## Faculty of Humanities and Social Sciences

# Accessing Mental Health Services: Asian-Canadians and their Experiences

2022 | Rico L. Misajon

**B.A. Applied Psychology (Honours) Thesis**

DOUGLAS COLLEGE

# ACCESSING MENTAL HEALTH RESOURCES: ASIAN CANADIANS AND THEIR EXPERIENCES

by

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B.A. (Honours), Douglas College, 2022

A THESIS PRESENTED TO THE DEPARTMENT OF PSYCHOLOGY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE BACHELOR OF ARTS WITH HONOURS DEGREE IN APPLIED PSYCHOLOGY

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B.A. Honours Thesis

April, 2022

Douglas College
New Westminster, British Columbia, Canada



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# Accessing Mental Health Services:

# Asian-Canadians and their Experiences

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PSYC 4400-001: Honour's Thesis

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## Abstract

This research study attempted to understand the mechanisms in which cultural values, acculturation status, and systemic barriers affected Asian Canadians attitudes towards accessing mental health resources. The sample of 134 students, staff and faculty affiliated with Douglas College were tasked with completing an online survey which consisted of three self-report measures, and questions regarding mental health related experiences. These measures assessed participants level of adherence to Asian American values, acculturation orientation, as well as their attitudes towards seeking mental health services. The multiple linear regression performed suggest that adherence to Asian American values were strongly predictive of scores on attitudes towards seeking mental health resources. The study also found that there were significant mean differences in attitudes toward seeking mental health resources, with participants who were more oriented towards Canada having higher scores compared to participants more oriented to their home culture. The study's results are consistent with previous literature and contribute deeper insight into the reasons for which Asian Canadians may not access mental health resources. Implications of the study's results suggest that shame and stigma, particularly from family, still contribute to the deterrents of care, in addition to being unaware of the pathways to care.

# The Guise of Cultural Values: Asian Canadians and Mental Health

In a 20-year span, Asian Americans in the United States have been one of the fastest growing demographics at a growth rate of 72% up until the year 2020 (DeVitre & Pan, 2020). In Canada, 59% of recent new immigrants are visible minorities which originate from Asia, primarily of Chinese or South Asian descent (Tiwari & Wang, 2008). These statistics suggest that Asian-Americans and Asian-Canadians are a rapidly growing demographic within the population of the Western world. Despite these large immigration trends, however, is an issue which finds that this demographic tends to under-utilize mental health services, especially when compared to other populations (DeVitre & Pan, 2020). Research has found that compared to the general population which sought mental health services at 17.9%, Asian Americans were two times less likely at 8.6% when seeking out mental health services (Shahid, Weiss, Stoner & Dewsbury, 2021). Another study found similar results, finding that despite one in six Asian Americans in their lifetime being diagnosed with a psychiatric disorder, they are three times less likely to seek out mental health resources (Shahid et al., 2021). There could be various reasons for these nuanced differences in the utilization of mental health care resources, and previous literature has pointed to various possible factors: acculturation rates, time of immigration, ethnic differences, gender differences, or even age. There have been mixed answers for this question, and it remains as an important issue to contend with and explore. With the prevalence of mental health awareness campaigns and the rise of self-care as a positive health habit, it is important to consider how applicable or accessible these resources are for Asian Canadians.

## Immigration for Asian Canadians

When individuals arrive in a new country, the immigration process can be a period of great change and adjustment which can create profound levels of stress and subsequent mental

health issues (Tiwari & Wang, 2008). In Canada, a large proportion of immigrants have come from Asia which is a trend mirrored across the border in the United States (Tiwari & Wang, 2008). In a study of transnational Taiwanese individuals in Vancouver, themes of loneliness were prevalent for newly immigrated families due to a severed social and peer support network. Youth also felt pressured to succeed academically due to parental sacrifices and have added responsibilities stemming from having to be cultural navigators for their families (Petersen & Park-Saltzman, 2010). Tiwari & Wang (2008) in their analysis of the Canadian community health survey in 2003 found that foreign born Asian Americans had a lower risk of mood disorders prior to immigration, which then begins to look more similarly to US born Asian Americans after a certain period after immigration. One explanation offered for this variance in health is due to the selection process of immigrants by receiving countries. Through more selective processes, the chosen immigrants coming from Asia often had lower rates of divorce, juvenile delinquency, good family environments, upward socio-economic mobility, as well as higher levels of education. Higher education as well as good family environments were posited to have influenced more reliance on the family as a support system and to promote habits such as good diet, exercise, and psychosocial relationships which falls in line with more holistic view of health in Asian cultures (Tiwari & Wang, 2008). This is described by Whitley, Wang, Fleury, Liu & Caron (2017) as *the healthy migrant effect*, suggesting that often their health is much better compared to the general public of their host cultures.

One interesting finding in past literature was that recent immigrants as well as long term immigrants were the lowest when it came to depressive symptomology, suggesting that individuals in-between these two situational contexts were markedly different (Nguyen & Lee, 2012). Past literature examined by Gee, Khera, Poblete, Kim & Buchwach (2020) found that first

generation Asian Americans reported greater underuse of mental health services. One explanation offered by Nguyen & Lee (2012) is that recent immigrants are often focused primarily on generativity and setting down roots for themselves. Recent immigrants are also likely not accultured to their host society quite yet, and therefore still retain their own cultural beliefs as to what 'mental health' is. According to Maslow's hierarchy of needs, one must focus on one's physiological and safety needs prior to psychological needs. The application of this theory to recent immigrants as well as long term immigrants may provide a sufficient explanation. If we look at recent immigrants, they are still establishing foundations for their physiological needs whereas long term immigrants have likely already established these needs and have become accultured enough to access these resources or have the necessary support to overcome any mental health challenges that may occur. Chiu, Amartey, Wang & Kurdyak (2018) finds similar results regarding long-term immigrants, non-immigrants, and white Canadians. In a similar vein, Gee et al. (2020) examined past research, finding that first generation Asian Americans were reported to have the greatest amount of under-use when it came to utilizing mental health resource. From this past literature, there does appear to be a trend where individuals may acculturate to their host society in varying degrees. Based on how an individual acculturates, they may either take on the values of their host culture or adhere to traditionally endorsed Asian American values, resulting in variations of attitudes towards seeking help.

**Cultural Values**

It is important to note that as more people immigrate from Asian countries into Canada, that different generations of Asian Canadians will exist in a bicultural context. They will be exposed to the dominant *Canadian* culture, whilst also possibly maintaining or engaging in one's 'home' culture. Therefore, it is important to consider the interplay of how these values may

shape attitudes and perceptions regarding mental health for this population. In Asian cultures, expressing one's negative emotions or true feelings have remained only appropriate behind closed doors, and in private (Gee et al., 2020). This is done to preserve *face*, which is a concept echoed in various eastern Asian cultures, and *saving face* is a fundamental idea rooted in social connections where it is indicative of your position in social networks and society (Gee et al., 2020). Engaging in behaviours which are discouraged by the culture or community may cause the fear of a loss of face, potentially acting as a deterrent to many behaviours which do not align with what is acceptable by normative society (Gee at al., 2020). Other values which also emerge are the practice of emotional restraint as well as self-effacement. However, Gee at al. (2020) suggests that these values may create conflict on the basis that *client-centered* care often goes against more eastern modalities of treatment and care. It is these very concepts as well as collectivist values which may influence the rates at which mental health services, as well as social supports are used for this demographic (DeVitre & Pan, 2020).

Traditional Asian American values were defined by Kim, Li & Ng (2005) with five main constructs: collectivism, emotional self-control, humility, family recognition through achievement, and conformity to norms. The original study by Kim & Omizo in 2003 found that adherence to traditional Asian cultural values influenced an individual's willingness to seek a counsellor. Across numerous research studies, retaining Asian American values were consistently found to be related to less positive attitudes towards seeking professional help whereas having more European American values were related with having more positive attitudes (Shahid et al., 2021; Choi & Miller, 2014). Past studies have previously only examined Asian American values through a unidimensional lens, which is why Shahid et al. (2021) in their study, attempt to view it multi-dimensionally. Their findings were consistent with past research,

extending this by highlighting the specific subscale of 'emotional self-control' as having the greatest effect on an attitude towards seeking help. Although collectivism is suggested to be an important cultural value, the collectivism and humility subscales were not found to be strongly correlated with attitudes towards seeking help. An explanation offered by Shahid et al. (2021), is that having a greater ability to manage one's own emotions are closely linked to their mental health help-seeking attitudes.

Choi & Miller (2014) builds upon this, hypothesizing that stigma towards counselling acts as a mediator between Asian American values and attitudes towards seeking help. Consistent with their hypothesis, they found that adherence to Asian values influenced *public stigma*, as well as *stigma from close others*, resulting in less positive attitudes towards seeking help. Based off these findings, Choi & Miller (2014) suggest that while culture is an important aspect of the mental health utilization issue, that perhaps stigma and attitudes are the main culprits. A study by Gee at al. (2020) provide further support for this, suggesting that Asian Americans strongly endorsed the idea of family and interdependence compared to European Asian counterparts. This relational tie has been suggested to be one differentiating factor when it comes to different rates of service use between Asian Americans and European Asian (Gee at al., 2020). An explanation offered for this line of thinking is that Asian Americans who inherit more European American values such as individualism and self-reliance may manifest because of a desire to not burden their family, which is concurrent with the idea of family and interconnectedness (Choi & Miller, 2014).

**Shame and stigma**

This interconnected belief leads to one of the stronger themes found in previous literature regarding mental health in Asian American populations: shame and stigma. Past literature has

framed stigma in various ways based on where the stigma is perceived such as stigma towards counseling, public stigma, stigma by close others, and self-stigma (Choi & Miller, 2014). Stigma towards counselling was defined as an individual's perceived feelings of devaluation, rejection, or discrimination which may occur if an individual receives counselling (Choi & Miller, 2014). This is especially prevalent for the AAPI (Asian American & Pacific Islander) community, who in comparison to other cultural groups, are reported to have higher levels of stigma towards counselling. The other forms of stigma include *public stigma* which is defined as the perceived negative feelings from society if one were to access counselling resources (Choi & Miller, 2014). *Stigma by close others* is defined as the perception of stigma from close relationships or social networks, and finally *self-stigma* is the belief that if one does seek counselling resources, that they are un-acceptable (Choi & Miller, 2014). These distinctions highlight the importance of what is perceived by an individual, as well the interconnected nature of social relationships in Asian cultures.

One way in which stigma by close others occurs, is based off how mental illness is often characterized as a hereditary disease in Asian cultures. These beliefs suggest that mental issues occur due to moral or character weaknesses, which in turn reflect poorly on the family of the individual, and its place in society (Nguyen, Shibusawa & Chen, 2012). Given these beliefs, many Asian individuals often do not publicly disclose or discuss if members of their family are facing difficulties with mental illness, in turn causing the family member to deny or hide these issues (Tung, 2011). Recent research has suggested that stigma by close others and public stigma influence attitudes towards seeking professional help indirectly through their effect on self-stigma (Choi & Miller, 2014). Perceived discrimination based off English-speaking ability was also reported to be a deterrent to seeking care (Nguyen et al., 2012). It is no surprise then that the

perceived stigma from others, especially in AAPI populations, become prevalent deterrents in seeking out resources such as counselling, leading to delays in seeking treatment.

**Conceptualization of Mental Health**

During the Renaissance, Descartes introduced the concept of 'cartesian dualism' which was the idea that the body and mind are separate entities, that explanations for illness can be extracted from the physical body alone (Hadjistavropoulos & Hadjistavropoulos, 2019). Body mass index, oxygen saturation, blood glucose levels, heart rate, blood pressure: observable and easily quantifiable biological evidence that we have used for centuries now to define what being *healthy* truly was. However, with the emergence of psychology in the 19th century, we know this not to be true anymore (Hadjistavropoulos & Hadjistavropoulos, 2019). Mental illness and the presence of psychological disorders became important pieces of the whole 'health' puzzle, characterizing the importance of receiving treatment and mental health resources as a tool for promoting health. One prominent model in health psychology that takes this into account is the biopsychosocial model, which considers the interplay between biological, psychological, and social factors giving us a more holistic approach to health (Hadjistavropoulos & Hadjistavropoulos, 2019). NAMI (National Alliance on Mental Illness) defines mental illness as 'medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning' (Tung, 2011). At present, with the emergence of social media as a tool for information, a paradigm shift towards greater mental health awareness and self-care have become integrated into what our idea of health and wellness may look like moving into the future. However, this only paints one picture of what health and wellness may look like for one population.

For Asian Canadians and especially new immigrants, mental health may be conceptualized in an entirely different light: influenced by cultural heritage and their upbringing, which may be why we may not see as much engagement in our western concept of 'mental health'. Historically in Asian cultures, mental illness was often linked with supernatural causes: punishment by Gods or ancestors for various reasons (Tung, 2011). If we look at East Asian perspectives today, they are often influenced by Confucianism, Taoism, Buddhism, and Hinduist beliefs resulting in the belief that there is no clear distinction between the mind and body, but rather a more holistic view of health (DeVitre & Pan, 2020; Nguyen et al., 2012). From this perspective, physical and psychological functions are interconnected, suggesting that health symptoms are indicative of a weak 'flow of energy', which is concept shared across many cultures, but under different names such as 'qi' or 'prana' (Nguyen et al., 2012). It is in this way that symptoms of mental illness may manifest differently such as a headache, dizziness, or diarrhea and it is up to the healthcare provider to interpret this accurately in a cross-cultural lens.

In their study, Nguyen & Bornheimer (2014) examine how mental health needs are perceived, and how it may translate to patterns of mental health service use. They hypothesized that individuals with a higher perceived level of mental health need will result in seeking specialized care at higher rates compared to those who perceive a lower or mild level of mental health need. Consistent with their hypothesis, they found that Asian Americans with more severe needs were more likely than those with lower needs to seek specialized mental health care or use a combination of both general medical care and specialist care. Half of the Asian American individuals with severe mental health needs sought specialized mental health care, which was far greater compared to the general population. Their study suggests that perceiving their needs specifically as mental health needs will influence individuals to seek specialized mental health

care or a combination of both specialized and general medical care. One nuance in their study was that Vietnamese, US born Asian Americans, and those who could speak English well were more likely to utilize general medical care for their mental health needs. Nguyen & Bornheimer (2014) suggest that this may be due to the lack of availability of culturally competent care, which may lead to delayed care or the use of general medical services in place of those services. This provides further evidence that more culturally competent services are essential to meet the mental health needs of the Asian demographic in a western setting.

**Mental Health Care System in Canada**

When we look at the literature, there is evidence which suggests that often ethnic minorities and especially recent immigrants face barriers when it comes to pathways to care as well as clinical assessments, perhaps providing an explanation for their under-representation in the utilization of mental health care (Ganesan, Mok & Mckenna, 2011). It is also important to note how we define or conceptualize what 'mental health care' resources are for the Asian Canadian community. Tung (2011) suggests that due to how mental health is conceptualized, often Asian individuals will turn to more informal sources for help such as themselves, family, or traditional modes of care such as acupuncturists or herbalist, interacting with mental health care professionals as a last resort if nothing else works. Traditional western mental health services also involve 'talk therapy' and discussing one's personal emotions which goes against most Asian cultural beliefs and may lead to dropping out of treatment (Tung, 2011).

In the study by Ganesan et al. (2011), they measured mental health utilization through psychiatric visits and hospitalizations, which we know does not represent all the forms in which we engage in mental health wellness. Despite this, their study provides valuable insight into how we can construct better mental health care in Canada. Ganesan et al. (2011) support the argument

which is that understanding the cultural variations of mental illness are fundamental to the accuracy of a diagnosis, the selection of client centered treatment, and the behaviours in which individuals may seek help. The cross-cultural psychiatric outpatient clinic in Vancouver where this study took place attempts to rectify this issue, providing care where patients are ethnically matched to find a better fit in terms of ideas or expectations, and to eliminate cultural or linguistic barriers in the process. However, results suggested that there was still a disconnect between the diagnosis given, finding that only 21% of the clients were able to identify their symptoms according to the DSM-IV given at this clinic (Ganesan et al., 2011). It is suggested that there may be other factors which influence this disconnect, and Ganesan presents an alternative suggesting that perhaps 'cognitive matching' may lead to finding a better 'fit' between client and health care professional. With this type of matching, ethnic and demographic factors take a back seat in comparison to attitudes, values, and expectations which take more precedence in finding the right alignment.

There have been many recommendations for more 'culturally competent' care in, and contrary to Ganesan et al.'s findings (2011), previous literature has also found some beneficial aspects for administering this type of care. In the utilization of Sue's culturally responsive hypothesis, culturally appropriate mental health care which includes ethnic and linguistic matching has been found to reduce drop-out rates, increased number of sessions, and predicted more positive treatment outcomes (Nguyen et al., 2012). In comparison to non-ethnically matched clients, ethnically and linguistically matched individuals were more receptive to referrals, were referred more often to community facilities rather than in-patient facilities and reported higher levels of satisfaction. In a study of Vietnamese individuals who utilized mental health care in Australia, contact with a Vietnamese caseworker yielded longer and more frequent

contact with continuing care teams, and a reduction in the utilization of crisis care and hospital services (Nguyen et al., 2012). This suggests that there may be numerous benefits to having more 'culturally competent care', however it is important to note that, consistent with Ganesan et al.'s (2011) findings, that matching does not necessarily improve treatment outcomes (Nguyen et al., 2012).

According to Ganesan et al. (2011), most mental health care is administered by primary care physicians, often acting as the first point of contact when individuals are seeking mental health resources. However, there is a fundamental issue which is that they may be ill equipped to provide this type of service, limited by their work environment and a lack of culturally competent training, and therefore act as gatekeepers this type of care. This highlights the importance of training for this type of care, or at least the need to better integrate mental health care into the health care system, which is easier to navigate, and is more accessible to the public. This was previously done in the US, with the implementation of 'The Bridge Program' which provides more ethnic and language matched mental health care to the Chinese American community in the primary health care setting (Nguyen et al., 2012). In this program, patients are screened for any mental health concerns routinely during their annual physical examinations by their primary care physician, who has the support of on-site mental health professionals. With this integrated type of care, primary care physicians and allied health care professionals work symbiotically to identify and address mental health needs for their community at a much earlier stage. The early intervention and culturally competent care address the issue of misdiagnosis, and the subsequent severity of mental illness that can often occur when care is delayed (Nguyen et al., 2012). This model of integrated care addresses many aspects which Asian Canadians find

difficulty with, which are cultural and systemic barriers and may be a possible solution that could be implemented in a Canadian context.

**Ethnic & Gender, Age Differences**

When it comes to differences, various studies have found inconsistent findings when it comes to demographic variables such as ethnicity, gender, or even age. In general, Asians were found to underutilize mental health services when compared to non-Hispanic Caucasian individuals, while also utilizing emergency services much more frequently (Nguyen et al., 2012). Other factors such as residence in high poverty versus low poverty areas also revealed that those in high-poverty areas were more likely to be diagnosed with severe mental illness, and consistently presents as such when admitted for health services (Nguyen et al., 2012). Ethnic studies have yielded varied findings and differences, suggesting that Asian Americans are not homogenous in their beliefs and attitudes regarding mental health, resulting in various inter-ethnic differences. An investigation of public mental health utilization in Hawaii found that while Filipinos tended to underutilize inpatient services at a greater rate, Chinese and Japanese Americans utilized both outpatient and inpatient services at a lower rate (Nguyen et al., 2012). In contrast to this Li & Browne (2000) suggest that Filipinos report the least number of barriers when trying to access care. There also existed inter-ethnic differences where Chinese respondents had an 18% prevalence, compared to Filipino respondents at 16.7%, and Vietnamese respondents at 14%. According to the NLAAS (National Latino and Asian American Study). Given the lower prevalence in Vietnamese respondents, it is consistent with the statistics found where 10% of them used mental health services, finding lower percentages for Chinese and Filipino respondents. Compared with other Asian ethnicities, the likelihood of mental health service use by Chinese and Vietnamese individuals decreased as age increased. Nguyen & Lee

suggest that this difference may be due to different things: lack of English proficiency, a lack of insurance, or traditional cultural beliefs where a tolerance for adversity is built. Southeast Asian elders were suggested to be at a higher risk for psychological distress possibly due to former war experiences, and this may be a common experience for individuals displaced involuntarily (Nguyen et al., 2012). However, among Asian ethnic groups Southeast Asians are also cited to be more likely to access services compared to other racial ethnicities, perhaps due to focused intervention for resettlement services for those displaced.

When it comes to gender differences, according to data from the NLAAS (National Latino and Asian American Study) a study of life-time prevalence found that there was only a .02% difference when it came to DSM-IV depressive, anxiety, or substance abuse disorders between men and women (Nguyen & Lee, 2012). However, other statistics found that adolescent females aged 14 – 24 have the highest suicide rates among their age group, and findings for older Asian American and Pacific Islander women aged 75 and older were similar, having a higher suicide rate compared to Caucasian and African American women (Nguyen et al., 2012). Women were also more likely to access specialized mental health care (Nguyen et al., 2012). Fung & Wong (2007) emphasize through the literature that often immigrant and refugee women face significantly more challenges, as well as stressors specific to retaining cultural values for the family system in the context of acculturation. This is in part due to the caregiver roles in which they take on in these settings, often neglecting their mental health needs to help family members adjust to a new country, therefore acting as facilitators or gatekeepers to accessing mental health services. Southeast Asian refugee women were specifically reported to have higher experienced psychological distress in comparison to men. Due to these various dimensions, it is important to

examine the data on various intersections, and Nguyen & Lee suggest that this be done based on two core concepts: biological time and social stratification.

Based on age differences, young adults in comparison to those in their mid-life were cited to be less likely to utilize mental health service (Nguyen & Lee, 2012). However, one demographic that is often overlooked when it comes to mental health care in Canada are the elderly. One study done on acculturative stress found that depressive symptomology was higher for Asian elders who were highly accultured or were experiencing family conflict (Nguyen & Lee, 2012). This could be explained by how the elderly accumulate various life as well as social stressors over time results in the elderly facing significant issues such as social isolation, self-esteem issues, psychological distress and as a result increased health and mental health needs (Sadavoy, Meier & Ong, 2004; Nguyen & Lee, 2012). For the Asian Canadian elderly population used in this sample, social isolation was a prevalent experience arising due to their inability to effectively communicate through language, a lack of community in their living accommodations, and a lack of knowledge required to utilize local transportation or services in the community (Sadavoy, et al., 2004). Based off historical factors, the level of mental health need is much greater among refugees from Southeast Asia, as well as elders from China, Japan, and Vietnam (Nguyen & Lee). For elderly refugees as well as elderly recent immigrants, uprooting geographically have rendered them unable to be self-sufficient, largely becoming dependant on their family for various forms of support. These shifts in experience and status result in the subsequent psychological and emotional distress endured by the elderly, facing numerous barriers and accessibility issues for necessary care (Sadavoy, et al., 2004). Given that previous literature surrounding stigma and mental illnesses perceived ‘heritability’, it is no surprise then that this acts as a major deterrent for seniors to not seek out resources, especially in the context

of their vulnerable positions in the family and society. It is also suggested that there is a lack of intersectional services which combine expertise on cultural values and mental health in a geriatric setting, even more so in suburban settings where seniors often live (Sadavoy et al., 2004). This may manifest as elderly individuals being reported to have varying patterns of service use (Nguyen et al., 2012).

**Key findings in the context of Asian Americans & Canadians**

Past and current research in a North American context has examined the Asian American and Asian Canadian population generally as well as specifically when it comes to differences and intersections of age, gender, ethnicity, as well as generational status. In their study, Li & Browne (2000) conducted personal interviews with 60 Asian Canadians in a northern community in BC with the goal of examining how mental illness was conceptualized and defined and how it relates to barriers with accessing mental health resources. This early research established similar narratives that are still present today: the underutilization of mental health services, and the presence of both systemic and cultural barriers to accessing services. Four main barriers were identified, which were the presence of shame and stigma, the lack of linguistically appropriate or culturally centered care, fear of discrimination, as well as a lack of knowledge in navigating the mental health system.

Kim & Omizo (2003) in their study tried to examine why Asian Americans underutilized mental health resources, examining 242 Asian American college students at a large mid-Atlantic university and a large university in Hawaii. They confirmed their hypothesis that adherence to Asian American values would have an inverse effect on attitudes towards seeking professional psychological help and willingness to see a counselor. Other research studies replicate and provide consistent evidence towards this effect, such as DeVitre & Pan (2020) who in their study

examine 75 Asian American's internalized values and its effect on seeking mental health services. They found that enculturation, or adherence to traditional Asian American values, negatively affects seeking mental health services and acculturation has an inverse relationship. Shahid et al (2020) build upon this, specifically looking at emotional self-control from the Asian American Values scale, examining 155 Asian American college students recruited from the community. Their findings were consistent with past research, also finding that greater emotional self-control had a greater effect compared to the other variables on attitudes towards seeking help. In contrast to this however, Gee at al. (2020) examined a subsample of 189 university students who had self-reported that they had experienced serious emotional or interpersonal problems the past year. They examined usage of mental health resources and found that mental health resource use is equivalent in both Asian Americans and European Americans in their sample of college students. However, an explanation offered by them is that the difference may be due to past research being conducted on first-generation Asian Americans, compared to their sample population which consisted mainly of second-generation Asian Americans. These research studies allude to cultural orientation as a variable of importance when it comes to whether an individual will seek mental health resources.

## The Present Study

The purpose of this study was to investigate whether adherence to Asian American values or acculturation levels would have a negative effect on attitudes towards seeking mental health resources, and thus act as a barrier towards accessing care. Participants were asked to fill out demographic information, as well as complete three different scales through an online platform. These scales were utilized to assess internalized cultural values, cultural orientation, as well as

general attitudes towards seeking mental health care resources. Individuals were also asked more in-depth questions regarding whether they have experienced mental health symptoms, what services they have utilized, whether they found them effective, and what barriers they faced when accessing care. Although there have been various research studies which sought to understand why the Asian American demographic has underutilized mental health resources, there have only been a few which have been conducted in a Canadian setting. Most other research studies in Canadian setting have examined specific ethnicities at an older age bracket, however, there have been minimal studies conducted on Asian Canadian college students specifically. Mental health care in Canada operates in a different way in comparison to America, and therefore may have specific barriers which are unaccounted for in American research studies.

## Method

### Participants

Participants accessed the online survey through Qualtrics and were recruited through a research participant pool or through snowball sampling. Instructors from the department of humanities and social sciences offered 1% of bonus course credit in exchange for students' participation in our research study. Other participants including staff, faculty, as well as other students not receiving course credit were obtained through snowball sampling by providing an advertisement with details regarding the study. Once informed consent was received, participants were instructed to complete demographic questions (e.g. "What is your cultural background/ethnic identity?"), mental health questions (e.g. "What is mental health to you?"), the Asian American Values – Multidimensional scale, the Acculturation Habits and Interests Multicultural Scale for Adolescents, and the Inventory of Attitudes towards Seeking Mental

Health Services scale in our online survey. After completing these questions, individuals were directed to the debriefing form which revealed the true purpose of our research study, our hypothesis, as well as mental health resources they could access at the college as well as in the community should they need it.

The sample consisted of college students, staff, and faculty from a western Canadian college who were at least 18 years or older at the time of the study and identified as either East Asian, Southeast Asian, or South Asian. Individuals who did not meet our eligibility criteria or who had low quality data were excluded from the study to adequately address our main hypothesis and research question. After cleaning, a total of 134 participants (105 domestic students, 23 international students, 3 staff, 3 faculty) completed the online questionnaire, with a mean age of 24.24 (*SD*=7.46) and a total of 25 males, 105 females, 2 non-binary, and one individual who did not disclose their gender.

## Measures

### *Demographics & Mental Health Experiences*

The questionnaire gathered participants age, gender, ethnic identity. Additional items include those pertaining to residency or immigration status in Canada, their country of birth and generational status, and their status in the college including which faculty they belong to. The mental health questionnaire investigated participants experience of any mental health issues, whether they had been formally diagnosed by a clinician, or accessed mental health resources. Participants were also encouraged to share their experiences accessing these resources, and any potential barriers that may be preventing them from obtaining the necessary support.

### *Asian American Values*

The Asian-American Values Scale-Multidimensional (AAVS-M) is a 42-item scale created by Kim et al. (2005) to examine the degree to which individuals adhere to traditional Asian-American values. The items are divided into 5 subscales measuring collectivism, conformity to norms, emotional self-control, family recognition through achievement, and humility. Items are based on a 7-point Likert-type scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) with higher scores reflecting a stronger attachment to traditional Asian-American values. Sample items from the AAVS-M include "One should adhere to the values, beliefs, and behaviours that one's society considers normal and acceptable" or "It is better to hold one's emotions inside than to burden others by expressing them".

The original Asian American Value scale consisted of 36-items and was created by Kim, Atkinson, and Yang in 1999 to measure adherence to traditional Asian values, which at the time, was found to be an important dimension of 'enculturation' (Kim et al., 2005). It was believed that first generation Asian Americans would adhere strongly to traditional Asian American values compared to their counterparts who were several generations removed from the process and lived experience of immigration (Kim et al., 2005). It was also theorized that this process of enculturation would also influence how they perceive and process issues regarding expressing their emotions and seeking help (Kim et al., 2005). Subsequent studies supported these theories, finding that individuals with high AVS scores would have less positive attitudes towards seeking help, as well as rating Asian American counselors as more empathic and credible compared to their European counterparts (Kim et al., 2005). However, repeated studies resulted in inconsistencies, possibly due to suffering from poor levels of internal consistency when using individual subscales as factors (Kim et al., 2005).

The AVS was later revised and created to have a multidimensional measure of the six value dimensions resulting in the AVS-M (Kim et al., 2005). In the creation of this scale, a three part-study was conducted. Initially, a nation-wide survey was first distributed to Asian American psychologists to identify dimensions and items pertaining to Asian values, and after revisions resulted in 30 items for each subscale and a total of 180 items. A principal component analysis was completed to reduce the number of items which were examined for internal consistency and compared with other measures to establish concurrent and discriminant validity. In the second part of the study the final instrument was administered to a sample of Asian American to examine the instrument scores factor structure, reliability, and concurrent and discriminant validity. In the third part of the study, the test re-test reliability was examined over two weeks.

A confirmatory factor analysis resulted in and provided support for the construct validity of the AAVS-M (Kim et al., 2005). There were also positive correlations between AAVS-M total scores and other measures such as the Loss of Face Scale (LOF), or the SCS Independent (Self-Construal Scale) suggesting a good level of concurrent validity (Kim et al., 2005). In the third study, Kim et al. (2005) reported that the AAVS-M has a high internal reliability $\alpha = .89$. In the test-retest, they found high scores regarding internal reliability in both tests ranging from $\alpha = .80 – 92$, and $\alpha = .86 - .95$ on the re-test (Kim et al., 2005). For the two-week test-retest reliability coefficients ranged from $\alpha = .73 - .92$. The current literature suggests that higher scores on the conformity to norms, humility, and emotional self-control subscales within the AVS are directly related to lower help-seeking attitudes, with emotional self-control having the strongest influence compared to the former (Kim et al., 2005).

***Acculturation***

The Acculturation, Habits, and Interests Multicultural Scale for Adolescents Acculturation Scale (AHIMSA) is an 8-item scale using a forced-choice response format which examines the degree to which an individual is acculturated to one's native or host society (Unger, Gallaher, Shakib, Ritt-Olson, Palmer & Johnson, 2002). Four responses are available for each item which include "a" is for "The United States", "b" is for "The country my family is from", "c" is for "Both", or "d" for "Neither". Scores based on which response was chosen will determine an individual's orientation in 4 categories: Assimilation (for higher scores in "Canada"), Separation (for higher scores in "The country my family is from"), Integration (for higher scores in "Both"), and Marginalization (for higher scores in "Neither"). Since this is an American based measure, the "a" response option was changed to "Canada" to suit the Canadian context where it was used.

This scale was originally developed due to acculturation being identified as a risk factor for unhealthy behaviour among adolescents who belonged to different ethnic groups (Unger et al., 2002). In current acculturation scales, they are often created with the adult demographic in mind and often contain cultural contexts which may not be suitable for multicultural and multi-age samples (Unger et al., 2002). Other acculturation scales have also been suggested to be long and time consuming, and therefore this was considered in the creation of this scale (Unger et al., 2002). This scale was originally used and developed for use in a research study assessing a new smoking prevention curriculum in a multicultural urban setting (Unger et al., 2002).

When developing the items for the scale, brevity, age-appropriateness, multicultural relevance, and assessment of multiple components of acculturation were considered (Unger et al., 2002). Items for this scale were created by a team of researchers which consisted of health

behaviour researchers, cultural studies teachers, psychometricians, health psychologists, etc. in the transdisciplinary tobacco use research center at the University of Southern California (Unger et al., 2002). A literature review was conducted, and items were adapted from previous acculturation measures to assess different forms of acculturation (Unger et al., 2002). Small focus groups of adolescents evaluated a pool of 30 items and eliminated or altered any items which were deemed too difficult (Unger et al., 2002). Pilot surveys were also conducted initially to assess the validity and reliability of questionnaire items so that items could be modified for inclusion in the baseline and post-intervention questionnaires (Unger et al., 2002). Unger at al. (2002) reported that the "Assimilation" and "Integration" orientations Cronbach's Alpha was an adequate level at $\alpha = 7.9$.

***Attitudes towards seeking mental health services***

The Inventory of Attitudes towards Seeking Mental Health Services (IASMHS) is a 24-item scale which examines disposition towards seeking mental health services (Makenzie et al., 2004). The items are divided into 3 subscales which measure psychological openness, help-seeking propensity, and indifference to stigma. Items are based on a 4-point Likert-type scale ranging from 0 (Disagree) to 4 (Agree) with higher scores reflecting more positive attitudes towards seeking mental health services. Sample items from the IASMHS include "People should work out their own problems; getting professional help should be a last resort" or "Important people in my life would think less of me if they were to find out that I was experiencing psychological problems".

This scale was initially created due to concern regarding the low rates of mental health treatment despite the prevalence of mental health issues (Hyland, Boduszek, Dhingra, Shevlin, Maguire & Morley, 2015). It was found that beliefs regarding treatment effectiveness, belief in

self to engage in counselling, and perception of social rejection have been identified as influential factors in why individuals may not seek mental health resources (Hyland et al., 2015). This scale was designed to assess the attitudinal factors, building upon Fischer & Turners (1970) Attitudes towards seeking professional psychological help scale (Hyland et al., 2015). The IASMHS initially had 41 items, however an exploratory factor analysis resulted in the 24 items that it contains now (Hyland et al., 2015).

Hyland et al. (2015) found empirical support for this scale's construct validity, concurrent validity, as well as internal reliability. Confirmatory bifactor modelling and three factor modelling found support for the scales construct validity indicating that each item was statistically significant (Hyland et al., 2015). The concurrent validity was assessed utilizing a structural equation modelling procedure, finding that all three items to be statistically significant (Hyland et al., 2015). Help-seeking propensity was found to be a moderately-strong, positive predictor of intentions, while psychological openness also positively predicted intentions, although the association was weaker (Hyland et al., 2015). Internal consistency coefficients for subscales were reported to be good with a Cronbach alpha level of $\alpha = 0.82$ for psychological openness, $\alpha = .76$ for help seeking propensity, and $\alpha = .79$ for indifference to stigma (Hyland et al., 2015). A composite reliability analysis found an adequate level for psychological openness (.70), help-seeking propensity (.76), and indifference to stigma (.77). Further analysis suggests that scores on the IASMHS were positively correlated with both past use and future intentions to use mental health services (Hyland et al., 2015). Psychological openness and help-seeking propensity was moderately correlated to past service use (Hyland et al., 2015). Psychological openness and indifference to stigma exhibited moderate correlations with intentions to seek

mental health services (Hyland et al., 2015). Help-seeking propensity was highly correlated with intentions to seek mental health services (Hyland et al., 2015).

**Analysis**

The researchers were interested in whether there would be significant relationships between an individual's cultural values, acculturation levels and attitudes towards mental health resources. A correlation matrix was first performed to determine the directionality of the relationship between our predictor variables with the criterion variable. The main analysis then utilized a multiple regression line to examine whether our predictor variables would have a strong relationship with our criterion variable. A one-way ANOVA was also employed on the AHIMSA scale which was collapsed into three categories for the purpose of the statistical test.

***Hypothesis 1***

Our first hypothesis was that individuals with a greater score on the Asian American Values Scale- Multidimensional scale would have an inverse negative relationship with the Attitudes towards seeking mental health services scale.

***Hypothesis 2***

Our second hypothesis was that individuals with a greater acculturation score on the AHIMSA, specifically if their most frequently occurring choice was 'Canada', would have a positive relationship with the Attitudes towards seeking mental health services scale.

***Exploratory Analyses***

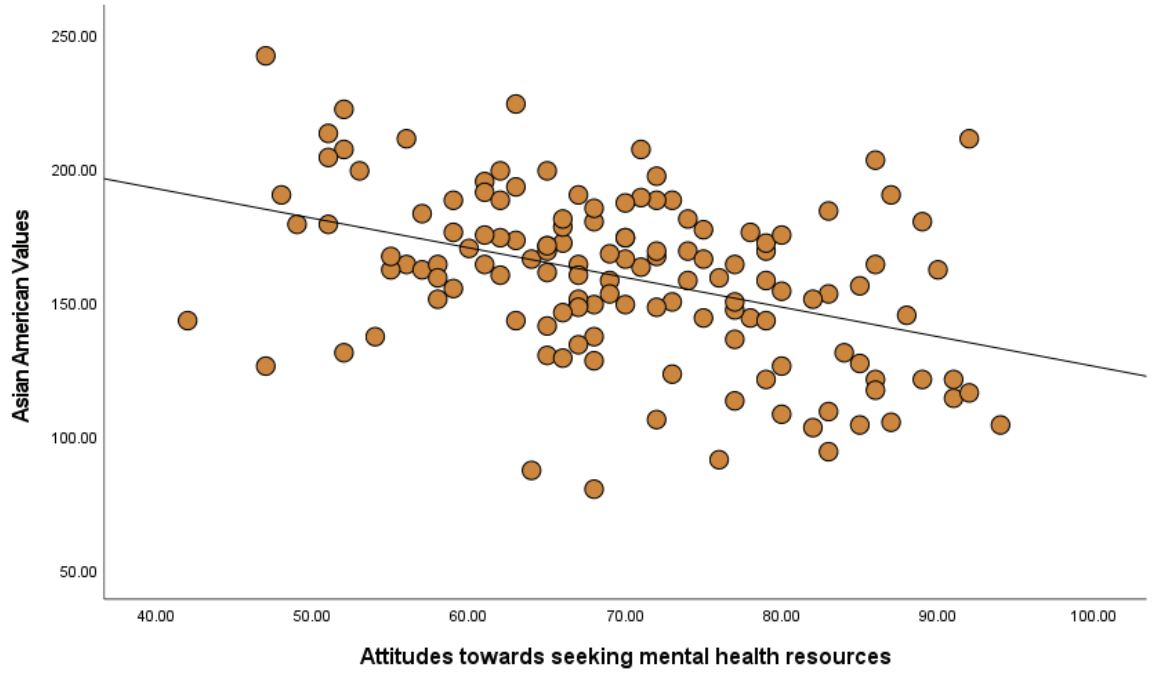
The researchers were also interested in whether demographic variables such as ethnic identity, age, or generational status would yield different mean differences or correlations in terms of scores on the attitudes towards seeking mental health resources scale. A correlation matrix was again utilized to determine whether any of these demographic variables had a

significant relationship with our criterion variable. One-way ANOVAs and independent t-tests were utilized to examine mean differences based on significantly correlated variables.

## Results

Our first hypothesis was intended to examine whether retaining Asian cultural values in the process of acculturating to a new country would have a negative relationship on attitudes towards seeking mental health resources. Our second hypothesis was that individuals who were more accultured to Canadian culture would have more favourable attitudes towards seeking mental health resources in comparison to those with lower acculturation levels. The Pearson correlation for the AAVS-M and the IASMHS was $r = -.411$, $p = < 0.001$, and the Pearson correlation between the AHIMSA and the IASMHS was $r = -.261$, $p = 0.002$. This indicates that the AAVS-M has a moderate significant negative relationship, whereas the AHIMSA has a small negative relationship with the IASMHS. The relationship between the AAVS-M scores by the IASMHS scores are plotted in *Figure 1*.

***Figure 1***



A multiple linear regression was utilized to examine whether individual scores on our two predictor variables, the AAVS-M, and the AHIMSA would account for the variance observed in participants raw scores on our criterion variable, the IASMHS. Preliminary analyses were performed to ensure there was no violation of the assumption of normality, linearity, or multicollinearity. The application of these two predictor variables in our regression model accounted for 17.8% of the variance depicted in the IASMHS scores (Adj. $R_2$, = 0.178) and the model was statistically significant in predicting the results, $F(2, 133) = 15.43$, $p = < .0001$. Out of our two predictor variables however, only the AAVS-M strongly contributed to this model ($\beta$ = -0.366, $t$ = -4.454, $p$ = 0.001), as indicated in *Table 1*.

***Table 1***

***Multiple Linear Regression Analysis for Inventory of Attitudes Towards Seeking Mental Health Services***

| *Predictor* | *$R_2$* | *Adj. $R_2$* | *F* | *p* | constant | *B* | *t* | *p* |
|---|---|---|---|---|---|---|---|---|
| Model | *0.191* | *0.178* | *15.42* | *<0.001* | *97.373* | | | |
| *AAVS-M* | | | | | | *-0.366* | *-4.454* | *<0.001* |
| *AHIMSA* | | | | | | *-0.155* | *-1.884* | *0.062* |

A one-way between subjects ANOVA was performed to compare whether an individual's predominant AHIMSA score (assimilation, integration, or separation category) would have significant differences on the IASMHS scores. The marginalization category as well as individuals who had an even number of responses in at least two categories were collapsed into other categories for more power. As indicated in *Table 2*, The one-way ANOVA revealed that there was a statistically significant difference between at least two groups $F(2,131) = 4.791$, $p$ =

0.010. A post-hoc Scheffe analysis determined that individuals who scored more frequently in the 'assimilation' category ($M$ = 74.76, $SD$ = 11.45) had significant mean differences on the IASMHS compared to those in the 'separation' category ($M$ = 64.59, $SD$ = 10.60), ($p$ = 0.13, 95% *C.I.* = [1.76, 18.58]). There was no statistically significant difference in mean scores between individuals in the assimilation and integration category ($p$ = 0.085), or between the integration and separation category ($p$ = 0.264).

***Table 2***

***Descriptive Statistics of IASMHS raw scores based on AHIMSA orientation***

| *Acculturation Orientation* | *N* | *Mean* | *Std. Deviation* | *Std. Error* | *Range* | *Minimum* | *Maximum* |
|---|---|---|---|---|---|---|---|
| *Assimilation* | 29 | 74.7586 | 11.45381 | 2.12692 | 45 | 49 | 94 |
| *Integration* | 88 | 69.4205 | 11.09802 | 1.18305 | 50 | 42 | 92 |
| *Separation* | 17 | 64.5882 | 10.60105 | 2.57113 | 42 | 47 | 89 |

For our exploratory analyses, we employed a Pearson's correlation to determine whether any of our demographic variables would have any significant relationships with the IASMHS measure. Contrary to our expectations, demographic variables such as generational status were not significantly correlated with our response variable. Despite this, other variables such as age had a small but significant positive relationship ($r$ = 0.199, $p$ = 0.022), gender had a small but significant positive relationship ($r$ = 0.205, $p$ = 0.018), and whether an individual took the course for credit or not had a significant negative relationship ($r$ = -0.235, $p$ = 0.006). In relation to mental health related experiences, whether someone had utilized mental health services had a moderate significant negative relationship with the IASMHS ($r$ = -.412, $p$ = <0.001), and so did ratings of previous mental health resource experience which had a small but significant negative

relationship with the IASMHS ($r$ = -.391, $p$ = <0.001). These results indicate that our response variable increases with age, that females generally have higher scores, and that having a good experience when utilizing services in the past correlate with higher scores.

***Table 3***

***Descriptive Statistics by Ethnicity***

| *Ethnicity* | *N* | *Mean* | *Std. Deviation* | *Std. Error* | *Range* | *Minimum* | *Maximum* |
|---|---|---|---|---|---|---|---|
| *Chinese* | 18 | 76.5556 | 10.2969 | 2.427 | 41 | 53 | 94 |
| *Indian* | 36 | 72.6111 | 11.35977 | 1.8933 | 43 | 48 | 91 |
| *Taiwanese* | 1 | 72 | - | - | 0 | 72 | 72 |
| *Korean* | 8 | 70.625 | 13.76266 | 4.86583 | 41 | 51 | 92 |
| *Mixed* | 20 | 70.55 | 9.09294 | 2.03324 | 38 | 51 | 89 |
| *Vietnamese* | 3 | 70.3333 | 5.85947 | 3.38296 | 11 | 66 | 77 |
| *Filipino* | 33 | 67.8788 | 11.17407 | 1.94516 | 50 | 42 | 92 |
| *Sri Lankan* | 1 | 63 | - | - | 0 | 63 | 63 |
| *Japanese* | 7 | 61 | 11 | 4.15761 | 33 | 47 | 80 |
| *Thai* | 1 | 61 | - | - | 0 | 61 | 61 |
| *Burmese* | 2 | 56 | 2.82843 | 2 | 4 | 54 | 58 |
| *Afghan* | 3 | 55.3333 | 10.40833 | 6.00925 | 20 | 47 | 67 |
| *Pakistani* | 1 | 55 | - | - | 0 | 55 | 55 |
| *Total* | 134 | 69.9627 | 11.42837 | 0.98726 | 52 | 42 | 94 |

Based on the correlational matrices conducted, multiple independent t-tests were conducted on various participant variables. First an independent t-test was performed to determine if there were mean differences on the IASMHS measure between male and female individuals. The independent t-test revealed a significant difference between females and males, with female identifying individuals having higher scores on the IASMHS scale ($M$ = 71.01, $SD$ = 11.41) compared to male identifying individuals ($M$ = 65.44, $SD$ = 10.46), [$t$(128)= -2.226, $p$ = 0.028, 95% *C.I.* = [-10.52, -0.62]], however based on Leven's test for equality of variance we fail to reject the null hypothesis. A second independent t-test was performed to determine if there

were mean differences on the IASMHS measure between individuals who self-reported perceiving social stigma as a barrier with those who did not. The independent t-test revealed that individuals who did not perceive social stigma had significantly higher scores on the IASMHS scale ($M$ = 67.42, $SD$ = 8.48) compared to those who did not ($M$ = 61.67, $SD$ = 8,42), [$t$(57)=2.501, $p$ = <0.015, 95% *C.I.* = [1.148, 10.361]], however based on Levene's test for equality of variance we fail to reject the null hypothesis. A final independent sample t-test was utilized to determine if there were mean differences between individuals who had previously utilized mental health resources and those who did not. As indicated in *figure 3*, individuals that had accessed mental health resources previously in this study had significantly higher scores on the IASMHS ($M$ = 74.38, $SD$ = 11.73) compared to individuals who have not accessed resources ($M$ = 64.98, $SD$ = 8.79), [*t(132)* = 5.193, $p$ = <0.001, 95% *C.I.* = [5.82, 12.98]].

***Table 4***

***Descriptive Statistics by Whether an Individual Previously Accessed Mental Health Resources***

| *Accessed Services* | *N* | *Mean* | *Std. Deviation* | *Std. Error* | *Range* | *Minimum* | *Maximum* |
|---|---|---|---|---|---|---|---|
| Yes | 71 | 74.3803 | 11.72588 | 1.39161 | 52 | 42 | 94 |
| No | 63 | 64.9841 | 8.7979 | 1.10843 | 38 | 47 | 85 |
| Total | 134 | 69.9627 | 11.42837 | 0.98726 | 52 | 42 | 94 |

In our last analysis, a one-way ANOVA was performed to compare individuals who had rated their experience utilizing mental health resources as either good, neutral, or bad. The one-way ANOVA revealed that there was a statistically significant difference between at least two groups $F$(2,67) = 6.293, $p$ = .003. A post-hoc Scheffe analysis determined that individuals who had rated their experience as 'good' had significantly different mean differences on the IASMHS compared to individuals who rated their experience as 'bad' ($p$ = 0.005, 95% *C.I.* = [3.81,

25.38]). There was no statistically significant difference in mean scores between individuals who had rated their experience as ‘good’ and ‘neutral’ ($p = 0.263$), or between ‘neutral’ and ‘bad’ ($p = 0.151$). D

***Table 5***

***Descriptive Statistics by Rated Experience of Accessed Resources***

| *Self-reported Experience* | *N* | *Mean* | *Std. Deviation* | *Std. Error* | *Range* | *Minimum* | *Maximum* |
|---|---|---|---|---|---|---|---|
| Good | 47 | 77.0213 | 10.19695 | 1.48738 | 41 | 51 | 92 |
| Neutral | 16 | 71.9375 | 11.3635 | 2.84088 | 37 | 57 | 94 |
| Bad | 7 | 62.4286 | 11.94232 | 4.51377 | 33 | 42 | 75 |
| Total | 70 | 74.4 | 11.42004 | 1.36496 | 52 | 42 | 94 |

## Discussion

The present study sought to understand the role of cultural values in the process of acculturation, and it's relationship to whether or not it would have be predictive of Asian Canadian's attitudes towards seeking mental health resources. We examined 134 Asian or bicultural identifying individual's cultural values and their relationship with attitudes towards seeking mental health resources. In line with previous literature, our analysis of the data reflects similar findings which is that there is a strong negative relationship between scores on the AAVS-M and IASMHS measures. This infers that individual with stronger adherence to traditional Asian values will have weaker attitudes towards seeking mental health services, which was anticipated and supports our first hypothesis. In previous literature, cultural values as measured by the AAVS-M have been consistent in their influence on measures which pertain to seeking mental health resources such as our dependent variable (DeVitre & Pan, 2020; Shahid et al., 2021). However, it is important to consider that each subscale involved in the AAVS-M has differing levels of influence.

A previous study which examined the AAVS-M multidimensionally found that the emotional self-control subscale was much more influential in an individual's decision to seek out mental health resources which was consistent in our study (Shahid et al., 2021). They suggest that this is an important variable to examine primarily due to its connection to an individual's ability to self-regulate their own emotions and the subsequent decision to seek out resources. Based on an alternative model where each subscale was utilized in a multiple linear regression, the results suggest that emotional self-control was the strongest predictor of scores on the IASMHS. Based on our qualitative section of the study, of the 58 individuals who reported that they have not accessed resources, 36.2% ($n$ = 21) of those individuals reported that they did not

need resources at the time despite 47.8% ($n$ = 11) of them reporting that they have experienced mental health symptoms, or anything considered a mental health issue in the past. This may be alluding to the fact that these individuals simply perceive a lower level of perceived need, or at least an adequate ability to self-regulate their own emotions. Another possible explanation for why these individuals may not seek resources, despite experiencing symptoms, is that they may utilize other informal sources of support such as friends, family, or community groups and perceive those as adequate resources already. Previous literature has suggested that Asian individuals may utilize more informal sources of support in fear of the social stigma attached to seeking out mental health resources (Gee et al., 2020). It has also been suggested that college students, which my sample mostly consists of, are often in a life stage where they are seeking more autonomy and therefore have a stronger preference for relying on oneself for support (Gee et al., 2020). This along with other barriers that pertain specifically to college students such as lack of time, and lack of finances may be contributing to the overall picture of why participants in the study do not access resources.

Contrary to Shahid et al. (2021)'s findings in their study that only the emotional self-control subscale as predictive in the AAVS-M, we found that the family recognition through achievement subscale was also a significant predictor of scores on the IASMHS in an alternative model. Based on our qualitative data, 24% of individuals who reported not accessing mental health services cited family or social stigma as the second most frequent reason for not seeking out resources. One individual indicated social and family stigma as a large deterrent, reporting that seeking mental health resources was 'especially frowned upon in my culture because it means that parents did something wrong'. Another individual cited similar concerns, citing that their parents would say 'there's nothing wrong' if they sought resources. These self-reported

experiences are concerning given the limited number of resources that college students may have, especially if they do have severe mental health needs. These findings suggest that family and social stigma play a significant role in terms of whether an individual accesses resources.

The second hypothesis of our study was that being more accultured to Canada would be predictive of higher scores on the IASMHS. Our analysis concluded that the AHIMSA was not a significant predictor of IASMHS scores in our model, and therefore reject our hypothesis that acculturation to Canada as measured by the AHIMSA is predictive of higher IASMHS scores. This finding is surprising given that previous studies which have measured acculturation through other measures have found them as a predictive of the IASMHS measures, and therefore wonder if the nature of the AHIMSA scale adequately measures what it proposes to measure for the purpose of this research study. Despite not being a significant predictor in our model however, we wanted to compare if there were mean differences between how individuals scored on the AHIMSA. After performing a one-way ANOVA, the results indicate that there was a significant mean difference between individuals in the *assimilation* and *separation* category. This suggests that although acculturation status as measured by the IASMHS is not predictive of seeking out resources, that there are differences in between individuals who are oriented more towards Canadian culture and individuals oriented more towards their home culture.

Because we wanted to measure different aspects of acculturation, in addition to the AHIMSA, we believed that there would be mean differences on IASMHS scores between which generation an individual identified with. We conducted an independent t-test between first generation and second-generation individuals, and the results suggest that there were no mean differences between either group on the IASMHS scores. This is an unexpected result given that previous literature has cited first generation Asian Americans as having greater underuse of

mental health services in comparison to later generations (Gee et al., 2020). A possible explanation for this discrepancy may be based on the length of time that first generation individuals have spent in Canada. First generation individuals who were born in other countries, but have since spent many years in Canada, may have accultured to host society and may respond similarly to individuals who were born in Canada. Despite this, when we look at the frequency of responses between first-generation and second-generation individuals on utilizing services, second generation individuals reported utilizing services 9% more while inversely first-generation individuals reported not utilizing services 9% less which provides support for previous literature but is not statistically significant.

According to previous literature, age, gender, in addition to inter-ethnic differences existed for mental health accessibility and outcomes, and therefore we utilized a correlation matrix to look for potential relationships between variables (Shahid et al., 2021; Sadavoy et al., 2004). Our correlation matrix yielded that there were relationships between age, gender, perception of social stigma, previously utilizing services, and rated experience with our dependent variable. Contrary to what we expected, despite the small number of individuals in the older bracket, a correlation matrix yielded that as age increased, scores on the IASMHS increased. We believed that, based on previous literature which cites older individuals facing multiple more barriers, that there would be a negative relationship between these two variables. An explanation that can be offered for this is that the range of these individuals ages are much younger compared to participants in other studies who are often retired, which may eliminate barriers such as financial constraints or geographical needs.

In terms of gender differences, the results of our analysis suggest that there are no mean differences between men and women on the IASMHS, which is inconsistent with previous

literature. A possible reason for this outcome is due to the significant uneven distribution of male and female participants in this analysis. Despite this, when comparing means between genders, men scored lower on the IASMHS, but scored slightly higher on the emotional self-control subscale which is in line with the literature, however, is not statistically significant in terms of differences. Shahid et al. (2021) suggests that these differences may be due to the Asian value of conformity, specifically tied to traditional gender roles where men are taught to be self-sufficient and therefore potentially have a higher level of emotional self-control.

In terms of mental health related analyses, our independent t-test results suggest that there are mean differences on IASMHS scores between individuals who have accessed resources and those who have not, with individuals who have accessed resources having statistically significant higher mean scores compared to those who did not. Because our dependent variable examines attitudes towards seeking resources, this finding is no surprise given that individuals who have previously sought out resources may already have more positive attitudes or have a need for these supports. However, we were also interested in the experiences of individuals who sought out resources, and the results of the analysis suggest that there were significant mean differences between individuals who rated their experience as ‘good’ and ‘bad’, with individuals having good experiences having significantly higher mean scores. This nuanced insight is important and suggests that good experiences may promote further engagement in mental health resources whereas bad experiences act may potentially act as a deterrent for additional care. Based on qualitative answers, a prevalent theme that arises is the lack of progress with one individual reporting that they ‘had really bad EFAP counsellors and confused psychologists where I just did guided imagery and made absolutely no progress’ and another individual reporting that the individual they saw ‘…did not seem to have any tools, advice, or solution to my issues’.

As this studies participant pool were made up of a majority of first year social science or humanities students, my sample may have more positive attitudes towards mental health than the general population, and therefore may potentially have demand characteristics. This is further evident especially given the nature of the research study which examines mental health attitudes experiences. Individuals who have an aversion to discussing mental health or have alternative conceptualizations or perceptions of mental health may not have engaged in this research study, especially if individuals perceived shame or stigma regarding this topic. Individuals also required basic English comprehension skills to participate in this research study, and therefore participants who did not have sufficient English comprehension were likely unable to participate, perhaps contributing further to the demand characteristics for this study. Given this limitation, we may not have been able to capture conceptualizations of mental health, especially if there are words which do not translate into the English language succinctly. Although we attempted to

One other limitation of our study was one of our independent variables, the AHIMSA. Although this test has been well validated and our results replicated similar numbers for each category, particular categories such as the marginalization subscale were hard to interpret in the context of our research study, and therefore for the purpose of our research study focused our analysis primarily on the assimilation, integration, and separation categories. There was also an unequal distribution in terms of the responses on this measure, with majority of individuals categorizing into integration which made it difficult to compare groups. There was also an unequal distribution of participants when it came to participation of students and staff or faculty, gender, as well as identification with cultural backgrounds and therefore no statistical analyses was utilized to compare these demographic variables. Due to the unequal distribution of participants in demographic variables, particular hypotheses utilizing t-tests had to be rejected

which may otherwise have different results. Based on these limitations, it should be noted that our sample utilized convenience sampling, and therefore may not be representative of the greater Asian population and may only be generalizable to other Asian-identifying college students in the lower mainland.

**Recommendations**

Although our study yielded a model which found factors that were predictive of attitudes towards seeking mental health resources, further insight is required into how the ways in which Asian American cultural values such as family or emotional self-control influence the choices an individual makes regarding mental wellness. Based on the limitations of this study, a study conducted with a greater reach beyond those of college students may yield a more representative sample, and possibly a more accurate picture of the mental health landscape for Asian Canadians. In addition to this, it would seem as though the acculturation process has complexities that were unable to be uncovered in our research study. Therefore, consistent with recommendations from previous literature, there is a great need for more qualitative research which can reveal a greater understanding of the aforementioned topics, as well as how mental wellness is culturally conceptualized. Although this research study engages participants with few qualitative questions, as suggested by previous research by Gee at al. (2020), more in depth qualitative interviews should be conducted to determine the decision making behind whether to seek resources. A commonly observed experience is the utilization of informal sources of support for this demographic population. Therefore, future studies should explore resilience levels as well as support systems utilized by Asian Canadians which may mediate the ways in which individuals interact with the mental health care system.

Based on various qualitative responses, individuals reported that a particular barrier that arose frequently was being unsure where or how to access services. Acknowledging that one requires resources is a big step, and therefore having this information readily accessible at the time of this realization may drastically reduce the perception of barriers for Asian Canadians. Previously, integration of mental health care into primary care in the US through 'The Bridge Program' was efficient and therefore a community approach which integrates mental health care into pre-existing systems that individuals already interact with regularly may rectify the disconnect of knowledge of how to access these services. Another cited concern based on qualitative reports were that individual who had accessed resources may have rated their experience poorly based on a lack of direction or progress. Based on previous literature, the implementation of client-centered or client-guided care may be incompatible with cultural variations of health for Asian identifying individuals. This is especially concerning given that individuals who self-reported as having a bad experience had lower mean scores on the IASMHS, which suggests that these experiences may act as a deterrent to care. Therefore, qualitative studies which examine preferences for care may be a step towards creating more culturally competent practice. These suggestions reflect that there should be a greater effort towards the implementation of cultural competence, given that we live in an increasingly multi-cultural world.

## References

Chiu, M., Amartey, A., Wang, X., & Kurdyak, P. (2018). Ethnic differences in mental health status and service utilization: A population-based study in Ontario, Canada. *The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie*, *63*(7), 481–491. https://doi.org/10.1177/0706743717741061

Choi, N.-Y., & Miller, M. J. (2014). AAPI college students' willingness to seek counseling: The role of culture, stigma, and attitudes. *Journal of Counseling Psychology*, *61*(3), 340–351. https://doi.org/10.1037/cou0000027

DeVitre, Z., & Pan, D. (2020). Asian American Values and Attitudes Towards Seeking Mental Health Services. *Journal of Asia Pacific Counseling*, *10*(1), 15–26. https://doi.org/10.18401/2020.10.1.2

Fung, K., & Wong, Y.-L. R. (2007). Factors influencing attitudes towards seeking professional help among East and Southeast Asian immigrant and refugee women. *International Journal of Social Psychiatry*, *53*(3), 216–231. https://doi.org/10.1177/0020764006074541

Ganesan, S., Mok, H., & McKenna, M. (2011). Perception of mental illness: Preliminary exploratory research at a cross-cultural outpatient psychiatric clinic. *International Journal of Social Psychiatry*, *57*(1), 81–89. https://doi.org/10.1177/0020764010104286

Gee, C. B., Khera, G. S., Poblete, A. T., Kim, B., & Buchwach, S. Y. (2020). Barriers to mental health service use in Asian American and European American college students. *Asian American Journal of Psychology*, *11*(2), 98–107. https://doi.org/10.1037/aap0000178

Hyland, P., Boduszek, D., Dhingra, K., Shevlin, M., Maguire, R., & Morley, K. (2015). A Test of the Inventory of Attitudes towards Seeking Mental Health Services. *British Journal of Guidance & Counselling*, *43*(4), 397–412.

Hadjistavropoulos, T., Hadjistavropoulos, H. (2019). Fundamentals of Health Psychology – Second Edition. Oxford University Press Canada.

Kim, B. K., Li, L. C., & Ng, G. F. (2005). The Asian American Values Scale--Multidimensional: Development, reliability, and validity. *Cultural Diversity and Ethnic Minority Psychology*, *11*(3), 187–201. https://doi.org/10.1037/1099-9809.11.3.187

Li, H. Z., & Browne, A. J. (2000). Defining mental illness and accessing mental health services: Perspectives of Asian Canadians. Canadian Journal of Community Mental Health, 19(1), 143–159. https://doi.org/10.7870/cjcmh-2000-0008

Kim, B. S. K., & Omizo, M. M. (2003). Asian cultural values, attitudes toward seeking professional psychological help, and willingness to see a counselor. *The Counseling Psychologist*, *31*(3), 343–361. https://doi.org/10.1177/0011000003031003008

Nguyen, D., & Bornheimer, L. A. (2014). Mental health service use types among Asian Americans with a psychiatric disorder: Considerations of culture and need. *The Journal of Behavioral Health Services & Research*, *41*(4), 520–528. https://doi.org/10.1007/s11414-013-9383-6

Nguyen, D., & Lee, R. (2012). Asian immigrants' mental health service use: An application of the life course perspective. *Asian American Journal of Psychology*, *3*(1), 53–63. https://doi.org/10.1037/a0026865

Nguyen, D., Shibusawa, T., & Chen, M. (2012). The Evolution of Community Mental Health Services in Asian American Communities. *Clinical Social Work Journal*, *40*(2), 134–143. https://doi.org/10.1007/s10615-011-0356-z

Petersen, L., & Park-Saltzman, J. (2010). Implications for counselling Asian transnational youth: The experiences of Taiwanese youth in Vancouver. *Canadian Journal of Counselling and Psychotherapy*, *44*(4), 402–420.

Sadavoy, J., Meier, R., & Ong, A. Y. M. (2004). Barriers to Access to Mental Health Services for Ethnic Seniors: The Toronto Study. *The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie*, *49*(3), 192–199

Shahid, M., Weiss, N. H., Stoner, G., & Dewsbury, B. (2021). Asian Americans' mental health help-seeking attitudes: The relative and unique roles of cultural values and ethnic identity. *Asian American Journal of Psychology*, *12*(2), 138–146. https://doi.org/10.1037/aap0000230

Tiwari, S. K., & JianLi Wang. (2008). Ethnic differences in mental health service use among White, Chinese, South Asian and South East Asian populations living in Canada. *Social Psychiatry & Psychiatric Epidemiology*, *43*(11), 866–871. https://doi.org/10.1007/s00127-008-0373-6

Tung, W.-C. (2011). Cultural barriers to mental health services among Asian Americans. *Home Health Care Management & Practice*, *23*(4), 303–305. https://doi.org/10.1177/1084822311401857

Unger, J. B., Gallaher, P., Shakib, S., Ritt-Olson, A., Palmer, P. H., & Johnson, C. A. (2002). The AHIMSA Acculturation Scale: A new measure of acculturation for adolescents in a

multicultural society. The Journal of Early Adolescence, 22(3), 225–251. https://doi.org/10.1177/02731602022003001

Whitley, R., Wang, J., Fleury, M.-J., Liu, A., & Caron, J. (2017). Mental health status, health care utilisation, and service satisfaction among immigrants in Montreal: An epidemiological comparison. *The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie*, *62*(8), 570–579. https://doi.org/10.1177/0706743716677724

## Appendix B

## Demographics

Have you completed this research study in the past?

How did you receive the link to this research study?

Are you a staff, student, or faculty member of Douglas College?

What faculty are you in?

What is your age? (ex. 22)

What is your gender? (ex. male, female, non-conforming)

What is your cultural/ethnic identity? (Japanese, Mixed, etc.)

What country were you born in?

If you were born in Canada, what generation are you? (ex. first, second, third generation).

What is your residency status? If you are an immigrant or non-permanent resident, how long have you been in Canada? (ex. 2 years)

## Mental Health

What is mental health to you?

Have you ever experienced mental health symptoms or anything you would consider a mental health issue?

Have you ever been formally diagnosed with a mental illness by a mental health professional? (e.g. depression, anxiety, PTSD)

Have you ever used mental health services? If yes, please elaborate (e.g., what type of service: 1-1 therapy, group counselling, addictions treatment, etc).

If you have used a mental health service, how often and long did you attend (e.g., once a week for 3 months, or once a month for 1 year, or only once, etc)

If you have not used mental health services, please describe why you did not access services. (e..g, family beliefs, stigma, accessibility, etc).

Were there any specific barriers you faced when trying to access these resources (e.g., financial, not knowing where to go, feelings like shame, etc).

If you have used mental health services, how would you describe them? (good experience, bad experience?)

If you are looking to use mental health services currently, is there anything stopping or preventing you from accessing services?

If you were to use mental health resources, what type of resources would you be looking for? (ex. psychologist/psychiatrist, counseling, peer support groups, medication, etc.)

How could mental health resources be more accessible or accommodating for you?

**The Asian American Values Scale- Multidimensional (AAVS-M):**

***Directions.*** Using the 7-point scale, please give your honest rating about the degree to which you personally agree or disagree with each statement. Please be as open and honest as you can.

1 2 3 4 5 6 7

**Strongly Disagree** **Strongly Agree**

___ 1. The welfare of the group should be put before that of the individual.

___ 2. One's efforts should be directed towards maintaining the well-being of the group first and the individual second.

___ 3. One's personal needs should be second to the needs of the group.

___ 4. The needs of the community should supersede those of the individual.

___ 5. One need not always consider the needs of the group.

___ 6. The group should be less important than the individual.

___ 7. One need not sacrifice oneself for the benefit of the group.

___ 8. One should recognize and adhere to the social expectations, norms, and practices.

___ 9. One should adhere to the values, beliefs, and behaviours that one's society considers normal and acceptable.

___ 10. Conforming to norms provides one with identity.

___ 11. One need not blend in with society.

___ 12. Conforming to norms is the safest path to travel.

___ 13. Conforming to norms provides order in the community.

___ 14. One should not do something that is outside of the norm.

___ 15. It is better to show emotions than to suffer quietly.

___ 16. One should be expressive with one's feelings.

___ 17. Openly expressing one's emotions is a sign of strength.

___ 18. It is better to hold one's emotions inside than to burden others by expressing them.

___ 19. It is more important to behave appropriately than to act on what one is feeling.

___ 20. One should not express strong emotions.

___ 21. One's emotional needs are less important than fulfilling one's responsibilities.

___ 22. One should not act based on emotions.

___ 23. One should achieve academically since it reflects on one's family.

___ 24. Succeeding occupationally is an important way of making one's family proud.

___ 25. Getting into a good school reflects well on one's family.

___ 26. Failing academically brings shame to one's family.

___ 27. One should go as far as one can academically and professionally on behalf of one's family.

___ 28. One's academic and occupational reputation reflects the family's reputation.

___ 29. Academic achievement should be highly valued among family members.

___ 30. One's achievements and status reflect on the whole family.

___ 31. Making achievements is an important way to show one's appreciation for one's family.

___ 32. One's educational success is a sign of personal and familial character.

___ 33. One should work hard so that one won't be a disappointment to one's family.

___ 34. It is one's duty to bring praise through achievement to one's family.

___ 35. Receiving awards for excellence need not reflect well on one's family.

___ 36. Children's achievements need not bring honour to their parents.

___ 37. One should be able to brag about one's achievements.

___ 38. One should be able to boast about one's achievements.

___ 39. One should not sing one's own praises.

___ 40. One should not openly talk about one's accomplishments.

___ 41. One should not be able to draw attention to one's accomplishments.

___ 42. Being boastful should not be a sign of one's weakness and insecurity.

**The Acculturation, Habits, and Interests Multicultural Scale for Adolescents Acculturation Scale (AHIMSA):**

***Directions.*** For each item, please choose the letter which adequately describes your honest feelings. Please be as open and honest as you can.

a. b. c. d.

**Canada** **The country my family is from** **Both** **Neither**

___ 1. I am most comfortable being with people from…

___ 2. My best friends are from…

___ 3. The people I fit in with best are from…

___ 4. My favorite music is from…

___ 5. My favourite TV shows are from…

___ 6. The holidays I celebrate are from…

___ 7. The food I eat at home is from…

___ 8. The way I do things and the way I think about things are from…

**Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS):**

***Directions.*** Using the 4-point scale, please give your honest rating about the degree to which you personally agree or disagree with each statement. Please be as open and honest as you can.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| **Disagree** | **Slightly Disagree** | **Slightly Agree** | **Agree** |

___ 1. There are certain problems which should not be discussed outside of one's immediate family.

___ 2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.

___ 3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.

___ 4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.

___ 5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.

___ 6. Having been mentally ill carries with it a burden of shame.

___ 7. It is probably best not to know everything about oneself.

___ 8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.

___ 9. People should work out their own problems; getting professional help should be a last resort.

___ 10. If I were to experience psychological problems, I could get professional help if I wanted.

___ 11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.

___ 12. Psychological problems, like many things, tend to work out by themselves.

___ 13. It would be relatively easy for me to find the time to see a professional for psychological problems.

___ 14. There are experiences in my life I would not discuss with anyone.

___ 15. I would want to get professional help if I were worried or upset for a long period of time.

___ 16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.

___ 17. Having been diagnosed with a mental disorder is a blot on a person's life.

___ 18. There is something admirable in the attitudes of people who are willing to cope with their conflicts and fears without resorting to professional help.

___ 19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.

___ 20. I would feel uneasy going to a professional because of what some people would think.

___ 21. People with strong characters get over psychological problems by themselves and would have little need for professional help.

___ 22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

___ 23. Had I received treatment for psychological problems, I would not feel that it ought to be 'covered up'.

___ 24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.