

How people from Chinese backgrounds make sense of and respond to the experiences of mental distress:

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DOI:

[10.1111/jpm.12406](https://doi.org/10.1111/jpm.12406)

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Document Version

Peer reviewed version

Citation for published version (Harvard):

Yeung, EYW, Irvine, F, Ng, SM & Tsang, KMS 2017, 'How people from Chinese backgrounds make sense of and respond to the experiences of mental distress: Thematic analysis', *Journal of Psychiatric and Mental Health Nursing*, vol. 24, no. 8, pp. 589-599. <https://doi.org/10.1111/jpm.12406>

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1 **How People from Chinese backgrounds Make Sense of and Respond to**
2 **the Experiences of Mental Distress: a Qualitative Study**

3

4 **Introduction**

5 Culture shapes the way people give meaning and respond to the experiences of mental
6 distress (Kleinman 1980, Lefley 2010). Although not the only model used, in many
7 Western societies the biomedical model, which suggests that mental distress is caused by
8 biochemical abnormalities, is prominently used to understand and manage mental distress
9 (Morrison 2014). In contrast, in non-western cultures, people tend to use alternative
10 models to explain these experiences (Hailemariam 2015, Johnson *et al.* 2012). Like many
11 other cultural groups, people from Chinese backgrounds hold with multiple explanations of
12 mental distress such as supernatural forces (Pearson 1993, Phillips *et al.* 2000),
13 environmental stress or interpersonal conflicts (Furnham & Chan 2004, Wong *et al.* 2004).
14 These multiple perspectives reflect their disinclination to use medical terminologies such as
15 ‘mental illness’ to understand mental health issues. Hence we use the terms ‘mental
16 distress’ and ‘mental health problems’ (MHPs) in this paper as they have a broader
17 definition and can be understood and alleviated by different means, according to cultural
18 preference (Cromby *et al.* 2013). The research reported in this paper examines how
19 Chinese populations in England, UK make sense of the experience of mental distress and
20 how this understanding influences their pathways to mental health care.

21 The Chinese population in the UK has grown rapidly, increasing from 247,403 in
22 2001 to 393,141 in 2011. It is estimated that about 80% of the Chinese population are

1 first generation migrants; nearly 27% from mainland China, 23% from Hong Kong, 13%
2 from Malaysia, 10% from Singapore and 7% from Vietnam (Office for National Statistics
3 2012). Because of the heterogeneities of the Chinese population in the UK, we use the
4 term ‘Chinese populations’ here to include those who self-identify as Chinese from
5 different countries (Long *et al.* 2015). There has been a similar marked growth in the
6 Chinese population in other developed countries, such as the US, Canada and Australia
7 (United States Census Bureau 2015, The Canadian Magazine of Immigration 2015,
8 Australian Government 2014). In the UK, a significant number of the Chinese
9 population lives in big cities such as London, Birmingham, Liverpool and Manchester.
10 The rest is spread thinly across the country. The wide geographical distribution means
11 that many might struggle to get help from culturally equivalent support networks in time
12 of need (Rochelle & Shardlow 2012, Author 2015). This raises the question of where
13 and to whom they will seek help for MHPs.

14 In the UK, people normally seek help from their general practitioner (GP) for
15 MHPs (Grater and Goldberg 1991). The GP may refer them to mental health specialists
16 if there are concerns about their mental health wellbeing. Compared to other minority
17 ethnic communities, Chinese populations are less likely to consult their GP for emotional
18 and psychological problems (The Information Centre 2006). However, the compulsory
19 admission rates to mental health hospitals and referral rates from Emergency
20 Departments for Chinese populations in England are higher than the general population
21 (Care Quality Commission 2011). Similar patterns of service use have been observed
22 among Chinese populations in the US and Australia (Sue *et al.* 2012, Klimidis *et al.*
23 2007). These survey data suggest that Chinese populations only come into contact with

1 mental health services when crises occur. Qualitative data will enhance our
2 understanding of their pathway experiences so that barriers for early intervention can be
3 identified.

4 A lack of knowledge of mainstream healthcare facilities (Liu *et al.* 2015) and low
5 levels of English language proficiency (Liu *et al.* 2015) are barriers for Chinese
6 populations accessing services. Further, there is a concern that mental health
7 professionals tend to adopt a Eurocentric approach to understand the experiences of
8 mental distress and hence they may not be able to fully address the mental health needs
9 of different minority ethnic communities (Kinderman 2014, Watters 2010). The strong
10 stigma attached to MHPs is another known factor that leads to late presentation to mental
11 health services among Chinese populations living in Western societies (Leung *et al.* 2012,
12 Yang 2007).

13 Differences in health beliefs and conceptualisation of care needs explain why
14 people in different Chinese societies follow other routes to manage mental distress.
15 Studies in mainland China (Tang *et al.* 2007), Hong Kong (Chiang *et al.* 2005),
16 Singapore (Chong *et al.* 2005) and Malaysia (Gill *et al.*, 2005) show that it is common for
17 people to consult traditional healers because of their belief that mental health distress is
18 caused by ‘evil spirits’. As most of these studies conducted in predominately Chinese
19 societies where there is an easier access to traditional healers, we know little about the
20 utilisation of traditional healing for mental distress among Chinese populations living in
21 Western societies.

1 Late presentation to formal services inevitably delays intervention, which can
2 cause further distress to individuals with mental distress and their families. This study
3 aimed to examine how Chinese populations give meaning to the experiences of mental
4 distress and how this meaning making impacts on their journey through mental health
5 care. This should help professionals to identify appropriate and timely intervention
6 strategies, whilst enabling people to make informed decisions about their mental health
7 care.

8 **Method**

9 The conduct of the study was influenced by Heidegger’s hermeneutic phenomenology
10 (Heidegger 1962). According to Heidegger, understanding and interpretation are
11 inseparable in the process of learning about one’s experience. Interpretation helps to
12 look beyond the description of phenomenon and unmask what is hidden or shown in
13 disguise (Kockelmans 1967, Moustakas 1994). People often use ‘historical interpretation’
14 and presumptions to help them make meaning of their experiences. Understanding is like
15 a ‘hermeneutic circle’; any prior knowledge plays a vital role in the act of meaning
16 making and should be utilised to aid understanding of experiences. In this study we
17 aimed to examine participants’ perceptions and attitudes towards mental distress, as they
18 influence their responses to mental health problems and their pathway experiences. We
19 also acknowledge that the research team brought with them experience and specialist
20 knowledge to the study which could be applied to enhance our understanding of
21 participants’ experiences.

22 **Participants**

1 We used a convenience sampling approach to recruit people who self-identified as
2 Chinese, aged 18 and above, and lived with MHPs. To enrich our understanding of their
3 experiences of mental health care, we also invited families who were involved in the
4 pathway journey to be interviewed. All recruitment materials were produced in Chinese
5 and English, and were sent to Chinese voluntary organisations in major cities in England
6 that provided support services for people with MHPs. Twenty potential participants were
7 invited. Four declined invitation and did not want their family to be approached because
8 they were previously involved in other research studies.

9 Fourteen Principal Participants (PPs) with MHPs were interviewed. Two
10 potential PPs declined to be interviewed but gave permission for their family to take part.
11 Sixteen Family Participants (FPs) were interviewed. Features of individual PPs can be
12 found in Table 1. All PPs were aware of their diagnosis although some did not accept the
13 label. Table 2 shows FPs' characteristics.

14 **Data collection**

15 In-depth interviews were used to enable participants to talk about their perceptions of
16 mental distress and their pathway to mental health care experiences. Open-ended questions
17 were used to minimise the impact of researchers' bias. EY, a bilingual Cantonese and
18 English speaking researcher, carried out all interviews. Interviews were conducted
19 between 2010 and 2011 in the preferred language of participants so that they could freely
20 express their experiences. Thirty-four interviews were undertaken in Cantonese and four in
21 English. Six PPs and two FPs were interviewed a second time. Prior knowledge was
22 incorporated into our preliminary interpretation of data collected and applied to reframe the

1 Table 1: *Characteristic of Individual Principal Participants (N=16)*

Principal Participants	Gender/ Age	Place of birth / years of residence in the UK	Educational level	English language skills	Diagnosis	Years of mental health history
A	F/49	UK / since birth	Undergraduate	Fluent	Schizophrenia	20 years
B	M/61	Hong Kong / 20 years	Primary	No English	Bi-polar affective disorder	8 years
C	F/37	UK / since birth	Undergraduate	Fluent	Schizo-affective disorder	18 years
D	M/46	Hong Kong / 33 years	Secondary	Limited English	Severe depression	10 years
E	F/32	UK / since birth	Secondary	Fluent	Schizophrenia	13 years
F	M/55	Vietnam / 30 years	Primary	No English	Schizophrenia	25 years
K	M/44	Vietnam / 30 years	Primary	Limited English	Schizophrenia	30 years
L	F/55	Vietnam / 32 years	Primary	Limited English	Schizophrenia	20+ years
M	F/42	China / 9 years	University	No English	Severe depression	10 years
MA	F/61	China / 20 years	No education	No English	Severe depression	10 years
ME	F/62	Hong Kong / 35 years	No education	Limited English	Bi-polar affective disorder	40+ years
MS	F/64	Hong Kong /42 years	Secondary	Limited English	Schizophrenia	40+ years
P	F/52	China / 26 years	No education	No English	Schizophrenia	3 years
S	F/43	China /14 years	No education	No English	Bi-polar affective disorder	9 years
T	F/25	UK / since birth	University	Fluent	Bi-polar affective disorder	7 years
W	M/39	Hong Kong / 39 years	Undergraduate	Fluent	Paranoid schizophrenia	10 years

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1 Table 2: *Summary of characteristics of Family Participants (N16)*

2

Characteristics	Number
Family members	
Husband	5
Wife	3
Father	3
Mother	4
Cousins	1
English language skills	
No English	9
Limited English	3
Fluent English	1

3

1 questions in the follow-up interviews to validate our initial understanding of the meaning
2 of their experiences. Interviews lasted between 30 and 120 minutes and all interviews were
3 recorded. Ethical approval was obtained from Liverpool John Moores University
4 (09/HEA/065LJMUREC).

5 **Data analysis**

6 All interviews were transcribed and analysed in the language of the interview so that the
7 original meaning of participants' narratives could be maintained (Al-Amer *et al.* 2015).
8 Each transcript was read thoroughly and checked for accuracy before the coding process
9 began. EY undertook initial coding of all transcripts. A sample of English and Chinese
10 transcripts was coded independently by FI and SMN respectively. We used a thematic
11 analysis approach to search for meaning units that illuminated how participants attached
12 meaning to the experiences of mental distress. All meaning units were systematically
13 categorised. The research team discussed each category to examine how participants'
14 perception of mental distress directed their pathway journey. Kleinman's health care
15 sector model was used as the analytic lens through which we searched for meaning units
16 that illustrated which health care sector the participants accessed during the pathway
17 journey. The development of thematic structure can be seen in Table 3. EY kept a
18 reflective journal and critically examined how previous practice and research knowledge
19 could be applied to confirm, clarify or challenge our understanding of participants'
20 experiences.

21 Quotations presented in this paper were translated into English by EY. Translated
22 quotations were verified independently by a bilingual Chinese social worker who

Emerging themes	Key themes	Initial responses to experiences of mental distress	Kleiman's Health Care Sectors
<p>Notice sudden changes of behaviours</p> <p>Talking nonsense</p> <p>Behaving like Monkey King</p> <p>Walked up and down</p>	<p>Something was wrong</p>	<p>Approached GP</p>	<p>Professional Sector</p>
<p>Notice gradual changes in behaviours and moods</p> <p>I could hear funny sound in my head but I thought it was normal</p> <p>It was her laughing, I asked her 'why laughing?'</p>	<p>Don't know what was wrong</p>	<p>Inaction and rely on family resources to manage difficult behaviours</p>	<p>Popular Sector</p>
<p>Physical health problem</p> <p>I couldn't sleep, I couldn't eat. I felt lighted headed, something pressed against my heart.</p> <p>I had sleeping problems, so I went to the chemist to buy sleeping tablets</p>	<p>A physical ailment</p>	<p>Resorted to self-treatment to resolve a physical problem</p>	<p>Popular Sector</p>
<p>Want to keep mental health problems to the family</p> <p>It is a shameful business and should be kept as a family secret</p> <p>It should not be discussed outside of the family</p>	<p>It was a shameful business</p>	<p>Refused outside help and rely on family resources to manage problems</p>	<p>Popular Sector</p>
<p>Ghost, dirty thing, being possessed</p> <p>She said the ghost, the dirty thing following her everywhere</p> <p>This water ghost drove me crazy, wherever I went, it followed me</p>	<p>Supernatural forces</p>	<p>Approached ritual healers in the UK and home countries</p>	<p>Folk Sector</p>

1 Table 3. *Development of Thematic Structur*

1 practised in England. We used NVivo software version 10 to store, organise and retrieve
2 the data. The software facilitated clear documentation of the decisions we took and the
3 procedures we followed (Houghton et al., 2016). This provided an audit trail to enhance
4 dependability and transparency of the study.

5 **Rigour**

6 Mindful of how our prior experiences and research knowledge could have contaminated
7 the entire research process, a number of strategies were used to manage the
8 presuppositions brought to the study. Independent coding was undertaken by a diverse
9 research team to enhance the credibility of the study. The composition of the research
10 team, which included an insider (EY: Cantonese speaking, UK based social worker) and
11 outsiders (FI English speaking, UK based nurse; SMN & ST Cantonese speaking, Hong
12 Kong based Chinese medicine practitioner and social worker respectively), ensured a
13 range of interpretive perspectives, were assimilated in the analysis which enhances
14 credibility (Liamputtong, 2008).

15 EY, who is bilingual and is originally from Hong Kong, shares similar
16 demographic features to most participants. This enhances authenticity of the study as she
17 understands the nuances of meaning in the language participants used when they talked
18 about mental health issues (Al-Amer et al., 2015). Furthermore, because of her social
19 work background, she is familiar with professional jargon used in different mental health
20 settings, which, according to Lopez et al. (2008) helps to promote the trustworthiness of
21 the study results. Working in the language of the participants augmented trustworthiness
22 and credibility. Twinn (1997) maintains that in cross-language studies, it is important to

1 analyses data in the source language and translation should be used at categories and
2 themes level. However, analysing data simultaneously in two different languages is not
3 without challenges. When ambiguities occurred, the research team discussed and
4 determined if the meaning of the terminologies used in different linguistic context
5 referred to the same concept or idea. The report of the study followed COREQ
6 guidelines.

7 **Findings**

8 Figure 1 summarises the relationship between participants' subjective experience of
9 mental distress and pathways to mental health care. Contrary to our previous
10 understanding, not all participants experienced delayed contact with mental health
11 services. Five PPs were referred by their GP to specialist mental health services early
12 because they or their families recognised that 'something was wrong'. Eleven PPs only
13 came into contact with mental health services when a crisis occurred. 'Didn't know what
14 was wrong', the belief that mental distress was related to 'a physical ailment' and was 'a
15 shameful business' were other reasons for delayed contact. Participants' understanding
16 of the experiences of mental distress was not static. Throughout the pathway journey,
17 they redefined the meaning of their experiences, evaluated the 'meaning of western
18 medication' and continued to search for alternative explanations to make sense of their
19 experiences.

20 **Something was wrong**

21 A number of PPs displayed disruptive behaviours which were highly visible to their
22 families. For example, *B's* wife said that 'he was talking nonsense; behaving liked a

1 monkey, jumping up and down'. *F's* wife observed that 'from night fall until dawn, he
2 walked up and down, up and down; he was very restless, very confused.' When families
3 noticed these sudden changes of behaviours, they realised something was obviously
4 wrong and took their relatives to see their GP.

5 Although none of these families referred to the medical framework to
6 describe and explain their relatives' behaviours, they sought advice from their GP
7 promptly. It is fair to conclude that they considered their relatives to be ill and
8 requiring medical attention. Of the six participants that took prompt action to consult
9 the GP, five of them were referred to specialist mental health services shortly
10 afterwards.

11 **Didn't know what was wrong**

12 Most PPs did not seek help when they first experienced mental distress. Although they
13 noticed changes in their moods and experiences, they did not associate these changes with
14 mental health issues and did not initiate help-seeking. Moreover, they did not share their
15 concerns with anyone and only relied on their personal resources to manage the distress
16 they experienced. For example, *C* heard funny sounds in her head and as she thought it
17 was normal, she did not seek help for some years. Inaction was a common response
18 because of a failure to recognise a MHP that required attention.

19 Families also noticed their relatives' initial behavioural changes and mood
20 fluctuations and similarly they struggled to make sense of these changes and did not
21 relate them to MHPs. *E's* father noticed her laughing. He said, 'I thought it was
22 normal but then I didn't understand why she was laughing. About 3-4 years later, I

1 took her to see the doctor'. *C's* father said:

2 I didn't think it had anything to do with mental illness. I never
3 thought that [mental illness] was the problem. She became very quiet.
4 I thought it was her personality.

5 These families normalised and rationalised their relatives' behaviours and
6 delayed seeking help. They only accessed mental health services when their relatives'
7 behaviour caused serious concerns that warranted compulsory treatment or
8 admissions to hospital.

9 **It was a physical ailment**

10 Some PPs perceived their 'sleeping problems' and 'losing appetite' as the result of a
11 physical illness and used self-treatment to manage these physical problems.
12 Although they eventually sought medical advice, their description and presentation of
13 their discomfort was predominantly in a physical form. Feelings of psychological
14 and mental distress such as sadness and anxiety were secondary and were not
15 communicated to medical professionals:

16 When it first happened I did not know it was depression. I had
17 sleeping problems so I bought sleeping tablets from mainland China.
18 I increased the dosage when it didn't work . . . Eventually, I went to
19 see a doctor and he told me it was depression. (*MA*)

20
21 Some FPs believed that their female relatives' sudden angry outbursts were
22 caused by changes in their biological clock and 'women's problems'. *P's* husband
23 thought 'it was because of her menopause'. *M's* husband said:

1 At the beginning, I didn't know it was her mental health . . . It
2 happened nearly once a month, she went crazy. I thought it was a
3 woman's problem. It was only later I realised it was depression.

4
5 As these FPs believed that their wives' difficult and irrational behaviours
6 were caused by the menstrual cycle or onset of menopause, which was a natural
7 physiological change, they tolerated their behaviours and did not consider help-
8 seeking to be necessary. These women only came into contact with mental health
9 services during crisis situations.

10 **It was a shameful business**

11 A strong theme emerging from participants' stories was the perception that MHPs are
12 highly stigmatising in Chinese societies. Labelling of MHPs could bring shame to
13 the family. There was an intense fear of 'losing face' and that the family name would
14 be stained if family history of MHPs was revealed to the outside world. Many
15 families therefore were reluctant to share their concerns with, and receive support
16 from, people outside of the family:

17 At the beginning, I couldn't accept it. I really didn't want her to go to the
18 hospital. The doctors came to our house for three consecutive days. They
19 explained that the sooner I admitted her to the hospital, the better chance
20 for her to recover . . . but I felt so sad, very sad, losing face. I didn't want
21 to talk to anyone about it. (*C's father*)

22 As most families involved in this study were not proficient in English, an
23 interpreter was often invited to aid communications with mental health professionals.

1 Some families refused input from bilingual workers, however, because of the concern
2 that their family's 'shameful business' would be spread in their local Chinese community:

3 I didn't want the hospital to find an interpreter. I worried that people
4 would be gossiping. It's like broadcasting in the newspaper. Because
5 this is a family affair, you know the Chinese saying: 'family's
6 shameful business should not be discussed outside the family'. (*S's*
7 husband)

8 The stigma attached to MHPs was not only felt by the family. Many PPs,
9 especially Chinese men, found it difficult to live with any label associated with
10 MHPs:

11 He attended the day centre for about a year and he enjoyed going there.
12 Then there was another Chinese person, he worried that other Chinese
13 people would talk about him, that he was not earning money, then he
14 stopped going. (*K's* wife)

15 The perceived discriminatory attitudes especially from the Chinese
16 community, explain why some PPs chose to avoid social contact with them. Social
17 avoidance was a strategy employed by many participants as it helped them to conceal
18 personal and family history of MHPs. This discouraged them from developing new,
19 and maintaining existing, social relationships. Thus their family became their only
20 link to the outside world.

21 **Supernatural forces**

22 Only one PP, *MS* and her husband attributed the cause of mental distress to supernatural
23 power at the beginning of the pathway journey. They believed that only ritual healers

1 could get rid of the ‘demons’. They travelled across the UK to visit a fortune-teller but his
2 ritual ceremony did not help *MS*. Feeling unable to help, her husband made several visits
3 to Hong Kong to search for more powerful ritual specialists.

4 However, when participants’ mental health showed no sign of improvement
5 after receiving conventional treatment, more families applied the supernatural
6 perspective to explain their relatives’ experiences and sought help from ritual healers:

7 She said the dirty thing troubled her, entered into her body and
8 possessed her. The ghost told her to go everywhere. The doctor said
9 it was her brain, but from my perspective, I don’t think it’s her brain,
10 it’s the dirty thing, the evil spirits. (*L’s mother*)

11 ‘Dirty thing’, ghosts, evil spirits and being possessed were frequently
12 mentioned by these families to explain the experiences. These families, rather than
13 the patient, made multiple trips to their home country to seek help from ritual healers
14 because such practices were not readily found in the UK. *L’s mother* went to Hong
15 Kong and Vietnam to find a Taoist priest to perform ritual rites to appease the evil
16 spirit. She said ‘the doctor could not help her. It was the ceremony that got rid of the
17 evil spirit completely. Now she is normal’.

18 **Meaning of western medication**

19 At the time of interview, fourteen PPs maintained regular contact with mental health
20 services. Although they were suspicious of the prescribed medication, most found that
21 they had limited alternatives but to follow the medication regime. Despite the unpleasant

1 side effects of the medication, many participants continued to take the medication to
2 avoid compulsory treatment and admissions to hospital:

3 I don't want to take it. I want to throw the medication away. But I
4 have to take it, if I don't take it, they will give me the injection. So I
5 have no choice. (*ME*)

6 As they travelled further in the mental health journey, participants applied
7 different explanatory models to make sense of their experiences. PPs who had multiple
8 relapses and admissions to hospital were more likely to search for alternative remedies to
9 manage the distress brought forth by MHPs. The following extracts best describe their
10 concurrent use of different approaches:

11 My problem is caused by mental illness and the water ghost. The
12 Taoist priest helps me to sort out the water ghost; the Western
13 medication sorts out my mental illness. They are different but I need
14 both of them. (*ME*)

15 The medication alone cannot cure me. My doctor has given me the
16 lowest dosage. Now I am not afraid of hearing voices . . . Both the
17 doctor and God help me to get well. You know, to get rid of those
18 curses, I have to go to hospital; they will give me the injection, the
19 injection will break the spells. (*MS*)

20

21 **Discussion**

22 Our study aims to explore how meaning given to the experiences of mental distress
23 influenced participants' pathway to mental health care. We found that Kleinman's (1980)
24 health care model provided a helpful conceptual framework to describe and understand
25 how Chinese populations responded to the distress caused by MHPs. The model also

1 helps to understand how they engaged with the popular, professional and folk sectors in
2 their pathway journey (see figure 1).

3 **Popular Sector**

4 People normally seek and receive help and advice from non-specialists in the popular
5 sector when they first experience health problems (Gervais & Jovchelovtich 1998). Very
6 often it is the family who first notice the illness, attach meaning to it and instigate help-
7 seeking (Kolstad & Gjesvik 2012). Our findings showed that in the popular sector, family
8 played a significant role throughout the pathway journey. In most cases, family members'
9 belief in, and attitudes towards, mental health determined when and who to consult for
10 advice. Consistent with current literature, most families tended to apply a non-biomedical
11 model to understand the experiences of mental distress (Tran *et al.* 2009). The majority of
12 families tolerated their relatives' challenging behaviours for a prolonged period. A number
13 of participants relied on their personal and family resources using self-treatment to manage
14 what they believed to be a physical illness. This is particularly evident among first
15 generation Chinese migrants living in the UK (Li *et al.* 2014) and other Western societies
16 (Low *et al.* 2011, Nguyen & Lee 2012). Similar levels of family involvement are found
17 amongst different ethnic and cultural groups in the US (Snowden *et al.* 2008).
18 Consequently, many only accessed mental health services when family resources were
19 exhausted and they were at a crisis point.

20 Our study also revealed a gendered help seeking pattern; fathers and husbands of
21 PPs were reluctant to seek help and accept support from the outside world. As men are
22 perceived to be the head of household in traditional Chinese societies, much like other male
23 dominated cultures, such as ethnic Arab people (Al-Krenawi & Graham 2001), seeking

1 help outside of the family implies that they are not able to perform their role properly and
2 will discredit the family name (Bond & Hwang 1988). Furthermore, we found that male
3 PPs with MHPs were more likely to avoid contact with the social world. Because of the
4 disabling impact of MHPs, most PPs were unable to keep their jobs and hence could not
5 continue to be the breadwinner of the family. Social avoidance is a strategy used by
6 Chinese men to prevent losing face in the wider social network (Kung 2001). For these
7 reasons, this study suggests that Chinese populations are less likely to approach the
8 professional sector for support when they develop MHPs. This placed families under
9 immense pressure as they bore the sole responsibility for looking after their relatives with
10 MHPs throughout the journey.

11 **Professional Sector**

12 Professional sector mainly refers to the mainstream mental health services that apply the
13 biomedical framework to understand and treat diseases (Miltiades & Wu 2008).
14 Research evidence on white British (Drake et al. 2000), African Caribbean and Black
15 African people in England (Morgan et al. 2005) reveals that living alone and social
16 isolation are associated with delayed contact with mental health services. However, our
17 findings reveal a different picture for Chinese populations whereby family involvement
18 in help seeking generally delays rather than hastens contact with mental health services
19 (Ryder *et al.* 2000). There was a manifest reluctance to seek advice from the professional
20 sector amongst our participants and the strong stigma attached to MHPs is a key
21 explanatory factor for this. Whilst the stigma of MHPs is a concern in Western Society
22 (Thornicroft 2008) as well as other minority groups (Jiminez *et al.* 2013), there are
23 particular nuances that affect Chinese populations. In Chinese societies, MHPs are

1 perceived to be a punishment inflicted on individuals because of misdeeds committed by
2 their ancestors (Leung *et al.* 2012). The deep fear that a family history of MHPs would
3 become public knowledge explains their reluctance to seek help outside the family
4 domain. An important finding from our work shows that this is especially the case when
5 help is offered by people from the local Chinese community. This has implications on
6 how the professional sector can be best used to support Chinese populations with MHPs.

7 | Language difference is an ongoing problem faced by Chinese populations and this
8 | influences pathway journeys, especially when the family has to rely on an interpreter
9 | from the Chinese community. This partly explains participants' inclination to contain
10 | their help-seeking to their family in the popular sector. As a result, many only came into
11 | contact with the professional sector during a crisis.

12 **Folk Sector**

13 In line with Kleinman's (1980) contention, this study revealed that people alternated
14 between the professional and folk sector or applied both Western interventions and
15 traditional healing simultaneously to manage MHPs. There is also a strong relationship
16 | between the use of multiple remedies and the number of relapses (Lam 2003, Rhi *et al.*
17 | 1995). We surmise that multiple relapses can cause additional distress to individuals and
18 | their families, and make them question the effectiveness of services provided by the
19 | professional sector. A number of families were prepared to travel across the country or
20 | the world to search for alternatives such as ritual healing as folk practice is not widely
21 | available in the UK.

22 **Limitations of the study**

1 As our participants were recruited from Chinese voluntary organisations, the experiences
2 of those who were not in contact with these organisations were not captured. Chinese
3 populations who were most affected by the stigma attached to MHPs may have been
4 disinclined to take part in the study, therefore the study findings might not reflect the
5 experiences of the most marginalised.

6 This was a PhD study completed on a part-time basis and hence there was a time
7 lapse between data collection and publication. However, study findings are still relevant
8 to current practice as there has been no significant difference in the referral process to
9 mental health services. Instead, it is evident that policies of austerity in recent years
10 serve to exacerbate health inequality (Mattheys, 2015), thus highlighting the importance
11 of the implications of this study.

12 **Implications for nursing practice and future research**

13 It is acknowledged that nurses have embraced a holistic approach to mental health care.
14 This has moved towards the development of partnerships between nurse and patient, with
15 the adoption of empathic approaches and a recovery-based understanding of mental
16 health nursing (Kidd *et al.* 2015, Sercu *et al.* 2014). Yet there is evidence of the
17 continued primacy of the biomedical, psychiatric model in contemporary mental health
18 care (Cutcliffe & Happell, 2009, Bracken *et al.* 2012). Our findings clearly show that
19 people will continue to search for alternatives such as folk practices to manage mental
20 distress when their mental health needs are not adequately addressed by the professional
21 sector. Thus the need to recognise different approaches to understanding and managing
22 MHPs, and to acknowledge their historical and cultural significance for people affected

1 by MHPs is ongoing. If their spiritual beliefs are disregarded and invalidated, then
2 people will be dissuaded from engaging with the professional sector. This will lead to
3 more acute presentations, requiring complex interventions.

4 Service provision must address issues of language barriers and be sensitive to the
5 cultural needs of Chinese populations. Nurses should be mindful of the stigma associated
6 with MHPs which is particularly acute in the Chinese community. Chinese populations
7 may be reluctant to use resources from their community. This is especially relevant for
8 male patients or for those whose main carers are men. A transcultural working approach
9 by employing more Chinese speaking mental health nurses will help to address issues of
10 language differences and deliver a culturally competent service (Arafat, 2016). Further
11 research to understand and tackle the extreme stigma associated with MHPs in Chinese
12 societies is needed so that mainstream mental health services and resources from the
13 Chinese community can be fully utilised.

14 **Conclusion**

15 Our work reveals that Chinese populations access and follow many different pathways in
16 their quest to recover from MHPs and highlights the complex interplay of influence
17 between the popular, professional and folk sectors to which mental health nurses must be
18 sensitive. As they travelled further on their pathway journey, people applied multiple
19 perspectives to make sense of their experiences of mental distress by using a pragmatic
20 pluralistic approach to explore resources from all three sectors to alleviate the distress
21 caused by MHPs.

1 The stigma associated with MHPs prevents people from making use of the
2 resources from the Chinese community. This means that people with MHPs would have
3 nowhere to turn unless nurses are able to deliver culturally competent services. Chinese
4 populations were uncomfortable seeking their support entirely from the professional
5 sector and hence their families shouldered the main responsibility to care for and support
6 their relatives with MHPs. Some families were prepared to travel across the country and
7 the globe to search for alternative treatments. Services that acknowledge the stigma
8 associated with MHPs would help families meet the physical and psychological demand
9 of their caring role and may limit their need to seek costly alternative services.

10