Stressors and coping strategies of ethnic minority youth: Youth and mental health practitioners' perspectives

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ARTICLE INFO

ABSTRACT

In this paper, we explore the mental health needs of ethnic minority youth in Hong Kong and examine the importance of mental health practitioners' cultural competence in an Asian context. Within a qualitative paradigm, five mental health practitioners who provide mental health services to ethnic minority youth were interviewed. A total of 38 young people (16 Pakistanis and 22 Filipinos) from ethnic minority backgrounds were also placed into six small groups. Each individual attended a meeting at which he or she discussed stressors and coping methods. The participants were individually interviewed immediately after the group meeting, to help us gain an understanding of their experiences in a group setting in regard to discussing their stress. We show in this exploratory study how the stressors and coping methods of young people from ethnic minorities align with their cultures and ethnicities. They demonstrated a paradoxical attitude toward disclosing their personal needs and problems. Chinese mental health practitioners, however, tended to underestimate the needs of ethnic minority youth and believed that they were less willing than were other youth to disclose their personal problems. The findings of this study suggest that cultural distance between ethnic minority youth and mental health practitioners is a barrier to multicultural mental health services. Hence, cultural competence should be further promoted and integrated into daily clinical practice.

1. Introduction

In Hong Kong, Indonesians, Filipinos, Indians, Pakistanis, and Nepalese are the main ethnic minority groups (Chinese being the dominant ethnic group). The ethnic minority population has increased in recent decades, now constituting 8% of the Hong Kong population. Filipinos and Pakistanis make up 2.5% and 0.2% respectively (Census and Statistics Department of the Government of the Hong Kong Special Administrative Region [HKSAR], 2017). Although the minority population has increased significantly, mental health services in Hong Kong have not kept up with the population change. First, there is a lack of ethnic-specific mental health services. Mental health services have expanded significantly across the territory in the past ten years, but the focus has been on providing services to clients from the mainstream culture. Second, in professional training (e.g., of social workers) little effort has been made to instruct frontline practitioners in how to serve clients from non-mainstream cultural backgrounds. Third, there is little published guidance and little research on the implementation of cultural competence in mental health services.

Against this background, the present study was triggered by the curiosity of a group of mental health practitioners from a Hong Kong mental health organization. One of their main duties was to offer mental health care service in secondary schools. They reported to us that they were unsure whether their usual mental health education groups were suitable for young people of ethnic minority backgrounds. They had found that many of these young people rarely mentioned their emotional problems; they seemed, in fact, to experience no significant stress problems. Even if, in a group setting, some of them mentioned a sad experience, others could laugh and shift the topic. Not being familiar with the needs of ethnic minority youth, these practitioners wanted to identify their unmet mental health needs, if any, and explore feasible intervention methods.

We consider ethnic diversity to be an important issue highly relevant to mental health care service: everyone should have the opportunity to access and benefit from mental health services. Hence, we (the research team) joined up with the above-mentioned group of mental health practitioners in order to examine the mental health needs of ethnic minority youth in Hong Kong. The aim of this study is to understand the mental health needs of ethnic minority youth and the mental health practitioners' perceptions of these youth.

2. Cultural barriers in the provision/use of mental health services

There has been extensive research on the specific needs of ethnic minorities in the mental health service context. Although many of the studies have been conducted in the US and with a focus on Asian Americans, they may help us understand the mental health needs of the members of ethnic minorities across contexts. A common issue among ethnic minority populations is the low rate of utilization of mental health services, which has drawn the attention of many researchers (Albritton, Angley, Gibson, Sipsma, & Kershaw, 2015; Bui & Takeuchi, 1992; Flaskerud, 1986; Garland et al., 2005; Kim & Zane, 2016; Leong & Lau, 2001; Scheffler & Miller, 1991; Snowden & Cheung, 1990; Takeuchi, Sue, & Yeh, 1995; Valdez & Langellier, 2015).

Ethnic disparities in the provision/use of mental health services result from cultural barriers (Okazaki & Ling, 2013; Primm, Lima, & Rowe, 1996) rather than from ethnic minorities having less need of such services. The cultural barriers can be classified into three major aspects: 1) language, 2) understanding of mental health issues, and 3) coping habits.

2.1. Language

Language and communication barriers have been found to be one of the most profound factors that affect minorities' help-seeking behaviour on mental health services across the world (Dastjerdi, 2012; Emami, Benner, & Ekman, 2001; Hassett, George, & Harrigan, 1999). Language barriers caused by the language differences between minorities and practitioners could affect minorities' understanding of existing services, expectations of outcome, and even trust-building toward the health care system and with the practitioners. Language capacity, a quintessential factor for communication, not only allows minorities to engage in the course of treatment but most importantly to articulate the cultural specifications and concerns to the practitioners for accurate analysis of the mental health condition.

It has been reported that ethnic minorities, especially South Asians, experience significant challenges in Hong Kong and that public services are often inaccessible to them due to language barriers (Census and Statistics Department of the Government of the HKSAR, 2012; Kapai, 2015). The first languages of most Filipinos is English or Filipino, and the first language of most Pakistanis is Urdu. Although some members of Hong Kong's ethnic minority population can speak Cantonese, many are not yet proficient; but Hong Kong's mental health profession is dominated by Hong Kong Chinese who mainly speak Cantonese.

2.2. Understanding of mental health issues

Cultural beliefs, norms and values construct a person's perception of reality. Studies show that different kinds of ethnic cultures have a big influence in shaping an individual's perceptions of mental health. Religious beliefs and spirituality dominating certain ethnic cultures are found to have constructed the concepts and understanding of mental health.

In examining ethnic minorities' understanding of mental health and their experiences of mental health services in the UK, researchers found that members of some ethnic minorities believe mental illness results from "bad thoughts", lack of will power, and a weak personality (Suan & Tyler, 1990). Leavey, Loewenthal, and King (2007) found that Muslims tend to believe that mental illness is not an illness but rather possession by jinn (a magic spirit) and therefore tend to seek help from imams (Muslim religious leaders) rather than from mental health professionals. Traditional Indian communities also consider mental health an "inherited idiosyncrasy, a family curse, or a life-long affliction with supernatural origins" (Leung, Cheung, & Tsui, 2011, p. 55). Wang, Locke, and Chonody (2013) found that non-white Americans displayed a stronger tendency to normalize mental illness, and African Americans exhibited a stronger tendency to view mental illness as caused by immorality or sinfulness.

2.3. Coping habits

These beliefs not only affect members of a particular ethnicity's perception of mental health but also their help-seeking behaviours. Individuals attributing mental health conditions to religious beliefs tend to seek help from the religious or spiritual leaders. Some South Asians, for example, tend to consider that "everything is being determined by the past and the present karma, and that there is nothing a person can do to change one's fate" (Kulanjiyil, 2010, p. 98).

It was found that individuals tend not to speak about their problems to non-family members, especially in Asian countries, due to the influence of traditional culture. One reason is that they are afraid their own situation would not be understood by others. Another is that, in collectivist cultures, family and community are prioritized, so it is perceived to be important to maintain the honour of the family and the community instead of individual needs (Hunt & de Voogd, 2007; Zwi, Woodland, Kalowski, & Parmeter, 2017). Therefore, individuals would turn to their family members for help instead of finding outside professional assistance. Cooper et al. (2003) found that race and ethnicity are related to whether or not people seek professional help. Specifically, race and ethnicity are related to people's beliefs about the causes of life problems, and their willingness to discuss personal problems with people outside the family (including professionals). The literature also suggests that ethnic minority service users may feel suspicious of other group members and professional service providers, so they tend to be reluctant to discuss their personal problems with them (Chen, Thombs, & Costa, 2003).

3. Cultural diversity and professionals' cultural competence

It is important to point out that having cultural diversity does not necessarily imply having barriers in the provision/use of mental health services. The causes of the barriers are not one sided and the barriers can be overcome if mental health practitioners can take into account ethnic differences and accommodate the cultural characteristics of clients from different cultures. In culturally diverse communities, mental health practitioners are expected to demonstrate cultural competence, "the ability to engage in actions or create conditions that maximize the optimal development of client and client systems" (Sue, 2001, p. 802).

Cultural competence can be developed by understanding the cultural characteristics and traditions of ethnic minorities. However, it is by no means an easy task, especially under the evolving cultural discourse. Generational differences can be observed in upholding traditional cultural values. The older generation tends to hold onto more traditional beliefs, whereas the younger generation shows evolving cultural adaptions, especially in migrant communities where they have more exposure to the host societies' cultures which are different from the traditional culture (Zwi et al., 2017). When culture is contextualized, it no longer refers only to ethnic-based culture; rather it is developed according to contextual demands, depending on the norms, values, language and institutions that a person identifies with (Cauce et al., 2002). The socioeconomic status of an individual also influences his or her cultural adaptation. Migrant and minority young people have a high level of interaction with the predominant cultural society and show a higher level of cultural shift from their traditional home cultures. Such shifting of cultural discourse imposes more challenges on the cultural competence of mental health care services and practitioners.

Another challenge faced by practitioners to achieve cultural competence is to obtain adequate cultural self-awareness (Lum, 2010; Yan & Wong, 2005). Language difference can be immediately noticed by practitioners. However, it may be harder for them to be sensitive to the different cultural assumptions of minorities and mainstream culture. Without this sensitivity, practitioners may take for granted their own