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Health Care Utilization and Child Care Practices among Chinese-Canadian Women in a Pediatric Practice

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Preface

We thank the Chinese Hospital Foundation for their material and moral support for this project. Dr. Terri Yu participated actively at an early stage of this project, writing much of the literature review presented in Chapter 1. Terri Yu, Fang Yang and Ho Hon Leung assisted with the development and translation of the questionnaires. Catherine Li ably conducted the interviews. Consuelo Quesney supervised data collection and coding of qualitative responses. Suzanne Taillefer assisted with data analysis and prepared the French translation of the résumé. Lucy Boothroyd edited the text and Kay Berckmans helped to assemble the final material.

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SUMMARY

One hundred Chinese women who brought their child for a health check-up at a community-based pediatric practice, were given structured interviews on their own general health and health care utilization, and on infant and child care experiences. The objectives of the survey included:

(1) to assess the pattern of health care utilization among mothers in a pediatric practice;

(2) to assess the quality of the following maternal-child health maintenance issues:
(a) pattern of utilization of perinatal services
(b) family attitudes and practices concerning childbirth and infant care
(c) discipline styles
(d) family recreation
(e) school preparation;

(3) to identify: (a) the prevalence of beliefs in *yin-yang* and hot-cold concepts of balance in the body and food as contributing to health and illness; and (b) the pattern of utilization of traditional Chinese medicine including acupuncture, herbal and alternative medicine, in relation to acculturation style;

(4) to pilot test a series of instruments for use in future community surveys in the Montreal Chinese community.

More than half of the women in this study were employed. In encounters with health professionals or social workers, respondents were evenly divided in thirds into those who used exclusively Cantonese or only English and those who used a combination. There was little use of French in the group. The retention of Chinese language and its substantial use at work and with health professionals points to the need for linguistic and ethnospecific services to meet the needs of this population.

The most common somatic symptoms reported were fatigue (18%), dizziness (13%), and excessive gas or bloating (12%). On a scale of psychological symptoms of distress, the most frequently endorsed symptoms were felt unhappy and depressed (34%), constantly under strain (30%), and couldn't overcome difficulties (20%). A factor analysis of somatic and psychological symptoms yielded a dimension of distress corresponding to neurasthenia with principal symptoms of weakness; sickly for most of one's life; not able to concentrate; and fatigue.

While 26 women had scores of 3 or more on the General Health Questionnaire (GHQ) indicating significant levels of distress, only 2 had talked to their family doctors about mental health issues in the past 12 months, and none had visited a social worker, psychiatrist, psychologist or any other type of professional for a problem with nerves, worries, emotional or mental health or a stress-related

problem. When women with at least one symptom on the GHQ were asked why they had not gone for help most of the reasons reflected a tendency to minimize and deal with problems on one's own, perhaps because the problems were mild or self-limited for many. It is of note, however, that time constraints were a common reason for not seeking help.

Almost 1/3 of the women made use of some Traditional Chinese Medicine at home in the last year and almost 1/4 saw a Chinese medical practitioner. Other forms of alternative or complementary medicine were not used by the women in this study. Chinese medicine (principally herbs) was used at similar rates for children's health problems. About 1/4 of respondents had taken their children to see a traditional Chinese doctor. The most common reasons for consultation were colds and stomach problems. One third of mothers used over-the-counter Chinese medicines for similar purposes.

Of the 100 Chinese women surveyed in this study, 51 had attended a prenatal course. While 12% claimed they had worried about childbirth often, 44% had worried at least some of the time. The most common reason for both mothers and fathers to not participate in a prenatal course was time limitation. This suggests the need to develop reading materials and brief courses that are practical and accessible for couples with heavy work or family obligations. In this sample of mothers, 19% recalled being sad and depressed for up to 2 weeks or more after childbirth and 14% experienced prolonged fatigue during the postpartum period.

A majority of women (73%) had intended during at least one of their pregnancies to breast feed. Despite these intentions, however, almost half (43%) did not breast feed any of their children. Prenatal classes (29%) and reading materials (19%) were cited most frequently as factors that influenced the decision to initiate breast feeding.

In summary, the results of this study indicate (1) the continuing need for ethnospecific services among this group of recent immigrants, and (2) the need for further development and promotion of perinatal education. Postnatal distress appears to be expressed primarily in terms of depressed mood and a neurasthenic syndrome that may go unrecognized and under-treated in both mental health and primary care sectors. Further research with a community sample may clarify the nature and impact of this distress and lead to better identification and treatment by physicians.

RÉSUMÉ

Une centaine de chinoises ayant amené leur-s enfant-s pour un examen de routine à une clinique communautaire prodiguant des soins pédiatriques ont été interrogées au sujet de leur santé en général, de leur utilisation des soins de santé, ainsi qu'au sujet de leurs expériences avec les soins de leur-s bébé-s et/ou enfant-s. Les buts de l'enquête inclus:

(1) l'évaluation des patterns d'utilisation des soins de santé chez les mères dans le cadre d'une pratique pédiatrique;

(2) l'évaluation des problèmes suivants associés à la qualité des maintients de la santé des mères et des enfants:
   (a) pattern d'utilisation des services en périnatalité
   (b) attitudes et pratiques familiales en ce qui a trait à l'accouchement et aux soins infantiles
   (c) styles de discipline
   (d) passe-temps familiaux
   (e) préparation scolaire;
(3) identifier: (a) la prévalence des croyances concernant les notions de *yin-yang* et de chaud-froid (*hot-cold*), dans le corps et la nourriture, comme facteurs contribuant à la santé et à la maladie; et (b) les patterns d'utilisa-tion de la médecine traditionnelle chinoise, incluant l'acupuncture, les herbes et la médecine alternative et ce, en relation avec le style d'accultu-ration;
(4) tester une série d'instruments destinés à être utilisés dans des enquêtes communautaire chez la communauté chinoise montréalaise.

Plus de la moitié des femmes de l'étude occupait un emploi. Au niveau des rencontres avec des professionnels de la santé ou travailleurs sociaux, le nombre de répondantes se divisait également en trois groupes: celles qui utili-saient exclusivement le chinois, l'anglais et une combinaison des deux. Le français n'était pas utilisé fréquemment dans le groupe de femmes. Le fait de maintenir la langue chinoise et son importante utilisation au travail et avec les professionels de la santé viennent confirmer le besoins de services linguis-tiques et ethnospécifiques afin de satisfaire les besoins de cette population.

Les symptômes somatiques les plus répandus sont fatigue (18%), étourdis-sements (13%) et gazs excessifs et ballonnement (12%). Sur une échelle de symptômes psychologiques de détresse, les symptômes endossés le plus souvent sont sentiment d'être malheureux et déprimé (34%), constamment tendu ou stressé (30%), et sentiment de ne pas pouvoir surmonter les diffi-cultés (20%). Une analyse factorielle des symptômes somatiques et psycholo-giques a identifié une dimension de détresse s'apparentant à la neurasthénie, avec comme symptômes principaux faiblesse, impression d'avoir presque toujours eu une mauvaise santé, incapacité de se concentrer et fatigue.

Bien que 26 femmes avaient des scores de 3 ou plus à l'échelle du *General Health Questionnaire* (*GHQ*) indiquant une taux de détresse élevé, seulement 2 avaient parlé à leur omnipraticien de leurs problèmes de santé mentale au cours des 12 derniers mois, et aucune avait visité un travailleur social, psy-chiatre, psychologue ou autres types de professionnels pour un problème mental, émotionel ou de stress. Quand on a demandé aux femmes ayant au moins un symptôme à l'échelle du *GHQ* pourquoi elles n'avaient pas consul-té, la majorité des réponses reflétaient une tendance à minimizer et à faire face aux problèmes seules, peut-être parce que les problèmes n'étaient pas graves ou se règleraient par eux-mêmes. Il faut noter toutefois, que les limites dans le temps était une raison fréquemment invoquées afin de justifier la non-utilisation des soins de santé dans ce cas.

Presqu'un tier des femmes on utilisé une forme ou une autre de médecine chinoise traditionnelle à la maison au cours de la dernière année et un quart ont vu un médecin chinois. D'autres formes de médecine alternative ou complémentaire n'ont pas été utilisées par les participantes de l'étude. Des médicaments chinois (principalement des herbes) ont été utilisés de façon similaire afin de contrer les problèmes de santé chez les enfants. Environ un quart des participantes ont amené leurs enfants chez un médecin chinois traditionnel. La consultation était le plus souvent motivée par des grippes et des problèmes d'estomac. Un tier des mères ont utilisé des médicaments chinois disponibles sans ordonnance pour soulager des problèmes similaires.

Parmi les 100 femmes chinoises interrogées dans cette étude, 51 ont assisté à des cours prénatals. Douze pour cent des femmes avouent s'être inquiétées souvent au sujet de l'accouchement, et 44% se sont inquiètées au moins quel-ques fois. La raison la plus populaire invoquée par les mères et les pères afin d'expliquer pourquoi ils n'avaient pas participé à des cours prénatals était le manque de temps. Ceci suggère le besoin de développer du matériel écrit et des cours abrégés, pratiques et accessibles aux couples ayant d'importantes obligations au niveau du travail et de la famille. Dans cet échantillon de jeunes mères, 19% se souviennent avoir été déprimées ou dépressives jusqu'à 2 semaines ou plus suite à la naissance de leur enfant ou de l'un de leurs enfants et 14% ont expérimenté de la fatigue durant la période post-natale.

Une majorité de femmes (73%) ont envisagé d'allaiter au moins une fois au cours de leurs grossesses. Malgré ces intentions, toutefois, presque la moitié (43%) n'ont pas allaité aucun de leurs enfants. Les cours prénatals (29%) et le matériel de lecture (19%) sont les facteurs qui ont influencé le plus la décision d'initier l'allaitement.

En résumé, les résultats de cette étude indiquent (1) le besoin soutenu de services ethnospécifiques parmi ce groupe d'immigrants récents et (2) le besoin de développer et de promouvoir davantage l'éducation périnatale. La détresse post-natale semble s'exprimer principalement en terme d'humeur dépressive et d'un syndrome neurasthénique pouvant passer inaperçus et sous-traités, à la fois dans les secteurs de la santé mentale et des soins de premières lignes. Des recherches accrues à l'aide d'un échantillon cummunautaire pourront peut-être clarifier la nature et l'impact de cette détresse et aider les médecins à mieux identifier et traiter celle-ci.

Chapter 1
Introduction

OBJECTIVES

This report describes a pilot study of 100 women attending a pediatric practice at the Chinese Hospital of Montreal. The aims of the study were twofold: (1) to determine the patterns of help-seeking and health care utilization for common medical and mental health problems in a sample of Chinese-Canadian women, as well as perceived barriers to care for mental health services; and (2) to assess the patterns of prenatal, infant and child care among Chinese immigrant women and determine their relationship to indicators of acculturation.

There is increasing recognition of the need for culturally appropriate care in the fields of primary care medicine, psychiatry, nursing and other health disciplines (Harwood, 1981; Kleinman, Eisenberg & Good, 1978). This has lead to efforts to incorporate cultural knowledge in medical training and practice. Most recently, standards of cultural competence have been developed for the training of psychologists and psychiatrists and parallel quality assurance standards for culturally responsive care are being instituted in California and other US states. Culturally competent care involves both general knowledge and skills and specific information and expertise with the relevant ethnocultural communities. Although they may be composed of people with roughly similar cultural backgrounds (e.g. Chinese-Canadians), ethnocultural communities vary substantially depending on their precise origins, history of migration and interaction with the local mix of peoples, cultures, values and institutions.

At present there is no information on the needs or adequacy of services for common somatic and psychosocial problems in the Montreal Chinese community. This project was undertaken to develop questionnaires and do preliminary work necessary for conducting an epidemiological survey of the mental health needs and practices of the Chinese community in Montreal.

CULTURAL DIVERSITY OF CHINESE-CANADIANS

Chinese-Americans, Chinese-Canadians and even Chinese-Montrealers are a heterogeneous group. In order to provide health care services in culturally acceptable forms, it is important to recognize that different subgroups in the Chinese population have different medical, cultural, religious and philosophical beliefs and, therefore, may have different needs and expectations of health care services. As Gaw (1993) has pointed out, knowledge of this cultural background is essential to understand how psychiatric symptoms are manifested in the Chinese population in ways that are both similar to and, at times, different from other ethnic groups. Cultural beliefs and practices also shape the views on mental illness and the role that the family plays in the care of mentally ill relatives.

Subgroups of Chinese may be distinguished in terms of (a) language and region of origin, (b) types of household and generational differences, and (c) philosophical or religious beliefs and practices.

Language and Region of Origin

Although Mandarin (referred to as *Guo-Yu* by Taiwanese and *Pu-Tong-Hua* by people from Mainland China) is the national language, other dialects commonly spoken by North American expatriates from China include (Gaw, 1993):

- Cantonese from Guangdong province in southern China and Hong Kong and Tai Shanese from Guangdong;
- Fukienese and Amoy from Fujian province;
- Shanghainese from Shanghai and its suburban area;
- Hakka (called *Kegia-hua* in Mainland China) from a region extending along an east-west axis from Fujian to Guangxi;
- Szechwanese from Sichuan province;
- Hunanese from Hunan province.

People speaking different dialects form subgroups related to folk religious and philosophical beliefs, value systems and socioeconomic levels. As yet there is little research to distinguish the different subgroups and their different needs for health care services.

Types of Household & Generational Differences

Gould-Martin and Ngin (1981) discerned four major types of Chinese-American households: (i) the single sojourner; (ii) the old immigrant couple; (iii) the new immigrant family; and (iv) the acculturated suburban family. They point out that the last type requires little special attention from health care providers; a physician may simply note that the risks for certain diseases among members of this subpopulation differ from those of white Americans in similar circumstances. The other three household types tend to be similar in their socioeconomic level, language problems, and residence in Chinatown. Since 1978, there has been a growing group of Chinese scholars and students newly arrived from different regions of Mainland China, Hong Kong and Taiwan who complicate this simple typology of Chinese-American households since they themselves constitute several different subgroups.

In relation to generations, five types similar to those above can be recognized:

(i) the single sojourner;
(ii) the old immigrant couple and their second and third generations;
(iii) the new immigrant family and their second generation;
(iv) the acculturated suburban family and their second and third generations;
(v) the families of scholars and students and their second generation.

While several studies have dealt with specific psychiatric or emotional problems of a certain subgroup of the American-Chinese population (Cheung et al., 1981; Raskin et al., 1992; Tseng, 1975; Ying, 1990; Zheng et al., 1992), no empirical data explore how different generations from different types or subgroups of families react to different emotional or psychiatric problems.

Philosophical and Religious Beliefs

Gaw (1993), Dien (1983) and Yang (1961) have pointed out that religious beliefs and philosophical thinking assume a key role in traditional Chinese social life. Traditional Chinese philosophical and religious beliefs involve two broad streams: the three great philosophical and religious traditions of the educated class (Hu, 1960; Dien, 1983) and folk religious beliefs.

Philosophical and Religious Traditions of the Educated Class

Confucianism is concerned with the elaboration of *Dao*, the 'Way', in the social sphere. It deals with visible facts and does not posit gods or supernatural dogma as part of its teachings; therefore, it is not a theistic religion but rather a series of philosophical ideas (Yang, 1961). As a social philosophy, it stresses family solidarity, friendship, social relations and imperial allegiance (Hu, 1960). Its attitude is moralistic, duty-bound and purposeful. It insists upon strict adherence to definitions of positions and rules of conduct. To Confucians, a wise man can achieve complete self-realization only through a commitment to public service (Dien, 1983). Chinese values such as *ren* (goodness in interpersonal relationships), *li* (propriety in interpersonal relationships) and the emphasis on morality and conformity to prescribed role behavior are Confucian in origin (Gaw, 1993). Confucianism regards the individual self as embedded in and, essentially, part of a larger organic whole: the individual self is united with family and society and so its wellness and illness depend on the harmonious functioning of the larger social sphere.

Taoism is an eclectic religious tradition that borrows many important features from Buddhism and incorporates many practices and beliefs from folk religion (Hu, 1960). Philosophically, Taoism delineates a path by which to achieve tranquillity, harmony and a sense of satisfaction in life (Dien, 1983). It teaches that what is most important is absolute freedom from artificiality. Interestingly, the basic concept of the Taoist 'selfless' self is similar to that of Confucianism since it holds that our existence is intertwined with that of others so that if we are sensitive to our world and become aware of people as they are, "we may experience an authentic encounter between them and ourselves at a deeply intimate level" (Stensrud & Stensrud, 1979). Unlike Confucianism, however, Taoism emphasizes personal mystical experience (Hu, 1960).

Buddhism, with its chief premise of salvation from *Guan-Yin* (the Goddess of Mercy), seeks enlightenment through avoidance of earthly or blind desires and ignorance (Hu, 1960). It teaches the eternity of life and the idea of rebirth.

Folk Religious Beliefs

Hu (1960) pointed out that the ancestor cult is the oldest and most pervasive of all Chinese religions. It is based on the beliefs that the living can directly communicate with the dead and the dead can still influence and be influenced by events in this world. Families carry out the rituals of ancestral worship. Ancestral tablets can be found in many homes, especially in the countryside in contemporary Mainland China. Offerings to ancestors, usually food, are observed during the Chinese New Year, the death anniversaries of ancestors and at other special festivals. The family burial place is cleaned, and food and money are offered to the departed at *Qing-Ming* (the beginning of spring). Gaw (1993) suggested that ancestor worship serves to perpetuate strong family ties.

Gaw (1993) stated that the conceptual basis for folk religion is a belief in a direct and reciprocal relationship between the terrestrial and the spiritual world, and between and among human beings, gods, and spirits. The celestial world, governed by the Jade Emperor, is believed to be populated by departed ancestors, gods, ghosts, demons, animal spirits and deified heroes of Chinese history. These celestial beings play a key role in the affairs of the common people. The kitchen god, land god and money god govern the major aspects of peasant life. Certain animals, like foxes and snakes, are thought to possess supernatural powers and can assume charming forms to seduce young men. This belief influences how peasants regard certain types of psychoses. The expert in dealing with the spiritual world is the *Wu*, or shaman. When the patient is thought to be possessed by malevolent or animal spirits, a Wu is sometimes called upon to intercede on a psychotic person's behalf.

CONCEPTS OF MENTAL HEALTH AND ILLNESS IN TRADITIONAL CHINESE MEDICINE

Traditional Chinese Medicine can be broadly divided into classical and popular versions (Gaw, 1993).

Classical Chinese Medicine

Traditional Chinese Medicine (TCM) has many rich and complex theories (Tseng, 1973; Unschuld, 1985). However, the major concepts linking body organs and emotions are illustrated in the scheme of correspondences displayed in Table 1-1 (Geng & Su, 1990; Ots, 1990; Tseng, 1973).

Table 1-1. Correspondences Between Organs and Emotions in TCM

Zeng Fu **(Organs)**	Liver Gall bladder	Heart Small intestine	Spleen Stomach	Lung Large intestine	Kidney Urinary tract
Senses	eye	tongue	mouth	nose	ear
Emotions	anger	joy	desire	melancholy	fear
Sound	shout	laugh	sing	cry	moan

As seen in Table 1-1, each emotion has a direct relation to one or several body organs. An imbalance of emotions disturbs the functional balance of bodily organs and vice versa. If a person was depressed, therefore, (which is described as melancholy), it would not be surprising if that person went to a traditional Chinese medical practitioner and was treated for a lung (more appropriately described as chest) ailment or for a problem related to the large intestine (in TCM the large intestine is not exactly the same as the concept in Western medical sense; instead, it relates to both the *Qi* channels and system, and the place in the body where the large intestine is located). The term a person uses when he is depressed has both somatic and emotional meaning: somatic because it actually describes the feelings of discomfort in the chest, and emotional since the second character of the term also means that a person is depressed and in a low spirit. As Lin (1983) has pointed out, once the physiological balance is disturbed due to psychological imbalance, treatment is sought in the form of physiological or medical intervention rather than psychological, since it is believed that while being treated for body symptoms, the psychological component is being dealt with as well.

Another point worth mentioning is that although psychological factors are clearly indicated in all the major functions of the organs, the attitude toward emotion regulation differs from that common in Western cultures. Contrary to the Greek and European tradition which stresses the therapeutic value of emotional catharsis, the Chinese direct their efforts towards avoiding excessive

emotions and aim to fit their emotional states to their natural and social milieu. Since excesses, rather than emotions per se, are regarded as pathogenic, a high value is placed on moderation and inhibition of affective expression (Lin, 1980).

Given the above explanation, it is not surprising that no separate attention is paid to mental illnesses, especially to minor ones, in TCM; instead they are fully integrated with other physiological problems, and treated in the same way. Emotions are regarded as important etiological factors for both types of illness. However, the major psychiatric problems producing dramatic or erratic effects pose difficulties for the traditional medical system. Sometimes, they are treated separately. A special chapter of the classic *Huang Di Nei Jing Ling Shu* is devoted to the problems of *Dian Kuang* (craziness) which originally included both psychosis and seizure disorder. The clinical description of psychosis (*Kuang*) is compatible with either schizophrenia or a manic episode. For these kinds of disorders, a psychological etiology is implicated and the problem is treated accordingly (Lin, 1980).

Popular Chinese Medical Beliefs

Popular medicine can be traced to Taoist, Buddhist and Confucian beliefs. Chinese folk healers include shamans, physiognomers, geomancers, bonesetters, and fortune-tellers. As mentioned in the section on folk religion, the world of humans is surrounded by gods (*Shen*, arising from yang) and demons (*Guei*, arising from yin). The human body can be invaded and fed upon by these spirits. Rituals and liturgies are performed to appease the gods since the daily life of common people is thought to be linked with the celestial world. If proper rituals are not performed illness may occur (Gaw, 1993; Lin, 1980).

The human body is thought to be infused with both Shen and Guei at birth. At death, Shen returns to the yang of heaven and Guei to the yin of the earth. Guei can also become a free-floating spirit called *Xie-Qi* (evil spirit). Family strife, failure to render filial obligations, interpersonal quarreling and social immorality are thought to create a human anomaly that can invite the invasion of Xie-Qi into the human body (which is then possessed) and so inflict illness. To treat the illness, a shaman possessed by the yang spirit will be called upon to perform a curing ritual to call back the sick person's soul. This supernatural approach to healing also extends into the realm of morality and ethics, rehabilitation and prevention; it treats the illness, patient, healer, human relations, the social order and the celestial hierarchy as aspects of a holistic system. All parties who are involved—individual, family, healer and gods—take part in the healing ritual in order to cure the afflicted individual (Gaw, 1993).

Obviously, Traditional Chinese medical and philosophical-religious beliefs influence help-seeking behavior of the Chinese. As yet, there are no empirical data to show how or to what extent the different blend of the above models influences help-seeking behavior.

Cultural Values Related to Help-Seeking Behavior

Chinese cultural values that may influence help-seeking for mental health-related problems include: (i) the central importance of family harmony; (ii) the emphasis on control of emotion; (iii) the high value placed on education and academic achievement; and (iv) the sociocentric concept of self and personhood.

The Importance of the Family

Wu and Tseng (1985) argued that central to Chinese culture is the value of the family as the fundamental unit of the society. Each member of the family has an essential obligation and responsibility to the family that persists even while other values may give way to Western influence in North America (Lum & Char, 1985). A family member's mental illness may cause the whole family to lose face.

The Control of Emotion

Based on the first MMPI tests ever done in Mainland China, Song (1985) concluded that, compared to Americans, the Mainland Chinese are "emotionally more reserved, introverted, fond of tranquillity, overly considerate, socially overcautious, [and] habituated to self-restraint." Wu and Tseng (1985) argued that these characteristics arise because Chinese are trained from childhood to control emotions that are considered adverse and disruptive to harmonious social interaction.

Value of Education and Achievement

Chinese parents tend to pay close attention to their children's behavior in school. Children who fail to live up to adults' standards of performance in school are often viewed as expressing abnormal, deviant, or antisocial behavior, which also reflects the failure of parenting (Wu & Tseng, 1985). It is not surprising, then, that overseas Chinese students or second generation Chinese may feel depressed and insist they have caused the family to lose "face" when they do not perform well academically.

The Concept of Self

Sue (1990) pointed out that the Chinese immigrant's concept of self is more merged with the family and society than that of Euroamericans. Earlier, Tseng (1973) and Hsu (1971) also stated that in Taiwan and Mainland China the Chinese self is much united with that of others—both family and society—compared to the individualism typical of North Americans (Roland, 1988).

The Stigma of Mental Illness

The stigma of mental illness may hinder many Chinese-American patients and their families from seeking mental health care. Gaw (1993) pointed out that if a family member is labeled mentally ill, it can bring shame upon the entire family and raise concern about the marriageability of the patient, other family members, or their offspring. Lin and Lin (1980) cited several common Chinese views of mental illness that may contribute to the development of stigma: (i) it is viewed as "misconduct" which requires corrective thinking and rectification of behavior; (ii) it is a sign of the wrath of the gods or ancestors caused by the transgression of family rituals in ancestor worship; (iii) it is considered a result of an imbalance of yin and yang; (iv) it is caused by a lack of hormones or vitamins, or results from diminished brain function; (v) it is caused by hereditary defects; (vi) it is a reaction to psychosocial stresses such as being jilted in love, failing in a business venture, or failing college entrance examinations. The result of these notions of mental illness is an acute feeling of shame, guilt, and embarrassment. As pointed out above, these notions are closely related to traditional medical and religious beliefs.

Family Reactions to Psychotic Members

Lin (1983; Lin & Lin, 1980) observed a distinctive pattern of help-seeking behavior among Chinese-Canadians in his study in Vancouver. Five phases were distinguished in the course of help-seeking from the onset of a psychiatric problem, especially for psychotic episodes:

> Phase 1. Exclusively intrafamilial coping, which could last from 10 to 20 years. At this stage, attempts are made by the family to influence the abnormal behavior of the sick member with every possible remedial means and resource within the family to its limit of tolerance.
>
> Phase 2. Inclusion of certain trusted outsiders in the intrafamilial attempt at coping, such as friends and elders in the community.
>
> Phase 3. Consultation with outside helpers such as herbalists, physicians and / or religious healers while keeping the patient at home.
>
> Phase 4. Labeling of mental illness of the sick member, seeking of help from psychiatrists first on an outpatient basis and then hospitalization.
>
> Phase 5. Scapegoating and rejection, while the sick member is kept in a distant mental hospital.

Gaw (1993) pointed out that this pattern is not uniquely Chinese. The difference is the degree to which a Chinese family will try to keep knowledge of such a problem from outsiders for fear of the shame, guilt, and stigma that such knowledge might bring upon the family should one of its members be labeled "mentally ill."

Somatic Complaints and Depression

The problem of somatization and depression has been given special attention among the Chinese on the Mainland (Kleinman, 1982; Zheng et al, 1986; Kleinman & Kleinman, 1985; Zheng et al, 1988; Zheng & Lin, 1991; Lin, 1989), in Hong Kong (Cheung et al., 1981; Cheung, 1987), and in Taiwan (Yamamoto et al, 1985; Tseng, 1975; Kleinman, 1977). It has been suggested that Euroamericans tend to seek psychiatric help for depression, whereas Chinese patients are more likely to seek help for somatic symptoms of emotional disturbance.

Tseng (1975) and Kleinman (1977) found somatization was common among Taiwanese depressive patients. Yamamoto et al. (1985) studied Taiwanese and American psychiatric outpatients to test this hypothesis. They found that Taiwanese patients scored higher on the measures of somatization but also on the measures of depression.

Cheung and colleagues (1981; Cheung, 1987) studied depressive illness in a general practice setting in Hong Kong and found that, although depressive patients tended to express their disturbances in somatic terms in their help-seeking processes, they were aware of the co-existing emotional disturbance.

Kleinman and Kleinman (1985, 1982) studied somatization and depression in Mainland China and concluded that somatization is the culturally and socially acceptable coping style and idiom of distress to express depression and other forms of distress.

Exploring the style of verbal expression among depressives and normal controls in China, Zheng and colleagues (1986) found that patients who have multiple somatic complaints are not more likely to express emotions somatically. The results did not support Kleinman's (1982, 1985) earlier findings. Based on their study, the authors stated that normal persons who experience depression may change from using a predominantly psychological expressive style to using a predominantly somatic style. They further suggested that bodily and psychological change are interconnected. If the individual perceives and experiences psychological change more strongly than physical change, this might tend to encourage psychological expression. If this process is reversed, it may encourage somatic expression.

Lin (1989) conducted an epidemiological study in Tianjin. Using the Center for Epidemiological Studies Depression Scale (CES-D) with 1000 residents, he developed the Chinese Depressive Symptom Scale (CDS) and tested its reliability and validity. The CDS contains 16 items from the CES-D and 6 additional items considered to be more culturally appropriate by the author. Lin then argued that while it may be true that the Chinese express mental problems in somatic terms, they are capable of responding to symptomatic questions about depression-related thoughts and feelings.

Research among Chinese in these three regions (Taiwan, Hong Kong and Mainland China) thus presents a complicated picture. Taking Traditional Chinese medical models (both folk and classical) as well as philosophical and religious beliefs into consideration, it is not difficult to understand that somatization may be a culturally acceptable mode to express distress; however, in expressing bodily discomfort, Chinese may also implicitly express psychological or emotional distress. As Zheng et al. (1986), Cheung and colleagues (1981, 1987) and Lin (1989) pointed out, while expressing depression in somatic terms, the Chinese were aware of the psychological element and, given the opportunity, were able to express psychological distress explicitly.

A few studies have addressed the psychometric problem of measuring depressive symptoms in Mainland China. Zheng et al. (1988, 1991) explored the applicability of the Chinese version of the Beck Depression Inventory (CBDI) and the Chinese Depression Inventory (CDI). In the CDI, the terms "suicide", "lack of sexual drive" and "sense of failure" were replaced by more euphemistic expressions: "being alive is not interesting", "not interested in the opposite sex" and "a weak person in life", respectively. The authors found the reliability and validity of the CDI to be much better than that of the CBDI, and the CDI appeared to be a more culturally sensitive instrument for measuring the severity of depression in Chinese (Zheng et al., 1991).

HEALTH CARE PRACTICES

Much work in epidemiology and anthropology indicates that immigrant groups preserve many of their traditional health care practices and combine them with use of biomedicine (Leslie & Young, 1992). Different “hierarchies of resort” may be used depending on the type of problem and the availability of specific services. The studies of pathways and barriers to care has emerged as a crucial dimension of assessing and refining culturally sensitive health care (Rogler & Cortes, 1993).

Primary Care as a Mental Health Resource

In the US, Britain and Canada, epidemiological research over the last two decades has made it clear that the primary care system is the only source of mental health services for most individuals (Regier, Goldberg & Taube, 1978). This makes the study of mental health services in primary care and general hospital settings a key component of assessing the overall system.

While many people who attend primary care settings have concurrent depression, anxiety or other stress-related problems, this does not mean that their problems are accurately recognized and treated. Indeed, there is much evidence that important problems often go unrecognized, in part because they are presented in exclusively somatic terms. This 'somatization' of distress may lead to under-recognition and under-treatment of emotional or social problems (Kirmayer, Robbins, Dworkind & Yaffe, 1993). This tendency to somatize

emotional distress, while widespread, may be more common in some ethnocultural groups. People from many different backgrounds tend to experience and express depression and anxiety in somatic terms and may present to the physician exclusively with physical symptoms (Cheung, Lau & Waldmann, 1981; Kirmayer, 1984) .

As discussed earlier in this report, this pattern of somatization fits with Traditional Chinese medicine which acknowledges close links between emotions and bodily processes (Ots, 1990). While Western psychiatric theory suggests that somatization is a problem, not only for accurate recognition of the nature of distress but for the patient's ability to cope, where somatization is culturally sanctioned, it may allow individuals to deal with their distress in culturally appropriate ways that result in a better outcome than that offered by conventional medical or psychiatric approaches.

Specialty Mental Health Care

Helping professionals have long noted that Chinese populations residing in North America tend to under-utilize mainstream health care resources, especially mental health services (Christensen, 1987). Sue and Kirk (1975) found that Chinese-American students also tend to under-utilize psychiatric facilities. In San Francisco, a community mental health services program report showed that for the 7 month period ending January 1977, only 10% of the total patients served at its mental health center were Chinese, while the Chinese comprised 29% of the Center's catchment area population. For the city as a whole, the Chinese represented almost 10% of the population, but constituted only 2% of the patients served in mental health programs (Cheung & Dobkin de Rios, 1982). Similarly, in a study of 17 community mental health centers in the greater Seattle area over a 3-year period, Sue and McKinney (1975) found that although Asians made up 2.4% of the population, they represented only 0.7% of the patients. Even when they made contact with mental health services, the dropout rate after the initial visit for Asian patients was 52%, about twice the rate for non-Asian patients.

It has been suggested that service under-utilization by Chinese immigrants to North America is due to strong family ties and a sense of community which sustains those in need of help (Christensen, 1987; Lin, 1983). There is also a widespread notion that Chinese immigrants prefer their traditional medical care givers such as acupuncturists and herbalists to the mainstream health care system. However, while there is evidence of the Chinese population under-utilizing the mainstream health care system (Christensen, 1987; Gould-Martin & Ngin, 1981; Sue & McKinney, 1975), no empirical data show that they use traditional care services at an especially high rate.

King & Bond (1985) and Lin (1983) pointed out that Chinese who suffer from minor mental disorders commonly start with self-medication, followed by consultation with Western-style doctors, then seek Chinese-style practitioners and finally resort to a general hospital for physical diseases. Seldom do they end up in psychiatric facilities. Lin (1983) stated that as a rule, traditional Chinese medical practitioners play a more prominent role in neurotic cases.

Few authors have dealt with help-seeking behavior among Chinese in North America. Christensen (1987) conducted a study in Montreal to examine help-seeking preferences of a random sample of 60 people of Chinese origin. She found that the family was the preferred first choice for most psychological and interpersonal problems; friends were a frequent second choice. Ying (1990) explored the explanatory models of major depression in a group of 40 recently immigrated Chinese-American women residing in San Francisco's Chinatown. She found that those who provided a psychological conceptualization of their problems were likely to not suggest professional services, but to rely on themselves or turn to family and friends for assistance. On the other hand, those who held a physical conceptualization were likely to seek out medical services.

Mau and Jepsen (1990) investigated help-seeking perceptions and behaviors of foreign-born Chinese graduate students at the University of Iowa (most of the Chinese students were from Taiwan) and native-born American graduate students. The authors found that compared with American students, the Chinese were less likely to define a situation as a "problem" and less likely to think of obtaining assistance. Interestingly, the authors found no difference between Chinese and American students in their notions of the ideal helpers: for both groups, a friend was the most favored helper in the personal and social problem areas. For those areas that required professional expertise (health and academic problems), a professional helper was preferred.

According to these findings, family or friends rather than professional helpers are preferred for problems related to psychological or emotional factors among the Chinese studied. It not surprising, then, that mental health professionals do not encounter many Chinese presenting emotional problems.

Not many Chinese patients seek (or maintain) psychotherapy in North America. Some mental health professionals who encounter Chinese patients experience frustration because they find the Chinese more likely to talk about somatic complaints during psychotherapy (Sue & McKinney, 1975; Lum & Char, 1985; Tsui & Schultz, 1985; Tung, 1991; Wu, 1982). Psychotherapy in North America usually presumes that patients acknowledge that intrapsychic and psychological conflicts are responsible for their problems. When they attribute their problems to somatic or social events, Chinese-Americans may be viewed as unsuitable for psychotherapy (Sue & Sue, 1987; Tseng & Hsu, 1979). This assumption on the part of some mental health practitioners is worth re-examining.

In summary, potential barriers to mental health care for Chinese in Canada include different conceptions of mental illness, the prevalence of somatic complaints, and tendency for intrafamilial coping with psychotic members in order to keep family secrets and save face. Other obvious barriers include language and subtle racism. In an exploratory study of the reactions of Chinese-American families of children with developmental disabilities to service providers, Smith and Ryan (1987) identified language as one of the most important barriers to utilization of health services. Other authors (Sue & Sue, 1987; Gaw, 1993; Cheung & Dobkin de Rios, 1982; Sue & McKinney, 1975; Sue, 1977; Sue, 1992) have also mentioned language as a significant barrier to obtaining help.

RESEARCH METHOD

The present study adapted methods and questionnaires developed by the Culture and Mental Health Research Unit of the Jewish General Hospital for a larger survey of help-seeking and health care utilization in the Côte des Neiges area on Montreal.

The study involved the following steps:

(1) a literature review on cultural idioms of distress and help-seeking among Chinese in urban settings in North America.
(2) translation of all research instruments into Chinese and checking of translation by independent back translation.
(3) pilot testing of interviews.
(4) final revision of interview instruments.
(5) pilot study on 100 women at the Montreal Chinese hospital.

All eligible subjects (Chinese immigrant women between the ages of 18 and 45 with at least one child under the age of 18) were approached in the office of a pediatrician affiliated with the Chinese hospital and were invited to participate in a survey on health care needs and utilization. All study subjects provided informed consent. Interviews were conducted in Cantonese by one interviewer during a 4 month period in 1997. The usual reason for refusing to participate was lack of time. A total of 101 women with young children were interviewed for the study providing 100 usable interviews. Data analysis was conducted at the Culture and Mental Health Research Unit of the Jewish General Hospital under the direction of Dr. Laurence Kirmayer.

Our sample was compared with a general population sample collected in the 'Pathways and Barriers to Care Project' (P&B), a community survey carried out in the catchment area of the CLSC Côte des Neiges from 1995 to 1997. This area of Montreal contains a large number of recent immigrants. The P&B study involved a random community sample of 2246 persons with over-sampling in specific census tracts to ensure representation of 5 cultural groups: Anglophone Canadian-born, Francophone Canadian-born, Vietnamese, Caribbean, and Filipino.

Chapter 2
Help-Seeking and Health Care Utilization

CHARACTERISTICS OF SAMPLE

Tables 2-1a & b present the sociodemographic characteristics of the study sample and compare them with a sample of residents from the Côte des Neiges area, collected for an earlier study by our team on "Pathways and Barriers to Care" (P&B). In addition to containing a culturally diverse Canadian-born sample, the P&B study involved over-sampling 3 immigrant groups (Caribbean, Vietnamese and Filipino) so that it provides a rough comparison of the range of symptoms or problems faced by other immigrant groups. Since the two samples differ markedly in gender composition, as well as in geographic location and with respect to many other sociodemographics, we use their comparison in the present report only to identify strong trends in the current data. In future analyses, we will compare a subset from the P&B study matched to the Chinese sample on crucial sociodemographic variables.

The Chinese-Canadian sample in the present study consisted entirely of married young mothers with an average of 2 young children. Many had additional adult family members living in the household. Two-thirds had more than high school education. Forty-four percent had worked for less than 6 months in the last year. The majority of respondents reported no religious affiliation; 25% were Buddhist and 10% were Protestant. While 10% attend religious services at least weekly, 12% practice religious rituals at home daily. Religious leaders are rarely consulted for help.

Table 2-2 summarizes the migration history of the women in the present study. More than 2/3 are citizens and 29% are landed immigrants. Most arrived in Canada in their twenties, on average 9 years ago. On average, they were accompanied by 2 family members and already had 2 family members in Canada. Less than 1/5 of the sample received financial help from family or friends when resettling in Canada. Fully 23% lived in another country from their country of birth before coming to Canada, on average for over 8 years.

The amount of schooling in Canada since arrival averaged about 1 year. The majority of the sample came from big cities in China. As seen in Table 2-3, just over half came from Mainland China, 35% from Hong Kong, and the remainder from Southeast Asia or Taiwan. In most cases, their husbands were born in the same country. In terms of ethnicity, most respondents described themselves as "Chinese" (88%), followed by Hong Kongese (10%) and Cambodian (2%). When asked if they had any other ethnic identification, almost 61% described themselves as Canadian, 1% as Vietnamese, and 1% as Cantonese.

Table 2-1a. Description of Sample

	Chinese Women (n=100)	P&B Total Sample (n=2246)
Gender (% Female)	100	59.8
Mean age (SD)	35.8 (6.1)	44.9 (18.1)
Marital status (%)		
Married	99.0	39.4
Living with someone	0	5.1
Never married	0	34.5
Widowed	0	10.0
Separated	1.0	3.0
Divorced	0	8.1
Of those married or cohabiting		
Currently living with partner (%)	98.0	95.6
Partner of same ethnicity (%)	100	82.9
N children living at home		
Mean total(SD)	1.9 (0.72)	0.69 (1.2)
Mean boys (SD)	0.88 (0.82)	-
Mean girls (SD)	1.1 (0.84)	-
Mean age of boys (SD)	6.8 (5.2)	-
Mean age of girls (SD)	6.5 (5.2)	-
N adults in household		
Mean (SD)	2.8 (1.2)	2.0 (1.0)
N adult males in household		
Mean (SD)	1.3 (0.67)	0.92 (0.75)

Table 2-1b. Description of Sample

	Chinese Women	P&B Total Sample
Mean years of education (SD)	10.5 (2.8)	13.1 (3.2)
Education > high school (%)	66.0	69.4
Still in school (%)	7.0	19.6
Worked < 6 mo. in last year (%)	44.0	40.7
Religion (%)		
Roman Catholic	2.0	44.5
Protestant	10.0	10.9
Other Christian	0	8.2
Moslem	0	1.6
Jewish	0	16.5
Buddhist	25.0	8.6
Hindu	0	1.4
Other	0	0.7
None	63.0	7.8
Attend religious services (%)		
Never	83.0	27.3
A few times a year	5.0	36.0
About monthly	2.0	8.4
Weekly or more	9.0	26.7
Daily	1.0	1.6
Practice religious rituals at home (%)		
Never	78.0	43.8
A few times	8.0	14.8
About monthly	2.0	2.8
Weekly or more	0	10.4
Daily	12.0	28.3
Turned to religious leader for help (%)		
Never	94.0	87.8
Once	0	2.7
Occasionally	5.0	7.1
Often	0	1.8
Never had problem	1.0	0.6

Table 2-2. Migration History

	Chinese Women	P&B Total Sample
Current status (%)		
Citizen	69.0	75.9
Landed Immigrant	29.0	21.5
Refugee	1.0	0.5
Other	1.0	2.1
Age arrived in Canada		
Mean (SD)	26.4 (5.2)	28.0 (13.1)
Length of stay in Canada (years)		
Mean (SD)	9.3 (6.0)	15.5 (12.7)
Proportion of life spent in Canada		
Mean (SD)	0.25 (0.14)	0.34 (0.23)
N family members came to Canada		
Mean (SD)	2.1 (1.9)	1.9 (2.4)
N family members already in Canada		
Mean (SD)	2.2 (3.3)	1.5 (2.6)
Got financial help from family / friends when resettling in Canada (%)	18.0	62.4
Schooling in Canada (years)		
Mean (SD)	1.1 (1.9)	2.6 (4.2)
Where lived before coming to Canada (%)		
Farm / Rural area	9.0	8.6
Small town or city	16.0	37.5
Big city	75.0	53.9
Lived in other country after leaving country of birth (%)	23.0	36.5
N years lived in other country		
Mean (SD)	8.5 (6.8)	5.6 (6.0)

Table 2-3. Most Frequent Country of Birth of Respondents and their Husbands (%)

Country of birth	Chinese Women (N=100)	Husbands (N=100)
China	54	58
Hong Kong	35	29
Vietnam	4	6
Indonesia, Malaysia	3	2
Cambodia	2	2
Laos	0	1
Taiwan	2	1
Canada	0	1

Table 2-4 summarizes the language most often used by respondents when growing up (their "mother tongue"), currently at home and in different social situations. The great majority spoke Cantonese while growing up and most continue to use it at home (78%) and to a somewhat lesser extent with friends (60%). About one third use Chinese at work, approximately one third use English, and the remainder use either Chinese and English or some other language (most often French). In encounters with health professionals or social workers, the respondents are evenly divided in thirds into those who use exclusively Cantonese or only English and those who use a combination of the two. Little use of French was reported.

The retention of Chinese language and its substantial use at work and with health professionals points to the need for linguistic and ethnospecific services to meet the needs of this population.

Table 2-4. Language Use (N=100)

	Language	(%)
Language used most often…		
when growing up	Cantonese	84.0
	Tai Shanese	6.0
	Mandarin	5.0
	Other	5.0
at home now	Cantonese	78.0
	Tai Shanese	7.0
	English + Chinese	6.0
	Other	9.0
at work now	English	36.4
	Cantonese	31.8
	English + Chinese	18.2
	Other	13.6
with doctor, nurse or social worker	Cantonese	30.0
	English + Chinese	30.0
	English	29.0
	Other	11.0
with friends	Cantonese	60.0
	English + Chinese	24.0
	Other	16.0

SYMPTOMATOLOGY AND LIFE EVENTS

On a list of 12 common somatic symptoms, the Chinese-Canadian mothers in our sample reported lower levels of distress in the past year compared to the respondents from 5 ethnocultural groups in our sample from Côte des Neiges. As shown in Table 2-5a, the most common somatic symptoms were fatigue (18%), dizziness (13%) and excessive gas or bloating (12%). Fully 11% reported that they had felt sickly most of their life. No one reported chest pain or fainting and abdominal pain was reported by only one person. In comparison, in the community sample, fatigue (32%), limb pain (24.6%), and excessive gas or bloating (19.5%) were the most frequent symptoms; fainting (2.3%), vomiting (4.4%), and feeling sickly for most of one's life (5%) were the least frequently reported symptoms.

The scale of somatic distress constructed from these items had moderate internal reliability in the Chinese-Canadian sample with Cronbach's alpha = 0.67; this is roughly equivalent to the value found in our larger sample of 0.73 (Table 2-5b). The reliability of the scale would be slightly improved if the item on abdominal pain was deleted. Regarding the item-total correlations, the three items most strongly associated with the overall scale were weakness, feeling sickly for most of one's life and fatigue. These may fit a syndrome of neurasthenia (Zheng et al., 1997).

In response to a question about whether they had had any symptom or problem over the last 12 months which a doctor could not diagnose or understand, 8% of the Chinese-Canadian women reported medically unexplained symptoms which could be classified into 6 broad categories: obstetric / gynecological problems (n=2), viral infection (2), abdominal pains (1), excessive gas or bloating (1), other musculoskeletal pains (1), and urogenital problems (1) (not shown in Table).

Fully 27% reported a chronic medical condition which could be classified as: endocrine (10), hematological (4), cardiovascular (3), gastrointestinal (3), allergic (3), musculoskeletal (2), and immunological (2) (not shown in Table). Symptoms for which a doctor had given a diagnosis in the past year were reported by 71% and included: viral infection (25), obstetric / gynecological conditions (11), musculoskeletal (7), gastrointestinal (6), allergies (5), ENT (ear, nose & throat) (4), cardiovascular (3), respiratory (3), hematological (3), endocrine (3), and urogenital (1) (not shown in Table).

Table 2-5a. Reporting of Somatic Symptoms in Last 12 Months

	Chinese Women (n=100)	P&B Total Sample (n=1710)*
Somatic Symptom Scale		
Overall mean	0.80	1.5
(SD)	(1.3)	(1.9)
Somatic items (% who reported symptom)		
1. abdominal pain	1.0	12.1
2. limb pain	3.0	24.6
3. chest pain	0	8.4
4. nausea	6.0	8.6
5. vomiting	3.0	4.9
6. loose bowels	3.0	13.8
7. excessive gas / bloating	12.0	19.5
8. dizziness	13.0	14.4
9. fainting	0	2.3
10. weakness	9.0	8.7
11. sickly for most of life	11.0	5.0
12. fatigue	18.0	32.0

* All subsequent comparisons involve a subset (N=1710) of the total P&B sample (N=2241) including only Anglophone and Francophone Canadian-born subjects and Caribbean, Vietnamese and Filipino immigrants.

Table 2-5b. Reliability Analysis of Somatic Symptom Index (N=100)

	Chinese Women
Alpha coefficient	0.67[1]
Item-total correlations:	
Somatic items	
1. abdominal pain	-0.06[2]
2. limb pain	0.31
3. chest pain	n/a
4. nausea	0.33
5. vomiting	0.21
6. loose bowels	0.08
7. excessive gas/bloating	0.33
8. dizziness	0.34
9. fainting	n/a
10. weakness	0.60
11. sickly (for most of life)	0.55
12. fatigue	0.49

[1] Alpha coefficient in P&B Total Sample = 0.73
[2] Alpha coefficient would increase slightly if item was deleted
n/a The item had zero variance in this group (mean and SD=0)

We adapted the 12-item version of the General Health Questionnaire (GHQ) to span the time interval of the last year with dichotomous response categories (yes / no). Table 2-6a shows the overall mean score and the percentage reporting individual items. The Chinese women reported a very similar average level of distress as the respondents in our community sample. The most frequently endorsed symptoms were felt unhappy and depressed (34%), constantly under strain (30%) and couldn't overcome difficulties (20%). The least frequent symptoms were not reasonably happy (1%), not playing a useful part in things (2%) and couldn't make decisions (2%). In comparison, the most frequent symptoms in the ethnically diverse community sample were couldn't make decisions (32.9%), felt unhappy and depressed (26.7%), and loss of sleep over worry (21.6%). The least frequent symptoms in the community sample were didn't face problems (3.2%), felt worthless (4.1%) and not reasonably happy (5.8%).

The Chinese version of the GHQ showed modest internal reliability, with Cronbach's alpha = .64; this was appreciably lower than the reliability of 0.73 found for the community sample in our earlier study (Table 2-6b). Deleting two items ("not playing a useful part in things"; "couldn't make decisions") would slightly increase the alpha. These items were perhaps infrequently reported and poorly associated with the overall measure of distress because the respondents were all mothers with primary responsibility for the care of young children and so could not evade decision making. As well, the notion of 'not playing a useful part in things' is so inconsistent with Chinese values of family and social inter-relatedness that it likely represents a very extreme symptom that few respondents would be willing to endorse even if they were distressed. As shown in Table 2-6b, the items most strongly associated with the overall score on the scale were loss of sleep over worry, constantly under strain, and felt unhappy and depressed.

We conducted a factor analysis with the items from both the somatic and psychological (GHQ) scales to examine underlying dimensions of distress. Principal components analysis followed by varimax rotation yielded 9 factors accounting for 69.9% of the variance. Only the first two factors were readily interpretable; examination of the factor scree plot also suggested extraction of 2 factors. Factor 1, accounting for 20.3% of the variance, had 4 items with factor loadings > 5: weakness; sickly for most of one's life; not able to concentrate; and fatigue. This corresponds closely to neurasthenia as defined in ICD-10 with prominent psychasthenic symptoms. Factor 2, accounting for 8.3% of the variance, was comprised of: lost sleep over worry; unhappy, depressed; not able to enjoy day-to-day activities; could not overcome difficulties; and constantly under strain. Factor 2 thus seems to reflect a dimension of dysphoric or depressed mood.

Table 2-6a. Reporting of General Health Questionnaire (GHQ) Symptoms of Emotional Distress

	Chinese Women (n=100)	P&B Total Sample (n=1710)
GHQ		
Overall mean	1.5	1.3
(SD)	(1.7)	(2.0)
GHQ items (% who reported symptom)		
1. not able to concentrate	9.0	6.5
2. loss of sleep over worry	18.0	21.6
3. not playing a useful part	2.0	8.3
4. couldn't make decisions	2.0	32.9
5. constantly under strain	30.0	19.8
6. couldn't overcome difficulties	20.0	11.4
7. didn't enjoy activities	5.0	6.4
8. didn't face problems	5.0	3.2
9. felt unhappy, depressed	34.0	26.7
10. loss of self-confidence	16.0	11.3
11. felt worthless	7.0	4.1
12. not reasonably happy	1.0	5.8

Table 2-6b. Reliability Analysis of General Health Questionnaire (GHQ)

	Chinese Women
Alpha coefficient	0.64[1]
Item-total correlations:	
GHQ items	
1. not able to concentrate	0.32
2. loss of sleep over worry	0.47
3. not playing a useful part	0.00[2]
4. couldn't make decisions	0.05[2]
5. constantly under strain	0.45
6. couldn't overcome difficulties	0.37
7. didn't enjoy activities	0.37
8. didn't face problems	0.19
9. felt unhappy, depressed	0.43
10. loss of self-confidence	0.26
11. felt worthless	0.17
12. not reasonably happy	0.27

[1] Alpha coefficient in P&B Total Sample = 0.73

[2] Alpha coefficient would increase slightly if item was deleted

Table 2-7. Recent Events

	Chinese women (n=100)	Total Sample (n=1710)
Recent Events		
Overall mean	0.63	1.0
(SD)	(1.2)	(1.3)
Recent Events (% who reported event)		
1. Difficulties at work or school	9.0	12.0
2. Major concerns with your children	2.0	7.1
3. Troubles with housing	0	5.5
4. Troubles because people did not understand your language	4.0	6.2
5. Troubles because of the neighborhood you live in	4.0	4.6
6. Troubles with the police	2.0	1.3
7. Troubles with prejudice or discrimination	8.0	6.5
8. Serious troubles because you did not have enough money	1.0	12.0
9. Troubles with your spouse or other adults in your family	7.0	9.4
10. Physical fights in your family	0	1.3
11. Serious arguments with friends	1.0	3.7
12. Illness or death in the family	17.0	22.9
13. Problems with government agencies	2.0	4.4
14. Been the victim of a crime or assault	5.0	2.3

Table 2-7 presents the frequency of life events in the past year using a list of 14 events covering a wide range of personal and social problems. On average, the Chinese sample reported fewer life events in the past 12 months than did our community sample. The most common events were illness or death in the family (17%), difficulties at work or school (9%) and trouble with prejudice or discrimination (8%). These results were similar to those observed in our community sample except that the latter also often reported economic problems (lack of money, housing).

HEALTH SERVICE UTILIZATION

Level of distress is an important determinant of health service utilization. Table 2-8 displays the rates of utilization of medical, mental health and social services in the last 12 months, comparing the sample of Chinese-Canadian women with groups of immigrants (primarily Caribbean, Vietnamese and Filipino) and non-immigrants (ethnically diverse Canadian-born Anglophone and Francophone residents) in the Côte des Neiges area.

The Chinese women were more likely than the community groups to have made some use of medical services in the past year. These visits were primarily to family doctors. (Table 2-9 summarizes the physical location of services used, which was primarily a doctor's private office.) The women were less likely to make use of medical services for mental health reasons and none had sought any specialty mental service or social work service. The overall rate of utilization of any service for a mental health reason was 2% among the Chinese women, compared to 5.5% overall for immigrants and 14.7% for Canadian-born respondents in the community survey.

For 83 women who had visited a family physician in the past year, the mean number of visits was 4.4 (SD=4.4); for the 20 who had visited a medical specialist, the mean number of visits was 3.5 (SD=4.2); and, for the 13 women who had visited an emergency room, the mean number of visits was 1.2 (SD=0.60) (not shown in Table).

While 26 women had scores of 3 or more on the GHQ indicating significant levels of distress, only 2 of these had talked to their family doctors about mental health issues in the past 12 months (not shown). None had visited a social worker, psychiatrist, psychologist or any other type of professional for a problem with nerves, worries, emotional or mental health, or a stress-related problem. (Among these 26 women, 22, 5 and 4 reported they had gone to a family doctor, medical specialist and emergency room, respectively, in the past year.) It was not possible to further analyze factors determining help-seeking for emotional distress in this group because only 2 women reported using any kind of service specifically for mental health problems.

Table 2-8. Service Utilization in the Last Year,
Chinese Women *vs.* Immigrants and Non-immigrants in the P&B Study (%)

	Chinese Women (n=100)	Immigrants (n=785)	Non-immigrants (n=925)
Sought any medical services	85.0	78.5	76.5
Emergency room	13.0	14.6	23.7
Family doctor	84.0	69.4	66.4
Medical specialist	21.0	36.6	50.5
Sought any medical services for mental health	2.0	3.6	5.8
Emergency room	0	0.5	1.5
Family doctor	1.0	2.8	4.5
Medical specialist	1.0	0.5	2.1
Sought social worker	0	3.2	4.2
Sought any specialty mental health services	0	2.5	11.7
Psychiatrist	0	1.2	5.0
Other mental health practitioner	0	0.6	6.8
Social worker for mental health	0	1.2	1.8
Other professional / agency for mental health	0	0.3	1.7
Sought any service for mental health	2.0	5.5	14.7

Table 2-9. Location of Service Used in Last Year by Chinese Women (%)

	(n=100)
CLSC	1
General hospital clinic	5
Mental health clinic / Psychiatric outpatient clinic	0
Emergency room	13
Private office	77

Table 2-10 summarizes the use of non-biomedical sources of health care in the past 12 months. None of the women sought help from someone in the community or from a religious leader. Fully 30% used Traditional Chinese medicine at home, on average about 5 times in the past year. Almost 1 / 4 (23%) consulted a Chinese medicine practitioner an average of 3 times. None of the

women used 'alternative medicine' (i.e. non-biomedical and non-TCM) at home and none consulted an alternative medicine practitioner.

Table 2-10. Utilization of Non-Biomedical Sources of Help in Last Year

	Chinese Women (n=100)
Sought help from anyone in community (%)	0
Sought help from religious leader (%)	0
Used any kind of Traditional medicine at home (%)	30.0
Of those using Traditional medicine at home:	
Mean number of times (SD)	4.7 (6.1)
Saw any kind of Chinese medicine practitioner (%)	23.2
Of those consulting Chinese medicine:	
Mean number of times (SD)	3.1 (2.2)
Used alternative medicine at home (%)	0
Saw alternative medicine practitioner (%)	0

In the last 12 months, 13% of the Chinese women had been hospitalized at least over night for a physical condition (Table 2-11). The reasons for hospitalization were obstetric / gynecological (9), gastrointestinal (3), and urogenital (1). The mean number of hospitalizations and number of days in hospital are summarized in Table 2-11. None of the women had ever been hospitalized in her lifetime for a problem with emotions, nerves, mental health or use of drugs or alcohol.

Table 2-11. Utilization of Inpatient Services in Last Year,
Chinese Women *vs.* Immigrants and Non-immigrants in the P&B Study

	Chinese Women (n=100)	Immigrants (n=785)	Non-immigrants (n=925)
Hospitalized overnight in last 12 months (%)	13.0	6.0	9.0
N times in hospital			
Mean	1.2	1.2	1.3
(SD)	(0.38)	(0.77)	(0.85)
N days in hospital			
Mean	3.9	7.7	16.0
(SD)	(3.3)	(13.8)	(46.6)

Table 2-12. Barriers to Mental Health Care among Chinese Women (n=59)

	n	%
1. The problem went away by itself	41	69.5
2. I thought the problem would get better by itself	26	44.1
3. I could not get time away from work or family responsibilities	8	13.6
4. It would have taken too much time or been inconvenient	4	6.8
5. I wanted to solve the problem on my own	3	5.1
6. There was a language problem	3	5.1
7. Help probably would not do any good	2	3.4
8. I was unsure about where to go to for help	1	1.7

Table 2-12 summarizes the barriers to seeking mental health care endorsed by the Chinese women who reported at least one psychological symptom of distress on the GHQ (in rank order). Of the 59 women who were asked these questions, 15 (25.4%) reported no barriers, 18 (30.5%) reported one barrier, 15 (25.4%) reported 2, 6 (10.2%) reported 3, 3 (5.1%) reported 4 and 2 (3.4%) reported 5 barriers (not shown in Table). Although most of the reasons reflect the fact that problems were probably mild or self-limited, it is of note that time constraints (#3, 4) were a fairly common reason for not obtaining help (reported by 20.3%).

ETHNIC IDENTIFICATION & ACCULTURATION

Three items on the questionnaire used in the present study assessed the extent to which respondents felt Canadian, a Quebecker, or their own self-defined ethnic identity (i.e. Chinese) (Lasry & Sayegh, 1992). On the basis of the scores on these items, individuals were classified into 4 groups following Berry's styles of acculturation (Berry et al., 1986): marginalization (low self-defined ethnic identity, low Canadian identity), assimilation (low, high), ethnocentricism (high, low) and integration (high, high). The percentages of Chinese women that were classified into each mode of acculturation were the following: marginalization (16%), assimilation (1%), ethnocentrism (77%) and integration (6%). None of the respondents reported significant self-identification as a Quebecker.

Chapter 3
Prenatal, Postpartum and Child Rearing Practices

PRENATAL EXPERIENCE

In 1987, a prenatal course was established at the Montreal Chinese Hospital to serve Chinese-speaking families. The success of the program resulted in negotiations between the Directors of the CLSC St. Louis du Parc and the Montreal Chinese Hospital aimed at transferring the program to become part of the perinatal services of the CLSC. The mandate of the CLSC as set out by the Regional Council includes perinatal services for expectant and new families.

Table 3-1 summarizes the prenatal experience of the present study sample. Of the 100 Chinese-Canadian women surveyed, 51 had attended a prenatal course. Of the 49 non-attendees, 24 (50%) had heard of the prenatal service but did not participate mostly because of time limitations. Only 22% of husbands took part in a prenatal course, representing less than half (43%) of the husbands of women who took the course. Most of the women (70%) had worked during their pregnancy.

The data collected suggest that this group of women needed more help in preparation for childbirth and infant care. The most common sources of information on pregnancy were a prenatal program (46%), reading materials (40%), obstetrician (36%) and friends (30%). Only 15 women had received information about pregnancy from their relatives and only 2 from their husbands. While 12% claimed they had worried about childbirth often or almost all the time, 44% were worried at least some of the time.

The majority of women (76%) stated that they had sought information about preventive health care for their infants before childbirth. Most acquired this from the prenatal program (41%), a doctor in a private office (26%) and relatives or friends (26%); only a few (9%) consulted the CLSC.

When women who had attended a prenatal course were compared with those who had not, there were no significant differences in the level of involvement of husbands or other family members in child care, the frequency or duration of breast feeding, or the frequency of feeding, disciplinary or other child care related problems. Women who attended prenatal classes were slightly *more* likely to have suffered a period of postnatal depression. This may reflect a self-selection bias whereby women who were more depressed or anxious before pregnancy were more likely to seek out a prenatal class and were more likely to continue to experience such symptoms after childbirth.

Table 3-1. Prenatal Experience

	% (n=100)
Participated in any prenatal course	51
Heard of service but did not participate*	24
Husband participated in prenatal course	22
Worked during pregnancy	70**
Obtained information about pregnancy from:	
Husband	2
Relatives	15
Friends	30
Reading materials	40
Obstetrician	36
Family doctor	8
Pediatrician	2
Prenatal program	46
Worried about how childbirth would go:	
Almost all the time	2
Often	10
Sometimes	44
Rarely	14
Never	30
Sought information about preventive health care for infant before childbirth	76
CLSC	9
Doctor in private office	34
Relatives or friends	26
Prenatal Program	41

* Most women (n=22) gave *time limitation* as the reason for not participating in a prenatal course. The same reason was given for the husband not participating (n=27).

** 20 worked until 8 months of pregnancy and 16 until 9 months.

INFANT FEEDING

Tables 3-2a & b summarize the breast feeding experiences of the women in our sample. A majority of women (73%) had intended to breast feed during at least one of their pregnancies, and 63% had planned to do so during their most recent pregnancy. The main reason for not planning to breast feed was inconvenience related to work schedules (n=17). Despite these intentions, however, 43% did not breast feed any of their children after childbirth. Of those who did breast feed at least one child, about half (28/57) did not breast feed to the fourth month. Prenatal classes (29%) and reading materials (19%) were cited most frequently as factors that influenced the decision to initiate breast feeding.

There is much evidence for the beneficial effects of breast feeding for both the infant and mother. It appears that better distribution of Chinese reading materials on breast feeding to pregnant women and the promotion of the value of attending prenatal classes are needed to encourage breast feeding. Breast feeding support services on the postpartum hospital ward and by the Chinese perinatal program may also enhance initial success and prolong the duration of breast feeding (Chan-Yip & Kramer, 1983; Chan-Yip & Wen, 1991).

Almost all the women (99%) had primary responsibility for feeding their infants, although for 18% husbands also helped with feeding and for 15% grandparents (15%) also participated (Table 3-2b). Given this level of involvement, information on infant feeding and advice on how to prevent or deal with potential difficulties should be transmitted to other child caretakers as well as to mothers.

Table 3-2a. Infant Feeding

	% (n=100)
Planned to breast feed child during any of your pregnancies	73
Made plans about how to feed this or last child before birth	98
Breast feeding	63
Formula feeding	35
How many children were actually breast fed	
0	43
1	30
2	22
3	5
Breast fed first child	46
Breast fed second child	36
Breast fed third child	7
How many children were breast fed at least 4 months?	
0	28
1	17
2	10
3	2
Final decision to breast feed influenced by:	
Husband	7
Relatives or friends	9
Obstetrician	12
Family doctor	0
Pediatrician	8
Nurse	9
Prenatal class	29
Reading materials	19
None of the above	2

Table 3-2b. Infant Feeding

	% (n=100)
Received advice for breast feeding when in need	
No	8
Yes*	12
Did not need help	38
Difficulty in feeding child**	27
Who fed child in first year:	
Self	99
Husband	18
Grandparents	12

* Mainly from husband and mother in law (n=8) and nurse (n=5)

** *Appetite problem* (n=16); *eats too slowly* (n=6); *throws up* (n=5)

POSTNATAL EXPERIENCE

Postpartum isolation and lack of support are associated with postpartum depression. As shown in Table 3-3, 19% of women in this sample recalled being sad and depressed for up to 2 weeks or more and 14% experienced prolonged fatigue during the postpartum period. One individual had prolonged fatigue for 6 months. Of the women experiencing sadness or depression, 11/18 (61.1%) did not know why they had these feelings (not shown in Table). Five women attributed the symptoms to hormonal changes accompanying parturition (not shown).

Despite their symptoms of postpartum sadness or fatigue only 5 women sought help (of those who specified their source of help, once each had approached a family physician, the CLSC and the husband). The most common reason for not seeking help, reported by 7 women, was that they did not know where to go or whether help was available (not shown in Table). Three women offered rationalizations for their symptoms (not shown).

Crying infants, especially during the newborn period, can be very stressful for mothers. The majority of the Chinese mothers stated that they would pick up their babies either immediately or after momentary waiting. However, 8 mothers reported they had just let their infant (under 4 months of age) cry until

it stopped on its own. Some mothers may be misinformed that picking up and cuddling infants can lead to spoiling.

Prolonged co-sleeping with parents was frequently practiced by the respondents in this study. Thirty five percent of mothers had their 2 month old infant sleep in the same bed as the mother, while 88% had the child sleep in same room. Almost half of the mothers (48.6%) still had their 2 year old child sleeping in the same room (not shown in Table).

Table 3-3. Postnatal Experience

	(n=100)
Experienced a period of at least 2 weeks of sadness or depression after child birth (%)	19
Experienced prolonged period of fatigue, weakness, headaches or imbalance after child birth (%)	14
Mean number of days (SD)*	16.6 (49.2)
Sought help for depression or fatigue (%)	5
Response to crying of baby (< 4 mo. old) (%)	
Pick him / her up right away	57
Wait a few minutes	51
Let him / her cry until he / she stops	8
Slept in same bed as mother (%)	35
Until what mean age in months (SD)	30 (20.7)
Slept in same room as mother (%)	88
Until what mean age in months (SD)	29.0 (21.0)

* minimum: 1 day, maximum: 4.5 days; 12 days of feeling fatigued for one woman and 180 days of fatigue for another

Table 3-4. Child Care Practices

	% (n=100)
Child received regular check-ups	98
CLSC	22
Private office of pediatrician	97
Private office of family physician	2
Hospital clinic	2
Know reasons for taking your child to regular health check-ups	93
Familiar with physical development of children	
Not at all	5
A little	65
A great deal	27
Very much	3
Familiar with psychological development of children	
Not at all	30
A little	63
A great deal	6
Very much	1
Where sought medical help when child was sick	
CLSC	17
Private office of pediatrician	91
Private office of family physician	26
Hospital emergency room	67

Fully 98% of this sample of mothers brought their children for regular health check-ups (Table 3-4). As expected given the source of the sample, almost all (97%) visited a pediatrician for this service; however, 1/5 also used the CLSC. Most subjects were able to elaborate on reasons for taking children to regular check-ups and the reasons given were quite uniformly stated as to ensure good health and normal growth of their infants.

Developmental monitoring in pediatric care emphasizes ensuring the normal physical growth of the child. In previous clinical work and research, the first author observed that Chinese mothers needed more anticipatory guidance during well-baby check-ups, as many of them seldom consulted health professionals on issues of child behavior and emotional development (Chan-Yip & Wen, 1991). While 30% acknowledged that they knew a great deal or very much about the physical developmental pattern of children, 70% knew little or nothing at all about psychological development. Only 7% felt they were very familiar with the psychological development of children.

HEALTH CARE UTILIZATION & USE OF TRADITIONAL CHINESE MEDICINE

The mothers' help seeking pattern for their children's sickness reflects that this is a selective sample of clients who are accustomed to using to pediatric services for continuity of care (91%), but respondents also made use of family physicians in private offices, CLSC services, and hospital emergency departments, presumably due to convenience of location and time of availability (Table 3-4).

As shown in Table 3-5, 24% of respondents had taken their child to see a traditional Chinese doctor; the most common reasons for consultation were colds and stomach problems. One third of mothers used over-the-counter Chinese medicines for similar purposes. Herbal medicines were used for children by 32% and 11% used them on a regular basis (as 'tonics'). These rates correspond closely to those found when the women were asked about their own use of a traditional Chinese medicine practitioner (used by 23%) and Chinese medicines at home (used by 30%) summarized in Table 2-10 above.

A belief in the concept of cold-hot imbalance as a cause of, or a contributor to, illness was acknowledged by 41 individuals. When asked what symptoms or illnesses they attributed to excess cold, 18 women stated the flu, while 17 said they did not know. A wider range of symptoms and illnesses were attributed to excess heat: 15 women said colds, sore throat, tonsillitis, cough, fever or sweating; 6 said eye problems; 5, constipation; and 3, mouth problems.

Table 3-5. Use of Chinese Medicine

	% (n=100)
Ever took child to traditional Chinese doctor	24
Cold	12
Stomach problems	6
Other	7
Ever gave Chinese medicine to child	33
Cold	20
Stomach problems	9
Other	3
Ever gave herbal medicine to child	32
Regular basis	11
Cold	8
Stomach problems	7
Other	6
Thought sickness is often due to imbalance between cold and hot in body	41
Chose to eat certain foods to remedy cold-hot excess related symptoms	35
Ever took child for acupuncture	2

Many foods are categorized by Chinese as hot or cold and used to counteract illnesses believed to be caused by hot or cold imbalance. Five respondents noted eating a lot of fried foods as a common cause of excess heat (not shown in Table). Selective eating of foods to resolve a hot/cold imbalance was practiced by 35 persons. Use of other forms of TCM was rare: only 2 children were taken to receive acupuncture, in both cases for asthma.

CHILD CARE, PARENTING AND SOCIALIZATION

Child care is often the shared responsibility of the extended family members in Chinese families. In this study sample, 44% of the respondents had relatives involved in child care, most often grandparents (32%) (Table 3-6). While all mothers (99%) assumed responsibility for discipline, 53% of the fathers also did so; 10% of respondents also involved grandparents in child discipline. The methods of discipline employed included reasoning (91%), scolding (61%), and physical punishment (50%). Only 2 subjects had resorted to the use of time-outs (limit setting), a method which has been considered highly effective by child care authorities.

Table 3-6. Parenting Style

	% (n=100)
Relatives involved with care of child	44
Grandparents	32
Responsible for disciplining your child	
Yourself	99
Husband	53
Grandparents	10
How disciplined children	
Scold	61
Physical punishment	50
Reasoning	91
Time-out	2

Clinical observations suggest that many immigrant children and their families have less than optimal socialization skills due to cultural isolation. With increased culture-specific community resources (Chinese radio station and newspaper; Chinese nursery school; churches; weekend Chinese schools and culture dancing groups) in the last 2 decades, immigrant families have become much less isolated. As seen in Table 3-7, 87% of mothers reported they brought their children to play with other children. The 13% who did not do so gave as the reasons that they had no time (3%) or no friends with children near-by (5%), or that their children were too young and they did not think that it was necessary (5%) (not shown in Table).

Table 3-7. Socialization of Children

	(n=100)
Ever brought children to play with other children (%)	87
Any children went to nursery school or pre-kindergarten (%)	79
Prepared children to learn (%):	
French	57
English	53
Children watch English / French television and videos regularly (%)	81
Mean number of hours / day (SD)	2.0 (1.1)
Children watched Chinese television or videos* (%)	55
Regulate programs and video watched by children (%)	52
Children's recreational activities (%)	
Individual sports	23
Home activities	21
Go to the park	17
Summer camps	16
Activities in community center	9
Group sports	9

* 31 women said *Occasionally*; 20 women said between 0.5 and 4 hours / day on average

The majority (79%) had sent their children to nursery school or pre-kindergarten. Of those who did not (21%), 14 claimed that it was not necessary and 6 others claimed that they were not familiar with the services, found the services too expensive, or had transportation problems.

Many immigrant couples have limited fluency in both English and French. Their children may experience adaptation difficulties in school due to language barriers unless they are enrolled in language preparatory programs, provided through nursery school or day care (Chan-Yip, 1988). Only 57% and 53% of mothers sent children to nursery or pre-kindergarten to learn French and English, respectively. Many children probably learned the official languages from television as 81% reported that their children watched either English or French TV channels, or videos regularly; 55% of children also watched Chinese television and videos regularly. In fact, 18% watched Chinese TV or videos between 1 and 4 hours a day on average (not shown in Table). Only 52% of mothers claimed that they regulated the TV programs and videos watched by their children.

The respondent's children participated in a limited number of other recreational activities: children of 16 mothers went to summer camps; 9 used community center facilities; and 9 joined group sports. Other recreation included going to the park (17%), individual sports (23%: swimming, bike riding, skating, hiking, etc.), and home activities (21%: computer games, drawing, Lego™, piano). Taking lessons (Chinese school, music, dance, Chinese calligraphy), shopping, church, scouts, dining out, and going to the library, museum or movies were also reported for children's activities (not shown in Table).

Conflicts with children in immigrant families can often be related to cultural issues. As shown in Table 3-8, only 4 subjects reported having had problems with their children (learning problems: 3; bad temper: 1). When asked where they would seek help to solve their children's problems, the most frequent sources were the pediatrician (55%), friends (55%), and relatives (48%).

More than half of the women (54%) acknowledged that they sometimes felt helpless in bringing up their children. This helplessness was attributed to lack of experience by 36 respondents, 13 women could not explain it, and 5 gave other reasons (e.g., felt pressured by elders, used incorrect parenting methods, could not control anger, had different child rearing background themselves) (not shown in Table).

Ten individuals had experienced difficulty in communicating with their children either because the children did not understand them and were disobedient (n=4) or because of cultural barriers (n=6; different cultural mentality: different language, different mind-set, parents were old-fashioned, or different education). Fifteen percent felt they had a 'generation gap' with their children because of language problems (n=4) or different cultural mentality (n=11). Conflict with children was reported by 30 women. The types of conflicts included arguments (n=16; difference of opinion, disputes, misunderstandings, verbal fights, children

being short-tempered), and disobedience (n=14; children not following instructions) (not shown).

Table 3-8. Child Problems and Help Seeking

	% (n=100)
Ever had any problems with children	4
Where would you go for help for problem with children?	
CLSC	9
Pediatrician	55
Family doctor	3
Psychiatrist	12
Social worker	10
Relatives	48
Friends	55
Elders in community	1
Within your own family	5
Felt sometimes helpless in bringing up children	54
Reason for feeling helpless:	
Lack of experience	36
Do not know	13
Had difficulties in communicating with children	10
Felt generation gap with children	15
Had conflicts with children	30
Talked to children about sex	41
Children confided in mother about private life	78

Sex education was not emphasized at home: only 41% of mothers talked about sex with their children; 42 felt their children were too young, and 15 avoided this topic because the subject was embarrassing, they had conservative views, they felt sex education was promoted at school, or their children did not raise this issue for discussion.

Alienation of children and parents is not often observed in Chinese families. The majority (78%) of respondents stated that their children confided in them about their private activities.

Social isolation has been recognized as a cause of depression among immigrant women. Although this sample of mothers reported a range of recreational and leisure activities, most of these took place inside the home and did not involve engagement with the host society. As summarized in Table 3-9, 71% watch TV or listen to the radio, 57% read, 36% listen to music, 20% play sports and 11% shop, dine-out or travel. No one reported visiting the Casino. This regular use of media suggests that public health education and mental health promotion could be effectively addressed to these women through the use of mass media and reading materials.

Table 3-9. Recreational Activities

	% (n=100)
Recreational activities in spare time:	
Listening to music	36
Sports	20
Watching TV, Listening to radio	71
Reading	57
Going to movie / theater	5
Going to casino	0
Cooking, sewing, knitting, puzzles	7
Shopping, dine-out, travel	11
Other (sleeping, bowling, outdoor activities)	6

Chapter 4
Discussion and Conclusion

At present there are few culture-specific mental health resources available for Chinese in Montreal. Accordingly, it is of great importance to understand how culture influences symptom expression and clinical presentation, problem definition and help-seeking among the Chinese. Determining the pattern of use of traditional, alternative and allopathic (Western) medicine will allow clinicians and planners to identify areas where hospital services are inadequate or where collaboration with other practitioners must be further developed. The present study was designed to examine the health and child care practices of a group of Chinese immigrant women.

The study involved a sample of 100 Chinese-Canadian immigrant women attending a pediatric practice at the Chinese Hospital of Montreal. Although the sample is not representative of the whole Chinese immigrant community it offers useful insights into the problems and concerns of young mothers who make up an important segment of the clinical population served by the Chinese Hospital.

The mothers in the sample tended to be in their mid-thirties and had an average of 2 children at home. Most had additional adult family members living in their households. Fully 2/3 had more than high school education and over half had been employed for 6 months or more in the last year. The women had arrived in Canada about 10 years ago on average and the majority were citizens, while almost 1/3 were landed immigrants. The great majority came from big cities in China or Hong Kong and almost 1/4 had lived in another country for several years after emigrating from China and before coming to Canada. They came to Canada with 2 other family members on average.

Cantonese and other Chinese dialects were the preferred languages used at home and with friends for the majority of women. Over 1/3 of the women used English primarily at work while about 1/3 used Cantonese and 1/3 used a combination. Language use with doctors, nurses or social workers was similarly divided into thirds for use of English, Cantonese or a combination. French was rarely used by this group of immigrants.

The majority of women (3/4) identified most strongly with Chinese ethnicity and only secondarily, if at all, with Canadian culture. None of the respondents reported significant self-identification as a Quebecker.

Taken together, these characteristics of the study sample suggest strong retention of Chinese language and culture in a group of recent immigrants. Meeting the health care needs of this population, therefore, requires that practitioners and institutions provide linguistically and culturally appropriate services through which a bridge can be made to the social realities of the larger society.

Symptoms of Distress and Health Care Utilization

The women in this sample reported fewer somatic symptoms but slightly more psychological symptoms of distress than those in our large community sample of residents of the Côte des Neiges area. Interestingly, weakness and feeling sickly for most of one's life were more common in the Chinese-Canadian female sample. This may reflect differences in the meaning of these items in translation to Chinese, differences in gender, or culture-specific modes of experiencing and expressing distress. The scale analysis showed high item-total correlations for these items suggesting that they are reliable indicators of a global dimension of distress. These symptoms fit with the category of neurasthenia which is still a popular diagnosis in many areas of China (Lee, 1994) and a common form of distress in Chinese immigrant populations in the US (Zheng et al., 1997).

Medically unexplained symptoms were not common in this group, with only 8% of women reporting a symptom or problem which a doctor could not diagnose in the past year. However, more than 1/4 women reported a chronic medical condition including endocrine, hematological, cardiovascular, gastrointestinal and allergy problems. Almost 3 out of every 4 women had an illness in the past year for which they had received a doctor's diagnosis. There is thus a significant burden of both acute and chronic illness in this population.

Levels of psychological distress as measured by the General Health Questionnaire were slightly higher in this sample than in the general population sample. Since women generally report such symptoms more often than do men in many cultural groups, this difference may reflect the gender difference in the two samples. More than 1/3 of the women reported feeling unhappy or depressed, and almost as many reported being constantly under strain. About 1/5 reported being unable to overcome their difficulties and/or losing sleep over worry. More than 1/4 of the sample reported more than 3 items on the GHQ, indicating significant levels of distress in the past year.

A factor analysis of somatic and psychological symptoms yielded a dimension of distress corresponding to neurasthenia with principal symptoms of weakness, feeling sickly for most of one's life, not able to concentrate, and fatigue.

The most common life events experienced by these women in the past year were illness or death in the family, difficulties at work or school, and troubles with prejudice or discrimination. This last problem points to specific issues experienced by immigrants who are visible minorities. These warrant closer examination to determine their origins and the corrective actions that may be taken, directed not so much as toward the Chinese community and its coping with such discrimination, but toward segments of the larger society where xenophobic attitudes may be prevalent and cause hardship for new Canadians.

Rates of medical care utilization in the last year were slightly higher for this Chinese-Canadian sample than for the immigrant and non-immigrant groups in our community survey. This may reflect the fact that the former sample was drawn from a clinical context (albeit one the subjects were attending for their

children, not themselves), or gender differences as a result of the smaller proportion of women in the community sample. These high rates of utilization do indicate ready access to medical care for this group. Strikingly, however, only 2 women reported seeking help for an emotional, stress or mental health problem and not a single woman sought such help from a specialized mental health caregiver. This lack of utilization of mental health services occurred despite appreciable levels of emotional distress as noted above. This observation fits with the literature on under-utilization of mental health services by Chinese and many other Asian groups in North America, as summarized in Chapter 1 of this report.

Almost 1/3 of the women made use of some Traditional Chinese Medicine at home in the last year and almost 1/4 saw a Chinese medical practitioner. Other forms of alternative or complementary medicine were not used by these women.

When women who reported at least one psychological symptom of distress on the GHQ (n=59) were read a list of barriers to seeking mental health care, about 3/4 reported at least one barrier. Although most of the barriers endorsed were likely related to the problems being mild (e.g., the problem went away by itself, reported by nearly 70%), time limitations were also important obstacles (endorsed by 20%) and 3 women reported language problems as a barrier to mental health care.

Prenatal Experience

About half of the women in the sample attended a prenatal course for Chinese-speaking families. The most common reason for both mothers and fathers to not participate in a prenatal course was time limitation. There were significant levels of apprehension about pregnancy which might be alleviated by prenatal education. This suggests the need to develop reading materials and brief courses that are practical and accessible for couples with heavy work or family obligations.

Postnatal Experience

In this sample of mothers, 19% of women recalled being sad and depressed for 2 weeks or more after childbirth and 14% experienced prolonged fatigue during the postpartum period. Despite their symptoms only 5 women sought help. The most common reason for not seeking help, reported by 7 women, was that they did not know where to go or whether help was available.

A majority of women (73%) had intended to breast feed during at least one of their pregnancies. Despite these intentions, however, almost half (43%) did not breast feed any of their children. About half of those who did breast feed did not continue to the fourth month. Prenatal classes (29%) and reading materials (19%)

were cited most frequently as factors that influenced the decision to initiate breast feeding.

Prolonged co-sleeping of young children with parents was frequently practiced by the respondents in this study. About half of mothers reported sharing a room or a bed with their 2 year old children. Developmental guidelines in North American pediatric practice suggest that milk bottle syndrome, feeding difficulties and excessive attachment may arise from such practices.

With the availability of universal health insurance, the Chinese children were generally brought in for regular check-ups.

Use of Traditional Chinese Medicine

About 1/4 of respondents had taken their child to see a traditional Chinese doctor. The most common reasons for consultation were colds and stomach problems. One third of mothers used over-the-counter Chinese medicines for similar purposes. Herbal medicines were used by 32% and 11% used them on a regular basis (as 'tonics'). These rates correspond closely to those found when asking the women about their own use of a traditional Chinese medical practitioner (23%) and use of Chinese medicines at home (30%).

A belief in the concept of cold-hot imbalance as a cause of, or a contributor to, illness was acknowledged by 41 individuals. When asked what symptoms or illnesses they attributed to excess cold, 18 women stated the flu, while 17 said they did not know. A wider range of symptoms and illnesses were attributed to excess heat, including: colds, sore throat, tonsillitis, cough, fever or sweating; eye problems; constipation; and mouth problems. Selective eating of foods to resolve a hot/cold imbalance was practiced by more than 1/3 of mothers. Use of other forms of TCM was rare: only 2 children were taken to receive acupuncture for asthma.

Parenting and Child Care

Almost half (44%) of the respondents had relatives involved in child care, most often grandparents (32%). While almost all mothers (99%) assumed responsibility for discipline, 53 and 10% of the women reported that the father and grandparents, respectively, were also involved in child discipline. The methods of discipline employed included reasoning (91%), scolding (61%), and physical punishment (50%). Only 2 subjects had resorted to the use of time-outs (limit setting), a method which has been considered highly effective by child care authorities. This points to the potential value of parenting education which should be offered not just to mothers but also to other adults in the household.

A great majority of mothers had sent their children to nursery school or pre-kindergarten and brought their young children to play with other children. Approximately equal numbers of mothers prepared their children to learn

French (57%) and English (53%). About 1/4 of children took part in other recreational activities. More than half of the children watched Chinese television programs or videos regularly, indicating substantial efforts to transmit and retain Chinese language and culture.

More than half of mothers acknowledged that they sometimes felt helpless in bringing up their children. Most attributed this helplessness to a lack of experience. Only 4 women reported having had 'problems with their children'. However, almost 1/3 of women reported conflict (arguments or disobedience) with their children and 15% felt that there was a generation gap. While 10% of mothers felt they had communication problems with their children, fully 3/4 of mothers also felt that their children confided in them. This is not surprising given the young age of the children, most of whom are not yet adolescents. The most likely sources of help these women would use for problems with their children were friends, a pediatrician and relatives. While most women reported one or more recreational past-times, activities outside the home were not common, perhaps owing to work and family responsibilities.

Limitations of the Study & Future Directions

The use of a small clinical sample limits the generalizability of these results which must be replicated with a larger community sample. We plan to extend the analysis by comparing the results with age and gender-matched samples from our larger community study in Côte des Neiges. We will also test a range of multivariate models to identify predictors of distress and child rearing problems among the Chinese-Canadian women in the present study. Finally, we plan to apply for funding to conduct a similar survey in the general population with the assistance of Chinese Family Services and the Center for Excellence on Immigration and Urbanization.

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