Use of the Recovery Approach to Support Chinese Immigrants Recovering from Mental Illness: A New Zealand Perspective

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Recovery has become a popular concept in mental health services. The Mental Health Commission in New Zealand has recently endorsed the recovery approach as an approach to working with people suffering from mental health problems. Ten recovery-based competencies were developed by the Commission as the underpinning principles for training of mental health professionals and delivery of mental health services. The ethnic composition of the New Zealand population has become increasingly diverse in recent years, including a rapid rise in the number of Chinese immigrants. Immigration is a stressful experience and it may result in changes in mental health. One vignette is used to discuss how health professionals can use the recovery-based competencies to help Chinese New Zealand immigrants with mental illness (re)gain their healthy life roles and (re)integrate into society. Further research is required to help identify specific intervention methods that contribute to successful recovery among Chinese immigrants with mental illness.

INTRODUCTION

More than 400 million people alive today suffer from some form of diagnosable mental illness or from psychosocial problems associated with alcohol and drug abuse (World Health Organization,

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This figure is based on information gathered from 181 countries covering 98.7% of the world’s population. With the current wave of globalization some individuals with mental illness may travel or immigrate to other countries, or individuals may develop mental health problems due to changes in culture, isolation from family and social networks, and adjustment difficulties related to language, employment, and housing after migrating to foreign countries (Aroian, 1990; Arthur, 2000). Culture can be defined as an abstraction, a complex idea or a set of perceptions used by members of a group and passed on to successive generations. Culture also refers to the shared language, behavior, customs, symbols, knowledge, and ways of comprehending reality (Priest, 1991). “People’s perceptions of and responses to health and illness tend to be culturally determined, with a person’s own culture being the reference point for other views” (Jungersen, 1992, p.746).

In the past two decades the ethnic composition of the New Zealand population has become increasingly diverse. Chinese immigration had increased at a very rapid rate. During the years from 1992 to 1998, the top four nationalities approved for residence in New Zealand were Great Britain (35,023 people or 14% of the immigration population), China and Taiwan (27,351 and 28,320 people respectively or both at approximately 11%) and South Africa (19,139 people or 7%; New Zealand Immigration Service, 2001). However, it is not clear how many of these immigrants actually reside and remain in the country. To date, the New Zealand mental health data only provides analysis on Maori (New Zealand indigenous people) and non-Maori (such as New Zealand European or Pakeha, Samoan, Chinese, Indian) in terms of the ethnic background of users of mental health services (New Zealand Health Information Service, 1996). Despite the fact that there is no official data on the overall mental health status of the Chinese community in New Zealand, the mental illness encountered by Chinese New Zealand immigrants should not be underestimated. Based on United States data, Asians tend not to use mental health services, or when they do utilize the services, they exhibit more severe mental symptoms than their American counterparts (Sue et al., 1991).

The aims of this article are twofold:

1. Explore issues which are relevant to effective management of mental illness for Chinese New Zealand immigrants.
2. Discuss how the recovery approach may be applied in supporting Chinese New Zealand immigrants recovering from mental illnesses.

THREE KEY ISSUES WHEN WORKING WITH CHINESE NEW ZEALAND IMMIGRANTS

Shame Associated with Mental Illness

The shamefulness of mental illness among Chinese can be illustrated by the following abstract from a bibliography of a Chinese woman residing in Australia when she recalled one of her relatives: “this cousin had a son who was a grown-up man, but he was mentally not right. He talked in a funny way and he’d stand on a chair and then jump down, and then he’d keep jumping up and jumping down. And he did all other silly things, so he never went to work. He had messy hair and I hated his eyes that seemed to peep all over you. The sun never touched him, he stayed pale. His pointy mouth and thinnish jaw made him look like a mouse” (Hanrahan, 1989, p.98). Maintenance of a good name (or face) for an individual or the entire family is affected by the behavior of an individual. The desire to avoid shame delays an individual who has mental illness and often his/her friends’ from help-seeking (Tabora & Flaskerud, 1997). This often affects the outcome of the psychiatric intervention adversely. Furthermore, the application of psychosocial intervention relies heavily on the therapeutic relationship between the client and the mental health professional. Avoiding shame also tends to make the person unwilling to self-disclose his/her own needs, feelings and thinking, in turn weakening the establishment of a trusting relationship (Tabora & Flaskerud, 1997).

When working with Chinese New Zealand immigrants, this dilemma of “losing face”/shame is further compounded by the subtleties in Chinese and English language. Suggestions can be easily misinterpreted as instructions or commands. Certain terms (e.g., empowerment), when expressed in English, do not have an easy, equivalent word in Chinese. It may also be the case that the health professionals have a first language other than English. Mistrust of mental health services or any government agencies among Chinese New Zealand immigrants make the development of a trusting therapeutic relationship even harder. Mistrust stems from the historical experiences of imprisonment, politically-related persecution, physical abuse, death of family members or friends and racial
discrimination, maltreatment, and disappointment upon arriving in New Zealand (Arthur, 2000). All these reasons exacerbate the difficulties in communication between the client and staff.

Shame is closely related to the pervasive influence of stigma and discrimination against people with mental illness. According to labelling theory, the degree of disability faced by individuals with psychiatric illness can be partly attributed to the stigma attached to having such an illness (Link & Cullen, 1990). Stigmatisation can be defined as the process of linking the bearer of the mental illness to unwanted, and usually undesirable, attributes that discredit him or her in the eyes of others. The consequences of stigma are many and can be devastating for the individual. They include exclusion from, or reduced access to, adequate housing, meaningful work, and routine social interactions, as well as essential services such as education, financial loans, health insurance, and even drivers’ licenses. As the stigmatizing attitudes of others are frequently internalized by those who encounter them, this can result in weakened self-efficacy beliefs and negative outcome expectancies of recovery on the part of those with mental illness (Kaminski & Harty, 1999). Stigma produces discrimination. Discrimination is an act or attitude by a person or organization, which fosters unfair treatment of an individual because he/she is different (South Project, District Advisory Groups, 1997). Discrimination develops from people’s fears about mental illness and the attitudes of others including mental health professionals, family, friends, and the general community (Arthur, 2000; McCue & Katz-Garris, 1983). An individual’s aspirations to leave the hospital may be viewed by health professionals or family members as “inappropriate” or “unrealistic” despite previous high psychosocial functioning in the area of self-care, work, and study (Peter, 1999). Persons with psychiatric disabilities are often treated as less-than-human and incompetent and it has been suggested that having a psychiatric history may be as difficult to shake off as is a criminal record (Miller, 1995). Such discrimination combined with the effects of the illness itself, can lead to feelings of disconnectedness and disempowerment. Within New Zealand, discrimination on the grounds of a past psychiatric history or because of impairment due to mental illness is probably widespread and may result in part from the fact that small communities make up much of the country, making it very difficult to remain anonymous (Miller, 1995). A Chinese with mental health issues in New Zealand may suffer a
"double dose of stigma and discrimination" being both mental health consumer and Chinese, especially in a small community. The attitudes and behavior of fellow consumers, friends and health professionals can be quite distressing and not helpful to recovery. There is insufficient literature related to the mental health of Chinese in New Zealand. There is not enough support from services and awareness and sensitivity of culture-related issues is inadequate. Lastly the negative impact of financial hardship or poverty, which may be due to lack of information on income support services in New Zealand, on the lives of Chinese with severe mental illness cannot be understated (Vecchio et al., 2000).

Dependence

Traditionally, extended-family structures or community-centered ideologies are one of the major characteristic of Chinese culture (Arthur, 2000). Fundamental to Confucian thinking it is thought that the maintenance of one's wellbeing begins with the individual and proceeds through the regulation of family and community and national life to the creation of an ideal commonwealth (Tseng, 1973a). Emphasis is placed upon harmonized relationships between the father and the son, the care between elder and the younger, and the mutual love and respect between husband and wife. The family is expected to and would provide the needed practical and emotional support to its family members during times of stress or health problems, whereas western culture in general is based on the notion of independence and self-reliance (Arthur, 2000). This sometimes presents a challenge to mental health practitioners in New Zealand or any western countries because this so-called dependent relationship between the person recovering from mental illness and his/her parents or carers is easily misinterpreted as dysfunctional or even pathological. Furthermore, traditional Chinese medicine tends to treat people with acute or chronic illness as dependent individuals somewhat contrary to western psychosocial interventions which emphasize the individual's independence, reaching individual potential and self-help. In Chinese culture people with sickness will often expect that others have an obligation to serve them. The serving may include preparation of herbs, acupuncture and moxibustion by expert practitioners, certain exercises done to the person or a special diet prescribed for the person aimed at regaining equilibrium between Yin and Yang, between
microcosm and macrocosm, and among the Five Elements (i.e., metal, wood, water, fire and earth; Li et al., 1972; Tseng, 1973b). In brief, health among Chinese is viewed as the state of physical and spiritual harmony with nature, and a mutually dependent relationship with members in a family. Disturbance of this harmony or relationship may lead to illness. Undeniably as a result of rapid urbanization and westernization of Asia, recent changes in Chinese family structure and the Chinese New Zealand immigrants' geographic distance from their family, the above-described dependency on family and the phenomena of a passive sick-role may not be very evident in New Zealand. However the challenge of how to become more sensitive to minority groups in the context of providing culturally appropriate mental health services in New Zealand remains unmet.

Fatalism

Closely related to the sick person's passive and dependent role, there is a notion of fatalism in the Chinese culture. Chinese tend to believe in the ultimate fairness of destiny or someone's fate and attribute all misfortune to universal laws which are beyond a person's control (Tseng 1973a, 1973b). This kind of attribution likely reinforces compliance with a situation such as having a severe mental illness rather than actively trying to solve the problem and achieve personal goals. As a result of this view, the person may have a negative attitude to the illness or treatment if he/she feels that there is no hope for the future. The person may feel so powerless and give up engaging in any therapeutic interventions including taking medications. However, it can be argued that fatalism sometimes may help the individual come to terms with his/her health situation and be in harmony with oneself.

USE OF RECOVERY APPROACH IN NEW ZEALAND

The recovery approach has international origins and has been recently developed and endorsed in New Zealand by Mental Health Commission as a new and fresh approach to working with people suffering from mental health problems. It has grown from both positive and negative roots: the failure of mental health institutions to meet the needs of people with psychiatric disabilities,
distrust of mental health professionals; and, on the positive side, reduction of stigma about mental illness; and promotion of community care where the seeds of the new self help ideology of recovery were sown (Tse, 2001). "Recovery" is defined as "the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name the experience)" (Mental Health Commission, 2000, p.1). Anthony (1993, p.15) defined recovery as "a deeply personal, unique process of changing one's attitudes, values, feelings, and goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life".

Other essential features of the approach include:

- Recovery is a process and an attitude, not a place.
- Recovery is about reclaiming the role of a "healthy" person.
- Recovery involves the person having a vision of the life he/she wants to live.
- Each person has his/her own definition of "living well".
- The experience of recovery is different for everyone.


Recovery is still an evolving paradigm for individuals with psychiatric disabilities. Based on studies of personal accounts of recovery, "recovery" encompasses concepts such as hope, information, knowledge and skills, sense of control, empowerment, self-determination, personal responsibility, and spirituality (for a review on the latest development of the conception of recovery and its research, see Ralph, 2000; Young & Ensing, 1999). Using a regression analysis model, Corrigan and associates (1999) found that self-esteem, empowerment, and age of an individual could account for up to 78% of the recovery scale variance. Additionally, greater numbers of support persons, better quality of life and low psychiatric symptoms ratings showed significant positive correlation with good recovery scores.

While there is no consensus about the nature of recovery from serious mental illness, a rapidly growing number of consumers and practitioners are embracing the belief that people with psychiatric disability can recover and lead meaningful lives (Russinova, 1999). The recovery paradigm integrates the strengths perspective and the empowerment perspective, both of which
have been gaining popularity in the field of human services. These perspectives are quite different from the deficit approach or medical model which has prevailed in the mental health field for decades. From a recovery perspective, the development of client's skills for engaging in meaningful activities and for rebuilding a deeply wounded self becomes the treatment priority, rather than symptom management and relapse prevention. Thus, the focus of service delivery changes from treating the disorder to treating the whole person. The development of the person's strengths becomes the road to overcoming the limitations of the illness and to recovery. In the context of the recovery paradigm, consumers and practitioners increasingly acknowledge the importance of hope as a major factor facilitating the recovery process (Russinova, 1999).

In New Zealand, Mary O'Hagan, who is the Mental Health Commissioner, took up the challenge to develop 10 recovery-based competencies to provide educators with guidelines on the inclusion of the recovery approach in the programs they offer for mental health professionals (Mental Health Commission, 2001). The 10 competencies are as follows:

1) understands recovery principles and experiences in the Aotearoa/New Zealand and international contexts;
2) recognizes and supports the personal resourcefulness of people with mental illness;
3) understands and accommodates the diverse views on mental illness, treatments, services and recovery;
4) has the self-awareness and skills to communicate respectfully and develop good relationships with service users;
5) understands and actively protects service users' rights;
6) understands discrimination and social exclusion, its impact on service users and how to reduce it;
7) acknowledges the different cultures of Aotearoa/New Zealand and knows how to provide a service in partnership with them;
8) has comprehensive knowledge of community services and resources and actively supports service users to use them;
9) has knowledge of the service user movement and is able to support their participation in services; and
10) has knowledge of family/whanau perspectives and is able to support their participation in services.

These recovery-based competencies will serve as a framework to discuss how the recovery approach can be utilized to support