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DOI

[10.1177/1363461514557887](https://doi.org/10.1177/1363461514557887)

Publication date

2015

Document Version

Final published version

Published in

Transcultural Psychiatry

[Link to publication](#)

Citation for published version (APA):

Liu, C. H., Meeuwesen, L., van Wesel, F., & Ingleby, D. (2015). Why do ethnic Chinese in the Netherlands underutilize mental health care services? Evidence from a qualitative study. *Transcultural Psychiatry*, 52(3), 331-352. <https://doi.org/10.1177/1363461514557887>

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Why do ethnic Chinese in the Netherlands underutilize mental health care services? Evidence from a qualitative study

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Abstract

Chinese immigrants in the Netherlands are less likely than other ethnic groups to utilize mainstream mental health care services. This study investigated the experiences of Chinese with mental health problems, to inform measures to make services more responsive to the needs of this group. Qualitative methods of analysis were applied to interview data in order to explore ways of finding help, barriers to accessing mainstream mental health care, experiences in care, factors jeopardizing the quality of care, and views on mental health services among Chinese migrants in the Netherlands. Rather than recruiting individuals with mental health problems, an indirect method was used in which ethnic Chinese participants were invited to tell us about one or more Chinese individuals in their social environment whom they regarded as having (had) mental health problems (精神问题). Although most Chinese regarded mainstream Dutch care as the appropriate resource for dealing with mental health problems, many barriers to access and threats to care quality were reported. In contrast to the widely accepted view that cultural differences in health beliefs underlie the low utilization of mental health services by Chinese in the West, the main obstacles identified in this

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study concerned practical issues such as communication problems and lack of knowledge of the health system. Respondents also described concerns about entitlement to care and discrimination (actual or anticipated). Measures suggested by respondents for improving care included increased use of interpreters and cultural mediators, encouraging migrants to increase their language proficiency, and better dissemination of information about the health system. The article concludes with a discussion of the policy implications of these findings.

Keywords

access to care, ethnic Chinese, mental health care utilization, migration and health, quality of care

Introduction

Although Chinese form the oldest and fifth largest non-Western minority in the Netherlands and their numbers are rapidly increasing, little research has explored their mental health status. Some limited research indicates this population is less likely than other ethnic groups to utilize mainstream mental health care services (Geense, 2003; Liu, Sbiti, Huijbregts, & Tonk, 2008; Schellingerhout, 2011). For example, in a survey carried out in 2009, only 2% of ethnic Chinese respondents had used mental health care services in past year, compared to 8% of native Dutch (Schellingerhout, 2011). This disparity highlights a need for an improved understanding of barriers to care affecting this population. This paper reports a study on the experiences of Chinese migrants with mental health problems, to inform measures to make services more responsive.

The Chinese population in the Netherlands is very diverse (Gijsberts, Huijnk, & Vogels, 2011) and can be divided into four main groups: (a) migrants from Chinese-speaking regions who arrived before 2000 and tend to have the lowest levels of education and language proficiency; (b) migrants from former Dutch colonies, many of whom arrived during the period of decolonization and tend not only to be proficient in Dutch, but also to have a high level of education; (c) migrants who arrived after 2000, most of whom come from Mainland China and are well educated (a considerable proportion being students or business people), although they often have a poor command of Dutch; and (d) the Dutch-born children of these migrant groups (the “second generation”), who speak Dutch as a native language and have (on average) a high level of education. Throughout this paper, the term “ethnic Chinese” will be used to refer to individuals in all four of these categories.

The Dutch mental healthcare system

In the Netherlands, mental health services are integrated into both primary and secondary care (Schäfer et al., 2010). The general practitioner (GP) acts as a “gatekeeper” for specialized health services and makes the initial assessment of patients’ needs.

For mental health problems, the GP may provide counseling or refer a patient to a psychologist working within the GP's own practice, and may also prescribe medication. Often, however, the GP will refer the patient on to a specialized mental health care provider for diagnosis and treatment. Within certain limits, the costs of mental health care are reimbursed under the Dutch system of health care coverage.

Occasionally, students or employees are able to access care directly through services provided by educational organizations or workplaces. Treatment by a psychiatrist or psychotherapist in private practice can also be accessed directly by those who can afford to pay for it themselves. Otherwise, it is generally not possible to get an appointment for specialized care, or at least to obtain reimbursement of the costs of specialized care, without a GP's letter of referral.

In theory, undocumented migrants in the Netherlands have the same entitlements to mental health care as nationals (Sandhu et al., 2012). However, both migrants and health care professionals are often not well informed about these rights. According to Doctors of the World (Médecins du monde/MdM; Chauvin, Parizot, & Simonnot, 2009), many service providers are unfamiliar with the rules regarding coverage of migrants and some fail to comply with them.

Mental health care utilization by ethnic Chinese in the West

Lower utilization of mental health services by ethnic Chinese living in the West has been widely reported (e.g., Abe-Kim et al., 2007; Chen, Kazanjian, & Wong, 2009; Kung, 2003). Almost all of the research on this topic has been carried out in English-speaking countries such as Australia, Canada, New Zealand, the United Kingdom, and the US; very few Dutch studies have investigated the issue (exceptions are Liu, Ingleby, & Meeuwesen, 2011; Liu et al., 2008; Schellingerhout, 2011; Smits, Seeleman, van Buren, & Yuen, 2006). One explanation of the observed low rate of utilization could be that Chinese migrants have fewer mental health problems, but epidemiological evidence does not seem to support this idea. Moreover, it is often found clinically that Chinese entering mental health treatment have more serious problems than patients from the general population (e.g., Chen, Sullivan, Lu, & Shibusawa, 2003; Chu & Sue, 2011; Geense, 2003).

Many authors have related low utilization to cultural beliefs concerning the nature, manifestations, and causes of mental illness. Chinese migrants are often said to be skeptical about the value of Western treatment methods and to prefer seeking help from Chinese traditional healers or using traditional remedies (Hsiao, Klimidis, Minas, & Tan, 2006; Kung, 2003; Ma, 1999; Parker, 2001; Yang, Corsini-Munt, Link, & Phelan, 2009; Yip, 2004). It is also frequently suggested that Chinese tend to equate "mental illness" with "madness" and to regard seeking professional help as bringing shame to the family (Green, Bradby, Chan, & Lee, 2006). Of course, such stigmatization also exists in the West (Sareen et al., 2007), but it is assumed to be more serious among individuals of Chinese origin (cf. Chen & Mak, 2008; Tabora & Flaskerud, 1997).

However, the idea that cultural beliefs explain the underutilization of mental health services by Chinese migrants is open to a number of criticisms. Many researchers (e.g., Chen & Mak, 2008; Chung, 2010; Sun, 2013; Yang et al., 2009) have pointed out that “Chinese culture” is not a homogenous entity. A variety of different health beliefs can be found among ethnic Chinese in the West, and these beliefs may be complex and multilayered; they may also change over time, as migrants take root in the host countries. Scholars have also pointed out that Western approaches to psychiatry have long been incorporated in health care in China (Koran, 1972).

Another weakness of this explanation is that although the mental health beliefs of ethnic Chinese may differ from those of Western mental health professionals, they may not differ substantially from those held by most lay people in the West (see Jorm, 2000). In fact, research on stigma among ethnic Chinese has rarely included a comparison with the native population.

In addition, the health care decisions of Chinese migrants often exceed simple either/or accounts of mental health service utilization, reflecting instead a reliance on several approaches to healing. This kind of “health pluralism” (Bodeker, Ong, Grundy, Burford, & Shein, 2005) is commonly reported in the literature; Chinese living in the West appear to adhere to multiple different health beliefs and practices (Hsiao et al., 2006) leading them, for example, to seek treatment from Western medical practitioners while simultaneously using traditional Chinese medicine (TCM; Chau & Yu, 2004).

Thus, there are many reasons for questioning culture-based explanations of low service uptake by Chinese migrants in the Netherlands. Indeed, van Dijk (1998) has suggested that such explanations may function primarily as an alibi for the health system’s failure to provide appropriate services. On the basis of a survey of 1,747 Chinese American respondents, Kung (2004) proposed that it is mainly practical barriers, rather than cultural beliefs, that lead to low uptake of services. Below we list the main practical barriers that have been identified in the literature. (It should be noted that few of these studies make allowances for variations in sample characteristics in terms of variables other than ethnicity.)

Communication problems

Communication barriers between Chinese users and health professionals are reported very frequently (Chen et al., 2009; Kung, 2004; Liu et al., 2011). Cross-cultural communication is not just a matter of understanding words, but also of appreciating idioms and cultural or social references. Inadequate communication can be especially detrimental to the quality of mental health care.

Lack of knowledge about the health care system

This reason for underutilization is frequently cited by researchers (e.g., Blignault, Ponzio, Rong, & Eisenbruch, 2008; Chan & Quine, 1997; Liu et al., 2011;

Wang, 2011). Poor language proficiency may make it harder for Chinese to acquire the knowledge they need.

Financial concerns

These include lack of affordable treatment and/or insurance coverage (Kung, 2004; Lin & Cheung, 1999; Ma, 2000). The seriousness of this barrier will vary depending on the group in question and the country they live in. However, when people are ill-informed about the health system, simply *expecting* high costs may be enough to deter them from seeking treatment (Blignault et al., 2008; Liu et al., 2011).

Lack of time and opportunity

Like many migrants, Chinese in the Netherlands often have jobs (for example in the catering industry) characterized by long hours of work and restricted possibilities to take time off for medical consultations (Liu et al., 2008). “Sickness presenteeism”—the tendency to carry on working despite being ill (Johns, 2010)—is a common phenomenon among migrant groups with “precarious” employment (cf. Agudelo-Suárez et al., 2010).

Service constraints

These may include long waiting times for an appointment, complicated administrative procedures, and the limited time allocated for consultations (Blignault et al., 2008; Kung, 2004; Liu et al., 2011).

Discrimination

Discrimination against Chinese users in health services has been reported in many studies (e.g., Chu & Sue, 2011; Spencer & Chen, 2004). Experiences of discrimination include receiving substandard treatment or being belittled by health service workers due to poor language proficiency or ethnic background. Spencer and Chen (2004) found that discrimination in health care is associated with greater use of informal services among Chinese Americans.

Low quality of care

Chinese often report worse health care experiences and lower satisfaction with care than other ethnic groups (Clough, Lee, & Chae, 2013). Disappointing experiences can deter users from seeking care again and can contribute to a negative image of services in the Chinese community. The same factors that impede access are often responsible for undermining the quality of care and patient satisfaction.

The present study used interview data to investigate the kinds of help that are sought by ethnic Chinese with mental health problems living in the Netherlands, difficulties they experience in obtaining care, their experiences receiving care, and their views on mainstream mental health services. This paper complements a previously published analysis of the same data focused on beliefs about mental illness among ethnic Chinese in the West (Liu, Meeuwesen, van Wesel, & Ingleby, 2013).

Method

Sample and procedure

The 25 respondents in this study consisted mainly of participants in an earlier questionnaire study (Liu et al., 2011). Participants were recruited on the streets in shopping areas heavily frequented by ethnic Chinese in the four major Dutch cities. About half of those approached agreed to cooperate. When the questionnaire was completed, participants were asked if they were willing to be interviewed in more depth at a later date about one or more Chinese people they were acquainted with who had experienced mental health problems while living in the Netherlands. Of the 102 participants, 26 volunteered. To replace those who later could not be reached or were unable to participate, nine new participants were recruited using a snowball technique. Material from two participants had to be discarded because it contained little information relevant to mental health, leaving a total of 23 respondents. The reason for not recruiting people with past or present mental health problems directly was to avoid the practical and ethical problems associated with recruiting and interviewing such a group.

Semistructured in-depth interviews were carried out using respondents' preferred language (14 in Mandarin, 4 in Cantonese, 4 in Dutch, and 1 in English). The five interviewers (including the first author) were trained in the skills necessary for carrying out in-depth interviews. Each of them was proficient in at least one of the languages listed above.

Respondents were invited to give accounts of one or more Chinese persons in their social environment whom they regarded as having (had) mental health problems (精神问题). A topic list was used to ensure that respondents addressed the three main themes of the study: (a) experiences of getting into mainstream mental health care; (b) experiences while in care; and (c) and views on the system. For a full description of the method readers are referred to an earlier publication (Liu et al., 2013), which analyzed the beliefs about mental health expressed in these accounts.

Interviews were audiotaped and transcribed verbatim. In this article all quotations have been translated into English when necessary. In cases where there was doubt about the equivalence of English terms, the Chinese or Dutch expressions used by the respondent are given in brackets.

In the discussion that follows we refer to the respondents as "narrators," who gave accounts of "cases" they knew with mental health problems. As some narrators were able to give accounts concerning more than one case, a total of 30 stories of cases were collected from the 23 interviews. Five narrators told their own story.

In all five of these cases, the participants spontaneously offered to discuss the difficulties they had experienced with mental health care services.

Data collection was based on the applicable ethical guidelines to protect respondents' rights and interests. These concerned explanation of the aims of the research, the procedures used, consent to participate, withdrawal, and confidentiality.

Data analysis

Data analysis followed the open, axial, and selective coding procedure described by Boeije (2010), which is based on grounded theory (Corbin & Strauss, 2008). Nvivo 9 software for qualitative data analysis (QSR International, 2010) was used for data management and analysis. Throughout the procedure, the research team exchanged views with one another about the interpretation of the texts. Data coding was carried out using a spiral process until the codes covered the data sufficiently. The results of analysis were discussed and reanalyzed repeatedly until all researchers reached agreement. This paper reflects on an analysis of themes related to health-seeking behavior, barriers to accessing mental health services, and experience of care; for a complementary analysis of broader beliefs related to mental healthcare see Liu et al. (2013).

Results

Background of narrators

The ages of the 23 narrators spanned a wide range (22–80, $M = 37$); 16 (70%) were female; 19 (83%) were first-generation Chinese migrants and the rest, second generation. In all, 15 narrators had higher education (4 were international students); 4 had completed secondary education; and 2 had primary education. In terms of marital status, 8 were single, 8 were married or living with partners, 5 were divorced, and 1 had been widowed. Some narrators did not provide all of the personal data requested.

First-generation narrators had resided in the Netherlands for between 2 and 56 years ($M = 22$); 12 of the 19 first-generation narrators had a permanent Dutch residence permit. The majority (16) came from a Chinese-speaking region, while three came from former Dutch colonies. In terms of reasons for migration, 10 stated that their motive was “family reasons”; six had come to study, while three had migrated in search of economic opportunities. The ages of the five second-generation narrators ranged from 22 to 37 years; their education level was high, with four having completed higher education.

Ways of finding help

Help-seeking behavior. About three quarters of the cases (23) sought help from Dutch mental health services and six had also used complementary care or undertook

specific activities to regain mental health, such as TCM, qigong, or religious practices. These activities could be undertaken before, during, or after treatment by mainstream services.

The other seven cases did not seek mainstream help. Among them, two patterns could be observed: three did not seek help of any kind, while the other four used other methods to cope with their problems, for example, seeking emotional or social support from family and friends or spiritual support from religion. However, it is noteworthy that nobody in this group sought help from a professional healer outside the regular system—that is, “alternative” care.

Pathways to mainstream care. In the 19 accounts that addressed this topic, four pathways could be distinguished: mental health care provided by the GP (4); onward referral by the GP (6); direct access to mental health services (2); and nonvoluntary help seeking (7). Although it is also possible in the Netherlands to obtain treatment privately from an independent psychologist or psychiatrist, no accounts in this study described using this pathway to care.

Case ID05-1, who went to his GP after suddenly fainting at his office, illustrates an onward referral to specialized mental health care:

The doctor thinks the fact that I lost control of myself and fainted was due to the stress and the anxiety. He said, it was possibly a consequence of the brain impairment which was caused by a car accident in my childhood. So he suggested to me to see a psychiatrist.

The cases who directly contacted psychological counseling services offered at school or work could recognize their mental health problems and wished to obtain professional help. “Her grades slipped lower and gradually she lost interest in the subject. She talked to a teacher during this time and was advised to seek psychological counseling” (ID06-1).

Professional help was sometimes sought on behalf of individuals by other people (“nonvoluntary”) because the affected individuals did not consider themselves in need of treatment, had refused to seek help themselves, or were regarded as at risk for suicide. An example is case ID11-3: “She felt she was OK . . . she wouldn’t go to see the doctor . . . It was her husband and the social workers from the women’s organization; they found a psychiatrist to visit her, to learn more about the situation.”

It is notable that the proportion of nonvoluntary users among the cases who received mental health care is quite high (seven out of 23). Suicide attempts were involved in four of these cases; six persons were hospitalized. We were unable to ascertain how many cases were the subjects of a compulsory admission order.

Barriers to accessing mainstream care

Insufficient language proficiency. Sometimes individuals were discouraged from using Dutch care services because of low language proficiency. Case ID10-1 was aware of

his drinking problem and related violent tendencies. However, he was reluctant to see a doctor:

He realized there was something wrong. I suggested him to see a doctor accompanied by me. When he was in a good mood, he said okay . . . After two days, he didn't want to go any more. He said, "I cannot communicate (with the doctor)" . . . It was, of course, because of the language . . . if (a person) doesn't know how to speak the language, how to see a doctor?

Lack of knowledge about the health system. Chinese migrants often lack adequate knowledge about the Dutch health care system. Case ID22-1, for example, recognized her mental health problems but gave the following reasons for not seeking mainstream help: "I didn't know where these institutes are, whom I should call . . . I am not sure if I am able to pay the medical expenses."

A common misunderstanding concerned the GP's "gatekeeper" function in health care. Many cases came from countries where users can directly access specialist services. Case ID06-1 was aware of her mental health problem but seemed not to know that visiting a GP was necessary to get help for it: "We know she should go to a family doctor. But in her belief, family doctors are for physical ailments. Psychological problems need psychologists."

Entitlement to use care services. Issues concerning entitlement were mainly related to legal status and financial resources. Sometimes undocumented migrants were not aware of their right to health care or avoided using services because they were worried that they would be reported to the authorities, as the following quotation illustrates: "But they won't go. Without legal status, they don't believe they should . . . The issue is about whether they trust the organization, and if there are police waiting, trouble brewing" (ID06-2).

For some regular Chinese migrants, the cost of mental health care was their central concern. They could not use the health system without health insurance, and some saved money by not taking out insurance. Even those with insurance sometimes assumed—incorrectly—that mental health services were not covered.

Unawareness of the need to seek help. Not realizing that problems were signs of mental illness sometimes delayed or deterred seeking mental health care. For example, for a long time, case ID24-1 could not sleep well. Only when she realized that her personality had also changed did she go to see the GP.

By that time, I didn't realize that I was sick because I thought it was a kind of modern illness that (I) could not fall in sleep until the early morning due to the stress. Later on I discovered that my personality was totally different from what it used to be. I had good temper in the beginning (of my sleep disorder). Thereafter I got angry easily.

Stigma. Narrators reported that some cases expressed concern about being labeled as mentally ill. However, in only three cases did help-seeking behavior seem to be affected by fear of stigmatization. Narrator ID21-1 perceived stigma as a reason that his sister sought support from religion instead of looking for psychological help: “She didn’t turn to healthcare . . . when you go that way you also give yourself the label that there’s something wrong in your mind and not a lot of people like to do that.” Another narrator mentioned that it was acceptable to talk about her mother’s mental illness in the family; however, the family would not talk about it in front of others in order to avoid gossip.

Negative attitudes towards Dutch health care. Some accounts expressed dissatisfaction about complicated procedures, long waiting lists, discrimination, and professionals’ inappropriate attitudes. For example, narrator ID09-1 talked about how the required procedures discouraged foreign students from using health care:

As foreign students, we don’t have personal GPs . . . If something is wrong, we have to go to a hospital. And our insurance policy is, for foreign students, we have to pay the cost in advance, and get reimbursed by submitting receipts later. So it’s troublesome. Furthermore they (the health institute) will ask us to show our visas when we have to make appointments and registrations. Very bothersome. On top of this, (getting into) the Dutch health system takes a long time.

When ID22-1 talked about her own reluctance to seek help from a professional, she exemplified worries about being discriminated against because of low Dutch proficiency and not being treated “sincerely” by Dutch professionals. In such cases, Dutch proficiency was not just an issue of communication—it was also linked to prejudice: “When they see that I am a foreigner and my Dutch is not good, they probably will look down me, and they won’t help you sincerely by thinking for you from your situation.”

Experiences in mental health care

Diagnoses

Psychiatric diagnoses were mentioned in 10 of the 23 accounts relating to individuals who used Dutch health care; only five accounts described the nature of the diagnosis. Most of these 10 cases accepted the diagnosis given, while two showed doubts about it. Two narrators felt doctors were unwilling to answer questions about the diagnosis. For example, ID07-1 accepted the doctor’s diagnosis of her son’s illness, but when she asked questions about it, she received no answers: “I don’t know (what the illness is about). I have asked the doctor if the illness can be cured. However, the doctor didn’t want to answer.”

Treatment

The treatments most frequently described were psychotherapy and medication. Two cases were referred for physiotherapy, while some received advice regarding their lifestyle.

Accounts rarely provided information about the precise nature of the *psychotherapy* received, so we use the term here to refer to any treatment based on verbal interaction between professionals and clients (e.g., counseling, behavior therapy, family therapy, etc.). In all, 16 out of 23 cases received some form of psychotherapy, 13 cases in combination with medication. The comments about psychotherapy were generally positive. One narrator indicated that the talks with therapists provided an “objective” opinion which helped him and his wife to see their problems differently. Some individuals found it easier to talk about their problems with a therapist than with their families; narrator ID02 commented on her mother’s story, “I think that the person is more open, and more likely to talk to an unknown (person) than his or her family.”

Overall, 15 cases received *medication*. In most accounts, however, the type of medication was not mentioned, or its purpose was not known. The two cases that presented with somatic complaints were first referred for *physiotherapy*. In both cases the results were unsatisfactory and they were eventually referred by the GP to specialized mental health care. In four accounts, a health professional gave *advice* about changing lifestyle, for example by taking life more lightly, getting exercise, and participating in social activities. Three cases were given additional social support from a social worker or home care service.

Adherence

Treatment adherence was mentioned in 12 accounts. In five cases, individuals complied with the recommended treatment. Three followed the treatment without problems, although two did not feel entirely comfortable about it. Among the seven accounts which reported nonadherence, four discontinued medication, two terminated or dropped out of psychotherapy, and one refused the recommended hospitalization.

Reasons for nonadherence included side effects of medication, lack of effect of the treatment, doubts about the diagnosis or treatment, fear of the unknown effects of the treatment, feeling there was no need to follow the treatment, and practical problems. Some cases had more than one reason for nonadherence. For example, ID05-1 had three reasons for rejecting the proposed hospitalization:

I was a bit afraid when I went there (psychiatric care) the first time. Because he (the psychiatrist) said, I had mental problems (was mentally ill). Also, when I was there, I saw a group of retards playing. Then I said (to him), “I am not a retard; I am normal” . . . He still suggested to me to stay in the hospital for 5 weeks in order to

take some tests. I considered myself a normal person; it was not necessary to stay there. Eventually I refused (his suggestion). I couldn't bear to miss my daughter. I was also afraid. I didn't know what would happen there during the nights.

ID12-2 discontinued his medication because of doubts about the diagnosis and treatment and lack of trust in the psychiatrist:

He (the doctor) prescribed me pills. I took them, but later I got really sick. I went back to the doctor and told him that I didn't want to take them, they made me sleepy, and I did not think I was really depressed. He still wanted me to keep swallowing them. At one point I got a phone call from the doctor's assistant: the psychiatrist was overworked and had had a breakdown. I immediately stopped taking the pills and felt ultimately relieved. I also believe that you need to use your own strength to overcome all problems.

Conversely, family support can be important for adherence, as shown by case ID03-1:

She did not take the pills and lied to her husband. She hid the pills in the hand and only swallowed the water... Later she started to accept the situation and take the medicine... Her husband deserved the credit. She later learned to take the pills obediently.

Outcomes

Fourteen accounts provided information about the outcome of mental health care. In most instances, we could only analyze the narrator's reflections about the treatment received by cases, and thus our findings may not represent actual treatment outcomes. In 11 accounts the symptoms appeared to be relieved or brought under control, but three cases apparently did not feel they were helped by treatment.

Some accounts contained very positive comments on Dutch mental health care. For example, narrator ID23-1 spoke of the care received by his daughter:

I think they (mental health care professionals) have done a good job. To solve it (the illness) is actually a great job... After a time, she still regularly visited the same doctor. But she didn't take the pills anymore, and no more therapy. (She) only kept normal appointments as controls.

In other cases, however, narrators and/or the patients described had reservations about the treatment provided, even when it seemed to be effective. Narrator ID11 mentioned that her friend had to continue taking medication in order to stay well:

She got better after taking medications from the psychiatrist... She's been taking them for 9 months. Her psychiatrist recommended her to stop... But whenever she

stopped (the medication), her symptoms kept coming back frequently...she might have to take them for a long time.

Of the cases who complained of unsuccessful treatments two of the three were international students. Eventually, both went back to China for further treatment, since Dutch care did not help them sufficiently.

Threats to care quality

Poor communication with professionals

This was the most frequently mentioned threat to care quality. It was mainly associated with limited Dutch proficiency, but also with differences in communication style and cultural background. Communication problems could make it difficult for individuals to obtain a referral for specialized treatment, lead to low adherence and dropout, or deter them from using Dutch health care in the future. In case ID06-1 for example:

She did three to five sessions of counseling. Because their communication was half with words and half with gestures, there wasn't much effect...she encountered a language barrier during the counseling, and no one was able to translate for her. How can others translate your personal emotions?... Especially when we are trying to express feelings, it's already hard to express ourselves correctly... She was thinking about seeking (further) psychological therapy in the Netherlands. But when she thought about her previous experience, she lost confidence in doing this.

Sometimes communication barriers did not concern language so much as cultural background and social context. Because professionals were often unfamiliar with Chinese culture, individuals could experience frustration in trying to explain their mental health issues. The story of ID05-1, who had lived in the Netherlands for more than 30 years, illustrates that communication problems can exist even when the professional and the care user speak the same language:

He (the doctor) didn't ask me if I needed an interpreter... He said he understood what I said completely... I understood what he talked about. However, I found it difficult to express myself to him. I didn't know if the doctor really understood what I have said or he pretended that he understood... Sometimes I said this and he said something else, or I said that and he replied with something irrelevant.

(Regarding the stress at work)... In the end, we are still Chinese. We are more conservative. We keep everything inside our heart. He (the psychiatrist) advised me to talk to my boss openly. Do you think I was a Dutch? To open yourself to a person by just saying it?

Case ID18-1 dropped out of psychotherapy because she thought that the psychologist would not be able to understand her difficulties:

I had a feeling that he could not help me at all. I talked him about my situation. Then he advised me, you shouldn't think like this way. I think this doctor didn't understand me. If you use Dutch mentality to treat me, you are not suitable [qualified; 適合] to treat my illness.

Discrimination

The experience of discrimination also had a negative effect on the quality of treatment. ID12-1 was a Chinese woman from Indonesia. Her treatment (psychotherapy) remained a struggle until she got help from a psychiatrist originating from the same country; there is a strong suggestion that discrimination played a role in the difficulties she initially encountered in treatment.

She thought it [the care] was terrible. They (the professionals) made a clear distinction between people from the East and full-blooded Dutch. I think it had to do with the clash between cultures... What struck me is that she said at one point it went better when she had an Indonesian psychiatrist.

Practical matters

Sometimes the demands of everyday life, such as working hours or lack of time for treatment, affected individual's ability to receive treatment. For example, ID11-5 still had to work when she was very ill:

She is very sick and she has to work... But she is really ill and cannot work. She needs to ask for sick leave often. Even she only works 3 days a week... If she doesn't need to work, she will be able to take a real rest. That will make a lot of difference.

Respondents' suggestions for improving care

Some narrators, including a few who described their own experiences, expressed opinions about the kinds of support that could help ethnic Chinese in the Netherlands to overcome factors that undermined the quality of care. Most suggestions focused on improving communication.

Better interpretation and translation services were seen as necessary to overcome communication barriers. It seemed that many Chinese were not aware of the interpretation services that are available. In some situations, family members were

invited to interpret for the patient. However, narrator ID11-1 pointed out the disadvantage of this:

Our kids have to make a living; they might not have time to go with us. Some of our kids can't speak Chinese that well either. For example, my hand was bitten by a dog recently. It seems like it was sprained [扭伤]. They (kids) weren't sure what it (the Chinese word) means. If you ask them to go to the doctor's with you, they don't know how to tell the doctor about your situation. This is a huge headache for us.

Employing more Chinese health workers was also seen as a measure that could reduce both linguistic and cultural barriers.

It's better to hire Chinese people who have knowledge in this field (medical specialty). It will be helpful to us, the older generation. At least we won't be confronted with the communication problem. (ID05-1)

More support from educational institutions or workplaces was felt to be desirable to help newcomers access available services. Narrator ID08 talked about how his university assists international students in accessing care:

When we arrived, our school had arranged a family doctor for us. If we were in another city, we needed to find one by ourselves. We can also find the nearest psychologist on the web... Our teacher will distribute the information. Our school gives support about living. Friends and colleagues also exchange relevant information.

Compared to the international students in other schools, this narrator felt lucky because his university not only provided the necessary information about Dutch health care to foreign students, but also helped them make use of the care available.

Discussion

Mainstream Dutch health care was seen by three quarters of the cases as the appropriate resource for dealing with mental health problems. The same proportion was found in an earlier questionnaire study on Chinese in the Netherlands (Liu et al., 2011). In terms of *pathways to care*, most individuals first consulted their GP; some of them were referred by the GP to a specialized mental health service provider. Other individuals sought help directly from mental health services provided by schools or employers, or were pressed to receive care by others in their immediate environment. These pathways are largely the same as those used by the majority Dutch population, with one exception: no accounts mentioned seeking help from a private psychologist or psychiatrist paid for entirely out-of-pocket. A few individuals undertook other activities in addition to seeking mainstream mental health care, but we found no examples of ethnic Chinese with mental

health problems seeking other kinds of professional help as an alternative to mainstream Dutch care.

Barriers to access were experienced in many cases. However, cultural health beliefs rarely seemed to deter individuals from seeking care. This finding is consistent with those of the questionnaire study mentioned above (Liu et al., 2011). Although fear of stigmatization was mentioned as a barrier in the present study, there were no indications that this obstacle to seeking professional help is greater among the Chinese community than in the general population. The most serious barriers described concerned practical issues. Virtually all the issues identified in our review of the literature regarding ethnic Chinese living in the West (above) were also found in this sample in the Netherlands: communication problems (including language barriers), lack of knowledge about the health care system, concerns about the costs of care, service constraints, and discrimination. Negative opinions about the quality of Dutch health care, whether or not based on personal experience, also deterred some people from using the system.

In the 10 accounts that provided information about diagnosis, eight cases accepted the diagnosis given, while two expressed doubts. Psychotherapy and medication were the most commonly described treatments, usually given in combination. Some cases received physiotherapy or advice regarding their lifestyle. In seven of the 12 accounts providing information about adherence, the individuals dropped out of treatment or refused it from the beginning.

Although positive outcomes were described in many accounts, difficulties in using mental health services were described in almost all of them. This suggests that available services are far from optimal for Chinese users. Factors that impaired the quality of care included poor communication, discrimination, and practical matters.

Poor communication was seen as a particularly salient threat to care quality. Participants reported that their problems in mastering the Dutch language made it harder for them to obtain knowledge about health and health care and to communicate successfully with professionals. In addition to individuals' limited language proficiency, the inability of professionals to appreciate their cultural background and social context was felt to make communication difficult, if not impossible.

Many cases expressed a need for interpreters, but participants seemed not to be aware that interpretation services were provided free of charge by the Dutch government at the time the interviews were conducted. Though health professionals did not make much use of these services, it is likely that some cases in our study would have asked for professional interpretation had they known it was available. Other recommendations concerned the employment of more Chinese health workers and additional support from educational institutions or workplaces.

Limitations of the study

The results of this qualitative study are consistent with the main findings of the quantitative study that preceded it (Liu et al., 2011). The rich detail of these

accounts provides additional insight into the nature of factors undermining the accessibility and quality of care. However, caution should be exercised in extrapolating these results to the entire Chinese population in the Netherlands. First, the sample size is small and most information about the experiences of people undergoing treatment was obtained second-hand. Second, although, like the Chinese population itself, the sample contains a great deal of diversity (in terms of country of origin, date of migration, age, etc.), no attempt was made to make the sample representative by matching proportions. Third, the method of recruitment and interviewing could have introduced biases. On the other hand, the fact that saturation was reached in the construction of codes (Liu et al., 2013) suggests that using a larger sample would not contribute much to the range of issues identified. The main value of this type of study is to clarify what respondents mean when they talk about, for example, barriers to access or problems in communication; a larger study would be needed to explore the sources of variation in service utilization.

Other limitations that should be borne in mind include the fact that interpretation of the concept “mental health problem” was left up to the respondent; no precise criteria were given. In addition, because data on other variables were not collected and the sample size was small, it was not possible to identify subgroups or characteristics that were associated with greater difficulty in using Dutch mental health care. The results should not be assumed to apply without distinction to all ethnic Chinese in the Netherlands.

Conclusion

The results of this study suggest that much needs to be done to improve the accessibility and quality of mental health care services for Chinese in the Netherlands. Cultural differences exist that can create barriers to mutual understanding, but they do not appear to prevent Chinese from seeking out Dutch health care. The main barriers described include low language proficiency, lack of knowledge of the health system, lack of cultural competence among professionals, and the failure of the health system to take steps to overcome these challenges.

Although it is important for migrants to acquire a certain level of proficiency in the language of the host country, many find Dutch difficult to learn. Information about the health system in migrants' own languages is needed and should be incorporated in integration programs. For irregular migrants, effective dissemination of information about their entitlements to health care is also needed.

Service providers should be empowered to provide professional interpretation services without creating financial barriers for patients. Unfortunately, while the Dutch government previously organized a program entitled “Health information in migrants' own languages and cultures” (Singels, Drewes, & van der Most van Spijk, 2008), in 2012 the government withdrew financial support for these services (VWS, 2011). As a result, the problem of language barriers for Chinese and other ethnic groups is likely to have become even more serious since our study was conducted. The position of the Dutch Health Minister is that informal

interpretation by friends or family members can fill the gap (VWS, 2013), but much research has demonstrated that this is a highly unsatisfactory solution (Liu et al., 2008; Meeuwesen, Twilt, ten Thije, & Harmsen, 2010; Mikado, 2012; Priebe et al., 2011).

It is also clear from our results that health workers require additional or improved training in intercultural communication. This has implications for the training of medical staff and the formulation of quality standards. The use of “cultural mediators” is another strategy that can be employed to bridge the gaps in language, knowledge, and culture between care users and professionals (Chen et al., 2009; Green et al., 2005).

In comparison with the four largest non-Western ethnic groups in the Netherlands, the Chinese minority has been subject to very few research studies on health care or health promotion programs. Given the increasing size of this group and the barriers to access and threats to health care quality that have been demonstrated by this and earlier studies, it is high time that more attention be paid to the health needs of ethnic Chinese in the Netherlands.

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