Access to Mental Health Care for East Asian Immigrant Youth

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List of Acronyms

MHC	Mental health care
GP	General practitioner
GGZ	Geestelijke Gezondheidszorg (Dutch mental healthcare)
CBT	Cognitive-behavioural therapy
ADHD	Attention-deficit hyperactivity disorder

Abstract

East Asian immigrant youth are a large and growing population in Europe. As young people who are expected to successfully navigate and have fully adapted to living in the country of residence, East Asian immigrant youth face many challenges which affect their mental health. Yet, despite the numerous studies which show the high prevalence of mental health problems and the underutilization of mainstream mental healthcare services by East Asian immigrant youth living in the west, few studies have been conducted on the help-seeking behaviour and use of mental health services by East Asian immigrant youth in Europe. This study aims to find the factors which impact help-seeking behaviours and utilization of mental health care (MHC) in the Netherlands. Information was gathered through semi-structured, in-depth interview with 6 East Asian participants. 4 participants were East Asian immigrant youth who have experience in utilizing or is currently utilizing the MHC in the Netherlands. 2 participants are professionals who currently work in the mental healthcare sector and identify as East Asian. Findings showed that help-seeking behaviour and utilization of MHC were affected by familial and cultural factors, stigma, previous exposure and experience to MHC, inadequate knowledge of mental health and MHC, affordability, and language barriers. The study was exploratory and due to the limited number of participants, was not able to examine other variations of sources of stress and factors to underutilization of MHC. The provision of relevant information on mental health and MHC for East Asian immigrant youth and the communities which they frequently interact with, would be beneficial to increase awareness and improve access. Understanding East Asian culture for practitioners in the mental healthcare sector would be important to increase access and provide culturally sensitive, quality services.

Relevance to Development Studies

Mental health is a component of public health and in order for the population to be healthy, mental health care, like health care, should be easily and accessible to the population. However, disparities exist, which make it difficult for certain groups of the population to not have access to it. Due to high prevalence of mental health problems, youth mental health, including mental health for East Asian immigrant youth, is a serious public health and development issue. Moreover, struggles with mental health while dealing with complex issues of racial discrimination, stereotypes, and stigma make this research significant for the field of development studies.

Keywords

Mental health, mental health care, accessibility, East Asian immigrants, East Asian immigrant youth, immigrant health, the Netherlands

Chapter 1
Introduction

Predominantly, Asian immigrant youth are seen as academically, economically, and socially more successful compared with other ethnic minority groups. This view perpetuates the "model minority" myth, which is a term given to stereotype Asians in the United States as being "universally high achieving and free from experience of systematic racism" (Arora & Khoo, 2020, p. 2590). This misperception supports the common belief that Asians are resistant to mental health problems and are better equipped to manage such problems compared with other minority groups (Cheng et al., 2018, p. 573). Immigrants of East Asian descent (i.e., people of Chinese, Japanese, and Korean heritage) in particular are more prone to this stereotype and are perceived to be academically and economically more successful compared to their other Asian minority groups (Lee, 2022, p. 118). Research proves however that Asian immigrant youth are at high risk of mental health problems. Despite being a highly vulnerable group with regards to prevalence of mental health problems, studies show that Asian youth have the lowest rates of utilization for mental health services (Arora & Khoo, 2020; Bear et al., 2014; Guo et al., 2013). The findings of these studies offer several factors which impact the underutilization of mental health care (MHC), such as stigma towards mental health care, mental health literacy, and the role of family and their perceptions around mental health care.

Many research has been conducted of mental health problems and accessibility of mental health care for East Asian migrants and migrant youth in the United States (Arora & Khoo, 2020; Cheng et al., 2018; Lee, 2022; Sim, 2021; Yang et al., 2020; Yasui et al, 2022), Canada (Fung et al., 2019; Moon et al., 2019) and Australia (Minas, 2022; Wynaden et al, 2005). However, a prominent gap exists in research for East Asian immigrant youth in European countries. Using a qualitative approach, this study sought to determine factors which impact access to mental health care for East Asian immigrant youth in the Netherlands. For the purpose of study, East Asian immigrant youth will be referred to as East Asian youth. Cauce et al.'s (2002) Model for Mental Health Help Seeking was used to understand the youth's help-seeking attitudes. The model is based on the main assumption that culture and context influences each of the three interconnected domains of the model, which are, (a) problem recognition, (b) decision to seek help, and (c) service selection. Through the model, the study further explored in what ways the factors are linked and how

they impact the decision of East Asian youth to seek mental health care. It is vital for mental health care providers to recognize the cultural aspects which dictate the perceptions around mental health issues and MHC to provide services which are accessible and of high quality.

Research objectives and questions

The main purpose of this study is to identify the factors which impact help-seeking behaviour and access to mental health care in the Netherlands for East Asian youth through a qualitative approach. The objective derives from the aim of this study, which is to analyze the factors which affect the utilization of mental health care in the Netherlands for East Asian youth. Therein, the research questions for the study are as follows:

- What are the factors which impact help-seeking behaviour and access to MHC for East Asian youth?
- How have these factors emerged?
- How do the factors impact the help-seeking behaviour and access to MHC for East Asian youth?

Relevance of research

Although there is a growing population of East Asian migrant youth in Europe, research on the demographic is limited. Specifically, studies in relation to mental health care for East Asian migrant youth is scarce. Studies in other Western societies show the high prevalence of mental health problems and the low utilization rate for mental health care of East Asian youth. This study will provide new perspectives in approaching factors which influence professional help-seeking behaviour by East Asian youth, and the accessibility of mental health care services. Within the East Asian communities, the study will spread awareness of mental health concerns and how mental health services can be useful to help alleviate mental health distress, which will evidently increase mental health literacy and lower stigmatization of mental health care. Furthermore, the findings from this study will provide valuable information for institutions, general practitioners (GPs) and mental health care practitioners to recognize the role of culture in the perceptions of health, mental disorders and mental health care which can assist in accurate assessment, diagnosis and treatment of East Asian youth and migrants.

Methodology

A qualitative research methodology has been employed in this study. Semi-structured, in depth interviews (Hennink et al, 2011) were conducted to collect data, using a sample of participants recruited through various community and social media platforms where a large East-Asian immigrant population is present. The platforms include the Facebook page of Asian Raisins, which is a group formed in 2020 to fight against discrimination and racism of Asian groups, and Aiming High in the Low Lands, a community page of South Korean immigrants residing in the Netherlands. Due to the nature of the topic at hand which involves the participants sharing sensitive information and the stigma which still exists around mental health issues, it was difficult to find participants through the social media platforms. One participant was recruited via the social platform and the snowball effect was then implemented to recruit further participants. The snowball effect was the most effective method of recruitment, although it took a longer period of time than expected to recruit the target number of participants. The interviews were conducted between August and October 2022, and conducted in locations, which were mutually agreed. The duration of each interview was between 1.5 to 2 hours long. The interviews were audio-recorded and transcribed verbatim. The interviews document the participants' personal accounts of their experience growing up or living in the Netherlands as an immigrant, their experiences with dealing with mental health distress, as well as their experiences with seeking mental health services in the Netherlands. The guiding questions can be found in Appendix 1.

Interviews were conducted with 6 participants (4 females and 2 males) in total (see Appendix 2). Participants had to fulfil four categories, which were: (a) self-identifying as East Asian; (b) currently residing in the Netherlands; (c) between the ages of 18-35, and (d) having had previous experience in seeking and/or utilizing mental health services in the Netherlands. Four of the participants were East Asian immigrant youth who had previous experience and/or were currently utilizing mental health services in the Netherlands. For the purpose of this study, youth were defined as individuals between the ages of 18 and 35 years. East Asians are defined as someone with one or both parents who are a native of China, Japan, Korea (both North and South) and Taiwan. Two practitioners working within the mental health care sector were also interviewed to include insight of their experiences around mental health care for East Asian immigrant youth.

Due to limitations of finding participants, an online survey (O'Leary, 2017) was created to support the findings of the study. The survey was anonymous and consisted of 6 questions in total. Three of the questions covered on demographics and three questions were regarding mental health care (see Appendix 3). The survey was uploaded on the Asian Raisins platform and received 7 responses during a span of 1 week in October 2022. Due to the low number of responses, it cannot be considered or analyzed as quantitative data, however, the responses were interesting and further established the findings from the qualitative interviews.

Ethical considerations

Prior to the interviews, each participant were given a consent form which outlined the following: the interview will be audio-recorded under the consent of the participants, the data shared by the participants during the interview will only be used for research purposes, the participants will be pseudonymized, and data which could potentially identify the participants will be modified accordingly. Due to the topic at hand, the interviews may involve discussions around sensitive issues on personal struggles and experiences which led to seeking mental health care, the participants could opt not to answer a question or withdraw from the interview altogether at any moment, if they felt they no longer wanted to participate.

Position of researcher

I am a second-generation Korean African, raised in South Africa, and currently reside in the Hague, Netherlands. I grew up in a Korean speaking household which strictly followed Roman Catholic and Confucianism principles. During my childhood, I've experienced countless accounts of racism and discrimination in the classroom, in the playground, at supermarkets and on streets, due to my ethnicity. As a young child, it was difficult to understand the emotions I was feeling as I wasn't taught about the concept of racism and discrimination, nor how to process the emotions which came with it. Although racism, racial bias and discrimination were prevalent in my daily environment, the topics were never discussed or examined within my household, the school, or any social settings, until I entered high school.

Growing up in this environment generated mental health distress and caused a lot of confusion around my identity. In my early twenties I sought mental health care and

uncovered a lot of suppressed emotions. In my late twenties, I was looking to start therapy again, but due to different reasons, I opted not to at that moment. I understand that I may be perceived as an outsider to the East Asian IOY in the Netherlands, as I have not been raised here and lived long enough to understand the socioecological setting of the country, however, I believe that I can relate to some of the issues they are facing as East Asian immigrant youth, growing up in a household and country where the culture and values are different, and as someone who has experienced mental health problems, and has sought professional help.

Chapter 2
Context / Background

Trends in 2020 illustrated that 12% of the Dutch population aged over 12 years experienced mental health concerns with an increase in the fourth quarter of the year, due to the prolonged restrictions of the COVID-19 pandemic. Mental health issues were more prevalent in the age group 18-39 years, when compared with the oldest and youngest age groups (Statistics Netherlands, 2021). In 2021, there was an increase to 18% of young people reporting to be mentally unwell (Statistics Netherlands, 2022). One article (Van Emmerik & Prins, 2022) outlined that in terms of mental health and mental healthcare use, 43.5% of the Dutch population received life-time diagnosis of mood disorders listed in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders), which provides a framework to classify disorders and define diagnostic criteria. Only 33.8% of clients with these disorders received mental health care (formal or informal) during the past year, and two-thirds did not receive any form of care.

Treatment, process of treatment and cost coverage

CBT (cognitive-behavioural therapy) is the first-line intervention administered in the Dutch treatment guidelines for common mental disorders (Van Emmerik & Prins, 2022). Relative to the general population of 17.5 million people, Netherlands has the highest number of cognitive behavioural therapists in Europe, and presumably the world. The Netherlands also ranks third in Europe, and presumably the world, for the absolute number of cognitive behavioural therapists when taking into account the number of members of cognitive behavioural therapy associations (EABCT, no date). Mental healthcare services (MHCS) are also generally affordable to most people over the age of 18 due to its entire or partial coverage by the basic healthcare insurance which is compulsory in the Netherlands. Despite it being seemingly accessible and affordable, due to issues of provision and funding, it has become confusing and complicated for clients and practitioners alike, to steer through the mental healthcare system (Van Emmerik & Prins, 2022).

Clients wanting to seek mental healthcare services are required to go through a long and burdensome process. Clients are first required to be registered with a general practitioner (GP), in which together with the general practice mental health worker, mild mental health concerns are treated. Online counselling (e-health) has also become an option to mental

healthcare after the COVID-19 pandemic started. If the GP and the general practice mental health worker deems the mental health concern as complex, a referral is provided for a primary or secondary mental healthcare provider, which are registered with the Dutch Association of Mental Health and Addiction Care (GGZ Nederland). Mild to moderate mental health concerns are treated by primary mental healthcare providers in the form of counselling with a psychologist, psychotherapist, or psychiatrist, a form of online mental health support (e-health), or a combination of counselling and online support. Secondary mental healthcare provides treatment by psychiatrists or clinical psychologists for clients with serious and complex psychiatric disorders, like ADHD, anxiety disorders, or post-traumatic stress disorder (PTSD). In certain instances, clients are required to be admitted to a mental health institution to treat serious and complex psychiatric disorders (Ministry of General Affairs, 2022).

Possibly due to aforementioned issues with funding and provision, practitioners and professionals in mental healthcare providers are strained with high amounts of administrative tasks and clients with long waiting times (Kiers, 2018). Clients are placed on waiting lists until the intake session, which is to assess the client, and the start of treatment. The maximum waiting time formally administered is 4 weeks to intake and 6 weeks from intake to the first treatment session. However, in 2018, the waiting time on average was 20 weeks for clients with personality-related disorders (Michas, 2020). The average waiting time for clients with unexplained pain and fatigue, in comparison, was 10 weeks (Ibid.). In 2014, a major reform was introduced in the mental health sector which aimed for clients to receive treatment in primary healthcare centres (preferably general practices), alternative to specialized mental healthcare centres which were costly (Magnée et al., 2017). GPs act as gatekeepers which only refer clients meeting formal criteria for psychiatric disorder to mental health care for short-term treatments of 12 consultations. One study (Magnée et al., 2017) which examined the feasibility of the new policy demonstrated that regardless of allocation of suitable treatment, clients showed improvement of symptoms in the allocated treatment period. However, the improvement of symptoms may be due to the good quality of treatment in the participating GPs. Solo-operating GPs or GPs without adequate mental health expertise need to be further explored. In the case the clients require further mental health care, it creates an additional step to take in getting referred to a mental health care, registering and waiting, which can become burdensome.

Health insurance in the Netherlands covers all or partial costs of primary and secondary mental healthcare services. The coverage differs according to the insurance company and

policies which the insurance company follows (Ministry of General Affairs, 2022). Certain private psychotherapy practices do not require referrals by the GP, have no long waiting times and provide a larger variety of therapy approach options other than CBT, such as body-mind psychology, expressive therapy, religious counselling, etc. in different languages other than Dutch and English. The treatments from these private practices, however, are largely not covered by the basic healthcare insurance, as they are not registered with the GGZ. This requires clients to take the full burden of the treatment costs, unless clients have supplementary insurance which could cover the treatment costs.

Factors affecting access to mental health care for youth in the Netherlands.

In addition to the above challenges, certain factors exist which impact youth in the Netherlands to access mental health care. Leijdesdorff et al. (2021) outlines multiple factors for Dutch youth in seeking and accessing mental health care which were categorized into three themes: (a) attitudes toward mental health concerns and seeking help, (b) entrance to care, and (c) in care itself. In the first theme of "attitudes toward mental health concerns and seeking help", the youth felt an array of different emotions toward mental health issues such as shame and fear of being stigmatized. They perceived themselves as being weak and felt obligated to fix the mental health issue themselves. They also worried that they would be a burden to family members and friends. Among students who had come to study in the Netherlands from abroad worried that seeking mental health care would be a threat to their future trajectory in finding work in the Netherlands. Prior exposure of seeking mental health care from own experiences or from other people also heavily impacted their expectations of future help-seeking.

The second theme of "entrance to care" explored mental health literacy, especially with regards to awareness of available resources to get help. The long waiting times and diagnostic assessment added to the delay in the process to get mental health care. Another concern was whether their condition was deemed severe enough to receive compensation from health insurance. The third theme of "in care itself", explored additional waiting times for youth who had to receive another referral due to their mental health issue being too severe or complex for the centre they visited. During treatment, cases of therapists leaving or the youth having to stop treatment due to residential relocation caused the treatment to be stopped prematurely which led to continuity of symptoms.

Chapter 3
Literature review

Despite the high prevalence of mental health distress, East Asian immigrants in Western countries display the lowest rate of seeking mental health care, compared to other ethnic-racial minority groups (Yang et al., 2020). This trend is also visible in adolescents and young people, where among Asian adolescents who was diagnosed with depression, only 19% had chosen to receive any treatment which compared with other racial-ethnic groups is significantly lower (White 40%, Black 32%, Latino 31%) (Arora & Khoo., 2020). This chapter will first examine East Asian culture, grounded on Confucianist principles, which is deeply embedded in familial norms and expectations as well as self-identity. The mechanism of emotion and mental health socialization will be explored on how East Asian familial norms and beliefs impact mental health of East Asian youth, as well as shape perceptions and attitudes in seeking and accessing mental health care. Furthermore, Cauce et al.'s (2002) Model for Mental Health Help Seeking, which is used to understand the youth's help-seeking attitudes, will be articulated. The model is based on the main assumption that culture and context influences each of the three interconnected domains of the model, which helps to understand how different factors contribute to each other and how they impact attitude and decision-making of young people to seek mental health care.

Acculturation and biculturalism

East Asian culture, which is largely influenced by Confucianist principles and teachings accentuates the prioritization of the needs of family over the needs of the individual family members. This constructs the basis of self-worth, where the achievements or failures of an individual equates to the achievements or failures of the family (Au, 2016). This orientation of collectivistic culture is a stark contrast to the individualistic culture of Western societies, which immigrants encounter post-migration. The traditions and values of the collectivistic East Asian culture prove both beneficial and detrimental on mental health in relation to stress. Au (2016) explains that individual's choices and behaviours heavily reflect their obligations to their family, to maintain a sense of filial piety. Consequently, the individual is portrayed as being more susceptible to accept family practices and beliefs, such as mental health treatment being seen as a threat to the social status of the family and thereby being

discouraged to seek professional help. Despite it reinforcing stress and stigma against mental health, the closeness and affection of the family is also a powerful contributor to counteract the stigma around mental health. A study by Bernstein (2007) on perceptions and understanding of mental health and illness by Korean American immigrants, demonstrated that the few Koreans who did seek mental health services did it for other family members.

Within an immigrant family, the parents and children are highly interdependent and have a strong belief that due to the "sacrifice" made by the parents to immigrate and provide a better life for the family, the children are expected to take advantage of the academic opportunity and succeed (Moon et al., 2019, p. 9). Education is seen as a mechanism to advance in society, and achievements in academics and career of an individual are aligned with collectivistic values, whereby it is perceived as the "rightful homage to their familial social status" (Au, 2016, p. 4). Individuals who were solely dedicated to education were less inclined to behave in problematic or delinquent ways which would bring dishonour to the family's social status. However, promoting the importance of academic achievement came at the cost of the individual's mental health, as disregarding their interests and emotions led to internalization of distress, causing social anxiety, depression and suicide (Au, 2016, p. 6; Moon et al., 2019, p 10).

Due to the image of being overachievers and highly dedicated to academics, East Asian immigrant youth are faced with the "model minority" stereotype which further perpetuates distress by having the need to conform to expectations (Cheng et al., 2016; Sim, 2021). The model minority stereotype is a common misperception, thereby called the model minority myth, in which East Asian immigrants in the United States are viewed as well-adjusted, high-functioning, high achievers who are more academically, economically and socially successful than other racial-ethnic minority groups (Cheng et al., 2016, p 573; Tran et al., 2021, p. 457). This stereotype illustrates East Asian immigrants as a homogenous ethnocultural group and reinforces the common belief that the population is not affected by mental health issues which ultimately overlooks the wide range of mental and physical health problems the diverse East Asian immigrant communities experience (Cheng et al., 2016). Furthermore, it also leads to misdiagnosis or underdiagnosis by practitioners, when help is actually required. The stereotype also dismisses one of the most common factors which consistently is reported as a major stressor to poor mental health of East Asian immigrants, which is racial discrimination (Tran et al., 2021, p. 457).

East Asian immigrant adolescents and young people, especially the second-generation, have higher prevalence of mental health issues compared with non-immigrant

population, due to having to balance the conflicting norms and expectations of the home environment and the environment they are exposed to outside their home (Mancenido et al., 2020). Compared with first-generation immigrant, who have stronger ties with cultural traditions, language and community, thereby a developed sense of identity, it is shown that second-generation immigrant youth living in "between two worlds" have more difficulty in defining their identity as well as identifying where they feel they belong to and can call home (Sim, 2021, p. 5). East Asian immigrant youth have options of different resources and strategies to cope with the stressors and issues experienced as a minority group. However, the most commonly and primarily sought support is from family and ethnic communities, which provides an environment of familiarity and emotional support. The strong social support system could promote assimilation but may also create resistance acculturation (Au, 2016, p. 5).

Emotion socialization

Socialization is the process which fosters individuals to learn values, norms and customs in relation to societal needs and expectations, thereby allowing the individual to be socially accepted. In turn, their choice of behaviours maintains the functioning of the society. Eisenberg et al. (1998) introduces the concept of emotion socialization where findings from this study show that the supportive or nonsupportive reactions of parents toward emotions influence children's understanding and displays of emotions. For example, parents who are more adept at teaching their children about emotions, and valuing emotions tend to have children who display lower aggression and higher emotion regulation skills (Ramsden et al., 2002). Chinese parents in the United States seemed to emphasize the value of proper behaviour through "emotion-critizing" socialization (Wang, 2001). Individuals are deemed as being mature by their ability to control their personal feelings, especially feelings of discontentment, which lead to restraining of articulating feelings or reflections and approaching the topic of emotions (Au, 2016, p. 3). Avoiding articulation of feelings of discontentment coincides with an emotional suppression which is similar to the *Hwabyung* syndrome, a somatization disorder characterized by repression of anger and disappointment, with feelings of hopelessness and helplessness (ibid.). Notably experienced by Korean women and elders, with unexplainable aches and pains, the Koreans interpret this as a natural and prevalent symptom, whereas in Western society, it is considered a psychosomatic illness (ibid.).

Mental health socialization

In the study by Yasui et al. (2022), parental socialization of mental health is explained as the process by which messages and practices of parents regarding mental health shapes the beliefs, attitudes and behaviours toward mental health and seeking mental health support. Culture is a factor which significantly influences the messages which parents send to their children on mental health. The study illustrates that Chinese American parents were highly likely to minimize or dismiss mental health distress of their children as a "passing phase" or equated mental health problems with being "crazy" and referenced mental health problems with "others" or "foreigners" or "Americans". Another study by Au (2016) notes the perception of mental illness by East Asian immigrants, as a "curse" rather than a legitimate disorder. The study further outlines how depression and causes of depression are recognized as an ordinary part of life and other mental health disorders are seen as unfortunate circumstances which the individual should endure through. East Asian immigrants only accessed professional help when their mental illness progressed to manifestation of psychotic or extreme physical complaints (Wynaden et al., 2005, p. 93).

Social status, or more commonly recognized as "face" in the East Asian communities, is a distinguished trait in the East Asian culture. Stigmatization exists around "mental health disorders" or "mental illness", especially within the East Asian communities, which is as a sign of weakness or failure of the individual, whereby feelings of shame follow with it (Sim, 2012, p. 8). Therefore, seeking treatment for and acknowledging mental health problems identifies the individual as being weak, which is perceived as smearing the family honour with shame, whereby the family loses face (Bernstein, 2007). This trait prevents or delays seeking professional help.

The "minority stress" model coined by Meyer (2003) helps to better understand mental health disparities of minority, and often oppressed, groups. The assumption is that certain (marginalized and oppressed) groups experience more incidents of psychological stress such as prejudice and discrimination, due to their race, sexuality, gender, disability, etc. Minority stress process influences health choices, seeking healthcare, and coping resources in complex ways which create health disparities (Williams et al., 2003). Mental health is shaped and influenced by both individual factors and sociocultural context in which the individual lives in. Historically, mental disorders and mental illness have been stigmatized in immigrant and racial-ethnic minority groups which has prevented them from receiving the

mental health care they need (ibid.). Thereby, it is vital for culturally appropriate and affirming mental health care to be provided for these groups.

Empathic concern

Empathic concern is the feeling of sympathy and concern which arise for other people in distress (Davis, 1983). Empathic concern is an "other-oriented" empathy to alleviate the distress of other people which according to Zheng et. al (2021), can be the motivating factor for the "other" to seek help. There are however differences in help-seeking behaviours in relation to different cultures. The study showed that during stressful events, European Canadians would more openly express and seek social support than Japanese individuals. This was in relation to cultural differences which influences the level of empathic concern. Furthermore, compared with Japanese, European Canadians were more prone to be concerned about the misfortune of others. Due to the impact social support seeking could have on the dynamics of a "harmonious" relationship, Japanese people were prone to be more reluctant in seeking social support which thereby impacts the decision to seek professional help.

Model for mental health help seeking

Cauce et al.'s (2002) model for mental health help seeking is framework which helps to better grasp the help-seeking attitudes of adolescent and young people. The model focuses on help-seeking over help-getting and considers culture and context as significant factors which influences each of the three interconnected domains of the model, which are, (a) problem recognition, (b) decision to seek help, and (c) service selection. According to Cauce et al., culture and context not only influences the help-seeking attitudes but is also a fundamental factor which influences every aspect of behavioural and emotional disorders, starting with establishing the problem to whether and how young people get treatment.

The first domain, "problem recognition" begins with when a problem or mental health need is first recognized which can be defined using two way, namely by epidemiological definition or self-perceived need. The epidemiological way assesses functional impairment from a symptoms-focused approach in guidance with the American Psychiatric Association's (APA) DSM. The second way is centred around the perception of the family or individual's need to seek help. In this domain, culture plays a critical role in whether the problem is considered mental health related or not. Different cultures may

provide alternative interpretations to the undesirable behaviours or issues. Undesirable behaviours and issues also differ according to social norms of different cultures. In fully understanding these factors, it not only closely exhibits the proper needs of young people but it also helps to understand the relation of the objective and subjective need and its impact on help-seeking (ibid.).

In the second domain of "decision to seek help", help-seeking presumably happens when a mental health problem or issue is perceived as undesirable and will not dissipate on its own. Differences in agreeing with severity and nature of problem between family members may exist but the first criteria is deemed as straight forward. The second criteria is often more challenging where family members tend to ignore behavioural problems in anticipation of them disappearing over time. This may lead to delayed help or not receiving adequate help when needed. Even though a problem is recognized as undesirable, certain cultures may advise to avoid thinking of the problem in hopes that it will disappear. Other cultures may encourage using willpower to overcome the difficult situation (ibid). Gender is also an important factor in deciding to seek help. Compared to male youth, female youth had a more positive attitude toward seeking professional help. They were more willing to utilize emotion coping techniques, compared with male youth who seemed to devalue expressing their issues (Fung et al., 2019). Socioeconomic status was also an important factor in determining help-seeking attitudes and behaviours. Young people from middle- and high-income backgrounds were more likely to seek professional mental health care than those from low-income backgrounds. Young people from low-income backgrounds have increased chances of identifying mental health issues due to being in contact with a broad network of social service institutions (Cauce et al., 2002, p. 49).

"Service selection" is the last domain which establishes where or to who young people or family members decide to go to for help. Social and familial norms may determine whether seeking professional help is feasible or not. In closely-knit networks or families, if norms do not align with the formal service environment, the individuals may be discouraged or forbade from seeking help (Cauce et al., 2002, p. 50). According to Cauce et al's study, a majority of Asian families only opt to seek help as a last resort when individuals display severe symptoms which prevent them from performing their day-to-day tasks. As a countermeasure to reluctance of individuals or family members, professionals who are not affiliated with the formal mental healthcare providers act as gatekeepers to provide connections with lower thresholds in locations such as educational institutions, churches, and community settings (ibid.). Other logistical and administrative factors, such as lack of transportation, inflexible

schedules, and long waiting times may also reduce access to help for certain racial-ethnic minority and low-income individuals and families.

Chapter 4
Findings

Multiple interesting findings were identified from the participants' responses in relation to the study's research questions and objectives. This chapter presents the findings of the interviews which are categorized into themes. The first group of themes are related to factors which impact the utilization of mental health services for East Asian IOY in the Netherlands. Six factors were identified, which were: (a) communicating feelings and emotions; (b) stigma towards mental health care; (c) past experience and exposure to mental health care; (d) awareness of mental health care; (e) affordability of mental health care; and (f) language barriers. The second group of themes are related to the sources of stress which contribute to the mental health of the participants. Four themes were identified, which were: (a) cultural identity; (b) familial norms and expectations; (c) lack of social support; and (d) racial discrimination. Although sources of stress was not a determinant which was to be examined within this study, they strongly tied with the topic of access to mental health care (MHC) as they potentially lead youth to seek professional help.

Factors which affect access to mental health care

Communicating feelings and emotions

Verbally expressing and communicating one's feelings and emotions was an uncommon practice in the household of the participants during their childhood. All participants had one or both parents who did not talk about feelings. Rather, expressing oneself was conducted through other means, such as acts of services or nagging. One participant, who was born in the Netherlands, but his parents had immigrated to the Netherlands from East Asia, mentioned that his parents' way of expressing love or to make amends was as follows:

> *"Asian families express their emotions and feelings in an indirect or different way, like, cooking a big meal"* (William)

Although it is not a common practice to verbally communicate your own emotions and feelings, what was commonly practiced and expected was to listen to other family members and to be considerate of what other family members may be feeling or thinking. The following participant is a therapist whose practice is based on body-oriented psychotherapy. She was born in the Netherlands to Asian parents and she shares her experiences on sharing feelings.

> *"I was born here but I have Chinese parents so they also never learned to go inside and ask me how are you, what do you feel, what do you want. And I think as a therapist I ask more of these questions and let people [ask it to themselves] also because I think a lot of people think about what others think but many people didn't learn to think for themselves, like, what do I think what do I want, so that's my main focus to be more aware of the me, the I and to empower that part."* (May)

Expressing one's feelings or emotions could be seen as a sign of weakness in some families, which could demonstrate the lack of expressing and communicating emotions and feelings. This lack of communicating emotions and feelings within the household, could result in one not being able to acknowledge, accept, and process emotions and feelings, which may lead to repression and suppression of these emotions. One participant distinctly remembers her experience in relation to this as a child.

> "*I grew up in like an Asian household and… you didn't learn from your parents to talk about your feelings. So, for me it was extra hard because I had all these feelings and like thoughts [about racism, discrimination, microaggression in school] but I didn't have a way to express it so I felt really alone as a child 'cause I couldn't go anywhere to kind of discuss my problems or whatever. So, I think that was very difficult for me.*" (Luna)

This participant further went on to describe how the repeated practice of suppressing her emotions while growing up led to difficulty in expressing her feelings, especially to her therapist.

> *"…your whole life you have all these ideas like of your parents, like, you know, they didn't give me enough attention but the moment when I got the opportunity to tell them, well not really them*

> *but through my psychologist, I just shut down and I couldn't say anything because it was like we haven't been taught how to communicate the feelings in a healthy way, because I always keep everything inside. And then, when I get angry or sad, I just shut down and I don't talk. I isolate."* (Luna)

Another participant, also explained her difficulty communicating with a therapist as she did not know how to articulate her experiences and feelings.

> "I don't think I truly know how to speak to a therapist because I just don't know how to communicate that way… I'm so used to suppressing so I just keep doing it without processing [the emotions] and I find no need for it [therapy]" (Amy)

Shame and stigma

Although mental health care is becoming more widely accepted, stigma is still prevalent around mental health disorders and mental health care which exist in the East Asian communities. Similarly to expressing one's feelings and emotions, experiencing mental health distress and seeking professional help for it was seen as a sign of weakness. Someone who experiences mental health distress and seeks help for it would be portrayed as not being able to perform what everybody else is doing on a daily basis. A participant described it as follows.

> *"I feel like because for Asians, mental health is becoming more common you know more people are going to the therapist compared to like 10 years ago, but I still feel like within our culture, it's still really kind of like, you need to work hard now, why are you complaining. Like parents would say we had it really hard you have such a good life so what are you complaining about?"* (Luna)

One participant was first diagnosed of his mental disorder in his home country in Asia, where he was displaying physical symptoms. His parents had difficulty in the beginning in accepting that the symptoms were caused due to mental health reasons.

> *"I don't even know that I was experiencing. It started with physical symptoms. For me it was nausea and stomach aches. And I went to different hospitals and nothing helped and then at some point a doctor said I should think of going to see a psychologist. And that's where I got my first*

diagnosis. It took some time for the doctor to convince my parents that it was something that needed to be taken seriously and it needed to be treated." (Jun)

Moreover, another participant described a possible reason for why East Asians tend to only seek professional health (and mental health) care when they experience physical barriers to an extreme point that it prevents them from executing the routines they follow on a daily basis.

"In my background if you show your crying then they will say you're weak so maybe the standard of myself is like really high. The standard is really high that they need to be burned out or they cannot get out of bed. People will not go to find help if it's about how to deal with better communication…. It's only physical barriers, not only mental barriers, that makes people seek help." (May)

Past experience and exposure

Past experiences of seeking mental health care or having prior exposure from friends or family members who have experienced mental health concerns and sought mental health care is a major factor which affect the choice to seek help. The past experiences of mental health care not only pertains to the interventions, such as the therapy sessions and its effectiveness, but also includes every step of the process from consultation with the GP, getting referral, being placed in the waiting lists of clinics, to the therapy sessions, and the after effects. One participant explicitly describes the long and tedious process that he had to undertake to receive therapy.

"I think it took around at least about a half a year to a year. Inhouse consultant then [transferred to] another [inhouse consultant], then referral to clinic. I went to a mental health clinic but it takes another few months for the first intake session. The first intake session was also chaotic because it was a phone interview, also because it was Covid. Then I had to explain everything again. And from the intake session to the first face-to-face session, it took another month. Then a session. When the session started it kind of like was a redo again of the assessment, so it's like you do it twice, the whole assessment. So it takes more than half a year. It's energy draining, disappointing and frustrating. Because a lot of people who are suffering from mental health issues they already really don't have the energy to, you know, to chase people to get to be treated so this is like, kind of like a paradox, in my view. They don't have energy to like take care of themselves too. It's like a

> *very tiring process… [then] there's this gap between the intake session and the actual therapy. And you don't know how long you have to wait. You just wait too long and that's really difficult."* (Jun)

Another participant describes a similar situation of having to communicate back and forth between different institutions and a long waiting period.

> *"I had some intake session and actually it took I think like around two months [to get an intake session] but then it had to be done by videocall. And I had two intake sessions where I told them I don't want to go through like the same process that I had in Amsterdam. I already had, you know, like this experience [of not feeling fully understood by the past two therapists] for two years so I don't want to be doing the same thing over again. And after our consultation, she told me maybe I should go to more like a specialized centre for anxiety disorder so I get more extensive help. So I applied there but the waiting list there is like six months. So next, I need to call my GP again and you know, like, just to tell them, hey you know the waiting list is six months, is there another option. But I feel like just in general in the Netherlands right now the waiting time for mental health is ridiculous. It's so long. The only way I think if you want help earlier is to look for providers that are not registered with GGZ and they're not registered so it means like you need to pay yourself for the treatment."* (Luna)

One participant details her experience as a teenager, receiving therapy with her mother present.

> *"I also got therapy for the angry outbursts but my mom had to be present for the sessions and her Dutch isn't that great so I felt like I had to translate my situation to her and then to the therapist and then translate what my mother is saying back to the therapist and back and forth. I felt like a translator. And there was a lot of misunderstanding because of the translation issue. It was frustrating and annoying, and it didn't feel like any of these sessions were helpful because I was just translating the whole time. I really couldn't process my own opinion at all whatsoever. I think it was the therapist's responsibility to provide a translator, but she just thought I could translate. I didn't know we could ask for a translator because I didn't know how health care works."* (Amy)

Sensitivity and awareness to culture and context by therapists adds to the experiences of help-seeking behaviour. Misinterpretations or miscommunications during diagnosis and

assessment could occur if there is a lack of understanding of the cultural background and context of clients, and in not recognizing the role of culture and context in perceiving mental health concerns and mental health care. Two participants' experience of diagnosis at a mental health clinic reflects this.

> *"It was strange because there was one question about something about, you know, like if things are not going as you plan would you be anxious or something. And I answered that I do feel anxious because I'm also a very organized person. I like to be on time and I like to be organized. I was saying it though in this way, like I mean compared to many of my peers back home. Maybe I was more organized but I cannot compare to how Dutch people can be organized so because of this they suspect I may have some kind of autism which is totally, it just didn't even make sense. So I asked back because I received the diagnosis and I asked like why is this like this. And I explained more what I was referring to. You know, there's a cultural difference so I think maybe in their view I was very dramatically stressed about time but it's not the case. I was just trying to say that I like to be more organized and not like a spontaneous type person. So that was the diagnosis part but that was clarified."* (Jun)

> *"I was diagnosed with ADHD when I was in high school, but I had a lot of mental breakdowns and lot of anger outbursts and anger issues. Now I know those are related with ADHD but I didn't really have any guidance with ADHD, like let's talk about your angry outbursts. The anger outbursts were not seen within the frame of ADHD but it was seen as a separate thing. I think that's a mistake they [therapist] made. (…) When I started my bachelor, in the first year, there were a lot of personal issues. I went to a therapist, but I felt like it wasn't helping me and I wasn't diagnosed correctly. I just didn't feel like pointing it out and it's weird to convince the expert that their diagnosis is wrong."* (Amy)

Thoroughly understanding the client's context, especially with regards to mental health problems may help in providing more effective therapy.

> *"Then I went back to therapy and this was specifically for ADHD. What I liked about this therapist was that she gave an analogy, where I was picking the eggs of the chicken but what I should have been doing was taming the chicken. I think that helped more and (…) She [therapist] was able to understand and get to the point because she herself had ADHD and she could relate.*

Because instead of examining me from a professional point of view, she did it from a personal point of view. She changed my whole plan. She aimed at focusing on my ADHD." (Amy)

Not recognizing or understanding the complex role of culture may possibly create an underlying "unresolved" issue within the therapy session, as one participant shared.

*"I was just really happy that I found her because she was also an East Asian immigrant. So she knew immediately, when I started talking about my problems, she knew, kind of like, the complex dynamics… When I went to like my regular therapist it was kind of like, yeah, but you know, you have to just think about your own needs. Like very individualistic, kind of like the Western mindset. The thing is that she did not understand. For her it's kind of like easy to say it because she grew up with it. And her parents already had, you know, a certain level of knowledge and wealth. And that's the difference. [For] most immigrants, we see all the struggles our parents had to make to come to another country, working their ass off to build a better future for us. So I think there's a lot of like guilt in that as well [as children]. You know we cannot be just egoistic and just be like, f*** my parents, I'm going to do whatever I want, because it's such a complex dynamic where you feel guilt and you feel you need to repay them. I think that's something that mostly like white people, or like my white therapist did not understand. She is not familiar and of course, you know, I cannot expect it from her. But at the same time it's something I need in order to work on my mental health so I think that is definitely an important factor that is missing within the mental health care system in the Netherlands… I felt like it was an important factor for me because I already had like 2 white therapists. Both of them I felt like, okay, I'm making a bit of progress but I still felt like there was something deeper that was not being covered."* (Luna)

Not recognizing or understanding the cultural background of a client or patient could also be perceived as a direct attack on the identity of the patient or client, making them feel defensive and not share valuable information which could be crucial in the therapy.

"I don't want to go to a therapist and hear that I had a bad Asian upbringing. And in my opinion, my parents did an amazing job in raising us. And going to therapy, me wanting to resolve issues and then having the therapist state that the culture I grew up is wrong. And that the western way of upbringing is right. I don't want my parents to be demonized. I don't think they fully understand the familial ties within Asian culture, so I just don't discuss that. I have tried to, in

*the first time in high school when I got therapy. And when I expressed it. My mom was there and I could feel the therapist judge my mom and I was like, what the f***."* (Amy)

In certain cases, however, having a therapist from the same or similar ethnic background is not a factor which determines the effectiveness of treatment.

"They automatically assigned me a Chinese psychiatrist which I understand to a certain extent because I understand that, you know, it does sometimes require understanding of the cultural background. Maybe speaking the same language would be easier with the therapy, but, you know, methodology also matters and when you have a good match with the therapist, it's also what matters. So I didn't quite make sense to me why it's [same racial-ethnic background therapist] automatically assigned to you. The first one [therapist] was originally from Hong Kong and I cannot vibe with her at all. I totally mismatched and I tried to convince her several times that you know I don't think this works out because the treatment is not working and I don't feel like I can do it or I don't feel that I'm empowered to do it. And after several times of mentioning she said, maybe I can transfer to another person and that then took another few months. Then, I got assigned to a therapist from Taiwan which was okay. But I don't have other experiences of therapy in the Netherlands to compare it with. But it served the purpose at least." (Jun)

Cognitive-behavioural therapy (CBT) is the first-line intervention administered in the Dutch treatment guidelines for common mental disorders. However, this standardized approach may not be suitable for everyone, but due to various reasons, this is the only form of intervention accessible for clients or patients.

"What happens is, because of high demand, most therapists provide CBT and that therapy is fast. Most of the time you don't really have the choice to what type of therapy you receive." (Jun)

"I mainly had cognitive behavioral therapy for two years… and according to her [the therapist] it was mainly social anxiety disorder, so I mainly had like CBT for that. And then it finished and she was like, okay, you know you finished the whole process so you should be good again, you can go back into the world. And I guess then I noticed, like, it actually became worse. So I had to look for help again. Western mental healthcare system is not everything in my opinion. You get CBT and if it doesn't work, you get prescribed antidepressants and that's like the normal route from what I understand and what they fail to cover is all these other types and methods of therapy

which I had to look up myself, like holistic family constellations psychosomatic therapy. Getting CBT or taking antidepressants is not curing the cause. It's just a method to kind of soften the pain or symptoms but it's not like seeing the actual cause and therefore I think mental health care system in general, not only in the Netherlands but worldwide, it really needs a change." (Luna)

It is vital to also recognize the constraints and limitations practitioners in MHC centres experience which may affect the treatment and care options.

"There are a lot of practitioners who are suffering from burnout, and it's very common that some people have to see 8 to 10 patients a day which is really a lot. And it's 45 minutes a session and becomes a bit like a therapy factory. That is detrimental to the quality [of care] and also to the health of the practitioner. But because we have such a long waiting list, we are also trying to resolve that. It's just an ongoing challenge. And the 15 minutes is for note-taking. And you go to the bathroom and prepare for the next therapy plan but it's not enough. Also, most of the sessions don't end in 45 minutes. You can't be like, okay 45 mins is done, let's go, especially when they're in crisis. I think the welfare for the practitioners is a huge factor in determining the quality of the practice (…) and a lot of them also have to try very hard not to get burnout." (Erin)

Prior exposure from friends or family who have accessed mental health care also made an impact on seeking professional help.

"There is an anecdote. I had a friend whose friend was a Muslim women and so she went to the therapist, Dutch, probably white therapist. And the therapist told her that if something like that happens you have to speak out. You have to speak out for yourself and those kinds of stuff. Usually those kinds of things work, but then like in other cultures, it makes things worse. For example, you maybe have the same thing, but if you go to your parents and do that it'll make things worse because culture expects you to be cautious and respect your elders. So I realized it's not easy to call a practitioner to help me so I also was very aware of that and very careful." (William)

Awareness

The topic of mental health care is not common and openly discussed, and unless active research is conducted, it is difficult to know how mental disorder symptoms are exhibited,

what various types of interventions are available, what steps are required to be taken for each.

> *"There is a lot of stigma but it should become more common to ask for help and [become more] easily accessible. It should be normal. It's not readily available, the information on the different kinds of therapies, and like the therapist you get. Not every therapist is the same and there should be more info on what kind of therapist there are, what kind of experience, what kind of characteristics, which are important to consider. It's like dating, you're sharing confidential information and thereby you should make it easier for people to decide from the information because you are getting into a long-term relationship with the therapist. It's all about accessibility… Every person is different in their way of expressing and feeling they need to find what really works for them or what doesn't work for them so by giving the trial [sessions] it gives them that space to see if it does work for them. It is important to feel safe with the person you will have therapy with."* (May)

Sharing of an individual's experience with mental health distress and mental health care may elicit other individuals to seek help. Two participants describe their experiences on exposure and awareness of mental health care.

> *"If people would open up more about what they struggled with, talking more with other people about it, being aware that they are not the only ones dealing with it, it would really be helpful. I think all the people could use it [mental health care] because everybody deals with emotions and struggles… I think if people would also talk more about how they deal with their problems… it can also work as a motivator."* (May)

Education level was also mentioned by one participant working in the mental health sector as a factor in relation to mental health awareness.

> "*And also, previous experience in getting mental health care helps. Because if they have previous experience or even exposure to mental health care it doesn't even have to be that they got the help but people around them got help, already it matters (…) but often times their education levels also matter, because often their education level corresponds with the awareness of mental health as a concept."* (Erin)

Affordability

Participants who were responsible for financing their own mental health care found affordability to be a factor which affect utilization of mental health care. If costs of intervention are not covered by insurance, seeking mental health care becomes a luxury. Certain types of therapy are not covered by the basic insurance. Therefore, the choice of therapeutic approach and therapists to seek becomes limited.

> *"I feel like just in general in the Netherlands right now the waiting time for mental health is ridiculous. It's so long. The only way I think if you want help earlier is to look for providers that are not registered with GGZ (geestelijke gezondheidszorg) and they're not registered so it means like you need to pay for the treatment yourself and from my experience this already is like 120 euros for one hour. And that's not something that everybody has access to."* (Luna)

> *"But I think insurance matters a lot. I think often times students have this insurance called AON and AON only provides 10 sessions and after the intake session it's already only 9 sessions which is very limiting. But it's good that there's insurance which covers mental health whereas it doesn't in many other Asian countries as far as I know. But each insurance had different policies so to what extent the insurance covers basically determines how much and what kind of help the patients can get."* (Erin)

Language barriers

One participant mentioned how language was also a critical factor which influenced access to mental health care.

> *"When it comes to east Asians, I hear that the language barrier is huge. Certain centers have Chinese and Japanese speaking psychologists who can provide therapy in those languages. So lingual barrier being one of the major factors and also how much of a support they get from their surroundings may impact a lot."* (Erin)

Sources of stress

Cultural identity

Four of the participants were second-generation immigrants, meaning they were Dutch-born individuals with one or more foreign-born parents from East Asia. As second-generation immigrant individuals, the participants described the struggles they faced in self-identification, especially in the cultural aspect while growing up in the Netherlands. To a question asked on how they identified themselves culturally, one of the participants answered:

> *"…I grew up in a pretty traditional Asian household so of course a lot of like the values that I have are more Asian. But then again, I grew up in the Netherlands, you know. I went to a western school system. I grew up with mostly like Dutch people so I think it's just like a mix of both my Chinese values and western values so it's a very difficult question to answer. I think it really depends. I had this conversation a while back with a friend and a white Dutch person will never see you as Dutch. You already look different so even though you speak the same language, you grew up in the Netherlands, you speak the language perfectly, you know all like the customs, values, whatever, um but just by how you look, you never fit in. Even your name, there would still be discrimination even though you perceive yourself as Dutch. I think because I'm really aware of that I also don't feel 100% Dutch because I know society doesn't see me that way. So, I think it's a combination. It's really complex."* (Luna)

Another participant described her experiences of not being able to truly "fit in" both in her ethnic and Dutch identity.

> "*I have a lot of incidents that made me realize I was different and it was difficult because you want to fit in, you want to speak proper Dutch, but also speak proper Cantonese. And my grandparents were always proud of me saying children my age can't speak well like this but I'm not good enough that I'm able to live in Hong Kong. Also, however hard I try, my Dutch always had an accent and some grammar would be wrong and people would pinpoint, oh it's because you're a child of an immigrant. And you're always in between. You're not good enough but you're also not bad. You're always in between… Understanding all those things made me understand feeling adequate compared to my white peers is not because of like biology or DNA, it's not*

embedded in me, I can choose to break free from it regardless of stereotypes and things that are projected on me." (Amy)

Their perceptions toward their cultural identity have shifted since childhood, however, one participant recalls how she felt as a child.

"In the afternoon when I was younger we always ate warm Chinese meals when I got home from school during lunch break and I remember I was always kind of like ashamed because whenever you know Dutch customers walk in, um, it was always kind of like typical Chinese food such as fish, but like a whole fish, you know with the head and or just food that smells different from like western cuisines. I was always really aware of how we were different or, you know, maybe white people would think it's disgusting or those kind of thoughts." (Luna)

Familial norms and expectations

Family was highly valued among most of the participants, and the familial norms and expectations played a pivotal role in shaping the current identities of the participants. In certain aspects, however, the norms and expectations sometimes deemed as perhaps too demanding.

"For Asian parents, it like becomes extra important to achieve that [life with a good job which pays well] because you know they [parents] had to sacrifice so they feel like you as a child need to repay them in a certain way and I think that makes it extra difficult for us. You're not only dealing with the, um, pressure of the society you're in but also the pressure from your parents that they expect you to do well because they worked so hard to provide this kind of lifestyle for you… I think it's kind of like the ideal image that our society has put for what success entails so it means like having a good job, you know, getting married, having a nice car, nice house, having two three children. And that is success for this society." (Luna)

There were also differences in the cultural aspect of what was expected in the family and in Dutch culture.

"In my family, it is that you have to listen, you have to do what's good for the family, and then in another surrounding, you are more aware of doing things for the other. And then, like the Dutch mentality is more 'I' instead of 'we'" (May)

Lack of social support

According to one participant, who is a practitioner in the mental health care sector, receiving social support for mental health concerns is an essential part of the treatment.

> *"Because what people often say is that real therapy happens outside therapy. So you can do a lot of exercises and interventions but you need a lot of outside help to implement those sessions, and that's heavily impacted by your surroundings. There needs to be support from their surroundings, such as from family or colleagues. But sometimes, some people want to seek help but the work environment doesn't allow it or sees it as a high risk, then you cannot go out during work hours to seek help. It's not like our clinic is open until 10pm, so those things matter a lot"* (Erin)

Lack of receiving support from family or friends was an important factor for individuals with mental health concerns which caused more distress.

> *"I know a lot of like friends of mine that are also Chinese. Their parents are not understanding. They don't understand. I hope they will change for them but from what I see right now it's like those parents are just really like, work hard, don't complain. And it's also difficult for them [my friends] because they don't even talk to their parents and that is also causing a lot of like internal conflict… I think understanding and getting support from your family can already contribute to your mental health. It really lifts off the pressure that you're carrying on your shoulder and that pressure I think is something that is causing many of the mental health problems in the first instance. Getting understanding from your support system is very important as well. You can go to a psychologist or get mental help but if you don't get the same support from your environment then it's still very difficult to actually get better."* (Luna)

Racial discrimination

As East Asian immigrant youth, the participants experienced racism and racial discrimination in school and social settings, especially in the cases of participants, who were as forementioned second-generation immigrants.

"I realized from very early on that I was East Asian because of how people would do things, like kids would slander eyes and say Ni Hao. And at school we would have the hanky panky happy birthday song. And it's not like you understand racism as a child. It's not like you can analyze your own feelings because you're a kid and no one else will explain to you how you can do it. I feel shitty but I don't know why I feel shitty and that's worse because if you don't know what's causing the pain, I don't think you can mend it because it just stays there." (Amy)

Chapter 5
Discussion

This chapter aims to outline noteworthy findings from the interviews and examines the reason behind their prominence. During the interviews, participants mentioned many distinguishable factors which they perceived as contributing to accessibility of MHC (mental health care). The factors have been categorized into past experiences and exposure to MHC, stigmatization of MHC, awareness, affordability and language barriers. The first and second factors mentioned hold noteworthy findings. In addition to these factors, another notable factor which the participants did not explicitly perceive and identify as a factor but was mentioned numerous times throughout most of the interviews was communicating feelings and emotions. Furthermore, the chapter investigates findings which were not anticipated or diverged from assumptions during the initial stages of the study but were later portrayed through the data.

Past experience and exposure to MHC

Findings demonstrate that previous experiences of getting mental health care, whether it be negative or positive, was not necessarily a contributing factor in the decision-making of seeking help. Rather it was whether an individual had previously utilized mental healthcare services or not, which determined reluctancy toward MHC and the decision to seek help. For example, participants who had previous experience in accessing MHC were aware of the tedious process of getting a referral, waiting on long lists, and having to reiterate their mental health issues to different parties every time they were referred or reassigned to a different MHC practitioner or provider. Yet, regardless of these negative experiences, participants would still decide to seek MHC, whether it be the formal or an alternative mental healthcare service. In comparison, stronger reluctance was demonstrated and the decision of not wanting to seek help was more prevalent, when participants had not utilized MHC before.

When considering Cauce et al.'s (2002) model, it may provide justification to why having utilized MHC determines help-seeking attitude. According to the second domain of the model, the decision to seek help is established once the mental health issues or problem is perceived as undesirable and it won't disappear on its own over time. Individuals who have utilized MHC are more adept in knowing their condition over individuals who have not

utilized MHC and thus is aware the problem will not disappear on its own. Therefore, they could be more compelled to decide to seek help. Furthermore, in knowing the procedure, the time it takes, and the financial coverage by insurance, it makes it easier for individuals to decide to seek help since they know what to anticipate.

Stigmatization of MHC

Stigmatization of mental health disorders and MHC was frequently mentioned in the interviews as a barrier to accessing mental health care. Participants had mentioned of other individuals within their social networks which experienced stigmatization of MHC within their families. However, immediate family members of the participants did not seem to have a heightened sense of stigma toward mental health disorders and MHC. Rather, the hostility and negative perceptions around MHC was due to lack of precise knowledge on the subject. Once participants disclosed their mental health problems and their status on utilizing MHC, family members displayed support and encouragement, and established an openness to accepting the utilization of MHC, despite not fully comprehending the concept of the mental health disorders or procedure for MHC. In comparison to earlier studies of perceptions on mental health care, which equated mental health disorder with being "crazy" (Yasui et al., 2022) and seeking mental health care due to being weak and not able to overcome adversities in life (Au, 2016), the openness toward MHC by family members could be due to the closeness and affection which exists within East Asian families toward each family member (ibid.).

Furthermore, even with the knowledge that there is a stigma toward MHC present in society or the communities they engage in, stigma was not a significant factor which affected participants' decisions to seek help. Moreover, participants did not constrain themselves in discussing the topic of mental health and their experiences with the MHC system within their social support networks. Instead, they exchanged experiences and information to other members of their social networks to suggest and recommend better options, especially to those who were seeking help. As living in a country where mental health care is more accepted, approachable and readily sought after, East Asian youth, and especially second-generation youth who have been exposed to the Dutch society, could be more accepting and open toward the concept of MHC (Mancenido et al., 2020; Sim., 2021). Moreover, empathic concern (Davis, 1983) may be heightened due to the exposure of Dutch culture and are more open to provide information which helps members of their social networks.

Awareness

As much as mental health problems and MHC are not openly discussed, it helps maintain shamefulness and stigmatized perception around it. In having information and knowledge readily and widely available, it not only helps in addressing stigma but also introduces an array of options on which treatment or therapy and providers are available, especially to individuals who are deciding whether to seek help. In providing more knowledge and information on MHC, it may motivate youth to feel more agency, making it easier to respond to the second domain of Cauce et al.'s model, which is the decision to seek help. It also addresses the third domain of the model, selection of service, as the choices of services have been widened. Having online and offline materials available in sharing information and knowledge is one option but another option for creating awareness is for people who have utilized MHC to speak more openly and frequently, within social setting but also bigger platforms, about their challenges with mental health problems and what approaches they used in alleviating their struggles.

Affordability

Options of MHC providers are available which do not require waiting on long lists. Most of these providers, however, do not carry licensure which allows insurance coverage and thereby require the client to cover their own costs. Insurance policies differ per company and thereby certain insurance could reimburse the costs. However, in most cases these insurance cost more. This pricey option is not accessible to youth who cannot afford to pay it and can affect the third domain of Cauce et al.'s model in reducing the options for selecting services.

Language barriers

East Asian youth whose language spoken at home may be different to Dutch or English, which is the main language of conduct in MHC centres. Not feeling comfortable or open to expressing oneself in Dutch or English could be a barrier which hinders decision-making to seek help, impacting the second domain of Cauce et al.'s model. However, certain MHC

providers have Chinese and Japanese speaking therapists who are able to proceed treatment or therapy in these languages.

Communicating feelings and emotions

Growing up in a familial environment where expressing and communicating emotions and feelings were not common practice, participants felt they experienced difficulty in articulating their feelings and emotions, and especially affected their interaction with their therapist. Although the interaction with the therapist is an important aspect in MHC, the capacity to articulate one's own emotions and feelings also affected participants' access to effective care. In situations where a misdiagnosis was delivered, compatibility with the therapist or treatment approach was weak, or more extensive care was required, participants who especially were not comfortable in expressing feelings of discontentment, avoided the topic at hand. This led to either, ineffective care which delayed treatment of symptoms or worsened the condition in some cases or terminated the treatment early by the participants. Furthermore, as they do not feel comfortable or are not adept at articulating their feelings and emotions, they do not confide their mental health issues within their social networks and thus do not have the possibility to receive support or help from fellow network members, which could further lead to professional help. Thereby, communication of feelings and emotions is a factor which impacts access to, not just mental health care, but effective, quality mental health care.

As demonstrated through emotion socialization (Eisenberg et al., 1998) where individual's understanding and display of emotions are fostered by parents support or nonsupportive reactions towards emotions, East Asian parents emphasize the ability to control one's own feelings, especially feelings of discontentment, as a trait of proper behaviour and maturity (Au, 2016; Wang, 2001). Thereby, continuous exposure within an environment which encourages restraining of emotions, could impact youth to refrain from speaking out about unpleasant or uncomfortable experiences which could be seen as showing feelings of discontentment.

Importance of compatibility

Another factor which could impact the quality of treatment is compatibility between the practitioner and client. Understanding and recognizing the culture and context of a client is crucial and needs to be well-established throughout the treatment. Hence, getting treatment

from a practitioner who is the same ethnicity and speaks the same language could indicate deeper understanding and stronger relations due to racial-ethnic similarity. Participants stated feeling more instantaneous connection and feelings of ease when starting therapy or treatment with a practitioner of similar ethnicity. Some even opted specifically to get help from a therapist of same ethnic background and did establish a trusting relationship with their therapist. However, the assumption that practitioners who are the same ethnicity and speak the same language as the client equates to good compatibility does not always hold true. One participant who got assigned an East Asian therapist did not feel compatible even after several sessions and had to request to be reassigned to another therapist. Another participant received treatment from a white, Dutch therapist who experienced a similar mental disorder as the participant and expressed that she finally felt seen and understood, which she didn't feel that way in previous instances where she sought professional help. Understanding and recognizing the culture and context of clients is crucial, but compatibility perhaps includes a sense of being seen, heard and understood for the client which doesn't necessarily have to be from someone of the same ethnic background.

The other side of MHC

This study sought to analyze and examine factors which impact help-seeking behaviour and accessibility of mental health care from the perspective of the client or service user of mental healthcare services. However, upon interviewing practitioners working within the MHC sector, it was possible to see the perspective of the MHC service providers and the challenges with which they encounter in providing MHC for clients. Possibly, due to funding provisions from the government (Van Emmerik & Prins, 2022), there is a shortage of placements for psychotherapists who can get licensure to be registered with the GGZ and work with insurance companies. This creates a bottleneck in the system which prevents the huge demand of MHC to be mitigated, resulting in the continuous influx of clients to the available MHC centres which work with insurance companies. As one practitioner described during the interview, practitioners in these centres are burdened by the continuous growing number of clients requiring diagnosis and treatment. On average, they are obliged to take 8-10 clients each day, with each session ranging from 45 minute to 1 hour each, as a means to counteract the growing number of clients. However, this only results in burnout of the practitioners and a detrimental impact to the quality of the practice. The welfare of the practitioners is at high risk and demand attention in order to maintain quality care for clients.

Interviewing professionals working within the MHC sector provided richer insight on not only Dutch mental healthcare system, context of the work they do and the experiences working with certain ethnic populations, but it also broadened the perspective of the study to understand the personal and professional challenges they are dealing with as individuals working in the MHC sector. As such, if given the opportunity to do the study again, the requirement for participants would not be restricted to individuals who have experience in accessing MHC but would also include East Asian individuals who have not accessed MHC but are acquainted with individuals who have. These participants would be independent commentators as they haven't experienced MHC and could provide an outsider's perspective of MHC. Youth and young people were the sample population in the study and the restriction of age was to examine traits or struggles of mental health problems, help-seeking behaviour and factors of accessing MHC, specific to the age group. None were found or possibly could not be found due to the limitation of the sample population. Possibly recruiting East Asian participants in other age groups would provide a basis to compare and find specific traits to young people.

Certain factors impacting help-seeking behaviour and access to mental health care have been mentioned in previous studies related to the topic for East Asian immigrant and immigrant youth populations, however, factors such as past experiences and exposure to MHC, communicating feelings and emotions and compatibility with therapists have not been readily researched or mentioned within research. These findings are note-worthy and could be a starting point to new research.

Chapter 6
Conclusion

High functioning and high achieving stereotypes of East Asian immigrants in western societies distort the realities of East Asian immigrants, especially in relation to mental health and mental health problems. Misperceptions such as the model minority stereotype elicit an image of the population to being immune to mental health issues and discounts the wide range of mental health problems the East Asian immigrants experience (Cheng et al., 2016). In fact, studies show high prevalence of mental health issues and lowest rates of MHC (mental health care) utilization for East Asian immigrants, which is especially prevalent in youth (Arora & Khoo, 2020). There is an increasing population of East Asian youth in western societies, and it is vital to determine what factors impact their decision to seek help and access MHC to counteract the low utilization rate. This study sought to examine the factors which impact help-seeking and accessing MHC of East Asian immigrant youth in the Netherlands. Through semi-structured, in-depth interviews with 6 East Asian participants, 6 factors which contribute to accessing MHC were identified: (a) communicating feelings and emotions; (b) stigma towards mental health care; (c) past experience or exposure to mental health care; (d) awareness of mental health care; (e) affordability of mental health care; and (f) language barriers.

The first factor demonstrated that communicating feelings and emotions affected communication with MHC professionals which determined the effectiveness and quality of the care. The second factor portrayed the negative perceptions around MHC among East Asian families which discourages seeking help for mental health problems. The first and second factors were heavily influenced by cultural and familial norms, dictated by Confucianist principles (Au, 2016). Both articulating emotions and seeking mental health care were deemed to be discouraged and inhibited within the families as being able to control one's own emotions was seen as a sign of maturity and seeking mental health care was equated with being weak and not able to overcome adversities. Upon closer analysis, however, stigma did not seem as prominent in the East Asian communities as presumed would be. Youth were more open to sharing their experiences with MHC within their social networks, while families were open and supportive of members who sought MHC.

The third factor determined whether past experience or exposure to MHC affected decision-making to seek help and in accessing MHC. The assumption was that if past experience was negative, the likelihood to seek help was lower and if the past experience was positive, the likelihood to seek help was higher. Findings showed, however, that regardless of the experiences being negative or positive, if an individual had previously utilized MHC, the likelihood to seek help again was high. Moreover, not having the experience of utilizing MHC showed higher reluctancy to seek help.

The fourth factor illustrated how low awareness of mental health problems and MHC helps sustain stigmatization and increasing awareness by openly sharing experiences could elicit more people to recognize the need to seek help and decide to utilize MHC. The fifth factor of affordability and the sixth factor of language barriers are closely linked with awareness and literacy. Certain MHC providers are not covered under the basic health insurance and thus are not as accessible. Thorough research is required on treatment programs provided in MHC centres which are covered by insurance. In addition, language barriers may be a factor which hinders individuals from seeking MHC. Although Dutch and English are the main languages in which MHC is provided, certain MHC centres have Chinese and Japanese speaking practitioners who are able to provide treatment in those languages.

Alongside the factors which impact help-seeking behaviour and access to MHC, sources of stress for East Asian youth were identified during the interviews. Although it was not an element which was under examination in this study, the sources of stress strongly tied with the topic of access to MHC as they potentially lead youth to seek professional help. The sources of stress identified were: (a) cultural identity; (b) familial norms and expectations; (c) lack of social support; and (d) racial discrimination. Cultural identity portrays the struggles of balancing both East Asian culture prominent within their familial settings and Dutch culture prominent within their social, educational, and possibly professional settings. Feelings of shame for being different and not fully fitting in to either culture led to mental and emotional distress. Familial norms and experiences exhibit the burden youth feel in having to uphold norms and expectations of families. Lack of social support portrays how youth with mental health problems experience more distress due to lack of support by family members. Racial discrimination refers to the racism and discrimination which youth, especially second-generation youth experienced within their school and social settings while growing up.

Within the findings, there were two factors which were unforeseen in the initial assumptions. First, is the compatibility between the therapist and client. The initial assumption was that getting treatment from a therapist with the same or similar racial-ethnic background would be beneficial to the effectiveness of the therapy. Having the same or similar racial-ethnic background is indeed a significant factor which does impact the relationship and quality of the treatment; however, it was not a determining factor for compatibility. Second, is the constraints and limitations experienced by practitioners of the MHC sector. Initially, the study was conducted to examine factors which affect access to mental health care from the client's point of view. However, in interviewing practitioners, it was possible to see the service provider's point of view in their challenges to providing effective, quality care. Structural limitations potentially created long waiting times in MHC centres and practitioners had to bear the burden of overworking in an effort to balance the demand and needs of MHC.

By broadening the scope of participants, it was possible to draw a larger variety of data from different perspectives. In adjusting the requirements for participants, not specific to a certain age group but to a larger population, intriguing research leading to compelling insight could be produced.

Recommendations for future research

When lifting the confinement of population to youth and broadening it to the East Asian immigrant population residing in the Netherlands, two possible research ideas can be proposed around the topic of accessibility to MHC. First, a research which examines and compares barriers of access to MHC for different socioeconomically positioned East Asian populations can be conducted. The research would introduce barriers specific to each socioeconomic background, taking into account, factors such as educational levels, literacy of MHC and awareness. Second, a research which compares the perceptions, help-seeking propensity and barriers of MHC between first and second-generation East Asian immigrants. The research could take into consideration the role of acculturation and assimilation in help-seeking behaviour and highlight differences in barriers specific to first- and second-generation immigrants.

Suggestions to alleviate barriers in accessing MHC

Certain prominent barriers from this study which hinder help-seeking behaviour and utilizing MHC can be addressed through various approaches. First, creating and increasing awareness of mental health problems and MHC in East Asian communities would be one of the most effective and efficient approaches to tackle stigma and raising mental health literacy rates. Social platforms which are easily accessible and of low threshold, such as online social community websites and social media can be actively utilized to share information on mental health, ways to take care of mental health, guidelines to distinguish whether one may need professional help, provide locations to find resources on MHC providers and social support groups, and lastly to share stories of people who have utilized MHC to normalize the topic of mental health problems and MHC. Second, to have GP (general practitioner) offices display information and provide advice on formal mental health care services as well as alternative MHC options for clients. Third, for educational institutions and MHC providers to implement training of professional on the topic of cultural sensitivity and awareness.

Mental health is a vital component of public health which without it cannot have a healthy population. It is thus the responsibility of the society and state to make mental health care accessible to all population, regardless of race, gender, immigration status, and socioeconomic background. Disparities exist, however, due to various complex reasons which do make it challenging for some populations to seek health and mental health care. I hope more research will be conducted on the topic of mental health in the development sector for barriers, especially established through institutional and structural means which promotes and reinforces discrimination, to be demolished.

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Appendix 1

Title: Interview guiding questions

General questions of demographics

1. Age
2. Gender
3. Ethnicity
4. Education

Life journey

1. Where did you grow up?
2. How was your childhood/teenage years/young adult years?
3. What is your study/work background?

*For practitioners

4. How did you choose to work in the field of mental health care?

Perceptions on mental health care

1. Have you had experience with accessing mental health care? (in the Netherlands, elsewhere)
2. What are the perceptions around mental health care in your culture/ethnic group?
3. What were your perceptions on mental health care when you were young (as a child, teenager, or young adult years)?
4. What is your perception around mental health care now after seeking mental health care?

Experience of mental health care

1. What were your expectations prior to accessing mental health care?
2. What was the process you took to get mental health care?
3. How long did the process from wanting to seek mental health care to seeking health care take?
4. What barriers did you experience during the process?
5. What enablers did you experience during the process?

* For practitioners

Experience as professional in mental health care sector

1. What led you to become a professional in the mental health care sector?
2. Do you think mental health care is important? Why/why not?
3. What is the demographics of people who seek mental health care in your practice? (age, economic status, gender, ethnicity, etc.)
4. As a mental health care professional, what are the barriers for people (especially East Asians) to access mental health care?
5. What are the enablers for people to access mental health care?

Suggestions

1. What suggestions/advice would you give to other East Asian youth who are struggling with mental health problems and want to seek mental health care?
2. What suggestions/advice would you give to policy makers or mental health care professionals to help make mental health care more accessible?

Appendix 2

Title: Information of interviewed participants

Name	Age range	Gender	Date of Interview
William	Late 20s	Male	6 August 2022
May*	Early 40s	Female	29 August 2022
Jun	Late 20s	Male	22 September 2022
Luna	Mid 20s	Female	25 September 2022
Erin*	Early 30s	Female	13 October 2022
Amy	Mid 20s	Female	17 October 2022

* Refers to participants who were practitioners working in the mental health care sector

Appendix 3

Title: Survey questions and results

Questions	Respondents						
	1	2	3	4	5	6	7
1. What is your age?	d	c	c	d	d	c	b
a) Under 18 years							
b) 18-25							
c) 26-35							
d) 36-45							
e) 36-55							
f) Over 55 years							
2. What is your gender?	male	female	female	male	female	male	female
3. What if your race/ethnicity?	Chinese	Dutch-born Chinese	East Asian	Chinese	Indo-Chinese	Chinese/Dutch	Chinese
4. Have you ever experienced a mental breakdown or any other mental health distress (eg. anxiety, profound sadness, mood swings, difficulty in anger management, etc.)?	No	Yes	Yes	No	Yes	No	Yes
Please describe your behaviour and/or emotions.		anxiety, sadness	Anxiety, Sadness, Depression, Agorafobie, PTSD		Anxiety, depression, mood swings, psychotic attacks		All of the examples above and also depressing episodes
5. Have you ever seen a mental health care professional (eg. psychiatrist, psychologist, counselor, therapist, etc.)?	No	Yes	Yes	No	Yes	No	Yes
If yes, please describe why.		due to depression	For PTSD, burnout and personality disorders	Not really needed one until now. But sure will look for one if I ever need one.	Yes, because of my diagnosis (bipolar disorder type 2 with rapid cycling)		because I realise I needed help and that this can't go on anymore
If no, please describe why.							
6. If you have seen a mental health care professional, what was your overall experience (with GP referral, intake sessions, type of therapy administered, effectiveness, etc.)?		Takes a long time to get to the therapy. A lot of explaining and repeating to different people	Slow process		Conventional therapy proved ineffective; MBSR Training (Jon Kabat-Zinn) proved highly effective		