Barriers to seeking help for mental health problems – Asian Mental Health Part 3

> "The help seeking process serves as an important filter such that only a portion of those who need professional mental health treatment actually seek such assistance"
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> **Ponterotto et al. (1995), p.416**

Reasons to suspect that barriers exist

It is known that ethnic minority groups are reticent about seeking mental health assistance, and those who do suffer from premature termination. In a study of 135 African-American outpatients only 25% of those seeing a white therapist returned after the first session, as compared to 43% who were seeing a same race therapist suggesting client-therapist ethnic match to be an important factor **(Terrell & Terrell 1984)**. Interestingly, the figures suggest that 57% of the population who were seeing a same race therapist didn't return and this would indicate that the ethnic match is far from the complete solution. Another study in a similar vein was conducted across 17 community mental health centres across the Seattle area of the USA - over 50% of Asian patients prematurely terminated therapy after just one session, as compared to a 29% rate for Caucasian patients **(Sue & McKinney, 1975)**. The authors explained this observation in terms of a difference in attitudes and beliefs regarding mental illness and psychotherapy, and also that the failure of therapists to consider these attitudes resulted in a failure to develop trust, rapport and a working therapeutic relationship. In a study where 83 black and 66 white university students were recruited by telephone, the white group were 6 times more likely than the black group to have sought help from a psychologist or psychiatrist **(Cheatham et al. 1987).**

Semi structured interviews were conducted with 48 psychiatric patients recruited from mental health care facilities **(Lin et al. 1982)**. The Asian group (consisting of Filipino, Korean, Japanese and Chinese people) had the longest delay between diagnosis of mental health problems and participation in a treatment programme, indicating a degree of reluctance to engage in the help seeking process. In the interim, it was found that this group had more extended, persistent and intensive family involvement than either the Black or Caucasian groups. The authors commented that psychiatric problems in Asian families may be taken as a threat to the homeostasis of the family as a whole. The family participate actively in denying such problems.

Using a random sample of migrants from India to the UK, **Cochrane & Stopes-Roe (1981)** found that they showed less evidence of emotional disturbance when compared to a matched English sample, using a scale which had been validated for both groups in question. This begs the question - do Asians utilise services less because they have less cause to do so, as opposed to there being barriers to obtain such help ? Given

equal numbers of stressful life events, as social support systems increase, one would expect the likelihood of experiencing psychological distress (and subsequently seeking counselling) to decrease. It is known that Asian communities in Britain tend to have strong links with the extended family, with family homes sometimes consisting of three generations. It may be that this support acts as a buffer during emotionally difficult periods. Other findings refute this suggestion - depression is thought to be diagnosed less commonly among West Indian and Asian patients in Psychiatric hospitals than among the British born, although this does not reflect the actual occurrence of depression in the community **(Littlewood & Lipsedge, 1989)**

What are the known barriers?

There may be barriers at an institutional level - the geographic inaccessibility of mental health services to the ethnic community; lack of child care; focus on an intra-psychic model and strict adherence to time schedules. In a study by **Acosta (1980)**, environmental constraints were ranked second as reasons for leaving therapy prematurely. Equally, there may be financial barriers (such as medical insurance within some countries, or time off work in order to attend); cultural barriers (such as language and attitudes to mental health problems). Reflecting upon Chinese Canadians, **Lee (1986)** comments that language barriers and cultural differences are less of an issue for second or third generation Chinese, who have integrated into the host country. Indeed, the English language has a rich source of adjectives to describe internal experience - such as despondent, despairing, disillusioned, gloomy, unhappy, miserable and so on - there may not be so many direct equivalents in the Asian languages. More probably, Asian clients may struggle to find English equivalents for words that they know perfectly well in their own mother tongue.

In a study by **Takeuchi et al. (1988),** over 2000 adults were interviewed about their perceptions of barriers to help seeking for two specific problems - alcoholism, and severe emotional problems. The Caucasian group perceived less barriers than any of the other Asian groups, and this remained so after controlling for various sociodemographic variables. A sense of shame was rated quite highly across each non-Caucasian ethnic group, and this is discussed in more detail later in the section. The second most popular response across groups was that services were inappropriate, or that they just weren't aware of them. Interestingly the least most important factor was accessibility of services and ethnic match of the therapist. In one of few studies carried out with Indian participants, **Jambunathan (1992)** conducted a content analysis of the responses given by Tamil women suffering with depression in India. Consistent with the findings of Takeuchi et al. (1988), treatment seeking behaviour was influenced by the stigma associated with their condition, and another deterring factor was lack of knowledge that treatment was available. The issue of shame seems further emphasised in that the women expressed feelings of wanting to 'wither away' rather than seek treatment.

The shame of needing to seek help

Shame has been equated with mental health problems within Asians, for sufferer and family alike - perhaps because it reflects a failing in upbringing, or some inherited component which would affect the families standing in the community. Mental illness seems to be taken by Asians as a weakness of character and the need to seek professional help is seen as a disgrace. In eastern thought there is a strong belief that all events are influenced to some degree by unseen forces, and any personal difficulty is a reflection of the misfortune of the sufferer. Isolation can set in, where people in the community tend to avoid associating with such a person, or the family. **Durvasula & Mylvaganam (1994)** suggest that ancient codes of India mean psychiatrically ill individuals did not qualify for certain social privileges, and this stigma around mental illness is clearly present in contemporary India. An escape from such stigma may be to conceal the difficulties - perhaps on a conscious level in the avoidance of professional sources of help, and also in the sub-conscious denial of all problems that are not physical. **Lee (1986)** comments that for the Chinese, mental illness is a disgrace and sufferers become family secrets, to the extent that the illness is denied proper care.

Joseph & Kuyken (1993) discuss a framework whereby stressful situations that are evaluated as a threat to self esteem provoke a 'self controlling' coping response (i.e. an inhibition or restraint of ongoing thoughts, feelings and actions). The shame associated with mental health problems is likely to be associated with such a threat to self esteem - and perhaps the reluctance to seek professional help is an extension of this self-controlling response. The avoidance of shame is further discussed by **Gilbert & Andrews (1998)**, with the avoidance of help seeking as one mechanism, amongst other withdrawing behaviours. The concept is simply that of withdrawing from situations in which shame could arise. It may be that a failure to live up to spiritual or cultural ideals fits a similar pattern to the other failures discussed in the literature.

The shame of failing to live up to ideals

Within a religious or spiritual framework for Asians, it is often the case that followers aspire towards a surrender to divine will - to accept their lot in life, be thankful for what they have and not to feel downhearted about difficulties or gaps in life. For Indians, religion is often a central part of family life. For Indians residing outside of their country of origin, worship has taken on an additional role - that of maintaining identity and sustaining a social network within their community. It may be suggested that a persons standing within this socio-religious sphere is questioned where mental health problems arise. After all, depression in lay terms is about unhappiness, and this opposes the religious ideal. What trust have you left in God, if you have lost hope ? How can you be a believer, if you do not believe God knows and does best ? Such internal dialogues are likely to influence not only internal judgements about the self (internal shame), but also judgements about the view that others in the community hold (external shame). As

Gilbert & Andrews (1998) comment, internal shame is derived from how the self judges the self, seeing oneself as bad, flawed, worthless and unattractive. Furthermore, shame must include some notion of a place or position that one does not wish to be in, or an image that one does not wish to create - perhaps because this image or position is associated with negative aversive attributes from which one struggles to escape. These ideas provide a helpful context for assertions made about Asian families being more preoccupied with what the neighbours must be thinking when a member of the household has been hospitalised for an overdose.

Shame induced within the professional consultation

A factor not given much attention is the shame that may be induced by professionals. Depressed patients who attend the GP surgery may be struggling with their symptoms, only to feel more distressed at not being able to express their concerns adequately. If there is a case that Asian groups display a different manifestation and expression of psychological symptoms, they may not understand the questions being asked of them in a consultation - this dynamic in itself can be shaming. A vague series of symptoms which do not make sense to a GP may cause the patient to grow more nervous and misunderstood, whilst making the GP increasingly irritated. In despair, the patient may seek help from different doctors, anxiously trying to convince them of something. Rack (1982) talks of societies where science, medicine, philosophy and religion are not separated into different compartments. Here, there may not be the same distinction between the GP's factual explanation and moral judgement - so that a statement about an illness being bad may imply to the patient that there is something terribly wrong with them as a person!

Service credibility

For a person to approach a practitioner for assistance, and then follow the advice given, it is clearly important for there to be a sense of trust and a feeling that the practitioner understands the difficulties. Practitioners are often trained in a diagnostic method (i.e. asking various questions to narrow down possibilities), and Rack (1982) argues, this may undermine the confidence that Asian patients place in their consultations. Patients often arrive at the surgery with their problems, and expect the doctor to *know* what is wrong with them. If GP's proceed to ask lots of 'what' questions, before looking at 'why' and 'how to help', this is likely to influence their credibility. Within the conceptual model of Asian immigrants, many questions before solutions may serve to reveal their GP's ignorance and reinforce the belief that such doctors simply don't understand.

Furthermore, there may be beliefs within Asian communities that strong feelings should be restrained **(Sue, 1994)**, that focusing on distress is unhelpful, and that it is better to rise above it and carry on. Such factors impact upon the credibility of a service, since it fails to fit beliefs about what is helpful. Clearly, attitudes

to seeking help are a great influence on whether help seeking actually occurs, or not. **Sue & Sue (1990)** describe credibility as a constellation of characteristics which make a service worthy of belief, entitled to confidence, reliability and trust. The ethnicity of the therapist and perceived 'cultural competence' may be an important factor in credibility beliefs. There is a potential for incongruities at various levels, to include problem conceptualisation, means for resolution, and goals for treatment - widely opposing ideas between therapist and client is likely to impact upon how credible the client perceives a service to be (Sue & Zane, 1987).

Tensions between cultural values and the western medical system

There may be a tension between the cultural values of certain ethnic groups and those of the western medical system. Therapy may involve an emphasis on verbal communication of distress and a focus on the individuals personal needs. However, for Asians it is widely believed that individual needs should rightly be subordinate to the needs of the family and collective as a whole **(Sue & Sue, 1977). Krausse (1989)** contends that for Punjabis, a diagnosis of depression is counterproductive, since it suggests a self-centredness to this community which is associated with negative social and cultural values, and such a diagnosis is likely to meet with denial and a breakdown in communication. The control of personal feelings is important since the 'self' needs to be relinquished in order to gain proximity to God, and one part of this bargain is to control emotions that are self-willed impulses. In one study by **Fenton & Sadiq-Sangster 1996**, Asian women in distress were found to talk about their difficulties by way of their circumstances, their families, their hopes, prayers and sorrows - they didn't talk about themselves!

It seems also that such close-knit family ties carry with them a 'sphere of privacy' **(Lin & Lin, 1978),** where the sharing of certain events and experiences outside this network would be considered as an act of bringing disgrace for the whole family. The notion of sitting with a stranger and discussing personal issues may not rest easily with individuals of Asian background. In a study looking at preferences for help sources, Asian Americans did not indicate a preference to see counsellors **(Pliner & Brown, 1985).**

Alternative sources of help

It seems that Asians prefer alternative health care (e.g. acupuncture, herbalists) as a first line of help for psychiatric symptoms and in India, many people use folk healers before turning to hospitals. Clearly, there are fewer folk healers in the Western world. The Asian healer (e.g a Vaid or Hakim) has been observed to conduct extended consultations with the patients that come to him for assistance. This consultation is akin to a counselling session, where the practitioner gets to know the patient and his concerns **(Aslam, 1979)**. Priests and religious specialists also play an important role in the health care of Asians in Britain. Beliefs in the contribution of cosmic factors to recovery manifest in traditional cultures around Asia **(Dalal &**

Singh, 1992) and these beliefs are shared by folk practitioners and patients. Some Punjabis are known to prefer Ayurvedic or Unani practitioners over and above more western medical practitioners, primarily because Western medicines are thought to be 'hot' and aggravate certain conditions.

In a British review of the literature on primary care presentation and disorders such as anxiety and depression among patients from ethnic minorities, **Lloyd (1992)** reports that the ethnic groups most likely to attend a GP were men and women of Pakistani origin. Male Asians including those born in Britain and those originating from the Indian subcontinent and East Africa were more likely than the general population to consult the GP. This would indicate that people are seeking help, but for various reasons the process of referral to mental health services is not occurring. Littlewood & Lipsedge (1989) propose one explanation, in that Asians who break down are more likely to be tolerated at home without more specialist consultation. Indeed it has been suggested that Asians who suffer with emotional difficulties are less likely to class these difficulties as pathological **(Beliappa, 1991),** and it is perhaps for this reason that such difficulties are not discussed with the GP.

Clearly, a number of other explanations are equally plausible - for example, perhaps the symptoms are seen as pathological, but the GP is not considered an appropriate source of help. Stigmatisation and shame have been addressed as important barriers to help seeking previously. Another issue is that problems affecting physical health may be seen as 'individual afflictions' which are amenable to a medical intervention, whereas more emotional or psychological problems are seen in the context of 'personhood and social roles'. Difficulties in the latter are seen to be within normal parameters - the ability to meet difficulties in life is held in high esteem.

As you will realise from the reading of this article, there are a plethora of barriers that sit between an Asian man or woman, and the help he or she needs with mental health problems. Some of these are barriers within health institutions themselves, although not knowingly created. Some are barriers of a cultural, social and spiritual belief system that are at odds with the western psychiatric approach. Depression, anxiety and stress take their toll – life satisfaction diminishes. Where will these people turn for help ? Perhaps to God, or hope of a better after life. Perhaps to

Drink, as a means of drowning out sorrows. Perhaps just through numbness, and lack of life energy, as the years limp on. As a British Asian, trained in psychology, I would like to make the plight of ethnic minorities in the UK known. Surely, we can all work together to offer help, compassion and care to one another.

If you would like to receive other articles in this series on Asian Mental Health, please email me via my website www.clinicalpsychologydirect.com, and I would be glad to forward them to you.

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