Chinese in Aotearoa and Their Attitudes Towards and Experiences of Talking Therapies/Mental Health in Aotearoa

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Abstract

Extensive research has examined the effectiveness of various "talking therapies" across populations and mental health disorders. Literature suggests that current "talking therapies", which are mainly based on Western values and theories, could be culturally adapted to improve effectiveness and overall experience for individuals from other cultural backgrounds. The Chinese population in Aotearoa has been steadily growing over the past decades and are a diverse and heterogeneous population. Despite being viewed as the "model minority", research suggests that there is also a need to address their mental health issues. However, despite the knowledge that culturally adapted talking therapies could be more effective, this area has often been neglected in research where there is limited information regarding the Chinese in Aotearoa population and their experiences with talking therapies and their attitudes towards mental health. This study aims to bridge this gap in the literature. This study utilized a qualitative methodology where 14 participants who identified as Chinese in Aotearoa with prior experience of "talking therapies" engaged in one-on-one semi-structured interviews. Thematic analysis revealed several themes categorised into *pre-therapeutic experiences* and *during/post-therapeutic experiences*. *Pre-therapeutic experiences* revealed the unique challenges and barriers that this population face before engaging in mental health services and the highly vulnerable state they are in when presenting at services. Notably, recommendations from trusted individuals could mitigate the barriers to accessing services. The *during/post-therapeutic experiences* revealed the importance of using psychoeducation, having a safe non-judgmental therapeutic space, culturally responsive and sensitive practice, and key factors leading to a positive therapeutic alliance. Markedly, there was an observed reluctance to involve family members as well as use of medication. It also highlights the importance of the therapeutic experience as a positive experience could contribute to de-stigmatization of mental health for this population. The findings underscore a need to address the barriers of accessing mental health support and implementing culturally responsive evidence-based practice for this population. This study aims to serve as a foundation for future research in the development of best-practice approaches and to evoke the continual movement in exploring and improving talking therapies in Aotearoa with this growing Chinese in Aotearoa population.

Keywords: Chinese in Aotearoa, talking therapy, barriers, cultural adaptations, mental health, client experiences, qualitative research

Dedication

To the wealth of knowledge and insight, my late supervisor Professor James Liu, who passed away unexpectedly in 2024. You will be forever remembered, and your wise contributions will be forever cherished.

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Chapter 1. Introduction

I would like to introduce this thesis by explaining and exploring the inspiration behind choosing to focus on Chinese in Aotearoa's experiences of "talking therapies" for my DClinPsych thesis. I personally identify as a Chinese in Aotearoa and have done so since I moved to Aotearoa with my parents when I was a young child. This identity felt both confusing and like a blessing. On the one hand, I felt a sense of isolation as I no longer looked like the majority resulting in feeling like an outsider. I had to try my best to blend in to feel a sense of belonging. I tried to learn the language quickly, bring the same type of school lunches, and wear the same type of clothes. All of which slowly eroded away some of my Chinese identity. On the other hand, as I grew older, I have come to embrace my uniqueness of being Chinese, where I celebrated traditional holidays, learnt about the rich history and mythologies, as well as immersing myself in the rich culinary flavors of my culture that I was privileged to experience through my parents. As I grew up, I grew more certain of my identity and felt more of a sense of belonging, something that as a person in between two cultures, felt like a struggle throughout my childhood. This was no easy task as I often went through waves of emotion where there were days when I loved being unique and there were other days when I just wanted to fit in. It is difficult to pinpoint exactly what happened in the process of becoming certain of my identity and my belonging, but I guess more or less, meeting people from similar backgrounds, gaining more confidence through expressing myself, and ultimately, the positive reinforcements from my parents supported in becoming who I am today. I remember going to Chinese language classes felt like such as tedious task, but now, I look back at those times with fondness and deep gratitude. I now feel proud knowing that I can speak the language and connect with family members, and it is one of the key factors which keep me so connected with my culture.

Intertwined was also my interest in mental health, a topic that was seldom discussed in my culture, at least from my experience. I distinctly remember a hushed conversation shared by the adults in my community about an individual they knew, and how they were "crazy" and "not well". These labels were used in a casual manner, but no explicit explanation as to what the individual was going through. There was also little empathy expressed in the discussions, likely due to the lack of understanding towards mental health. It did not feel like mental health was taken as seriously as physical health, as the conversations surrounding medical conversations had sounded drastically different, where more care and empathy were given to those who suffered from physical illness, less so was given to those

with similar mental concerns. This disparity in attitudes increased my interest in the area. This interest combined with my personal background inspired me to pursue this clinical pathway and fuelled my inspiration for this research.

Furthermore, as I became more immersed in my studies, I was made aware of more organizations and discussions around Asian mental health in Aotearoa. I realized that the focus on Asian mental health was increasing and that there were specific organizations which aimed specifically to work with this population. Lectures in psychology degrees had dedicated space to discuss Asian mental health and how cultural differences impacted clinical practice. Even at my own GP practice, information sheets in different languages regarding mental health were becoming more common. However, I quickly realized that even with the increased interest in Asian mental health, there were several areas that were lacking. Firstly, all the different ethnicities were being homogenized under one umbrella, Asian, which stripped away the uniqueness and differences that are clearly visible between each of the "Asian" cultures. Additionally, there was also a scarcity of research regarding mental health for each of the different cultures being amalgamated under the "Asian" umbrella. The more nuanced experiences of individuals belonging to each culture should be further explored to identify specific issues and specific approaches to clinical practice. Hence, I felt that this research was a valuable opportunity for me to contribute further to this area of mental health, particularly for the Chinese in Aotearoa community.

Introduction to this Thesis

This introduction section will provide a background of the context which this thesis aims to explore in terms of the focus population (Chinese in Aotearoa), their place in Aotearoa, the current mental health of this population and the therapy climate in Aotearoa. This will be followed by a literature review section which aims to examine the existing studies that relate to this research area. This includes research on Chinese perspectives of "talking therapies", research on Chinese conceptions of therapy, and existing research on outcomes of therapy for Chinese in China as well as in overseas countries. Following the literature review, a background and rationale of these will be presented. The study methodology and procedure are then explained in detail. The following chapter will focus on presenting the analysis of the data of what the participants shared on what their experiences of "talking therapies" were like in Aotearoa. To conclude, the discussion chapter will analyze how this current research contributed to the existing literature and its implications both at a service level as well as at an individual level for clinicians clinically, and suggestions for

future research. For the purpose of this thesis, "talking therapies" refers to psychological treatments for mental and emotional concerns such as anxiety, depression, and other mental health concerns addressed by a trained therapist typically delivered through talking to the client. The decision to include all "talking therapies" will be discussed further in the methodology section.

Chinese in Aotearoa

Aotearoa New Zealand is officially recognized as a bicultural country via the provisions of Te Tiriti o Waitangi, a formal agreement signed between indigenous Māori chiefs and the British Crown in 1840. Since the signing of Te Tiriti, Aotearoa has diversified dramatically and is now a culturally diverse country given the recently recorded increase of immigrants choosing to immigrate to Aotearoa (Bartley & Spoonley, 2008; Ip, 2003; Wang, 2018). Of these immigrants, those who identify as Chinese have been steadily increasing as evidenced in the most recent available 2018 Census New Zealand data, where it was recorded that the individuals who identify as ethnically Chinese make up over 5% of the total population in Aotearoa, making them the fourth largest ethnic group in Aotearoa. Moreover, this data also showed an increase in individuals who speak Mandarin across Aotearoa compared to the 2013 Census as well as an increase in individuals across Aotearoa who reported being born in the People's Republic of China (2018 census totals by topic – national highlights, 2019). Given all the reported statistics, the Chinese community can be considered a significant part of Aotearoa's overall population. The term Chinese is broadly defined as an ethno-cultural descriptor that refers to individuals who share a common heritage linked back to China (Ip & Pang, 2005). This population presents with a unique set of cultural differences, as well as aspects of their identity that have emerged as they navigate the process of adjusting to a new country. Moreover, although the Te Tiriti aims to reduce inequities in various domains including healthcare between Māori and the Crown, this leaves a gap for other minority communities in Aotearoa where there are no legislations that commit to their wellbeing, thus resulting in concern in a gap of service delivery and development.

As with any culture, there is tremendous diversity within the Chinese community in Aotearoa. This is apparent through the range of languages spoken, the places of origin from which they immigrated, the age at which they arrived in Aotearoa, as well as the degree of assimilation/acculturation they exhibit. The history of this community in Aotearoa spans over 150 years where the first Chinese immigrants to arrive in Aotearoa was reported to be in the 1880s during the gold rush (Liu, 2017; Ip, 2003). The immigrants were mainly males from

the countryside of Guangzhou who came to Aotearoa with the intention of earning income and then returning home. These initial immigrants faced adverse discrimination which resulted in the formation of a tight community between these Chinese gold miners. Policies were passed such as the Chinese Immigration Act of 1881 to prevent them from gaining the same benefits as the rest of the New Zealanders and few could settle in Aotearoa and form families, although some did stay. These immigrants did not assimilate as Chinese were still considered "aliens" at the time and thus demonstrated patterns of transnationalism (Ip, 2003). However, during the 1940s, the offspring of these early immigrants demonstrated patterns of assimilation as this was encouraged by the government. Hence, to gain improved opportunities and avoid discrimination, they tried to assimilate and as a result, maintenance of language and cultural traditions became more difficult challenging and disrupting their sense of identity. Due to the assimilation, the Chinese in Aotearoa began to be more involved in Aotearoa's mainstream society and a culture of "quietly fitting in" as well as a new identity for the Chinese in Aotearoa community was developed (Ip, 2003). This resulted in multigenerational Chinese currently in Aotearoa.

Following the change in the global political landscape, Aotearoa's' immigration policies also began to transform. In 1987, Aotearoa changed to a points-based immigration system, where immigrants were evaluated based on their skills and qualifications regardless of country of origin, newer Chinese migrants began coming to Aotearoa, which disrupted the ways of the old Chinese community in Aotearoa had established as they brought a new way of residing in Aotearoa (Burke, 1986; Ip, 2003; Wang, 2018). Due to the policy change, many ethnic Chinese qualified for entry due to their high credentials, and came from different areas such as Taiwan, Hong Kong, and mainland China, which were drastically different to those earlier immigrants who came from rural Guangzhou and by now were well-integrated into Aotearoa society. These immigrants demonstrated less assimilation and more transnationalism patterns due to richer skill sets and confidence of the new immigrants (Bartley, 2010; Ip, 2003).

Transnationalism refers to immigrants that have social fields which cross geographical and cultural borders (Bartley, 2010). This allowed them to feel more valued and confident in preserving their Chinese identity (Bartley, 2010; Grbic, 2010). Hence, the newer immigrants could maintain more of their Chinese identity and language due to the increased connections that they have (Bartley, 2010). Due to these changes in the socio-economic climate, these transmigrants do not abandon their own culture/society completely, instead, the

two social fields interact and co-exist via intense contact and exchange between the home and host countries resulting in the acceptance of the host society but also retention of their original home society (Bartley, 2010; Ip, 2003). Unlike the offspring of the earlier immigrants, the newer generation of Chinese immigrants in Aotearoa found it easier to maintain their cultural and linguistic backgrounds from their home country (Bartley, 2010). This results in the retention of many cultural aspects of their identity such as collectivism and the multigenerational family network that Chinese often adopt (Podsiadlowski & Fox, 2011; Wang & Collins, 2020) whereby it is valued to have members from multiple generations living in the same household. This factor may also feed into the transnational lifestyle many Chinese families maintain, as they would want to keep their familial connections with members who did not immigrate to Aotearoa.

Over the past three decades, there has been a huge increase in the Chinese community in Aotearoa, particularly those from mainland China (Liu, 2017). As shown in the 2018 Census, the new Chinese immigrants in Aotearoa make up 5% of Aotearoa's total population. This contributes significantly to Aotearoa's overall multicultural climate and diversity evidenced through an observed increase of Chinese cultural events such as the Lantern Festival held annually in Auckland. Furthermore, this increase is also reflected in the education system and subsequently the workforce due to the immigration policy change in 2003 which promoted highly skilled individuals to immigrate to Aotearoa (Liu, 2017). It is also observed that there are a multitude of international students from China coming to Aotearoa to pursue tertiary studies (Ding; 2016; Liu, 2017; Zhang & Brunton, 2007). This suggests that the Chinese community in Aotearoa tend to be those who are well-educated and highly skilled. Recent research exploring the Chinese community revealed that although many demonstrate the transnational lifestyle, they also demonstrate genuine efforts to integrate into Aotearoa when residing here. It is suggested that integration could be achieved in many ways, such as overcoming the language barrier, joining the workforce and local activities, and venturing out of their own social Chinese circle as well as exposing themselves to local news outlets (Ip & Friesen, 2001; Liu, 2017). Research also suggests that the migration aspirations are temporally distributed across every day, individual, and institutional timelines and may change depending on the different factors (Wang & Collins, 2020). This also contributes to the transnational nature of the Chinese immigrants, as depending on what their needs are, the mobility of these immigrants tends to differ where it is often observed that

some immigrants will migrate back to their home country or to another third country (Wang, 2018; Wang & Collins, 2020).

Given the history of Chinese migrants/immigrants in Aotearoa, this results in varying terminology used to describe individuals in Aotearoa. As previously mentioned, Chinese, refers to an ethno-cultural descriptor for people with heritage linked to China or the Chinese diaspora (Ip & Pang, 2005). Those individuals who identify as being of Chinese ethnicity who are New Zealand citizens or permanent residents, emphasizing national belonging, are often referred to as Chinese New Zealanders (Murphy, 2003). Other labelling terms include Chinese immigrants/migrants which refers to prior to gaining citizenship, individuals who migrate to Aotearoa are often referred to as migrants, a broad term that describes the act of moving from one country to another, defined by mobility and legal status, whereas immigrants refer to those who move with the intent to permanently stay (Frisen, 2001). These specific distinctions thus hinge on axes of ethnicity, nationality, legal status, and statistical classification. For the purpose of this thesis, the terminology chosen was Chinese in Aotearoa, with the intention of including all those who identify as Chinese that reside in Aotearoa, regardless of citizenship or intent to remain, to capture a holistic view of the experiences of mental health for everyone that identifies as Chinese in Aotearoa.

When viewing the current Chinese community, it is also important to acknowledge that although Aotearoa has now changed its immigration policies to be more accepting of immigrants (Liu, 2017), many still face the implications of discrimination directed at the Chinese population (Liu et al., 2023; Yeung et al., 2025; Zhu et al., 2021). This in turn can result in serious detrimental effects on the quality and wellbeing of the Chinese individual through various facets which will explored in the following section. Most recently, the impacts that COVID-19 has had since its emergence on the discrimination faced by the Chinese community in Aotearoa has significantly increased (Liu et al., 2023). Hence, with the immigration policy changes where skilled and business immigration was more encouraged, the Chinese community in Aotearoa also significantly changed in terms of the composition resulting in the current diversity amongst this population. The diversity within this population suggests that depending on when the Chinese immigrants came to Aotearoa, their psychological wellbeing and mental health can also be impacted differently. Furthermore, in a recent survey conducted by Zhu et al., (2021), it was discovered that amongst the Asian ethnicities, Chinese in Aotearoa reported the most experiences of racial discrimination following COVID which may have contributed to an increase in mental health

distress. This indicates that with the changing environment of the host country, mental health concerns are also changing constantly.

Immigration and Mental Health

As mentioned in the previous section, Chinese immigrants in Aotearoa face many changes in adjusting to a new country and exhibit transnational patterns. This leads to subsequent changes in many aspects of their life and in particular, their mental health can also be impacted. Immigration to a new country can have consequences on the wellbeing of the individual. When an individual immigrates to a different country, a change in the environment occurs which may lead to consequences such as identity loss, acculturation, a sense of cultural homelessness, or language shifts (Bhugra & Becker, 2005). The identity of an individual refers to how an individual manages their self-image and the performance of others' expectations in everyday life (Goffman, 2002). Identity itself is not static but rather a dynamic process that changes depending on different social interactions and social contexts (Bhugra, & Becker, 2005). The factors that can affect identity can include the cultural background of the individual and the linguistics of a social context such as the use of the home language in the home country and the use of the host language in the host country (Liu, 2015). When moving to a new country, this can unsettle an individual's cultural identity as they struggle to balance their home and host societies' culture. This can, in turn, influence their self-esteem and psychological well-being (Bhugra & Becker, 2005). A strong cultural identity can lead to a sense of belonging and hence form a strong foundation for high self-esteem and positive psychological wellbeing (Eyou, Adair, & Dixon, 2000) which in turn would influence how well an individual can perform and feel good physically and emotionally in different environments.

As proposed in Acculturation theory by Ward & Geeraert, (2016), the process of moving to a new cultural context can pose as a significant life stressor. This acculturative stress can be a combination of language hurdles, cultural value clashes, homesickness, and perceived discrimination, thus this further proves the psychological impact that immigrants face that could influence their mental health. In the context of Aotearoa, this could potentially play out in the intergenerational conflict as children acculturate faster (challenging traditional filial piety); workplace integration pressures; and the strain of maintaining dual cultural identities.

The consequences of immigration can vary depending on the ethnicity of immigrants, the generation of immigrants, the environment of the host country as well as the home

language (Bartley, 2010; Eyou, et al., 2000; Liu, 2015). It can also differ depending on the year they arrive in the country due to the constantly changing social environment as time passes. For example, the earlier Chinese immigrants who arrived in Aotearoa would be affected differently by the process of immigration compared to more recent Chinese immigrants. Hence, the current Chinese in Aotearoa, which consists of descendants from earlier immigrants and more recent immigrants, mainly from mainland China, can be considered as a heterogeneous population which may result in different perspectives towards mental health and psychotherapy.

Furthermore, the generation a migrant belongs to can have an impact on the degree of influence that immigration has on an individual (Li & Chan, 2018; Liu, 2015). The first generation of immigrants generally refers to the generation that immigrated to another country, 1.5 generation immigrants refers to those who were born in their home country, but then immigrated to a new country with their parents at a young age or during their adolescent years, and second-generation immigrants refer to those individuals that were born in the new country to first-generation immigrants (Bartley, 2010; Li & Chan, 2018; Liu, 2015). It is suggested that different generations of immigrants experience a change in social environments differently. First-generation immigrants are thought to retain both their home and host country's cultures in an attempt to fit in with the social environment of the host country (Holmes et al., 1993). Conversely, the second generation of immigrants is thought to have fewer ties with their home country due to growing up in a completely different country leading to a higher level of acculturation to the host country, although, they would also be exposed to their home culture to a certain degree depending on their parental influences at home (Li & Chan, 2018; Liu, 2015). For those individuals that fit under the 1.5 generation, it is believed that because they have experienced their home country, they would have formed opinions and cultural ties with their home country as well as having ties with their host country through domains such as education (Liu 2015; Wang & Collins, 2016). Given the differences in exposure to the home and host country social environments and culture between the different generations, it would be interesting to explore how this would impact their perspectives on mental health.

Additionally, as highlighted in Asian Critical Race Theory (Iftikar & Museus, 2018), for Chinese in Aotearoa, they potentially face an extra layer of stress relating to the "model minority" stereotype which as a covert form of discrimination and can create internalized pressure and overshadow mental health needs given the expectation that this population

functions well. Furthermore, according to the Healthy Migrant Effect proposed by Simon-Kumar et al., (2025), it is posited that migrants will often arrive with better physical and mental health which will slowly erode over time due to several different factors related to immigration. It is suggested that pressures of adopting negative host-country behaviors, labor discrimination, social exclusion and racism, can all lead to cumulative stress which has severe impacts on the individual's mental health. Hence it is evidenced that for the Chinese in Aotearoa, there are various vulnerabilities related to the immigration status that could impact their mental health.

Hence it can be seen that as immigrants living in a new country, many factors can influence the Chinese in Aotearoa's mental health. The loss of identity and belongingness can impact wellbeing. The process of adjusting to a new environment also comes with a loss of previous support networks which may also lead to social isolation, hence impacting their mental health. The potential discrimination faced by the Chinese in Aotearoa can also have negative impacts on their mental health. Furthermore, the language barriers faced by many new Chinese immigrants can also impact their sense of belongingness as well as act as a barrier to receiving the support they need. This further highlights the need for research into how this population experiences psychotherapy to meet the mental health needs of this population. In addition, there is great heterogeneity and diversity amongst the current Chinese in Aotearoa population. The newer Chinese post-1987 immigrants came from three different distinct locations due to the changes in immigration policy which promoted more diverse reasons for immigrating, where the socio-political climate of each is quite different, and distinct from the local-born Chinese, whose families have been in Aotearoa since the 1860s. Hence, it is expected that within the Chinese in Aotearoa population, there would also be different perspectives and understanding of mental health and psychotherapy which would be important to explore to further improve psychotherapeutic intervention with the Chinese population in Aotearoa.

Mental Health in Aotearoa

Aotearoa's mental health landscape has changed considerably over the last several decades. Notably, the "Mason Report" in 1996 acted as a major turning point in Aotearoa's approach to mental health where it highlighted that the mental health sector was severely under-resourced (Mason & New Zealand Ministry of Heath 1996). Subsequently, inquiries have also taken place recently to identify how Aotearoa is managing mental health needs and to provide recommendations to better address this (New Zealand Government, 2018). The

focus on mental health has steadily increased not only worldwide but also in Aotearoa, with many studies being conducted to assess mental health prevalence in Aotearoa, mental health inequities amongst different populations in Aotearoa to help improve awareness and promotion for mental health and corresponding services (Cunningham et al., 2017; Menzies et al., 2020; Lockett et al., 2018; Roberts et al., 2018; Tan et al., 2020; Vaughan & Hansen, 2004; Wells et al., 2006). For example, the "Like Minds, Like Mine" project has been shown to successfully reduce the stigma and discrimination associated with mental health via mass media promotion and community education (Vaughan & Hansen, 2004). The recognition of the importance of how mental health can affect an individual has been acknowledged and this has been demonstrated in Aotearoa via the recent implementation of a wellbeing budget (The wellbeing budget – taking mental health seriously, 2019). The wellbeing budget aims to provide affordable, professional mental health services to those not only with high mental health needs but also those in the mild to moderate category so that those who require support can access it easily (The wellbeing budget – taking mental health seriously, 2019). This shows that Aotearoa is recognizing the importance of mental health and enforcing strategies to help improve the mental health of individuals in the community.

Research suggests that the Aotearoa perspective towards mental health has become more open and understood with less stigma attached (Bingham & O'Brien, 2018; Cunningham, Peterson, & Collings, 2016; Ellis & Collings, 1997; Vaughan & Hansen, 2004). The consequences of poor mental health are well-explored and investigated (Ellis & Cillings, 1997; Hobbs et al., 2021; Lockett et al., 2018; Sutcliffe et al., 2023). This is shown by the successful implementation of the 'Like Minds, Like Mine' project which was initiated to reduce the stigma and discrimination attached to mental health and to educate those who are unaware that mental illness is not shameful and is just like any other illness that should be addressed respectfully by using mass media and influential figures (Cunningham et al., 2016). Furthermore, a study conducted by Bingham & O'Brien (2018), where they implemented a curriculum to help decrease stigmatizing attitudes from undergraduate nursing students towards patients with mental health issues also implies that NZ's perspective towards mental health has become more understanding and less stigmatizing.

However, despite the increased awareness and decreased stigmatization, data from a mental health research survey indicated that mental health disorders are still pervasive across Aotearoa, with 39.5% of the total population having experienced a mental health disorder at some point in their life (Wells et al., 2006). Additionally, it is predicted that there is a trend

upwards of more individuals in Aotearoa experiencing increased mental distress over time (Wilson & Nicolson, 2020). It suggests that access to mental health services differs amongst the different ethnic groups in Aotearoa, particularly for Māori and Pacific people who were identified as less likely to access mental health services for their mental health issues (Wells et al., 2006). Research also suggested that there has been a rapid rise in the psychological distress and suicide rates for youths in Aotearoa, which following the impacts of COVID-19, is likely to be enduring and extensive (Menzies et al., 2020; Wells et al., 2006). The morbidity rates for mental health concerns for youths were reported to have doubled the in last two decades, for both males and females (Menzies et al., 2020). Moreover, it is suggested that there are socioeconomic inequities where youth from higher deprivation areas have higher rates of self-reported depressive symptoms as well as ethnic inequalities where Māori youths report higher symptoms of depression compared to their Pākehā counterparts. Beyond that, a systematic review revealed that in Aotearoa, experiences of racial/ethnic discrimination are linked to poorer health outcomes, including mental health as well as decreased chance of service utilization (Talamaivao et al., 2020).

Mental health services in Aotearoa have also undergone changes in the past several decades. Following the international shift of deinstitutionalisation of large psychiatric hospitals to more community-based mental health care in the late 1950s, Aotearoa also saw this shift in the late 1960s (Barnett & Newberry, 2002; Mellsop et al., 1993; Williams et al., 2017). This model of mental health care shifted from an illness model to a recovery model where the rights of the patient were emphasized and served individuals with moderate to severe issues (Williams et al., 2017). This shift to community care also led to the formation of numerous non-government organizations (NGOs) aiming to support patients exiting institutionalized care (Williams et al., 2017). Currently, mental health services can be categorised into two sections, those who are overseen by Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority (previously known as District Health Boards (DHBs)) and those with Primary Health organizations (PHOs) such as private practitioners, various NGOs, and General Practitioners. In general, only the moderate to severe are seen under the Te Whatu Ora/Te Aka Whai Ora which often leaves those who do not qualify to slip in between the mental health system (Kulshrestha & Shahid, 2022; Williams et al., 2017). Indeed, research suggests that the utilization of mental health services has been made more difficult through the various barriers reported (Kulshrestha & Shahid, 2022). The key reported barriers include long waitlist time, overburdened workforce, lack of

awareness and information and limited options for different demographic groups which is echoed in other studies (Clark et al., 2014; Fa'alogo-Lilo & Cartwright, 2021; Jatrana & Crampton, 2021; Kulshrestha & Shahid, 2022). To combat these gaps, PHOs were open to developing several mental health services that targeted specific populations such as iwi-based and Pasifika organizations that specialized in working with their own community (Dowell et al., 2009). The digitalization of mental health services also opened new avenues of access, such as online websites such as thelowdown, JustaThought (Williams et al., 2017). Of interest, recent research has also suggested that there has been an increase in the utilization of digital mental health services in Aotearoa following the COVID-19 pandemic (Mahoney et al., 2021).

Despite the growing research on mental health in Aotearoa, few studies have explored mental health amongst the Chinese population in Aotearoa with existing studies mainly grouping the Asian population as a subgroup altogether (Ho, 2004; Ho et al., 2002; Ho et al., 2013). Existing research suggests that there is a huge need for mental health services for the Asian population and Chinese in Aotearoa (Abbott et al., 1999; Chung et al., 2022; Ho 2004; Ho et al., 2013). The research noted similar prevalence rates of mental health issues amongst Asian populations in Aotearoa, however, also noted significantly lower rates of mental health utilization (Ho, 2004; Chow & Mulder, 2017). The key findings from this literature will be discussed and explored in greater depth in the literature review section.

Models of "Talking Therapy" in Aotearoa

A guide published by Te Pou o Te Whakaaro Nui (2009) highlighted insightful details on the available models of talking therapies in Aotearoa. "Talking therapies" are often used to support individuals with difficulties in emotional difficulties and mental health issues to promote positive change in their daily living. There is a vast amount of research that evaluates the effectiveness of talking therapies and as of now, there are many different types of talking therapies that have been proven to be effective in treating different types of mental health issues such as depression, anxiety, phobias, addiction and many more. They may also be used in combination with medication to treat the issues. Commonly used talking therapies in Aotearoa include Acceptance and Commitment Therapy, Counselling, Cognitive Behavioural Therapy, Family Therapy, Motivational Interviewing, Psychotherapy, Dialectical Behavior Therapy, Interpersonal Psychotherapy, and Multisystemic therapy (Te Pou, 2009). Individual clinicians providing talking therapies may also draw from each of the models in an eclectic manner (Te Pou, 2009). It is important to actively participate in the

talking therapy process as the ultimate goal of the therapist is not to solve the issues for the client, but rather, to support them in accessing the means to support themselves. Notably, the commonality of all the listed talking therapies available in Aotearoa is all developed in a Western context by Western scholars such as Sigmund Freud with psychotherapy, Dr. Aaron Beck for CBT, and Dr. Marsha Linehan with DBT (Te Pou, 2009).

In recognition that these models are mainly based on Western philosophies, Te Pou also published a guide in 2010 called He rongoā kei te kōrero. Talking therapies for Māori: Wise practice guide for mental health and addiction services, which detailed the available talking therapies in Aotearoa (similar to the previous section for the general Aotearoa population) for Māori whaiora with a particular emphasis on how to complement the traditional talking therapies through acknowledgement and incorporation of Māori tradition, cultural values, and influences. Acknowledgement of Māori worldviews such as their Tikanga, Wairua, and Whakawhanaunga are emphasized when engaging in talking therapies with Māori whaiora. In Aotearoa, there is also a focus on developing Māori models of mental health to better suit the needs of Māori whaiora. A few common and more researched models include Te Whare Tapa Whā and the Meihana model, which highlights the acknowledgement of all the different aspects of an individual's life which can contribute to whaiora's wellbeing.

Similarly, Te Pou also developed a guide in 2010 aimed to inform the available talking therapies in Aotearoa for Asian People (Te Pou, 2010b). The guide acknowledges that there is great diversity within the term "Asian" and when engaging with Asian clients, the approach should be with care and exploratory in nature while keeping in mind the individuals' cultural values, religious values, language ability, and migration history. From the consultations with practicing therapies, it was noted that particular models of talking therapies such as CBT, family therapy, problem-solving, counselling and motivational interviewing were common modalities used with Asian clients, however, it is recommended that a flexible approach be adopted when deciding which talking therapy to use and the possibility of drawing on aspects from multiple talking therapies.

Hence, it is inferred that in Aotearoa, the main forms of talking therapy utilized by mental health professionals are developed based on Western perspectives. However, it is acknowledged that due to the multicultural climate of Aotearoa, adaptation of models and becoming aware of cultural values and perspectives are vital when using these models with clients from different cultural backgrounds.

Chinese Perspectives of Mental Health

With the recent focus on mental health in Aotearoa, services such as Asian Family Services (AFS) have also taken the initiative to investigate the mental health and wellbeing of Asians in Aotearoa. From their recent research exploring the mental health and wellbeing of Asians in Aotearoa where overl 663 Asians across Aotearoa participated, it was discovered that amongst all the Asian ethnicities, those who identified as Chinese were found to perceive the most barriers to seeking mental health support (Zhu et al., 2021). Furthermore, they are also more likely to hold the expressions of stigma with mental health as being a burden/risk to society. This is a common theme where many studies have emphasized that the stigma attached to mental health is a big deterrent in support-seeking behaviors, as Asians (Chinese included) tended to view mental illnesses as being vulnerable and weak and those who seek support risk "losing face" for their families (Ng & James, 2013).

Previous research suggests that the typical Chinese view towards mental health is relatively different from the general Western perspective where it is more widely accepted. Mental health is very stigmatized in Chinese culture (Chung & Wong, 2004; Ng, 1997; Xu et al., 2018). Research suggests that amongst the Chinese, mental health can be viewed as moral misconduct passed down ancestrally as a form of punishment (Lin & Lin, 1981; Ng, 1997). Furthermore, it is suggested that mental health could also be due to possession by spirits and demons (Ng, 1997). It is also suggested that there is a sense of shame associated with mental health, where those with mental health issues are thought to bring shame and embarrassment towards the family (Ng, 1997). Mental illnesses associated with violent, unpredictable and antisocial behavior are highly stigmatized (Xu et al., 2018). These may lead to refusal of accessing services or turning to alternative treatments such as Chinese Traditional Medicine (Shi et al., 2020). Furthermore, it is suggested that due to the lack of knowledge of what mental health is, it is believed that mental illnesses are personal problems leading to higher stigma (Xu et al., 2018). This could also lead to ignorance of the severity of mental distress and under recognition of the need for intervention, thus contributing to the barriers experienced by this population (Shi et al., 2020).

Studies have also identified gender differences in the attitudes towards mental health and talking therapies for the Chinese population where it was noted that males tended to be less responsive towards mental health concerns (Yue et al., 2017; Wong et al., 2012). The gender differences are often attributed to traditional masculine gender norms/stereotypes, where being self-reliant, strong, and having strong emotional control are more valued (Nam

et al., 2010; Qiu et al., 2024). Typically, males are thought to view psychological treatment as more of a sign of weakness hence leading to less service utilization (Silvestrini & Chen, 2023). Studies which explored gender differences towards mental health help-seeking identified notable differences where higher levels of traditional masculine ideology were associated with more negative attitudes towards help-seeking (Qiu et al., 2024; Wong et al., 2012). Moreover, other potential factors which contribute to this gender difference include women being more open to disclosing their concerns compared to men as well as experiencing more significant symptoms thus pushing women to seek support (Leong & Zachar, 1999; Weissman et al., 1993). These gender differences are also observed within the Chinese population where studies have identified similar patterns where Chinese males had more negative attitudes towards mental health as well as less likely to engage in emotional disclosure (Qiu et al., 2024). It is suggested that Chinese males have a stronger tendency for a "deal with it alone" mindset when mental health is concerned (Wong et al., 2012). These findings further compound the existing barriers that the Chinese experience when attempting to access mental health support indicating that Chinese men may be prone to more severe barriers.

Recently, a shift in attitudes and awareness towards mental health has been observed (Zhang, 2014). Nationwide campaigns to raise awareness for mental health were organized by the government as well as the launching of television programs which highlight what a counseling session may involve all contributed to increased awareness and de-stigmatizing of mental health disorders amongst Chinese (Zhang, 2014). Training programs for individuals to become registered counsellors/therapists were also launched, however, it observed that trainees often come through with limited counselling experience and thus are poorly prepared for actual practice (Zhang, 2014). This suggests that although there is growing interest in mental health in China, there are still limitations in terms of access and availability across the country.

Prior research also posits that Western views towards mental health tend to focus on individualism and personal wellbeing, which does not align with the Chinese perspective, where more emphasis is placed on the collective wellbeing and self-sacrifice (Wang, 2022; Yip, 2005). Alternate Chinese models of mental health could be inferred from Confucianism and Taoism principles where mental health could be defined as balance at individual, moral, and interpersonal levels (Confucianism) or transcendence of self-interest and alignment with natural laws leading to inner peace and ultimate happiness (Taoism) (Wang, 2022; Yip,

2005). The conflicting definitions of mental health led to different expectations in achieving this. For example, from a Western perspective, weight is given to self-worth and self-actualization, however, from a Chinese perspective, individuals are rooted in interpersonal relationships and maintaining collective harmony (Ho, 1995; Yang, 1993; Yip, 2005). Furthermore, from a Western viewpoint, emotion expression is encouraged to promote mental health wellbeing, however, from a traditional Chinese concept of mental health, restraint in emotional expression is promoted (Yip, 2005). Hence, it is evident that cultural differences in the interpretation and definition of mental health lead to different values and goals for mental wellbeing.

In summary, there is a clear difference between Chinese perspectives and Western perspectives of mental health despite the growing acceptance and awareness in China towards Western models of mental health. Individualism versus collectivist mindsets and discrimination and stigma towards mental health act as prominent variances that may affect access, engagement and effectiveness of talking therapies. Given these differences, it is assumed that alterations or adaptations of Western models of talking therapies would be necessary to be considered an effective intervention for Chinese individuals.

Cultural Adaptations of "Talking Therapies" for Asian Populations

Many factors can influence the effectiveness of talking therapies, such as the cultural background of the client, the mental health disorder being addressed, clinician characteristics, and language. With the increase of literature emphasizing the importance of cultural competency within a therapeutic relationship, there has been an active push towards developing cultural competency for mental health professionals to provide the most effective treatment plans. Past literature which has explored how effective talking therapies can be for Asian populations suggests that common talking therapies can be equally effective for the Asian population with many mental health disorders, however, those talking therapies that include some form of cultural adaptation are deemed more effective (Huey & Tilley, 2018). Cultural adaptation refers to the process of systematic modification of an intervention to consider culture, language, and context which aims at improving the compatibility of the intervention with the client's own cultural values and patterns (Bernal et al., 2009). Various types of cultural considerations have been identified which include but are not limited to the matching of race/ethnicity between clients and therapist, incorporation of cultural values into the intervention, provision of services in the native language of the client, and cultural sensitivity training for staff (Bernal et al., 2009).

Several more specific models to guide culturally adapted interventions have also been developed. The cultural accommodation model (CAM) formulated by Leong and Lee (2006) focused on providing a framework to guide the adaptation of treatments to serve the needs of culturally diverse clientele based on theoretical understanding. The Psychotherapy Adaptation and Modification Framework (PAMF) developed by Hwang (2006) is another theory-driven model that aims to culturally adapt existing models of talking therapies. PAMF is a three-tiered model which refers to domains, principles, and rationales where the focus is to move from general cultural competence to more specific skills and strategies for diverse clients (Hwang, 2006). Domains refer to broad areas where adaptations may be needed such as understanding cultural beliefs about mental health and therapist-client relationships (Hwang, 2006). Principles refer to specific guidelines for different populations, and rationales provide explanations of the benefits of the adaptations (Hwang, 2006). Following the development of PAMF, the Formative Method for Adapting Psychotherapy (FMAP) was developed by Hwang (2009) with the intention to be used in conjunction with PAMF. FMAP is a community collaborative approach that involves input from both mental health providers and consumers in a bottom-up approach. These two models were used to adapt CBT to implement with Chinese Americans in a study by Hwang et al., (2015). A randomized controlled trial was used to evaluate the effectiveness of CBT and culturally adapted CBT through these models in depressed Chinese American adults (Hwang et al., 2015). The results from this study indicated that those who had culturally adapted CBT exhibited a greater overall decrease in depressive symptoms, however, both groups had similar depression rates at the last session (Hwang et al., 2015). This suggests that short-term treatments were not sufficient, however, culturally adapted CBT could grant additional treatment benefits (Hwang et al., 2015). There has also been one Aotearoa literature where a culturally adapted model of CBT based on the 5-part-model by Padesky and Mooney (1990) was proposed (Williams et al., 2004). It was suggested that due to the cultural differences, some parts of the CBT model would hold more prominence for a Chinese client such as the environmental influences where they highlighted the importance of evaluating the acculturation level of the client as cultural identity is linked to help-seeking behaviours. Moreover, they reference that how mental health is viewed and addressed may be linked to Confucian/Taoist/Buddhist influences, which leads to different interpretations and understandings of mental health and how treatment should proceed. The authors also suggest that practitioners should be aware that Traditional Chinese Medicine (TCM) could also be incorporated when working with Chinese clients due to their cultural background and acceptance of this mode of treatment. When

assessing the situation/problem the authors suggest that Chinese people tend to value the collective over the individual, thus mental health issues should be regarded as societal or relational rather than individually oriented. The authors also share how the expectations of the Chinese client could potentially impact the therapeutic relationship, where it is acknowledged that Chinese people may often view professionals as authority figures of expertise and knowledge, hence, to increase rapport and trust, a directive approach initially in the therapeutic process enhance this. They also highlight the difference in family dynamics where in Chinese families, it is common for families to be highly intertwined/enmeshed and its influence on individuals in the family unit to be strong such as the strong parental influence on children and emphasis on success, which non-Chinese may find hard to interpret and understand. In relation to the biological/emotional/behavioral/cognition part of the model, the authors posit that Chinese clients have a strong emphasis on emotional restraint and control, hence disclosure of difficult emotions may be hard and may imply a preference to discuss somatic symptoms during initial phases to establish sufficient trust and rapport before shifting to more difficult discussions/concepts related to emotions in therapy (Williams et al., 2004). The authors conclude that these are preliminary recommendations to guide further research to gauge its effectiveness when working with the Chinese in Aotearoa population. All models discussed can act as potential avenues of exploration for the effectiveness of talking therapies with Chinese in Aotearoa.

Literature suggests that compared to non-culturally adapted models, culturally adapted models yielded better results for clients of a non-Western culture. In a meta-analysis conducted by Ng and Wong (2018), where the effectiveness of CBT versus culturally adapted CBT was reviewed with various mental health disorders, it was found that although CBT by itself was an effective treatment intervention for Chinese, culturally adapted CBT tailored specially for the Asian American minorities, yielded a bigger effect size than those interventions which were tailored broadly for minorities or no tailoring at all. This suggests that the more specific cultural tailoring for different ethnic groups, the better the treatment effects. In another meta-analysis conducted by Griner and Smith (2006) where they examined ethnic/culture-specific forms of treatment, it was found that interventions that were adapted for a specific ethnicity were four times more effective than those which were not. Amongst the “talking therapies”, CBT is thought to be the most compatible form of talking therapy for Chinese culture given its focus on structure and solution-based intervention. It is suggested that Asians (including Chinese) tend to have a lower tolerance for ambiguity and are more focused on the results. Furthermore, the structured therapy sessions combined with more

immediate and practical solutions to their issues are welcomed by Chinese clients (Iwamasa et al., 2019). Additionally, clinicians who are more active in the intervention process and adopt a more directive approach align more with what the Chinese clients expect of talking therapies (Lin, 2002). In particular, there are many American studies that evaluate how effective CBT is for Asian Americans and Chinese Americans (Ching 2021; Iwamasa et al., 2019). It is suggested that generally, CBT is effective for individuals who identify as Chinese. In the Aotearoa study, it was found that CBT can be of benefit to the Chinese client as long as cultural considerations are acknowledged when formulating the problem and incorporated into the treatment process (Williams et al., 2006). It is suggested that not only do cultural adaptations of talking therapies improve the effectiveness, but it also contribute to the prevention of under-utilization of mental health services as it aligns with the client's expectations more, so they are less likely to terminate earlier (Ng & James, 2013).

To conclude, there has been previous research which explored and developed cultural adaptations of talking therapies to be better tailored to those with different values and cultural perspectives. These adaptations include more general considerations such as matching of ethnicity between therapist and client, cultural sensitivity training for staff, and matching of language preferences. More specific models have also been developed such as CAM and PAMF which provide a more structured adaptation method to adapt existing talking therapies. These adapted versions have been shown in studies to provide more effective outcomes for clients of different cultural backgrounds as well as in the promotion of utilization of services, hence highlighting the need for cultural backgrounds to be considered when engaging in talking therapies with individuals from different cultural backgrounds.

Summary

To summarize, the Chinese in Aotearoa are a prominent and unique population that has grown in population since the 1860s and have a unique culture and own set of values with their own set of mental health concerns. Furthermore, as mentioned above, even within this population there is great heterogeneity with clear differences between those who were earlier immigrants to Aotearoa and those who have more recently immigrated. As research indicates, being an immigrant in a new country, they are presented with situations where their mental health could be compromised while having limited access to services that could provide support. Although the mental health landscape in Aotearoa has significantly improved and shifted over the years, where is it now less stigmatized and more mental health services are offered with various talking therapies available, there are still gaps in service provision and

access, particularly with the Chinese community. A shift has also been observed in the Chinese community regarding their perspectives towards mental health, with more historical views being negative and stigmatized to recently, a more accepting stance has been adopted. However, it is still acknowledged that there are more steps before it is fully accepted. Talking therapies have also been introduced relatively recently to the Chinese population and often are based on Western models. It is seen that culturally adapted models of talking therapies are thought to improve the effectiveness of talking therapies with the Chinese population as they seek to align more with Chinese values and philosophies. Overall, this is a relatively new area of focus with growing research indicating the need to address this gap in mental health service delivery and engagement with the Chinese population in Aotearoa which this current study aims to do.

Chapter 2. Background of Thesis

Rationale for Current Study

The existing literature on what the experiences of psychotherapy are for Chinese in Aotearoa is scarce, with the focus mainly on CBT and single case studies. Other literature explores the mental health of Asians as an entire population which research has already suggested to be surface-level investigation that requires further exploration due to the immense diversity amongst those who identify as Asian. Furthermore, studies in America which focus on Chinese, and their experiences of psychotherapy mainly use quantitative research methods which evaluate the effectiveness of certain psychotherapies with certain disorders but fail to explore in-depth factors that contribute to the effectiveness of these psychotherapies. Additionally, due to the current environment where there has been an increase of racist and discriminatory experiences by Asians in Aotearoa (Zhu et al., 2021), it is even more important to increase the focus on their mental health and talking therapy experiences.

Research Aims

This study aims to explore the experiences of therapy and attitudes towards mental health of Chinese in Aotearoa in Aotearoa. To achieve this, a qualitative lens through reflexive thematic analysis was utilized which will be further discussed in the next chapter. This current study aims to explore and understand the experiences and attitudes that this unique population holds towards therapy and mental health as firstly, there is a gap in literature where there is a lack of mental health research amongst this population despite the population growth observed in recent years. Hence, it is hoped that this research will provide some initial insight into this area which can lead to more nuanced future research of clinical relevance. Secondly, through exploring their experiences, this research aims to explore and identify different facets which can influence their overall therapeutic experience. By identifying these facets, this can inform clinical practice such as implementing future interventions to improve engagement with services and address different components of therapy that could be adapted to be more effective and responsive for this population. This in turn can improve mental health outcomes for the Chinese population residing in New Zealand.

Explicitly, the research aims for this current study are:

1. What are the attitudes towards mental health for Chinese in Aotearoa?

2. What are the experiences of “talking therapy” for the Chinese in Aotearoa population in Aotearoa?
3. From these experiences and attitudes, what can be extrapolated to inform clinical practices when working with this unique population in a mental health context?
4. How can this study inform/lead to future research?

Chapter 3. Literature Review

This next section focuses on a review of the literature relevant to the present research. Hence, past research on Chinese/immigrants' experiences of mental health, as well as client experiences of talking therapies, is discussed and evaluated as these areas are the primary focus of the current research. This will be presented in two parts, with part one focusing on international literature and Aotearoa literature regarding what factors are considered when discussing the mental health of Chinese and immigrant populations and part two focusing on international and Aotearoa literature on client experiences of talking therapies with particular attention on Asian/immigrant client experiences. Studies which focus on client's experiences from both the client and practitioner perspective will be included and discussed, however, only studies that explore clients who are either immigrants or of Chinese ethnicity will be included as these are the defining characteristics of the focus population of the current research. This provides context to the current study as the results from existing studies will reveal potential themes around client experiences of talking therapies which may be echoed in this current study or reveal differences that may arise due to environmental/contextual disparities.

Part 1: Factors Impacting Mental Health for Immigrants

There have been numerous studies which explored factors that can influence an individual's mental health such as gender, religion, cultural factors, and stress like unemployment and educational expectations (e.g., Afifi, 2007; Kramer et al., 2010; Levin 2010; Paul & Moser, 2009; Reynolds & Baird, 2010). Within these factors, some are due to an individual's immigrant or minority group status (Pumariega et al., 2005). Although few studies have been conducted that focused on the Chinese immigrants in Aotearoa, there have been a number of studies which focused on immigrant populations across the world and explored unique factors that specifically affected immigrant/minority groups' mental health (e.g., Balidemaj & Small, 2019; Pernice & Brook, 1996; Pumariega et al., 2005; Szaflarski & Bauldry, 2019; Urzúa et al., 2019; Yip et al., 2008)

Ethnic Identity and Discrimination

Ethnic identity and discrimination have been noted by prior research as factors that could influence mental health for individuals who belong to a minority group such as immigrants (Balidemaj & Small, 2019). In an earlier study conducted on immigrants and refugees of Aotearoa by Pernice and Brook (1996), it was discovered that experiences of discrimination by immigrants negatively influenced their mental health. Similar results are

also evident in non-Aotearoa immigrant populations (Elshahat et al., 2022). In a more recent study that investigated perceived discrimination in association with mental health that focused on American immigrants, similar results were obtained where perceived discrimination impacted both physical and mental health negatively (Szaflarski & Bauldry, 2019). In another American study that focused on Asian immigrants conducted by Choi et al. (2017), it was found that experiences of racial micro-aggressions were significantly associated with psychological distress. Mossakowski (2003) also produced similar results in a sample of Asian-Filipinos. Similar results were obtained with a South American immigrant sample in Chile, where it was discovered that discrimination had a positive relationship with psychological distress in the forms of depressive and anxiety symptoms (Urzúa et al., 2019). Furthermore, similar effects of perceived discrimination on mental health have been observed in Chinese migrant populations where it was discovered that perceived discrimination by migrants led to detrimental consequences on their mental health (Liu & Zhao, 2016; Wang et al., 2018). Naeem, et al., (2024) also supported this concept, where it was identified by the client's receiving psychotherapy that socio-political factors such as racism, discrimination, and immigration were directly linked to consequential distress. Hence it can be seen that amongst immigrant and minority groups, perceived discrimination appears to be a common factor that can influence mental health. However, few recent studies focus on the effects of perceived discrimination on mental health within the Chinese in Aotearoa population, hence by exploring the attitudes and experiences of mental health and talking therapies in this present study, this may highlight perceived discrimination as potential factor leading to mental distress.

Ethnic identity has also been a common factor to investigate for influencing mental health amongst immigrant/minority groups (Balidemaj & Small; 2019; Yip et al., 2019). It is thought that ethnic identity could either be a buffer against the effects of discrimination on mental health (Phinney, 1990) or a factor that could exacerbate the effects of mental health (Yip et al., 2019). The buffering theory of ethnic identity links with the Social Identity Theory, where it is believed that individuals tend to identify themselves as certain members of a group and hence demonstrate favouritism towards that group, thus identification and belongingness to their self-identified group is now part of their own identity which will, in turn, enhance their self-esteem (Tajfel & Turner, 2001). When applying this to ethnic identity, it would imply that individuals who believe ethnic identity is more central to their overall identity, then they would be more inclined to feel good regarding their group

membership, hence when faced with discrimination, their ethnic identity would buffer the effects (Yip et al., 2019). A study conducted by Massakowski (2003) with Filipino Americans supported this hypothesis where it was found that a stronger ethnic identity could buffer the effects of discrimination. This was also observed for African American college students where those who reported high ethnic centrality had less psychological distress due to discrimination (Neblett, et al., 2004). Furthermore, another study conducted on Asian Americans also produced similar results (Choi et al., 2017). On the other hand, ethnic identity has also been shown to exacerbate the effects of discrimination on mental health by influencing the individual so that they are more aware of experiencing discrimination (Yip et al., 2019). Studies conducted on immigrant populations in America suggest that individuals who have strong ethnic identities tend to respond more towards subtle forms of racism (Operario & Fisker, 2001). Furthermore, past research suggests that not only are individuals with strong ethnic identities more aware of discrimination, but they also tend to respond more negatively to it too (Operario & Fiske, 2001). As little research has been conducted on Chinese in Aotearoa regarding ethnic identity and its effects on mental health, there is scope for further exploration of the Chinese immigrant experience here.

International studies also suggest that the challenges associated with belonging to a minority group for immigrants can also lead to unique increased mental health distress. The minority stress model which was originally theorized for sexual minority populations has also been applied to other minority/marginalized groups as well, such as the Chinese immigrant population (Meyer, 2003; Lei et al., 2022). This model posits that minority populations experience higher psychological distress due to chronic stressors such as discrimination, language barriers and cultural isolation. The stressors can be further categorized into distal stressors which are external to the person (e.g. racism, exclusion) and proximal stressors, which are internal to the person (e.g. internalized stigma, expectations of rejection) (Lei et al., 2022). International studies have been conducted to explore the effects and mechanisms of how these stressors impact mental health and psychological distress for Asian Americans. A study conducted by Lei et al. (2022) examined how the racist stressors (discrimination, internalized racism, rejection expectations) and coping strategies (self-blame, emotional detachment) identified from the minority stress model and the psychological mediation model could impact mental health in Asian Americans. The results identified mechanisms in which racist discrimination was linked to increased expectations of rejection and maladaptive coping but not internalized racism, suggesting that discrimination may affect stereotype

beliefs more than self-attitudes. They also identified that discrimination, rejection fears, internalized racism, and maladaptive coping were associated with poorer mental health. Furthermore, self-blame and detachment were the strongest predictors of distress whereas detachment and internalized racism led to harmed wellbeing. They identified that coping strategies such as self-blame and detachment contributed to how discrimination may worsen distress and that detachment alone was linked discrimination resulting in lower wellbeing. However, rejection expectations and internalized racism did not mediate mental health outcomes. This suggests that while discrimination and racism impact mental health negatively, how individuals cope (e.g. through self-blame or withdrawal) has a critical role in how an individual's mental health is impacted, sometimes more than racism itself. Hence, it is suggested that it is vital to address coping strategies towards discrimination in interventions for Asian Americans with mental health issues that have faced discrimination.

Other studies also identified a few other factors which impact the wellbeing of an immigrant belonging to a minority group (Arora & Khoo, 2020). Factors include the innate pressure to succeed both in education and careers, family dynamics, and cultural identity struggles (Arora & Khoo, 2020). It is suggested that youths belonging to an immigrant group feel more pressure to succeed in their new home country due to cultural reasons such as strong values on education as well as the need to strive in a host country (Hwang et al., 2006). Another study by Li and Browne (2000) conducted with Asian Canadians in the northern community of the province of British Columbia identified several themes that participants noted as significant factors that they felt defined mental health. These included difficulties in understanding and dealing with a new environment, high anxiety levels, perceptions of mental illness as serious and potentially untreatable and feeling lonely. Hwang et al., (2006) also identified common stressors that Chinese immigrants tended to face including migration stress, family dynamics, and cultural identity struggles. This research also reiterated important cultural values for Chinese such as influences of Confucianism, Taoism, and Buddhism which emphasize family, education, and a balance of energy. A case study by Chang et al., (2019) illustrated how immigration-related stress factors could lead to mental health concerns such as generalized anxiety disorder. This case noted that the client had felt anxiety related to guilt over her perceived failures in fulfilling family obligations after immigrating to America. The study noted that although there was an improvement in her symptoms after therapy, these improvements were diminished at the 4-month follow-up due

to stress with her husband's deportation proceedings, a significant and genuine stressor related to immigration for immigrants.

A study that explored the experiences of Chinese patients with mental illness and their caregivers in Australia identified key factors that contribute to the patient's experiences of distress, thus identifying focus areas that talking therapies should address (Hsiao et al., 2006). Interviews were conducted with 28 Chinese-Australian patients and their caregivers where it was revealed that their mental well-being is significantly influenced by interpersonal relationships and maintenance of a harmonious relationship such as disturbance through failure to fulfil cultural expectations of behavioural as a family member and these failures leading to a diminished sense of self-worth and increased fault and shame.

An article that discussed the mental health experiences of Chinese immigrants in Malaysia also echoed similar findings regarding the unique stressors leading to mental health struggles that Chinese immigrants face (Ting & Foo, 2021). The article highlighted the diversity amongst this population due to acculturation differences leading to differences in cultural identity, practices, and linguistic preferences. These in turn may impact the mental health of this population differently and act as potential mental health stressors. Several stressors unique to this population were identified such as pressures of achievement linked to family and societal expectations of achievement. Another stressor that was identified was family differentiation stress due to circumstances such as enmeshment and mutigenerational living together which could be protective as well as stress-inducing. This could lead to challenges in asserting individuality as adults and managing conflicts with traditional family expectations. They also identified differences in ways of experiencing emotional distress amongst this population as it is often expressed through somatic symptoms. The mix of these traditional values and current socio-political factors leads to unique psychological stressors experienced by this population. Chen (2022) further elaborated on the specific stressors that Chinese North American youths may face due to their unique position managing the interactions between North American and Chinese cultures navigating through family acculturation and intergenerational conflicts, similar to the article on Chinese in Malaysia. Differences in culture may lead to challenges with language barriers, stereotypes, and cultural shock such as a focus on independence. These in turn could lead to mental health struggles. Furthermore, previous research has also identified some Chinese values such as maintaining strict discipline, exerting moderation, self-control, and being able to survive in adverse

situations as factors which may impact mental health (Huang & Sprugeon, 2006; Lin & Cheung, 1999; Tse et al., 2010; Yip, 2003)

A study conducted by Chen et al., (2013) explored mental health illness disclosure in Chinese immigrant communities in relation to the cultural concept of "guanxi". This concept refers to an individual's personalized social network which includes any relationship that they may exchange support, resources, benefits, or opportunities from (Yang & Kleinman, 2008). It is suggested that family is the foundation of guanxi (Chen et al., 2013). Through semi-structured interviews with bilingual psychologists and 53 Chinese psychiatric patients in NYC, this study identified that disclosures were usually to family and relatives which were guided by ganqing, renqing, and concerns over lian (Chen et al., 2013). Ganqing refers to the depth of feeling of an interpersonal relationship which develops over time through trust and usually is based on the mutual demonstration of renqing (Chen et al., 2013). Renqing refers to reciprocal kindness which is obligated through part of the moral code to extend compassion and care (Chen et al., 2013). Those who are not part of the family network could be included through the development of ganqing and renqing. Lian refers to face/dignity which is often a deterrent of disclosure due to stigma and risk of loss of face. The research uncovered that ganqing ultimately determined who had the privilege to know of their mental health struggles and renqing further influenced more disclosure whereas the risk of losing lian led to decreased disclosure. It highlighted the need for culturally sensitive practices to aid disclosure in Chinese-immigrant communities to promote mental health recovery (Chen et al., 2013).

Hence, it can be seen through existing research that for immigrants, discrimination, ethnic identity, and unique cultural backgrounds play a significant role in shaping the mental health experience and outcomes for this population, which includes Chinese immigrants. Previous research conducted with various ethnic minority groups suggests that discrimination experienced often leads to negative mental health outcomes and the role of ethnic identity could either act as a buffer or exacerbate these effects. Furthermore, previous research also suggests that within the Chinese immigrant population, unique stressors related to the distinct cultural and socio-political condition of the immigrants such as cultural expectations, family dynamics, and acculturation challenges may also contribute to negative mental health outcomes. However, there is scant research on the Chinese community in Aotearoa which explores these factors.

Underutilization

Within the NZ context, there appears to have been an increase in the focus on improving mental health services in recent years (Cunningham et al., 2017; Ellis & Collings, 1997; Vaughan & Hansen, 2004). However, little research has been conducted regarding how the Chinese in Aotearoa population is responding to these changes. Past research in this area is limited and outdated (Abbott, Williams, Au, & Young, 1999; Hauraki, 2005; Zhang, Jeffrey, & Barnett, 2013) and only limited recent studies focus on this (Chung et al., 2024). Furthermore, many of the studies conducted do not focus on the Chinese population alone, but rather on the entire Asian population in Aotearoa (Ho, 2004; Ho, Au, Bedford & Cooper, 2002). These studies suggest that the Chinese in Aotearoa are not utilizing the mental health services available to them due to various reasons such as stigma, financial constraints, language barrier, lack of knowledge of these services, and cultural factors such as preference for traditional Chinese medicine (Hauraki, 2005; Zhang et al., 2013). This underutilization of mental health services is not only evident for Chinese in Aotearoa but also for Chinese immigrants in other countries (Chen, Kazanjian & Wong, 2009; Li, 2008; Mo & Mak, 2009). A study conducted on Chinese Canadians by Chen et al., (2009) investigated the reasons behind why Chinese Canadians accessed mental health services and discovered that a large part was due to the cultural factors associated with mental health such as the stigma. In another study conducted with Chinese immigrants in America by Li, (2008), similar reasons as to why underutilization of mental health services occurred were obtained, where stigma was identified as the factor behind this. Hence, it would be interesting to gain an updated view and investigate whether this underutilization is also the case for the Chinese in Aotearoa in the present moment. Past literature which explored Asian mental health in NZ also provided potential strategies that could be implemented to improve the underutilization of services (Ho, 2004; Ho et al., 2002). Suggestions included providing more English interpretation services to overcome the language barrier, providing service providers with information regarding cultural issues, and encouraging the development of cultural community groups, where individuals of the same background can gather together and form mutual support systems (Ho et al., 2002).

Part Two: Client Experiences of "Talking Therapies"

This section aims to explore how clients engage and perceive "talking therapies". By exploring client experiences such as their engagement, progress, and overall satisfaction with the therapeutic process, it can highlight specific action points which may improve outcomes

of “talking therapies”. Numerous international studies have explored immigrant’s perspectives and experiences of talking therapies (Arora & Khoo, 2020; Kim et al., 2011; Li & Browne, 2000; Leong & Lau, 2001; Liu et al., 2020; Naeem et al., 2024; Sorkin et al., 2011; Su-Kubricht et al., 2024; Ting & Foo, 2021; Tung, 2011; Wang et al., 2019). This section reviews the existing literature on how clients experience talking therapies, focusing on common factors that emerged from the research including perceived barriers, the role of language, culturally responsive practice, and therapeutic alliance with the clinician. Both positive and negative aspects of the client’s experiences are examined with the aim of providing a broad picture of what contributes to effective therapy and what improvements could be implemented to improve the therapeutic experience for clients of immigrant backgrounds.

Asian Immigrants' Experiences of “Talking Therapies”

This section focuses on the experiences of talking therapies of Asian immigrants from international literature which corresponds to the population of interest for the current study and aims to explore which factors Asian immigrants perceived as influential in therapeutic experiences.

A study conducted by Su-Kubricht et al., (2024) provided the perspective of Asian American clients who were receiving mental health services and identified four areas where services were lacking for this population. The study adopted a thematic analysis approach towards the online questionnaire answered by 93 participants who all identified as “Asian” or “Asian American”. It was recognized that these clients felt a lack of trust in the therapeutic interventions as well as the clinicians, they also experienced a lack of cultural understanding demonstrated by the clinicians. Furthermore, language barriers and challenges related to service access and resources were also notable barriers experienced by this population.

Liu et al. (2020) also explored Asian American students’ experiences with mental health services which identified several cultural factors similar to previous research with adult populations. They conducted interviews with five Chinese and four Korean international students who accessed counselling services at universities in the U.S. and analyzed the data through an interpretative phenomenological approach. The findings highlighted particular cultural factors which impacted the participant’s experience of seeking mental health support such as the influence of social networks promoting access and stigma limiting access. Furthermore, they identified that due to the lack of awareness of mental health, participants expected support to be given in the form of the medical model, thus

leading to a mismatch of expectations resulting in disappointed experiences of counselling. Additionally, the perceived cultural competence of clinicians also contributed to therapy outcomes, where those who were viewed as less competent had a detrimental effect on the therapeutic effectiveness. The counsellors' backgrounds also contributed to the perceived effectiveness of therapy, where many participants noted that they felt that they would have gained more from the therapeutic experience if they had counsellors who were of a similar cultural background, as they would be able to understand certain concepts better as well as provide ease of access with using the same language. This study echoed similar findings to other research on Asian immigrants' experiences of mental health services.

Barriers. It is evident across research that individuals from marginalized groups experience numerous barriers when accessing mental health support, both youth and adult populations (Arora & Khoo, 2020; Kim et al., 2011; Li & Browne, 2000; Leong & Lau, 2001; Naeem et al., 2024; Sorkin et al., 2011; Tung, 2011; Wang et al., 2019) where numerous studies have explored the barriers which Asian Americans experience when accessing mental health services. Fewer studies have been conducted in Aotearoa, however, some research also echoes similar findings in terms of existing mental health barriers (Chung et al., 2022; Ho, 2004). Barriers identified include culturally related stigma, lack of awareness, lack of cultural responsivity, language, and cost. All these create a combined result of under-utilization of services when needed.

In an article by Ting & Foo (2021), they identified several barriers to access to mental health services experienced by Chinese immigrants in Malaysia. Even though Malaysia as a country shared similarity with China, the Chinese immigrants there still faced barriers noted by other Chinese immigrants in other countries. Prevalent across research, stigma and shame were also identified in this article as a key deterrent to access due to cultural norms discouraging open discussion of mental health concerns. As most mental health services in Malaysia were privately funded, the cost was another named deterrent that prevented the Chinese in Malaysia from seeking support. They also identified that language was another barrier as not all clinicians spoke Mandarin, hence hindering accessibility and limiting effective communication. Furthermore, they also pointed out that in mental health in general, there was a lack of localized resources, which alluded to the Western-based psychological assessments and psychometrics in general, which are not always culturally adapted for the Chinese population. Hence, this may lead to inaccurate diagnosis. Additionally, they also noted that there was inadequate multicultural training, hence reducing the ability of clinicians

when addressing the unique socio-political and culturally related psychological distress that the Chinese immigrant clients may present with. Another barrier that was noted specific to the Malaysian context was the lack of family therapists. The authors suggested that in Chinese culture, there is a strong value placed on families, given that most therapies are individual-based, and there is a huge demand for family therapy that is not met.

Li & Browne, (2000) also identified similar barriers of poor English language ability acting as a major barrier to accessing mental health services. Furthermore, a lack of understanding of mainstream culture and awareness also contributed to this. Naeem et al., (2024) discovered that within their sample population, the cost of services was a huge barrier that prevented individuals of immigrant populations from accessing mental health services.

Many other studies also identified stigma amongst the Asian population as a key deterrent to utilizing mental health services (Chung & Wong, 2004; Tse et al., 2010). As previously discussed in the introduction section, mental health is often seen as a source of shame or a sign of familial failure, hence to "save face", mental health services are avoided. This is closely linked with a lack of awareness of mental health concepts as well as mental health services.

Language. Previous literature on mental health experiences of immigrant/minority populations revealed that language is an important aspect to consider when exploring therapeutic experiences of clients in talking therapies, as this is the main mode of communication.

A study by Satiago-Rivera et al. (2009) explored the therapeutic experience of Spanish-English speaking clients from the therapist's perspective, where it was revealed that code-switching was used by the therapist to establish trust and rapport with clients, as well as promoting disclosure through the use of specific words/phrases. Code-switching refers to the practice of alternating between two languages/dialects/communication styles within one conversation/interaction (Satiago-Rivera et al., 2009). A study which explored 182 multilingual client's experiences of talking therapies from various countries through an online questionnaire revealed that code-switching (CS) was often used during emotionally intense moments such as when discussing trauma/shame. The use of CS by multilingual therapists promoted empathy and the therapeutic environment where multilingualism was used was appreciated by the clients (Dewaele & Costa, 2013). Studies have also explored clients' experiences of talking therapies while with an interpreter where it was identified that

there were mixed experiences where some clients found the experience satisfactory and worked well with the clinician to provide effective therapeutic intervention whereas others found the role of the interpretation as confusing and disappointing (Costa & Briggs, 2014)

Naeem et al., (2024) also supported this, where it was identified that language was an important factor to consider, whereby instead of translating verbatim, adaptation of the language should be utilized to communicate key therapy concepts. This suggested that instead of translating therapeutic concepts directly, the concepts should be culturally adapted to increase appropriateness and understanding with the South Asian population for the effectiveness of therapy to increase.

Culturally Responsive Practice. Numerous studies conducted overseas which explored the client experiences identified the importance of culturally responsive practice within psychotherapy practices for the Asian immigrant populations.

In a systematic review conducted by Sadusky et al., (2024) they explored the client's perspectives on cultural and racial awareness and responsiveness of mental health professionals with the aims of identifying focus areas which can contribute to a better experience for clients. A total of 48 studies were included in the review which embodied the views of 652 clients across 10 countries. They identified that clients often experience cultural responsiveness through mental health clinicians' behaviors, clients' own cultural factors as well as how these factors interact, or inter-relational factors. Specifically, they noted that mental health professionals who lacked an understanding of racial and cultural backgrounds or had stereotypical assumptions about cultural backgrounds could lead to clients feeling less trust and culturally safe in the therapeutic relationship. Furthermore, over-confidence in their understanding of cultural backgrounds could also lead to overall detrimental effects on the therapeutic relationship. The study also revealed that clients' personal experiences with mental health services also contributed to how they viewed the therapeutic experience hence highlighting the importance of all experiences with mental health services. Conversely, mental health professionals who demonstrated cultural humility and willingness to be open to learning led to positive experiences from clients. The welcoming environment which visibly conveyed inclusion and anti-racism also contributed to a felt sense of cultural affirmation towards the clients. Therefore, it is important for mental health professionals to acknowledge their knowledge gaps, pursue professional development, and develop a sense of self-awareness of their biases and assumptions to improve outcomes for marginalized clients. This review also identified the importance of shared identity, where clients are more likely to feel

a sense of therapeutic alliance with a mental health professional who shares a similar aspect with their identity, whether it be culturally, gender, or belonging to the same minority. In the absence of a shared identity, genuine empathy and warmth can also contribute to a strong therapeutic alliance. In light of this, the review highlights the need to provide equitable access to training for members of minority groups, challenging systemic barriers in education and practice to achieve meaningful change in the therapy space.

Another study by Naeem et al., (2024) explored how culturally-adapted CBT could be used to improve community mental health services for South Asians in Canada. Similar findings to previous studies conducted with cultural minorities were revealed. It is indicated that cultural awareness of the cultural differences from the clinicians' perspective is highly valued as well as awareness of the client's cultural and spiritual values. Furthermore, an important finding from this research highlighted the importance of the underlying mechanisms of "collectivist" communities, where acceptance of psychotherapy, a relatively foreign concept, was increased when it is endorsed by a trusted individual, such as families and friends. Conversely, it was also discovered that the reputation of service providers was also severely influenced by endorsement from trusted individuals, where it was shared by participants that the consensus was that there was a lack of culturally competent services and interventions for this community, hence, contributing to lesser likelihood of engagement.

Hwang et al., (2006) further explored the importance of cultural responsivity in treatment modalities through a focused exploration of CBT. They discussed in depth how a traditionally effective modality of therapy, CBT, could be adapted to accommodate the unique challenges faced by Chinese Americans due to cultural, linguistic and acculturative differences. Previous research had identified that this population tended to prefer directive approaches due to cultural values such as structure, direction, and symptom-focused approaches, however, as noted in other literature, this may not be the case for all Chinese immigrants (Liu et al., 2024; Williams et al., 2006). They identified key themes and principles that they utilized in their adaptation which was then incorporated within a case study where treatment of adapted CBT was done with a Chinese American 12-year old boy. These key principles included education and orientation, cultural learning, goal-driven therapy, psychoeducation, cultural bridging and strengthening of client-therapist relationships through defining roles and managing expectations, recognizing communication styles, acknowledging the Chinese cultural respect for hierarchy by viewing therapists as credible roles, and building rapport by exploring client backgrounds' and using shared cultural

traditions. The study also listed cultural factors to take into consideration when working with Chinese clients, such as using family-oriented treatment, addressing issues of stigma and shame, promoting emotional expression (due to cultural values of emotional restraint), addressing cultural values that may clash with therapeutic goals, such as collectivist vs. individualistic goals, using cultural strengths such as Taoist/Buddhist ways of practices like mindfulness to enhance CBT, addressing cultural understanding of mental health (such as priority of somatic symptoms), and acknowledging alternative healing practices such as use of traditional Chinese medicine/acupuncture. The case study proved that culturally adapting CBT could lead to improved therapeutic outcomes and reinforced the importance of understanding clients' cultural backgrounds and cultural sensitivity to modify treatment approaches to allow improved efficacy, and client satisfaction.

Another case study by Chang et al., (2019) explored the use of Taoist Cognitive Therapy (TCT) for a middle-aged Chinese American immigrant woman with generalized anxiety disorder (GAD). TCT is a culturally adapted therapy based on Taoist principles of moderation, humility, acceptance, and harmony with nature. The case study illustrated an improvement in her anxiety and worries after 16 sessions of TCT demonstrating the usefulness of culturally adapted therapy. This case study further supports previous literature which highlights the importance of cultural responsivity when working with Chinese immigrants.

Numerous studies which focus on Asian American clients of psychotherapy also support the importance of cultural responsiveness in psychotherapy (Kim-Goh et al., 2015; Kodish et al., 2021; Root, 1985; Sue, 1998). It is suggested that due to the nature of the presentations often being associated with cultural factors, incorporating culturally adapted practices is vital in building rapport and therapeutic alliance, which subsequently leads to improved outcomes. Acknowledgement of the collectivist nature as well as awareness and mitigation of stigma are viewed as important when working with this population. Furthermore, Kodish et al., (2021) also emphasized the importance of culturally adapting existing psychotherapy models to address cultural constructs such as acculturation dynamics and emotional suppression to enhance acceptability and effectiveness of psychotherapy.

In a study by Bercean et al., (2020), they also explored culturally adapted CBT for Chinese immigrants, with a focus on depression. This study's findings reiterated the importance of adopting a culturally sensitive practice where cultural humility is more valued than just cultural competence. They specified that instead of assuming expertise, there is a

need to learn from the clients regarding their culture and worldviews to demonstrate cultural humility. Ma & Lan (2022) published another case study which described the process of therapy with a 2nd-generation Chinese American adolescent with mental health concerns and discussed the importance of incorporating relational, contextual, and cultural factors when working with ethnic and gender minority youth. They used relation-cultural theory (RCT) to create connections, a safe environment, and validated the sociopolitical factors leading to psychological distress within the client.

Therapeutic Alliance. International literature indicated that therapeutic alliance between the client and clinician is essential to facilitate positive outcomes in talking therapies (Chang & Berk, 2009; Jim & Pstrang, 2007; Liu et al., 2024; Thompson & Alexander, 2006). Therapist characteristics have been vastly studied and researched and are known to contribute to the overall effectiveness of therapy (Kim et al., 2005; Liu et al., 2024; Meyer et al., 2011). Through investigating literature on the mental health experiences of Asian immigrants, it is of interest that therapist qualities were a common topic discussed along with cultural considerations when exploring the therapeutic experiences of this population.

A study by Chang & Berk (2009) which explored the experiences of ethnic minority clients treated by White, European or American therapists revealed that client satisfaction highly depended on individual clinician characteristics and relation processes. Specific clinician traits such as compassion, responsiveness, non-judgment, culturally aware and adaptive were listed as factors that led to higher client satisfaction. Furthermore, self-disclosures as well as the ability to repair relational ruptures were identified as critical factors for building trust and therapeutic alliance. Interestingly, although cultural competence was valued, clients could minimize racial differences themselves to adapt to the perceived therapist's limitations. Hence, this study emphasized balancing universal therapeutic skills along with culturally tailored interventions to lead to effective outcomes.

Similarly, a related study by Thompson & Alexander (2006) explored therapy experiences of African American clients with therapists who were either African American or European American, using either interpersonal or problem-solving approaches. Clients working with African American therapists reported greater understanding and acceptance of treatment and perceived higher therapeutic benefits. Interestingly, discussions of race initiated by European American therapists in the first session did not influence therapy ratings. The authors suggested that race likely shaped client-therapist interactions and subsequent evaluations, though the lack of qualitative insights limited their ability to identify

specific mechanisms or explain why race discussions had no discernible effect on therapy outcomes.

Liu et al., (2024) investigated the therapists' experiences at a university counseling center who worked with Asian American clients. Through the conducted interviews, it was identified that family stress was the more frequent concern reported amongst this population, often co-occurring with academic stress, emotion regulation issues, and identity exploration. They highlighted the complex role of family obligations, which could impact identity development and academic performance negatively or act as a protective factor against mental health concerns. Contrary to previous research where it was noted that Asian populations tended to prefer more directive approaches, clinicians noted that they had used both directive and insight-orientated approaches. This study also discussed the impacts of ethnic matching amongst client and clinician where it was noted that the effects of this tended to vary depending on the client and clinician dyads. Similar to previous research, this study highlighted the importance of cultural responsiveness and awareness contributing to more positive therapeutic outcomes as well as adopting a culturally tailored approach when working with this population.

The results of another study by Jim & Pstrang (2007) complemented results from previous research, where it was identified that although cultural knowledge was important to establishing effective therapy between client and therapist, empathy, curiosity and sensitivity to individual contexts were more valued. The results of this study emphasized that empathy and creating a safe space through non-judgmental listening, trust, and therapist expertise coupled with acknowledgement of cultural knowledge (such as through contextualizing clients presenting issues to their cultural background) resulted in more positive therapeutic experiences. Furthermore, it highlighted that failure to explore cultural contexts at all can lead to misunderstandings and ruptured therapeutic relationships, resulting in ineffective therapy. Overall, the findings of this study emphasized the importance of both cultural and individual factors when providing therapy rather than just pure cultural matching between therapist and client.

A further study which explored immigrant college students' perceptions of their clinicians' cultural competence by Rogers-Sirin et al., (2015) echoed similar findings to the aforementioned literature. This study focused on exploring the clients' perceptions of the clinicians' behaviors' which was identified to have a significant impact on the client's impressions of therapy. Participants identified several therapeutic flaws of the clinician which

impacted their overall therapeutic experience such as overt discrimination or microaggressions, lack of understanding of the client's needs demonstrated through inadequate explanations of the therapeutic process or messy approaches to culturally related discussions. This study reiterated the importance of clinicians' developing cultural competence and awareness through engaging in transformative learning of emotional understanding of cultural issues and self-awareness.

To summarize, the extensive literature supports the notion of blending universal therapeutic skills to create a strong therapeutic alliance in combination with culturally responsive practices to improve therapeutic outcomes for clients of ethnic minorities. Through research, it is indicated that key traits of clinicians that contribute to a stronger therapeutic alliance include empathy, engaging in non-judgmental listening, building trust, creating a safe environment, and the ability to repair relational ruptures. Although cultural competence is valued, research suggests that clinicians should also acknowledge individual client contexts without making assumptions through cultural humility. This approach creates a balance between cultural sensitivity and individualized care, leading to more positive therapeutic experiences and outcomes.

Client Experiences of "Talking Therapies" in Aotearoa

There is a scarcity of research which explores the client perspectives of talking therapies in Aotearoa, with more research focused on the clinicians' perspective of their hypotheses of the client's experiences. Within this area of client experiences, even fewer studies focused on Asian populations and even fewer on Chinese immigrants. However, in the existing research, there are common factors which studies have identified as important factors which can impact the perceived quality of mental health services received. Similar to international literature, these include culturally responsive practice, therapist characteristics such as non-judgmental listening and providing a safe space. Barriers to services were also discussed in these studies and again, echoed similar findings to international literature, with the key barriers being accessibility issues such as cost, wait time, difficulty with cultural differences and lack of awareness of services.

In a study conducted by Fa'alogo & Cartwright (2021), they explored both the provider's and ex-service users' perspectives regarding mental health services via interviews using a Pasifika-appropriate Talanoa approach. Through this research, they identified several barriers to access to services which included stigma, rigidity in finding solutions within the family, and both mistrust and lack of knowledge of services. They noted that within services,

it was perceived that non-Pasifika providers often lack an understanding of collectivist cultural values and practices including spiritual beliefs thus hindering the therapeutic experience. Clients shared that they were more likely to use services if clinicians were respectful of Pasifika practices and paid attention to developing relationships in a culturally appropriate way such as including the family in the process. Furthermore, assessment and intervention should include an understanding and respect for cultural interpretation of mental health issues in terms of the individual, family and community.

Another article by Mathieson et al., (2023) explores clinicians' perspectives on a large youth mental health pilot project (for 18–25-year-olds) which encompassed a CBT component. The clinicians' views on cultural responsiveness, therapy (delivery, modality and duration) and working with LGBTQIA+ youth were explored using both individual interviews and focus groups at various stages of the life of the project. Many clinicians shared a positive affinity toward using CBT due to its client-centred approach and reported good effect was reached through CBT. Some clinicians felt that family therapy would have been preferred over CBT approaches. Clinicians noted that having a more culturally diverse workforce would allow more space for culturally responsive practice as well as more training to increase their own cultural competence. Another avenue they noted that would support them in working with culturally diverse populations was to increase access to cultural supervision.

Nazari & van Ommen (2019) explored the client perspective of university students in Aotearoa regarding their experiences with university mental health services via interviews. The findings of this study highlighted that therapist characteristics were a key factor in determining their perceived service quality, echoing international literature mentioned in the previous section (Liu et al., 2024). In contrast, the long wait times, and lack of information provided about the therapies and services were noted as perceived barriers to a positive experience of mental health services. Advertisements could be used to increase awareness and reduce stigma around mental health service use.

Gibson et al., (2016) also explored the perspectives of mental health services of youths (13-18 years old) in Aotearoa. These youths engaged in either a hospital-based mental health service, school-based counselling service, telephone counselling service, or a text-based counselling service. The findings of this study shed insight into what the youths prioritised when deciding to engage in services and what they valued throughout the therapeutic process. Similar to previous literature, this study identified that the clients

preferred to be able to talk freely and be listened to, implying the necessity of a safe environment and non-judgemental listening. They also noted practical factors such as the service being accessible and flexible to accommodate their lives, which echoes findings from other literature that highlighted the need to remove the barriers of cost and lack of awareness. Interestingly, the participants shared that they would like a relationship with their clinician as one more like a friendship than a professional, which resonates with previous literature that mentioned the key to a positive therapeutic experience was the clinician's characteristics.

Tse et al., (2010) explored the perspectives of a specific intervention, strengths model, for mental health concerns of Chinese in Aotearoa through individual interviews and focus groups. The findings of this study identified that the strengths-based approach was positive in its ability to shift away from solely focusing on the issues related to mental illness, thus reducing the stigma and shame associated with seeking support. Furthermore, the practical and structured approach with a strong emphasis on outcomes was seen to align with traditional Chinese values of maintaining discipline and self-control. They also identified a secondary benefit of this model as it allowed flexibility to include migration settlement goals, allowing effective integration into a new country, which subsequently decreased the associated stress of immigration (social isolation, language barriers). However, despite the positives, there were also a number of challenges associated with this model that align with what has already been identified in previous literature. A key challenge was the lack of appropriate translation of the tools and incorporation of cultural contexts as this hinders the communication between clinician and client.

In a more recent study by Chung et al., (2022), clinicians who provided mental health services to Chinese in Aotearoa discussed their perspectives on the care received by the clients and what they believed was important in contributing to the therapeutic experience. The consensus from this research indicated that clinicians believed that the mental health services provided were not adequate due to the lack of language and culturally appropriate care available. To elaborate, they identified a lack of mental health awareness amongst Chinese in Aotearoa and a lack of awareness among clinicians regarding the needs of this population leading to low utilisation rates of services.

To summarize, regardless of the limited literature exploring clients from minority groups' experiences of talking therapies in Aotearoa, the existing research does correspond to international literature where a lack of culturally responsive therapies leads to poorer outcomes for clients of minority/immigrant backgrounds. Studies from Aotearoa noted

similar barriers limiting access to services such as lack of awareness, cost, and language difficulties. Notable factors which impacted therapeutic processes included the lack of culturally responsive therapy and therapist characteristics, all of which were also identified in international literature.

Summary

There has been extensive research conducted internationally where immigrant client experiences of mental health services have been explored. Many identified unique cultural and socio-political factors that impact the mental health of this population, leading to unique psychological stressors. Studies which explored the client experiences noted unique factors which impacted their perception of the therapeutic experience. Notably, the importance of being culturally responsive while maintaining key clinician characteristics such as empathy, non-judgmental listening, and creating a safe space were all vital in a positive therapeutic experience. In terms of research in Aotearoa, while there have been studies that investigated the potential barriers faced by immigrants in Aotearoa to accessing mental health support, there is limited research that explores how the Chinese in Aotearoa experience talking therapies in Aotearoa. Additionally, only a few studies have explored how culturally adapted CBT could benefit Chinese clients in Aotearoa, with most research in this area being conducted internationally. Given that Aotearoa is a different environment to other countries, different factors could influence the experiences of talking therapies by the Chinese community in Aotearoa and thus impact the effectiveness of the intervention. Moreover, there is little attention given to how the clients themselves experienced therapy, and what their expectations and thoughts were regarding the process. This results in a one-sided perspective and more investigation should be given to the consumer experience. Furthermore, most research tends to focus on only one type of talking therapy, this current study would aim to draw common factors across all talking therapies that work well with the different Chinese clients in Aotearoa. To date, there have been no studies that examine their unique experiences of psychotherapy in Aotearoa from a consumer viewpoint; this proposed study will aim to bridge this gap.

Chapter 4. Methodology

This chapter will outline the methodology used in this current study. Firstly, the theoretical foundations of the study design will be discussed followed by the description of the ethical considerations of this study and then an outline of the methods. This includes the procedure of the study such as recruitment, data collection process, and the participant details. The data analysis process will then be detailed as well as the quality criteria and comments on researcher reflexivity.

Theoretical Approach

Qualitative Approach

This study assumed a qualitative research design which enables researchers to explore and understand complex phenomena by investigating non-numeric data, such as words, images, or objects without manipulating the phenomena (Ezzy, 2013). This approach enables researchers to generate a deeper, contextualized understanding of the experiences, behaviours, emotions, thoughts, and social processes of individuals within their social-cultural context (Willig, 2013). Qualitative research is exploratory in nature, where the aim is often to generate new insights and hypotheses rather than testing pre-existing hypotheses and adopt a flexible design, allowing for adjustments to be made in response to emerging discoveries through the research progress (Willig, 2012). It also provides a subjective perspective where it emphasizes understanding phenomena from the participant's point of view through their descriptions of their subjective experiences (Ezzy, 2013). Qualitative approaches also acknowledge the researchers' role and how this may impact the research process and encourage the researcher to engage in reflexivity, where their own biases, and assumptions are often reflected on (Braun & Clarke, 2012). Finally, qualitative research provides rich descriptions of the phenomena being explored and places a strong emphasis on the context in which the phenomena present themselves (Willig, 2012). Hence, a qualitative approach can be considered an effective approach to exploring and understanding the complex experiences of an individual by focusing on depth, context, and the participants' perspectives.

Qualitative research makes a distinction between Big Q and little q. "Big Q" refers to the full commitment of qualitative research as a complete methodological approach and epistemological stance whereas "little q" refers to the use of qualitative method in a more limited manner or supplementary role, where it often is used within a quantitative framework without full commitment to the qualitative methodology (Braun & Clarke, 2013). It is

acknowledged that due to its qualitative values, Big Q approach seeks to understand and interpret phenomena while recognizing that understanding can be partial and acknowledges that personal involvement and subjective meanings may contribute to the understanding (Terry & Hayfield, 2021). With this approach, generated data are often rich and detailed (Braun & Clarke, 2022).

This Big Q approach was selected for the current study as it is best suited to the research aims. Firstly, there is scant existing research which explores the therapeutic experiences of the Chinese in Aotearoa population, this aligns with the current approach as it aims to be exploratory and interpretive in nature as well as focusing on gaining understanding and meaning which is facilitative in the generation of new theory. Furthermore, this approach will allow the researcher to gain insight into the specific details of therapy that Chinese in Aotearoa find helpful to provide practical application into how clinical practice could be adapted to better suit the needs of this population. Additionally, the richness of the details will also allow the researcher to explore potential barriers that the population experiences which again could be adapted clinically to promote engagement in mental health services. It is acknowledged that there is tremendous diversity amongst this population however obtaining an adequate sample size to ensure representation of the breadth of this diversity is beyond the scope of this research. Hence the goal is to engage in an exploration of the experiences of therapy for the Chinese in Aotearoa population where the focus is to explore the subjective "lived" experiences of individuals in depth.

Reflexive Thematic Analysis (TA)

Reflexive TA is a form of thematic analysis which is a theoretically flexible interpretative approach to qualitative analysis that avoids positivist conceptions of data interpretation (Braun & Clarke, 2012). Similarly, to other forms of TA, reflexive TA allows for the identification and analysis of themes or patterns across a data set. However, what is distinctive in this approach is that it highlights the researchers' active role in the research process and information production (Braun et al., 2019). The generated codes are the products of the researcher's interpretation of the meaningful patterns in the dataset via interpretation of the dataset, the theoretical underpinnings of the analysis, and the analytical skills/background of the researcher (Braun and Clarke, 2019). It is often expected that these will differ across researchers' and thus no expectation that similar codes or themes will arise through analysis by two different researchers (Braun & Clarke, 2019). The creativity, reflexivity, and subjectivity of the researcher are embraced and encouraged to be viewed as

assets in research generation (Braun & Clarke, 2019). This analytic approach was chosen given that the researcher connects closely with this target population as a Chinese in Aotearoa. This will be further discussed in the researcher reflexivity section of this thesis. Thus, it was decided that with this approach, the insight that the researcher brings can be viewed as an advantage to engage with the data fully and deeply as well as facilitating acknowledgement and awareness of the potential biases that the researcher will be mindfully reflective of.

There are four domains of reflexive TA to consider when analysing the data in this approach and process (Braun and Clarke, 2020). These domains are an integral role in shaping the research approach and analysis. The current study leaned towards a predominantly inductive, latent-semantic, experiential, and constructionist approach. The decision behind this will be further explained and explored.

Firstly, inductive versus deductive where inductive refers to a "bottom-up" approach to the data, where the data is the starting point for meaning and interpreting data (Braun & Clarke, 2013). Deductive refers to a "top-down" approach, where the researcher brings existing theoretical concepts/theories that provide a foundation for "viewing" the data and the basis of interpretation of the data (Braun & Clarke, 2013). A deductive approach is less bound by the semantic meaning contained in the data. This research leans towards more of an inductive approach where data-based interpretations were emphasized as there is minimal previous research conducted in this area with this specific population; less consideration was given to utilizing pre-existing theories to view the data in the current study. However, a degree of deductive analysis was used to ensure that produced codes and themes were meaningful and relevant to the research aims.

The second domain considered was semantic versus latent approach. With a semantic approach, the analysis occurs at the surface level of the data, where meanings are not considered beyond what the participant had said (Braun & Clarke, 2012). The data presented is purely the content of data as communicated by the participants. With a latent approach, the data is interpreted at a "deeper" level, where meanings, concepts, and themes may not be explicitly communicated by the participant, but interpreted by the researcher (Braun & Clarke, 2013). In this research, both semantic and latent approaches were adopted for the analysis of the data, where some coding was done through the semantic approach and reported at the surface level such as specific aspects of therapy that the clients found helpful. Latent analysis was utilized to explore deeper underlying cultural influences and meanings

that may have contributed to the participants' descriptions of their experiences with therapy such as how cost may have been a major consideration due to underlying stressors that immigration may have.

The next domain considered was an experiential versus critical orientation. Adopting an experiential lens to understanding data gives priority to how a phenomenon may be experienced by a participant (Braun & Clarke, 2014). The focal point would be the participants' given meaning to the phenomenon and the meaningfulness of the phenomenon to the participant (Braun & Clarke, 2014). From this approach, the aim is to understand the participants lived experiences from their own perspectives. In contrast, a critical orientation would focus on how the wider socio-cultural context influences the experiences of the participant (Terry et al., 2017). This orientation aims to interrogate patterns and themes of the data with the theoretical background that language can create a given social reality rather than just reflecting on this (Braun & Clarke, 2012). For this study, an experiential orientation was adopted to focus on the experiences of the participants with priority given to understanding their experiences and attitudes toward therapy and mental health, rather than what may underlie the development of these experiences/attitudes. The main focus was to explore their own experiences of therapy rather than to make conclusions regarding what contributed to the development of these, although this was also taken into consideration.

Lastly, for essentialist versus constructionist epistemologies, when a researcher adopts an essentialism approach, the researcher undertakes a unidirectional understanding of the relationship between the communicated experience and language (Braun & Clarke, 2014). This suggests that the experiences and meanings verbalized by participants of a study are straightforward and can be directly accessed through the data (Braun & Clarke, 2014). Fundamentally, this approach diminishes the interpretative potential of TA. Contrariwise, there is a bidirectional understanding of the communicated experience and language for researchers with a constructionist approach (Braun and Clarke, 2012). It is thought that rather than just the recurrence of information in the dataset, meaningfulness is highly influential in the development and interpretation of codes and themes. This lens posits that knowledge and meaning are constructed through social interactions and cultural contexts (Braun & Clarke, 2012). For this study, in complying with the qualitative philosophy of reflexive TA, the epistemological approach taken were constructionist, where the social and cultural contexts influence the participants' meaning and experiences of therapy were considered.

The theoretical approach in this study allows for a deep, nuanced understanding of the participant's own experiences of therapy regarding both the importance of their perspectives and considering the broader social and cultural contexts and providing valuable insights.

Ethical Considerations

This study received ethical approval by the Central Human and Disabilities Ethics Committee (HDEC) on the 22nd of November 2021, reference number: 2021 EXP 11512. Several ethical considerations were identified and addressed through the implementation of the appropriate measures to combat these considerations.

Participant Safety

The risk of harm to participants of this research was predicted to be minimal. However, it is acknowledged that topics discussed in the interviews may have been sensitive in nature and therefore steps were taken to ensure the safety of the clients. The interviews were conducted in a sensitive manner and participants were given verbal and written information regarding their rights. In the unlikely event that a participant started to feel distressed, the interview would have been paused until the participant agreed to resume the interview or terminated altogether if the participant wished to. Throughout the interviews, Dr Simon Bennett, who is my supervisor and a clinical psychologist, was available via phone to provide any assistance/support if required. The participants were also provided with an information sheet that listed services/phone numbers which they could contact if they required further support after the interview took place attached in Appendix C/D.

Informed Consent

Prior to any commencement of interviews, participants were advised that their participation is completely voluntary and if for any reason, they would like to stop or pause the interviews, they were able to do so. At the beginning of the interview, participants were given a participant information sheet and consent form which the researcher verbally went through with the participants to obtain consent from the participants. The participants were offered an opportunity to ask any questions related to the study, the participant information sheet and the consent form to ensure that they have a full understanding of their rights. Throughout the interview, the participants were entitled to not answer any questions that they were not comfortable with answering. The participants were allowed to withdraw from the study within two weeks of the interview. A signed consent form was obtained by the researcher, and the participants were offered a copy.

Confidentiality

A data management plan was composed prior to the commencement of the study which detailed how the data from participants will be kept in confidentiality. All data collected in this study was kept confidential. Only the direct research team had access to the data and all information collected from participants was coded for anonymization of the data. The audio recordings of the interviews were transcribed by the researcher and upon completion, were deleted from the recording device. In compliance with HDEC requirements, all data will be secured safely for 10 years after completion of this research and electronic copies will be stored in password-protected devices. If this research were to be published, no identifying information of the participants would be included.

Procedure

Recruitment was conducted via a snowball sampling method through word-of-mouth and advertisements amongst Chinese/Asian communities and university/community clinics as previous research suggests that this is an effective recruitment method for Asian participants (Park & Sha, 2014). Posters and advertisements (both physical copies and online copies – refer to Appendix A, B) contained the study description as well as a QR code which led the respondent to an online questionnaire which interested individuals filled out to indicate their interest in participating in the study. The questionnaire contained an introduction to this current study, where the purpose, confidentiality, and introductions of the researcher were provided. The participants were then invited to leave their contact details for the researcher to initiate engagement either through email, phone, or text. The researcher subsequently contacted these interested individuals via their contact details provided on the online survey to confirm eligibility, sent them the participant information sheet, and organized the interview time/location.

Interviews were arranged with those individuals who voluntarily responded to the researcher and either took place via Zoom or in-person. The researcher provided the participant information sheet and consent form via email to those who participated on Zoom and in-person for those who participated in-person. The consent form was signed by the participants and stored securely by the researcher. The location for the in-person interview was determined collaboratively between the researcher and participant, with the requirement that it would be a safe, private space, often in the community.

The interviews were conducted in a one-on-one semi-structured format to provide an overarching guideline but also allow for a natural flow, like that of a conversation. This

allowed for in-depth discussions of the participant's experiences and perspectives and an opportunity for the researcher to build some rapport initially. The semi-structured interview comprised some open-ended questions listed in an interview schedule. The five sections of the interview schedule include background information, how the participant selected the mental health service, the overall experience of psychotherapy, specifics of the therapy that were helpful, and which aspects they did not find helpful. These interview schedules are attached in Appendix G/H which may be referred to for further clarification. The purpose of the interview schedule was to provide a preliminary outline of potential topics to be discussed to address the research aims, however, corresponding to the qualitative approach, the interviews did not strictly follow the interview schedule, rather, the interviews aimed to follow the participant's lead. The interviews generally ranged from 50 minutes to 90 minutes, with the average being around 70 minutes. The interviews were audio-recorded on a recording device in either English or Mandarin and then transcribed verbatim. For those conducted via Zoom, they were recorded through the recording function on Zoom after obtaining both verbal and written consent from the participants. For the interviews conducted in Mandarin, the researcher chose to analyse these in Mandarin to preserve the authenticity of the transcripts. However, extracts included in the results section were then translated by the researcher into English for data presentation. These transcriptions were then uploaded onto the software, QRS NVivo for data analysis. Upon completion of the interview, the participants were given a $20 koha to thank them for their time and openness in sharing their experiences. No participants chose to terminate their interview during the process. To anonymise the data, codes (P1 to P14) were randomly assigned to the participants' transcripts and their real names were removed from the transcripts.

Participant Inclusion Criteria

As previously noted, there is considerable diversity within the Chinese in Aotearoa community, however, due to predicted difficulty with recruitment and contextual limitations, it was decided that all those who identify as Chinese in Aotearoa would be eligible to participate. Furthermore, the age range, acculturation status, and other demographic factors which add to the heterogeneity of the Chinese in Aotearoa community were not limited. There were also no limitations on which type of therapy the individual engaged in, as long as it was a form of "talking therapy". This is due to the awareness that mental health/therapy is a sensitive topic and not many individuals from this community may want to participate, hence any individual who identified as Chinese in Aotearoa with any experience of "talking

therapy" in Aotearoa was invited to participate to reach the desired sample size for data saturation. Initially, the study also considered including those individuals who did not seek therapy but had experienced mental distress prior, however, given that there were enough interested individuals who had received therapy prior, the study only included those with therapeutic experience. As this thesis was undertaken as part of a DClinPsych degree, there was limited time (one year) and resources available for the research and thus the participant inclusion criteria were kept broad to ensure sufficient participants would be obtained within the limited time frame.

Participants

A total of 14 participants (11 females, 3 males) aged between their 20s to 40s took part in this research. All participants identified as Chinese in Aotearoa.

Table 1

Participant Demographics

Participant	Gender	Generation of Immigrant	Language Used in Interview
P1	F	2nd	English
P2	F	1.5	English
P3	M	2nd	English
P4	F	2nd	English
P5	F	1st	English
P6	F	1st	Mandarin
P7	F	1.5	English
P8	F	1st	Mandarin
P9	F	1st	English
P10	F	1st	English
P11	F	1st	Mandarin
P12	M	1.5	English
P13	F	2nd	English
P14	M	1.5	English

Data Analysis

Data analysis of the transcripts was conducted through a reflexive thematic analysis where common themes were identified amongst all the participant responses. The analytic process followed the six-phase steps described by Braun and Clarke (2022). It is acknowledged that these six-phases were not linear, rather the analytic process was iterative and recursive, where there was a movement back and forth through the phases as required. These phases were used as guidelines rather than a strict set of rules and were applied with flexibility suited to the data and research aims.

Phase one, also known as the familiarization phase, is where the researcher reads and re-reads the entire dataset to become intimately familiar with the data. The researcher should read through the transcripts to identify broad ideas and themes while making casual observational notes to allow immersion into the dataset. This allowed the researcher to establish a foundational understanding of the dataset. In this current study, the researcher was also the individual who transcribed the transcripts; hence this allowed the researcher to gain an initial contextual understanding of the data as well. The researcher then reviewed the transcripts against the audio recordings again for accuracy as well as a process to familiarise the data.

Phase two involved the generation of initial codes. The codes would be the fundamental puzzle pieces that would later combine to form themes. This process included the systematic process of organizing the data into common ideas. This creates succinct descriptions and labels for aspects of the data that may be relevant to the research aims and questions. The codes should be brief but also contain enough detail to provide information regarding the underlying commonality of the data items in relation to the research topic. In the current study, the researcher made note of the codes through the use of the NVivo software. The transcripts were uploaded on to NVivo and the researcher went through each transcript to generate descriptive and interpretative codes for each transcript. If a similar code arose from a later transcript, this would be grouped into the same code tab in NVivo. New codes would be generated from each transcript if not already from previous transcripts. For example, a code that was identified in the current research was “no support from family members”. Through the reiteration of the coding process, further familiarisation with the data also took place. All codes identified were then transferred into a Word document with a notation of the corresponding participant that generated the code as well as the corresponding quotes.

Phase three involved theme development, where the focus shifted from the interpretation of individual datasets to the interpretation of combined meaningfulness across the entire dataset. The generated codes are reviewed and analysed in relation to the shared meanings to form themes or subthemes. This step involves collapsing multiple codes that may share similar underlying interpretations into one code or one code could be promoted into an overarching theme. Furthermore, with the review, codes may also be removed if the underlying meaning does not fit into the narrative of the research aims or provide additional insight into the overall analysis. Towards the end of this phase, a thematic map were produced that organizes the codes and data items in relation to the corresponding themes. In this current research, the researcher collated the list of codes from each transcript and compared the codes from each of the datasets. Codes which shared a similar narrative were combined and reviewed to form potential themes and subthemes. Codes which did not address the research aims were eliminated. At this point, the researcher noticed a pattern through the emerging codes and codes were collapsed into themes, such as all codes that identified barriers to access were grouped into the barriers to accessing services theme.

Phase four involves reviewing the potential themes. Reviewing and defining themes are the next steps in the analytic process. Reviewing allows the researcher to ensure that the themes work well in relation to the research question, dataset, and coded data. In this phase, there are a series of key questions that should be considered when reviewing potential themes posited Braun and Clarke (2012, p. 65). The questions include, is this a theme, what is the quality of the theme, what are the boundaries of the theme, is there enough meaningful data to support this theme, and does the theme lack coherence? The key purpose of this phase is to determine and review whether the codes are appropriate to form the theme and whether the theme is appropriate to inform the interpretation of the dataset or provide a coherent narrative of the research aims.

Phase five refers to the defining and naming of themes. During this phase, the researcher moves to a more interpretative orientation and summarizes the conceptual meaning of each identified theme, describing each theme and where the boundaries lie.

Phase six of the analytic process refers to the production of the report which can be blurred with the previous phase. This phase rarely only occurs at the end of analysis and often is a process that is interwoven in the entire process of the analysis (Braun & Clarke, 2006; Terry et al., 2017). The themes were written and discussed with corresponding extracts to

create a narrative which explores the experiences of therapy and attitudes towards the mental health of Chinese in Aotearoa population.

Data extracts were mainly presented illustratively; however, some did also contain extracts that contextualized in relation to literature in the results as seemed fit to convey the narrative of the research aims. Data analysis was conducted by the primary researcher (author) as limited resources were available and thus cross-coding from another researcher was not achievable.

Quality Criteria

This current study referenced several quality criteria to ensure that the quality or rigor of the qualitative research is sound and trustworthy. These criteria include credibility, transferability, dependability, and confirmability. The next section aims to discuss what and how these criteria were utilized for this present study.

Credibility refers to the confidence in the truth of the data and the extent to which the data accurately represents the participants' experiences (Treharne & Riggs, 2015). In this study, several processes were adopted to adhere to this criterion. Firstly, this was achieved through selecting a research method that is well-researched and appropriate for the research aims. Additionally, prior to commencing interviews, participants were briefed to ensure that they were fully aware of their consent and confidentiality so that they could feel safe to share their experiences. They were also informed that they could refuse to answer any questions and that there were no right or wrong answers. Furthermore, the interviews were in-depth and followed the participants' lead, allowing for rich, nuanced data collection. Through the employment of these processes, it was ensured the data would reflect the participant's genuine views and experiences.

Transferability refers to the extent to which the results could be applied or transferred to other contexts (Johnson et al., 2020). Given that it has been previously acknowledged that qualitative research findings are generally specific to a certain set of individuals and environments, this criterion aims to provide an ample description of the research phenomenon to allow other researchers to compare between similar phenomena across different settings (Treharne & Riggs, 2015). Therefore, this current study aimed to describe clear boundaries to develop an initial understanding of Chinese in Aotearoa and their experiences of therapy and attitudes towards mental health. This was done by detailing the

population of interest with an inclusion criterion, the data collection and analytic process, as well as the participants that contributed to the data.

Dependability refers to the consistency and stability of the research process over time (Johnson et al., 2020). Within qualitative research, this does not imply that findings could be entirely replicated as it acknowledges the constantly changing nature of social reality as well as acknowledging the important role that the researchers themselves can contribute in data interpretation (Johnson et al., 2020). The current study adheres to this criterion by detailing and documenting all the stages of the research process such as data collection and analysis. Additionally, the researcher also engaged in continuous reflexive practice, ensuring that the researchers' influence on the research process is critically examined. Peer/supervision debriefing sessions were also applied to allow external feedback on the research process and findings.

Lastly, confirmability refers to the degree to which the results are shaped by the participants, in the absence of the researchers' biases and perspectives (Treharne & Riggs, 2015). Similar to the previous criterion, to achieve this criterion, the researcher engaged in constant reflexive practice, where the researcher reflected on their own positionality, assumptions and perspectives. Furthermore, direct quotations from the participants were used extensively throughout the results section to illustrate the themes which aim to demonstrate that the findings were grounded in their own words and experiences. This allows visibility for the connection between the data and interpretation by the researcher.

Through adhering to these criteria, this current study aims to present findings that can accurately represent the participants' experiences of therapy and provide insights into their perspectives of mental health and their therapeutic journeys.

Researcher Reflexivity

As mentioned in the previous section, researcher reflexivity played a vital role in ensuring the quality of the research (Braun & Clarke, 2019). Reflexivity refers to the awareness of the researcher's role in the research process (Patnaik, 2013). It calls for reflection as to how my interest began and how it may have shifted through the research process. It acknowledges that researchers are part of the social world that is being studied and encourages reflection on their own socio-cultural background and maintain a curious stance on how this may influence aspects of the research and thus their interpretations of

information and knowledge (Patnaik, 2013). The key to reflexivity is to make this explicit. Through this, the research process and outcomes can be enriched.

The following section will be written in the first person given the reflective nature. I, as the researcher, reflected on what sparked my interest in this topic and it simply was the want of contributing back to my community. I identify as a Chinese person growing up in Aotearoa New Zealand, having experienced the mixed identity, and as previously mentioned, having awareness (perhaps limited) of both cultures and their interpretations and understandings of mental health, I was inspired to take initiative and explore how to bring attention to the mental health of this population. I felt that exploring the existing experiences of this population and gaining an in-depth understanding of these experiences could be a feasible contribution to this.

As mentioned in the introduction chapter, I came into this research with an identity of being a Chinese in Aotearoa. I moved to Aotearoa with my family when I was just starting primary school and learnt to speak English through school. At home, I would converse with my parents in Mandarin, our mother-tongue. I also attended Chinese classes weekly to learn how to read and write. Through this experience, it allowed me to connect with my culture through language where I learnt similar stories and poems as children back in China. This allowed me to have an awareness and understanding of the cultural influences that the participants might be impacted by. This shared background was in many ways an advantage, where I found building rapport more natural when communicating with the participants. Additionally, I was able to understand implicit cultural assumptions, such as the normalization of not talking about emotions, without needing extensive explanation from the participants which made the interview process feel more natural and flowed smoothly.

Furthermore, I am also bilingual and can speak and understand English and Mandarin conversationally, and thus could give participants the option to speak in either Mandarin or English depending on what language they were comfortable in, further removing a layer of potential barrier and allowing them to express themselves more freely. This contributed to rapport building as well as the depth of the information conveyed, as code-switching was allowed. Hence, participants could share their experiences in the language they wished to, and at times, used both whenever one language was more fitting to their experiences or could convey a concept better. This language advantage was particularly noted in the 1st generation participants who were slightly older and thus was more used to speaking in their native tongue. I felt that the combination of these factors allowed the participants to feel more

comfortable/safe and be more open in sharing their experiences and allowed me to gain a richer understanding of the shared experiences.

However, it was important to acknowledge that there is huge diversity in this population, and I needed to be careful that my own perspectives, biases, and understanding did not undermine, skew, or impose on the shared experiences of my participants. I maintained a respectful and curious stance throughout my interviews. I was careful throughout all the interactions with the participants to remain partial and to clarify whether I had truly understood what they were expressing and would often summarize to ask for clarity. This was evident when interviewing those who was 1.5 generation Chinese in Aotearoa, as this was the population I belonged to. Some of the experiences shared were quite different in contrast to my opinions and to ensure that I captured their true meaning, I would ask follow-up questions and repeat statements to acknowledge that what I heard was what they meant to convey.

It was also important to consider how the participants viewed me, as the researcher, someone from a similar background, given what was shared was sensitive information which may have led to the participants feeling vulnerable. To address this, I ensured that I communicated clearly to the participants that this research is completely confidential as well as client-led, where they have full control over what they would like to share or not. I often checked in throughout the interview to ensure that the participants felt comfortable to share or not share as they wished.

Aside from my cultural background, I also reflected on how my gender, age, and role as a doctoral student studying clinical psychology may have impacted the research process. I acknowledge that although sharing the same cultural background may have encouraged establishing rapport, it may have felt different for participants who were of a different generation or gender. Furthermore, my position as a researcher undertaking study as a future mental health clinician may have impacted how participants viewed my understanding of therapy and led to assumptions. To address this, I ensured that I clarified that there were no right or wrong answers, rather, what they experienced personally was most important to discuss.

Chapter 5. Results

The focus of this research was to explore Chinese in Aotearoa experiences of "talking therapies" and mental health in Aotearoa. Although the participants of this study all identified as "Chinese in Aotearoa", they also presented with diversity in their backgrounds, echoing the diversity amongst the Chinese population currently residing in Aotearoa. The sample consisted of fourteen participants, 11 identified as female and 3 as male. The participants' ages ranged from early 20s to early 40s. There was also a range of 1st, 1.5, and 2nd generation Chinese in Aotearoa among the participants. All the participants in this study had obtained tertiary level education, with many who had some form of exposure to information around mental health either via university or work prior to their own experience of therapy. Analysis of the data revealed significant diversity observed in their experiences of psychotherapy in Aotearoa evidenced in various facets such as the causes of their mental distress, the type of psychotherapy received, and their general experience of "talking therapies". The participants also varied in terms of the number of times they engaged with "talking therapies" prior to this research. Nevertheless, all the participants voiced a positive experience of "talking therapies" in general and there were multiple main themes that arose from the data.

Analysis of the interview transcripts with the fourteen participants revealed themes that reflected two stages of engagement with therapy, which all participants described progressing through. These engagement stages map with the listed research aims. The first category, "pre-therapy experiences" explores the challenges, barriers and motivators that the participants faced in accessing talking therapies in Aotearoa as a Chinese in Aotearoa which corresponds to the research aim one which looks at the 'attitudes towards mental health/therapy'. The second category, "during-therapy experiences and reflections" captures the participant's therapeutic experience, such as which aspects they found helpful, challenging, and needed improvement in terms of the therapy that was received which corresponds to the second aim of looking at their experiences of talking therapies. The therapist characteristics as well as the reflections that participants shared after engaging in therapy were also elaborated in this section further elaborating on their attitudes towards mental health post-therapeutic experience. The themes are presented in these two categories to form a coherent guide; where part one covers the systematic considerations of initial access to services and part two covers the clinical implications of working with this population for clinicians and service providers. These themes also highlight the unique circumstances that the Chinese in Aotearoa experience in a therapeutic context.

Pre-therapy Experiences

All participants were asked about their experiences and considerations prior to accessing therapy when reflecting on their therapeutic journey. Several notable themes emerged from these conversations around the culture-related causes of seeking therapy, being pushed to breaking point and recognizing the need for therapy, impacts of lack of availability and awareness amongst Chinese in Aotearoa contributing to the barriers of accessing services and significance of recommendations from trusted confidants. All of which impacted their therapeutic journey and contributed to the outcomes of therapy. These themes will be explored and presented in more detail below.

Theme 1: Cultural Impacts and Challenges of Accessing Services for Chinese in Aotearoa

The participants described a myriad of triggers behind their mental health distress that led to their initial attempt to access therapy, such as stress from relationships, work, and university. Interestingly, when discussing these stressors, most participants alluded that their identity as Chinese in Aotearoa seemed to lead to specific stressors or exacerbate common life stressors. One participant described that as an immigrant, she did not have family support in Aotearoa, which exacerbated her mood issues as she did not have anyone to turn to for support when her symptoms initially emerged. Another participant suggested that immigration itself was a stressful process, adjusting to a new country alone led to increased emotional distress.

> *P7: stress response to like migrating and being adjusting to new, settling into a new country*
>
> *P9: work, finding job, seeking job, yea from family or from yea, from the stress staying in New Zealand or back to China or yeah…*

Another participant shared that as their family was more preoccupied with surviving in a new country, more focus was put on providing for her physical needs, rather than attending to her mental health.

P7: …it was stressful for the whole family to be moving and then um arriving in another country and then having to settle, like buying a new house or buying a new car and then having to find jobs for the parents

Notably, many participants shared that as emotions were not commonly spoken about in their family, when they first experienced mental health distress, they did not know how to manage this, leading to a worsening of symptoms.

Participants with families and children identified challenges that revolved around relationship conflict such as living with in-laws, and navigating multiple complex relationship dynamics, a pattern that is typical within Chinese culture where it is common to have multiple generations living in close proximity, or in the same house. Additionally, participants also commented on cultural values pertaining to being hardworking and successful leading to an increase in internalised stress which may contribute to a higher likelihood of mental distress.

P6: … when they [in-laws] came, they lived with us, when my mum came, she also lived with us, and there was a lot of conflict in our everyday lives, just a lot of things to adjust to…

P7: I felt a lot of self-hate and um and disappointment, in the way that I was going downhill and having breakdowns and um I was a high achieving student … it was a struggle and I had no sense of um self-worth.

A number of participants commented on how their cultural background impacted their preference for selecting potential therapists when accessing support. They commented on preferences regarding gender, age, and qualification of the therapist, noting specific characteristics that made them feel more receptive to the therapist. Some participants shared that they had wanted someone who could understand their cultural perspectives and speak their language as this would support the overall therapeutic experience as the therapist would have an initial understanding of them. Additionally, the qualification and experience of the therapist was another factor that the participants considered, this occurrence aligns with prior research which noted that Chinese individuals adhere to a social hierarchy and professionals

are often viewed as experts and those who have more qualifications therefore are viewed to have more credibility.

P2: I guess, um I think I would look more at experience.

P4: Yeah, I… I've always worked with um females, like I think it's just easier for me to… connect with and more comfortable opening up about really private issues....um Yeah, I don't know why. It's just my preference.

P9: erm, yea I consider, yea because then I'm, I can, that time I English is not, my English is not very good, and for the counselling, so many like medical and professional word, so I wish I can find a Mandarin speaking counsellor, yea,

In summary, participants located the onset of their mental health difficulties within everyday stressors such as study, work, and family relationships, but emphasised that these were intensified by their experiences as Chinese immigrants in Aotearoa. The process of migration, loss of extended family support, and families' focus on basic resettlement tasks (housing, employment, material security) meant that emotional needs were often sidelined. Limited family communication about emotions further constrained participants' ability to recognise and respond to emerging distress, contributing to symptom escalation. For those with partners and children, intergenerational and in-law tensions, shaped by culturally normative multigenerational living arrangements, added further relational strain to an already challenging adjustment context.

Theme 2: "…I can't…anymore…我不能再... 了"- Pushed to the Breaking Point

Although participants described a range of mental health issues that led them to seek therapy and how they sought to manage it, all participants shared a similar narrative when describing the factors that pushed them to actively seek support for therapy. The mental health issues included depression, anxiety, panic, relational issues, schizophrenia, obsessive-compulsive disorder, and perinatal mental health concerns. The participants all felt they were pushed to breaking point implying that therapy is often considered as a last resort for this population.

P3: … it got out of control…

P4: … yea, it got to a stage that I absolutely can't help myself

P6: … it felt like the sky was falling down

P7: … I was not able to function… there was a crisis point

P10: … at the time, I felt that if I didn't seek help, there is no other solution…

P12: … and I was like, I can't do this anymore

P14: … at the time, I couldn't like that… I was desperate for help… I feel like I can't live like that…

The participants shared various ways of attempting to cope with their stressors prior to reaching their breaking point such as through distraction which extended their experiences of distress. Distraction techniques included avoiding certain thoughts through mental suppression, drinking alcohol, suppression of emotions, sleeping, reading, writing, physical harm, and studying. Participants shared that these were in general unhelpful coping strategies and were often just temporary solutions that did not work for them in the long term. Other participants also shared more helpful strategies such as in engaging physical activity, meditation, turning to their religion, and eating nutritious foods, however, these skills all admittedly did not work well to manage their distress in the long term either.

P2: one thing I did, I would always just sleep… umm so in my mind, I felt like if I were just asleep, I wouldn't… feel, in a way.

P3: I did yoga for a while as I thought doing yoga would help with calming my emotions and to think more openly and calmly. But I don't think it had any particularly good effects.

P12: Yeah, I remember feeling a lot like Ah, just shove it to one side, one corner of my brain and leave it there. And as a result of it'll just like bottle up into like, a lot of unresolved thoughts, just come barrelling out in some awful, awful uh crisis moment so no, I didn't have good coping strategies.

Many noted that as they were at breaking point, they accessed whichever service responded back first or whichever service provider had less of a waitlist, hence they had less autonomy over the service they received.

P3: because I don't know much and I was stumbled upon whatever I could find.

P4: Um, I think, it wasn't much of a choice. I think a lot of, the ones I reached out to were just fully booked and didn't have the capacity to take on clients and she was, I think the first one that came back to me, that she could take me on. And it wasn't like a ridiculous price either. So, it was reasonable. And just the first one that could see me, slim pickings out there

P5: Um, and she, yeah, she had I think she had more appointment slots than the others.

It is evident that with this population, there is a strong tendency to push themselves to the limit before attempting to access services. This is an important factor to consider when engaging with this population as it emphasizes the importance making services more accessible through the wide promotion of services even more pivotal.

Theme 3: "…we didn't have…我们没有…"- Limited Accessibility

Through the participants' reflections on their journey of accessing therapy in Aotearoa once they ultimately made their decision to seek support, it was clear that they experienced a plethora of barriers that made an already stressful experience, even more challenging. They noted significant barriers such as the availability of services for Chinese clients.

Firstly, participants shared that there are not a lot of service providers who can speak their language. Although many participants shared that they were fluent in English, many reflected that English used for therapy sessions can still be quite challenging in terms of communicating clearly their feelings and emotions, hence they would prefer to attend therapy with a Mandarin provider. Participants also commented on the limitations of availability in terms of the general scarcity of therapy providers that they could access that would match their schedules.

P2: I would say time, like availability, just because I had a really busy schedule. Yeah. Because I had to study and work. So, I was only free like, maybe weekends or something. Not a lot of people are free to you know, offer sessions during weekends

P13: My… reasoning was that, it was in [Auckland suburb]. They were only open Monday to Friday. I was in uni.

Another major barrier to accessibility that most participants named was the cost of services. While some participants framed this as being reluctant to spend money on therapy, this appeared closely tied to uncertainty about its benefits and to financial pressures associated with migration. As this study did not systematically assess participants' financial capacity or socioeconomic status, it is not possible to determine to what extent their decisions reflected true unaffordability versus reluctance to invest in a service whose usefulness was unclear.

P2: but because it's so expensive, I couldn't afford it.

P6: … money was important, like with the Japanese counsellor, the first two sessions were free. The sessions after required payment but that was acceptable…

P7: Um I didn't go to a counsellor also because my parents were not very um financially um, we didn't have much money at that time. Um so a counsellor would cost like, I don't know, $100 an hour $150 an hour and the service of accessing a private counsellor was beyond my financial status

P12: …you might actually be able to see a psychologist, but if not, like that's going to cost you 150, $200 an hour… and especially, for me, um… my parents, well, I suppose they grew up in relative poverty. So, they would not, in their wildest dreams, think of spending $150 or $200 an hour on talking, like that to them is completely bizarre

P13: And I looked him up. And I think it was over $100 an hour. But I was still in uni and I was like, I can't… But I think like the philosophy that I grew up with, in my very Asian household, was to save your money.

Analysis revealed that there were some common avenues via which the participants accessed services. Most of the participants had researched online, however, few accessed supports that was found through an online search due to their belief that it could be less credible as well as the cost associated with the type of services that were available online. Participants had mostly accessed therapy through their university, employee assistance programs at work, and their GP referral. One participant had accessed support through an advertisement on Chinese social media.

P8: I saw the ad that should if you are unhappy, or if you are having arguments often… you could go for support

P10: my told GP told me they had three free sessions, so I thought I'd give it a try

P13: I tried to look for… a counsellor on the like, the New Zealand directory of like counsellors or something, of therapists and I tried to look for someone who was specifically Asian… oh well, not many of them worked with adults. And, those who did mostly worked in, in a high school, as a school counsellor. And I was like, Well, fuck,

P14: yea so I, at first went to the… uni um… clinic

In Aotearoa New Zealand, publicly funded mental health services are available primarily through specialist services, with variable waiting times, and many community or private therapy options require co-payment or full fees. As these participant narratives reflect, for recent immigrants, navigating these systems and understanding eligibility for subsidised or low-cost services (e.g., through primary care or community organisations) can be complex. This context may partly explain why participants perceived therapy as financially burdensome or as a 'luxury', particularly when prioritising basic resettlement costs described in Theme 1. It is important to acknowledge that the perceived lack of availability for this population can contribute significantly to decreased access to services. Hence when addressing service engagement and outreach to this population, it will be important to be mindful of these factors that could improve the likelihood that Chinese in Aotearoa access potential services.

Theme 4: 'It never crossed my mind, 我从未想过' - Lack of Awareness

Through analysis, it was evident that all participants expressed a lack of awareness/limited awareness of mental health and mental health services prior to their own experience of therapy. This acted as a significant barrier to accessing service providers as they were unaware of how to look for support for their mental health issues in Aotearoa and hence could not begin the process. This lack of awareness also led to misconceptions/discomfort around mental health for these participants.

> *P3: it never crossed my mind to… look for mental health services, health service, general health services, I would know because, I have my own doctor and I know where to go during after hours, but when it comes to mental health or, other particular services I would have to start from scratch…*
>
> *P5: … I tried to, to google it and just some, some people just have this random website. … Um, Yeah, I was like wait, where do I even find... a psychologist*

Another aspect of mental health that the participants shared having limited awareness of was regarding emotions. The participants also shared that because they had not talked about emotions prior in their lives before, the concept of therapy was foreign and felt uncomfortable. Participants noted that it felt unnatural to talk to a stranger about a topic that they have not even discussed with close people in their lives. Furthermore, due to misconceptions on what mental health issues might look like, as many grew up with the notion that if mental illness equals psychotic or crazy, this further deterred them from accessing support.

> *P2: And I wasn't comfortable about talking about my issues with the stranger.*
>
> *P4: I think so. I think it's not, really talked about much, well that's my perception in anyway um, like in [home country], it's not really talked about that much, but it's probably better these days, but I guess when my parents were growing up it wasn't a thing. And if you were mental, you'd probably be in like Institute or something like that.*

P13: and I guess growing up in a very… Chinese household, you talk about your feelings, because of the whole like, keep the peace mentality and that you don't want to burden other people.

Due to the reported lack of awareness of mental health and mental health services by the participants, this also affected their initial expectations of therapy. Many participants shared that they went into therapy with very vague expectations as they did not know what could happen in therapy and what could be expected. Many shared that they just wanted help but were not sure what type of support/help they would be truly receiving.

P4: And I guess… from memory, I kind of had no idea what I was going into so I didn't really have that many expectations.

P5: And I, I did not like honestly, I did not have a clue at that time, what, what type of, what kind of help that they could provide.

P8: before I didn't know, and I didn't know if it could help me. So I didn't have big expectations, and I didn't understand where the problem was…

One participant shared that they had wanted their problems to be solved completely, however, were unsure how this would be achieved.

P12: I was like, oh, maybe they can diagnose me and fix my problem. Just like, just or just maybe not diagnose, just fix my problem. Like I have a problem with currently focus and all that stuff. And hopefully after that, after date, the day after that, I'll be cured.

A few participants engaged in therapy with somewhat more specific intentions, such as wanting to better understand their experiences and to gain tools they could use in everyday life to support themselves in coping with difficult situations.

P6: In the beginning, I did not know anything about therapy… wanted to help out family relationships become better…

P10: The first thing is that I hope someone can listen to me talk about my issues. Then I thought through this process it could help me organize my experiences…. Um, and secondly, I wanted to get some effective ways to solve conflict… and tools to control my emotions

Despite these articulated expectations, there was a common thread of vagueness in how participants understood therapy and what it could offer them, which appeared to stem from their limited awareness of mental health services.

Theme 5: "I really trusted my.... 我非常信任我的..." - Significance of Recommendation of Trusted Confidants

Notably, another common reason which influenced their decision to seek therapy was that a trusted person in their life had suggested that they seek support. These trusted people ranged from a family member who had prior experience with mental health issues, to a friend or colleague at work, to a tutor at university. Participants shared that because these people were someone they trusted, or looked up to, the suggestion was more acceptable coming from them. This aligns with the cultural value of "guanxi" and illustrates how significant relationships could aid in the support of the individual.

P3: … just by a lecturer who said, you want to speak to the, one of the, the guys at [university] counselling

P5: because I think for me, I… especially for things like this. I… I will always trust someone being recommended rather than, because I don't have much knowledge… about it. You know, I it's, it's not like buying toilet paper. You know, it's a high involvement decision making process. Especially when I have no knowledge, of where to find information or whether…

P9: oh my friend told me… they work in a professional maybe healthcare… they know how, who can help me, so they suggest me to find [therapist]

P10: … I really trusted my GP…

P12: … I was quite close to one of the lecturers… he saw I was in complete disarray…he said look after yourself…

Hence it can be seen that having a trusted individual encourage engagement with mental health services could be an essential port of entry for service engagement with this population.

To summarize, as evident in this research where participants discussed their pre-therapy experiences, it is important to acknowledge that the process of seeking support is not a linear one. There are many loops and bumps along the way that this population need to navigate to even arrive at the starting line of receiving support. Factors such as their cultural background, which may exacerbate common stressors as well as limit their capacity to access support often result in them feeling like they are at breaking point before they can even consider accessing support. This is further made more difficult through their limited awareness and perceived limited availability of the type of services they can access. These barriers commented on by the participants mirror those already identified in existing research (Ho, 2004; Li, 2018; Ning & Feng, 2021). However, given the participants' comments, this illustrates how the barriers are still an existing issue yet to be addressed in the Aotearoa context despite existing research (Chung et al., 2023; Ho, 2004; Li, 2018; Ning & Feng, 2021). It is vital to be mindful of these potential barriers that this population experiences when implementing systemic interventions to promote mental health and related supports amongst this population. Conversely, this research also identified a potential port of entry where many participants shared that through recommendations from trusted confidants, they were more likely to seek out support. Hence, this suggests that mental health promotion through word of mouth, much like how this research was conducted, could be an effective way of increasing access to services for this population.

During Therapy Experiences and Reflections

In the analysis of participant's reflections on the therapy they engaged in and what they felt, thought and experienced through those sessions, several themes that impacted their engagement, therapeutic experience, and satisfaction with mental health services were identified. All participants shared their reflections on how they felt when they finished their set of therapy sessions. Many shared that it was a positive experience overall and had made plentiful gains that supported them in improving their life both individually and in terms of

relationships in their life. The participants also shared their views on what they would consider if they were to engage with mental health services in the future. Key themes that arose regarding the therapeutic experiences are the importance of psychoeducation, skills, and signposting, having a safe, non-judgmental therapy space, the importance of cultural responsivity and sensitivity, impacts of the physical environment, strong therapeutic alliance, absence of family involvement, stigma towards medication, and removal of stigma through experiencing therapy.

Theme 6: "…draw on… the theory… and apply it to my life/参考这个理论，用在我的生活里" - Importance of Therapeutic Skills/Psychoeducation

There was some struggle for participants to identify exactly what they found helpful in therapy; however, they did note that what they found helpful in therapy was the psychoeducation on mental health that was given in the sessions to support them in understanding their mental health distress. This was either through resources given for them to read or from discussing during the session. Some participants shared that it was helpful as it aligned with what their initial expectation of what therapy might involve and what they sought. Furthermore, as noted in the previous section, many participants shared that due to their upbringing and background, their awareness of mental health was relatively low, hence when they first entered therapy, the psychoeducation provided them with some guidance as to what they were experiencing and also provided the confirmation that therapy could be somewhat helpful for them.

> *P2: Um… I think… knowing more about my OCD and anxiety*
>
> *P5: And then when I went, to seek help from this counsellor, she, she start, introducing me about my taught self and, and true self, you know, that concept and then she started to explain to me all of those things…*
>
> *P12: well, it was actually really nice to talk through like the theory behind it. Or the, the thought processes, oh, you know, a thought process enters and you get so scared by that thought and it just creates this whole cycle and it just like and then just like, putting these mental images or the theory of what gives an anxiety, that causes an anxiety attack*

P13: Yeah, her ability to kind of draw on… the theory… and apply it to my life.

In addition to the psychoeducation, participants were able to identify that practical strategies/tools were also helpful as they could refer to these strategies even after therapy had finished. For example, one commented on the helpfulness of breathing exercises and another on the usefulness of being able to identify her warning signs.

P3: Yes um, through breathing exercises…, it was helpful, because, the whole purpose of the exercise was being able to… react on the spot

P7: um it was mainly the prevention, so like knowing the early warning signs and like when I don't sleep for a night, I need three more days to recover from that, and then like that, that repeated sleeplessness, and then the racing thoughts and having anger irritability or being depressed and unable to get out of bed, not motivated. That sort of warning signs learning about those. And when I have a warning sign I tell my support network, like my mom or my friends who knows about my condition, and then I seek help and I know at what point I need to speak up straight away. And that was good.

All participants commented that they had found therapy to be helpful in general, with a few commenting on some aspects of therapy that they thought could be improved as they felt it made the overall experience feel more helpful. Firstly, a few participants shared that they felt that there was a point in therapy where they did not know where the therapy was going. They described patterns such as the therapist repeating similar concepts and skills, which led them to feel that things were not progressing in therapy. Furthermore, participants also shared that they also thought that there could have been more structure, such as signposting what they will be doing in therapy may have helped them understand the therapy process better.

P2: I definitely felt she was dragging on her sessions a bit. Like, sometimes some things I've said before, she would forget …you know, I've already said that and she would want me to re-say it or um sometimes like, I would say a lot and she'd be like "oh, we'll do with next session," and my next session, she would forget or I would forget

From the participant's shared appreciation for psychoeducation, skills, and signposting, it can be inferred that due to the generally low awareness of mental health and services, these aspects of therapy are particularly helpful for this population as it would provide them with initial clarity around what to expect and what therapy may involve, thus increasing their engagement and acceptance of something that they would consider foreign.

Theme 7: "he wouldn't judge what I said… I felt safe with 他不会对我的话指指点点…让我很有安全感" -Safe, Non-Judgmental Therapeutic Space

Apart from the specific items of therapy, many participants also commented on the importance of the therapeutic space, where they found it validating to have a space where they could share their issues without judgment. Many noted that this was the first experience in their life where they can openly share and discuss their emotional distress. They noted that by having this space, they were able to process their experiences and support them in feeling more comfortable discussing and acknowledging the importance of their emotions and normalizing emotions.

> *P4: I don't, I can't remember specific um things but I guess, it was helpful. Getting things off my chest and saying things out loud. Just to process things, out loud and it would help me kind of wrap my head around the situation or what's going on, sometimes. Set from a different perspective. I guess that was helpful.*

Some participants noted that even by talking through their experiences with their therapist, they were able to process some of the issues themselves and come to a solution. They noted flow on effects into their daily life where other aspects of their life also improved even though it may not have been specifically what they discussed in therapy.

> *P14: But there are a lot of stuff that I didn't expect and… actually came like.... … being a lot more… like, confident and… finding like…. what I want to do in the future… kind of… developing like… deeper relationships with others…*

The concept of non-judgmental listening was also reported by many participants to be an important therapist quality. They shared that being in therapy already created a sense of incompetence, hence, having someone to be able to non-judgmentally listen to their concerns felt validating and safe. One participant noted that they already receive a lot of judgment in their life due to their circumstance, thus having this therapeutic space where this judgment could be stripped away, felt particularly important for her.

> *P8: yes, I trusted them a lot, I felt, just by talking to them it was stress-relieving, I didn't have to worry about them judging me, why I was like that. Just very trusting… I felt that whatever I said they would be accepting of it*
>
> *P10: … I felt comfortable talking to him, he wouldn't be impatient, and when he talked he was gentle… and he wouldn't judge what I said… I felt safe with him…*

This implies that for this population, it is vital that the therapeutic space is one of non-judgmental attitude which can significantly improve engagement between the clients. This may be a potential result of the lack of awareness as well as previous stigma towards mental health.

Theme 8: "they understood what it's like to be... Chinese 他们明白作为一个中国人意味着什么"- Cultural Sensitivity/Responsivity

Through analysis, it was revealed that for many participants who presented with issues that included a cultural element, they shared that having a therapist who was culturally sensitive, responsive and understood their culture was important and helpful.

> *P7: I think so. They were, they were from a Chinese background. And so they, they understood what it's like to be a Chinese versus, like an Asian person and then that, that there will be expectations on the um from the parents to that child and that they would, they'll have the same language and they would be able to speak my mom and, and like, like, the rapport was, instantly there*

Conversely, some participants reported feeling disconnected with their therapist when they perceived their therapist to not understand how their cultural background impacted their presentation. This disconnect then proceeded to impact their therapeutic relationship negatively.

P2: Yep. And then for my counsellors, my other therapist, when I talked about arguments with my family, they were more like, Oh, just a very Western way of thinking like, just remove yourself from the family. You know, move out.

P13: one of the things in particular was that… even though I felt like she understood, no, even though I felt like she was listening to me in terms of… like… me saying that. A lot of these things were very cultural, like the experiences and the feelings that I was feeling were very cultural… And I didn't feel like… sometimes in the ways that she spoke, or like responded to, my thoughts, showed that, yes, she was listening, but she didn't get it in the same way that I would, like someone else would have in terms of like the, she didn't have personal experience with that kind of thing.

A few participants shared that given their vulnerable and exhausted state when they commenced therapy, having to explain to someone their cultural background and how it relates to their presenting issue was just too much to commit to and in the instance of the participant below this led to them withdrawing from therapy. Hence having a therapist who is already aware of the cultural issues experienced by the Chinese in Aotearoa, made the experience smoother.

P5: Um, then I realized there is a cultural difference here, and then that made it more complicated for me because I have to explain to her that… They did it because of, we lived in China. You know, we didn't have that privilege to… stay at home or stay close to my parents. Because, like, where I grew up, we didn't have the best education. And my parents made the decision to send me away when I was 11. Because they want to give me the best um, but, that, that she didn't really understand, the Kiwi counsellor so I, so I quickly realized that, I don't have that energy, to explain to her because I'm like, I need help..

Additionally, even though some participants presented with issues that were not culturally related, they still noted that it was a positive addition when the therapist was culturally responsive in terms of acknowledging their cultural background and how they may differ in terms of response to certain topics.

> *P7: I think cultural safety training like cultural responsive training of, someone with any cultural background is important, is essential um whether their identity is Chinese or not, that's genetic, and that's something that no one can choose. So I think it's like having, having the training, like professional development of a therapist or psychologists, psychiatrists, of having that professional development opportunity, to be able to um not like be an expert in Chinese culture, but like to learn about how to cope, like how a Chinese person's worldview is different and how their cultures, that cultural awareness or like being appropriate is important*

Conversely, multiple participants shared that even though it was important to acknowledge their cultural background, it is also equally important to not let this aspect of their identity overshadow their individuality. Some participants shared that over-referencing their cultural background in relation to their presenting issue was more unhelpful than helpful as it made them feel invalidated and misunderstood.

> *P14: Yeah, so the counsellor was… actually she, she did… she does talk a lot about like Chinese culture like when she kind of interprets my kind of response or behaviour… She'll interpreted it oh that's probably because of your culture, upbringing um…yea um… I feel it wasn't as personal…But I think um… there was an overemphasis on like, I guess…. um me being Chinese actually, yeah, like… I guess um…-long pause- it's like it's, maybe very good to have the culture in mind, but um… maybe have it more implicitly*

A few participants commented on how they felt that the therapy they received was not person-centric enough, where they felt that the therapy they received was just a broad process

that was used for everyone with one mental health issue, such as anxiety or depression, rather than individualizing the treatment for them in particular.

> *P12: Like that's, that's just part of psychology. You can't expect every session to be amazing. And you can't expect to make breakthroughs every session… I think it's just, it feels um like I'm just being using a broad brush strategy, like rather than actually addressing a patient and a patient centric needs. It's just like, oh, yeah, okay. So… just you hear someone okay, this person has depression, therefore, pull out the depression bucket. Step one, go for this, step two go with that. Like it wasn't. It just felt like they weren't necessarily understanding the stressors*

Although CBT is the most common therapeutic approach for which there is a body of literature available regarding its application with Asian populations, only one participant spoke specifically to CBT strategies and interestingly noted it was not very helpful as it did not account for their individuality and their cultural background.

> *P14: And I feel… it's [CBT] a very… Western framework.... not individualized and... ultimately it doesn't, it works to a very, to a degree…*

It is evident that for this population, being culturally responsive and sensitive is a key element to consider when working clinically as they do have their own unique cultural factors which contribute to their presentation. However, as commented on by participants, over emphasis on their cultural background may also be detrimental as this may create bias that limits the clinician from viewing the client as an individual. Hence, person-centric practice while being mindful of how culture could influence the client would be better practice.

Theme 9: 'a nice welcoming environment… made me feel more relaxed and comfy 温馨友好的氛围…让我感到特别放松和自在' - Impacts of Physical Therapeutic Spaces

Several participants also commented on how the physical environment of the therapy impacted their therapeutic experience. Many shared that they appreciated a therapy room which was well-decorated and appeared less like an office. They shared that this created a

relaxing atmosphere which allowed to them feel more comfortable discussing their issues when feeling vulnerable. Several participants commented that the simple gesture of offering tea/coffee/water helped them feel more welcomed and comfortable.

> *P4: I think maybe like… the environments of, the, like the couch and the pillow, the tea and the water, a nice welcoming environment… compared to when I went to the hospital and it was –laughs- very different. So I think maybe if that made me feel more relaxed and comfy… Just if I'm more, I'm more relaxed and comfortable. I guess it would help me. Just to be more open and talk more.*
>
> *P12: they like got you a mug. They got you like a cup of tea or something. I don't know. It's just much easier to talk about these things when you have a nice warm...*

Many participants had had experiences of Zoom/phone counselling as well as face-to-face. Of these participants, most reflected that face-to-face sessions would be the preferred option as it allowed them to form a stronger connection with the therapist. They shared that being in-person made them feel more present and less likely to be avoidant when sharing their concerns.

> *P1: I do, I guess enjoy the in-person experience more like… it's just, I don't know, a little bit more open, I guess like, in person. It more, it egg me on more, to I guess, like open up more*
>
> *P5: it always felt like, can't really connect with these people. Yeah, that's as h-… I, especially when I'm sharing something so personal and so that emotional as well. It is really hard to go through, you know, sharing things like this with zoom, because I want to see, I want them to be able to see my, my body language and all of that but, you can't do that through zoom. And um the moment about offline and then back, back to reality again. So I actually have never enjoyed, the zoom counselling session.*

This observed pattern aligns with previous research suggesting that the environment in which therapy is conducted is an important factor influencing clients' experience and engagement (Taiwo et al., 2013). This may be especially relevant for this population, given

their unfamiliarity with therapy and the associated stigma around mental health. A setting that signals safety and comfort appears conducive to building rapport and supporting vulnerability. As several participants highlighted, feeling fully present was more easily achieved in person than online or via phone, and the experience of physically being in a safe therapeutic space appeared to be a key factor in facilitating effective therapy among this sample.

Theme 10: Therapist Skills and Attributes that Facilitate a Positive Alliance

Participants identified a range of clinical skills demonstrated by their therapist which they felt facilitated positive engagement. These were described as key characteristics which allowed them to feel connected to their therapist. The importance of having a strong therapeutic alliance with one's therapist is well established as a key predictor of therapeutic outcome (Liu et al., 2024) therefore these factors should be given consideration when working with Chinese clients in Aotearoa.

Many participants described active listening as a quality of their therapist which they found to be very helpful. Through the act of active listening, participants felt more connected to their therapist and understood by their therapist. Through this, they could be more open and use the therapy space more effectively.

> *P1: I was like, Oh, you actually are listening to me like actually are understanding my situation… But then when she was like you know remembering the names… yea, I think that's probably why I felt really connected to her, more like, I was like, "oh my gosh, you're trying to understand me"*
>
> *P2: To be like, actively listening and engaging and, you know, like, "Oh, I feel that" you know, you know having empathy, you know, like truly listening. Um, so I think that was really helpful*

Participants shared that through this they felt "truly" heard, often something that they had not felt before. Participants pointed out that active listening was different to how other people in their live had responded to them, such as friends or family, and this is what made the therapeutic relationship effective and special. They were also more likely to respond well

to their therapist and increase this increased trust with their therapist. Many participants shared that it was important for them to establish a trusting relationship with the therapist to feel connected and comfortable to engage in therapy.

P11: [therapist] was very good at listening…through summarizing what I said… and accommodating, like when I cried they didn't stop me

P13: remembered, recognized, acknowledged because, like, she would take notes during our sessions, so I felt like she was very invested in me as a person as well

P14: I think, firstly um, he's very accepting and he listens. Um, and I can… feel he really cares about me um… He listened very carefully

Another common therapist quality that participants mentioned was the gentle demeanour of the therapist. Many participants described their therapist to be gentle, soft, and warm, often illustrated through their body language, or tone of voice. This contributed to them feeling safe and held, which in turn increased their sense of connection with their therapist. The participants shared that this warmth and gentleness made them feel that the therapist genuinely cared about them and wanted to understand them, which allowed them to be more open with their therapist. Furthermore, participants also shared that they appreciated the humble quality of their therapist, which allowed them to feel more understood by their therapist and supported them to feel less affected by the power imbalance.

P2: Yeah, I would say, tone of voice… Yeah, she would, you know, she would speak very softly. She'll keep nodding, a lot of nods.

P4: Very warm and open and accepting.

P10: I think he is very gentle, and also very… very humble… he was very patient and spoke in a gentle manner... and he didn't make any judgments about me

P12: Yeah. And he speaks with a warm voice, which is always quite nice.

P13: She was very kind

A few participants also shared that they found occasional appropriate self-disclosure by their therapist to be helpful. Often this self-disclosure came through when the participants described a similar issue which the therapist may have also experienced, particularly when it was related to their culture. The participants shared that through the self-disclosure, it communicated to them that their therapist was also "human" and could truly understand their experience. This shared experience further contributed to establishing a strong connection between the therapist and the client.

P6: … it was more comfortable with the Japanese counsellor… he shared that he also had experienced similar things so he understands us…

P7: I think they shared that they were human. And that they had, also have problems

Many participants commented on how the therapist was very skilful in the way that they "talked" to them. They shared that the way their therapist talked to them in therapy differed greatly from how other people in their lives would talk to them about their issues, such as their family and friends. Many noted that due to this "skilful talking" and questioning, they felt engaged in therapy and could develop insight into viewing their issues from a different perspective. Many commented that rather than being completely "directive" in their approach, the therapist guided them to discover different perspectives themselves, thus providing them with a sense of autonomy. However, participants did also acknowledge that depending on the context, a more "directive" approach was also appreciated, as they also needed some clear directions. The participants shared that they thought it was important that the therapist was flexible and able to adapt the process that was tailored to their needs when appropriate.

P4: So, it is kind of like she's, giving me guidance and directing me on the next steps, but not telling me that this is the way to do it. so, figuring out myself is probably more effective and beneficial. As opposed to telling me you do this.

P6: … we know that we have problems, so we need some solutions and not to self-reflect on these problems… it feels like a bit of a waste of time

P13: [liked more self-guided process] I felt like I was more in control of my own, decision making and also my own recovery, like, being able to be… it's like the whole working with and not for like, I felt like she was working with me rather than for me.

The participants also shared some aspects of the therapist that they felt could be improved to increase the therapeutic alliance. One participant shared that they felt unheard, as the therapist would often ask them similar questions and they would have to repeat the same information often. Another shared that they felt invalidated when the therapist commented that many people experience similar issues to them, which may have been an attempt to normalize their experience, however, did not achieve the desired effect. Additionally, another participant shared that the timing of questions could also be improved, specifically regarding asking more in-depth and personal questions once rapport had been established, rather than at the beginning of the therapeutic relationship. The idea of building a good therapeutic relationship was also echoed by another participant, who shared that due to the way that the therapist communicated with them, they felt like they were getting told off by a teacher in school, rather than receiving therapy from a therapist.

P1: so I'd be like, you know, repeating bits at the beginning which you know, she sees so many people that Yeah…, but then like half it would just be me repeating the same story

P2: …and I said some other things and she was kind of like invalidating, and also kind of said, "Oh, but you know, my other patients go through this, which is a lot worse," and I was kind of like, "okay, but that's not, you know," it was kind of making me seem like my feelings weren't validated…

P12: it felt like felt like we're just circling over, similar concepts again, and again, I didn't feel getting much out of it… I was just talking about, I was just talking about certain subjects… that I just… that were quite deeply invasive of my… uh it's just I'd only seen her for two sessions and I just, maybe it was just a lack of trust or just a lack of rapport and I just, it was a, it was a part of me that I was very private about that.

The concept of a strong therapeutic alliance for this population was achieved through active listening, gentle demeanour of the therapist, appropriate self-disclosure, and skilful questioning/talking. Through building a strong therapeutic alliance, the participants noted that this supported them in feeling more engaged and supported in the therapy process as well as allowed them to be vulnerable and open. This significantly contributed to their perceived effectiveness of therapy as many reported through this, they felt that therapy was beneficial for them.

Theme 11: Reluctance of Family Involvement

An interesting post-therapy reflection that participants shared was that many did not involve their families during their time in therapy. This was due to a few key reasons. Firstly, a common reason for not sharing with their family that they were receiving therapy was that they did not want to worry their parents. A few participants were alone in Aotearoa, hence, they felt that sharing with their parents that they were experiencing mental health distress would create necessary worry in their parents. Additionally, as their parents were overseas, they were physically not able to be present in the participants' lives to support them.

P1: Not at all. I think my mother would think I was actually like… with her, I think she thinks like depression, like stuff like that is like "oh my god, you're going to commit suicide", it's like no…

P5: um… I was worried that they will be, they will be worried about me. Because… it was pretty horrible at that time and I was not in a good state… And I… didn't want to tell them.

P8: …Because, um, because for Chinese people, for example, my mother is a person who is very accepting of new things and is very advanced. She is a very accepting person for her age, but when I was in therapy, I didn't dare to share it with her. Because we usually share everything, but I didn't share with her about the psychological counselling because I was afraid that she would think that I was unhappy, depressed, or had some negative things like these. I was afraid that she would be worried for me

P12: Well, I think uh on one hand, it's like, on one hand, I didn't want my parents, to worry too much…

Secondly, many shared that they felt their parents would not understand, due to emotions/mental health not being spoken about in their upbringing, hence sharing with them would be pointless and could be more detrimental than helpful. One participant described that going to therapy was already exhausting, having to explain to their parents what they were doing would be an extra layer of stress.

P4: they just wouldn't understand. And uh… I think it would cause me more grief trying to get them to understand, and… convince them… why it's valid

P12: …And, but also it's just like, ok, on one hand, I knew they wouldn't understand very much and I just couldn't be, I didn't have the energy to explain it to them. But on the other hand, it's just like, um like, I was worried they might just like, disregard, or just think it's a non-issue and, and therefore be like, "Well, why are you going to see this person, just talk to us,"

Other participants also shared that one of the reasons which contributed to the difficulty of sharing how they felt with their parents was the language barrier.

P12: Yeah. Yeah. Like it's just talking to my parents is inherently… unhelpful. Um, our, as a 1.5 Gen like, because now my English is much better than my Mandarin. If I was to, try to explain to them what I was experiencing, or was feeling. It's just difficult to, so uh... And so as a result, like it's just difficult to explain to them…

P13: My parents don't know that I had counselling… the first time I told my mom that I needed help. I was, I didn't have the vocabulary to say it in Chinese. I still don't have the vocabulary to say it in Chinese, maybe that's part of the problem, that I don't have, I'm not able to communicate it with her, in terms that are… I guess accurate

Of the few participants who did share with their family the therapeutic journey, some only told their partners and not their parents, due to similar reasons of not wanting to worry their parents who were in China rather than Aotearoa. Those who told their parents only said very briefly that they were going to therapy but would not go into detail or involve them in the process as they felt uncomfortable talking about emotions with them. One participant shared that their parents did not understand why they needed to go to therapy and thus telling them had only led to more stress.

> *P3: they were aware of it… My mom told me that… I can have all the counselling in the world but, it all comes down to me… taking the initiative and… being able to face the fears. My dad had a… different approach he… he's, he told me just to keep pushing on…I think he told me to harden up… [were they supportive?] not so much*

Thus, for this population, it is important to recognize that while engaging in therapy, they are likely to lack familial support, and in some cases, the family dynamics may act as an additional stressor. Clinicians should therefore carefully explore this area when working with these individuals.

Theme 12: Cultural Attitudes Towards Medication

During the interviews, the topic of medication was often mentioned by participants as medication was linked to their therapeutic experience as it was often offered to clients as an option to compliment the therapy. Most participants shared that they had negative views towards medication and were not open to using this to support their mental health issues during their therapeutic experience. This was due to several concerns such as the potential side effects that the medication would bring and the possibility that they would become dependent on this. These views were often influenced by their family.

> *P5: Um… I just don't want to be dependent on it. I just don't want to… take it as a quick… you know…*
>
> *P12: My, so my views was…, initially it was just like, okay, the doctor told me to do that. I'll do it. But there's always an inherent like bias as to not taking them um.,,*

Especially my mom. She's like, Oh, it's unnatural. I'm like, what does that even mean? So I was, I was always an emphasis on not taking them. Yeah, I mean…, I actually recently stopped taking my one. I weaned myself off just because of the side effects

One participant (P10) shared the Chinese saying "是药三分毒" which roughly translates to, all medication contains 30% poison, which they shared contributed to their resistance to using medication for their mental health issue. Furthermore, another participant noted that they were resistant against using the medication as they were unsure how the medications work to help with mental health issues. Of the few participants who were open to taking medication, they shared that they are open to this if it is coupled with talking therapy. These were also the participants who had a family history of taking medications and so were more accustomed to using medication.

P6: I feel that as long as there are no side-effects I can accept taking medication… I grew up having Chinese medication… so I'm used to it

Much like the previous theme, this emerging information around their caution with medication use should be considered when working with this population in therapy. This reflects the therapeutic model which most mental health services utilize in Aotearoa where talking therapies are often complemented with medication, whether through GPs or psychiatrists. Hence clear consideration and clarity in forms of psychoeducation around the medication could be a helpful starting point.

Theme 13: Impacts of Experiencing Therapy

All participants shared that their understanding of mental health in general had changed drastically after experiencing therapy themselves. Many mentioned that through experiencing therapy themselves, they realized how important an individual's mental health is, and how strong the impacts of mental health could be.

P4: I think I have a whole new appreciation for it…it's not what I thought, it would be like you'd go in and then get the help and then you get told what to do and then you do

it and then you're better kind of thing. It's not straightforward. It's not… Yeah, it's not, a simple process like that at all. It is a very… I think before it was just more like you told me to do and I do the work. But I think now, I kind of realized that it is, like a colla- collaboration of two people working, working out a situation… Yeah, I just think everyone should go to therapy, even if you don't need it, like it's so beneficial

P8: Since finishing therapy, my mood has significantly improved, and I've been promoting therapy to others, it has helped me a lot

They shared that they have become more accepting of mental health and associate less shame with therapy through normalizing mental health in therapy. Furthermore, many noted that they have increased their knowledge and understanding of mental health after engaging in therapy themselves. They shared that they have become more open in discussing this with friends and would also strongly recommend therapy to others in their lives who are going through similar issues that they were in the past. A few participants shared how helpful it was that they came across the ads on Chinese social media, and noted that it would be helpful in the future if there were more advertisements spread on Chinese social media, such as WeChat or Weibo to promote understanding of mental health and available mental health services in Aotearoa.

P10: …before, was more resistant…now I'm more accepting and have suggested therapy to friends

P11: I know more about mental health services, like in Aotearoa which services can provide free sessions…

P12: it's really opened my eyes as, it's actually, these things are important like just being able to explain emotions quite... And having talked about emotion, so much, so long through various psych- psychology sessions… And so when I talked about it, I talked about it as if it's like normal. And I think that's really helpful from, from my sessions, because I've normalized emotions in my mind

All participants shared that their expectations of therapy were met after they attended therapy themselves. The participants all shared that they would definitely be open to

receiving more therapy in the future if they need to and would not wait until the breaking point to seek support again. After experiencing therapy, many participants established a clearer understanding of therapy and what they need/want in a therapist.

Many participants shared that they would prefer to engage with a therapist who was similar to them in the background for various reasons. A common reason shared by the participants was so that their perspective and cultural context could be better understood by the therapist and so they could relate to the therapist more easily.

> *P7: I will look for cultural responsiveness and like a culturally appropriate service for ethnic person, such as Chinese um…*

For example, many participants shared that they believe a therapist would be able to understand the cultural implications of how family can impact mental health or what implications of belonging to a collectivist culture may include or what the potential impacts of immigration are.

> *P1: Yeah. If I had a choice, I probably go with someone…that was more similar… Because I feel like they would understand the background, like more with a whole like, even like the losing face thing, where like, you know*

Participants shared that from their perspective, even if the therapist was not from the same cultural background, it would be helpful if they shared some similar defining characteristics to themselves, such as also being of immigrant status, or someone who was also from a collectivist culture.

> *P2: Um, I tend to find, if they're… even like the, so my first therapist who was Russian, she was white, Russian, I felt a connection because she knew what it felt like to be an immigrant to a foreign country, despite you know, her being white, so I guess it's like, that was enough for me…*

P13: would want a… my ideal would probably be someone, not necessarily that they have to be Chinese or be um Asian but I like a… someone from an Eastern culture would be really interesting. Like, whether that is Pacifica or Asian or even Maori because they have very similar worldviews. Um, It would be interesting to see how those strategies that they provide and insights that they provide differ. And also like 1.5 generation migrants is always like, bang on the money for me.

P14: although he's not Chinese, but he's… also an immigrant and he, I guess he has a lot of experience with refugees, because he volunteers for it, counselling for refugees. So it's like… he is sensitive about that kind of stuff, and … But yeah, I think um… he didn't push the culture onto me even though he would ask questions about it.

Furthermore, a few participants shared that they would prefer a therapist who could speak Mandarin, as this allowed better communication and thus connection. They shared that through their first therapy experience, they realized even though initially they felt their English was good enough to communicate in everyday life, therapy was more effective when they could express their feelings in Mandarin which they were more fluent in. However, a few participants also shared that they would not prefer someone who was 100% similar to them, as they would be worried that the therapist would be too subjective or feel too familiar, like a family member.

P2: because now that I think about it, because I feel like… maybe they've just reminded me too much of family and I like in a way I'm so uncomfortable about telling… maybe you know what, I think it's maybe like I want somebody who's close, but not so close that… like it almost feels like family, like they connect me to a certain level but I still need a distance towards them.

P4: You know, like, if those were the demographics, if your demographics are a little bit similar, you might feel a bit easier to make a connection with them… I'm not sure. I'm not sure how I would… um I'm not sure how I would work with… working with like, someone that's Chinese… it might be just a bit too close to home. A bit too familiar? A bit too… I think it depends as well, it were immigrant, or if they were, been here a long time, like me kind of thing. And that would have a different feel as well

Some participants shared that they would still prefer a free service, such as EAP or NGO service. However, many shared that after their initial experience, they are now more willing to pay for this service, as they do see the benefits of therapy and see this as something worth investing money and time in.

> *P7: Um I'll probably be paying for the treatment and looking for a person who has experience treating Chinese clients, but they don't have to be Chinese.*
>
> *P12: it was like so, if once you get your pay check, like what do you spend money on? I've put mental health right up there, like it's one of my top priorities, followed by other things.*

It is evident that through their own experience of therapy, the stigma attached was minimized and awareness around what mental health and services involve in Aotearoa was increased. This positive experience led to more openness around talking about mental health, thus expanding the conversation to others around them. This creates opportunities for promotion around mental health with this population, hence it is important to commit to providing services that are of best practice and standard to meet the needs of this population.

Summary

The thematic analysis revealed several interconnected themes that reflected how Chinese in Aotearoa experience talking therapies and mental health, both before and during/post-therapy. These themes highlighted unique cultural and experiential factors that can inform how clinicians and services adapt to better support this population. Broadly, the two main categories related to (1) promoting, accessing, and engaging with mental health services, and (2) clinical considerations in therapeutic work.

The findings suggest that Chinese in Aotearoa face distinct stressors that influence both their mental health and access to care. When they do seek support, they often do so at a point of heightened vulnerability. Consistent with previous studies, barriers to access included language differences, service costs, unfamiliar platforms, and limited awareness of mental health and available services. This lack of awareness reduces both willingness and ability to engage. The research also highlighted the importance of referrals or recommendations from trusted individuals to help overcome these barriers.

Clinically, participants responded particularly well to psychoeducation, clear signposting, and practical skill-building in therapy. They emphasized the value of a safe, non-judgmental, and culturally responsive environment that fosters openness and trust. The physical therapy space itself played a role in supporting feelings of safety and vulnerability. Establishing a strong therapeutic alliance emerged as a core factor linked to positive outcomes. The study further noted a tendency among participants to be cautious about involving family in therapy and identified specific cultural attitudes toward medication shaped by personal and community experiences.

Finally, participants described that personally engaging in therapy helped them become more open and accepting of mental health issues and talking therapies, reducing stigma within their communities. These findings will be further explored in relation to existing literature and their broader implications in the following section.

Chapter 6. Discussion

This discussion chapter begins with the aim to summarize and contextualize the findings of the present study in relation to the research questions and broader literature. The implications of the study will then be discussed regarding how the results could contribute to clinical practice and provide recommendations for services. The limitations and strengths of this study will then be considered and then conclude with suggestions for future research.

Referring to the original focus of this research, the research aims were as follows:

1. What are the attitudes towards mental health for Chinese in Aotearoa?
2. What are the experiences of "talking therapy" for the Chinese in Aotearoa population in Aotearoa?
3. From these experiences and attitudes, what can be extrapolated to inform clinical practices when working with this unique population in a mental health context?
4. How can this study inform/lead to future research?

The first, second, and third questions will be discussed in the following section as I delve in-depth into the results of this research and relate this with previous literature, with the second question being further discussed in the implications section. The fourth question will be addressed in the future considerations section.

Calls for more culturally responsive and safe mental health care for Chinese communities in Aotearoa New Zealand sit within a longer-standing Indigenous scholarship on cultural safety in health. Māori health leaders such as Mason Durie have argued that effective mental health services must be grounded in Indigenous frameworks that prioritise whānau, wairua, and secure cultural identity as core determinants of wellbeing (Durie, 1985). More recently, Curtis and colleagues have articulated cultural safety as an Indigenous-led approach that addresses power, racism, and structural determinants of health inequities, and have emphasized that culturally safe practice is required for all population groups, not only Māori (Curtis et al., 2025). The recommendations arising from the present study therefore align with, and can be seen as extending, these shared aspirations for mental health services that are culturally safe and equitable for Chinese communities in Aotearoa.

While much important work has been undertaken in the Māori space, there is a relative paucity exploring the experiences of Chinese in Aoteroa. This has been one of the first studies to explore the client experiences of talking therapies in Aotearoa with a focus on the Chinese in Aotearoa population. Using reflexive thematic analysis of fourteen interviews,

this study sought to explore and understand the participants' pre-therapeutic experiences, such as their attitudes and understanding of mental health, with the intention of gaining insights into which areas could be improved for service engagement. This study then continued to explore the participants' during-therapy experiences to identify both positive and negative factors which impacted their therapeutic experience with the intention of improving service delivery for clinicians.

Firstly, it is important to note that all participants identified as ethnically Chinese and had at least tertiary-level education, consistent with literature highlighting the cultural importance of academic and career success in Chinese communities (Chen, 2022; Ting & Foo, 2021). This profile suggests relatively high mental health literacy, as all participants reported prior exposure to mental health concepts through education, work, or personal networks. The sample also spanned different immigrant generations, implying varied levels of acculturation, and was skewed towards women, aligning with evidence that men are less likely to seek mental health support (Liddon et al., 2018; Wong et al., 2012). Although participants differed in their mental health difficulties and the types of talking therapies accessed, this diversity, combined with broad recruitment criteria, is appropriate for an exploratory study and supports a nuanced understanding of Chinese mental health experiences in Aotearoa.

Overall, all participants reported positive outcomes from therapy, including improved relationships, better coping with distress, and enhanced mood and functioning. At the same time, many described aspects of therapy that felt unsatisfying or could be improved, often linked to cultural differences and mismatched expectations. This pattern suggests that while talking therapies are generally effective for Chinese clients in Aotearoa, culturally adapted approaches may better address their specific experiences and improve engagement and acceptability. The findings also align with research highlighting growing demand for mental health support among Chinese communities in Aotearoa, who experience relatively low service utilisation but elevated mental health needs (Chow & Mulder, 2017; Parackal & Holroyd, 2024; Zhu et al., 2021). The following sections elaborate on these results by examining participants' pre-therapy experiences and their during/post-therapy experiences

Pre-therapy Experiences

Firstly, this study delved into the participants' pre-therapeutic experiences, where barriers and motivators of accessing mental health support as well as what mental health meant to them were explored. This section aims to discuss in depth these findings in relation to the existing literature to allow further improvement at a service level to promote engagement amongst Chinese mental health service users in Aotearoa.

Corresponding to previous literature where it was highlighted that Chinese immigrants tended to experience unique stressors leading to a decrease in mental health wellbeing (Arora & Khoo, 2020; Hsiao et al., 2006; Hwang et al., 2006; Lei et al., 2022; Li & Browne, 2000; Ting & Foo, 2021) this present study also echoed this finding. It was noted that there were subtle differences in the stressors noted by the participants depending on the age, immigrant status, and gender of the participants. For those who immigrated to Aotearoa by themselves, their main mental health concerns related to the stressors which arose due to the immigration process as well as the environment which resulted from the immigration process. For example, participants shared that the requirements such as application for a visa created an extra layer of stress on their everyday functioning and limited their help-seeking as they believed that this would impact the outcome of the visa application. Furthermore, participants commented that due to immigration, they felt more socially isolated and lonely with a lack of family support, which previous literature had already highlighted was extremely important in Chinese culture (Chang et al., 2019; Chen, 2022; Hwang et al., 2006). Participants who immigrated with their families at a young age expressed different unique stressors which impacted their mental health. Many commented on the focus on needing to "survive" in a new country, hence the focus was often more on providing physical resources for them rather than their mental health. Hence, it is suggested that the children of immigrants may be neglected in terms of their mental and emotional wellbeing as the caregivers may have different priorities.

Furthermore, these participants also commented on the lack of emotional expression by their families suggesting that there is unfamiliarity of mental health distress amongst immigrants, hence, potentially leading to the underutilization of services as well as worsening of symptoms. Previous research also supports this where it was indicated that Chinese individuals tended to have lower mental health literacy which led to lower rates of early detection and higher rates of underutilization (Wong et al., 2017). Moreover, this lack of emotional expression from the family led to the participants managing their stress alone without the support of the family, which is another heavy contributor to exacerbated stress.

The stigma which seemingly stemmed from the lack of emotional expression amongst the family inserted another barrier to support for the participants. This further strengthens how stigma, which was heavily emphasized in previous literature as a barrier to mental health service utilization, can prevent access to support (Chen et al., 2013).

Another category of participants in this research were those who had immigrated as adults and settled in Aotearoa, having started a family of their own, also referred to as first generation immigrants. These individuals identified several unique stressors which heavily revolved around the complex family dynamics and navigating multigenerational experiences in one single household. Previous literature has acknowledged that family dynamics amongst Chinese individuals are complex in nature, strongly valued, and rooted in Confucius values (Chung et al., 2023; Ting & Foo, 2021). The results of the current study echo similarities highlighting the conflict between maintaining familial peace and adhering to the family roles when experiencing stressors and adjusting to a new country with a different set of cultural expectations which may all compound into significant mental health distress. Previous literature also indicated the strong value of success amongst Chinese individuals (Chen, 2022; Williams et al., 2004). The participants of this study also echoed this, where it was identified that this pressure to succeed contributed heavily to the mental health distress experienced via exacerbated perceptions of failure in a new country and reduced ability to cope with this. These findings are vital in informing the current mental health providers as they could contribute to their formulation of the mental health concerns as well as provide direction in terms of what should be explored during the assessment phase. The identification of these unique stressors could provide markers for exploration for mental health providers and to be mindful of when working with this population.

This study also explored the key considerations that the participants contemplated prior to accessing support. Given many of the participants had limited awareness of mental health services available, participants initially had few preferences and simply accessed what was available to them at the time, such as through university services and work EAP programs with little knowledge of other potential factors. However, there were a few factors that the participants did consider important to them even with limited awareness. Most of the clients who did not grow up in Aotearoa identified the practical factor of language as a key determinant for who they chose to work with. Given that talking therapies rely heavily on conversation, it was apparent that most participants identified this as an especially relevant and strong influencer. Participants shared that it was important for them to be able to convey what they felt and this often was difficult when communicating in English which is their

second language. This aligns with previous research which highlighted the critical role that language plays in therapeutic effectiveness (Li & Browne, 2000; Naeem et al., 2024; Santiago-Rivera et al., 2009). Participants emphasized the additional challenge of articulating emotions in a second language, especially given their limited experience of expressing emotions in their native tongue. This was particularly evident among those who identified as 1st generation immigrants, where the majority had opted to converse in Mandarin even during the present study's interview, illustrating that this was the language where they felt they were able to express themselves better in. Interestingly, many had code-switched during the interview, suggesting that some concepts are more easily expressed in English. Conversely, those who identified as 1.5 and 2nd generation Chinese in Aotearoa opted to carry out the interview in English, with a few who engaged in code-switching.

Along similar observations, participants also preferred to work with clinicians with cultural awareness or similar cultural backgrounds. This suggests that a shared background or shared cultural understanding between client and therapist fostered familiarity, strengthened rapport, and facilitated discussion of sensitive topics in therapy. Much of the previous literature echoed similar findings, where it was indicated that cultural matching was preferred as it enhanced rapport building (Jim & Pstrang, 2007; Rogers-Sirin et al., 2015; Thompson & Alexander, 2006).

Another factor identified by the participants of the current research was qualification and experience. Some participants shared that they would prefer to work with clinicians who had more experience and higher qualifications which implied that they would be more effective. This corresponds to previous research where it was posited that Chinese individuals tended to prefer therapists from more prestigious educational backgrounds (Ip et al., 2016). This potential bias could stem from the limited awareness of mental health services available and various therapist training backgrounds and hence would be important to consider and respond to. Psychoeducation around the different available therapists and services could address the underlying biases and improve engagement for this population. Consequently, it can be inferred that for the Chinese population in Aotearoa, it is important to acknowledge their preferences for certain "types" of providers and extra steps could be taken to ensure that their expectations can be managed or met depending on what is available.

A key finding which emerged from this study was the concept of "being pushed to the breaking point" before accessing support. Although many participants shared differing causes of mental health distress, all noted that the final tipping point for them to seek support was due to feeling like they were at "breaking point". This is likely to be due to the limited

awareness of what they could access to support themselves as well as the potential stigma and "losing face" associated with seeking mental health support as mentioned by previous research (Chen et al., 2013; Ng & James, 2013). The participants described unsuccessfully attempting to use coping strategies prior to reaching the "breaking point" to manage, none were effective, often resulting in an exacerbation of distress. This suggests that for this population, their initial response to mental health distress is to try to cope with this themselves, and when they eventually seek support, they are at a stage where the issues are most severe. This pattern may be explained by the Chinese perspective of mental health identified in previous research, where it is emphasized that restraint in emotional expression is valued and the collective harmony is more valued than individuality (Ho, 1995; Williams et al., 2004; Yang, 1993; Yip, 2005). Hence it is highly likely that this population is waiting until breaking point to maintain a sense of collective harmony within their immediate social circle or they are exercising restraint and resilience. Additionally, this concept of "being pushed to the breaking point" could also be attributed to the healthy migrant effect (Simon-Kumar et al., 2025), where the cultural mismatch between their Chinese cultural values and their current environment, acculturation stress, and difference between previous lifestyles eventually build up leading to poorer mental health, thus resulting in "breaking point".

This has several severe consequences as being at breaking point leaves them with a sense of urgency resulting in limited options for services, a large sense of hopelessness, and their mental state at its worst. This is particularly important to be aware of for mental health providers as this implies that with this population when they present to services, they tend to be in their most vulnerable state and have exhausted their own resources. Hence, clinicians should be sensitive to this and provide support in a responsive and attuned manner, being mindful that more intensive treatment may be needed and that stabilization may be the first step due to the severity of the issues. Furthermore, this also suggests that there is more that needs to be done in terms of awareness promotion so that early intervention is possible. Previous research often refers to the lack of awareness of mental health services for this population, however, does not highlight this "pushed to the breaking point" vulnerable state that Chinese individuals who do present at services may be at (Ho et al., 2002; Ho, 2004; Parackal & Holroyd, 2024; Zhu et al., 2021). Previous literature often highlights the under-utilization of services that occur for this population and the need for early intervention, however, as seen in this study, the current climate does not appear to have changed for these participants though there has been movement towards mental health promotion. This suggests

that there is more to be done in the community to create awareness and de-stigmatization and more resources should be implemented for the Chinese in Aotearoa community.

Another significant finding from this study regarding pre-therapeutic experiences which echoed previous literature was the plethora of barriers that contributed to the lack of accessibility of services for the participants when attempting to access support in Aotearoa. As discussed prior, language was identified as a factor which participants had considered when researching services, it is also consequently a significant factor which acted as a barrier to accessing services. The participants noted that they could not access providers who spoke their language, hence hindering their ability to communicate clearly thus limiting their choices when accessing services. Participants also noted a shortage of providers with availability that aligned with their schedules, making it difficult to attend therapy amidst work or study commitments. Given that Chinese individuals often prioritize educational and career success (Ting & Foo, 2021), these scheduling barriers likely further limit their access to mental health services.

Participants also identified cost as a huge barrier to accessing services in Aotearoa and provided reasons for this. The uncertainty around what the services could provide and uncertainty with the potential outcomes of the services all contributed to an unwillingness to pay hence acting as a barrier to support. Furthermore, many participants commented on the immigrant mindset of needing to save money which made accessing mental health support feel like a luxury they were not opportune to given their immigrant status. These findings align with previous literature where it was identified that Chinese immigrants often do not prioritize mental health thus leading to a myriad of barriers (Xu et al., 2018; Zhu et al., 2021). Although cost is often identified as a barrier to access to mental health services for many different populations, the findings of the current research point to specific reasons behind this resistance that is unique to the Chinese in Aotearoa population. Namely, the lack of awareness regarding mental health services and what they can provide leads to ambiguity around the usefulness of the service. As a result, this leads to the prioritization of accessing the services, which in turn leads to the high cost of mental health services in Aotearoa undesirable and unworthy of attending to. Hence it is suggested that clear explanations of what mental health services can offer are vital in early engagement to allow clients to set realistic expectations and to provide pivotal reasons in overcoming the bias that comes with the costs associated with mental health services.

Following this, the lack of awareness of mental health concepts was another theme that was strongly highlighted in this current research which impacted the pre-therapeutic experiences of the participants in many ways. Most of the participants described a lack of awareness of mental health including what the definition of this was, the services that were available, misconceptions around mental health disorders, and discussion about emotions and feelings was foreign. Previous literature has also identified low mental health awareness amongst the Chinese population (Xu et al., 2018) although research does suggest a recent move towards more awareness (Zhang, 2014). This lack of awareness hindered participants' help-seeking behaviors as it limited their knowledge of available services and created discomfort in discussing emotions. Therefore, many struggled to articulate mental health concerns, especially with a stranger (clinician) which further complicated engagement. Misleading information about mental health disorders due to the lack of awareness created stigma, causing people to be labelled as "crazy" or "psychotic" which further deterred participants from seeking support. The lack of awareness also led to skewed expectations of therapy. Many participants shared that they expected therapy to be a quick fix to their problems which was often not the case. However, this unrealistic expectation led to ruptures in the relationship and decreased trust in therapy, thus leading to an overall decrease in trust in mental health services. This further supports the notion that psychoeducation prior to engaging with services for the Chinese in Aotearoa may be an important step in establishing a stable foundation for therapeutic work to commence.

This study uncovered a potential solution in which the barriers to access could be addressed. The theme of trusted confidants was discovered to be of significant motivation for the participants to seek therapeutic support. It was evident that most participants had sought support after being recommended to do so by trusted confidants. This significantly links in with the concept of "guanxi" (personalized social network), "ganqing" (depth of feeling of an interpersonal relationship) and "renqing" (reciprocal kindness). Previous research has identified that due to varying aspects of "gaunxi", the likelihood of disclosure of mental health illness was impacted (Chen et al., 2013). The finding of this current research supplements the idea that when a trusted individual from the "guanxi" network, likely someone who has strong "ganqing" and "renqing" with the individual, then their recommendation is more likely to be well received and lead to a stronger impact where the participants will be more likely to seek support based on the recommendation. This contributed to the existing research which highlights the critical role that the influence of

"guanxi" and interpersonal relationships has on mitigating the barriers to accessing mental health support for this population in conjunction with its influence on mental health illness disclosures. The findings emphasize the importance of leveraging trusted relationships within the individual's "guanxi" to encourage mental health support-seeking, especially in the Chinese in Aotearoa community where stigma and cultural barriers act as deterrents to seeking support.

To summarize, the results of this study which focused on the pre-therapeutic experiences of the Chinese in Aotearoa revealed unique stressors linked to immigration status, age, gender, and cultural background which evidently also illustrated the diversity amongst this population which resulted in a range of unique stressors. The theme around delaying seeking support until "breaking point" which is then exacerbated by the themes of low mental health awareness and limited accessibility/barriers to services can result in significant detrimental mental health outcomes for this population, all prior to entering any services. To counter this, the present research identified that the use of trusted confidants within an individual's "guanxi" can be a crucial role in motivating support-seeking, particularly with those who have a strong "ganqing" and "renqing". These findings highlight the need for greater promotion and psychoeducation around mental health and associated services available for this population as a form of early intervention to address and mitigate the barriers and stigma that the Chinese in Aotearoa face. The widespread of information will in turn support the leverage of "guanxi" and the use of interpersonal relationships to further promote and improve accessibility and engagement of services for the Chinese in Aotearoa community.

During Therapy Experiences and Reflections

The second half of this study then explored the participants during therapy experiences and post-therapy reflections, where specific themes around their engagement, therapeutic experiences, and factors contributing to their satisfaction with the experience were explored. This section aims to discuss and reflect on these findings in conjunction with the existing literature to inform service providers allowing clinicians to adapt their practice at an individual level to better support Chinese mental health service users in Aotearoa.

Firstly, the findings from this study highlighted the critical role of psychoeducation and clear signposting in facilitating positive therapeutic experiences. It was suggested that by providing the relevant psychoeducation and use of signposting throughout the therapeutic process, it addressed the key issue of the lack of awareness surrounding mental health

services as well as clarified the expectations early. This allowed the minimization of potential ruptures of the therapeutic relationship that can arise from miscommunication or unmet expectations thus leading to more positive engagement with therapy. This finding aligns with previous literature where it was identified that the Chinese population tended to respond well to directive approaches as they were not familiar with the therapeutic process thus guidance around what to do was well received (Lin, 2002; Williams et al., 2006). Furthermore, previous literature also suggested that psychoeducation can enhance therapeutic outcomes through managing expectations and defining roles (Hwang et al., 2006). Another important finding was the appreciation participants articulated for the teaching of practical skills during therapy which they could refer to post-therapy allowing them to sustain their progress independently. This resonated with previous research which illustrated the usefulness of interventions that emphasized skill building such as CBT allowing for long-term self-efficacy and relapse prevention (Ching 2021; Hwang et al., 2006; Iwamasa et al., 2019). It can be inferred from this finding that psychoeducation and clear expectation setting at the onset and throughout the therapeutic process could be a useful way to promote better engagement and outcomes for the Chinese in Aotearoa population.

Prior literature emphasizes the stigma that the Chinese immigrant population experiences in relation to mental health (Chung & Wong, 2004; Lei et al., 2022; Li, 2008; Shi et al., 2020; Xu et al., 2018). This study identified a potential avenue for addressing this. Most participants identified the importance of having a safe therapeutic space as facilitative in establishing an effective therapeutic relationship and positive outcomes for the Chinese in Aotearoa population. They described their experience of therapy as the first opportunity that they had of being able to openly discuss their emotions and feelings, hence it was particularly important for them to do so in a space that felt safe. A safe space enabled them to explore their emotions, acknowledge the importance of their emotions, and normalize their emotional experiences, thus removing some of the stigma surrounding their mental health concerns. For the participants, the key factor that contributed to their sense of safety in the therapy space was to not be judged. Those who perceived judgment from the clinician reported notably fewer positive experiences and fewer chances of sharing their true feelings in therapy. Previous literature also identified the importance of having a non-judgmental space in facilitating positive therapeutic outcomes (Chang & Berk, 2009; Jim & Pstrang, 2007). This is of significance as many participants reported experiences of external stigma regarding mental health and had felt judged prior to engaging in therapy. This stigma also contributed

to feelings of inadequacy when seeking support/therapy, thus amplifying participants' vulnerability and emotional sensitivity during the sessions. These findings emphasize the importance of a non-judgmental therapeutic environment which may serve as a counterbalance to the stigma and feelings of incompetence for the Chinese in Aotearoa clients.

Building on the significance of a safe therapeutic environment, participants also commented on the strong influence that the physical environment had on their therapeutic experience which has been echoed in previous literature (Taiwo et al., 2023). These findings also suggest that this was also important for Chinese in Aotearoa clients. The findings suggest that having an accommodating physical environment could support the clients in attending face-to-face sessions, which in turn facilitates more chances of connection and less avoidance of sharing of emotional experiences. The participants shared that by attending face-to-face sessions, they felt more inclined to share their experiences openly whereas online/telephones allowed for avoidance. Furthermore, participants also noted that they felt when the physical environment was decorated in a way which created a relaxing atmosphere, it was easier to talk about difficult subjects such as their emotional experience, a subject that was identified as something difficult to discuss. The offering of tea or coffee was also viewed as welcoming and comfort-inducing by the participants. Although not previously noted in the literature, it is posited that this may be due to the traditional Chinese culture of offering tea when guests arrive into your home (Xiusong, 1993). This in turn could create a modality of cultural ritual of welcome which suggests a creation of a building of "guanxi" between the therapist and client which is important in enhancing trust (Chen et al., 2013; Hwang, 1998). Hence this current study suggests that for the Chinese in Aotearoa population, having therapy sessions that are in-person, in a safe and comfortable physical environment facilitated through décor or offering of beverages, could be conducive to creating connection and an open therapeutic space, thus allowing the developmental of a therapeutic relationship leading to better engagement outcomes.

Additionally, another key facilitator of a safe therapeutic space that was identified from this research was the importance of therapy being culturally responsive and sensitive. Much of the previous literature stresses the importance of cultural competence, sensitivity, humility, and responsivity when working with clients from different cultural backgrounds to ensure best practice (Griner & Smith, 2006; Naeem et al., 2024; Ng & James, 2013; Ng & Wong, 2018; Sadusky et al., 2024) and the findings of the present study echo the same

sentiment. It also further contributes to the existing literature as it also revealed that the importance of being culturally sensitive and responsive is not only achieved through knowing about the culture of the client but more importantly about not making assumptions of the individual based on their cultural background. The participants shared that their presenting issues often contained a cultural element, which emphasized the need that the clinicians needed to have some understanding of their cultural background which allowed connection and trust to be created. Furthermore, this understanding is important as many participants had expressed that although they did not expect clinicians from a different background to be knowledgeable, they did not have the emotional capacity to repeatedly explain cultural nuances as they were already emotionally vulnerable and fatigued when presenting at the services. Hence if the clinicians lacked awareness of how cultural factors played into their experiences, it led to feelings of unseen, disconnection and misunderstanding. This corresponds to existing research where it is noted that culturally responsive practice led to a felt sense of cultural affirmation as well as positive therapeutic experiences (Kodish et al., 2021; Sadusky et al., 2024). Conversely, it was also identified that over-referencing or making assumptions about their presentations and experiences based on culture could lead to feelings of invalidation and strip them of their individuality which also corresponded with previous research (Sadusky et al., 2024). Hence it is apparent that finding a balance between acknowledging cultural differences without letting this overshadow the individuality of each client is vital in maintaining an effective person-centered approach. This is in line with previous research emphasizing the need for culturally responsive therapy while honoring individual experiences (Bercean et al., 2020; Kodish et al., 2021; Liu et al., 2024; Sadusky et al., 2024). Interestingly in line with this, one participant also commented on the Western-centric nature of CBT where it was identified that CBT felt lacking in individualization, which is echoed in previous literature where the universal applicability of Western therapeutic models was questioned (Chang et al., 2016; Guo & Hanley, 2015; Lin, 2002; Naeem et al., 2024; Williams et al., 2006). These findings together highlight the importance of combining cultural sensitivity with individualized, person-centric care to create a safe therapeutic place to enhance therapeutic rapport and effectiveness.

The development of a strong therapeutic alliance was also identified as a key factor contributing to participants' positive therapy experiences and establishing a safe therapeutic space, with several qualities of the therapist contributing to this alliance. Through active listening, a trusting relationship could be established between the clinician and the client.

Participants described feeling more connected and understood through active listening, which enabled them to use the therapeutic space more effectively and openly. They noted that this experience was unique as it differed from their previous interactions with others outside of therapy, such as family and friends who listened but did not demonstrate similar active listening qualities as the clinicians did. This aligns with previous research where it was identified that empathetic listening, trust, and mutual understanding were foundational to the therapeutic alliance in enhancing client engagement and outcomes (Chang & Berk, 2009; Liu et al., 2024; Rogers-Sirin et al., 2015).

Furthermore, the clinician's warm, gentle demeanor evidenced through their body language and tone of voice was also noted as crucial in creating a sense of safety for the clients. They also noted that humility on the part of the clinicians softened the power imbalance between client and therapist. For some participants, this contrasted with their experiences of "tough love" in Asian parenting styles where the clinicians' gentle approach allowed participants to feel more "held" and supported which led to more openness in sharing their experiences.

Occasional and appropriate self-disclosure by the clinician was also reported to strengthen the alliance, as it humanized the therapist to foster a deeper connection. However, it is noted that a fine balance with this should be adhered to as over-sharing from a clinician may also indicate unprofessionalism to the client. This is supported by previous research where it was identified that purposeful self-disclosure can enhance rapport (Chang & Berk, 2009).

Participants also commented on the skillful questioning and guided exploration demonstrated by clinicians which were different to how friends/family may communicate with them, further strengthening the therapeutic alliance as it proved to them that therapy was more effective than just "chatting". Through the flexible approach of using both directive and non-directive communication, these supported participants to gain new perspectives on their issues. This flexibility in therapeutic style, balancing guided exploration with clear direction when needed, echoes literature advocating for adaptable, client-centered approaches (Matheison et al., 2023; Sadusky et al., 2024). This supports existing research where it was identified that Chinese in Aotearoa clients tend to prefer directive approaches (Williams et al., 2006), however, also contributes to research that a mixed approach may be suited to this client population too.

Participants also noted that factors that they observed to be contributing to negative therapeutic alliance, were mostly all related to poorly timed rapport-building efforts, such as asking deep questions too early or repeatedly asking the same questions. It is suggested that rapport building for this population is vital due to the unfamiliarity with mental health and emotions that they hold when they initially engage in therapy, hence when the timing of questions is not well thought through, it may lead to ruptures in the therapeutic alliance. Participants also commented on feelings of being unheard or "told off," which could lead to negative therapeutic alliances, as it made them feel invalidated and felt familiar to when they shared concerns with family members. Cumulatively, these findings emphasize the centrality of therapeutic alliance in establishing effective therapy for not only the general population but also the Chinese in Aotearoa population, providing nuanced factors which contribute to the development of this as well as factors which could undermine its development.

An interesting insight that arose from this study was the absence of family involvement for most of the participants during their time in therapy where many opted to not disclose or involve the family members as part of therapeutic journey. This expands upon existing literature as much of the previous literature alludes to the benefit of involving family support given the collectivist culture of Chinese immigrants and the lack of this could lead to exacerbated feelings of isolation and stress (Hwang et al., 2006; Ting & Foo, 2021). For example, many Chinese in Aotearoa would have been immigrants who have had to leave their families in another country, hence, there is a high likelihood that there would be an absence of family support leading to more stress. However, this present study noted that amongst the participants, most had not included their family as there were various factors preventing this, hence suggesting that although family support could be helpful during therapy, the involvement of family should be heeded with caution and dependent on the context/situation of the client.

Furthermore, it was identified involvement of family could act as an additional stressor, a finding that contrasts with existing literature where family are often framed as a protective factor (Ting & Foo, 2021). The factors identified by the participants were the reluctance to worry their parents, as many were first-generation immigrants, hence their family/parents were still back in China, thus this caused difficulty in communication and acted as a physical barrier for family involvement. This coupled with the perception that parents would not understand their struggles, given the assumption that mental health is not commonly discussed, which was noted by the first, 1.5, and second-generation Chinese

immigrants, led to further avoidance of having family involvement during therapy. These echo the findings from prior studies on intergenerational cultural conflicts, where immigrant children often shield their parents from their emotional burdens to avoid adding to familial stress (Chen 2022; Ting & Foo, 2021).

The language barrier between the participants who grew up in Aotearoa (1.5 generation) and their parents further complicates this dynamic, this resonates with previous research where it was noted that limited proficiency in their home language can restrict effective communication and emotional expression (Naeem et al., 2024; Su-Kubricht et al., 2024). Additionally, some participants reported that even when partners were involved, it introduced additional stress via conflict between the couple due to disagreements between or different views held towards mental health, further highlighting the complexity of familial roles in mental health. By providing an alternate view of family as a definite support system for the Chinese in Aotearoa population, this study calls for a more situational understanding of how familial dynamics, cultural expectations, and language barriers intersect to influence mental health experiences, particularly for 1.5-generation immigrants navigating dual cultural identities. Although earlier in this section, it was identified that encouragement from trusted confidants promoted access to mental healthcare, it is interesting to note that disclosure of mental health concerns is inhibited to family members. This suggests that even though strong relationships could promote action on seeking support, the act of disclosure is vastly different and limited. Furthermore, it also suggested that family, for this population, may lay outside of the barriers of “trusted confidants”.

Another unexpected finding from this study revolved around the discussion of stigma towards medication, represented by the participants' hesitancy to incorporate pharmacological interventions as part of their therapeutic treatment mainly due to cultural bias, unknown mechanisms of the medication, and fear of dependency. This approach is commonly utilized in mental health services in Aotearoa hence important to discuss (Te Pou, 2009). This finding aligns with previous literature, which has consistently highlighted the longstanding stigma associated with psychiatric disorders and thus related, medication which is often rooted in misconceptions, cultural beliefs, or fears of dependency (Chen et al., 2013; Corrigan et al., 2012). However, participants also viewed medication as a potential complement to psychotherapy suggesting some level of acceptance towards this.

This was particularly applicable for those who had a history of using Traditional Chinese Medicine (TCM), and who had less of a fear of dependency given the historical

regular medicinal intake. This suggests a more complex interconnection between medication attitudes and therapeutic engagement. To address this hesitancy, increased psychoeducation may be beneficial, as it could help de-stigmatize medicinal treatments and provide a more balanced understanding of their role within the "talking therapy" framework as previous research suggests that psychoeducational interventions can reduce stigma and improve treatment outcomes (Hwang et al., 2006; Williams et al., 2006). However, the findings do highlight the need for culturally sensitive approaches by being aware of the unique concerns surrounding medication for this population, thus it would be important when promoting awareness and education around medication use, it should be carefully tailored to resonate with the unique experiences and perspectives of the Chinese in Aotearoa population within the therapeutic process.

The final findings of this research highlight an important phenomenon where there is the removal of the associated stigma with mental health services via experiencing a positive therapy experience. This contributes significantly to the existing literature on mental health stigma, particularly for the Chinese in Aotearoa immigrant population and culturally diverse populations as it identifies a strong determinant in removing stigma. Previous research has consistently highlighted the pervasive stigma surrounding mental health in Chinese immigrant populations, where awareness of mental health is limited and often referred to as being "crazy" or "weak" and the use of therapy is often viewed as a sign of weakness or failure (Ng & James, 2013; Qiu et al., 2024).

The findings of the current study reveal a transformative shift in participants' perspectives after engaging in therapy which they viewed as a positive experience, supporting previous literature that emphasizes the destigmatizing effects of firsthand experience with mental health services also occurs with this population, where the stigma associated can be quite severe (Corrigan et al., 2012). All participants of the current study reported an increased awareness of the importance of mental health since experiencing therapy themselves and furthermore, have also become more accepting and open to discussing mental health with peers and to some extent, family members. This finding strongly suggests that a personal positive therapeutic experience could be a powerful tool in challenging deeply ingrained cultural attitudes for both the individual and consequently, the community that the individual belongs to.

The importance of a positive therapeutic experience is also key to note, as it suggests that this may be a key factor that alleviates the stigma surrounding mental health. Therefore,

to facilitate a positive therapeutic environment, it is important to provide culturally sensitive and responsive care as well as a strong therapeutic alliance. Furthermore, some participants also commented on the powerful impact that the role of Chinese social media has also had in their journey of de-stigmatizing and normalizing mental health. This also aligns with previous research where it was identified that education can also be a pathway in which stigma associated with mental health may be removed (Corrigan et al., 2012). This finding is particularly significant as it identifies the preferred "type" of education that the Chinese in Aotearoa population are more accepting of and responsive to. This suggests that the use of Chinese digital platforms such as Wechat, Weibo, and Rednote (social media apps) could be more utilized to promote mental health, thus removing some of the barriers associated with accessing mental health support.

To summarize, the findings of the present study provide highly relevant and critical information regarding the pre-therapy and during/post-therapeutic experiences of the Chinese in Aotearoa population. Specifically, the results of this research provide insight into how Chinese clients in Aotearoa view talking therapies and mental health as well as the importance of cultural awareness and responsivity in establishing engagement and providing effective treatment to these clients which echoes previous literature that focused on Chinese in Aotearoa populations. It also supports previous literature where it was identified that this population face numerous barriers in accessing mental health support, such as lack of accessibility and own cultural attitudes leading to bias and stigma. The repeated results suggest a lack of change since the identification of this from previous literature, calling for more necessary change to occur. However, adding to previous research, it is observed from this study that a positive experience with mental health services and clinicians can create a significant shift in their perceptions, future involvement and promotion with mental health services thus emphasizing the importance of having a positive therapeutic experience could be for this population. These all correspond to different implications which could be implemented to improve the mental health service accessibility and outcomes for this population which will be discussed in the next section.

Implications

The intention of the present study was to provide insights into the attitudes and experiences of mental health and talking therapies of the Chinese in Aotearoa population to inform mental health services both with the promotion of mental health as well as improving the effectiveness of the talking therapies themselves. The findings of this study build on

existing research to strengthen known implications as well as provide new insights into mental health awareness promotion and practically adapting talking therapies to be better suited for this population.

Firstly, by exploring the pre-therapeutic experiences of this population, this study unveiled their attitudes towards mental health and talking therapies in Aotearoa both before and after experiencing talking therapies themselves. The results support previous research where similar barriers and challenges to accessing mental health services were identified. This is particularly important to note as it suggests that although these barriers have been previously noted, there is limited change that has since occurred which failed to address the barriers. This implies that more needs to be done in terms of promoting mental health awareness amongst the Chinese in Aotearoa population as well as de-stigmatizing mental health and related services. The findings from this study provide some initial direction in terms of this. For example, participants shared that suggestions from trust confidants due to "guanxi" are more accepted thus promotion should be community-based. More community-based events/placements of informative brochures at known Chinese services can lead to more awareness regarding mental health amongst this population. Furthermore, it was suggested that Chinese social media has been a good platform to promote awareness around mental health as well as potential service providers, thus this should be utilized by not only Asian services but also mainstream mental health services.

Another important finding from this study which is particularly relevant for service providers is the initial presentation of the Chinese in Aotearoa clients which they may present with when first engaging with services. Previous studies have identified the potential causes of seeking therapy that is unique to this population, however, few note the mental/emotional/psychological state that the individuals may present with. The findings from this study suggest that they are likely to be at their breaking point and present at services when they are most vulnerable. Hence this implies that in the beginning phases of therapy, it is essential to be aware of this vulnerable presentation and take the appropriate measures to accommodate and address this. It may mean that more time is spent on establishing rapport and trust (both of which have been identified by participants as key in feeling that the talking therapy was effective and helpful) or that more time is spent on risk management given the immense emotional struggles that they may be present with. This suggests that initial stabilization of the client for this population is highly important and relevant in providing the appropriate support required.

Furthermore, from the during-therapeutic experiences this study identified specific factors which could be adapted to better suit Chinese in Aotearoa clients. Some of the factors reinstate the importance of previously identified factors in research which promote therapeutic outcomes and other factors contribute to the existing literature and are unique to this population. Nonetheless, the findings support the notion of the importance of having services/treatments that are tailored towards the Chinese population in Aotearoa to promote better mental health outcomes for this population. Firstly, it was identified by the participants that psychoeducation and practical skills/strategies felt particularly helpful. This implies that similar to what previous research identified, a directive approach could be well-suited to this population given the cultural backgrounds and dynamics that this population presents with. It contributes to the literature by specifically identifying the key underlying factors that a "directive approach" could be referring to. Psychoeducation specifically was perceived well by this population given the limited awareness of mental health prior to engaging with services, it provides a strong foundation on which to build their expectations thus allowing for better connection. Furthermore, signposting also supports this as it provides a rough guideline on what to expect and clarifies the therapeutic process and allows the client to feel less "unaware" of the processes.

Another important implication from this study highlights the importance of having a safe therapeutic space for this population as well as potential ways to achieve this such as via having a strong therapeutic alliance and considering the physical aspects of the therapy room. The findings imply there are similar factors which contribute to a positive therapeutic outcome between the Chinese in Aotearoa population and other populations as previous research suggests, however, the mechanisms which underlie this are culturally unique for this population. This suggests that how clinicians approach the beginning phase of therapy is vital in establishing a strong therapeutic foundation for positive therapeutic outcomes for this population. For example, the importance of a safe therapeutic space has been mentioned in prior literature which explored the important factors which contribute to effective therapy, however, this current study identifies the specific reasons underpinning this for this population.

It is suggested that due to the high stigma associated with mental health and lack of expression of emotions throughout their lives, having a space where they feel safe and not judged is key in facilitating communication of what they may be feeling and experiencing. Given the stigma around mental health, seeking support already places the individual in a

position where they feel less competent, hence without the felt sense of safety and non-judgement, it is much harder to share their experiences and truly utilize the therapeutic space. The findings of the present study also echo previous literature where it was identified that the therapeutic alliance had a strong impact on the therapeutic outcomes.

For this population, it is implied that the skilled way in which therapists used communication contributed to the development of trust between the client and therapist, thus increasing the therapeutic alliance. This suggests that when working with clients from this population, it is important to be flexible and acknowledge how their upbringing and cultural differences may impact how they respond to the therapist's approaches through active listening, appropriate self-disclosure and the body language/tone of voice. This suggests that the therapeutic alliance is an essential component of effective therapy that is an active, dynamic process which requires intentionality on the therapist's behalf. Many mentioned the lack of emotional expression until their first experience of therapy; thus, it can be inferred that therapeutic alliance could be the first experience where the emotions can be normalized and validated, thus creating a huge cathartic impact.

Furthermore, from this study, another key aspect that contributed to the safe therapeutic space was the physical aspect of the room. Prior literature has pointed to the impact of how the physical space of the therapeutic room could impact the therapeutic experience (Taiwo et al., 2023) and the findings of the current study suggest that this also applies to the Chinese in Aotearoa population. It is suggested that the physical aspect of the room when curated in a way that facilitates a comfortable and relaxing atmosphere, can also support the sharing of more difficult subjects. A well-decorated, lit room with comfortable seating that does not remind clients of an office space was often described as an ideal room. Furthermore, the offer of tea/coffee was also highlighted as a simple, yet important gesture that signaled to the individual that this space was welcoming and inviting. In relating this to the target population, given their unfamiliarity with therapy and the associated stigma with mental health, a well-decorated physical environment can be conducive to the process of building rapport if it signals to the clients that it is a safe and comfortable space where they can be vulnerable. Hence the findings combine to highlight the essential notion of having a safe, therapeutic space to facilitate better rapport and connection for the Chinese in Aotearoa population and for a positive therapeutic outcome.

The findings of this study also strongly highlight the importance of not only having culturally competent clinicians, but also being culturally sensitive and responsive. This also

relates to the establishment of a strong therapeutic alliance but is of importance to discuss in depth given the cultural background of the Chinese in Aotearoa population. This suggests that beyond the general characteristics of a therapist, for this population, cultural influence is also a strong influencer of their therapeutic experience. The implications from this finding are key as it highlights the difference between being culturally aware and applying it as being culturally responsive and sensitive. The findings suggest that not only is it important to be aware of the basic cultural background and what it means for the client, but it is also important to be flexible and sensitive in responding appropriately to the given information. What this suggests is that although it is important to be aware of the cultural factors that a client presents with, such as values and traditional practices, it is also important that while applying this knowledge, clinicians do so in a sensitive manner that is not over-generalizing without considering the individuality of the client. This is especially relevant to the Chinese in Aotearoa population as they do present with such diversity, thus assuming a cultural basis for the presentation should be done with caution given the differing degrees of cultural mixes for the Chinese in Aotearoa. It can be viewed as invalidating when clinicians assume a predetermined bias just based on the cultural background of the client. This can damage the trust and therapeutic alliance leading to worse therapeutic outcomes.

Building on the previous research, the findings of the present study also highlight the importance of family dynamics for the Chinese in Aotearoa population. Previous literature often notes the importance of family based on the collectivist culture of China and many tend to note the strengths of including family members for mental health support. The findings from the current study contribute to the existing literature by providing an alternate viewpoint and an important one to consider, where many participants, in fact, expressed a reluctance to have family involved in their therapeutic process. This could be due to a myriad of reasons as previously discussed, the key point is that assuming the collectivist background means that involving the family in the therapeutic process could be detrimental to the therapeutic outcomes. For the Chinese in Aotearoa population, the preferred approach is to not include family initially as it tends to bring more stress and internal conflict. Thus, this is important for clinicians to be aware of when working with these clients and suggests that rather than assuming involving family could be helpful for the process, careful consideration should be taken before suggesting to the client if family involvement could be helpful.

Adding to the existing service engagement/improvement strategies, this study highlights an essential point of mental health services for the Chinese in Aotearoa population

which has huge implications for the increase of mental health awareness and acceptance. The findings suggested that a positive therapeutic experience positively reinforces participants to further seek out mental health support as well as pushes individuals to share their experiences with others in their social circle, thus prompting conversation and de-stigmatizing mental health. This suggests that the first encounter with mental health services in some sense can act as a promoter for further support both at an individual level and at a community level. Hence, this highlights that care and consideration should be applied with working with the Chinese in Aotearoa clients, especially if this is their first time at a mental health service, as it could have serious implications for any further contact.

The findings of this study provide invaluable suggestions for mental health awareness promotion as well as evidence-based best practice for the Chinese in Aotearoa population regarding talking therapies of mental health services. It highlights long-existing known barriers and draws attention to the continuous need to address these barriers. It also contributes to the existing service improvement strategies by discussing factors which impact the therapeutic experience for this population and highlights key factors to implement when working with this population to facilitate positive therapeutic outcomes and experiences.

Limitations

While this study provides valuable insights into the therapeutic experiences of the Chinese in Aotearoa community, it is not without limitations. The primary limitation of this study is its limited generalisability due to participant demographics. Given the small sample size and the fact that all participants were based in one island of Aotearoa the results of this study cannot be generalized to the entire Chinese in Aotearoa population. Although it is documented that Auckland has the largest Chinese in Aotearoa community, by not exploring the perspectives of those from another perhaps smaller region, insights that are unique to that population may be missed. For example, those from a smaller Chinese in Aotearoa community may have even fewer options in terms of mental health services and the language and cultural barrier may be of even bigger influence, however, this was not able to be explored in the current study. Furthermore, as observed in the current study, the diversity amongst the Chinese in Aotearoa population is immense, thus further adding to the limited generalisability of the findings of the study. Depending on the generation of the immigrant, gender, age, type of therapy experienced and length of therapeutic experience, the experiences could differ significantly. However, none of these were controlled for in the current study, although for good reasons as explained in the methodology, this significantly

hinders the generalizability of the findings of the present study. Also, notably, the demographics within this sample were skewed, where there were more female participants than male, as well as no participants were under the age of 18 years or over 60 years, potentially leading to the under-representation of Chinese in Aotearoa belonging to these age groups. From previous research, these age groups are likely to present with their own unique set of experiences due to the socio-political context, hence the findings of this present study may be unlikely to be generalizable to this population.

In addition, another limitation was the potential for self-selection bias. The participants of this study were voluntarily recruited through mainly advertisements in services which worked with Asian clients as well as through word of mouth amongst the community. Given this, it is likely that those who are more open to sharing these experiences or who were interested in this area would have signed up for this study. Hence, the sample may not be representative of the broader population who may gone through mental health services but were less comfortable with sharing. Thus, the results of the study may not fully reflect the experiences of the individuals who may have viewed the therapeutic process more negatively. Despite this possibility, there were participants in the current study who were able to share their experiences which they did not feel were positive thus also allowing for the difference in views.

Another limitation relates to the data collection of the present study. The data was collected retrospectively, where the participants were asked to reflect on their experiences of previous therapeutic experiences which may introduce inaccuracies or bias of the data. As this relied mainly on the participant's own recollection of their experience, details of the experience may be overlooked, and incomplete accounts may be reported. However, despite this, it suggested that what was discussed by the participants could be identified as significant and important enough to be remembered thus providing insights into their personal perceptions and nuanced experiences to enhance the richness of the data. Recalling on their past experiences, can encourage reflection of the experience which may not be evident during the actual experience, thus allowing for further depth and insight into their experience.

As with any methodology design, the chosen design for this study also presents with its limitations. Even though through this qualitative method, in-depth unique perspectives were obtained from participants and a rich understanding of their experiences was captured. However, given the small number of participants in this method, this contributes to the limited generalizability of the results to the broader population. Furthermore, given that the

recounts are subjective experiences, it is more difficult to determine patterns to inform interventions. Despite this, initial suggestions can still be extrapolated from the data to inform best practices.

Reflecting on the implicit influence of the researcher who mainly conducted the research and identifies as Chinese in Aotearoa, the population of interest, this can be perceived as a two-edged sword throughout the process of the study. By being an "insider" of this group, it allowed an ease of communication and connection. The participants could communicate freely between Mandarin and English as the researcher could understand both languages which allowed for ease of communication and smoother reiteration of information and experiences. The researcher was also familiar with cultural nuances and phrases so that participants did not have to over-explain themselves. It also contributed to the researcher's subjectivity and allowed for initial direction and understanding of the research questions. However, it is also acknowledged that with the "insider" status, it may have led to hesitation in participants to share certain knowledge for fear of judgment or mutual connections. Furthermore, there are potential biases from the researcher which may impact the analysis of the data as well as during the interview process where the researcher may assume an understanding of what the participant is sharing without clarifying with the participant. Careful reflexivity has been implemented to avoid these limitations; however, it is not assumed that this could be completely eliminated during the entire research process.

Notwithstanding these limitations, this current study fills a key gap in the literature by exploring the experiences and attitudes towards mental health of the Chinese in Aotearoa community. There has been limited research which focuses on the client experiences and only a handful of previous literature which focuses on this target population. The present research separates this population from the general "Asian" subgroup that most research tends to focus on. Furthermore, more research on Asian client experiences of mental health services has been conducted internationally however, given the unique cultural and socio-political climate of Aotearoa, it is crucial that research which aims to inform service promotion and provision also be conducted in the same environment. A good understanding of the Chinese in Aotearoa's experiences provides a solid and informed base from which service promotion, delivery, interventions, policies and practices for this unique population can be inferred.

Future Research Considerations

Given the stated implications and limitations of this present study, it naturally points to areas of future research that could further enrich the findings of this present study and

contribute to existing literature relevant to the Chinese in Aotearoa population. Due to the significant growth of this population in Aotearoa, the mental health of this population proves important to explore and address.

Notably, given the immense diversity amongst the Chinese in Aotearoa population, future research can aim to focus on specific populations within this group such as the different generations of immigrants, to determine more direct factors which impact the therapeutic experience as this current study was unable to. For example, those who are first-generation immigrants may present with significantly different presenting concerns compared to those who are second generation or 1.5 generation. Hence, it would be reasonable to separate these populations to further explore which unique factors may impact their mental health. Different genders could face different mental health stressors and likewise with different age groups which previous studies with other ethnic groups have already identified (Qiu et al., 2024). These demographic factors should all be taken into consideration in future research on the Chinese in Aotearoa population. This could focus on the therapeutic experiences of these different demographic populations with the aim of adapting interventions to be better suited for each of the populations.

Furthermore, while this current study attempted to explore specific parts of the different interventions that participants had found helpful and unhelpful, it was notably difficult to achieve given one, the lack of clarity the participants themselves had towards what therapy they received, and two, the vagueness in which they could recount their experience. Hence, the diversity amongst the type of therapy they received as well as the time spent in therapy could also be controlled for in future research. This will allow for specific exploration of a given type of model of therapy to then provide appropriate cultural adaptations for the named therapy. For example, one participant had said that CBT felt unhelpful but was unable to identify the specifics of why they felt that way. Future research could specifically aim to explore what aspects of CBT were unhelpful through research with participants who specifically experienced CBT as an intervention and potentially doing during and post-therapy interviews to capture their experiences across time. Additionally, future research could also control and implement a minimum amount of time spent in therapy when recruiting participants as it could contribute to richer data as participants would have more material to reflect upon. As in the current study, there were a few participants who have had only a few sessions of talking therapies, thus limiting their reflections. Moreover, having a set time frame of how long ago they had experienced therapy or how many sessions they

would have needed to have received before participating in the study could also be helpful in capturing more reliable and valid data.

The present study focused on the client's experiences; however, it is acknowledged that in talking therapies, there are two individuals involved in the relationship. Hence, future research could also incorporate clinician perspectives to explore what they felt was helpful and unhelpful when providing talking therapies to clients from the Chinese in Aotearoa population. By exploring the therapist's perspective, it allows insight into what professionals find difficult in terms of establishing a good therapeutic alliance and providing good therapeutic outcomes, thus dictating what training may be beneficial to support the clinicians when working with this target population.

Finally, future research could also focus on exploring the actual outcomes of a culturally adapted model of talking therapy for the Chinese in Aotearoa population. Based on factors identified in this current study and previous literature, a culturally adapted model of existing models of talking therapies (e.g. CBT) could be hypothesized and formulated, which can be then used to be trialed with a specific sample of participants. This could lead to a model of talking therapy that will be evidence-based and suited for the Chinese in Aotearoa population, allowing for better outcomes from therapy and further identifying how each of the factors may interact and impact the therapeutic experience.

Conclusion/Final Statement

As a member of the Chinese in Aotearoa community, I have observed that there is a great need for this population to be seen in terms of their mental health and receiving the appropriate support. They face numerous barriers, both cultural and situational which are often deemed unimportant or left undetected. Often viewed as the model minority, their mental health suffering can be invisible. Coupled with the immense stigma evident throughout the generations of immigrants, as well as internal conflict with those who are more open but wary of others' judgment, access to mental health services can be extremely challenging. Furthermore, the availability of support in the form of talking therapies is often based on Western approaches, thus overlooking the unique cultural needs of this population. This present research provides some foundational starting points for future research on developing best-practice approaches for working with the Chinese in Aotearoa population for talking therapies. It highlights multiple areas where more research would be beneficial for addressing the barriers and implementing evidence-based practice that can be culturally sensitive and responsive. This research supports the notion that there is a need for improving service promotion, utilization and delivery for this population despite the assumption that individuals from this population do not tend to need mental health support. It provides some initial starting points for utilizing social media and community networks to diminish stigma around mental health and to normalize emotions and mental health. It is essential that this continues to evoke movement in exploring and improving talking therapies in Aotearoa with this population given the growing population.

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Appendices

Appendix A: Advertisement Poster (English)

Chinese Participants Needed!

If you identify as Chinese living in New Zealand and have either received any psychotherapy in the past (not current) or have experienced some mental distress in the past but not sought psychotherapy... you are invited to participate!

Study for Chinese in NZ to share their thoughts/experiences on psychotherapy/mental health

This project aims to explore the experiences of psychotherapy of Chinese in New Zealand and the attitudes towards mental health of Chinese in New Zealand to contribute to better understanding of how psychotherapy can be tailored for Chinese individuals living in NZ.

You will be invited to an interview with the researcher to discuss your thoughts and experiences of psychotherapy or past mental health distress. The interview will take 45-90 minutes.

As a thank you and compensation for your time, participants will be gifted a $20 voucher

Eligibility:

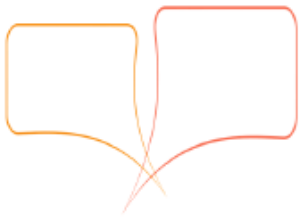
Must identify as Chinese and live in New Zealand aged over 16 years old and either:

- Have experienced any form of psychotherapy (counselling, CBT, ACT, group counselling etc.) in the past
- Have not experienced any psychotherapy but have felt mental health distress in the past

Contact Details:

If you are interested in participating or would like more information, please contact Luyu (Lucy) Qiu by email: luyu.qiu.1@uni.massey.ac.nz

Or scan the QR code to register your interest!



Approved by Health and Disability Ethics Committee (HDEC) on 22 November 2021.
Reference Number 2021 EXP 11512

Contact: luyu.qiu.1@uni.massey.ac.nz
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Appendix B: Advertisement Poster (Chinese)

需要在新西兰的中国参与者!

如果您是居住在新西兰的华人，并且过去 接受过任何心理治疗，**或者**过去曾经历过一些心理困难但没有寻求心理治疗……您被邀请参加!

需要新西兰华人分享他们对心理治疗/心理健康的想法/经验

本研究项目在探讨新西兰华人心理治疗的经验以及新西兰华人对心理健康的态度，以帮助更好地了解如何为居住在新西兰的华人定制心理治疗。

您将被邀请与研究人员进行面谈，讨论您对心理治疗或过去的心理健康困扰的想法和经历。访问需要 45-90 分钟。

作为对您时间的感谢和补偿，参与者将获得 20 NZD 的代金券。

参与者要求:

必须确定为中国人并在新西兰居住，且年满 16 岁，并且:

- 过去曾经历过任何形式的心理治疗（咨询、CBT、ACT、团体咨询等）
- 没有经历过任何心理治疗，但过去曾感到心理健康困扰

联系方式:

如果您有兴趣参与或想了解更多信息，请通过电子邮件联系 Luyu (Lucy) Qiu: luyu.qiu.1@uni.massey.ac.nz

或扫描二维码注册您的兴趣!

于 2021 年 11 月 22 日由中央健康与伦理残疾伦理委员会已经批准了这项研究。参考编号 2021 EXP 11512

Appendix C: Participant Information Sheet (English)

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Chinese in New Zealand and Their Experiences of and Attitudes Towards Psychotherapy/Mental Health in New Zealand

Coordinating Investigator: Luyu Qiu

Supervisors: Dr. Simon Bennett and Prof. James Liu

Ethics committee ref.: 11512

INFORMATION SHEET

My name is Luyu, and as part of my Doctorate of Clinical Psychology program at Massey University, I am conducting my doctoral research on the attitudes and experiences of Chinese people living in New Zealand of psychotherapy and mental health.

Project Description

Despite being an established migrant group in New Zealand there has been little research on the attitudes Chinese in NZ hold towards mental health and psychotherapy, which has grown to become the center of research for wellbeing over the years. Our study will explore the different factors that may impact on the perspectives they hold towards mental health and psychotherapy in their 'new' home country. By exploring these factors, we hope to establish some foundational information regarding how psychotherapy could be adapted to be better suited for those that identify as Chinese in New Zealand as well as strategies to overcome the potential barriers faced by Chinese in New Zealand when accessing mental health support.

You are invited to take part in this study. Whether you decide to take part or not is your choice. If you do not want to take part, you do not have to give a reason. This Information Sheet will help you decide if you want to participate in this study.

Who can participate in this project?

Participants will be recruited through social media and poster advertisements in community areas.

Inclusion criteria

- Individuals over the age of 16 years of age
- Self-identified as Chinese in New Zealand
- Have either;
    - engaged in a form of psychotherapy in NZ which can include but not limited to:
        - CBT
        - ACT
        - Mindfulness
        - Group work
        - Counselling
        - Addiction support
    - or have experienced some form of emotional distress in past but not accessed any mental health support/services
- Reside in New Zealand for face-to-face/zoom interviews (interviews may be conducted in English or Mandarin)

If you participate what will you be required to do?

If you wish to participate you will be invited to take part in one semi-structured interview, at a time and place that we mutually agree on. Face-to-face interviews will be offered, but if participants prefer, these can be conducted via Zoom and of course if COVID lockdowns occur we can move to on-line interviews. The interview will focus on your personal experiences of psychotherapy. The interview will include questions regarding your experiences of psychotherapy and seeking support for psychological distress to contribute to knowledge of psychotherapy of Chinese in NZ. The interview should take no longer than one to two hours.

Your responses will be audio recorded and transcribed later and checked for the purposes of analysis. Please note that you will be given the opportunity to view your transcripts and make comments but alterations will not be made as your responses and thoughts are the focus of the research.

Due to the challenges of recounting potentially stressful experiences, I understand that it may be difficult to discuss your experiences. I do not anticipate harm or discomfort as part of this research however, I do acknowledge that it is a difficult subject, and it may be hard for you to discuss. You do not have to talk to me about anything that you do not want, you can stop the interview at any time, and you have the right to ask questions. A registered clinical psychologist will be available on call to ensure safety of participants. However, please be aware that this study is focused on exploring your experiences and is not a counselling session. If you would like to withdraw from the study, you can withdraw at any time.

If you decide to participate, you will need to sign a consent form. You may take a copy of both the participant information sheet and consent form upon reading and signing these. Upon completion of the interview, you will receive a $20 voucher to thank you for your time and participation.

Data Management

The interviews will all be recorded on a voice recorder with your permission. The data will be stored securely and only the researcher and supervisor will have access to this information.

To ensure autonomy, all identifying information will be removed from the transcript, the data and the write up of the research. However, there is the possibility that your response may be used in research publications. All personal information and data will be stored on a password protected computer and on a Massey University hard drive for 10 years after the completion of the study, and then it will be deleted. The data is stored in Massey H drive as the data saved to Massey University's network is backed up, maintained and managed, secure, replicated and protected against viruses.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular questions
- Withdraw from the study at any time up until 2 weeks after the interview
- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used unless you give permission to the researcher
- Be given access to a summary of the project findings when it is concluded
- Ask for the recorder to be turned off at any time during the interview

Confidentiality:

Your identity will be kept confidential throughout the research. To achieve this, the information you provide will be coded and names will be removed to lessen the chance of identification. If the information you provide is reported or published, it will be done in a way that does not identify you as the source.

Discomforts and risks?

It is not anticipated that you will experience any discomfort or distress from participating in this research. If, however, you experience any distress from participating in the interview you can contact various mental health support providers such as:

Student Health and Counselling Service (for Massey University students only)
Free call or text 1737 (Need to Talk) number.
Youthline free text 234 or free call 0800 376 633
The Lowdown – free call 0800 111757 or text 562
OUTline – free call 0800 688 5463
Suicide Crisis Helpline – free call 0508 828 865
Lifeline– call 0800 543 354 (0800 LIFELINE) or free text 4357 (HELP)
Depression helpline – call 0800 111 757
Asian Family Services - 0800 862 342

Please contact the research or supervisor if you have any questions about the project.

Contact details below:

Researcher:
Luyu Qiu
luyu.qiu.1@uni.massey.ac.nz
[redacted]

Supervisors:
Dr. Simon Bennett
+6449793609
S.T.Bennett@massey.ac.nz

Prof. James Liu
+6492136279
J.H.Liu@massey.ac.nz

Committee Approval Statement

This study has been approved by an independent group of people called a Health and Disability Ethics Committee (HDEC), who check that studies meet established ethical standards. The Central Health and Ethics Disability Ethics Committee has approved this study.

Appendix D: Participant Information Sheet (Mandarin)

研究在新西兰居住的华人对待心理健康的态度和心理治疗经验

研究人员: Luyu Qiu

监督员: Dr. Simon Bennett and Prof. James Liu

伦理委员会参考号: 11512

参与者信息表

我的名字是 Luyu，作为我在梅西大学的临床心理学博士论文的一部分，我正在研究住在新西兰的中国人对新西兰心理健康的态度和心理治疗的经验。

项目描述：

这些年来，心理健康和心理治疗已发展成为研究身体健康的中心。尽管华人在新西兰已经是一个悠久的移民群体，但很少有人研究过中国移民群体对待心理健康的态度和自身的心理治疗体验。 我们的研究将探讨可能影响在新西兰居住的华人对"新"国家的心理健康和心理治疗的看法的不同因素。通过探索这些因素，我们希望建立一些关于如何调整心理治疗以更好地适应新西兰华人的需求，以及消除新西兰华人在获得心理健康的帮助时有可能面临的障碍。

您被邀请参与这项研究。是否参加是您的选择。如果您不想参加，则不必给出理由。本信息表将帮助您决定是否要参与本研究。

谁可以参与这个项目？

参与者将通过社交媒体和社区区域的海报广告招募。

纳入标准

- 16 岁以上的成年人
- 居住在新西兰的中国人

- 有；
    - 以前在新西兰接受过某种形式的心理治疗，包括但不限于：
        - CBT (认知行为治疗)
        - ACT (接受和托付治疗)
        - Mindfulness (正念减压法)
        - Group Work (小组心理咨询)
        - Counselling (心里咨询)
        - Addictions Support (上瘾质询)
    - 或过去曾经历过某种形式的情绪困扰但未获得任何心理健康支持/服务
- 居住在新西兰并可以进行面对面/网上面试（面试可以用英语或普通话进行）

如果您选择参加，您需要做什么？

如果您想参加，您将被邀请参加一次一对一的采访。时间和地点会提前和您商定。采访是面对面的形式，但如果有特别原因，可以通过 网上/Zoom 进行。如果因 COVID 限制，我们可以转为在线采访。采访内容是关于您在心理治疗方面的个人经历。为了添加对新西兰华人的心理治疗知识的了解，面试内容将包括有关您的心理治疗经历或寻求心理困扰帮助的经历和态度。面试时间不应超过一到两个小时。

您的回答将被录音并在稍后转录并进行检查以进行分析。请注意，您将有机会查看您的转录并发表评论，但不会进行更改，因为您的回答和想法是研究的重点。

由于采访中有可能聊到一些关于您以前经历过的压力，我理解这有可能会有点难以致辞。这项研究因该不会造成伤害或不适，但是，我承认这是一个严肃的话题，您可能有时会有难以讨论。在这采访中您若有不想提到的的事可以不用跟我说，可以随时停止采访，也有提问的权利。如果有需要，在采访时，会可以联系到一位注册临床心理学家，以确保参与者的安全。但是，请注意，这项研究的重点是探索您的经历，而不是一个心理辅导机会。如果您想退出研究，您可以随时退出。

如果您决定参加，您将需要签署一份同意书。您可以在阅读并签署参与者信息表和同意书后复印一份带走。面试结束后，您将收到一张 20 NZD 的代金券，以感谢您的时间和参与。

数据管理

在您允许的情况下，所有采访都将被记录在录音设备上。 这些数据将被安全的存储，只有研究人员和监督员才能接触这些信息。

为确保自主性，所有识别信息将从转录上、数据和研究报告中删除。 但是，您的回答可能会被用于研究出版物。 所有个人信息和数据将存储在受密码保护的计算机和梅西大学硬盘上。在研究完成的十年后，这些信息和数据将被删除。这些数据之所以会存储在梅西 H 驱动器中是因为梅西大学网络的数据会有备份、维护和管理、安全、复制和病毒防护。

参与者的权利

您没有义务接受此邀请。 如果您决定参加，您有权：

- 拒绝回答任何采访问题
- 在采访完成的两周后退出研究
- 在参与期间随时提出有关研究的任何问题
- 在采访中提供有关信息，除非您给予研究人员许可，否则不会使用您的姓名
- 在项目结束时获得项目结果的概括
- 在采访过程中随时要求关闭录音设备

保密性

您的身份将在整个研究过程中保密。 为此，您提供的信息将被编码，姓名将被删除，以减少被识别的机会。 如果您提供的信息被报告或发布，将不会显示您标识为来源的方式进行。

不适和风险？

预计您不会因参与本研究而感到任何不适或困扰。 但是，如果您在参加面试时遇到任何困难，可以联系各种心理健康支持提供者，例如：

Student Health and Counselling Service (只限于梅西大学的学生)

Free call or text 1737 (Need to Talk) number.

Youthline free text 234 or free call 0800 376 633

The Lowdown – free call 0800 111757 or text 562

OUTline – free call 0800 688 5463

Suicide Crisis Helpline – free call 0508 828 865

Lifeline– call 0800 543 354 (0800 LIFELINE) or free text 4357 (HELP)

Depression helpline – call 0800 111 757

Asian Family Service/亚裔家庭服务中心 – 0800 862 342

非常感谢您对本研究的帮助。 感谢您阅读此信息表并考虑此邀请。 如果您愿意参与和/或对此研究有任何疑问，请随时联系研究人员（详情如下）。

研究人员:

Luyu Qiu

luyu.qiu.1@uni.massey.ac.nz

[redacted]

监督员:

Dr. Simon Bennett

+6449793609

S.T.Bennett@massey.ac.nz

Prof. James Liu

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J.H.Liu@massey.ac.nz

委员会批准声明:

这项研究已经获得了一个名为健康与残疾伦理委员会 (HDEC) 的独立团体的批准，该委员会负责检查研究是否符合既定的道德标准。中央健康与伦理残疾伦理委员会已经批准了这项研究。

Appendix E: Participant Consent Form (English)

Investigating Chinese in New Zealand and Their Attitudes Toward and Experiences of Psychotherapy/Mental Health in New Zealand

CONSENT FORM

I have read the Participant Information Sheet, have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I understand that I will be completing an interview that will take approximately 45-120 minutes
- I understand that the interview will be audio recorded and transcribed for the purposes of analysis
- I understand that I will be gifted with a $20 voucher as a token of appreciation for participating in this research
- I understand that I will be given an opportunity to check the transcript of the recorded data
- I understand that my data will be stored securely until the completion of the study at a location at Massey University and access will be restricted to the researchers
- I understand that all data will be destroyed (disks erased and hard copies shredded) 10 years after the completion of the study
- I understand that my data will only be used for the purposes of the research and if the information I provide is reported or published, it will be done in a way that does not identify me as the source.
- I understand that my participation is voluntary, and I am free to withdraw from the project and withdraw any data provided up until two weeks after the interview without reason
- I understand that if I experience any discomfort or distress from participating in the interview I can contact the counsellors at Lifeline (0800 543 354) for support.

I wish/ do not wish to receive the summary of findings via email. YES / NO

My e-mail is _____

Declaration by participant:

I hereby consent to take part in this study.

Participant's name:	
Signature:	Date:

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher's name:	
Signature:	Date:

Approved by Health and Disability Ethics Committee (HDEC) on 22 November 2021.
Reference Number 2021 EXP 11512

Appendix F: Participant Consent Form (Mandarin)

研究在新西兰居住的华人对待心理健康的态度和心理治疗经验

同意书

我已阅读参与者信息表，了解研究的性质以及我被选中的原因。 我有机会提出问题，并得到了令我满意的答复。

- 我知道我将完成一次约 45-120 分钟的面试
- 我理解，为了分析的目的，采访将被录音和转录
- 我知道我将获得一张$20 的优惠券作为参与这项研究的谢意
- 我懂得我会有机会检查转录
- 我理解，我的数据将在梅西大学的一个地方安全存储，访问权限仅限于研究人员
- 我了解我的数据将被安全存储在梅西大学的硬盘里，直到完成研究，并且仅限研究人员访问
- 我明白所有数据将在研究完成十年后会被销毁（磁盘擦除和硬拷贝粉碎）
- 我知道我的数据只会用于研究目的，如果我提供的信息被报告或发布，它将以不会将我识别为来源的方式完成。
- 我理解我的参与是自愿的，我可以在面试后两周内自由退出项目，并无理由地提取所提供的任何数据
- 我理解，如果我在参加面试时遇到任何不适或困扰，我可以联系 Lifeline（0800 543 354）的辅导员寻求支持/帮助。

我希望/不希望通过电子邮件收到调查结果。　　是/否

我的电子邮件是：-

_____

参与者声明:

我同意参加这项研究：

参与者姓名：_____

参与者签名：_____ 日期：_____

研究组成员声明：

我已经向参与者口头说明了研究项目，并回答了参与者的问题。 我相信参与者了解研究并已同意参与。

研究组成员姓名：_____

研究组成员签名：_____日期：_____

Health and Disability Ethics Committee (HDEC/健康与残疾伦理委员会) 批准日期 2021 年 11 月 22 号

参考编号 2021 EXP 11512

Appendix G: Interview Schedule (English)

Interview schedule

Begin interview with explaining PIS/CF, then ask what language they prefer to have the interview in, make sure participant is feeling comfortable and settled in

Note: Questions are not necessarily asked verbatim as written on this schedule, this schedule acts only as a guide to which areas I would like to cover, however, it is acknowledged that during the interview, it will mostly be participant led and questions will arise and carry from what the participant's last comments were

Section A – Introduction and background

- What is your age, gender, occupation, how long they've been in NZ for, language of choice.? (if comfortable sharing)
- What are your thoughts on mental health? How would you define it?
    - How was this view formed? What was it influenced by?
- How long ago did you finish therapy?
- How long was the duration of the course of therapy?
- What were the causes of seeking out therapy?/ What brought you to therapy?
- If known, what type of therapy was it? (ACT, CBT, mindfulness, group work etc.?)
- Did you have any techniques or skills that you used to cope before picking out a service?

Section B – How did you pick the service you received?

- *Prompts for myself:*
    - *How did you find out about the service?*
        - *Promotional resources, GP referral, word of mouth by friends and family*
    - *What factors influenced your decision to use this service?*
        - *Location, language of staff, environment, cost?*

- *Did you prefer someone with a high professional standing? (e.g. psychiatrists as opposed to psychologists and counsellors)*
- *Did you tell your family first about this? Or friends?*
- *Was your family involved in the process?*
- *Explore family dynamics/relationship?*

Section C – Overall experience of psychotherapy

- What did you expect going into therapy?
- Were your expectations met or not met, how so?
- What did a typical therapy session look like for you?
- What kind of things did you do with your therapist during a typical session?

Section D – Specifics of therapy that were helpful

- What parts of therapy did you find particularly helpful?
  - What made these aspects helpful?
  - What kind of things did the therapist do to make you feel more supported? *(what makes a therapist good?)*
  - What physical aspects (e.g. arrangement of room) made you feel supported?

Section E – Specifics of the therapy that you felt could be improved

- What parts of therapy did you find not so helpful, areas that could have been skipped?
- Looking back, what would you change about your experience that you feel would have made it more effective/enjoyable/comfortable?
  - Could you give an example of this?
- In the future, what do you think would cause you to seek therapy again, and what would you look for in selecting services?
- Has your understanding of psychotherapy changed since receiving this?

Appendix H: Interview Schedule (Mandarin)

访谈安排**:**

开场流程

1. 解释参与者信息书**(PIS)**及同意书**(CF)**

2. 询问受访者偏好的访谈语言

3. 确认参与者处于舒适状态

注：问题无需严格按照本提纲逐字提问，本提纲仅作为讨论领域的指引。实际访谈将以参与者为主导，问题将根据受访者上一回答自然延伸。

A 部分：背景信息

• 基础信息（若愿意分享）：

- 年龄、性别、职业、在新西兰居住时长、首选语言

• 对心理健康的认知：

- 您如何定义心理健康？

- 这种观点是如何形成的？受哪些因素影响？

• 治疗时间信息：

- 治疗结束距今多久？

- 总治疗时长？

• 求助动机：

- 什么原因促使您寻求心理治疗？

• 治疗类型：

- 您接受的是哪种疗法？（如 **ACT**、**CBT**、正念、团体治疗等）

• 既往应对方式：

- 在接受专业服务前，您是否有自用的应对技巧？

B 部分：服务选择过程

• 服务发现途径：

- 如何获知该服务？（宣传资料、家庭医生转介、亲友推荐等）

• 决策影响因素：

- 选择该服务时考虑哪些因素？（地理位置、工作人员语言、环境、费用等）

• 专业资质偏好：

- 是否更看重治疗师的职称？（如倾向精神科医生而非心理咨询师）

• 社会支持：

- 您先告知了家人还是朋友？

- 家人是否参与治疗过程？

- （需探讨家庭关系动态）

C 部分：治疗整体体验

• 初始预期：

- 您对治疗有何预期？

• 预期吻合度：

- 这些预期是否得到满足？如何体现？

• 治疗场景：

- 典型的治疗会话是怎样的？

- 您与治疗师通常会进行哪些活动？

D 部分：有益的治疗要素

• 有效性评估：

- 哪些治疗环节特别有帮助？为什么？

• 治疗师特质：

- 治疗师哪些做法让您感到被支持？（优秀治疗师的特质）

• 环境因素：

- 哪些实体环境布置（如房间陈设）让您感到安心？

E 部分：待改进领域

• 局限性分析：

- 哪些治疗环节效果有限或可省略？

• 优化建议：

- 回顾经历，您认为哪些改变能提升疗效/舒适度？（请举例）

• 未来考量：

- 未来何种情况下会再次寻求治疗？选择服务时会注重哪些因素？

• 认知变化：

- 接受治疗后，您对心理治疗的认知是否有所改变？

Appendix I: 175.993 Thesis Part C: Research Case Study

Massey University

Clinical Psychology

RESEARCH CASE STUDY 1

My Doctoral Research and Its Contributions to my Clinical Practice as an Intern at Kari Centre

Candidate: Luyu Qiu

Clinical Psychology Programme Massey University

Student ID:

Setting: Kari Centre

Supervisor: Dr. Francisca Montedonico Godoy

This case was completed during internship at Kari Centre in 2023 and represents the work of the candidate

---

Supervisor	**Student**
Dr. Francisca Montedonico Godoy	**Luyu Qiu**
Senior Clinical Psychologist	
_____	_____

Date:

Abstract

This case study aims to explore and reflect on the contributions that my doctoral research had on my clinical practice during my year of internship at a child and adolescent community mental health service. My doctoral research explored the experiences of Chinese New Zealanders regarding the therapeutic interventions they received in New Zealand for their mental health concerns. This year, I worked as an intern psychologist for a child and adolescent community mental health service where my clients have mostly been adolescents, infants and their parents, some of which identified as Asian/Chinese. This case study will follow a format where I will first give a brief overview of my research and then a summary of my internship. This case study will conclude with a discussion around my reflections regarding how my research has contributed to my clinical practice the child and adolescent mental health service.

Key Words: Chinese New Zealanders Mental Health, Child and Adolescent Community Mental Health (CAMHS)

Doctoral Research Overview

I am supervised by Dr. Simon Bennett and Prof. James Liu for my doctoral research, titled: Chinese in NZ and Their Attitudes Towards and Experiences of Psychotherapy/Mental Health in NZ.

Origins of Research Idea

Growing up in New Zealand (NZ) as a Chinese immigrant who immigrated at young age, I was exposed to both the "Chinese", eastern way of experiencing/navigating the world as well as the "NZ" more westernized way. This split has impacted my own worldviews in a way that I believe is quite unique and in a way, conflicting. As I navigated the world, I came across many areas where the two different perspectives have caused me to respond and think of issues differently to others around me. In particular, as I grew older and became interested in psychology and mental health issues, both in my personal life and exposure through different media formats, I began to wonder, what do others who have a similar background to me think about these issues.

I was privileged enough to pursue studies in clinical psychology, this presented me with an amazing opportunity to bring my wonderings into fruition through my thesis research. Through discussions with my supervisors and investigating existing research, the current research was refined to its present version where the focus will be on exploring the experiences of therapy that Chinese New Zealanders experienced in NZ.

Study Rationale and Aim

Chinese in NZ are a unique population in NZ that has significantly increased in population size since the 1860s (2018 census totals by topic – national highlights, 2019). This population come with a unique cultural background and own set of values with their own set of mental health concerns (Ho & Ho, 2003; Ho et al., 2013; Ning & Feng, 2021). Furthermore, even within this population there is great heterogeneity with clear differences between those who were earlier immigrants to NZ and those who have more recently immigrated (Bartley, 2010; Murphy, 2003). Being an immigrant in a new country, they are presented with situations where their mental health could be compromised while having limited access to services that could provide support (Bhugra & Becker, 2005). While there have been studies that investigated, the potential barriers faced by Asians in NZ to accessing mental health support, there is limited research that explores how the Chinese in NZ experience psychotherapy in NZ (Ng & James, 2013). Additionally, only a few studies have explored how culturally adapted CBT could benefit Chinese clients in NZ, with most research in this area being conducted overseas in America Americans (Ching 2021; Iwamasa et al., 2019). Given that NZ is a different environment to America, different factors could influence the experiences of psychotherapy by the Chinese population and thus impact the effectiveness of the intervention. Moreover, many of these studies only focused on the end results of therapy to gauge its effectiveness, while little attention is given to how the clients' themselves experienced therapy, what their expectations and thoughts were regarding the process (Ching, 2021; Iwamasa et al., 2019; Lin, 2002; Williams et al., 2006). This results in a one-sided perspective and more investigation should be given to the consumer experience. Furthermore, most research tends to focus on only one type of psychotherapy, this current research would aim to draw common factors across all psychotherapy that work well with the different Chinese clients in NZ. To date, there have been no studies that examine their unique

experiences of psychotherapy in NZ from a consumer viewpoint; the current research will aim to bridge this gap.

The existing literature around what the experiences of psychotherapy are for Chinese in NZ are scarce, with the focus mainly on CBT and single case studies (Ching, 2021; Iwamasa et al., 2019; Lin, 2002; Williams et al., 2006). Other literature explores mental health with Asians as an entire population which research has already suggested to be a surface investigation that requires further exploration due to the immense diversity amongst those who identify as Asian. Furthermore, studies in America that focus on Chinese and their experiences of psychotherapy mainly use quantitative research methods which evaluates the effectiveness of certain psychotherapies with certain disorders but fails to explore in-depth factors that contribute to the effectiveness of these psychotherapies (Ching, 2021; Iwamasa et al., 2019). Furthermore, due to the current environment where there has been an increase of racism and discrimination experienced by Asians in NZ, it is even more important to increase the focus on their mental health and psychotherapy experiences (Bartley, 2010; Bo & Feng, 2020).

This current research aimed to identify factors of psychotherapy in New Zealand that are effective for the diverse Chinese population living in New Zealand via in-depth interviews. It is expected that those who are more assimilated would have different experiences and expectations towards mental health and psychotherapy compared to those who are newer immigrants. This research aimed to explore what their experiences of psychotherapy were to identify aspects of the process that they found effective and resonated with them. Through identifying these factors, new knowledge regarding aspects of psychotherapy can be targeted and adapted to be more effective forms of psychotherapy for the different groups of Chinese in NZ could be attained, thus improving the level of mental health support given to them. This in turn can improve health outcomes for the diverse Chinese population living in New Zealand. Furthermore, by identifying existing barriers that are preventing the Chinese population in New Zealand from accessing mental health services, future interventions can be implemented to eliminate these barriers and thus improve the health outcomes of Chinese in New Zealand by aiding them to find the right kind of support when required.

Methodology

A qualitative approach was taken for this research, using a thematic analysis where the focus is to explore the subjective “lived” experiences of individuals as there has been little research in this area prior. Data will be generated through semi-structured interviews conducted and then transcribed by researcher.

Participants

The current study recruited 14 participants via a snowball sampling method through word-of-mouth amongst Chinese communities and university/community clinics. Posters and ads (physical and online) were posted to online communities such as Asian Family Services as well as circuited through existing Asian health communities. An online survey attached to the posters was completed by those were interested to ensure that the participants met selection criteria. Criteria for inclusion were if the individual identified as a Chinese New Zealander and had received some form of therapy while in New Zealand. The criteria was

intentionally kept broad as it was acknowledged due to the sensitivity of the discussion topic (mental health and therapy) and cultural influences, recruiting could be difficult if the criteria was quite limited.

Procedure

Participants who fit the criteria were invited to participate in a 60-90 minute long semi-structured video either in person or via zoom and were compensated with a $20 voucher as koha. Participants were provided with a participant information sheet and consent form to sign prior to the interview beginning. Participants answered a series of questions regarding their experiences and attitudes towards mental health and therapy and could answer as little as much as they would like. Participants had the right to skip any questions they did not want to answer. Details of mental health services were given to the participants in the participant information sheet for their access given the sensitivities of the discussions. A trained clinical psychologist was available over phone during the interview process should the need arise.

Data Analysis

The interviews will be recorded on a recording device in either English or Mandarin and then transcribed verbatim. The transcripts will be kept in a secure storage and identification of participants will be through pseudonyms. These transcriptions will then be uploaded into the software, QRS NVivo for data analysis. Thematic analysis will be utilized to analyse the transcribed data where common themes will be identified amongst all participant responses. The analytic process will follow the six-phase steps described by Braun and Clarke (2006). By using this method, this research will be driven by the data rather than pre-existing conceptual framework (Braun & Clarke, 2006). This approach matches well with the current study as little research has been conducted which investigates the Chinese in NZ and their experiences of psychotherapy.

Ethics

An ethics application for this research was made and approved by the Central Human and Disabilities Ethics Committee (HDEC) on the 22nd of November 2021, reference number: 2021 EXP 11512.

It was anticipated that the risk of harm to participants whilst participating in this study will be minimal. However, it is acknowledged that topics that may be discussed in the interviews can be sensitive in nature and therefore extra steps were taken to ensure the safety of the clients. The interviews were conducted in a sensitive manner and participants were given verbal and written information regarding what rights they were entitled to. In the unlikely event that a participant started to feel distressed, the interview could be paused until the participant felt alright enough to begin again or terminated altogether. A clinical psychologist was available via phone throughout the interview. Participants were also provided with an information sheet of services or contact details of services that could be contacted if the participants required further support after the interview.

Participants were provided a consent form with details of participation and acknowledgement that should they wish to withdraw from the research, they were able to do within two weeks after the interview took place.

A data management plan was composed which included the details of how the data from participants can be kept in confidentiality. All data collected throughout this proposed study will be kept confidential. Only the direct research team will have access to the data and all information collected from participants will be coded for anonymization of the data. The audio recordings of the interviews will be transcribed and upon completion, will be deleted from the recording device. In compliance with HDEC requirements, all data will be secured safely for 10 years after completion of this research and electronic copies will be stored in password-protected devices. If this research were to be published, no identifying information of the participants will be included.

Clinical Psychology Internship Reflections

My internship began in late-February 2023, at a child and adolescent community mental health service where the population serviced was mainly aged from 0 to 18 years of age experiencing moderate-severe levels of mental health difficulties. This service accepted referrals from a range of sources including GPs and school counsellors. I was able to work in a range of teams across this service, which included assessment and treatment of young people experiencing mental health difficulties such as depression, anxiety, OCD as well as participate in groups as a facilitator. I was also involved in some neurodevelopmental assessments for Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder and Intellectual Disability as well as work with parents and the young person aged from 0-4 years old. However, I had limited experience working with those who identified as a Chinese New Zealander. Additionally, the target population of my research focused on those who were 18 years old and above. Despite these two conditions, I was still able to identify many reflections that stemmed from my research which impacted my thinking and clinical practice during my internship year. The subsequent discussion will focus on my reflections of how my research contributed to my clinical practice.

Diversity and Commonalities Amongst Chinese New Zealanders (NZers)

A key theme which emerged from my research was the diversity across the Chinese NZers population and how unique each individuals' experience is. As a researcher who also identified as a Chinese NZer, I was aware that diversity would be expected in this population but was not aware of the specifics and their impact. For example, the participants ranged in gender, age, how long they have been in NZ for and the context that immigration occurred for the individuals. All of these factors appeared to contribute to the formation of their worldviews and attitudes towards different aspects of their life, such as mental health. Although there were commonalities (such as all identifying as Chinese NZers and all have experiences with mental health services in NZ) there were clear differences in their experiences of residing in NZ and thus in the formation of their mental health concerns and their experiences of mental health services. Additionally, it was also extremely interesting to see some similarities as well with this population, particularly in relation to mental health. To begin, although the immigration experience was different for participants, almost all reported some experienced some stress due to this circumstance. For example, being the child of immigrants had significant impacts on their identity formation and conflicting family values, leading to mental health issues. Those who immigrated themselves at an older age also resulted in similar stressors of conflicting values leading to mental health issues. The distance

from their home country also served as a significant stressor which impacted the mental health of participants.

Taking these factors into account during my internship year, I was vigilant of not generalizing or making assumptions of a client's experience simply by recognizing their ethnicity as a Chinese NZer. I was able to enter assessments with an open mind, careful of not stereotyping or jumping to conclusions about what may have contributed to a client's presentation. However, I was also able to keep in the back of mind a substantial list of potential stressors that could have contributed to the client's presentation given their identity of a Chinese NZer. This allowed me to relate more easily to the clients but also show respect in listening to their experiences. For example, one client whom I saw during the course of my internship had Chinese listed under ethnicity on their file. I prepared for this assessment with their cultural background in mind, however, did not make any assumptions on what she identified as and through the course of assessment, the client shared that they did not identify with their Chinese background at all. Hence, this provides a clear example on how diverse the population in NZ is and to keep an open mind prior to meeting the individual.

Family Dynamics in Relation to Mental Health

All my participants were either in their early 20's or well into adulthood, however, many reported difficulties in their differing types of relationships which contributed to their mental health difficulties. Many participants reflected childhood experiences where they were placed in situations which were stressful, such as being part of an immigrant family. Other participants spoke about how the typical "Chinese" family can be invalidating towards emotional difficulties, resulting in a pattern of unhealthy relationships. Furthermore, many participants identified that relationship issues had acted as a significant stressor which led to mental health struggles.

This finding was of particular interest for and had strong implications in my internship year at a CAMHS. Given that family dynamics is a strong consideration when exploring and treating mental health issues in child and adolescent populations, having pre-existing knowledge around how this can also be a significant factor for Chinese NZers mental health allowed me to be more aware of enquiring around this in sessions with clients. Furthermore, this provided me insight into the significance of family dynamics in general for mental health in youths and awareness around the different dynamics that could play out between the parents and the child.

Barriers Towards Mental Health

Through my research, it was evident that significant barriers still exist for Chinese NZers in accessing mental health services. Although these participants have all had some form of mental health support, the majority also shared their views on the initial barriers in accessing support at an earlier stage of their mental health issue. Firstly, those who were newly immigrated struggled with the language barrier in accessing mental health support as often times, mental health discussions involve nuanced communication. Moreover, participants identified stigma and shame as another major barrier, especially for those who are of younger age and had family influence over them. Additionally, lack of understanding in general of mental health due to different cultural perspectives contributed to mistuning of mental health struggles as a physical illness and lack of awareness of the potential mental health services available to the individuals.

Through these interviews, it reiterated to me the importance of addressing these barriers when working with the Chinese NZer population. Upon reflection, I feel that I was more aware of these barriers for clients during my internship year which influenced me to address issues earlier on. For example, when working with a Chinese family, I was careful to clearly explain what our service can offer and what the process may involve. Furthermore, I used more validation to address the potential shame they may experience from coming to the service. Moreover, I was mindful of the potential lost in translation of terms so tended to pick simpler terms in English to use when explaining to clients the process of therapy.

Research Interviews and Clinical Practice

During my years of clinical training, I was given opportunities to practice my clinical interviewing skills, either through a roleplay format or experiences during my placements. The semi-structured interviews that I conducted for my research gave me an opportunity to work on the clinical skills of using open-ended questions and a flexible structure to encourage participants to express themselves freely. These shared similarities with the clinical assessments that I frequently conducted in my internship year given the exploratory nature and commitment to understanding individuals' subjective experiences. Through the research interviews, I was able to practice prioritize establishing rapport and trust between participant/client and I, where I was able to facilitate an environment conducive to open communication. During the research interviews I learnt the importance of using skills to build rapport with the clients, enough so they feel heard and comfortable enough to share their lived experiences and trust the process. I learnt to be adaptable in these interviews, as even though I had a semi-structured interview schedule, often times, the participants offered information freely and I learnt to navigate the interview in a way that also made sense to the participant. This provided me with some confidence heading into the first couple of assessments during my internship. As I reflect on this now, I note that I was more nervous during the initial assessments during internship, however, as I had previously conducted the research interviews, I did not feel too foreign and uncomfortable. I was able to build on these skills during the course of my internship and improve in my clinical assessment ability.

Final Reflections

As a clinical psychologist, the scientist-practitioner model acts as a defining characteristic where to provide the best and clinically sound treatment possible, we are expected to use evidence-based practices. By conducting this research, I was able to reflect on the scientist-practitioner model by exploring how good research can be conducted and what to look out for in reviewing research for treatments. Furthermore, this research provided me with invaluable knowledge around working with Chinese NZers in the mental health field as well as allowing myself to reflect on how my own identity can impact my clinical practice. Through the research and the internship year, I feel that I have truly grown as a professional and in my clinical practice.

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