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Parent Perceptions of Mental Illness in Chinese American Youth

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Abstract

Background: Although parents are often the first to facilitate help-seeking in their children, parental perceptions regarding mental health serve as a significant barrier to the access of mental health services. This study examined mental health perceptions held by Chinese immigrant parents of youth.

Methods: Eighteen parents (13 female, 5 male), who identified as having children between the ages of 13 and 21 years, participated in audio-recorded interviews using five vignettes depicting depression with and without a somatic emphasis, schizophrenia with paranoid features, attenuated psychosis syndrome, and social anxiety in youth. Questions about potential causes, likely diagnosis, and health-seeking behaviors in relation to these vignettes were asked. Interviews were analyzed for themes using a deductive-inductive hybrid approach, informed by the explanatory models that have shed light on Asian perceptions of mental illness and approaches to help-seeking.

Results: While Asian groups are often considered as lacking in mental health knowledge, we found that Chinese immigrant parents were comfortable with psychological terminology as it pertained to identifying causes and describing supportive strategies and the seeking of Western-based providers. However, the majority of Chinese immigrant parent respondents did not easily note suicidality. Furthermore, respondents did not consider social anxiety as a major mental health issue among Chinese immigrant parents and attributed social anxiety to personality or cultural differences.

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Discussion: These findings provide an understanding of how Chinese immigrant parents conceptualize mental illness and help-seeking, which may be helpful for providers when working with Chinese immigrant parents of children that have a mental health concern.

Keywords

Chinese immigrants; qualitative research; mental illness; youth

1. Introduction

Recent research on mental health disparities among White and Asian American patients have found that White patients are more likely than Asian American patients to carry a diagnosis of a mental disorder and receive medication treatment, suggesting that mental disorders may be under-recognized and under-utilized in the Asian American community (Wu, Chiang, Harrington, Kim, Ziedonis, & Fan, 2018). In particular, data from both population and community-based samples of Chinese immigrants indicate low rates of mental health service utilization (Spencer & Chen, 2004; Kung, 2004; Chen, Kazanjian, & Wong, 2009). The factors associated with low rates of mental health service utilization among Chinese immigrants include high cost of service use, limited English proficiency, and parental perceptions regarding child mental health problems (Chen, Kazanjian, & Wong, 2009; Owens et al, 2002). This study focuses on U.S. Chinese immigrant parents' perceptions of mental health among youth and the approaches to support their child if confronted with problematic behaviors.

1.1. Chinese mental health perceptions and help-seeking behaviors

Culturally-influenced explanatory models of mental illness (Karasz, Sacajiu, & Garcia, 2003; Kleinman, 2004; McCabe & Priebe, 2004) suggest that culture shapes how patients make sense of their illness, how it impacts their expected process for recovery, and the approaches they take for help-seeking (Kasahara-Kiritani, Matoba, Kikuzawa, Sakano, Sugiyama et al., 2018; Lam et al., 2010; Li, Friedman-Yakoobian, Min, Granato, & Seidman, 2013; Yang & Singla, 2011). Low mental health literacy among the Chinese has been found to be associated with the use of informal networks (lay help and alternative treatments), which can result in greater delays in formal psychiatric treatment (Wong & Li, 2014). For instance, because the cause of mental illness is believed to have stemmed from social or personal causes (WonPat-Borja, Yang, Link, & Phelan, 2012; Yang et al., 2013), there have been negative associations with help-seeking from mental health professionals (Chen & Mak, 2008) among the Chinese. Those who seek treatment from specialists have severe mental problems (Lin, 2012) and thus, seeking treatment may bring shame to the individual and family (Lam et al., 2010). Further, the role of stigma may be a barrier in formal help-seeking even as knowledge of mental health increases, suggesting that illness beliefs are also important to address along with recognition (Chen, Hung, Parkin, Fava & Yeung, 2018).

There is a lack of distinction between the physical and psychological manifestations through the somatic presentation held by Asians. East Asians tend to describe their emotional problems by emphasizing their physical symptoms (Kleinman, 1977; Chan, Parker, Chan, &

Parker, 2004), with this somatization being an “idiom of distress” (Katon, Ries, & Kleinman, 1984). The lack of a distinction between the physical and psychological manifestations through the somatic presentation held by Asians (Leung, 1998; Parker, Gladstone, & Chee, 2001; Parker, Cheah, & Roy, 2001) facilitates the search for physical treatments (Kung & Lu, 2008; Ying, 1990). For instance, the seeking of practitioners, such as herbalists or acupuncturists (Kung, 2004), is consistent with the notion that changes in lifestyle or diet play a role in well-being. The emphasis of modifying one’s lifestyle and diet can mitigate psychological issues, but in turn, delay help-seeking from a mental health professional (Lin & Lin, 1981). Given the literature on traditional or lay beliefs regarding mental health in Chinese populations, the interest is whether these traditional viewpoints emerge when U.S. Chinese immigrant parents are asked to perceive their children’s mental health.

1.2. The emergence of mental illnesses among Chinese youth

Assessing parent perceptions and approaches to help-seeking for children of Chinese immigrant families is also imperative given that mental illness often manifests during adolescence (Kessler et al., 2005). Despite the prevalence and severity of depression, psychosis, and social anxiety, respectively, there is a low rate of accurate identification of these illnesses among the Chinese (Li et al., 2013; Wong, Lam, & Poon, 2010; Zhang et al., 2013).

Prevalence rates for depression documented among Chinese youth ranges between 23%–64% in mainland China and Hong Kong (Chan, 1995; 1997; Yang, Yao, Zhu, & Zhang, 2010). Rates of depression are of particular concern in the U.S. among Asian American youth, who have low rates of mental health diagnoses but higher rates of suicidal ideation than their White peers (Liu, Stevens, Wong, Yasui, & Chen, 2018). The rates of depression are of concern in relation to low rates of treatment seeking in U.S. Asians (Abe-Kim et al., 2007).

Prodromal symptoms of psychosis also often emerge during youth. The lack of knowledge about psychosis delays help-seeking among Chinese first-episode patients and their parents, leading to a longer duration of untreated psychosis of their parents relative to other ethnic groups (Chiang, Chow, Chan, Law, & Chen, 2005; Skeate, Jackson, Birchwood, & Jones, 2002).

Finally, the experience of social anxiety may also be particularly salient to youth with a Chinese background, given cultural differences in social and expressive norms. Asian-American college students, with a large proportion being East Asian, have shown to have significantly higher levels of social anxiety than White Americans (Lau, Fung, Wang, & Kang, 2009; Okazaki, 1997, 2002; Okazaki, Liu, Longworth, & Minn, 2002). However, epidemiological studies have found lower rates of social phobia diagnosis among Asians, including those who are Chinese, compared to White Americans (Lewis-Fernández et al., 2010), suggesting that distress about social anxiety symptoms may be experienced differently across cultures. The cultural implications in the experience and help-seeking for depression, psychosis, and social anxiety based on prior work highlights the need to

understand how Chinese immigrant parents describe mental health and help seeking as it pertains to their youth.

The purpose of this study is to understand the perception of mental illness in youth among Chinese immigrant parents and their approaches in supporting their children. To accomplish this, we conducted individual interviews with Chinese immigrant parents to examine their knowledge about youth mental health symptoms, related to major mental disorders (depression, psychosis, and social anxiety) through hypothetical mental illness cases and their decisions in helping their child, if confronted with these concerns. Chinese immigrant parents and their perception of youth mental health is largely unknown, but obtaining this information could inform mental health providers, who work with Chinese immigrant parents and their children.

2. Methods

2.1. Setting and Participants

The data was collected from Chinese immigrants in a greater metropolitan area within New England. Participants were initially recruited from a Chinese community center in an inner-city area and from Chinese churches and schools from the suburban areas, and through a snowball sampling method. To meet eligibility, participants needed to be ethnically Chinese and born outside of the U.S., and to have at least one child between the ages of 13–21 years. Table 1 displays additional information on participant demographics. Prior to data collection, participants signed the informed consent. This was an IRB approved study.

2.2. Measures

2.2.1. Participant questionnaire.—We collected demographic information including: age, gender, birthplace, language, education, and income from each parent participant.

2.2.2. Vignettes and semi-structured individual interview.—Previous studies on mental health knowledge (Jorm, Wright, & Morgan, 2007; Klimidis et al., 2007) extensively utilized vignettes describing depression, psychosis, and social anxiety to investigate participants' knowledge of mental illness, attitudes towards mental health, and help-seeking behaviors. The use of vignettes to understand the causes of mental illness has been utilized with Chinese populations (Klimidis et al., 2007; Lam, Chan, & Chen, 1996; Ying, 1990). As well, it has been used with parents (Jorm et al., 2007), including those who are immigrants (Chapman & Stein, 2014; Ko & Choi, 2015), with researchers developing vignettes to assess parent mental health attitudes for the particular population of interest (Chapman & Stein, 2014; Ko & Choi, 2015).

In our study, we adapted four of our vignettes from vignettes used in prior work among an Australian population (Wright et al. (2005). According to Wright and colleagues (2005), the vignettes used for the Australian population were developed to include individuals displaying symptoms that met both ICD-10 and DSM-IV minimum diagnostic criteria for the disorders. For our population, we modified our vignettes in the following way. First, to capture the possibility of recognizing mental health concerns through psychosomatic symptoms among Chinese immigrant parents, we created two depression vignettes with one

prominently featuring somatic symptoms. One vignette emphasized a constellation of somatic symptoms including loss of appetite/weight loss, problems with sleeping, and low energy, as well as a “heavy and pressured sensation,” a symptom that often characterizes psychosomatic expressions of depression among Chinese (Tan, Wu, Chen, 2013). Anhedonia was also included in this vignette given that the symptom may be particularly salient to Asian culture. The second vignette focused primarily on sadness as a primary symptom, as well as suicidality, with the latter included because of increased Chinese parent concerns about suicide in youth (Kam, 2013). Finally, academic concerns were elaborated in the vignettes overall given the focus on academic achievement as an important outcome among Chinese immigrant parents. To obtain additional information on the recognition of prodromal symptoms for psychosis, we also developed an additional vignette based on a case illustration previously published on psychosis risk in Chinese American youth (Li et al., 2013) to be included alongside the other four vignettes. The interview involved a presentation of vignettes describing behaviors associated with the following disorders: Appendix I displays each of these vignettes.

Follow-up questions were asked following the presentation of each vignette to obtain 1) parental impressions of a presenting mental illness, 2) parental beliefs about the cause of the mental illness, 3) parents’ approaches to help-seeking and intervening for youth with the mental illness, and 4) parents’ views about the role of diet and activity in addressing a mental illness. These questions included the following: “If you were the parent of this child, what do you think is going on?” “Why is this child showing these behaviors?” “What do you think caused this child’s behavior?” “If this were your child, what would you do, if anything?” “Would you approach someone or some service regarding this behavior?” If yes: “Whom/where would you go and seek consultation or help?” If no: “Why?” “What would (stated consultation/service) do for your child?” Given the role of diet and lifestyle on mental health in Chinese cultures (Wong & Li, 2014), we also assessed whether families considered these factors in their thinking regarding the vignettes. Thus, as a check, we posed the following questions: “Would you change her diet or her activity? Activity could be anything the child is participating in outside of school.” If yes, “How would you change her diet or activity? What would (stated changes to diet or activity) do for your child?” If no: “Why?”

2.3. Data Collection

Two bilingual-Chinese American psychology researchers conducted interviews, one with a doctoral degree in school psychology (H.L.) and another a resident psychiatrist (E.W.). The participants first completed the Participant Questionnaire and then took part in a semi-structured, open-ended individual interview (60 minutes). All the interviews were conducted in the participant’s preferred dialect (8 interviews in Cantonese and 10 in Mandarin) and their preferred location (home for the 8 participants via Skype and a community center for those who did the in-person interviews). We recorded all interviews with audio digital recording system. Two research assistants transcribed the interviews, which were checked for accuracy by the second author of the article. All responses were obtained in Chinese from the participants, with exception to the usage of the terms “depression,” “social anxiety,” and “social phobia,” which were stated in English by four parents. The

transcription was followed by the translation of the interviews to English, which were done by research assistants bilingual in Chinese and English. The translation of the medical terminology was reviewed with the interviewers to ensure accuracy prior to coding.

2.4. Coding and Data Analyses

A deductive-inductive hybrid approach was used for the data collection and analysis of this project, a strategy that has been used by other qualitative research (Fereday & Muir-Cochrane, 2006; Selvam & Collicutt, 2013). Informed by the explanatory models that have shed light on Asian perceptions of mental illness and approaches to help-seeking, a theory-driven perspective facilitated the construction of the vignettes, the follow-up questions, and the coding themes. Two researchers independently read all the transcripts to confirm the use of the initial coding structure that captured the distinction between physical and psychological manifestations of an illness, the distinction between reliance on professional and non-professional resources, and the role of diet in improving mental health.

We also took an inductive approach that considered the possibility of the data to reformulate aspects of the theoretical framework. Four transcripts were then randomly selected for independent coding by two researchers. Additional themes that emerged from the data were identified and discussed. Finally, new inductive codes and clusters of codes were categorized into themes and subthemes. Disagreements in the coding were discussed until the reviewers reached a consensus, and overlapping codes were eliminated which further refined the coding system. The remaining transcripts were then assigned to a primary coder with review by a secondary coder, with this second step resulting in further discussion towards consensus.

Altogether, the stages for coding involved the following: 1) the design of theoretically informed coding template, 2) the application of codes to the dataset, and 3) examining the emerging themes to either corroborate or challenge the theoretical framework used from the deductive approach.

3. Results

Below, we describe parent responses that support the themes that emerged from interviews. The quotes described represent common perspectives toward the theme, unless otherwise noted.

3.1. What Are Parents' Impressions of the Presenting Illness?

Parents characterized mental health concerns among youth by making a distinction regarding the physical or psychological origins of the disorders that were presented to them (*Physical/Psychological Distinction*) with the majority of parents making this distinction across all disorders, with exception to the vignette on social anxiety. The "Depression with a somatic emphasis" vignette was regarded as a physical disorder, whereas the "Schizophrenia with paranoid features" vignette was regarded as a psychological disorder. For instance, in relation to "Depression with a somatic emphasis" vignette, some parents stated: "I'm more inclined to think it might be due to physical causes, given the decreased appetite and weight loss," and "The child might have some body discomfort, or is encountering too much

pressure.” On the other hand, when asked what they thought of the “Schizophrenia with paranoid features” vignette, parents indicated, “The child obviously has a psychological problem because he says the neighbors are watching him,” and suggested that there was “some dysfunction psychologically, a mental disease.” In their deliberation, some parents focused on the somatic symptoms such as “decreased appetite,” or they wondered what it meant to have “pressured sensation in chest” or whether there may be problems with hearing. Parents also evaluated whether it was a “mental health problem.”

Terminology that revolved around mental health (e.g., specific symptoms, personality traits, or diagnoses) was used, revealing a new theme (*Labeling Mental Health*). We found that parents were able to identify that the behaviors represented a mental health disorder across all vignettes, as stated through phrases such as “mental disorder,” “mental disturbance,” or “psychological illness.” They were more likely to label the schizophrenia and psychosis risk vignettes with these terms relative to the other vignettes. Furthermore, in labeling the depression vignettes, parents tended to use terms such as “depression,” or “anhedonia.” Parents used “losing appetite,” “physical discomfort,” to describe the “Depression with somatic emphasis” vignette. For the schizophrenia and psychosis vignettes, they used terms such as “schizophrenia,” “delusion,” “paranoid,” and “lacking reality,” with the word “autism” being used substantially for the schizophrenia vignette. Some speculated “OCD” in describing the psychosis risk vignette. More of the parent comments were oriented around this particular theme relative to the other themes for the social anxiety vignette. For this, there were many instances in which parents labeled the behavior as representing “social anxiety,” “shyness,” or having a “weak personality.”

Only four parents from the study explicitly referenced the suicidal ideation described in the depression with non-somatic emphasis vignette. One parent suggested seeking ways to understand why the child would not value their life, and another response directly addressed the need to prevent suicide. An additional two parents indicated that they had heard about suicides occurring locally but that they seem infrequent, with one parent stating: “I don’t know any less extreme cases (referring to the vignette that described suicidal thoughts, not a completed suicide), because the Chinese community doesn’t like to talk about such issues.”

Parents assessed how problematic the behavior was (*Determining Severity*). This was not the most prevalent theme among the responses, however, the specific mention of severity was not uncommon. Comments on the severity of the behavior was highly dependent on the particular vignette, with this theme being particularly strong for the “Schizophrenia” vignette, and following this, the two Depression vignettes. In describing the level of severity in the schizophrenia vignette, some descriptions included “it’s far beyond normal behavior” and “this is obviously problematic.” One parent directly compared and contrasted the “Depression with somatic emphasis” vignette with the “Depression without somatic emphasis” vignette: “This case does not seem as serious as the previous one. The psychosocial stressors are very similar to the previous case, including academic problems, friendship, family death, family relationship conflict.”

3.2. What Are the Parents' Beliefs about the Cause of the Mental Illness?

Parents speculated on a number of different possibilities that could give rise to the behaviors. Five themes were identified through their responses that captured the different domains by which the problems might have originated (*Peer Relationships, Academics, Personality, Family Stress, Developmental Change*). In general, there was a greater number of comments pertaining to the causes of the problem for the two depression vignettes and the social anxiety vignettes, but fewer comments across the themes for the schizophrenia and psychosis risk vignettes.

Nonetheless, the majority of parents attributed stress from *peer relationships* and *academics* as a source of the disorder across vignettes, but particularly for the depression vignettes. For instance, parents wondered if conflicts with friends, such as being bullied or threatened, having problems in a romantic relationship, or being lonely might have contributed to the symptoms. For one participant, they listed various possibilities within these domains: "I will first talk with the child myself to see what the causes are. For example, are there any hardships in his/her life? Given the age of the child, maybe romantic relationships? If not, is it because of academic problems? Maybe he/she got frustrated with a bad exam score? Or maybe conflict with classmates? Bullied by others in school?"

Furthermore, parents attributed specific *personality* characteristics with the social anxiety vignette, citing that being socially awkward or lacking confidence, or having a poor self-esteem would lead to those symptoms: "I don't think the child has any problems. It seems like her parents raised her up as a nerdy child who is timid and does not know how to deal with people. She does not know how to be confident in front of strangers." Even more, a number of parent responses invoked culture and personality as contributors to the behavior within the social anxiety vignette: "She's just a very typical Chinese kid...good grades, unsociable, doesn't participate in activities (except for some science clubs, likes to be in his/her own comfort zone," and "[It's a] personality problem...too shy...doesn't like to make friends." Another parent stated: "As the Chinese saying goes, 'he who talks much errs much'. Maybe that is why she is so reticent. She possibly cares too much about others view about her." Finally, one parent made a direct contrast between the parental norms across the two cultures: "I have a feeling that the pervasiveness might be lower among non-Asian children, because the parents encourage self-expression more. Also, non-Asian parents seem to care more about the child's happiness than their achievement. The non-Asian and Asian parents have different values."

Stress from the family was mentioned as a possibility across vignettes, although not as emphasized relative to the other subthemes. Some parents suggested conflict or poor communication in the family environment as potential contributors to children's behavior: "The causes could be due to changes and conflicts in the relationship between the parents... If there are fights at home, it will not only threaten the safety of the child, but could also disturb her sleep/rest." In another instance, one parent shared how parent expectations could serve as a vulnerability for risks: "If parents have really high expectations for the child and no tolerance for failures, the child might end up having a weak personality and become easily affected by negative incidents. On the contrary, if the parents don't place such

exclusive emphasis on success and encourage the child to contribute to the society in his/her own way, the child might not experience such problems.”

Although it was not as likely to be endorsed, some parents wondered if *developmental change* such as puberty was a possible risk or vulnerability for the depression vignettes: “Rebellion during puberty, hormonal changes, and inattentiveness are the causes of her behavior” and “during puberty, children might have more extreme mood swings, and incidents might trigger (depression) more easily.” Developmental considerations were also made in evaluating the social anxiety vignette as one parent shared, “This is probably pretty frequent among Chinese children...some just get better in time.”

Finally, one parent endorsed spiritual forces as a potential contributor of the mental illness, in addition to other factors such as family stress and personality, sharing: “I think all happenings are under God’s will,” and that delusions “could be the result of demon’s possession.” The parent acknowledged that her perspective was rooted in her strong Christian worldview.

3.3. What Are the Parents’ Approaches to Help-Seeking and Intervening for Youth with Mental Illness?

In their initial response to the vignettes, some parents specified the steps that they would take if they were confronted with these signs and symptoms in their own children. These included their need to directly communicate with their child (*Direct Communication with Child*), which was emphasized for the depression vignettes. Parents also stated that they would try to understand where their child was coming from, and to offer support and comfort, but to also find out directly from the child what might be causing the problem. As one parent stated: “First, I would provide comfort and support. Under these circumstances, criticism, and blame would make it worse. It would make the child more unwilling to communicate. I would show my child that I understand.” As indicated by another parent, “I would pay more attention to my child’s daily functioning, improve my communication with the child, and try to find the underlying cause.”

There was also recognition among parents that the child might need further assistance beyond parental support. The sources of assistance included health professionals (*Health Professionals*) and non-health professionals (*Non-Health Professionals*).

Parents tended to endorse health professionals over non-health professionals, with the specific health professional varying depending on the particular vignette. Health professionals mentioned included: primary care physicians, psychiatrists and psychologists, and school counselors. For instance, parents seemed to refer to primary care physicians in their responses but did not rule out the support from either psychiatrists or psychologists across the vignettes. One parent shared the steps that they would take: “If the situation didn’t improve, I might bring the child to a primary care physician first. After ruling out the possibility of physical problems, I would seek help from a psychologist.” Only three parents indicated a preference for a Chinese medicine practitioner explaining that they would be more apt to resolve the stress related to the depression with somatic symptoms vignette.

Some parents were more willing to refer to psychiatrists or psychologists than primary care physicians for the schizophrenia and psychosis vignettes. There were only a few instances in which parents indicated going directly to the emergency room or seeking an otologist (ear doctor). One parent described: “I would take the child to an otologist, since she’s experiencing discomfort with her ears.” Additionally, there were only a few instances where parents indicated not being sure which professional to see or reported having some sort of distrust of the health care system.

Parents also mentioned seeking out non-health professionals, which included family friends, community organizations such as their spiritual community or minister, their partner, school teacher, or online resources. Seeking advice from the community was mentioned more frequently for the depression vignettes and in particular, for the “Depression with somatic emphasis” vignette, where there were more remarks made on seeking counsel from the school (teacher), community services, and family friends than with a health professional. For instance, parents shared: “I would talk to other children’s parents and talk to the child’s teacher,” and “I would seek help from the school. Maybe the teachers would provide some resources such as websites to look at and contact information for services. I would also talk to friends to obtain more resources which I would utilize.”

In asking parents what they expected would happen as a result of seeking outside assistance, parents reported across vignettes a hope that their child would learn to cope and that the intervention would help to identify a cause, provide medication, or be generally helpful in reducing the problematic behaviors. In contrast to their responses for what they, as parents, would immediately do upon realizing that there was a problem, there was less specificity in their expectations for what could be possible through outside intervention, though most held hope that things could resolve. As one parent shared, “I would find out the cause and try to see what can be done to relieve the child’s stress and help the child return to normal life.”

3.4. What Are Parents’ Views on the Role of Diet and Activity in Addressing These Concerns?

Given common somatic conceptualizations of mental health in the Chinese culture, we followed up with our primary questions by asking parents specifically if they held any beliefs on the role of diet and activity regarding the behaviors presented in the vignettes. In general, parents did not believe that changing the child’s diet would be very useful in helping the child (i.e. “I may try to change the child’s diet, but I don’t think it will be helpful.”). However, some parents did indicate that offering foods that the child likes would help increase their appetite and provide more energy, and would also address some of the somatic concerns by increasing activity, as that could improve their mood.

Parents did indicate that increasing physical activities, social interactions, increasing participating in community services, or changing activities and improving sleep quality could help to improve children’s mood, help them relax, or distract them from their distress. Going outdoors and playing games were activities that parents mentioned for improving mood in the “Depression without somatic emphasis” vignette, (e.g., “I would bring him outdoors, have him go play basketball, and go hang out with friends.” and “I will take the child into the nature to help him/her relax,”) whereas increasing contact with others was a

strategy that parents considered more for the social anxiety vignette: “I would help the child to make more friends,” “I would encourage the child to join more activities, and spend more time with friends. I would encourage him not to be shy and to expand his social circle. To be brave.”

4. Discussion

Our study goal was to understand how Chinese immigrant parents perceive mental health concerns of youth and how they might provide support to youth in their psychological distress.

4.1. Parent Initial Impressions of Mental Health Problems

Consistent with other studies that have presented vignettes to parents regarding problematic child behavior (Chapman & Stein, 2014), determining the severity of the issue was a primary concern for parents. In describing the vignettes, most of the language used focused on the psychological aspects of the problem. This diverges from what might be expected among the Chinese, which is the tendency to somaticize psychological disorders. Recent research with depressed Chinese immigrant primary care patients showed that the participants were more likely to endorse symptoms related to mood rather than depressed neurovegetative or non-neurovegetative symptoms (Chen, Hung, Parkin, Fava, & Yeung, 2015). Given our focus on immigrant parents, it is possible that acculturation to U.S. culture increases use of psychological terminology.

This was also observed in the parents’ ability to differentiate the behaviors presented. The parents in our sample were fairly accurate in their descriptions of depression, schizophrenia, and psychosis, using terminology that included symptoms of each disorder, such as “depression” or “anhedonia” for depression, or “schizophrenia,” “paranoid,” or “delusion” for schizophrenia or psychosis. While some parents may have speculated other disorders such as OCD or autism, in general, their use of the mental health terminology indicates more accurate terminology in describing depression (Chen et al., 2015) and psychosis (Klimidis et al., 2007) among immigrants. Prior research among East Asian samples indicated difficulties differentiating disorders due to lack of knowledge (Ko & Choi, 2015; Yeung et al., 2004). Given the immigrant status of the parents, it is possible that those in our sample have more knowledge of the Western framework for mental illness (Chen et al., 2015). Furthermore, recent efforts for raising mental health awareness among the Asian immigrant community may have enhanced the use of mental health terminology among Chinese immigrant parents (Burge, 2014; Spencer, 2017). Nonetheless, only a few parents noted suicidal ideation. Only one parent directly used the term suicidality and advocated for the need to prevent it, whereas others commented that it as an infrequent occurrence, which they heard in passing, noting the stigma within the Chinese community. The descriptor “better off dead” may not have been sufficiently explicit for participants to label it as suicidality. However, there was no deliberation by parents as to what this meant compared to the deliberation regarding other symptoms across vignettes. This lack of discussion among our respondents may reflect the stigma of suicidality. While our sample size is small, it appears that greater public

psychoeducation and open sharing about suicidality within this community remains necessary.

4.2. Parent Beliefs about the Causes of Mental Illness

There were five themes related to determining the cause of the problems: *Peer Relationships, Academics, Personality, Family Stress, and Developmental Change*. As the vignettes characterized children, parents' speculation regarding the cause of the problems afforded an opportunity to determine how the parents conceptualize the experiences of children. The domains for causes that emerged take into account developmental and contextual considerations suggesting that parents believe mental health behaviors in children arise from psychosocial experiences. This is consistent with how family members of patients in previous studies have attributed causes for depression as psychological stress (Chapman & Stein, 2014; Chen and colleagues 2015, below) and have believed causes for schizophrenia as social, interpersonal, and psychological rather than biological (Phillips et al., 2000) in youth. Given the importance of strong interpersonal social networks among the Chinese population (Cheng, Lam, Kwok, Ng, & Fung, 2013), it may be no surprise that relationship issues are considered a primary driver for psychological distress.

It is notable that the attributed causes for the social anxiety vignette diverged somewhat from the depression and psychosis vignettes. The social anxiety vignette seemed to yield responses that invoked both personality and culture, with parents tending to attribute the issues to being socially awkward, shy, or being a "typical" Chinese child. In general, anxiety is overlooked universally (Hansen, Oerbeck, Skirbekk, & Kristensen, 2016; Masi, Millepiedi, Mucci, Poli, Bertini, & Milantoni, 2004). Social anxiety has been found to be more challenging to recognize as a mental health disorder (Coles et al., 2016) and a disorder where professional help-seeking is less encouraged in non-Chinese samples (Jorm et al., 2007). However, our study points to the possibility that Chinese immigrant parents cultivate their perceptions of social behaviors from their culturally based understanding of behavioral norms as it pertains to being Chinese in the U.S. Shyness has been considered to be a positive outcome in Chinese cultures, and thus, not necessarily seen as a problem, although this view of shyness is shifting over time with greater recognition of problematic social inhibition (Chen, 2010; Chen, Chen, Li, & He, 2005). Perhaps there exists a higher threshold for considering social anxiety to be pathological among East Asian cultures relative to that of Western (Hong & Woody, 2007). As such, normalizing the cause for social anxiety can be potentially problematic, as Chinese parents may not see social anxiety as a mental health problem that can or should be resolved.

4.3. Parent Approaches to Seeking Help for Children

Unsurprisingly, parents in our study indicated they would want to speak directly to their child if confronted with the behavioral issues characterized in the vignettes, and to do so in a supportive manner. This was also found previously in studies using vignettes with Latino parents who indicated parental intervention as being a first line of defense (Chapman & Stein, 2014) and in Australian parents who indicated that they would want to listen and support the individual (Jorm et al., 2007). Yet, the parents in our study also recognized the need for additional intervention, and indicated they would solicit guidance from both their

community and health professionals. Previous findings have demonstrated that Chinese and Chinese Americans prefer using friends and family rather than health professionals for mental health problems (Chin, Chan, Lam, Lam, & Wan, 2015; Leung, Cheung, & Tsui, 2012), with the reliance on social networks consistent with assumptions that community and family are sufficient for supporting individuals in their distress, such distress does not require outside intervention (Dhooper & Tran, 1987; Sue, 1994). There may also be the assumption that emotional challenges are normal and can be addressed by the community, as going to outsiders may be “shameful.”

However, the parents in our study commonly cited the primary care physician from whom they would seek further assistance. They were also able to articulate that a mental health professional, such as a psychiatrist, psychologist, or school counselor might also be warranted; interestingly, most did not indicate seeking a traditional medicine healer as a primary service provider for their child. Overall, our study findings contrasts with other research on Chinese or Chinese Americans showing a lower preference for a health care professional for mental health problems (Chin et al., 2015; Leung et al., 2012). It is possible that the inclusion of schizophrenia and psychosis within our vignettes highlighted the severity of the mental illnesses overall. Growing awareness of the pressures faced by Chinese American youth and the related advocacy for the wellbeing of said youth may also play a factor in parent concerns and willingness to seek outside assistance for their children’s mental health (Kaminsky, 2014). Another possible reason may be due to the location of our sampling. The metropolitan area where recruitment took place is home to many medical centers. Given this environment, access for a healthcare professional is more readily available. Notably, however, parents responded with being more likely to seek a non-health professional for assistance compared to a health professional for depression that was characterized with somatic symptoms, versus that of somatic symptoms. While intriguing, one interpretation may be that parents view the somatic symptoms to be less concerning than experiences of sadness and suicidality, and such problems could be dealt with by non-health professionals.

While the parents in our sample appropriately identified health care professionals able to address the concerns characterized in the vignettes, there appeared to be less specificity in parent responses when probed further about what they expected after seeking assistance from healthcare professionals, with a general hope that things would resolve through medication or other means of coping. This lack of specificity was also observed in Latino parents when asked about what a professional mental health care provider might be able to do to address their children’s behavioral problems (Chapman & Stein, 2014). Having a more concrete understanding of the process, the scope, and expectations for treatment may help parents prepare for recovery and/or encourage greater help seeking.

The interviews did not yield any explanations for why diet would or would not be associated with mental health, nor did any parents directly refer to energy imbalance as a cause for mental health problems. However, they did emphasize that lifestyle changes, instead of diet, as a potential means for improving mood. Toward this end, they were particularly focused on helping the child engage in positive activities. By knowing the emphasis that parents place on psychosocial experiences and lifestyle changes in youth mental health, providers may

frame the therapeutic process accordingly. This is in line with approaches from cognitive behavioral therapy (CBT) framework. That is, behavioral activation may be more familiar or acceptable to a parent and also feasible for the parent to support.

4.4. Limitations and Directions for Future Research

First, while our study gathered in-depth reflections of parents through vignettes, we were unable to quantitatively test the relationships between the themes and the extent to which their responses were influenced by gender, age, acculturation, or demographic background given the small sample size. There is great heterogeneity in the Chinese immigrant population, as is the case in our own sample, and background characteristics may reveal differences in parental knowledge of mental health. Second, because we relied on parent responses to hypothetical vignettes, and not to actual experiences of a child displaying such mental health symptoms, it is not known whether their responses represent the actual actions they would take if confronted with the issue. We focused on parent responses, yet parent responses are often dependent on dynamic circumstances, including how children might react. Thus, the vignettes are a starting point for understanding parent knowledge and response. It would be helpful to obtain parent responses to these vignettes among parents whose children have had mental health problems and to compare their responses to the hypothetical responses provided by the parents in our study. Third, our findings may not be generalizable to all Chinese immigrant parents, for we sampled only 18 parents from a metropolitan region in New England. For instance, stressors that parents identified may not be prevalent in other Chinese immigrant communities in the U.S. or elsewhere in the world. Furthermore, the response of the parents in help-seeking may be biased based on their experiences with the extensive health care system within the region. As a result, a replication of this work in other communities would be beneficial.

5. Conclusion

Our findings indicate a strong parent desire to support and advocate for their children. While it is promising that parents in our sample would be willing to seek health professionals, and not only non-health professionals, these findings underscore the need for parents to be better aware of how mental health treatment can be beneficial for children. Educating them on the treatment process and explaining what to expect may be critical in their willingness to engage with providers.

First, based on our findings, parents may be open to Western-based providers; however, it appears that seeking such support is more aligned with presentations of greater symptom severity. As such, an important next step is to help parents understand that symptoms such as low mood or loss of interest, and social anxiety, in addition to serious symptoms such as psychosis, are treatable. Because parents did not readily comment on suicidal ideation, greater efforts to recognize and take steps to address suicidal ideation is a critical next step. Providers should acknowledge the presenting concerns that parents may have (e.g., decreased academic engagement), even if they are not well aligned with the symptoms of primary concern to the provider or the reported distress by the youth and to align the treatment recommendation toward both the parent and youth concerns. Second, Chinese

immigrant parents largely rely on social networks for information. Thus, psychoeducational programming that takes place within such contexts (churches, language schools, cultural organizations) may be particularly effective. Greater efforts for provider-based organizations to identify and partner with community-based organizations, in order to promote resources is recommended in order for families to understand how to access services.

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Appendix

Depression without a somatic emphasis

Lingling is a 15-year-old girl who has been feeling unusually sad and miserable for the last few weeks. She has been thinking that she would be better off if she were dead. She can't keep her mind on her studies and her grades have dropped. Even day-to-day tasks seem too much for her. This has come to the attention of her teachers who are concerned about her lowered activity. Her teachers and friends are very concerned about her.

Depression with a somatic emphasis

Mei is a 15-year-old high school freshman girl who, in the last two months has lost interest in many things she usually enjoys, such as talking to friends and watching television. She has lost her appetite and has lost some weight. She also has trouble sleeping nearly every night, feels easily fatigued, and has less energy. She experiences a persistent heavy and pressured sensation in her chest. She has difficulty concentrating on schoolwork.

Schizophrenia with paranoid features

Xiao Min is a 15-year-old high school freshman girl who, over the past six months, has stopped interacting with her friends at school and has stopped picking up her phone or texting them when they try to contact her. She has begun locking herself in her bedroom and refusing to eat with the family. Min will neglect to take a shower or brush her teeth in the morning. Even though her parents know that she is alone, they have heard her mumbling and sometimes arguing as if someone else is there. When they try to encourage her to do more outdoor things, she whispers that she won't leave home because she is being 'spied' on their neighbors.

Psychosis risk syndrome

Jiajia is a 15-year-old high school freshman girl who had been an A/B student up until this fall, when her grades dropped to all F's. She noted that she was having trouble with her ears, feeling like everything was louder than usual. She also had a number of other somatic complaints, including a concern that radio waves produced by satellites might be affecting

the flow of blood in her brain, causing her to forget things and to have trouble concentrating on her homework. She was able to entertain the possibility that this was in her imagination, but had been thinking about this idea multiple times per day starting in the past month. Jiajia was placed on academic probation and was put into an extra tutoring program.

Social anxiety

Huahua is a 15-year-old high school freshman girl, who over the past year, has become even more shy than usual and has made only one friend in high school. She would really like to make more friends but is scared that she'll do or say something embarrassing when she's around others. Although Huahua's work is OK she rarely says a word in class and becomes incredibly nervous, trembles, blushes and seems like she might vomit if she has to answer a question or speak in front of the class. At home, Huahua is quite talkative with her family, but becomes quiet if anyone she doesn't know well comes over. She never answers the phone and she refuses to attend social gatherings. She knows her fears are unreasonable but she can't seem to control them and this really upsets her.

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Highlights

- Chinese immigrant parents reviewed five vignettes of youth mental health concerns.
- Parents were fairly accurate in identifying causes and strategies for help.
- Only a few parents noted suicidal ideation in vignettes.
- Social anxiety was not perceived to be a mental health problem.
- Study has implications for parent perceptions of mental health and help-seeking.

Table 1

Participant Demographics

Demographics	Descriptives
Participating parent (<i>n</i> =18)	Mother = 13, Father = 5
Participant age (<i>n</i> =17)	Range = 38–62, <i>M</i> = 47.3, <i>SD</i> = 6.7
Years living in US (<i>n</i> =17)	Range = 7–27, <i>M</i> = 15.5, <i>SD</i> = 6.4
Highest educational level Attained (<i>n</i> =17)	High School = 4, Some College = 4, College = 3, Master's = 1, Doctoral = 5
Household income (<i>n</i> =17)	<\$10,000 = 1, \$10,000–29,999 = 5, \$30,000–49,999 = 3, \$70,000–89,999 = 2, >\$ 130,000 = 5
Home province in China (<i>n</i> =17)	Guangdong = 5, Zhejiang = 1, Shandong = 2, Fujian = 1, Jiangsu = 1, Henan = 1, Shanghai = 1, None indicated = 5
Number of participants with specific numbers of children (<i>n</i> =17)	1 child = 1 participant, 2 children =14 participants, 3 child children = 2 participants

Note: Questionnaire data which contained demographic information was missing from one participant.

Table 2

Summary of identified themes and parents endorsement by vignette

Themes	% of Parents Endorsed				
	V1	V2	V3	V4	V5
What Are Parents' Initial Impressions of the Presenting Illness?					
Determining Severity	28	28	33	11	17
Physical/Psychological Distinction	50	56	61	83	33
Behavior Labeling	44	11	0	28	44
What Are the Parents' Beliefs about the Cause of the Mental Illness?					
Peer Relationships	67	39	11	28	39
Academics	39	22	6	17	6
Personality	28	0	11	11	44
Family Stress	22	11	11	11	6
Developmental Change	22	11	0	6	28
What Are The Parent's Approaches to Help-Seeking and Intervening for Youth With The Mental Illness?					
Direct Communication with Child	83	67	22	28	50
Health Professionals	67	22	94	78	39
Non-Health Professionals	56	94	28	28	28
What Is the Role of Diet and Activity in Addressing These Concerns?					
Diet does not make a difference	39	11	22	50	6
Diet makes a difference	0	6	6	17	33
Activities can help child relax	50	67	50	33	67

Note: V1 = depression without a somatic emphasis, V2 = depression with a somatic emphasis, V3 = schizophrenia with paranoid features, V4 = attenuated psychosis syndrome, V5 = social anxiety.