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# Living in two cultures: Chinese Canadians' Perspectives on Health

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Abstract:

OBJECTIVES: Chinese people have distinctive perspectives on health and illness that are largely unrecognized in Western society. The purpose of this descriptive study was to develop a profile of Chinese immigrants' beliefs and practices related to diet, mental and social health, and sexual health.
METHODS: A quantitative survey with descriptive and correlational analyses was employed to examine 100 first-generation Chinese immigrants living in four urban centres across Canada (Vancouver, Toronto, Halifax, and St. Catharines).
RESULTS: Although most Chinese immigrants preferred a Chinese diet, where they resided affected the groceries they bought and the meals they ate. Almost all participants reported their mental health was important to them and most felt comfortable discussing mental health issues with others. However, only a third would see a psychiatrist if they believed they had a mental health problem. Most participants believed social relationships were important for their health. Only a small number of participants, however, preferred making friends with mainstream Caucasian Canadians. More men than women believed sexuality contributed to health and were comfortable talking about sexual health.
CONCLUSION: Chinese immigrants should be encouraged to be more engaged in the larger community in order to fully integrate themselves into Canadian society while still being encouraged to retain their healthy practices. These findings may help educators and practitioners enhance their understandings of Chinese immigrants' perspectives on health and develop culturally competent education and services in health care and health promotion.


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**Living in Two Cultures: Chinese Canadians' Perspectives on Health**

## INTRODUCTION

China has become a major source country for emigration around the world (1). In the multicultural landscape of Canada, Chinese immigrants account for 4.0% of the total population and Chinese is the most common ethnic origin for first-generation immigrants (1). Population projections suggest this situation will continue for many years to come, thereby underlining the need for health-service providers to understand the perspectives of this continually growing population group (2). Chinese immigrants have distinctive perspectives on health that are fundamentally different from those of people in the West and of Western medicine (3, 4). Health care and health promotion services rooted in Western conceptions of health may not be effective for Chinese immigrants who favour a perspective embedded in traditional Chinese medicine (4, 5). The purpose of this descriptive study was to develop a profile of Chinese immigrants' health-related beliefs and health practices. Specifically, we sought to document Chinese immigrants' beliefs and practices related to diet, mental and social health, and sexual health over the course of immigration in four Canadian cities.

Prior research found 44% of Chinese Canadians believed a traditional Chinese diet was more healthful than the typical Western diet and 60% of them preferred eating Chinese versus Western foods (6). Other research indicated that first-generation Chinese immigrants seemed to increase their knowledge and practices related to healthy foods, including increasing consumption of fruits and vegetables and decreasing consumption of deep-fried foods. However, those who lived in Canada the longest consumed larger portion sizes, dined out more frequently,

and used convenience foods more often (7). These transitions toward a Western diet indicate acculturation.

Research on Chinese Canadians' mental health has mainly focused on the use of mental health services. Relevant studies demonstrated that Chinese Canadians (first-generation immigrants and Canadian born) are much less likely to consult health professionals for mental health issues than Canadians from other ethnocultural backgrounds (immigrants and Canadian born) (8). Cultural orientation was identified as a major factor in these differences with lower usage of mental health services for those individuals who identified more with Chinese than Canadian culture (8). Western psychiatry is rooted in a focus on individual treatment and recovery, so it may be ill positioned to intervene effectively when mental health problems are assumed to be associated with culturally rooted concerns (e.g., interpersonal harmony). Social relationships and other social aspects of health have been shown to be important for overall health (9). In particular, strong social supports and friendships are associated with resilience and mental health for Chinese immigrants (10). Establishing social relationships within local communities influences acculturation (11).

There is a dearth of literature about Chinese immigrant sexuality. One of the few available studies found Chinese Canadians reported that they seldom discussed the topic of sex despite engaging more freely in sexual behaviours after immigration (12).

A consequence of these disparities across diet, mental and social health, and sexual health is that Chinese immigrants have been found to have one of the lowest rates of health care resource use in Canada, which could have tremendous effects on their overall health (13). Therefore, it is essential to develop culturally competent services to meet the needs of this large immigrant community.

Although there are studies of Chinese-specific health-related issues in Canada (2, 6, 8), a comprehensive profile of Chinese immigrants' health perspectives has not yet been developed. A comprehensive study can provide a holistic understanding of Chinese immigrants' views about health and enhance understandings about the specific health issues facing this ethnocultural group. This descriptive study focuses on three major health areas: diet, mental and social health, and sexual health. Based upon the existing literature and understandings about traditional Chinese beliefs and practices, we hypothesized that Chinese immigrants would (a) prefer Chinese diets and Chinese friendships, and (b) be reluctant to address mental or sexual health issues.

The findings from the current study will provide researchers with baseline information for further investigations about this specific population group and comparisons with other ethnocultural groups, and help educators and practitioners advance their understandings about the health perspectives of this large ethnocultural group and develop more culturally competent education and services for health care and health promotion.

## METHODS

### Participants

This study focuses on 100 first-generation Chinese immigrants, aged 25 or above, residing in one of four urban centres: Toronto (the largest Chinese community in the largest urban centre in Canada), Vancouver (the highest percentage Chinese population in Canada), Halifax (the urban centre with the largest foreign-born population in the Atlantic provinces of Canada), and St. Catharines (a small urban centre in Canada). Sample recruitment targeted proportionate representation from these four urban centres and from three major Chinese immigrant origin locations (mainland China, Hong Kong, and Taiwan) as well as both sexes and

diverse age groups. A mixed sampling strategy combined purposive sampling (e.g., Chinese community leaders, Chinese and Western health care providers), snowball sampling in Chinese communities, and open calls for participants (through Chinese websites and flyers distributed in Chinese supermarkets).

**Instrument**

The questionnaire used in this study was developed and refined in a pilot study (3). Face validity was established by consulting over 20 scholars and professionals in general health sciences, medicine, nutrition, oral health, psychology, sociology, cultural studies, health education, and kinesiology. There are 75 questions about (a) demographics and general health (e.g., age, sex, height, weight, educational level, employment, income, immigration time, residency, marriage, health insurance and benefits, health status, medical history, and alcohol and tobacco use); (b) diet; (c) mental and social health; and (d) sexual health. The questionnaire was available in a bilingual English and Chinese format (see Appendix A).

**Data collection**

The project received ethics clearance from a university research ethics review board. All participants provided free and informed consent. The bilingual Chinese and English questionnaire was completed in the language of choice through email or a face-to-face meeting at the participants' convenience (e.g., time, location). Assistance (via email, telephone, or in person) was available while completing the questionnaire.

**Data analysis**

SPSS (version 16.0; SPSS Inc., 2008) was employed to analyze data. Descriptive statistics were used to profile participants' demographic characteristics, and their beliefs and practices related to diet, mental and social health, and sexual health. Correlational analysis was

used to examine linear relationships among dietary variables, among mental and social health variables, and among sexual health variables. We also used correlational analysis to examine changes in diet, mental and social health, and sexual health based upon time since immigration.

Most variables were measured on ordinal scales with a non-random and unknown distribution in the population, therefore Spearman correlation coefficients (denoted by $r_s$) and chi-square tests were used to explore possible relations among the different measures of health beliefs and practices. Chi-square independence tests were conducted for dichotomous variables.

## RESULTS

The heterogeneous sample of 100 participants included 51 women and 49 men: 68 from mainland China, 23 from Hong Kong, and 9 from Taiwan; and 40 living in Toronto, 35 in Vancouver, 14 in Halifax, and 11 in St. Catharines. Participants had lived in Canada from 4 months to 39 years (*M* = 9.8 years, *SD* = 8.0) and ranged in age from 25 to 73 years (*M* = 43.4, *SD* = 11.4). They had diverse educational backgrounds (from high school diploma to doctoral degree), employment status (full-time, part-time, unemployed, retired), marriage status (78% married), citizenship status (56% Canadian citizens), and annual gross income (ranging from under $20,000 to above $100,000; with most earning $40,000–$60,000). Table 1 provides key demographic characteristics of the participants. Overall, most participants characterized their health status as “good” (50%) or “excellent” (13%), many identified it as “okay” (33%), and a small number characterized their health as “poor” (4%).

### Chinese diet

Most participants (71%) believed maintaining a Chinese diet was important for their health. The majority (78%) reported shopping for Chinese groceries at least once a week. Almost all participants reported eating Chinese meals daily (92%) with only 22% reporting consuming

Western fast foods weekly. Table 2 shows the correlations among the dietary variables. There was a positive relationship between the respondents' beliefs in the contributions of a Chinese diet to their health and how often they shopped for Chinese groceries ($r_s = 0.32$, $p = 0.001$). The longer they had lived in Canada, the less they associated Chinese diets with health ($r_s = -0.24$, $p = 0.014$). The length of stay was not significantly associated with any other dietary variables. The urban centres in which the participants resided affected how frequently they purchased Chinese groceries ($\chi^2 = 35.60$, $p = 0.001$) and subsequently consumed Chinese meals ($\chi^2 = 28.90$, $p = 0.001$). The purchasing of Chinese groceries and the consumption of Chinese meals were highly correlated ($r_s = 0.39$, $p < 0.001$). Chinese groceries ($r_s = 0.83$, $p = 0.002$) and meals ($r_s = 0.75$, $p = 0.008$) were strongly related to participants' attitudes toward Chinese diets in St. Catharines only. The relationship between buying Chinese groceries and attitude toward Chinese diets was evident for participants in Halifax ($r_s = 0.83$, $p = 0.002$), but not the relation between consuming Chinese meals and attitude to Chinese diets. These two relations were not found among participants in Toronto or Vancouver.

**Mental and social health**

Almost all participants (98%) believed mental health was important (21%) or very important (77%). Overall, 92% of participants felt comfortable (50%) or very comfortable (42%) talking about their mental health. In contrast, only 34% of participants indicated they would obtain mental health services if needed (specifically, to see a psychiatrist for psychological problems). Similarly, 38% of participants would suggest that their parents obtain mental health services if needed. Further, half the participants (50%) would absolutely recommend their children obtain mental health services if needed.

Table 3 shows that participants who attached more importance to their mental health were also more likely to report they were comfortable talking about their mental health with others ($r_s = 0.27$, $p = 0.006$). Comfort talking to others about mental health was also positively associated with an expressed willingness to obtain mental health services ($r_s = 0.25$, $p = 0.011$), to suggest that parents obtain mental health services ($r_s = 0.36$, $p < 0.001$), and to suggest that children obtain mental health services ($r_s = 0.25$, $p = 0.013$). Willingness to obtain mental health services if needed was positively related to suggesting parents ($r_s = 0.68$, $p < 0.001$) and children obtain mental health services if needed ($r_s = 0.58$, $p < 0.001$). Women expressed greater willingness to obtain mental health services than did men ($\chi^2 = 11.25$, $p = 0.024$). There were no differences based upon time since immigration.

Generally, participants believed social relationships were important (54%) or very important (28%) factors for health, whereas none believed they were unimportant. More than half the participants (56%) preferred making all kinds of friends; however, 40% preferred making friends with Chinese people and only 3% preferred Caucasian friends. Table 3 shows no relationships between the perceived importance of social and mental health.

**Sexual health**

Most participants (72%) believed sexual health was important (57%) or very important (15%). When asked how comfortable they were talking about their sexual health, 63% felt very comfortable or comfortable. More men (75%) than women (69%) believed sexual health was important or very important. Three times as many women (13%) as men (4%) reported they were uncomfortable talking about sexual health. As shown in Table 4, participants who attached more importance to sexual health were more comfortable talking about this topic ($r_s = 0.24$, $p = 0.016$);

however, the longer they stayed in Canada, the less comfortable they felt talking about sexual health ($r_s = -0.28$, $p < 0.001$).

## DISCUSSION

This study examined Chinese immigrants' health beliefs and practices including diet, mental and social health, and sexual health over the course of immigration in four Canadian cities (Toronto, Vancouver, Halifax, and St. Catharines).

It is evident that the majority of participants believed in the importance of having a Chinese diet, and consumed Chinese meals on a regular basis. This confirms our hypothesis and corresponds to previous research findings (3, 6). What is new in the present study is that place of residence was identified as a factor in participants' attitudes toward Chinese dietary habits and Chinese grocery shopping practices only in the smaller urban centres of Halifax and St. Catharines. Shopping for and consuming a Chinese diet takes concerted effort when there are insufficient Chinese groceries available in the area. In contrast, there were no relationships between participants' attitudes toward Chinese diets and purchasing groceries or meals in the large urban centres of Toronto and Vancouver, which is similar to the finding in a previous study conducted in Vancouver (7). This was likely because Chinese groceries and meals were readily available in Toronto and Vancouver, and people did not have to expend energy or time to seek them out. Nonetheless, people in these larger urban centres did place great importance on, and regularly ate, a Chinese diet.

Although there are a handful of studies on Chinese Canadians' mental health issues, they have mostly focused on the use of mental health services (8). Few studies have investigated Chinese Canadians' beliefs and expressed willingness to obtain mental health services. The present study reveals that almost all participants believed mental health was important, which

may result from the awareness of mental health promoted by the media in Canada. Yet, it was surprising to see that most participants felt comfortable or very comfortable talking about mental health, which is incongruent with some previous findings that show Chinese immigrants normally do not disclose mental health issues due to their cultural beliefs (e.g., collective identity, holistic well-being, indigenous treatment) and a strong stigma against mental illness (8). Despite the importance the participants attached to mental health and their expressed willingness to talk about mental health issues, few people were willing to seek professional help if needed, or to recommend that their parents or children seek such help. The likelihood that people would actually take these steps should the need arise may be even lower (8, 14). These findings raise important questions about how to increase the willingness of Chinese immigrants to use mental health services should they need them. The use of mental health services by ethnocultural minority groups in Canada has not been well documented, and more research on the factors and barriers to the use of mental health services among Chinese immigrants in Canada is needed (8). Educational and outreach strategies may be effective as our findings indicate that participants who expressed willingness to obtain mental health services were also more likely to encourage their parents and children to do so. It is noteworthy, however, that there were no evident differences over the course of immigration, such that longer term immigrants were no more likely to seek mental health services than more recent immigrants.

There have been dramatic changes in sexual beliefs and behaviours in China in recent decades. For example, premarital sex and having a child before marriage have become more acceptable now, particularly among younger generations affected by Western influences and China's socio-economic-cultural transformation over the past 30 years (12, 15). Nonetheless, sex and sexual health are still sensitive topics and are seldom discussed openly (12). It is fairly

surprising to observe that most participants (63%) indicated they were comfortable talking about sexual health, in contrast with previous findings (12, 16). This may result from profound changes in contemporary China and participants' acculturation in Canada as immigrants. Additionally, in contrast to the present findings about gender differences in openness toward obtaining mental health services, more Chinese men than women believed sexual health was important and felt comfortable talking about sexual health. This may be because men are more likely to be sexually bold but feel uncomfortable seeking help. Another finding in the present study that is difficult to explain is that participants tended to feel less comfortable talking about sexual health the longer they lived in Canada. One possible reason is that newer immigrants may suddenly feel free to talk about sex-related topics when just immigrating to Canada and these newcomers may have a perception (influenced by media or movies prior to their immigration) that people in Canada are more sexually open than may be the reality. These perceptions may diminish as people get to know Canadians' attitudes better.

**Strengths and limitations of the study**

To our knowledge, this is the first descriptive study of Chinese immigrants' overall beliefs and practices related to health in Canada. There are a few strengths in this study. The research team consisted of researchers with Chinese–English bilingual and bicultural backgrounds that contributed to culturally competent research design and implementation (17). Further, most data were collected face-to-face and always in the language of each participant's preference (e.g., Mandarin, Cantonese, English) to ensure participants' comfort. In addition, data analysis and report preparation involved researchers with mainstream Canadian cultural and Chinese language cultural backgrounds that enhanced the authenticity and in-depth understanding of the findings and addressed culturally complex issues in relation to the health

literature. Another strength of this study is that it covered both large and small urban centres where Chinese Canadians live across Canada whereas prior research has focused on large urban centres such as Toronto or Vancouver where the findings may not necessarily reflect the spectrum of the population as revealed in the present study. However, a few limitations in the study should be noted. Although the sample size was statistically large, the participants in the present study were not randomly selected and may not accurately represent the entire population of Chinese immigrants. Thus, the generalizability of the results may be more limited than studies using randomly selected participants. In addition, this study took place in four urban centres, including the greater Toronto and Vancouver areas where most Chinese immigrants reside; it is unclear whether the findings could be generalizable to the broader Chinese population living in other areas of Canada. Lastly, all data in this study were self-reported and may not accurately reflect the actual health beliefs and practices of participants.

## CONCLUSION

The present study reveals a profile of Chinese immigrants' health beliefs and practice including diet, mental and social health, and sexual health. It is our hope that this profile provides a holistic understanding of Chinese immigrants' health beliefs and practice, serves as a baseline for further studies of this ethnocultural group, and helps educators and practitioners enhance their understandings about the health perspectives of this large ethnocultural group and develop more culturally competent education and services in health care and health promotion.

Most participants valued a traditional Chinese diet, but this preference tended to decrease over the course of immigration. Thus, efforts should be exerted to encourage Chinese immigrants to retain their practice of healthy Chinese diets because the traditional Chinese diet has been identified as generally healthier than a typical North American diet (18). Given the extremely

strong beliefs about mental health revealed in the present study in contrast to the low rates of willingness to seek mental health services (rates that remained low even long after immigration), more studies are needed to examine barriers to Chinese immigrants' usage of the mental health system and more measures are required to educate this population group to access mental health services. In addition, the sexual health of Chinese immigrants is basically an unknown area and needs further attention. For future studies, data collection related to culturally sensitive questions should be carefully designed and handled (e.g., through online questionnaires). One future investigation arising from the present study is to examine why Chinese immigrants tend to feel less comfortable talking about sexual health the longer they have lived in Canada. Also, due to the nature of quantitative surveying, many questions regarding *why* or *how* could not be answered; qualitative interviews are needed to provide in-depth explanations of Chinese immigrants' health beliefs and practices, which is the focus of a subsequent paper (19). In addition, longitudinal studies would help understand more fully changes in people's perspectives about health over the course of immigration. Moreover, future studies can use the findings in the present study as a baseline to examine the second or subsequent generations of Chinese immigrants' perspectives about health and acculturation. Furthermore, the results in the present study can be used to compare to other ethnocultural groups to understand similarities and differences for a bigger picture of the culturally diverse populations in Canada.

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Table 1.

*Demographic Variables for 100 Chinese Canadian Participants*

| Variable | *n* |
|---|---|
| Gender | |
| Male | 51 |
| Female | 49 |
| Age | |
| 25- to 44-years old | 52 |
| 45- to 64-years old | 36 |
| 65 and older | 7 |
| Educational Background | |
| Less than high school | 2 |
| High school | 5 |
| Diploma | 18 |
| Bachelor | 35 |
| Master’s | 25 |
| Doctorate or medical degree | 14 |
| Marriage Status | |
| Married | 74 |
| Unmarried | 21 |
| Employment Status | |
| Unemployed | 17 |
| Part-time work | 57 |
| Full-time work | 11 |
| Retired | 13 |
| Annual Family Gross Income | |
| Under $20,000 | 14 |
| $20,000–$40,000 | 17 |
| $40,000–$60,000 | 26 |
| $60,000–$80,000 | 11 |
| $80,000–$100,000 | 9 |
| More than $100,000 | 14 |
| Place of Origin | |
| Mainland China | 68 |
| Hong Kong | 23 |
| Taiwan | 9 |
| Place of Residence | |
| Vancouver | 35 |
| Toronto | 40 |
| Halifax | 14 |
| St. Catharines | 11 |

*Note*. Participants did not respond to every question so some variables do not include all 100 participants.

Table 2.

*Spearman Correlations Involving Dietary Variables and Immigration Length for Chinese Canadians*

| Variable | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| 1. Chinese diet | -- | .32** | .19 | .00 | .04 | -.24** |
| 2. Chinese groceries | | -- | .39** | -.16 | -.03 | .03 |
| 3. Chinese meals | | | -- | -.10 | -.20* | -.17 |
| 4. Junk or fast food | | | | -- | -.03 | .12 |
| 5. Meals on time | | | | | | -.07 |
| 6. Time in Canada | | | | | | -- |

* $p < .05$, ** $p < .01$

2
3
4 347 Table 3.
5
6
7 348 *Spearman Correlations Involving Mental and Social Health Variables and Immigration Length*
8
9 349 *for Chinese Canadians*
10

| Variable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| 1. Importance of mental health | -- | .27** | .05 | .16 | .14 | .18 | .07 |
| 2. Comfort discussing mental health | | -- | .25* | .36** | .25* | -.03 | .04 |
| 3. Access mental health services | | | -- | .68** | .58** | -.11 | -.07 |
| 4. Send parents to mental health services | | | | -- | .76** | -.12 | .17 |
| 5. Send children to mental health services | | | | | -- | -.19 | -.01 |
| 6. Importance of social health | | | | | | -- | .03 |
| 7. Time in Canada | | | | | | | -- |

11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52
53 350 * $p < .05$, ** $p < .01$
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Table 4.

*Spearman Correlations Involving Sexual Health Variables and Immigration Length for Chinese Canadians*

| Variable | 1 | 2 | 3 |
|---|---|---|---|
| 1. Importance of sexual health | -- | .24* | -.03 |
| 2. Comfort discussing sexual health | | -- | -.28** |
| 3. Time in Canada | | | -- |

* $p < .05$, ** $p < .01$