		2			1	1				7	1	4	1		1	1	1	1		1	27	16
	24	10	8	14	22	29	15	21	26	16	7	20	12	21	17	5	30	18	13	42	11	24	20	29	9	16	10	35	15	11		
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*19*	*20*	*21*	*22*	*23*	*24*	*25*	*26*	*27*	*28*	*29*	*30*		30

Appendix 16: Sample of collating extracts to super-ordinate themes

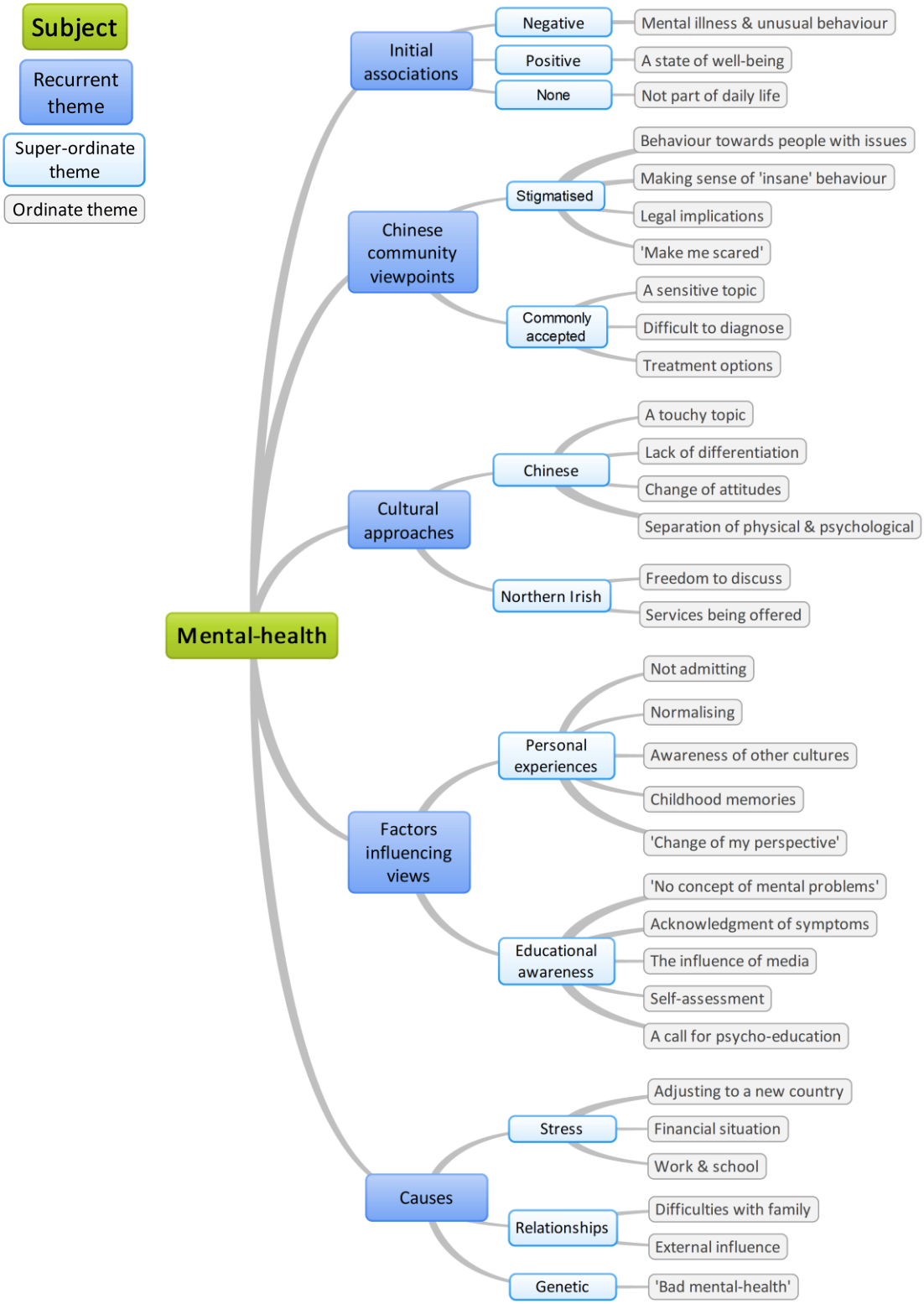
Mental health

Initial thoughts	
Negative	[p9-2] *when I first heard about mental health, I will think of the negative side of it, the mental ill health* [p13-1] *Usually, people will think about it negative way. You have problem.*
Positive	[p10-2] *I think it is more about mental well-being if you have a balance of life*
Attitudes	
Society	[p6-10] *You'd be identified as mental, you don't have any friend, no anything you know. People don't want to have to do anything with you, you know. They are, in that kind of social society, environment, that will be very isolating they are kind of very helpless, you know.* [p29-19] *And it will affect your career probably when you put a CV, and then you have to say, I have mental health issue... is not a very great thing to put down*
Personal	[p12-16] *I think I have a very good attitude, it doesn't matter if it is mental health or any other illnesses, it is not the person's fault. To be more sympathetic* [p26-9] *Well, when I mention it, it is quite normal for people to have such mental issues. Just like the cold or flu you have, it is quite normal. That is my understanding of the mental health issues*
Differences East & West	
West	[p4-62] *But here it is quite common, and we trust here, as we know everything is trustable here. But in China, we don't know which organisation we can trust.* [p26-9] *Well, as far as I am concerned, people here in the Western world, including NI, people give more care or more attention to such issues.*
East	[p14-5] *They will use some kind of medicine, they believe, to calm you down. Use herbal things, for nerves to calm*

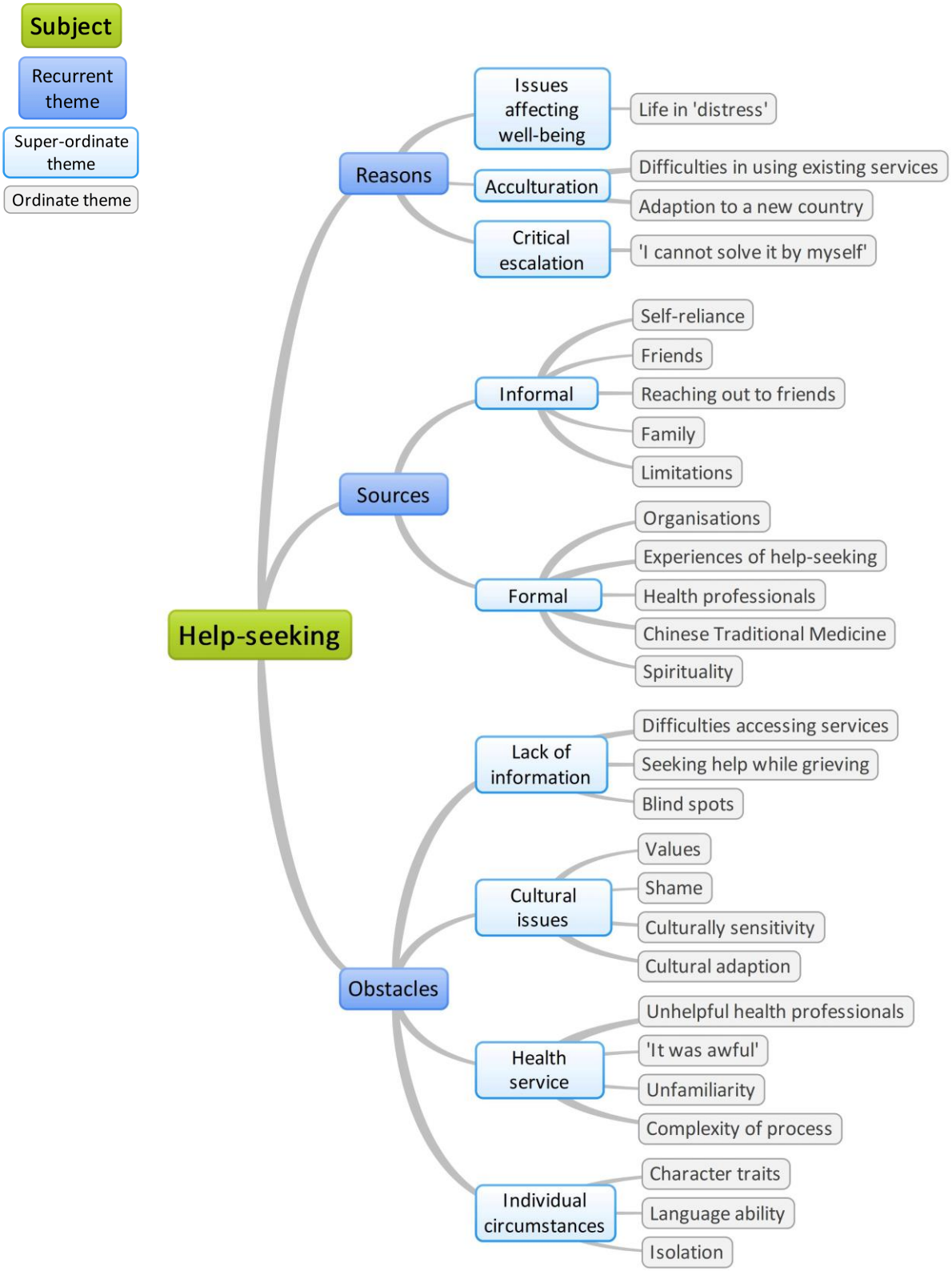
	down [p25-10] *In China, you go to the hospital you register, you pay, different level of money, to get access to the different level of doctor you wanted, for example, for the lesser experienced, the registration fee is maybe just 10 yuan, which is £1, but for the more experienced maybe 50 yuan, which is £5. So, people have the choice, you know.*
Factors influencing view on Mental health	
Psycho-education	[p1-10] *People need to be educated… it is that people usually people still living the bias of mental health and they should be educated on that, they should have a way, so that express themselves in a confidential basis* [p10-18] *Yeah, I think in the last couple of years it has slightly improved, we have done something about mental health, we have raised awareness and have done a number of distress programs, so I think the knowledge about mental health in the Chinese community has improved* [p22-32] *'Cause they are far too young to differentiate that and will do damage to the children's relationship with the family.*
Personal experiences	[p7-9] *I suffered from postnatal depression, but I knew I could get help from the health visitor etc.* [p8-3] *I personally, my family and the Chinese generally, have been exposed to that kind of trauma and incidents which are related to sectarian divide, violence etc.* [p19-21] *Even I was hiding, I didn't want people to know, so ashamed… So honest, myself, in the past months, many valleys, so I have mercy, you know, the people with mental problem.*
Second-hand experiences	[p5-5] *Their son was born with some kind of mental health issues, and we all know that.* [p16-4] *I think that is the point that my husband realised the pressure on life and financial as well. But without any explanation, he started to get palpitations and then he became very depressed and then he had to see doctor.*

Appendix 17: Mind maps of preliminary recurrent themes

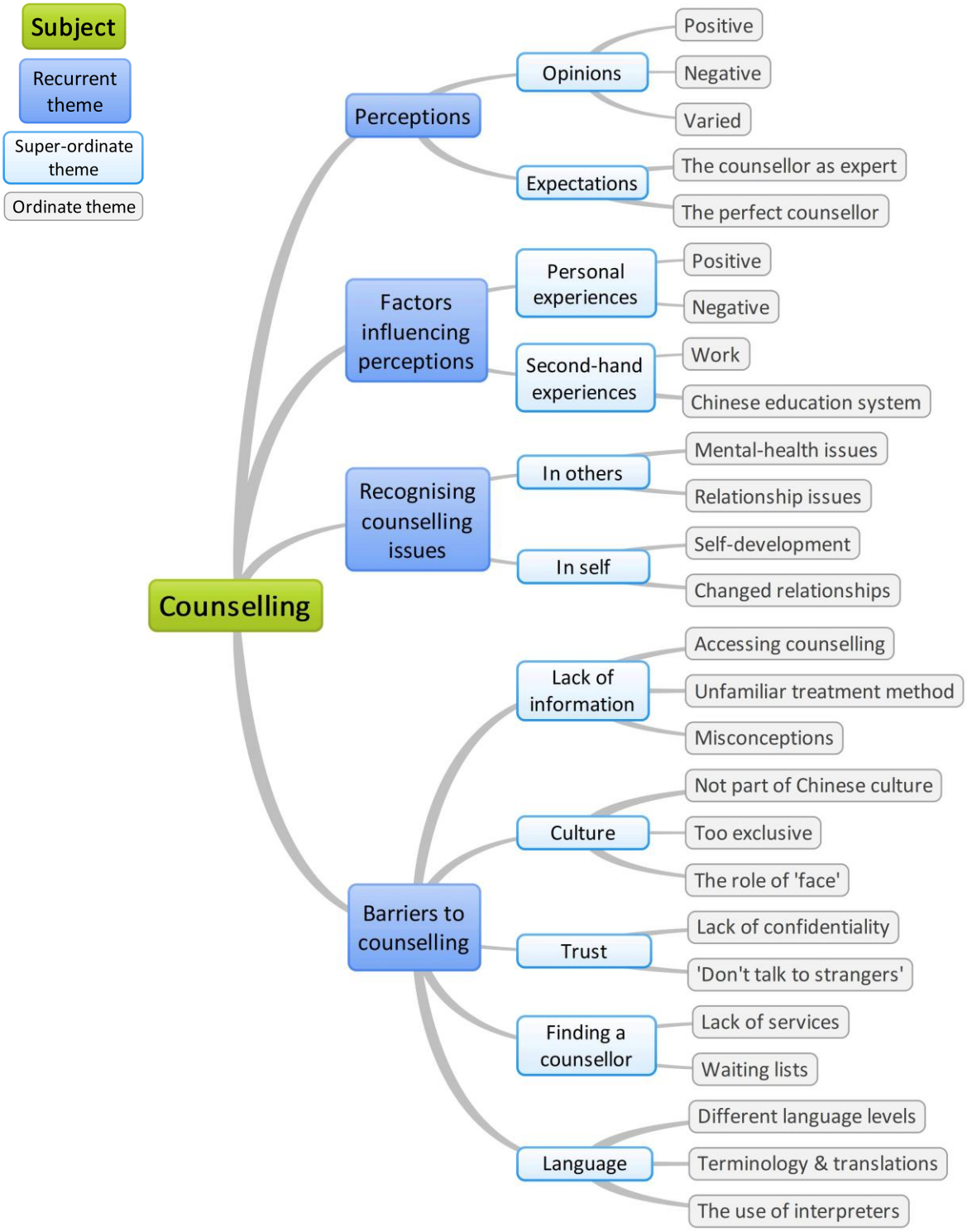
Mental health



Help-seeking



Counselling



Appendix 18: Example of transcript and coding

Partial transcript of participant 29

[r29] So, but from your experience or from your knowledge, when you hear the term counselling, does that mean anything to you?

[p29-48] Yes, aha. There are many counselling, but most of them is like a talking therapy and, ah, recently there was counselling for somebody, to think that dealing with mental health problems is like dealing with a medical problem that they need medication in order for them to get well.

They don't believe by talking, like go the psychiatrist and sit there and talk for hours, that kind of things. Then open up and talk to a stranger and then and how they can help you. And of course for the first few session, that the person, the doctor or the psychiatrist or counselling person, need to get you know you first and try to talk things out and they try and are quite irritated by and say, why are you asking all this. What are those for and what does that help and maybe the first few sessions they don't find that this helps at all. Right and then they just give up.

And especially the guy, the doctor knows him for over ten years, and the doctor referred him for counselling, and you know.

And then he went there for few, I mean, actually, the first two sessions finished and he find out very pointless and waste of time because there is a lot of questionnaire to ask and to fill in that is the first session, the second session also, maybe the third session also filling in a different kind of questionnaire, then they just, after finish the session, they don't think there is any help, they don't have patience for this and thinking by just talking, you don't solve my problem, you don't solve my immediate problem and things. They don't understand counselling is something that need to take time to talk about and to open up yourself and ask you to think things differently maybe. And so, they don't have patience to go for counselling for more than ten sessions before they think, there is any benefit for them. You know.

[r29] That is interesting to hear.

Coded transcript

Key to coding: Descriptive, Conceptual, Linguistic, **Hermeneutic circle**

[r29] So, but from your experience or from your knowledge, when you hear the term counselling, does that mean anything to you?

[p29-48] Yes, aha. There are many counselling, **but most of them is like a talking therapy** and, ah, recently there was counselling for somebody, to think that dealing with mental health problems is like dealing with a medical problem that they need medication in order for them to get well. They don't believe by talking, like go the psychiatrist and sit there and talk for hours, that kind of things Then open up and talk to a stranger and then and how they can help you. And of course for the first few session, that the person, the doctor or the psychiatrist or counselling person, need to get you know you first and try to talk things out and they try and are quite irritated by and say, why are you asking all this. What are those for and what does that help and maybe the first few sessions they don't find, that this helps at all. Right and then they just give up and especially the guy, the doctor knows him for over ten years, and the doctor referred him for counselling, and you know. And then he went there for few, I mean, actually, the first two sessions finished and he find out very pointless and waste of time because there is a lot of questionnaire to ask and to fill in that is the first session, the second session also, maybe the third session also filling in a different kind of questionnaire then they just, after finish the session, they don't think there is any help, they don't have patience for this and thinking by just talking, you don't solve my problem, you don't solve my immediate problem and things. They don't understand counselling is something that need to take time to talk about and to open up yourself and ask you to think things differently maybe. And so, they don't have patience to go for counselling for more than ten sessions before they think, there is any benefit for them. You know.

[r29] That is interesting to hear.

Coded transcript, including IPA analysis

Key to coding: Descriptive, Conceptual, Linguistic, **Hermeneutic circle**, {IPA analysis}

[r29] So, but from your experience or from your knowledge, when you hear the term counselling, does that mean anything to you?

[p29-48] Yes, aha. There are many counselling {Descriptive: has knowledge about counselling}, **but most of them is like a talking therapy** {Descriptive: describes counselling as talking therapy; Hermeneutic circle: it sounds like putting counselling down – there are many counselling approaches, yet they are all the same} and, ah, recently there was counselling for somebody, to think that dealing with mental health problems is like dealing with a medical problem {Conceptual: puts Mental health problem in connection with medical problem} that they need medication in order for them to get well. They don't believe by talking, like go the psychiatrist and sit there and talk for hours, that kind of things {Linguistic: uses the word believe - 'believe' is not for sure - you do not have proof - also you need to belief in something otherwise it won't work} Then open up {Linguistic: open up - so something is closed to be opened up - issue needs to be shown} and talk to a stranger {Linguistic: health professional is a stranger} and then and how they can help you {Descriptive: counselling needs to open}. And of course for the first few session, that the person, the doctor or the psychiatrist or counselling person {Descriptive: names all the people who could do counselling, there is no distinction}, need to get you know you first and try to talk things out, and they try and are quite irritated {Linguistic: irritated – indicates confusion, but also some annoyance} by and say, why are you asking all this {Linguistic: all this – think counsellor need to get to know them; Conceptual: this might be a misunderstanding as Counsellor needs to get to know the problem – what does to know mean} What are those for and what does that help {Conceptual: have no understanding of process of counselling: why… what… what…} and maybe the first few sessions they don't find, that this helps at all {Descriptive: first few sessions are not experienced as helpful}. Right and then they just

give up {Descriptive: behaviour is to give up – as they do not experience it as helpful; Linguistic: participant uses 'they', at the start it is someone sg- generalises it to they- has she observed that more often?} And especially the guy, the doctor knows him for over ten years {Linguistic: knows him for over ten years- does that imply that doctor should know if that would help the patient?} and the doctor referred him for counselling, and you know. And then he went there for few {Descriptive: patient went on doctors order- did what doctor said- follow instructions}, I mean, actually, the first two sessions finished and he find out very pointless {Descriptive: evaluation of two sessions; Linguistic: pointless – negative emotion} and waste of time {Linguistic: waste of time: negative experience} because there is a lot of questionnaire to ask and to fill in that is the first session {Descriptive: description of first session: fill out questionnaire}, the second session also, maybe the third session also filling in a different kind of questionnaire {Descriptive: counselling equals filling out questionnaire} then they just, after finish the session, they don't think there is any help {Descriptive: filling out questionnaire is no help}, they don't have patience for this and thinking by just talking, you don't solve my problem, you don't solve my immediate problem and things {Descriptive: wish is to get their problem solved} They don't understand counselling is something that need to take time to talk about {Descriptive: participants sees that time is needed to talk} and to open up yourself {Descriptive: time is needed to open up} and ask you to think things differently maybe {Descriptive: participants knows something about counselling -thinking differently}. And so, they don't have patience to go for counselling for more than ten sessions before they think, there is any benefit for them {Conceptual: participant implies that counselling needs more than ten sessions}. You know.

[r29] That is interesting to hear.