



Comparing the mental health literacy of Chinese people in Australia, China, Hong Kong and Taiwan: Implications for mental health promotion



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ABSTRACT

Using data of 200, 522, 572, and 287 Chinese from Australia, China, Hong Kong and Taiwan respectively, this study aimed at comparing the mental health literacy of Chinese people from different communities, and between Chinese communities and the Australian general public. The participants were asked questions that assessed their recognition of depression and schizophrenia. Compared with the Australians, much lower percentages of Chinese in the four Chinese communities could correctly identify depression and early schizophrenia. Commonalities in the preference for ‘psychiatrist’, ‘psychologist’, ‘Chinese medical doctor’, and ‘Chinese traditional healer’, a lack of knowledge of medications, and a higher likelihood of endorsement of traditional Chinese medicines were found among the four Chinese communities. Differences in the preference for ‘general practitioner’ and ‘social worker’, and a higher percentage of endorsement of herbal medicines were observed among the different Chinese communities. Cultural factors such as Chinese perceptions of mental illness, and socio-contextual factors such as differences in mental health care system in the four communities were offered to explain these commonalities and differences. Mental health promotion programmes for Chinese people may need to consider the above-mentioned cultural and socio-contextual factors so that specific promotion programmes can be developed.

1. Introduction

Mental health literacy refers to “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm, 2000). Inherent in this concept is the assumption that individuals who have a higher level of mental health literacy will be more willing to seek professional help for themselves or for people who may be suffering from a mental disorder. Jorm et al. (2007) maintain that people who do not have sufficient knowledge of mental illness may have difficulty recognising the symptoms of a mental disorder, and cannot adequately communicate information to others. Consequently, this lack of knowledge may lengthen the duration of an untreated mental health condition (Drake et al., 2000). In Chinese communities, studies have generally found that Chinese people have a much lower level of mental health literacy when compared to other cultural groups (Wong et al., 2010, 2012). For example, far fewer Chinese people in

Hong Kong and Australia could correctly recognise depression and schizophrenia compared to the Australian general public (Wong et al., 2012). These cited studies also found that there was a large number of Chinese people who did not have much understanding of the medical treatments for people with mental illness (e.g., drugs and hospitalisation) and some espoused the helpfulness of traditional medical and social treatments for their mental health problems.

Cultural values and practices influence both the perception of mental illness and the subsequent choice of treatment modalities (Mubbashar and Farooq, 2001). An understanding of the cultural dimension of the knowledge of mental illness can lead to greater understanding of the factors influencing the help-seeking behaviours of Chinese people with mental health problems. In addition, it can lead to the development of culturally relevant models and strategies to facilitate the general public to receive appropriate help in a timely manner. Incidentally, epidemiological studies on help-seeking behaviours of

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Chinese often conclude that Chinese people experience a long delay of one to two years in help-seeking (Lam, 2001; Phillips et al., 2000). This is a serious concern because individuals with a longer duration of untreated psychiatric conditions are likely to be less responsive to treatment in general and require more resources and long-term intensive intervention (Wang et al., 2007).

Traditional causal beliefs of mental illness are consistently mentioned in the literature as being related to a lowering of mental health literacy among Chinese people. In Chinese culture, Confucianism, Buddhism and Taoism contribute to the contents of several traditional perspectives on health beliefs about mental illness: moral, religious, cosmological and traditional Chinese medical perspectives (Lin, 1982). The moral perspective regards mental illness as a punishment for the misconduct of family members and/or their ancestors. The religious and cosmological perspective suggests that mental illness is a fate inflicted by the supreme beings. Taoist priests or folk healers often perform prayers and make offerings at temples or render shamanistic rites as healing rituals (Lin, 1982). Traditional Chinese medical beliefs of illness emphasise the proper balance of Yin and Yang forces and the correct proportion of the Five Elements: metal, wood, water, fire, and earth (Lin, 1982). An excess or deficiency in any of the five elements and the imbalance of the yin–yang forces have been assumed to lead to different types of mental health problems. Chinese people use herbal and dietetic remedies to restore the proper balance of these different forces and elements in the body (National Institutes of Health, 2015).

While studies generally suggest that very few Chinese people continue to believe in the moral, religious and cosmological perspectives, there is evidence to suggest that many Chinese people still adhere to the traditional Chinese medical perspective of mental illness (Wong et al., 2012). However, due to different levels of modernity, variations in the level of adherence to traditional views of mental illness may exist among Chinese in different parts of the world and in different areas within Chinese society.

While culture may play an important part in shaping the knowledge of mental illness among people of a cultural group, general statements about cultural characteristics of a given cultural group may invite stereotyping of individuals based on their appearance or affiliation (Department of Health and Human Services, 2001). Due to differences in geographical, social, economic and policy contexts, Chinese people living in different parts of the world may have different levels of knowledge about mental disorders and may perceive the causes of mental illness – as well as the helpfulness of certain mental health professionals, medications and interventions – differently. It is of interest to explore the extent to which some of these perspectives may still be held and practiced by Chinese people, in addition to exploring the variations that may be found in different Chinese communities. Such an exploration of the commonalities and differences in the mental health literacy found among different Chinese communities will provide specific information towards developing culturally relevant strategies for addressing the issues of mental health knowledge of Chinese people.

In this study, we included four sets of data on mental health literacy of Chinese people, namely, Chinese in Australia, China, Hong Kong and Taiwan. We also included one set of data from the Australian general population from Reavley and Jorm's study (2012). We chose these five samples for comparison because, on the one hand, a comparison with the Australian sample might elucidate the possible cultural differences in the preference for professional help, medications and treatments between Australians and Chinese. On the other hand, a comparison among different Chinese samples (i.e. presumably to be culturally more homogeneous) might illuminate the socio-contextual factors accounting for differences in the preference for professional help, medications and treatments between the four communities. Through these comparisons, we hoped to identify the patterns of mental health literacy among the four Chinese communities and explore possible cultural and socio-contextual factors that may explain the commonalities and differences

in the findings regarding the preference for professionals, medications and treatments among Chinese people in the four Chinese communities.

1.1. Objectives

- (1) To understand the commonalities and differences in the knowledge of mental illness and preference for professional help, medications and treatments among Chinese people in Taiwan, Hong Kong, Shanghai, China and Melbourne, Australia.
- (2) To explore the possible socio-contextual factors that may account for the commonalities and differences in the knowledge of mental illness and preferences for professional help, medications and treatments among Chinese people in Taiwan, Hong Kong, Shanghai, China and Melbourne, Australia.

2. Method

2.1. Procedure

This study adopted a comparative approach to identify the similarities and differences in mental health literacy among five sets of data using the same questionnaire and response formats developed by Jorm et al. (1997). Ethical approvals were sought in their respective studies and informed consent was obtained from all individual participants (Wong et al., 2010, 2012). Brief descriptions of the sampling methods are presented below (Table 1):

2.1.1. Chinese Australian

This study adopted a cluster convenience sampling method in which subjects were taken from the four main areas of cosmopolitan Melbourne where most Chinese people in the country live, namely, Box Hill, Doncaster, Monash and Preston. The participants were recruited through social service organisations that serve the Chinese population in these four areas in 2008. Potential participants who were interested in the study then approached the research team for further clarification. The selection criteria for participants included being 18 or over, being an Australian or an immigrant of a Chinese-speaking background and being a first-generation migrant living in Melbourne. A total of 200 participants were recruited. Face-to-face interview was conducted by mental health workers of local social service organisations. The Chinese Australian sample was found to be broadly comparable to the population of Chinese-speaking Australians and immigrants described in the Australian Census, except that the female-to-male ratio is higher than those reported in the census (Wong et al., 2010).

2.1.2. Shanghai Chinese

A multistage cluster sampling method in which participants were randomly selected from six of the 20 districts in Shanghai, China was adopted for this study in 2010. One resident committee was randomly selected from each district before 1% of the households in each of the six chosen districts were approached. The first adult, between the ages of 18 and 60, that the research assistants met was then asked to fill out

Table 1
Detailed information on individual survey of Chinese communities.

	Time conducted	Languages	Mode of survey
Chinese Australian	2008	Traditional Chinese & Simplified Chinese	Face-to-face
Shanghai Chinese	2010	Simplified Chinese	Face-to-face
Hong Kong Chinese	2008	Traditional Chinese	Face-to-face
Taiwan Chinese	2015	Traditional Chinese	Face-to-face

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