Mental Illness Stigma in Asian Populations Impacting Access to Counselling

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Abstract

Mental illness stigma diminishes help-seeking behaviours and creates barriers for effective treatment options. Particularly affected are those from racial minorities and more specifically, the Asian subpopulation. As a result of stigma, Asian individuals of varying demographics like age, gender, education level, regional location, presenting symptoms, and generational status are differentially affected. Some of the main attitudes and beliefs that worsen stigmatization include saving face at all costs; prioritizing collective harmony; religious underpinnings of Confucianism, Taoism, and Buddhism; and a tendency to somatise mental health conditions. According to the literature, the main issues to be addressed are twofold: improving public knowledge about mental health and access to resources; and ensuring the quality of service. Mental health professionals are encouraged to make adjustments to their therapeutic approaches that are congruent with their client's Asian cultural beliefs and practices. Some adaptations include: mindfulness of cultural factors such as collectivistic values, hierarchical structure, nonverbal cues, and passive communication styles; and the implementation of CBT and family therapy. Recommendations for future directions of research entail bridging the gaps in literature; assessing the role of family in various Asian subgroups; and the prospect of online counselling.

Mental Illness Stigma in Asian Populations Impacting Access to Counselling

Mental health concerns that are left untreated is a global issue that has led to worsened health outcomes (Boonstra et al., 2012). Although much progress has been made in the frontier of social movements and social change in the 21st century, stigmas that have ties to mental illness remain an ongoing issue. The media perpetuates this issue through disproportionately portraying persons with mental health struggles as being unpredictable and dangerous, producing a cognitive separation between "us" and "them" (Wong et al., 2018). Mental illness stigma diminishes help-seeking behaviours and creates barriers for effective treatment options (Corrigan et al., 2014). Besides the adverse effects on accessing treatment, mental illness stigma is correlated with lower quality of life for suffering individuals, as well as varied experiences of discrimination (Cheng et al., 2015; Corrigan et al., 2014). Particularly affected are those from racial minorities and more specifically, the Asian subpopulation (Abe-Kim et al., 2007; Hsu et al., 2008; Mellor et al., 2013).

Based on the National Centers for Disease Control and Prevention's (CDC) mortality statistics (2015), the leading cause of death for Asian Americans between the ages of 20-24 is suicide; in the case for those aged 10-19 and 25-34 years old, suicide is the second leading cause of death. In Canada, suicide is the leading cause of death for those aged 10-14 years old and the second leading cause of death for those aged 15-34 years old (Statistics Canada, 2018). On a global scale, the average rate of suicide is 11.6 deaths per 100,000 people; Korea has the highest rates of suicide with 23 deaths; Japan is the seventh highest with 14.9 deaths; United Stated is the ninth highest with 14.5 deaths; and Canada is the sixteenth highest with 11 deaths (Organisation for Economic Co-operation and Development [OECD], 2017). With Asia being the largest

source of Canadian immigrants (Statistics Canada, 2017), these alarming figures emphasize the urgency and importance of providing enhanced support to the Asian demographic.

Despite Asian individuals being commonly regarded as a "model minority" (Ling et al., 2014) – a group characterized by high achievement – there is abundant research that reveals the psychosocial challenges encountered by this population (Lee et al., 2015). Researchers suggest the weight of cultural attitudes and beliefs concerning mental illness that may contribute to increased stigmatization (Augsberger et al., 2015; Chiu et al., 2015; Livingston et al., 2018; Yang et al., 2013). Some of the main reasons, each of which will be elaborated on in later sections, include the maintenance of social reputation, or "saving face" (Cheng et al., 2015; Han & Pong, 2015); prioritizing collective harmony by exercising self-reliance (Kikuzawa et al., 2019); religious underpinnings from Confucianism, Taoism, and Buddhism (Larson et al., 2010); and a tendency to experience mental health issues somatically due to faulty understanding (Hsu et al., 2008).

It seems that an acknowledgment of mental health issues equates to the tarnishing of an affected individual's family name, honour, and ancestry, generating immense shame and guilt (Cheng et al., 2015). Discrimination is usually accompanied by a negative emotional reaction and manifests as exclusion or rejection of those affected by mental illness (Abbey et al., 2011; Corrigan et al., 2014). Because of stigma, help-seeking behaviours are affected by various contextual factors such as age, gender, education level, regional location, presenting symptoms, and generational status – all of which will be explained later in the manuscript (Do et al., 2014; Han & Pong, 2015; Li, Li, et al., 2014; Ling et al., 2014; Tieu & Konnert, 2014; Yu et al., 2015).

Han and Pong's (2015) study provides insight into Asian individuals' use of emotional suppression and social withdrawal as main coping mechanisms. Means of self-control that are

rooted in cultural values were found to delay and prevent help-seeking behaviours (Han & Pong, 2015). Not only does this create an underutilization of mental health services, but also multi-marginalizing factors against those associated with the mentally ill – friends, family, and caretakers alike (Cheng et al., 2015; Chiu et al., 2013; Wong et al., 2018).

Many Asian cultures adhere to certain normative values such as "religious philosophies (e.g., Confucianism, Hinduism), beliefs about social and family obligations (e.g., filial piety), social structure (e.g., collectivism, familyism) and language (e.g., cultural idioms)" (Livingston et al., 2018, p. 680), which are often imbedded into the structure of daily living (Wong et al., 2018). These cultural beliefs and practices greatly affect the ways that mental illness is perceived, experienced and treated. Because mental illness remains a highly stigmatized topic, unchallenged personal beliefs lead to the perpetuation of myths and misinformation. For example, many of the participants in Do et al.'s (2014) study reveal the assumption that if an individual begins ruminating about or admitting abnormality of their mind, then they may actually become crazy. This type of conjecture is not based in research and impedes the treatment of suffering individuals.

As a result of stigmatization, Asian Americans who access mental health services experience a higher rate of premature termination from therapy than non-minority clients (Corrigan et al., 2014). Ng and James (2013) propose a possible explanation of Asian clients in Western settings feeling misunderstood by their culturally dissimilar therapist, causing a loss of motivation to continue treatment. The presenting problems also tend to be more severe amongst those who reach out for help, likely due to delaying therapy until symptoms become unmanageable (Chu & Sue, 2011). It is clear that there is an abundance of barriers in acknowledging mental illness never mind the next steps for seeking help. As a topic that is near

and dear to my heart, the purpose of this manuscript is fourfold: a) to offer baseline understanding for the terminology that permeates this topic; b) to investigate the cultural ideals around mental illness that bears consequence on accessing counselling services; c) to suggest some best practices in working with Asian populations in counselling settings; and d) to offer recommendations for future research based on this exploration. By investigating the factors that impede accessing counselling services, I wish to shed light on the ways that mental health professionals may begin tackling the issues of mental illness stigma in Asian populations.

Self-Positioning Statement

Mental illness stigma in the Asian population is a particularly intriguing topic due to personal experience as well as from gathering similar anecdotes from friends and colleagues. Growing up in my traditional Asian household, mental illness and mental health on the whole were rarely discussed and if it was, the subject was regarded extremely negatively. I admit that this subjective reality creates a biased point of view that will be managed through supervision and deliberate self-reflection. Despite a lingering fear of vulnerability, my main intentions for this manuscript are to pay homage to my journey as a survivor of mental illness stigma and trauma, and offer a better understanding of how we may support Asian individuals.

There were many instances in my upbringing where individuals who did not fit my parents' definition of "normal"—meaning mean docile, hard working, poised, and successful—were ostracised. When the opportunity arose, the differences between "us" and "them" were highlighted so that our reputation would remain untainted. We ceased to visit our cousins, Jane and Phil, after my parents discovered they had learning disabilities. I was told to stay away from strangers at the supermarket that looked or acted "crazy". In grade eight I was praised for never having a boyfriend because my cousin Mandy slumped into depression over a breakup. Finally, I

did not find out about the suicide in our extended family until I asked specifically for an academic paper. All of these examples shine light on the prevailing notion of negativity with regards to anything related to mental wellness and mental illness.

As a product of living under a traditional Asian household, my brother and I were subjected to a series of family rules. Our home was considered a sacred space to be kept clean and organized in every waking moment. Time and money were intimately interconnected; we were to work hard in every aspect of life, especially academically, wherein our efforts would be paid off in due time. An image of perfection was paramount so that we would be highly regarded amongst our extended family and the community on the whole. As a result of these important rituals, “losing face”, or damage to one’s reputation, was a matter to be evaded at all costs, which often meant that secrecy was the solution to our problems. Oftentimes, my cousins would be brought up in conversation to serve as comparative entities; if they were painted in a negative light, we were advised to oppose their behaviours and vice-versa if they were regarded positively.

My parents went to great lengths to ensure that my brother and I never veered off the road to success that they envisioned for us. It was clear that showing vulnerability was equivalent to showing weakness, and especially in the company of others. Although their intentions were good-natured and fundamentally pure from their own upbringing, I felt increasingly misunderstood, trapped and hopeless, and began to resent them. I suffered silently under all their pressure.

In my family shame and neglect are the prevailing reactions associated with mental health concerns. Individual problems are rarely disclosed and in the odd cases that they are, the root cause of the issue is always blamed elsewhere and never unpacked. Undesirable grades were

a by-product of lack of discipline instead of overwhelming stress or struggles with understanding the material. Jealousy was the outcome of caring too much rather than miscommunications or feelings of inadequacy. Substance abuse was a result of bad parenting rather than a cry for help. Eventually I learned to share less authentically, especially when it concerned personal struggles.

During the darkest moments of my life, I thus felt that my only option was to internalize my discomfort. I kept to myself about the maltreatments from whom I had experienced and the constant gloominess that consumed my thoughts. Thoughts of suicide and crippling emotional pain were never disclosed to my loved ones, and eventually anxiety became the norm rather than the exception. The possibility of engaging in therapy never crossed my mind, but instead, my saving graces were playing with friends, expressive writing and listening to music. I chose to refocus my energy on activities that were guaranteed to give me joy.

I have since been able to tackle the pains of my past, create healthier coping mechanisms, and celebrate the resiliency that was exhibited during my years of solitude. However, not all who have suffered as I did share the same fate. My upbringing thus dictates much of the passion and curiosity I have acquired towards mental health advocacy. My hope is that by connecting my experiences to a larger societal context, it will be beneficial to other struggling individuals of various cultural and racial descents as well as for practitioners in the field. The linking of personal experiences to relevant scholarly literature contributes to the empowerment of individuals who have internalized stigmas; promotes a greater understanding of cultural values; and the development of stronger therapeutic alliances.

To honour my experiences means to step into discomfort, understand the cultural underpinnings, allow room for mistakes, all the while rejecting the status quo when it does not align with my own set of values. As an aspiring psychologist, I wish to continually implement all

these principles as well as apply this paper's findings to my work with future clients. There is no step-by-step manual to conducting effective therapy with Asian individuals but there are at least some recommendations supported by research. By encouraging individuals to seek counselling as routinely as seeking a doctor for physical ailments, it is hoped that they may enhance their supports and stray away from internalizing their distress or struggle in isolation as I did.

Key Terminology

In order to minimize confusion or assumptions, this section aims to provide clarity for terminology that will be interjected throughout the paper. Some of the terms include a general description about the roles they play in mental health service utilization by Asian individuals.

Asians

First and foremost, extreme caution must be taken in making the generalization that all Asian individuals adhere to the same traditions, values and belief systems because behaviours can vary depending on the country of origin. To say "all Asians are the same" is to perpetuate racial stereotypes that discriminate individuals and work against social justice objectives. In this manuscript, the term "Asian" will encompass East and Southeast Asian individuals of various backgrounds including those from China, Taiwan, Hong Kong, Japan, South Korea, Vietnam, Singapore, Indonesia, Thailand, Philippines, Malaysia, Myanmar, Cambodia, Laos, and Mongolia. Please note that it is not my intention to ignore the cultural differences that exist within Asian ethnic groups but rather to highlight the common cultural values in how they relate to the counselling process.

Asian Canadian Versus Asian American

Also included under the "Asian" designation for this paper are those with backgrounds from the abovementioned Asian countries and those who were born in Canada or the United

States. Most of the literature reviewed in this paper assess the experiences of Asian Americans and thus, the results may not be generalizable to Asian Canadians. Arthur and Collins (2005) propose that although many similarities may be drawn between Canadian and American society, economy, and culture, such as being highly individualistic cultures, there is one significant difference: The United States adopts a "melting pot model" whereas Canada embraces multiculturalism. They also suggest that the melting pot model involves the replacing of an immigrant group's native beliefs, values, and traditional practices with that of the dominant culture. These descriptions have been provided in order to present a general awareness of the possible similarities and differences between Asian Americans and Asian Canadians.

Collectivism Versus Individualism

The distinction between individualism and collectivism concerns the manner in which "individuals are viewed as separate and autonomous entities or as interconnected and embedded in interdependent social relationships" (Brewer & Chen, 2007, p. 133). According to Brewer and Chen (2007), individualism is characterized by "'I' consciousness, autonomy, emotional independence, individual initiative, right to privacy, pleasure seeking, financial security, need for specific friendship, and universalism" (pp. 133-134), whereas collectivism emphasizes "'we' consciousness, collective identity, emotional dependence, group solidarity, sharing, duties and obligations, need for stable and predetermined friendship, group decision, and particularism" (p. 134). Asian cultures typically adopt collectivistic views, and thus, convey different communication styles and emotional disclosures than those of individualist cultures (Cheng et al., 2015).

The manner in which psychology and traditional modalities, such as psychoanalysis or behavioural therapies that focus on an individual's presentations alone, are applied to those with

collectivistic values can be questioned because counselling and psychotherapy has been largely a product of individualist cultures (Cheng et al., 2015). The onus is on mental health professionals to employ a culturally sensitive framework that considers a client's cultural values and their resulting life experiences during treatment.

Acculturation

As the world becomes more and more globalized, along with it comes the ease of accessibility to international transportation and the Internet, and a rise in immigration rates for study or work purposes. The current cultural milieu in Canada exhibits this globalization: more than one in five Canadians are immigrants, and 21.9% of the total population consists of citizens born from other countries (Statistics Canada, 2017). While moving to another country brings exciting opportunities, with it comes its own set of challenges including those relating to acculturation.

Berry (2005) describes acculturation as "a dual process of cultural and psychological change that takes place as a result of contract between two or more cultural groups and their individual members" (as cited in Li et al., 2016, p. 66). In this process, Berry (2005) suggests there is potential for conflict that creates cross-cultural adaptations in the form of four distinct approaches:

> a) Integration (i.e., individuals maintain their native cultural identity and accept the host culture), b) assimilation (i.e., individuals accept the host culture and abandon their native cultural identity), c) separation (i.e., individuals maintain their native cultural identity and reject the host culture), and d) marginalization (i.e., individuals abandon their native cultural identity and reject the host culture). (as cited in Li et al., 2016, p. 66)

Berry (2005) offers that the impact of acculturation is strongly associated with the level of similarity or difference between one's home culture and the host culture (as cited in Li et al., 2016); the greater the differences between the two cultures present added difficulty to adapt. It seems however, that higher levels of acculturation translate to more positive attitudes towards accessing mental health services (Li et al., 2016; Miller et al., 2011), which will be explored in more detail in the literature review portion of this paper.

Ethnic Identity

Rather than the physical cues denoting one's ethnicity (i.e., skin tone), ethnic identity refers to a sense of "belonging to an ethnic group and the part of one's thinking, perceptions, feelings, and behaviour that is due to ethnic group membership" (Rotheram & Phinney, 1987, p. 13). Phinney (1996) highlights three sequential stages of ethnic identity development in which individuals identify with their own and other groups: "a) the pre-encounter stage (i.e., unexamined ethnic identity), b) the resistance stage (i.e., exploration of ethnic identity), and c) the internalization stage (i.e., achieved ethnic identity)" (p. 67). Ethnic identity can represent an important part of the acculturation process based on the extent to which individuals seek to maintain connection to their original cultures or assimilate to the host culture (Kim et al., 2014). Existing literature suggests that a stronger adherence to one's ethnic identity reflects higher levels of acculturative stress and lower desires to seek professional counselling services (Kim et al., 2014; Li et al., 2016).

Intersectionality

Kimberle Crenshaw (1989), an American professor and civil rights advocate, describes intersectionality as the connections between an individual's cultural characteristics of race, ethnicity, gender, sexual orientation, social class, and ability, and their effects on lived

experiences. The interplay of these identities reminds us that they "are fluid and constructed across times, situations, and social interactions" (Arthur, 2018, p. 286). In this manner, a person could belong to a certain group yet adopt entirely different perceptions and values than that of another person belonging to the same group. A key principle of intersectionality is that any single experience can vary in intensity and meaning depending on the person and context (Arthur, 2018). For instance, an Asian, single mother will likely have different parenting struggles than a Caucasian mother who is supported by a spouse. The result of intersectionality is a layering effect that showcases an individual's unique worldview.

Somatization

As a term that frequently appears in the literature on counselling Asian individuals, I reckoned it was necessary to include this concept in this section. Somatization explains the propensity for individuals to undergo physical symptoms of discomfort whilst experiencing psychological stress (Haralambous et al., 2016). Some common symptoms of somatization include headaches, stomach aches, muscle or back pain, loss of appetite, and/or weakness when the underlying culprit is mental health struggles (Haralambous et al., 2016; Hsu et al., 2008). This leads to a propensity to meet with doctors rather than mental health experts, resulting in disproportionate use of resources that negatively impacts professionals and clients alike (Hsu et al., 2008).

Review of the Literature

Mental illness stigma in Asian populations is a topic that has been extensively researched; however, few articles have compiled and organized the information in a manner that incorporates the most recent literature that may benefit mental health professionals. This section of the paper aims to bridge that gap through a comprehensive review of perspectives. In turn, this

information may enhance counselling interventions for Asian populations that are influenced by service utilization barriers.

Differences in Stigmatization Compared to Non-Asian Cultures

Stigmatization of mental illness is pervasive across cultures, but especially so for Asian and other ethnic groups compared to European ethnic groups (Cheng, 2015; Mellor et al., 2013; Yang et al., 2013). In a study by Cummings and Druss (2011), only 19% of Asian American youth with major depression received any mental health care. This percentage was noticeably lower than their Caucasian peers (40%) as well as those of Black youth (32%) and Hispanic youth (31%; Cummings & Druss, 2011). Compared with European-American groups, Yang et al. (2013) find that Chinese-Americans display more socially restrictive and distant attitudes toward people with diagnoses such as depression and schizophrenia. Perceptions of threat, in terms of personal safety as well as society's well being, are higher in Chinese groups than European groups (Yang et al., 2013). Social distance maintained from the mentally ill population seems to be positively correlated with the belief that they are violent and dangerous (Chong et al., 2007). Hsu et al. (2008) propose that the severity of stigma is determined by "fear, shame, cognitive distortion, social communication, consensus, and sanction" (p. 210). Although the focus of their study is solely on depression, Hsu et al. (2008) conclude that stigmatization is worse among Chinese Americans than Caucasian Americans.

Mellor et al. (2013) compared stigmatizing outlooks toward the mentally ill among four focus groups: Taiwanese, Chinese immigrants in Australia, Australian-born Chinese individuals, and Caucasian Australians. They offer that the Chinese immigrants and the Taiwanese hold significantly more stigmatizing attitudes and are more likely to socially distance from the mentally ill than their Australian-born Chinese and Caucasian Australian counterparts (Mellor et

al., 2013). The Caucasian Australian participants report more accepting attitudes towards the mentally ill than all other groups, where Mellor et al. (2013) suggest that these observations are tied to cultural differences, such as collectivist and individualist values, and an emphasis on Confucian principles, compared to the Western group.

In the study by Cheng (2015), a comparison was proposed between Asian Americans and Caucasian Americans on the biological and social explanations for mental illness. The two groups of participants were instructed to evaluate a reading about an individual with major depression and "were randomly assigned to be informed that the cause was either genetic, neurobiological, social, or unknown" (Cheng, 2015, p. 767). The results were consistent with previous research in that Asian Americans stigmatized mental illness far more than Caucasian Americans.

The study by Chu et al. (2011) deviates from the previous studies by providing on the insight on the stigma differences between two minority groups: Asian Americans and Latino Americans. Asian Americans seemed to prefer nonprofessional sources of help to professional sources, and those who reported suicidal attempts (64.3%) were found to recognize a need for and pursue help less often than Latino Americans (89.7%). In particular, Asian Americans were "less likely than their Latino counterparts to seek help from mental health professionals, psychotherapy, or medications, but not from religious/spiritual or other healers or nonprofessional sources such as online support groups, self-help groups, and hotlines" (Chu et al., 2011, p. 34). Alarmingly, a substantial number of Asian Americans (35.7%) who had attempted suicide never sought any help throughout their lifetime, which exacerbates the need for advocacy and education of these issues.

Another notable finding across Chu et al.'s (2011) investigation pertains to English-language proficiency that which creates a higher likelihood of service utilization for Asian Americans. Once Asian Americans familiarize themselves with English and improve their mental health literacy, the chances of recognizing the need for help and acting on it will be far greater.

Differences in Demographic Characteristics Affecting Service Utilization

Help-seeking behaviours are affected by various contextual factors. Lee and Jang (2017) and Livingston et al. (2018) found features such as age, gender, education level, generational status, regional location, employment status, and presenting symptoms to have differential degrees of influence. During the designing of community-based or individual anti-stigma interventions, one should expect to consider each of these sociocultural dimensions (Saint Arnault et al., 2018). For example, Asian individuals who share similar lived experiences "may benefit from specific types of mental health outreach, such as targeted invitations to join psychoeducational groups" (Livingston et al., 2018, p. 686). Group work presents an opportunity for individuals to connect and leave feeling more supported and informed.

Whereas psychoeducational groups encourage those with shared experiences to come together, individual counselling adopts a different approach by nature. By cultivating an understanding of intersectionality, a therapist may be more successful in developing a positive counselling relationship with their client, as well as nuanced conceptualizations and treatments (Shin et al., 2017). Shin et al. (2017) recommend implementing intervention strategies that target individual, cultural, and systemic levels so as to deem clients as whole, integrated persons. The application of a culturally informed approach is well supported when working with individuals of any demographic.

Instead of placing a focus on the factors limiting counselling service utilization, Lee and Jang (2017) take a unique approach in studying factors that increase willingness to seek mental health services. By applying a particular behavioural model, attention was brought to "the role of predisposing (age, gender, marital status, education, and years in the United States), need (depressive symptoms), and enabling (health insurance, acculturation, and personal beliefs about depression) variables" (Lee & Jang, 2017, p. 200), which yields understanding about the best ways of intervention. The following segments will introduce demographic characteristics that have been found to impact trends in service utilization.

Age

According to the research by Ling et al. (2014), mental health service providers were interviewed about their work with Asian American adolescents. Many of the respondents acknowledged a struggle in working with youth who demonstrate an abundance of unmet needs. These needs are associated with personal and interpersonal domains such as identity development, academic stress, coping mechanisms, parenting, family system, structural stressors (e.g. finances, home environment and legal status), stigma, and severity of discrimination. An acknowledgment of these domains may allow for greater understanding of external factors that impact young perceptions about mental illness.

Park et al. (2015) evaluate the impact of age that is associated with the utilization of mental health services after adjusting for various socio-demographic factors. The participants are categorized into three cohorts according to their age: young (18-39), middle-aged (40-59), and late adulthood (60-74). Results indicate that the oldest cohort is more prone to stigmatize and harbour misconceptions about mental illness than the two younger groups, which was reflected in their lowered rates of accessing help. Upon further investigation, it seems that the elderly

participants tend to adhere to “traditional and Confucian values, which regard mental illness as an internal problem that must tolerated rather than as a medical issue that has treatable biological origins” (Park et al., 2015, p. 763).

Chong et al. (2007) support these findings wherein younger individuals (aged 15-24) rather than the older ones (aged 65-69) adopted more tolerant views towards the mentally ill. The younger respondents did not categorize those with mental health complications as dangerous and acknowledged their right to be treated like everyone else; this group was also more forthcoming about their struggles with mental health (Chong et al., 2007). Based on the results, it is suggested that older participants maintain a stronger connection to their ethnic identity and have lower levels of acculturation.

Similar to Park et al.’s (2015) research, Tieu and Konnert (2014) and Jang et al. (2009) propose that older participants are more invested in traditional values. They classify mental illness as a personal problem to be endured instead of a medical issue with genetic roots. In this manner, elderly personnel are more inclined to forego mental health services to avoid being perceived as weak or targets of institutionalization (Jang et al., 2009). Research by Haralambous et al. (2016) shares these conclusions as well as gives detailed insight into the views of anxiety and depression among older Chinese immigrants. Thematic analysis collected five main principles that explain participants’ perceptions: “lack of knowledge; personal weakness rather than illness; stigma; somatisation; and experience of migration in later life” (Haralambous et al., 2016, p. 251).

Among different ethno-cultural groups, individuals of Asian descent were contended to have a greater likelihood of presenting psychological problems as physical complaints (Dreher et al., 2017). Hsu et al. (2008) propose that the somatisation of mental health symptoms is a highly

common phenomenon among older generations of Asian immigrants based on indoctrinated cultural values, language/semantic structure, and their conception of health. In these age groups, symptoms that are normative of depression are passed off as lack of appetite, lack of sleep, and loss of energy rather than describing experiences with an emotional or psychological basis, such as feeling sad or hopeless (Hsu et al., 2008).

Immigrating to Westernized countries later in life poses particular challenges on older individuals that massively affect mental health utilization (Haralambous et al., 2016; Tieu & Konnert, 2014). Mental health literacy is significantly decreased in older Asian populations for the primary reason of language barriers, causing lack of access to resources to become knowledgeable. There may also be the case of inadequate mental health services that can ameliorate the language barriers, and especially in rural areas of Western countries. Haralambous et al. (2016) suggest some modes of delivery for educating older immigrants include distribution of information through family members, social group gatherings, and media platforms, such as radio and television.

Gender

Due to varying factors such as "racism, xenophobic nationalism, acculturation pressures and patriarchal social relations" (Livingston et al., 2018, p. 679), Asian men in Westernized environments may be more prone to unhealthy perceptions around mental illness and treatment services. Mental illness is perceived as a force that compromises their ability to exhibit masculinity as well as satisfy their moral obligations of being a provider (Livingston et al., 2018). These internalized ideals create significant challenges for Asian men in acknowledging mental health concerns and pursuing treatment (Ando et al., 2013). The result is an increased concern for discrimination, isolation and social withdrawal.

Consistent with general mental health literature that points to a leniency for women to express emotions and exercise vulnerability (Jang et al., 2009), Asian women seem to be more inclined to endorse mental health services "even after adjusting for the presence of mental disorders and other demographic variables" (Lee & Jang, 2017, p. 763). Park et al.'s (2015) study aligns with these results for the middle-aged group of participants (40-59 years-old), where being an unmarried woman was a significant factor in accessing mental health services. More specifically, Saint Arnault et al. (2018) identify the factors impacting service utilization among 402 South Korean women as being "perceived need, attitude, and belief toward mental illness"; the participants either did not recognize a need for mental health support, wanted to solve problems on their own, or believed that problems would improve naturally. Saint Arnault et al.'s (2018) findings reveal the importance of positive mental illness interpretations and consequences as a predictor of help-seeking behaviour in women.

Educational Background

Whereas the study by Wa-chan et al. (2014) suggests that higher education levels lead to greater stigmatizing attitudes as a result of hierarchical disparities, findings by Evans-Lacko et al. (2013) argue the opposite that higher socioeconomic statuses relate to positive attitudes toward mental illness. Given that higher education levels are typically associated with higher-income occupations, such individuals are more likely to have access to insurance benefits that cover therapy expenses. Effectively, health benefits enable a willingness to seek mental health services (Lee & Jang, 2017). Yang et al. (2012) suggest that individuals with higher education are expected to adopt personal responsibility of the mentally ill due to likelihood of previous contact with such individuals. By contrast, those with lower educational levels likely have had

limited access to information and direct contact that restricts understanding of mental illness (Yang et al., 2012).

Level of Acculturation

In instances where families immigrate to Western countries, they can become categorized into groups according to generation. This transition between countries "introduces exposure to new cultures, inevitably initiating an acculturation process" (Berry, 2005, p. 698). There is an expectation for immigrants to adjust, adapt, and integrate the ideologies of the dominant cultural group while assessing the influence of their own culture (Berry, 2005).

Research by Abe-Kim et al. (2007) suggests American-born Asians exhibit higher rates of service use over their immigrant counterparts. The service use patterns seem to be similar amongst first and second-generation immigrants and begin to increase amongst third-generation immigrants. Similarly, Botha et al. (2017) propose that the longer immigrants have lived in America, the greater the propensity for Westernized values and ways of living to be adopted; the outcome becomes a decrease in stigmatization of the mentally ill. Those who are further acculturated and loosely adhere to traditional values are considerably more willing to pursue mental health support (Lee & Jang, 2017). Instead of seeking professional help only when a mental illness has progressed into psychotic or dangerous behaviours, preliminary signs are intentionally addressed, such as personal problems or emotional distress.

In the case of first generation immigrants or anyone entering therapy for the first time, Kim-goh et al. (2015) emphasize the importance of spending more time in the initial sessions to elucidate the purpose and process of therapy. Psychoeducation about the role of the therapist and exploring expectations about the therapeutic relationship can help ease feelings of apprehension

or guardedness. These specific considerations will be elaborated upon in the implications for practice section.

Regional Location

Yu et al. (2015) examined the mental health seeking behaviours of Chinese adults that lived in rural communities. The results indicate that "nearly 80% of respondents were willing to seek psychological help if needed, and 72.4% preferred to get help from medical organizations, yet only 12% knew of any hospitals or clinics providing such help" (Yu et al., 2015, p. 1). It seems that although a desire for mental health services exists, there is a severe gap in knowledge about the ways to access these resources. Chen (2018) notes that cultural barriers are not exclusively responsible for the under-treatment of mental illnesses, but is amplified by the limited access to healthcare resources. It could very well be that rural settings complicate accessibility and affordability to services, ultimately deterring individuals that may be seeking help.

In Japan, Kikuzawa et al. (2019) reveals insight on the reasons for low mental healthcare utilization rates through a concept called "cultural mapping". This idea involves an unravelling of a group's unique values and traditions based on the cultural scripts around mental illness, thereby giving an ideological "map". Because the Japanese adopt more traditional East Asian beliefs about health, self-reliance is a highly encouraged practice more than is found in Western medicinal frameworks. A second relevant factor in cultural mapping lies in the emphasis on a family's responsibility in caring for their members. Dependency on others outside of the family is considered shameful because it imposes "obligations that one is morally obliged to repay" (Kikuzawa et al., 2019, p. 253). Japanese individuals prioritize harmonious social relationships whereby "implicit social support" is provided without disclosing stressful events. The reluctance

in getting help arises out of a fear of overstepping relationships with others, disturbing group harmony, and/or unwanted disapproval.

Presenting Symptoms

There are symptoms and skill deficits that arise from being mentally ill that impact the social functioning and quality of living of affected individuals. Because mental health difficulties, like depression, can negatively impact work and academia, Asian individuals often link their performance to a personal weakness in character (Cheng et al., 2015). The designation of being weak or unusual translates into a "state of disharmony" that falls on the responsibility of the family; the individual experiences a considerable amount of shame and perpetuates mental health stigma in collectivist cultures (Cheng et al., 2015). Depression, like many other mental health conditions, has genetic predispositions that can be passed on through generations, which can jeopardize social harmony and family reputation – two concepts that are immensely valued in Asian cultures (Livingston et al., 2018; Wong et al., 2018). Despite genetic influence in the development of mental illnesses, Cheng (2015) highlights environmental interactions for the origins of illness that may help to reduce stigma – an elaboration on the effects of nurture over nature. Stepping away from a narrative of being doomed to illness and instead, placing emphasis on the effectiveness of treatment could increase hope in Asian populations (Cheng, 2015).

Asian American women who are children of immigrants face higher rates of depression, suicidal ideation and suicide attempts; however, the connection between mental health utilization and barriers to accessing treatment remains unresolved (Augsberger et al., 2015). Among the participants in Augsberger et al.'s (2015) study, 43% of women described suffering from either "current moderate to severe depression symptoms or a lifetime history of suicidal ideation or suicide attempt" (p. 5). While the overall proportion of mental health utilization was higher in

the high-risk groups than the low and medium-risk groups, “more than 60% of the high-risk group did not access any mental health care, and more than 80% did not receive minimally adequate care” (Augsberger et al., 2015, p. 5). The results give a resounding impression of underutilization of services and beckons understanding of the underlying factors including gender. The researchers’ qualitative analysis identified three main reasons for mental health stigma amongst the participants: familial influences, community contributions, and a disparity between cultural needs and available services.

Multi-Marginalizing Effects of Mental Illness Stigma

It is imperative to address issues concerning mental illness stigma given that individuals who disclose the diagnosis of a mental disorder may become subject to several negative outcomes including discrimination, harassment, and avoidance of social contact (Cheng et al., 2015; Chiu et al., 2013; Wong et al., 2018). Family, friends, caretakers, and acquaintances to those diagnosed with a mental illness experience enhanced pressures to meet the needs of their loved ones all the while maintaining their own social statuses (Cheng et al., 2015; Wong et al., 2018). The perceived stigma of being devalued by others adversely impacts their own quality of life in the long run (Chiu et al., 2013); in these cultural contexts, affected individuals suppress emotional expressions and rarely self-disclose in order to preserve collective harmony and family honour.

In China, Yin et al. (2014) investigated the experiences of caregivers of family members with schizophrenia. Although caregivers play an important role in the treatment and recovery process, they face stigma and discrimination as a result of their family ties. Findings indicate that 65% of caregivers admit to concealing their family members’ illness and 71% lack supportive friendships (Yin et al., 2014). The widespread fear of unpredictability and dangerousness is the

prevailing attitude towards those with mental health problems (Chong et al., 2007; Yin et al., 2014). Wa-chan et al.'s (2014) research on the perceptions on psychosis echoes similar conclusions; however, an emphasis is placed on the lack of mental health literacy that leads to misconceptions. It seems that those who are female, with enhanced education and a general knowledge about psychosis, exhibited higher levels of understanding rather than resorting to discrimination (Wa-chan et al., 2014).

Implications and Recommendations for Practice

The cultural profile of Canada and the United States has rapidly diversified and evolved over a span of 50 years; this transformation raises concerns about therapy because traditional counselling frameworks have been shaped from dominant cultural groups (Arthur, 2018). It was only recently that culture-infused counselling models were introduced to improve the effectiveness of therapy for culturally diverse individuals. When it comes to navigating an individual's presenting challenges, it is imperative that intersectionality is taken into account. To continue evolving the realm of multicultural counselling, therapists must assess the unique needs of ethnic groups across Canada, especially for those of Asian descent who are experiencing high rates of suicide (CDC, 2015; OECD, 2017) and premature termination in therapy (Corrigan et al., 2014). This section of the paper aims to highlight approaches to counselling that may enhance therapeutic outcomes for Asian clientele.

Lack of Mental Health Literacy

In many of the studies that have been introduced in this paper, there is a prevailing theme of participants who lack mental health literacy. The gap in understanding about mental illness by the general public was observed in research by Ando et al. (2013), Gong and Furham (2014), Park et al. (2015), Wa-chan et al. (2016), and Wong and Li (2014). Participants of Wa-chan et

al.'s (2016) survey reveals how psychosis is inaccurately viewed as having multiple personality disorder where affected individuals are considered unpredictable and dangerous. When considering the causes of mental illness, Wong et al. (2018) found that the Chinese participants believed the most popular origin of schizophrenia to be psychosocial factors, one of which included personal weakness. Gong and Furnham (2014) argue that besides people's inadequate understanding of mental illness, inaccurate attempts to self-diagnose also prevent the seeking of professional help; this combination of ignorance with overconfidence bears great consequences to proper treatment. Finally, because mass media is often a main information source about mental illness, it contributes to skewed perceptions, biases, and myths, and especially for those who lack interactions with people who are affected by mental health issues (Ando et al., 2013). Until Asian communities are properly educated about the intricacies of mental health, the result will likely be a perpetuation of misinformation and stigma.

The studies by Botha et al. (2017), Chen (2018), Wa-chan et al. (2016), and Wong and Li (2014) all underline the importance of outreach efforts in the attempt to combat the deeply rooted stigmas of Asian populations. In particular, Botha et al. (2017) launched an array of awareness campaigns to Asian undergraduate students in Canada. Botha et al.'s (2017) use of the "reasoned action approach", developed by Ajzen and Fishbein (2011), describes a methodology of examining human behaviour as it pertains to changes in stigma. The intention behind behaviours is determined by three factors:

> (a) The perception of social norms—the likely approval or disproval of a behaviour by the individual's relatives, friends, professional people, and the like; (b) attitude toward a behaviour—reflects the net cost or benefit that is associated with performing the specific

> behaviour; and (c) perceived behavioural control—a person's self-efficacy related to a behaviour. (Botha et al., 2017, p. 117)

The outcomes of their study emphasize perceived norms and self-efficacy as the main areas of concern when developing anti-stigma programs for depression in Asian communities. Based on these collective studies it appears that targeted interventions could ameliorate some of the stigma concerns surrounding mental illness.

Access to Resources

Substantial improvements for mental health objectives will not be possible until individuals who are struggling with mental illnesses begin accessing services. It appears that although individuals are open to receiving mental health support, there is an overwhelming lack of awareness for where or how to access these resources (Chen, 2018; Wong & Li, 2014). In a cross-sectional survey by Yu et al. (2015), "nearly 80% of respondents were willing to seek psychological help if needed, and 72.4% preferred to get help from medical organizations, yet only 12% knew of any hospitals or clinics providing such help" (p. 2). Wong and Li's (2014) study claim that 91.3% of the 173 million adults in China who are living with mental illness have never received professional help of any kind. To make matters worse, the vast majority of mental healthcare is concentrated in large cities, which creates an enormous disadvantage for people who dwell in lower populated areas (Chen, 2018).

Participants from Chen's (2018), Han and Pong's (2015), and Kit et al.'s (2019) studies express an interest for online services that may improve the barriers to access. The existence of online support groups has provided a platform to connect with other individuals undergoing similar struggles, allowing an opportunity to share their experiences and receive some form of emotional support (Han & Pong, 2015; Kit et al., 2019). Many online options for therapy now

exist including companies like BetterHelp, Talkspace, My Online Therapy, or directly with therapists that offer online services. Since privacy and confidentiality is of utmost importance to preserve an Asian individual and their family's reputation, online therapy offers a means of receiving mental health support without the stressors of public disclosure as well as locational difficulties (Perle et al., 2011).

The onset of the global pandemic, COVID-19 in 2020, has especially amplified the need for online methods of therapy due to quarantine procedures and social distancing. Under these circumstances, many individuals have had to access mental health care through online forums, phone calls, videoconferencing, text messaging, smartphone apps, and emails (Zhou et al., 2020) but many have not. Despite the convenience and anonymity that online therapy can provide, Chen et al. (2020) elaborate on the challenges faced by Chinese service providers including legal scope of service a counsellor can provide; lack of criteria for regulating professional qualifications; crisis intervention for clients who were at immediate risk; technical difficulties with telephones or Internet; and social justice concerns pertaining to individuals who have trouble accessing telephones or Internet.

Other barriers to accessing appropriate support pertain to class differences (Chen, 2018), lack of financial resources or insurance benefits (Sim et al., 2017), and language barriers (Ling et al., 2014). Individuals who are affected by mental illness often perceive therapy as a service for the upper-middle and upper classes, rather than catering to those with lower socioeconomic statuses. Financial barriers, especially in cases where individuals do not have insurance, effectively inhibit them from seeking or continuing with treatment. For Asian individuals who immigrate to Western countries, there exists a potential language complication, where there may be a lack of clarity or lack of translation services at all (Ling et al., 2014).

Quality of Service

Quality of service is the next area of concern once individuals have been connected with a service provider. It is paramount that practitioners are diligent in developing a culturally informed practice that incorporates an individual's unique cultural background whenever possible (Arthur, 2018; Kim-goh et al., 2015). The onus is on the practitioner to regularly evaluate their personal assumptions or biases and ensure that the therapy space is one of safety and security for clients to explore themselves. Having a general understanding of the psychosocial challenges facing low-income immigrant families (Ling et al., 2014); socio-historical background of clients' native countries (Sim et al., 2017); employment status as being a crucial factor in sense of identity and life purpose (Cheng et al, 2015); or medical diagnoses being burdens to the family and reasons for self-disappointment (Wong et al., 2018), are just a few examples of the cultural details that may permeate an individual's perceived worldviews. The following sections aim to introduce some key considerations when working with Asian clients that may enhance therapeutic outcomes.

Client Expectations

An abundance of research supports the notion that Asian individuals have different expectations to counselling due to certain cultural factors (Augsberger et al., 2015; Chiu et al., 2015; Chu & Sue, 2011; Kim-goh et al., 2015; Livingston et al., 2018; Yang et al., 2013). Since Asian culture typically places a high value on limiting emotional expression, there is a tendency to believe that suffering should be done silently (Han & Pong, 2015; Kim-goh et al., 2015). Many Asian individuals exercise resistance when it comes to discussing their problems and feelings because emotional expression is regarded as personal weakness or lacking self-discipline. Dwelling on and analyzing upsetting thoughts is considered detrimental and should be

controlled by willpower or avoidance (Han & Pong, 2015). Because counselling often involves verbal articulation of emotions, Asian clientele may lack the vocabulary to describe their circumstances or become intimidated by such an experience (Kim-goh et al., 2015). The desire to seek therapeutic support is thus taboo and presents particular challenges for clinicians in reconciling these perceptions.

In a counselling setting, Asian clients may talk about their problems in an indirect manner (Kim-goh et al., 2015) or hold onto "unexpressed wishes, disagreements, or negative feelings toward participants or [the therapist]" (Wu et al., 2016, p. 317) as a way to save face. Emotional suppression often creates a gap in familiarity with vocalizing one's internal experiences and if a counsellor insists on more direct articulation, they may run the risk of harming the therapeutic alliance (Kim & Park, 2015). As such, clinicians should take great caution in not passing clients off as being uncooperative or unresponsive to therapy when the underlying reason lies in cultural factors. To mitigate chances of therapeutic rupture, counsellors are encouraged to thoroughly explain the therapeutic process and ask for clarification and consent frequently (Kim & Park, 2015). Development of the therapeutic alliance relies heavily on a counsellor's efforts to understand and accommodate their client's cultural values and how they play a part in their perceptions (Kim & Park, 2015; Kim-goh et al., 2015).

A major cultural consideration for mental health professionals concerns the practice of creating an egalitarian relationship with a client, which is typical of many Western counselling approaches (Augsberger et al., 2015; Ng & James, 2013). On the contrary, it is customary for Asian clientele to expect a hierarchical therapeutic relationship due to the cultural emphasis on educational background and collectivistic ideals (Kim-goh et al., 2015; Kuo et al., 2011). Kuo et al. (2011) suggest that early client engagement may be achieved by accentuating a counsellor's

expertise and authority during the initial introduction; doing this "exercise[s] the credibility that [Taiwanese] society has afforded professionals" (p. 9). According to Kim-goh et al. (2015), counsellors are encouraged to be cognizant of the influence of their individual characteristics including age, gender, class, educational background, and professional achievements on the therapeutic relationship. It is commonplace for professional personnel with ascribed and achieved status to be highly regarded with respect and is often an indicator of healthy client retention rates (Kim-goh et al., 2015).

In Kim and Park's (2015) study, much attention is paid to cultural values as they relate to communication styles. A number of participants described adequate client care as requiring verbal exchanges in a client's native language as well as attentiveness to nonverbal aspects of communication. For example, lack of eye contact may suggest an act of following hierarchical customs (Kim & Park, 2015). Mental health professionals should be able to address and understand nonverbal cues and associated cultural norms so as to maintain clients' trust and respect in the working relationship.

Counselling Preferences

In line with the importance of saving face, Sim et al. (2017) caution therapists in requesting their Asian clientele to engage in audio or video recordings. Engagement in therapy seems to be a significant feat in and of itself without the added pressure of another outsider's involvement. An emphasis on recordings may cause rupture of the therapeutic alliance in the event that a therapist overlooks this detail; thus, therapist respect and sensitivity "to the needs of these [clients will prove useful], despite the need for documentation and research" (Sim et al., 2017, p. 135).

Due to the hierarchical structure of Asian culture, Asian individuals tend to view counsellors as experts and authority figures whose role is to provide advice and essentially cure their symptoms, much like a medical doctor (Kim-goh et al., 2015; Kuo et al., 2011). This inspires a preference for a "directive, concrete, and problem-solving approach to mental health treatment, rather than insight-oriented therapy" (Kim-goh et al., 2015, p. 69). Counsellors that work with Asian individuals are encouraged to address cultural nuances and expectations for therapy within the consultation and initial sessions (Kim & Park, 2015). In the case that the client leans towards a directive approach, a focus on psychoeducation and problem solving can help strengthen the therapeutic alliance between client and therapist. Once a strong therapeutic alliance has been established, Asian clients have been reported to inquire about their therapist's personal life in order to create a more collectivistic atmosphere (Kim & Park, 2015). In the event that this happens, the culturally sensitive therapist may exercise strategic self-disclosure and suitable emotional expression in order to reinforce the working relationship. Kuo et al. (2011) and Ng and James (2013) attest to the power of self-disclosure in deepening the trust and understanding between client and therapist.

Cognitive behavioural therapy (CBT) is commonly noted as an effective modality when working with Asian clients (Hwang et al., 2018; Hwang et al., 2015; Kim & Park, 2015; Kim-goh et al., 2015; Sue et al., 2009). Because the principles of CBT are in line with the cultural values and expectations of Asian individuals, clinicians are able to modify and apply them within sessions. Sue et al. (2009) elucidate the ways that CBT aligns with Asian American clients:

> CBT has a) a didactic orientation that provides structure to treatment and education about the therapeutic process; b) a classroom format that reduces the stigma of psychotherapy; c) a match with client expectations of receiving a directive and active intervention from

> the provider; d) an orientation focused on the present and on problem-solving; and e) concrete solutions and techniques to be used when facing problems. (p. 538)

Aside from the directive nature of CBT, psychoeducation is an important aspect of implementing this modality. Because first generation Asians are often unfamiliar with the purpose, process, or goals of therapy, it will be paramount to discuss these details early in treatment (Kim-goh et al., 2015). Having initial conversations that clarify the therapeutic process and roles involved will aid in diminishing the mystery of therapy as well as any misunderstandings concerning expectations.

Family therapy is another modality that has gained a lot of traction when counselling Asian clientele (Kuo et al., 2011; Liu et al., 2020; Quek & Chen, 2017; Wu et al., 2016). Owing to the centrality of collectivism and filial piety in Asian culture, the systemic nature of family therapy investigates the nuances of family interactions and shared goals of the entire family (Kuo et al., 2011). When working with Chinese families, Quek and Chen (2017) highlight a consideration for the country's historical and societal influences, especially because China is "a changing society with numerous economic, social and political transformations, [which] has created a shift of structure and relational power in the family" (p.19). Under these circumstances, clients of varying generations and acculturation levels may need to evaluate their options for self-differentiation in relation to maintaining loyalty to the family. Tackling the topic of self-differentiation becomes a delicate balancing act for the therapist, especially when considering their age, life experiences and background (Sim et al., 2017). It seems that closer in age the therapist is to the younger family members attempting to self-differentiate, the greater the likelihood of alienating the older generation and vice versa (Sim et al., 2017); it is up to the therapist to skilfully collaborate with all family members to establish a working relationship.

Regardless of the therapeutic modality that is used, researchers stress the importance of exercising flexibility and a process-oriented approach to counselling that allows for more effective results (Quek & Chen, 2017; Sim et al., 2017).

According to Kuo et al. (2011) and Sue et al. (2009), the matching of clients with counsellors by gender, ethnicity, and language enhances therapeutic outcomes for Asian Americans when compared to services that disregard these cultural dimensions. Culturally informed interventions such as language match, consideration of systemic influences, and conscious methods of treatment delivery, have been found to increase service utilization as well as decrease the frequency of premature termination (Sue et al., 2009). Hiring more multicultural, multilingual, and culturally competent service providers who can enhance engagement with Asian individuals will be vital in furthering mental health initiatives.

Fundamental Next Steps for Research

Based on current literature, the result of stigmatization has become an underutilization of counselling services and a diminished quality of life for suffering individuals (Cheng et al., 2015; Livingston et al., 2018). To make matters worse, Corrigan et al. (2014) reveal the greater rates of premature termination for Asian Americans who attend therapy compared to non-minority clients. At this rate, the main issues to be addressed are twofold: giving adequate education and awareness around mental health topics; and then once therapy has begun, ensuring that the quality of service is achieved. The following sections are some recommendations for future directions of research.

Gaps in Literature

I begin this segment by noting the gap in literature for Asian Canadians. In my experience it seems that an abundance of research exists for Asian Americans and those dwelling

in their home and new countries; however, research that centered on mental health challenges faced by Asian Canadians was much more difficult to find. As explained in the Key Terminology section, Asian Canadians may experience different challenges than those of Asian Americans despite the societal, cultural, and economical similarities between the United States and Canada. More research that specifically targets Asian Canadian experiences may bring insight on how to better serve this demographic in their unique sets of challenges.

From my observations of the literature concerning minority mental health, Asian individuals are frequently treated as a single group rather than according to their individual countries of origin. Since Asian individuals represent such a diverse congregate of subgroups, each with their own cultural, socioeconomic and political nuances, Kim-goh et al. (2015) suggest future research ought to "examine inter-ethnic as well as inter-generational differences among Asian Americans in the expression of emotional distress and therapeutic responses" (p. 75). Future researchers are encouraged to expend recruitment efforts in targeting particular subgroups to generate comparative data. Specifically for Asian Canadians, I believe in the benefits of reviewing the effects of intersectionality on mental health access for each subgroup according to their cultural values; doing this could offer insight into perceptions about mental illness by Asian minority subgroups and the effects on help-seeking attitudes. More importantly, these kinds of studies would reduce the formation of stereotypes and inappropriate overgeneralization of findings.

The Role of Family

Many researchers have emphasized the theme of addressing family as a crucial component in Asian minority group counselling (Ling et al., 2014; Wong et al., 2018; Yu et al., 2015). Whether directly or indirectly, the inclusion of family in therapy is in congruence with

Asian cultural norms and expectations; especially given the primacy of family reputation and fear of burdening family members, more research in this area is expected to bring valuable insights (Wong et al., 2018). It is not only important to address client needs on an individual level, but also systemically in order to tackle societal and community stigmas that prevent adequate mental health support (Ling et al., 2014). According to Ling et al. (2014), future research should consider the intricate ways that family contributes to mental health stigma, either as perpetuators or recipients of the issues. Because mental illness stigma in this population is so deeply rooted in collectivist values and religion, changing attitudes by way of advocacy and education may not be adequate. The question becomes a matter of uncovering procedures, including the possible involvement of family members, which could bring about more effective outcomes (Lam et al., 2010; Liu et al., 2020). Considering the high concentration of Chinese studies in my research, there is a need to evaluate other Asian subgroups and in various settings that I was unable to uncover.

Online Counselling

As revealed in the literature review, various locational complications and fears of losing face affect the service utilization by many Asian individuals. Online counselling may be an option to bypass these issues; in fact, many countries have seen an increase in popularity for internet-based therapies (Kit et al., 2019; Perle et al., 2011). Participants of Kit et al.'s (2019) study indicate Singaporean children's preference for online mental health support due to feeling safer sharing in the private nature of the online environment. The researchers propose that future studies could examine alternative ways of acquiring feedback about online counselling by use of both quantitative and qualitative methods to minimize skewed results. It would be informative to

compare the data outcomes of survey participants from varying Asian subgroups, ages, educational backgrounds, regional locations, and levels of acculturation.

Reflexive Self-Statement

The entirety of my life seems to be a clash of cultures. I am a second generation Chinese Canadian and I have firsthand experience in wrestling with and balancing the ideals of my Asian cultural beliefs and expectations with that of my Canadian background and new knowledge. Whether it comes to deciding a career path, romantic interests, spending habits, or food preferences, I am endlessly guided by the values of my dual identity. At times it feels as though I am in the middle of a tug of war because of the adversarial nature of my collectively individualistic makeup. I rely heavily on my intuition because more often than not, inaction is the result if I am left to think too deeply. If I must be honest, inaction was the perpetual outcome during my attempts to complete this manuscript. I was ecstatic to begin the journey upon deciding the research topic but as the process unfolded, eventually feelings of defeat, embarrassment, shame, and anger trickled into my awareness.

Defeat came first as I was reacquainted with a demon called perfectionism. My perfectionistic tendencies seem to be amplified whenever a task or personal work is to be inspected by credible figures of authority. This time, however, the personal work would decide the fate of my graduate degree. In my mind I had a minimal margin for error, which instigated expectations for a flawless document in order to achieve the end goal. The result became an overflow of fear, anxiety, and crippling unproductivity. Every time I sat down to write I felt defeated when the battle had barely begun. I was afraid to admit my feelings of self-inadequacy.

Next came embarrassment. Having been raised by immigrant parents with a proud Chinese identity and successes that matched expectations of the “model minority”, I am well

versed in the customs of emotional suppression and saving face. From a young age I have practiced when to keep quiet and conceal my discomfort for fear of showing “weakness”. To express negative emotions meant a lack of self-discipline and poor parenting abilities, and we were taught to always prioritize family reputation before acting. The research I was doing began mirroring my experiences and it became incredibly triggering. Beneath my cheerful façade and long hours of attempting to write, I was overcome with embarrassment for struggling like I did after all the academic writing that had entailed my undergraduate and graduate experiences. I was also embarrassed about my own struggles with accessing counselling, but remained hopeful in learning about the underlying reasons for my apprehension through my research. It never occurred to me that so many culturally entrenched values dictated my daily life.

Embarrassment quickly transformed into shame as I silenced my distress and requested for multiple extensions without disclosing the true nature of my suffering. Around this point in time, I had bottled up my concerns so frequently that the person who I trusted the most suggested it would be best I sought counselling for myself. More shame resulted from not only failing to rely on myself in personal matters, but also in burdening a loved one.

Anger was the last emotion I experienced before I reflected on all the events that lead to my breakdown. I was angry with my parents, my upbringing, my deeply entrenched routines, and my cultural roots, but mostly with myself for not being self-reliant enough as well as not being brave enough to begin counselling. It was a toxic cycle of shame and self-defeat fuelled by the false belief that suffering was proof that my work would be valuable. After some time of reflection and a couple heartfelt conversations with my supervisor, I finally realized the weight of my low self-worth. I overlooked giving myself the humility and compassion that I so easily give to others; I neglected my own feelings and needs in the pursuit of success. Beneath the fear,

embarrassment, shame and anger was a burning desire to prove myself. During my recovery I called upon my rational thoughts and reminded myself that I experience and struggle with emotions, like every other human being, and that my productivity is unlinked to my self-worth.

Although Asian cultural values such as my own are tied to collectivistic goals, it is imperative that I strive to act according to what feels best for me. My intention in sharing my research journey is not to scrutinize the Asian cultural values that are engrained in my day-to-day interactions, but to highlight the dangers of blindly adhering to ideals that may not reflect my personal values. Having a dual identity as a Chinese Canadian allows me to explore both cultures in the hopes of finding a balance – not only that but to nurture the ideals that authentically fit best with who I am. I am grateful to have chosen a research topic that has allowed insight into the factors impacting my own patterns of help seeking as well as for other Asian individuals. In hindsight I recognize that my experiences have contributed to inherent bias that overshadows this manuscript. My hope is that this particular lens through which I have used to tackle the research contributes to the empowerment of individuals who have internalized stigmas, and increases understanding of cultural values that greatly affect therapeutic outcomes.

Conclusion

When it comes to accessing adequate mental health care, Asian individuals experience several pervasive barriers. More than their European and Latin counterparts, the effects of shame and stigma frequently delay and prevent Asian individuals from seeking proper mental health support (Cheng, 2015; Mellor et al., 2013; Yang et al., 2013). The result has become a pattern of only pursuing treatment when symptoms have worsened to a point of extreme dysregulation (Chu & Sue, 2011). Premature termination from therapy is also an outcome of mental illness stigmas and the lack of environmental supports in the client's continuation (Corrigan et al.,

2014). Because of the challenges faced by this population, the purpose of this paper has been presented through four main sections, sandwiched between my personal reflections: a) to offer baseline understanding of the terminology permeating this topic, b) to review the cultural ideals around mental illness that cause service underutilization c) to suggest some best practices in working with Asian populations, and d) to offer recommendations for future research based on recent literature.

Mental health stigma seems to differentially affect individuals of varying demographics such as age, gender, education level, regional location, presenting symptoms, and generational status (Do et al., 2014; Han & Pong, 2015; Li, Li, et al., 2014; Ling et al., 2014; Tieu & Konnert, 2014; Yu et al., 2015). The following section summarizes these findings. Due to adoption of traditional Confucian values, older Asian individuals are more likely to misunderstand mental health conditions than younger groups, which is reflected their lower rates of service utilization (Chong et al., 2007; Jang et al., 2009; Park et al., 2015; Tieu & Konnert, 2014). Asian men in Western societies are more likely to have negative associations concerning mental illness and treatment services (Ando et al., 2013; Livingston et al., 2018). Those with lower education levels reflect limited access to information and direct contact that restricts understanding of mental illness (Yang et al., 2012); better socioeconomic statuses thus relate to better attitudes toward mental illness (Evans-Lacko et al., 2013). Rural settings complicate accessibility and affordability to appropriate services (Yu et al., 2015). The shame associated with being unusual or flawed falls on the responsibility of the family; as such, symptoms and skill deficits that arise from mentally illness impact the social functioning and life qualities of affected individuals and their loved ones (Cheng et al., 2015; Kikuzawa et al., 2019; Wong et al., 2018). Finally, service use patterns seem to be similar amongst first and second-generation immigrants, and begin to

increase for third-generation immigrants (Abe-Kim et al., 2007; Botha et al., 2017); those who are considered more acculturated, or more loosely adhere to traditional Asian values, are more open to pursuing mental health support (Lee & Jang, 2017).

As a result of the rapidly evolving cultural make-up of Canada and the United States, counsellors face particular challenges because traditional counselling approaches have been shaped from dominant cultural groups (Arthur, 2018) – those of which are individualistic in nature. The literature suggests that the main issues to be addressed are twofold: improving the lack of mental health literacy through adequate education and awareness; and then once therapy has begun, ensuring that the quality of service is achieved.

To combat the challenges of mental health stigma, mental health professionals are encouraged to make adjustments to their therapeutic approaches that are congruent with their client's Asian cultural beliefs and practices. Some adaptations include mindfulness of cultural factors such as collectivistic views (Cheng et al., 2015), hierarchical structure (Kim-goh et al., 2015; Kuo et al., 2011), nonverbal cues (Kim & Park, 2015), and passive communication styles (Kim & Park, 2015; Wu et al., 2016); and the implementation of CBT (Hwang et al., 2018; Hwang et al., 2015; Kim & Park, 2015; Kim-goh et al., 2015; Sue et al., 2009) and family therapy (Kuo et al., 2011; Liu et al., 2020; Quek & Chen, 2017; Wu et al., 2016). Recommendations for future directions of research entail bridging the gaps in literature particularly for Asian Canadians and various subgroups of the Asian minority group; assessing the role of family in various Asian subgroups; and the potential success of online counselling that respects collectivistic ideals.

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