Lived Experience of Recovering from Mental Distress: People from Chinese Cultural Backgrounds Living in Australia

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Statement of Originality

This is to certify that to the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.

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Abstract

This study explores the lived experiences of mental distress among people from Chinese cultural backgrounds in the Australian social context, through an intersectionality lens based on social constructionism and critical race theory on mental health. It also delves into how these people have responded to challenges in mental distress and navigated their roles and identities during their recovery journeys.

The study explores the social determinants of mental distress, participants' help-seeking patterns, complex perspectives on recovery, and discusses the roles of social workers in supporting Australian Chinese people's recovery. By conducting 19 in-depth semi-structured interviews and applying thematic analysis, this qualitative study reveals three major themes: (1) power imbalances and mental health; (2) heterogeneity and help-seeking patterns; (3) contested notions of recovery.

Although this study applied social constructionism and critical race theory on mental health to explore the recovery pathways of mental distress, participants were impacted by both biomedical perspectives and cultural interpretations of mental distress and shame. The findings reveal that much more attention is needed to build supports for Chinese people experiencing distress in Australia, whose voices are rarely heard in mainstream mental health conversations.

This study outlines implications for Australian policies and Australian mental health care systems, mental health service providers and practitioners, informal supports, Australian social work practice, and potential further research. The research found that the Australian social context and the Chinese cultural context intersected in the participants' complex lived experiences of mental distress, with implications for how power dynamics, identities and roles can be understood during experiences of distress and recovery.

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Abbreviations

ABS - Australian Bureau of Statistics

AIHW - Australian Institute of Health and Welfare

AOD - Alcohol and Other Drugs

CALD- Culturally and Linguistically Diverse

CHIME - Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment (Leamy et al., 2011)

CIMH - the Cultural Influence on Mental Health model (Hwang et al., 2008)

COS(s) - Chinese overseas student(s)

COVID-19 - Coronavirus Disease of 2019

CRT - Critical Race Theory

DSM - The Diagnostic and Statistical Manual of Mental Disorders

DV - Domestic Violence

GP - General practitioner

HIV - Human Immunodeficiency Virus

MBS- The Medicare Benefits Schedule

MHCC – Mental Health Coordinating Council

NDIS - National Disability Insurance Scheme

NSW - New South Wales

STIs - Sexually transmitted infections

TA - Thematic analysis

TCM – Traditional Chinese Medicine

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CHAPTER 1 Introduction

The introductory chapter of this study sets the scene by providing a background on the research and discussing the personal motivation behind conducting the study. The chapter also offers a concise overview of the research aim and the main research question. Furthermore, it defines key terms, summarises the theoretical framework, describes the methodology used throughout the study, and highlights the significance of the research.

1.1 Background and context of the Study

Australia is an ethnically diverse nation. In 2021, Australia had significant ethnic diversity, with over 30% (8.4 million) of its population born outside the country (Appendix 4, Table 1. Country of birth of person by age, ABS Census of Population and Housing: Cultural diversity data summary, 2021). Almost half (49%) of the population have at least one parent born overseas or were born overseas themselves, which means that at least half of the Australian population have culturally and linguistically diverse (CALD) backgrounds. Approximately 2 in 5 (8.6 million) Australians between the ages of 16 and 85 have been diagnosed with mental illness at some point in their lives (AIHW, 2023). However, Minas et al. (2013b) challenged the adequacy of the representation of CALD populations in national data collections. They highlighted the general neglect of CALD-related issues in the design and reporting of Australian studies. In the recent overview report of CALD Australians, AIHW (2022) point out the discrimination and barriers that the CALD population are exposed to when dealing with the health and welfare systems, including the language barrier, non-Western understandings over health, and access and navigation of the systems. These could also be experiences that are relevant to Chinese people in the Australian context. People from Chinese cultural backgrounds living in Australia are the third largest group in the culturally and linguistically diverse population, accounting for 700,000 people (Appendix 3 &4). Despite the considerable growth of literature pertaining to mental health among the Chinese population in general over the last three decades, there is insufficient evidence relating to the mental wellbeing of people of Chinese ethnicity in Australia.

From the limited national data of mental health of Australian Chinese, a recurring argument around the low uptake of mental health services for the Chinese population is that Chinese people have poor mental health literacy. It is assumed that Chinese people are less likely to identify and/or report mental distress because of limited understandings (X. Lin et al., 2016; Uygur et al., 2011; Wong et al., 2012; Wong et al., 2010). An increasing body of studies have shed light on the cultural factors that contribute to people's understanding of mental distress (Marsella & White, 2012; Marsella & Yamada, 2000; Niaz & Hassan, 2006). The mainstream Confucian knowledge has been deeply ingrained into Chinese people's notions of mental health through its strict ethical and moral hierarchies and systems (Lam et al., 2022; Tabora & Flaskerud, 1997; Yip, 2003). Therefore, this study explores the perspective that culture could wield a substantial influence on how Chinese individuals perceive, comprehend, and articulate distress experiences. Furthermore, the limited utilisation of mental health services may be indicative of culturally linked meanings. Starting from this point, this study aims at a more nuanced exploration of the following questions: How do cultural factors impact the way in which Chinese people understand mental distress? How do Chinese people who are brought up in Chinese cultural contexts experience, understand and interpret their lived experiences of mental distress in the Australian social context? How do Chinese people understand the recovery journey? Moreover, given that the Chinese diaspora came from a range of regional, cultural and religious, class, educational and language backgrounds, with different immigration experiences (Gungwu, 2004), many studies have downplayed the significant heterogeneity of the subgroups sharing the same Chinese ethnic label. Given the limited understandings on the Australian Chinese population's mental wellbeing, it is worth examining how heterogeneity is reflected in the Australian social context, with a commitment to contribute new information for social work profession and culturally sensitive practice concepts (Chan et al., 2004; Chan & Ritchie, 2011) for the public health system.

My postgraduate social work placement experiences in a psychiatric hospital have also acted as an initial motivation to explore the lived experiences of people with mental distress. I undertook my placement in the biggest psychiatric hospital in Guangzhou, China, which I believe had – and might still have –the highest comprehensive service level in southern China. The branch of the hospital which was a residence for long-term hospitalised people was far away from the city and crowded suburbs. People living nearby were profoundly impacted by the long history of stigmatizing hospitalised people with mental distress as 'mad, crazy and dangerous people.' Long before I commenced my placement in the hospital, it had been considered ominous and dangerous.

Two hospitalised people I worked with during my placement were particularly memorable. The first had been living there for more than 40 years. He was a boy when he was first involuntarily admitted to the hospital. When he was to be discharged, his parents passed away or disappeared for some reason. As he was considered not able to live independently, he had to stay in the hospital for the rest of his life, as no relatives were eligible to collect him from the hospital. The second person was an alumnus from the university where I was undertaking my Master's degree. He recounted that his admission was an outcome of a political confrontation in 2000. Since then, he had mostly stayed in the hospital and rarely stepped out of the hospital area. It was shocking for me to communicate with them for the first time, when I realised that their long-term institutionalisation and experiences of social exclusion had dehumanised and restricted lives. The hospital was potentially the final destination of their lives, with repetitive daily activities into the foreseeable future. It was hard to conclude whether this was a legitimate form of care. They were allowed to stay in a safe place with three meals and care provided daily. On the other hand, they were stripped of their autonomy and freedom. I was impressed by the phrase 'hun san dun fan' (混三顿饭), which translates to staying and doing nothing but waiting to be fed three meals a day, with each day passing in the same way.

The other memorable aspect was the dominant biomedical practices and values that prevailed across the hospital. For example, doctors were afforded high status and the power to prescribe medications for each patient. I could see a three-layer trolley filled with small bottles of medications with people's names on them every time after the meals. I also heard that the doctors frequently prescribed medications to prevent constipation. Hospitalised people did not have much power to question the prescribed treatment, because the national welfare insurance covered most of the amount. As time went by, there was very little space to ask questions and compliance was expected.

Patient-expert relationships in the hospital indicated a power imbalance between hospitalised people and medical practitioners. Providing quality services and humane care was stated as a rhetorical commitment, but hospitalised people were eventually put in a position where they experienced force and coercion. Some hospitalised persons spoke about their experiences of being tied to the wheeled bed when they were considered to be 'acting crazily.' Some people said they had to wear diapers when limbs were tied on the beds, because they were not allowed to get up, go to the bathroom, let alone do personal self-care.

There was discrimination, not only in the daily interactions between medical staff and the hospitalised people, but also among medical peers themselves. Working in a psychiatric hospital carried less status than working in general hospitals. Stereotypes and stigmas around mental health services came from peers, families, friends and others. The pressure of working with hospitalised people may contribute to further coercive practices. Even though payments in mental hospitals were generally higher than in general hospitals, these hospitals were always short-staffed.

Through my experience of working in a psychiatric hospital placement, I developed a curiosity about the experiences of individuals who were hospitalised as 'mentally ill patients'; I wanted to understand their experiences of mental distress more deeply and holistically. This questioning was the foundational impetus for undertaking the present study. Based on the fact that Australian Chinese population represents a high proportion of migrant communities, the currently limited qualitative study in similar area, and my own Chinese cultural background, the Australian social environment affords an opportunity to thoroughly explore these questions and the latest data for mental health research concerning the Australian Chinese population.

1.2 The aim and research questions of the study

This study examines the first-person accounts of people of Chinese cultural backgrounds experiencing mental distress within the Australian social context. It also delves into how participants responded to challenges in mental distress, and the strategies they used to navigate their roles and identities as they progressed towards recovery. While a broad range of lived experiences of mental distress among Chinese people has been discussed in other major Western countries (e.g., U.S., UK and Canada) (Cheng et al., 2015; Dong et al., 2012; Law et al., 2021; Tang & Pilgrim, 2017), lived experiences within the Australian context have rarely been examined. Written from and for the social work profession, this study also aims to provide information of Chinese people's understandings of recovery and the perspectives on mental health services for public health system.

Starting from the academic and personal contexts, this study is interested in the questions: How do people from Chinese cultural backgrounds experience mental distress? What are their perceptions of mental health services and support? How do they understand and construct recovery? What knowledge might contribute to improving social work's support for them? The overarching research question underpinning this study is: What are the lived experiences of mental distress among people from Chinese cultural backgrounds living in Australia, and how do they understand the recovery journey?

1.3 Explanations of the key terms

As previously stated, this study aims to challenge the biomedical paradigm of mental health, which attributes distress to individuals' internal biomedical imbalances and genetic deficits. As a result of the biomedicine discourse, individuals experiencing mental distress may be at risk of being pathologised and positioned as passive recipients of medical diagnoses and interventions (Clement & Sumeet, 2017; Coppock & Dunn, 2010b; Ramon et al., 2007). In this regard, language is particularly important when it relates to a complex discussion of mental health and recovery. Drawing inspiration from the recovery-oriented perspective, the present study aims to employ language that conveys a sense of positivity, strength, hope and opportunities (Mental Health Coordinating Council, 2018). By doing so, the study seeks to redirect attention towards the social, cultural, and structural factors that play a pivotal role in shaping individuals' lived experiences with mental distress and the recovery journey.

1.3.1 Understanding mental distress through multiple lenses

The terminology used to describe an individual's mental health condition can vary depending on philosophical, theoretical, and ideological perspectives. Mental illness, mental disorder, mental health problems, and mental distress are among the terms used. By exploring the lived experiences of mental health challenges, this study carries on the tradition of the social model of disability and the ideas from the consumer–survivor–ex-patient movement (the c/s/x movement), which seek to privilege people's lived experiences and understandings of mental distress.

The social model of disability posits that distress should not be seen as an inherently negative consequence of biological conditions. Instead, it can be considered a coping or survival mechanism employed by individuals to navigate specific challenging experiences. People experiencing distress may have understandable feelings of powerlessness in relation to issues such as gender and sexuality (including marriage, sexism, and homophobia), race and ethnicity, cultural differences, economic status (including poverty and unemployment), ageism, disability, social relationships, and other life-altering events, such as bereavement, loss, isolation, and violence(Coppock & Dunn, 2010a; Karban, 2016; Tew, 2004a). Therefore, the concept of distress within the social model of disability decentres the absolute knowledge of mental health from professionals' perspectives, shifting to a position where service users, family members, and important others should be seen as crucial holders of experiential knowledge, significance and meanings, and authentic expertise regarding their lived experiences (Tew, 2004b; Wallcraft, 2004).

Broader critiques of the biomedical model encourage a wider exploration of multidimensional social aspects regarding mental health in contemporary contexts. Inspired by the *Routledge International Handbook of Critical Mental Health* (Cohen, 2017c), this study argues that understandings of mental distress are likely to be insufficient if the intricate interplay of psychological, political, socioeconomic, cultural, and religious factors is not taken into account.

To ensure consistency and adherence to respectful language, the terminology employed in this study will be informed by the *Recovery Oriented Language Guide – Second Edition Revised* (Mental Health Coordinating Council, 2018*)*. The term 'mental distress' is favoured in this study as it corresponds with the recovery-oriented perspectives and epistemological position that I adopt regarding the need for a social perspective on distress. The use of this term acknowledges the participants as individuals with valuable experience to share, in contrast to a deficit-based approach.

1.3.2 Participants: People from Chinese cultural backgrounds

Instead of limiting the examination of Chinese identity to nationality, this study broadens the definition to encompass a wider range of Chinese people with demographically diverse features, addressing a gap in previous research that limited the participants' pool with narrower or unmatched definitions of the sample population. For example, some are limited to people from mainland China (X Lin et al., 2016), overseas-born background (Lu et al., 2014), first-generation migrants (Wong et al., 2017), or recruited Melbourne participants with convenience sampling (Pan & Keung Wong, 2011; Poon et al., 2013; Wong et al., 2017); none of these sufficiently represent the claimed 'Chinese people in Australia' population.

The intended participants for this study were those who identified as having Chinese cultural backgrounds, were living in Australia, had experienced mental distress, and were over 18 years old. There were no constraints on any other demographic features, such as class, education level, age, gender, sexual orientation, occupation, marital status, religion, immigration status, language(s) spoken (Cantonese, Mandarin and/or English).

Additionally, it is important to clarify some terms that this study applies to describe participants. Nowadays, 'consumer' is a widely accepted term in the Australian social context (Mcdermott et al., 2012; Reavey et al., 2013). In the MHCC guideline (MHCC, 2018), consumers, people with lived experiences of mental distress, people diagnosed with mental illness and lived expertise are used interchangeably in the context. Patients, mentally ill people, or people with mental illness are not used.

1.3.3 The Concept of Recovery

From the deinstitutionalisation movement onwards, the notion of recovery was no longer limited to the biomedical criteria that suggested the biomedical correction of body dysfunctions (Mcdermott et al., 2012). Deinstitutionalisation enabled many people with mental distress to live in a safe and familiar community environment free from confinement (H. Richard Lamb & Leona L. Bachrach, 2001; Piat, 1992). Since the 1980s, formal mental health services in Western countries have increasingly acknowledged consumer efforts to promote recovery in a form beyond the professional vision of recovery, and thereafter triggered the growth of consumer-led, but more often, consumer-involved recovery services. It was hoped that recovery for mental health consumers could be a full human experience with meaningful identity processes (Deegan, 1996; Timander et al., 2015; Topor, 2001).

It has been argued that the journey of recovery becomes more likely when individuals are supported to recognise their current situation within the larger socio-political contexts, and receive resources and support to facilitate meaning-making recovery (Slade & Longden, 2015). This interpretation of recovery challenges biomedical understandings, which predominantly regard recovery as the cessation of symptoms and an extended period of non-recurrence (Anthony, 1993; Jacob, 2015; Wallcraft, 2004). By extending and re-shaping the definition of recovery to include regaining hope, strength, self-resourcefulness, self-determination, advocacy of wellbeing and improved quality of life (Ellison et al., 2018; Repper, 2003; Slade, 2009), recovery encompasses meaningful engagement with supportive social relationships and connections through accessing more constructive forms of social capital (Marino, 2016; Provencher & Keyes, 2011; Repper, 2003).

1.4 Summary of the theoretical framework and the Methodology

The present thesis adopts an epistemological position that prioritises sensitivity towards multiple ways of comprehending mental distress, influenced by varying backgrounds, experiences, worldviews, and values. The study seeks to explore diverse lived experiences of mental distress and recovery understandings among people from Chinese cultural backgrounds residing in Australia. Therefore, social constructionism and critical race theory are well-placed to provide the theoretical foundation for answering the research question.

Social constructionism posits that the notion of an objective truth relating to human experiences should be critiqued (Bradley, 2022; Burr, 2019). Instead, facts are regarded as artifacts and outcomes that are produced within specific social and cultural contexts. The way we understand the world is the outcome of historically and socially interactive processes through which we engage and negotiate with diverse groups of people (Galbin, 2014). Social constructionism creates a space that allows us to question the idea that mental distress can be fully explained by objective natural science. It argues that the biomedical framework used to label an individual as 'mentally ill' lacks a legitimate foundation and is instead a reflection of the values and biases of psychiatric professionals, as well as the prevailing societal norms of a given historical and cultural context (Galbin, 2014).

The aim of this study is to investigate the experiences of Australian Chinese individuals who have experienced mental distress, exploring participants’ personal narratives as opposed to professional perspectives on their ‘illness.’ Drawing from the epistemology of social constructionism, the study provides a framework that enables a description of not only the detailed experiences of mental distress, but also an understanding of how meanings related to recovery were generated and how participants navigated their roles and power (or lack of power) within these experiences. Furthermore, a social constructionist paradigm can be seen to align with a recovery-oriented approach that seeks to empower and provide hope to participants, through challenging the biomedical discourse that individualises mental distress as personal responsibility.

Through the influence of social constructionism, rich and perspicacious examinations of social factors, such as gender, class, race, culture, and so on, have become possible in developing critical perspectives on mental health. Critical race theory (CRT) is used in this study because it allows for an intersectional perspective to illuminate the multifaceted nature of oppression, and explores how diverse forms of inequality and identity (such as race, gender, and national origin) interact in various contexts (Moodley et al., 2017). As such, the incorporation of CRT acknowledges the intersecting lived experiences of mental distress among individuals. Furthermore, it facilitates a more elaborate and nuanced examination of the lived experiences of participants belonging to ethnic minority groups who may encounter various forms of inequality (especially the social and structural forms) during their recovery journey.

Informed by the epistemological foundations that have been outlined, this study employs qualitative methodology to explore nuanced accounts of the lived experiences of mental distress among Chinese people living in Australia. Purposeful sampling with the addition of snowball sampling to compensate for the limitations of the recruitment strategies was applied. By conducting in-depth semi-structured interviews and thematic analysis of participants' narratives, this study reports on participants' first-hand perspectives of distress and perceptions of the recovery process.

1.5 The significance of the study

The primary significance of the study is its aim to explore detailed and nuanced contemporary narratives of people from Chinese cultural backgrounds. It also delves into how people have responded to challenges in mental distress and navigated their roles and identities during their recovery journey, and how meanings were generated from these processes.

Bringing Australian Chinese people's voices to public attention is vital. As for a very long time, their accounts of mental distress have been substantially sidelined within Australia, due to the dominance of a white Western perspective. Further, this study seeks to address the lack of exploration of heterogeneity among demographically diverse Chinese individuals in the existing literature. Specifically, the study aims to examine the cultural backgrounds of Chinese participants as a means of expanding the range of potential participants without imposing unnecessary restrictions on their political identities. This approach will expect a more comprehensive exploration of the lived experiences of all potential participants.

The additional impact of the findings of the study challenges the biomedical paradigm of mental health, illustrating that participants are individuals with the potential to respond to the challenges of distress and redirect the control of their lives. In this process, the findings of the study are also relevant to the improvement of culturally responsive and competent mental health services, including the progressive social work practice (Brown, 2021; Khawaja et al., 2013; Morley, 2003; Poon & Lee, 2019; Poon et al., 2013).

1.6 The overview of the Thesis structure

Chapter Two provides a detailed review of existing studies on mental distress through multiple lenses: the Australian literature relating to the lived experiences of mental distress of the Chinese ethnicity; the heterogeneous strategies Chinese people applied in responding to mental health challenges; and Australian social work practice in mental health when working with people from culturally and linguistically diverse social backgrounds.

Chapter Three describes how the study was conducted. It provides a justification for the theoretical frameworks and the methodology applied in this study, followed by a discussion of ethical concerns and ensuring rigour. In addition to the detailed process of how the data were collected, transcribed and analysed, this chapter also explores the practice of self-reflexivity, which allows me to acknowledge the dynamic between my stance as a researcher and the knowledge shared by the participants.

Chapter Four presents a summary of the participants' brief narratives in this study. It is important to note that during the interviews, diagnostic language was avoided except for when a psychiatric diagnosis was obtained from the participants' own narratives.

Chapters Five, Six and Seven present the findings of the participants’ narratives, regarding the challenges of having mental distress; how participants responded to the challenges of mental distress; and participants' understandings and interpretations of recovery, also including implications for social work practice and the roles social workers can play in the future.

Chapter Eight discusses the three major themes: (1) power imbalances and mental health; (2) heterogeneity and help-seeking patterns; (3) contested notions of recovery. This chapter also discusses the relevance of these themes and how they resonate with the findings of previous studies, as well as the fresh perspectives they offer. Additionally, the practical implications for social policies, social workers, and other mental health practitioners and service providers are addressed. Limitations and recommendations for future research are examined.

CHAPTER 2 Literature review

While a broad range of lived experiences of mental distress among Chinese people has been discussed in other major Western countries (e.g., U.S., UK and Canada) (Cheng et al., 2015; Dong et al., 2012; Law et al., 2021; Tang & Pilgrim, 2017), lived experiences within the Australian context have rarely been examined. This chapter provides a comprehensive review of the literature relevant to the research question: how individuals with Chinese cultural backgrounds living in Australia experience mental distress and perceive their journey towards recovery. The chapter begins with a clarification of the definition of mental health concepts in different epistemological knowledge bases, with the aim of establishing recovery-led perspectives and a critical research stance on the social model of mental health. The third section delves into the conceptualisation of recovery, including its development and various recovery models. This section also explores literature on Chinese people's recovery experience from other Western countries for comparison and presents the Australian one. The chapter concludes by examining Australian social work practice relating to Chinese consumers, which enables a nuanced understanding of Chinese people's lived experiences of mental distress and their recovery strategies.

2.1 Mental distress through multiple lenses

2.1.1 Mental illness in the biomedical model

Development of the concept of mental distress can be traced to ancient Greece, when Plato coined the term 'mental health.' and Hippocrates defined 'mental illness' as imbalances within the self (Malla et al., 2015). In medieval Europe in the 17th century, people with mentally ill traits were convicted as witches (Friedman et al., 2009; Johnstone, 2006). But this situation was significantly challenged thereafter by the discourse of rationality that has been central since the Enlightenment from the 18th century (Mcdermott et al., 2012), wherein mental illness explanations evolved from a moral and religious framework to a disease framework. In 1845, Griesinger first termed mental illness a brain illness (Malla et al., 2015;

Strickland & Patrick, 2015). With the fast development of modern medicine and science, mental illness came to be considered a somatic syndrome like other physical dysfunctions (Mcdermott et al., 2012). In the last century, categories of mental illness have become more specific. For example, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association, could be seen as a successful product of the predominant biomedical paradigm that categorises different experiences of mental distress with sophisticated diagnoses. The significant advances in genetics and brain imaging have strengthened the claims made by biological psychiatry and contributed to the reification of mental diseases as brain illnesses (Malla et al., 2015), although such claims are highly contested. Overall, the biomedical model conceptualises, diagnoses and treats mental illnesses, securing its solid scientific status with the endorsement of scientific medicine and its positivistic data.

Generally, mental health problems in the biomedical discourse refer to mental illness or mental disorder, considered a form of biochemical malfunctioning, biomedical imbalance, deviations or neurophysiological disturbance. Through the lens of modern medicine and psychiatry, mental illness is thought to be relieved or remedied by medical and chemical interventions (Dalal & Misra, 2011; Johnstone, 2006; Strickland & Patrick, 2015). The biomedical model gained prominence by equating mental illness with medical conditions, aiming to foster understanding and reduce societal judgment. It was also hoped that, as a result, people with mental illness would encounter less social stigma, which is a crucial barrier to people seeking and/or getting assistance, and that minimising stigma would help people become reaccepted as productive members of society (Malla et al., 2015).

However, despite this idealistic vision, the biomedical model has been challenged in recent decades. Debates have focused both on the claims made by psychiatry and its philosophical base. The biomedical model sees mental illness as an ‘error’ that should be ‘corrected’ by medical interventions, and people diagnosed with mental illness should be treated as passive recipients of medications (Dalal & Misra, 2011; Malla et al., 2015; McNally, 2011). When diagnosis and classification are used as measurements to identify the reasons for mental distress, the uniqueness of individuals and the important first-person accounts of mental distress are largely overlooked. It is argued that expert-based knowledge and authority have become a powerful toolkit to exclude people with mental distress and disempower them by ‘depriving people of their personhood, agency and personal meanings’ (Coppock & Dunn, 2010a; Johnstone, 2006).

Because the diagnosis of mental illness has a strong biochemical background, the fearful and unsympathetic attitude of the public effectively stigmatise and exclude people with mental distress from complete integration into society. When stigma is internalised, the negative terminology might further lead to more negative self-concepts, discrimination and disempowerment (Australian Health Ministers’ Advisory Council, 2013b; Fawcett & Hearn, 2004; Malla et al., 2015). Moreover, social work practice with a biomedical value base has been contested, as it in fact marginalises people experiencing mental distress with the distinction of ‘us’ and ‘them’ and further, puts people into roles of passivity, social exclusion and potential dangerousness through its emphasis on the expertise of professionals (Tew, 2002). Coppock and Dunn (2010a) challenge the biomedical assumption by restating that classification and diagnostic systems within the biomedical model do not always provide objective, expert judgments. The procedure relies primarily on interpretation and assessment, with diagnosis plainly subject to subjective values and perceptions.

In her thorough examination of psychiatry's lack of legitimacy as a discipline of medical science, Johnstone (2006) offered a general philosophical investigation of the biomedical paradigm by challenging its positivism, reductionism and determinism. She commented that the biomedical model relies heavily on quantitative criteria and data that treat people diagnosed with mental illness as objects, overlooking the meanings of their lives and the unique intricacies that every one of us as human beings carries throughout our lives. Complex factors contributing to mental distress have been reduced to simplistic conclusions, viewing people as ‘no more than the sum total of their biochemical or other physiological reactions.’ Also, this model is highly deterministic, arguing that biochemical deviations and imbalances are ‘inevitable results of your biology.’ Johnstone (2006) demonstrated that psychiatry, as a branch of medical science, was rootless. It cannot prove its validity and reliability as an independent medical science completely quarantined from subjective judgements, individual values and biases.

As the meaning of mental health and distress has been explored beyond the biomedical paradigm, more inclusive models for understanding mental health under specific social and cultural contexts are necessary for uncovering multifaceted personal experiential knowledge, values and perspectives. Johnstone (2006) argues that a more holistic, radically different model with ‘a full acknowledgement that our distress has both meaning and purpose’(p. 98) should be incorporated to understand mental health and distress. A social model that emphasises personal values, knowledge and lived experience in exploring the specific meaning-making process of mental health and distress is upheld (Coppock & Dunn, 2010a; Mcdermott et al., 2012).

Before understanding mental distress from broader and more critical lenses, it is important to clarify the terminology used throughout the rest of this study. This study is informed by the basic guidelines of the burgeoning social model, constantly communicating with and challenging the biomedical tradition of mental health topics through social, cultural, political, structural and other dimensions. Informed by the social model, non-pathologising, recovery-oriented language will be applied in this research, as it highlights people's abilities, strengths, and experiences while also conveying a sense of commitment, hope, and opportunity. Mental illness, mental disorder, mental health problems, and mental distress can describe an individual’s mental health status. However, they are from different philosophical, theoretical and ideological perspectives. I choose the term ‘mental distress’ throughout this study as it best expresses my value position and attitude in accordance with the basic elements of the psychosocial model (Tew, 2002) towards my participants. And it shows the acknowledgement of participants who have strengths and autonomy while also experiencing mental health challenges.

2.1.2 Mental distress in the social model

Even before the biomedical discourse interpreted people with mental distress as individuals with internal biochemical imbalances and genetic deficits, people with disabilities had been positioned as passive and objectified roles in pathologised medical diagnoses. People with disabilities encountered a slew of impediments to full social and economic involvement, all of which were motivated by structural oppressions and inequalities such as stigma, discrimination, and prejudice (Tew, 2004a). The development of the social model for understanding mental health and distress has been informed by the social model of disability and the mental health consumer/survivor movement. The ‘Mad Movement’ dates back to the early 1970s, and ‘Mad Pride’ events have since taken place in nations such as Australia, Canada, England, and the United States(Price, 2013). In the mid-1980s, the development of the mental health service users/survivors movement challenged the dominant medical and psychiatric ideologies on a radical basis (Beresford, 2002).

Ideas derived from the consumer movement critiqued the terms ‘patients’ and ‘clients’ by their fundamentally pathologising traits. Being labelled as ‘mentally ill’ became a barrier to speaking out about a person’s needs, discrimination and rights. The terms ‘consumers.’ ‘survivors.’ and ‘service users.’ therefore, were gradually accepted by people diagnosed with mental illness (Mcdermott et al., 2012). Besides the change of terms, the consumer-survivor-expatient movement (c/s/x) acknowledges people’s lived experiences and understandings of mental distress. It is believed that people diagnosed with mental illness should be supported with self-determination and empowerment practices, such as strategies focusing on individual strengths rather than deficits, non-pathologising terminology, and supportive networks from different stakeholders (Read & Dillon, 2013). The social model of disability and the c/s/x movement redirect attention to the study of mental health and distress, emphasising the need for a more complex analysis of the external environment and factors that might contribute to greater oppression and inequalities in social inclusion (Mulvany, 2000; Samaha, 2007; Tew, 2004a).

Exploration of the distress experience within the social model reflects the notion of intersectionality (Karban, 2016), embracing a more holistic perspective that suggests a range of non-biomedical factors might be the primary driver of mental problems, thus promoting diversity and inclusivity in understanding mental distress (Cromby et al., 2013). Distress may not necessarily indicate a negative consequence of challenging life events, but a coping or survival strategy employed by an individual to deal with specific challenging experiences. Beneath the distressed manifestation, people might possess impressive stories of fighting against powerlessness with regard to gender and sexuality (marriage, sexism and homophobia), race and ethnicity, culture, economic status (poverty and unemployment), ageism, disability, social relationships, and other life-changing events such as bereavement and loss, isolation and violence (Coppock & Dunn, 2010a; Karban, 2016; Tew, 2004a). Therefore, the social model shifts the emphasis away from individual problematisation and medicalisation towards 'a reflection of people's resourcefulness and ingenuity' (Tew, 2004a).

In addition to acquiring knowledge from mental health professionals and authorities, the social model de-centres the role of 'professionals' to construct themselves as trustworthy sources of mental health expertise. It holds that lived experiences and situated knowledge can be seen as results of re-negotiating self-recognition and social identity (Tew, 2002). Therefore, service users, family members, and important others should be seen as vital sources of experiential knowledge, meaning, and expertise regarding their direct experience (Tew, 2004b; Wallcraft, 2004).

The development of the social model of mental distress also faces challenges. Participants in Beresford's research (2016) critiqued that the biomedical model could not fully recognise them as people with trauma while facing potential risks of powerlessness, inequality and oppression. They recognised that the social lens would alleviate rather than propagate stigma and negative stereotyping of mental health service users, and would confront rather than exacerbate the hostility and discrimination they encounter. However, they were also profoundly impacted by the deficit-and-pathology discourse; consumer participants had yet to fully embrace non-biomedical discourse. Therefore, Beresford and his colleagues strongly supported broader and deeper discussions around the social model and mental distress.

It is important to clarify that this study focuses on the recovery pathways of mental distress, which is informed by the social model of mental health. Therefore, it is also essential to clarify its critical stance regarding the biopsychosocial model, even though it has been seen as complementing the biomedical model and leading mainstream psychology (Strickland & Patrick, 2015). The biopsychosocial model, also referred to as the 'vulnerability-stress' or the 'stress-diathesis' perceives practically every human situation as the product of biological, psychological, and social influences (Johnstone, 2006). This clarification is inspired by the work of Jerry Tew, who is recognised for his vital role in setting the contemporary foundation of the social model of mental distress. In his 2002 work,'Going social: Championing a holistic model of mental distress within professional education,' Tew tried to balance the importance of biomedical and social factors by indicating that the social model does not deny the 'innate vulnerabilities'(p. 148) that might contribute to mental distress (Tew, 2002). But from his 2004 work onwards, he argued that the major role that social factors play contributes to 'longer-term vulnerability to breakdown (Tew, 2004a, p. 21). He also acknowledged 'the interconnectedness between the dynamics of what may be going on inside a person and what may be happening (or have happened in the past) in their social context' (Tew, 2004b, p. 218). He critiqued the ways in which the biopsychosocial model failed to adequately account for power issues, disparities in value bases, and perhaps fundamental inequalities in methodologies. If this issue was not resolved, the bioessentialism of the biopsychosocial model might continue to play a prominent role in diagnosing and treating people's mental illnesses. Based on the above concerns, he pointed out the importance of shifting the focus from the inability and vulnerability of an individual to a more inclusive perspective that sees mental distress as a continuum of factors including internal and external forces.

Johnstone (2006) also argues that the biopsychosocial model admits the 'vulnerability' and 'bio-' traits, still centralising the significance of medicine and biology by accepting that mental distress is an illness, and the widely related consequences of overlooking social factors as 'solely triggering events' might enhance its biomedical dominance. Social and environmental factors are relegated to a 'trigger' role, depriving them of their human significance and meaning, 'while medication deals with the 'real' underlying problem'

(Johnstone, 2006, p. 95). Gould (2016) puts forward the opinion that even though the biopsychosocial model provided a theoretical umbrella for the prosperity of multidisciplinary scholarship in the last century, it failed to draw a boundary between its idea and the hierarchical connotations of the biomedical model, and further reinforced a strong focus on biological factors, for example, the genetic study and medications.

This study explores the social factors and the impacts on distress experiences in the Australian CALD context. Understanding mental distress from an inclusive social perspective might help people negotiate their social identities within the broader contexts and ensure 'their actual or potential access to more productive forms of personal and social power' (Tew, 2004b, p. 220). Although there is a strong trend towards the social perspective, the biomedical model still prevails in mental health academia (Beresford et al., 2016; Tew, 2004a, 2004b). This study is committed to applying the social model to investigate people's lived experiences of mental distress. It not only aims to challenge the predominant pathologising paradigm with a critical stance, but also seeks richer narratives of people's resilience in responding to the distress and challenges in their everyday lives.

2.1.3 Seeing mental health through critical models

The critical perspectives on mental health develop from the critique of the biomedical model, encouraging a broader investigation of multidimensional social aspects in contemporary contexts. In his remarkable edited collection, *Routledge International Handbook of Critical Mental Health*, Cohen (2017a)mounts a persuasive argument that no substantial progress in the mental health system has been made in the past decades; mental health professionals are still involved in their growing expertise in psychiatry, even though its biomedical foundation has been questioned. The emerging critical perspectives on mental health have challenged the predominant biomedical paradigm of mental health in the contemporary context. These theories explore the construction of mental distress through diverse non-biomedical lenses and provide profound insights into understanding mental health and distress in complex social contexts.

According to Cohen (2017c), some key foundations of critical work on contemporary mental health is the labelling theory, social constructionist theory, Foucauldian theory and anti-psychiatry. In labelling theory, societal stability is upheld by rules or dominant social orders. Violation of residual rules designates individuals as 'deviant', potentially leading to their behaviours being labelled as 'mental illness.' In that way, labelling theory understands people diagnosed with mental illness as ‘rule breakers’. It questions the individual-centric cause of mental illness in the biomedical discourse, recognising labelling as socially constructed. This process assigns varying meanings and judgment criteria to rule-breaking as society evolves. While not directly causing mental distress, labelling amplifies adverse social reactions to 'abnormality', such as stigma and discrimination, exacerbating trauma for those already labelled 'mentally ill’ (Sjöström, 2017).

Similar to labelling theory, social constructionist theory sees mental distress as the product of a specific socio-historical period rather than an independently existing nature or reality (White, 2017). It queries the notion that objective natural science fully accounts for mental distress, as labelling someone 'mentally ill' isn't grounded in proven biomedical facts but follows psychiatric criteria. Thus, psychiatry is a form of structural power that aims to maintain the governance of the population through pathologising ‘deviant’ behaviours. This perspective is consistent with Michel Foucault’s scholarship, which believed that medicine, invested in official power by psychiatric professionals, states and drug companies, has replaced the role of religion and law, acting as the dominant instrument of social control. According to Foucault (1967), mental distress is not a disease but the product of psychiatry classification systems. The interplay of power in social relationships shapes knowledge and subjectivity through the work of discourse. In this way, people with mental distress are subject to power that discursively positions the passive recipients of ‘expert truth’ as ‘mentally ill’ (Fullagar, 2017).

The mentioned core theories offer critical insights into mental health by challenging the biomedical discourse and its inherent dichotomies (e.g., normal/abnormal, healthy/unhealthy, etc.). Some viewpoints further critique Western mental health systems as sites perpetuating oppression based on gender, ethnicity, class, and sexual orientation. For example, Ussher

(2017) points out the long history of pathologisation of femininity and regulation of women through patriarchal psychiatric discourse. Feminine emotions are seen as signs of mental illness. ‘Mental illnesses’ such as hysteria, anorexia and depression have always been regarded as ‘women’s problems.’ However, men’s emotions are always explainable and acceptable. Under such patriarchal discourse, femininity is defined as psychiatrically unhealthy. The binaries also appear in critical race theory and critical cultural theory. Moodley et al. (2017) hold that sociocultural forces shape our understandings, perceptions, experiences, and responses to race. Racism is deeply rooted within the existing power and societal structures, privileging whites and white supremacy and marginalising the people of colour. In other words, mental distress is such a social product that the culturally and epistemologically racial hierarchies fragment people into ‘normal whites’ and ‘deviant non-whites.’ Critical cultural theory rejects the naive acceptance of neoliberalism, which links competition to societal and cultural influence. Neoliberalism shifts mental distress causation and solutions to individuals, promoting mental health services and product purchases. Therefore, it is possible for psychiatric medications and services to expand their markets for such enormous profits. Critical cultural theory criticises neoliberalism for reducing individuals to market-based economic value (Timimi, 2017).

The emerging critical perspectives challenge the dominant biomedical approach to mental health. These theories explore mental distress through the interplay of psychological, political, socioeconomic, cultural, religious lenses and specific individual contexts (Kleinman, 2004; Ng, 1997; U.S. Department of Health and Human Services, 2001), offering profound insights into broader social backgrounds that relate to mental health challenges.

2.1.4 Mental distress in different cultural interpretations

Mental health and distress from the cultural lens

Culture can significantly impact the way in which people make sense of and respond to distress. In their rework of the Cultural Influence on Mental Health (CIMH) model based on Kleinman’s work (Kleinman, 1978; Kleinman, 1977), Hwang et al. (2008) pointed out that individuals' cultural backgrounds influence the definition and socio-cultural connotations of mental distress. The sociocultural meanings, in turn, are moulded by cultural norms and beliefs, and serve as a filter to determine how people interpret their challenges. Different cultural backgrounds construct different understandings and interpretations of distress experiences and further affix unique cultural labels to people's experiences.

Cultural factors gain increasing significance when individuals with ethnic minority backgrounds strive to situate their societal roles and values within multicultural social environments. Kolstad and Gjesvik (2014) contend that broadening a narrow cultural perspective and expecting to quickly comprehend Western ideas can induce tension and even contribute to mental distress. This point of view echoes acculturative stress from the CIMH model, which refers to stress related to transitioning and adapting to a new environment, e.g., linguistic difficulties, assimilation pressures, separation from family, discrimination experiences, and acculturation-related intergenerational family conflicts (Hwang et al., 2008).

A problem within the discussion of the relationship between culture and mental health should be raised: some authors reduce the importance of cultural factors by regarding it as simply one factor among many while continuing to assert the centrality of the biomedical paradigm, failing to address it as an independent aspect that sits beyond the medicalised discourse (Good & Good, 1982; Spector, 2002; U.S. Department of Health and Human Services, 2001). Seeing culture as a complementary component to the biomedical paradigm and Western health ideas, however, culture-related discussion of mental health and distress is subject to the biomedical framework. The lack of awareness of diverse cultures may also lead to more unhelpful practitioner-consumer relationships in the mental health service systems (Cauce et al., 2002; Gopalkrishnan, 2018; Kleinman, 2004; Spector, 2002; Tobert & Cornwall, 2016; U.S. Department of Health and Human Services, 2001). Therefore, improved cultural understanding in a holistic manner towards mental health is urgently needed (Hwang et al., 2008).

Mental health and distress from the Chinese mainstream cultural lens

Before this section begins, it is important to clarify that ‘Chinese people’ in this study refers to people brought up and shaped within Chinese cultural practices. By using the plural term backgrounds/practices, this study acknowledges and respects the heterogeneity of Chinese ethnicities from various social backgrounds that inherit Chinese cultural values.

Mental health and illness are concepts created by Western histories and cultures. However, other cultures also provide diverse and nuanced understandings of mental distress beyond the Western discourse. For example, it is recorded that Chinese people apply somatic organ-based terminologies to reveal their emotions, thoughts and feelings (Ng, 1997; Wu, 1982). The word *xin*, which refers to the ‘heart’, appears in most descriptions of mental health problems in Chinese discourse. In Chinese, ‘heart’ can refer to both the heart and the mind, which has also been interpreted as ‘mentality.’ In the past, ‘heart problems’ was the socially acceptable term in the Chinese context to refer to what are considered minor mental illnesses in the West (Kolstad & Gjesvik, 2014). The Chinese discourse has the tradition of describing the experiences of mental distress as somatised descriptions(Wu, 1982). It is different to the biomedical model that focuses on the physical brain. Such a phenomenon was explained as a strategy for avoiding public stigmatisation and marginalisation based on the Chinese traditional notion that weakness implies shame (Yip, 2003).

The somatisation of psychological problems is strongly associated with the core ideas of traditional Chinese culture, including the notions from traditional Chinese medicine (TCM) and Confucianism. The Chinese view of health is based on the Yin-Yang principle and the five universal elements. A healthy mind contributes to the Yin-Yang balance, while good health depends on the balance of five basic emotions and organs. The key to comprehending body physiology is to know the five Yin viscera and the six Yang intestinal organs. All regions of the human body are connected by *ching-lo* systems, or ‘meridians.’ which channel *ch'i*, or life essence, and blood. If *ch'i* gets weak, the disease will infiltrate the body and cause illness. Excessive emotional activities can lead to Yin and Yang imbalances, *ch'i* and blood insufficiency, *ching-lo* obstruction, and organ malfunction, ultimately leading to illnesses

(Gopalkrishnan, 2018; Ng, 1997; Wu, 1982). Therefore, traditional Chinese medicine sees everybody's malfunction as a dysfunction of the above basic elements, mixing the boundary of body and mind and treating them as a whole and interdependent. Health and mental health are not seen as entirely separate - they are connected and both reflect dysfunctions of the basic elements in different ways.

Moreover, the approach and explanation method of diseases in TCM do not necessarily separate body and mind as in dualism. The treatment of diseases tends to treat the psychological and physical parts as a whole, depending on herbs, acupuncture, moxibustion, and other methods to reestablish the internal balance (Wu, 1982). TCM offers an alternative to Western medicine, especially when genetic and cerebral explanations fail to convince Chinese people. And such a phenomenon is prominent overseas (Ng et al., 2008; Tabora & Flaskerud, 1997; Wu, 1982). This way, TCM addresses the somatic feature in expressing and coping with mental distress among Chinese people.

Mental distress is comprehended not solely through the framework of traditional Chinese medicine; the restraints of individual emotions, collectivism and filial piety also feature strongly from traditional Confucian core thoughts. Traditional Confucianism profoundly influences Chinese people’s values and orientations regarding the construction of self-worth, interpersonal relationships and the prosperity of society (Kolstad & Gjesvik, 2014; Liu, 2018; Yip, 2016). Confucianism encourages self-control and collective harmony. On the individual level, Confucianism defines self-worth through the concepts of ‘social order’ and ‘rectification of name.’ In Confucianism, an individual can only be a contented and reputable adult with a pure mind, disciplined conduct, and consistency in words and deeds (Yip, 2003, 2016). It is believed that the ability to avoid mental stress and pressure reflects a person’s *Shiu-yang* (cultivation), which is frequently equated with suppression of emotions. The emphasis on social harmony in Chinese culture constructs equanimity and suppression of emotions as a psycho-cultural, refined coping mechanism for emotions (Wu, 1982). Abdullah and Brown (2011) find that in China, there is a widespread notion that mental illness is a penalty for not honouring one's ancestors, the result of having a weak character or possession by evil forces. On the interpersonal level, individual submissiveness is emphasised in order to promote collective harmony. Traditional Confucian mental health principles advise people to inhibit self-actualisation by regulating emotions, avoiding interpersonal conflict, and limiting individual rights to achieve social harmony (Yip, 2003, 2016).

Collectivism is one of the most important characteristics of the Confucian core ideas. Many scholars have identified a hierarchical, vertical feature in Confucian culture (Kolstad and Gjesvik (2014). A person's self-value lies first and foremost within the hierarchical social ties, such as governor to his people, father to son, elder brother to the younger, and husband to wife. An individual is never expected to be a separate, self-contained entity. Kolstad and Gjesvik add, 'individuals are social and interactive beings; society is a humanising agent.' (p. 266). Individual worth is integral to collective cultural achievement and harmony. Meeting collective goals enhances prosperity and competitivity of the family, group and society, leading to a greater sense of security and contentment for each member. Therefore, individuals' sense of mental peace and satisfaction hinges on the holistic group quality. In Confucianism, self-value relies on in-group acknowledgment. Collectivism is integral to robust mental health perceptions.

Filial piety is a Confucian notion firmly ingrained and intertwined in Chinese culture, both traditionally documented in Chinese cultural construct and contemporarily borne by Chinese people (Lam et al., 2022). Filial piety is also an essential virtue in Chinese ethical principles, and forms the moral and political foundation of the traditional family and feudal systems. It involves the respectful and loyal determination of males and the continuity and prosperity of the family, and it can also extend to state allegiance.

Previous research categorised two predominant relationships in traditional Chinese society, emphasising patrilineal and patriarchal authority in family and social systems. The vertical relationship (parent-child relationship) is patrilineal. Filial norms include respecting and honouring one's parents and ancestry, as well as conducting oneself in a way that honours the family name. Filial piety also requires children to be obedient, respectful, and responsible for providing their aging parents with adequate emotional and financial support and care. By learning responsibility, cooperation, obedience and self-control over their desires, demands and behaviours, children are expected to build up skills for further success in team collaboration (Foo, 2019).

The horizontal relationship refers to the intimate partner relationship. Confucius contended that a woman's subjectivity was formed inside the familial household, which prevented her from distancing herself from or abandoning her family. Husbands are the core of the family, engaged in productive activities, while the wife's role is to complement his efforts. Also, to preserve the facade of a harmonious, joyful family for husbands and children in the community, women are expected to be subject to suppressing emotions, self-sacrifice, and unquestioning obedience to their male family members. In this way, women are relegated to an inferior role which reduces the significance and power of the female as a mother, a wife or a daughter in feudal society. They are gradually socialised to embrace the patriarchal values and their duties to the family under such ideological influence and restrictions, in accordance with customary practises (Han, 2012). As a result, based on the popularisation and normalisation of Confucianism, filial piety transferred its moral and ethical attributes into a powerful practice that supports the superiority of patriarchy (Han, 2012; Hu & Scott, 2016).

Traditional Confucianism is considered enormously influential in Chinese people's thinking and behaviours in the contemporary context (Liu, 2018). People are believed to obtain their self-worth through their suppressed emotions and unquestioned sacrifice of individual benefits to the ‘collective superficial harmony.’ Confucianism emphasises glorifications, such as *Shu* (forgiveness), *Yen* (benevolence), *Yin* (righteousness), and virtues, such as ‘sincerity in knowledge, rectifying in heart, cultivating persons, regulating families, ordering well states, ruling the kingdom by virtue’ (p. 74) are refined moral characteristics used to determine and evaluate an individual's achievement in following Confucian thought in their words and deeds. Individuals unable to adhere to such strict moral standards often develop a sense of remorse and shame (Yip, 2003, 2016). Therefore, traditional Confucian culture develops a consensus that one’s inability to have emotional and/or behavioural control reflects a lack of *Shiu-yang* that their family should have educated them to live by. And thus, their own ‘misbehaviours’ disgrace the family’s name, reputation and even the ancestry (Ng, 1997; Tabora & Flaskerud, 1997).

Confucian cultural interpretations of such 'misbehaviours' potentially add familial, societal and moral meanings to the stigma of mental distress, suppressing the personal expression of authentic emotions and feelings and discouraging help-seeking behaviours. The reluctance to seek help from psychiatric professionals is seen as the result of adherence to traditional Chinese cultural influence (Meeuwesen & Ingleby, 2013; Ng, 1997; Tabora & Flaskerud, 1997). However, in contrast to the biomedical perspective, there is a strong body of literature that also explores the value of less formal supports and resources. It is also argued that less formal support, such as family and local culture, can be resources for people with mental distress (this can also be found in the section *Chinese people's help-seeking attitudes and behaviours* in this chapter). The suppression and expression of emotions play vital roles in maintaining social equilibrium in wider society (Chan, 2007). Therefore, Chinese people tend to interpret their experiences of mental distress as a situation where they confront significant challenges in daily life and relationships. They describe the sense of distress in somatic discourse such as 'the heart problems' (Kolstad & Gjesvik, 2014). They inherently trust the effectiveness of TCM, which treats their body and mind as one (Hwang et al., 2008; Meeuwesen & Ingleby, 2013; Ng et al., 2008).

In a contemporary context, Chinese people are also affected by various political ideologies, such as Maoism, Marxism, Capitalism, Materialism and Democracy; and other cultures such as Taoism and Buddhism. Individuals with varying ages, interests, expertise, and exposure to traditional Confucian culture may also experience varying degrees of influence from the latter. Therefore, it has been pointed out that Chinese people living in a multicultural environment might develop the ability to understand cultural meanings from various cultural icons through internalising two or more cultural frameworks (Yip, 2003, 2004, 2016). Chinese people located in Western contexts are going through an 'emerging composite self' process, which encompasses both traditional Chinese culture and Western culture (Kolstad & Gjesvik, 2014). Given the emerging trend, it is pertinent to explore how Chinese culture impacts the understanding of mental distress and recovery among people from Chinese cultural backgrounds in Australia.

2.2 People with Chinese cultural backgrounds and their distress experiences: a review of Australian literature

People from Chinese cultural backgrounds have a long and complex history in Australia. Chinese people first came to Australia in the 14th century as fishermen, well before British colonisation. Chinese people worked in the agricultural industry in the 1830s, fleeing civil unrest, floods and famine in southern China. In the 1850s, they met a hostile reception due to the growth in the Chinese population because of gold mining in New South Wales and Victoria. The inflow of Chinese people throughout the middle of the nineteenth century resulted in the introduction of a poll tax, a precursor to the White Australia Policy, as well as numerous other types of racial discrimination. The Immigration Restriction Act, enacted in 1901, primarily targeted Chinese immigration and additional Asian immigration, and became the most significant factor that restricted the population growth of Chinese people. This racial animosity eased after the end of the Second World War and the introduction of the non-discriminatory immigration policy in 1973. After 1985, the multicultural population in Australia witnessed a significant increase of Chinese and Asian overseas students due to the Commonwealth government's decision to provide educational services and opportunities for non-English speaking students. The Australian government also granted more than 37,000 Chinese people and their immediate family members asylum and permanent residency after the 1989 Tian'anmen Square (or June 4th) Incident. Since then, people with Chinese cultural backgrounds from Hong Kong, Taiwan, Singapore, Malaysia, Vietnam and other nations with Chinese ancestry have migrated to Australia as highly-skilled professionals, managers, workers, business individuals and entrepreneurs (Department of Immigration and Citizenship, 2014; Ip et al., 2007; Mak & Chan, 1995; Poon et al., 2013; Uygur et al., 2011). The latest 2021 Census revealed 595,630 Chinese-born people in Australia, up 14.45% from the 2011 Census, ranking as the third largest ethnic minority group in Australia (ABS, 2021).

In the past three decades, the growing volume of mental health studies around Australian Chinese people has heavily focused on the sociocultural factors and specific disadvantaged groups (women, elderly, international students, caregivers, etc.). Migration and the matter of acculturation are the major causes of distress experiences. On the micro social level, research participants reported that the lack of family support and tensions in family relationships and marriage contributed to depression and anxiety (Fung, 1997; Hsiao et al., 2006a; X Lin et al., 2016; Mak & Chan, 1995). Challenges on the macro social level include discrimination, racism and exclusion (Leung, 2001; Lu et al., 2014; Mak & Chan, 1995). An Australian study in the CALD communities has found that poor mental health is related to the volume of racist incidents experienced (Ferdinand et al., 2015). However, there has been inadequate investigation into racial discrimination experiences among the Chinese community, specifically concerning individuals who have undergone mental distress. The link between lived experiences of racial discrimination and mental distress need further investigation. Isolation is a common theme among Chinese women, older people, international students and caregivers**.** Older people, especially women, in this predicament are more neglected due to the established impression that many of the older Chinese parents are well looked after by children in their post-immigration period (Ip et al., 2007; X Lin et al., 2016). International students might also be disadvantaged in their connections to society, but that is a more complicated outcome generated from the other interplaying social factors (F. Martin, 2020). Caregivers are at higher risk of social isolation through a combination of familial piety discourses and the stigma of mental distress in the public environment; they are subject to intense family relationships and physical and mental exhaustion (Kokanovic et al., 2006a; Poon et al., 2021; Poon et al., 2013).

The challenge of understanding and adapting to a new culture has multifaceted impacts on the experiences of distress. Lack of English proficiency and conflicts over different cultural values not only contribute to the lived experiences of loneliness and lower life satisfaction (Fung, 1997; X. Lin et al., 2016; Mak & Chan, 1995), but also prevent people from accessing timely mental health services (Blignault et al., 2008; Chan, 2007; Lu et al., 2014; Uygur et al., 2011). According to the literature, these acculturative stressors are more distinct in women, older people and international students (Ip et al., 2007; Leung, 2002; Pan & Keung Wong, 2011). On the other hand, echoing the bi-dimensional model of acculturation (Chan et al., 2004; Hsiao et al., 2006b), Australian Chinese people with a higher degree of acculturation tended to reshape their understanding, reflect a Western perspective of mental distress and became more easily in receiving mental care services (Parker et al., 2005).

The growing Australian literature differs from the worldwide literature in identifying the relationship between educational factors and the mental wellbeing of Chinese international students (Leung, 2001; Pan & Keung Wong, 2011). Adaptation to unfamiliar academic environments, challenging academic requirements, English proficiency and interpersonal relationships in the student community are complex pressures (F. Martin, 2020). A recent study reveals that Chinese international students exposed to risky factors of mental distress are a significantly under-examined group (Lu et al., 2014).

Although not much stated, Australian research finds unemployment and underemployment are stresses to the Chinese population's mental wellbeing (X Lin et al., 2016; Mak & Chan, 1995; F. Martin, 2020). This is particularly evident among older Chinese people who depend heavily on their adult children due to insufficient social capital (Ip et al., 2007). Caregivers also confront mental health difficulties. They report economic loss in acting out their care duty to their loved ones. Moreover, long-term care also present tense in family relationships, physical and mental exhaustion and potential social isolation on caregivers (Kokanovic et al., 2006a; Poon et al., 2021).

A recurring discussion is around Chinese people's mental health literacy. According to Jorm, A. F. (2000), also cited in Wong et al. (2010, p. 2), mental health literacy as a Western concept refers to 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention.' Throughout the literature, Australian Chinese people were less likely to identify or report mental distress (Parker et al., 2001; Tang et al., 2009; Wong et al., 2017; Wong et al., 2010). Some scholars believe that the mental health literacy of the general Australian Chinese population is low (X. Lin et al., 2016; Uygur et al., 2011; Wong et al., 2012; Wong et al., 2010). However, scholars argue that Chinese culture challenges the Westernised concept of mental health literacy (Parker et al., 2001). To challenge simplistic understandings of a lack of mental health 'literacy' (Blignault et al., 2008; Kokanovic et al., 2006a; X. Lin et al., 2016; Poon et al., 2021), Chinese people tend to somatise the distress and shape their understandings of mental distress in specific Chinese cultural expressions (Chan et al., 2004; Parker et al., 2001). Cultural impacts on the understandings of mental distress could further lead to different help-seeking attitudes and behaviours (Parker et al., 2005; Parker et al., 2001). Therefore, it is believed that there is a less visible, higher rate of mental distress experienced among the Australian Chinese population than previously reported (Tang et al., 2009).

Generalisability is not the priority for these studies, which stress the importance of including different demographic characteristics of subgroups that share the same ethnic label (Blignault et al., 2008; Hsiao et al., 2006b; Lu et al., 2014). Exploring different perspectives and descriptions through different groups will enrich the complexity of the findings (Blignault et al., 2008) and might help generate more practical advice for culturally sensitive mental health services (Leung, 2001).

Early in their 2001 and 2005 work, Parker and his colleagues argued that Chinese people's perspectives on mental distress might evolve with time. It is necessary to explore the subtle and culturally nuanced beliefs about distress. This study adopts a critical cultural lens in reviewing Chinese people's perspectives on mental health and distress. Consideration of the prevailing findings regarding Chinese people's mental health literacy provides valuable insights for the subsequent analysis of the study's findings.

Gathering qualitative data around the demographically diverse Chinese population in Australia has been rare in the last decade; therefore, this study aims to provide more recent lived experience narratives from Chinese people.

2.3 Responding to mental distress: winding ways to recovery

2.3.1 Conceptualising Recovery

The development of the recovery vision

Deinstitutionalisation is a policy reform that transferred the responsibilities for mental services from hospitals to communities. It determinedly turned away from the traditional hospitalised settings and toward community-based practice. Conventional coercive medical treatments are challenged by recovery-oriented services that are shaking the dominance of biomedical psychiatry. Deinstitutionalisation both removed the government's responsibility for the immense financial upgrade of these facilities, and responded to the civil-libertarian focus on individual liberties and environmental change as means of bringing about social change (Gooding, 2016; H. Richard Lamb & Leona L. Bachrach, 2001; Kunitoh, 2013; Leona L. Bachrach, 1978; Piat, 1992; Rosen, 2006).

Deinstitutionalisation provides a chance to live in an environment free from confinement (H. Richard Lamb & Leona L. Bachrach, 2001; Piat, 1992). Some studies also reported consumers' improvements in their social functioning, psychiatric symptoms, increased self-agency, self-determination and quality of life (Gooding, 2016; Kunitoh, 2013). However, deinstitutionalisation also created 'a demonstrable service vacuum', which might negatively impact consumers, families and communities (Gooding, 2016, p. 43). Piat (1992) pointed out that deinstitutionalisation was not linear and smooth. It challenged family members who were poorly prepared for the full capacity of in-home care for their loved ones. Communities might not be resourced enough to provide care and inclusion for people experiencing distress, and neighbours in the community might generate stigma, fear, prejudice and rejection of these people, especially if they carry the identity of homeless, criminal or other 'deviant' labels (H. Richard Lamb & Leona L. Bachrach, 2001; Turner, 2004). Alongside the exploration of service transformation and delivery (Rosen, 2006), consumers might confront a challenging 'functional vacuum' (Leona L. Bachrach, 1978, p. 576) between the harm of coercive practices and neglect in the community. Mental service consumers might need more person-centred services that do not just relieve their psychiatric symptoms, but also respect their decisions on the preferred services that aim to support their social, educational, and vocational goals and self-improvements. The growth of the consumer-survivor-ex-patient (c/s/x) movement in the 1970s and the community support services targeted civil rights as they aimed to re-establish the full human rights of community inclusion. In the 1980s, the formal mental health system increasingly acknowledged consumer-led efforts and began to fund some consumer-run recovery programs. The establishment of the community support system, consumer-led services and a more comprehensive understanding of mental distress generated a new vision of recovery and the mental care system in the 1990s (Anthony, 1993; Australian Health Ministers' Advisory Council, 2013b; Mcdermott et al., 2012; Starnino, 2009).

The recovery vision opens a space for the recovery model and practice, which refused to be defined within the conventional yet powerful biomedical paradigm. Instead, it encourages consumers to live a more meaningful life with core ideas such as hope, strength, empowerment, self-management, self-determination and a full recovery beyond and above the remission of symptoms (Australian Health Ministers' Advisory Council, 2013b; Davidson, 2016; Jaeger & Hoff, 2012; Starnino, 2009). Since then, the majority of Anglophone countries have adopted a recovery approach as a core component of mental health policy (O'Donnell & Shaw, 2016; Pincus et al., 2016).

Discussion of recovery

Definition

The discussion of the concept of recovery has been going on for decades. Generally, recovery involves an active reconstruction of meanings and identities within individuals and their contexts (Anthony, 1993; Deegan, 2005; Higgins, 2008; Kalathil, 2014; Slade, 2010). Some scholars view recovery as a full human experience encompassing negotiation of dynamic and intricate identity and meaning-making (Deegan, 1996; Gwinner et al., 2013; Onken et al., 2007; Timander et al., 2015; Topor, 2001). Some studies explore how the reconstruction and negotiation process of identity involves dealing with the impact of structural oppression, discrimination and stigma (Tew et al., 2012; Timander et al., 2015). From this perspective, recovery refers to resistance to the impacts of discrimination and oppression to reclaim and reconstruct a positive sense of self. In all, meanings and identities play a significant role in the recovery journey when consumers take stock of where they are in their lives and the broader contexts, what resources and support they have to achieve their goals and give meaning to their lives. Resilience and supportive conditions might help enrich and reclaim deeper and more layered identities against challenges that have narrowed people to the thin identity of 'patients' (Slade & Longden, 2015).

It has been argued that recovery contains a richer day-to-day definition. Recovery is mostly seen as an interaction of internal and external changes (Higgins, 2008; Nora Jacobson & Dianne Greenley, 2001). Under the recovery-oriented perspective, the existence of symptoms is not the focus and the powerful influence of biomedical discourse is diminished, with its focus on recovery as the remission of symptoms and recurring relapses (Anthony, 1993; Devon Partnership Trust and Torbay Care Trust, 2008; Fardella, 2008; Jacob, 2015; Jaeger & Hoff, 2012; Wallcraft, 2004). Recovery from the consequences of mental distress might be more challenging than recovery from the 'mental illness' itself, considering that illness carries the labels of stigma, discrimination, and acquiescence to violation of civil rights, guilt and shame (Andresen et al., 2003; Bonney & Stickley, 2008; Davidson, 2005; Provencher & Keyes, 2011). Therefore, recovery may be considered a journey of regaining hope, strength, self-resourcefulness, self-determination, advocacy of wellbeing and improved quality of life (Carpenter, 2002; Ellison et al., 2018; Repper, 2003; Ridgway, 2001; Slade, 2009).

People do not recover in isolation. Studies have found that consumers developed a confident sense of self by meaningfully engaging in supportive social relationships and connections and through accessing more effective forms of social capital (Devon Partnership Trust and Torbay Care Trust, 2008; Marino, 2016; Provencher & Keyes, 2011; Repper, 2003). A dynamic web of relationships of peers, professionals, families, friends, religious groups and other non-professional others could provide people with support and encouragement, meaningful interpersonal networks and the hope of recovery (Australian Health Ministers' Advisory Council, 2013a; Cheng et al., 2016; Loumpa, 2012; Mead & Copeland, 2000). Peer support has been gradually encouraged and facilitated in consumers' recovery journey in the recent decade, which significantly witnessed the development of the acknowledgement of the principle of 'expert by experience' (Loumpa, 2012, p. 56). Peer support is based on the recognition that people who have experienced and survived mental distress might support and encourage others facing comparable challenges in a manner distinct from that of professionally trained practitioners. It describes a method of establishing a mutually sympathetic environment in which recovering individuals can explore ways of making sense of the self. Peer support is considered an effective approach to sustaining consumers' mental wellbeing, compared with its professional counterparts (Loumpa, 2012).

Interestingly, some studies continue to highlight the value of mental professionals, grounded on the premise that consumers need to be treated equally and with dignity in trustworthy relationships (Ådnøy Eriksen et al., 2014; Fardella, 2008; Hansen et al., 2019; Leete, 1988; Liu, 2014; McCabe et al., 2018; Topor, 2001; Topor et al., 2011). Meaningful and enjoyable activities and services also contribute to recovery. Community-based services and social work interventions, consumer-driven services, and precautionary measures become supportive when they offer practical support to consumers' living conditions and their needs for social inclusion (Australian Health Ministers' Advisory Council, 2013a; Holttum, 2012; Jaeger & Hoff, 2012; Leete, 1988; Topor et al., 2011; Wallcraft, 2004; Warner, 2009). First-person consumer narratives also confirmed the importance of basic material conditions and employment in addition to financial security. Consumers have claimed their right to proper housing and healthy living conditions, and have commented that getting employment is a milestone for them on their recovery journey (Jacob, 2015; Jenny Secker et al., 2002; Leete, 1988; Wallcraft, 2004).

Intersectional social justice analysis of recovery revealed that power is dispersed within the mental health care system and the associated, interconnected oppressive forms through which it functions, such as biomedicalism, racialisation, sanism, sexism, ageism, heterosexism, etc. (Morrow & Weisser, 2012). Therefore, an inclusive societal context that embraces and accepts diversity may create a better environment for people to recover, especially those from culturally and linguistically diverse backgrounds (Jacob, 2015; Wallcraft, 2004). This perspective underlines participants' experience of more heightened experiences of discrimination due to their CALD backgrounds.

Recovery is a non-linear and intricate process; achievements and difficulties might coexist (Anthony, 1993; Higgins, 2008; Nora Jacobson & Dianne Greenley, 2001; Onken et al., 2007; Ridgway, 2001). Factors contributing to recovery might also have the 'relativity' feature. For example, factors such as hope and relationship with family might not be consistently supportive. According to recent research on Chinese people in the UK, hope can be diminished by oppression brought on by mental health discrimination, ageism, gender ideology, and so on. Consequently, disempowerment through these social inequalities might reduce consumers' agency and sense of self-worth by restraining their development of the ability to live a meaningful and purposeful life (Tang, 2019b). Family members sometimes do not have sufficient knowledge of mental health challenges to sufficiently empathise with their family members with mental health challenges (Hansen et al., 2019). A USA study found that family members could be more tightly bonded when they confronted limited social capital and isolation due to immigration. However, such tight connections to the extended family generated both strong support and excessive stress (Kung, 2016).

The importance of the first-person account

It is worth emphasising that different people have different understandings of recovery. For some, 'recovery' might not help consumers make sense of their mental distress or experience (Beresford et al., 2016; Mcdermott et al., 2012). Some people with severe mental illness (SMI) considered recovery as a series of small achievements assisted by evidence-based services and clinical practice (Drake & Whitley, 2014). But other consumers with different diagnoses of mental illness understood and interpreted their recovery in different ways and rejected the discursive context of recovery, attributing the term to a clinical expectation of symptoms being withdrawn and the impairment being fixed (Gwinner et al., 2013). This echoes the stance Goemans (2012) held on the dichotomy between recovery and 'symptoms,' interpreting that the term 'recovery' implies the problematic and the 'to-be-fixed' nature of consumers, and 'nullifies any challenge to the individualistic nature of the biomedical illness model.' (p. 93). Mental distress itself could be subjective and open to debate. Therefore, the recovery narrative should centre on the voices of people with lived experiences of mental distress and recovery (Beresford et al., 2016; Holschuh et al., 2012).

Many studies acknowledge people with direct experiences of distress, and their insights into distress and recovery. By virtue of becoming self-determining, active and showing self-agency, consumers might find ways to make sense of what they have been through and how their resilience and empowerment in these experiences return them to a sense of self-worth, responsibility and acceptance of who they are (Deegan, 1996; Starnino, 2009; Tew, 2002; Wallcraft, 2004). It is argued that consumers should be allowed to define the details of their distress through a holistic personal discourse rather than the pathologised medical terminology (Leete, 1988; Wallcraft, 2004).

Recovery frameworks

The recovery perspective challenges the predominant biomedical paradigm, even though the latter still prevails, with its medical paternalism, and continues to be accepted as fundamental 'truth' (Jacob, 2015; McCabe et al., 2018; Walker, 2006). The effectiveness and long-term results of recovery that primarily uses biomedical approaches have been questioned (Jacob, 2015; Tew, 2002). It is argued that professionals 'lend' their care responsibilities to consumers while attributing consumers' recovery efforts to professional interventions (Davidson, 2005; McCabe et al., 2018). The recovery perspective challenges the biomedical model by shifting its focus on the 'self.' It refuses to regard consumers as patients with inevitably chronic mental illness – irreversible courses of relapse, recurrence, remission and lifelong disability based on the physical disease-like diagnosis (Jacob, 2015; Ridgway, 2001; Walker, 2006). Instead, the recovery paradigm encourages seeing consumers as full humans with both weakness and strength, with the ability and determination to rebound and regain full control over their lives even with accompanying ongoing mental challenges (Tew, 2013; Topor, 2001).

This point of view echoes the concept of personal recovery. Personal recovery refers to creating and living a meaningful and contributing life in society, with or without the existence and challenges of mental distress (Australian Health Ministers' Advisory Council, 2013b; Slade et al., 2008). Personal recovery is considered 'an ongoing journey of personal growth and wellbeing' (Department of Health, 2011), encompassing four major tasks: the development of a positive identity beyond and above the distress; the development of satisfying meaning to frame the lived experience of mental distress; exercising personal responsibility through self-management; and the claim of new social identity and role (Slade, 2009, 2010). Self-determination, the capability of self-development, the capability of control over one's life, empowerment, and individual agency can also infuse power to recover (Fardella, 2008; Jacob et al., 2015; Liu, 2014; Tew et al., 2012; Tooth et al., 2003; Wallcraft, 2004; Warner, 2009). Deegan (2005) argued that these self-initiated, non-pharmaceutical self-care practices are crucial in giving life meanings and purposes, raising self-worth, and improving mood, perceptions, behaviours, and general wellbeing.

Leamy et al. (2011) proposed a conceptual framework for personal recovery from mental distress. This conceptual framework contains 13 characteristics of the recovery journey and five recovery processes and stages mapped on the transtheoretical model of change. Connectedness, hope and optimism about the future, identity, meaning in life, and empowerment form the five recovery processes, also named the CHIME framework. The validity of the CHIME framework has been reported in the analysis of English-language publications (Slade et al., 2012), consumers (Bird et al., 2014) and their relationships with mental health professionals (Ådnøy Eriksen et al., 2014), and empirically-proved interventions (Slade et al., 2014).

However, Price-Robertson et al. (2017) point out that, if the notion of recovery relies heavily on personal achievement in developing resilience, especially the introduction of the CHIME framework, recovery will eventually be constructed as 'an intra-psychic process,' transferring the recovery mission squarely onto consumers' ability to self-govern. Social determinants will fall to a secondary position in their recovery journey. By pointing out how individualism features in the understanding of recovery in Western countries, Price-Robertson and his colleagues highlighted the gap between individualism and collectivism – a negotiation that is beyond and above inherent cognition; from a relational perspective, the opponent of individualism from a relational perspective is not collectivism, but rather something more akin to interdependence. People should be considered inseparable from their living context; interpersonal relationships permeate each aspect of recovery. A call for a revised framework was proposed to acknowledge consumers' multiple relational roles and identities, the capacity to manage life environments, and the goals of living a purposeful life (Casadi, 2014; Department of Health, 2011; Marino, 2016).

Other recovery models include the stage model of recovery, the social construction of recovery, the ecological model of recovery, and Wilber's conceptual framework. In her instructive work in 2003, Andresen et al. (2003) proposed four key processes of recovery (finding hope, re-establishing identity, finding meaning in life and taking responsibility for recovery); five key stages of recovery (moratorium, awareness, preparation, rebuilding and growth); and the outcome of recovery (the pursual of authentic personal goals and the development of resilience). Andresen and her colleagues further developed the Stages of Recovery Instrument (STORI) to measure whether the recovery processes and stages are validated. Andresen's stage model of recovery has much in common with other stages models developed thereafter (de Jager et al., 2016; Emrich, 2018). These models particularly concentrate on reaching a new understanding of self and witnessing self-growth in this process. Although the CHIME model reflects similar recovery stages, Leamy's analysis of the literature on recovery stages revealed that there might be little consensus about the number of recovery phases; unique, non-unified and various patterns or models for the recovery process seem to be more welcome (Leamy et al., 2011).

From an ecological perspective, Onken et al. (2007)identified four key elements of recovery (person-centred, re-authoring, exchange-centred and community-centred) from symptoms and resistance to structural oppression. This approach shifts the emphasis from internal deficits to the dynamics between individuals and the environment they live in.

The recovery model has been considered an iterative development of the social model, which challenges the biomedical model by focusing on the non-biomedical factors that relate to distress (Tew, 2004b). There is an increasing consensus on the importance of developing a more holistic framework for understanding recovery perspectives, as different people have different understandings and experiences of the recovery (Slade, 2009; Starnino, 2009). A more holistic recovery framework was argued 'in terms of the ability to "get on with life" in a way that seems appropriate and meaningful to them' (Tew, 2002, p. 151). Wilber's four-quadrant approach is relevant.

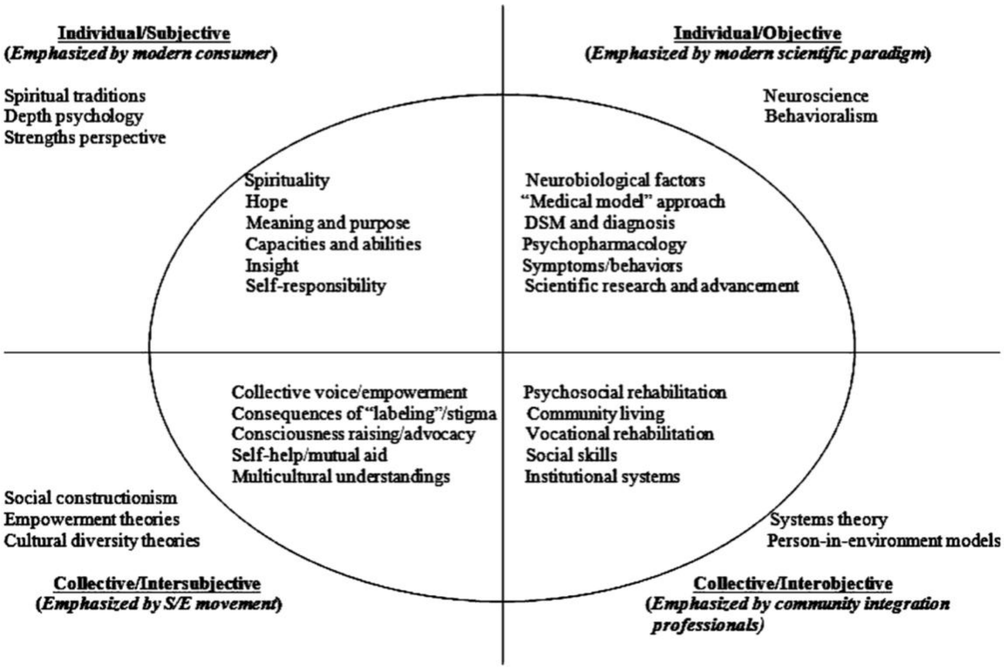


Figure 1 2.1. Recovery themes situated into quadrants alongside their respective philosophical underpinnings. Wilber (2001), cited in Vincent R. Starnino, An Integral Approach to Mental Health Recovery: Implications for Social Work, 2009,p. 833

The four quadrants provide a framework for classifying theories across four distinct domains based on the particular lens used to perceive the world. Through the interior consciousness and exterior physical correlates, the four quadrants illustrate the subjective and objective lens for perceiving the world in an individualistic or collectivist way. A connecting circle linking each quadrant illustrates the interdependence of all perspectives and ideas. No single perspective or sector provides the entire truth in its own (Starnino, 2009). Wilber (2001) believed that what appear to be opposing perspectives are frequently only different ways of looking at the same issue. This framework itself is a constructed concept and interpretation. It questions whether there should be a more holistic strategy to bring together the diverse ideological contributions that comprise the modern recovery vision. Therefore, Wilber's integral approach is not a unified or 'single' model of recovery, but a method to integrate different views under a framework to understand and to give flexibility and continuity to the recovery vision (Slade, 2010).

2.3.2 Chinese people's help-seeking attitudes and behaviours

Chinese people in Western countries outside Australia

The first section has elaborated on the emotional suppression and endurance promoted in mainstream traditional Chinese culture – the Confucian culture. The reputation and benefit of the larger family and society predominate over the individual's feelings, thoughts and experiences. Although 'shame' shares a range of social contexts worldwide, shame in Chinese culture is profoundly associated with an individual's 'weak' character, which is regarded as dishonouring their ancestors and family reputations. Experiencing mental distress and seeking help from outside would be subtly interpreted as 'losing face' in the Chinese lingual context (Tieu & Konnert, 2014), which may further explain Chinese people's recovery attitudes and strategies.

Generally, people from Chinese cultural backgrounds in Western countries (e.g. USA, UK, Canada, New Zealand) have demonstrated reluctance to seek help from mainstream mental health services (Ma, 1999; Maeshima & Parent, 2022; Na et al., 2016; Tang, 2019a; Tieu & Konnert, 2014; Zhang et al., 2013). Some studies have found that Chinese people tend to seek informal resources in response to their distress, such as self-care treatment and in-home remedies (Ma, 1999), and through relatives and friends (Spencer & Chen, 2004). The barriers toward accessing formal mental health services include but are not limited to inadequate culturally responsive services, language-based discrimination, lack of English proficiency, different cultural-based perspectives on shame, lack of Westernised mental health literacy, rejection of a pathologised diagnosis, structural discrimination (e.g. insufficient mental health-related policies for immigrants and lack of access to affordable services), unpleasant therapeutic relationships with professionals and involuntary experiences of hospitalisation (Chen et al., 2010; Li & Chong, 2012; Liu et al., 2015; Neufeld et al., 2002; Spencer & Chen, 2004; Tabora & Flaskerud, 1997; Tang, 2019a; Tse, 2004; Yang et al., 2014; Zhang et al., 2013).

The Chinese cultural values of collectivism and filial piety might also explain the low uptake of mental health services. Tse (2004) pointed out that Chinese people tend to believe in the 'ultimate fairness' of destiny or someone's fate and ascribe all sufferings to universal rules beyond humans' control. This kind of attribution makes it more likely that someone will accept an experience of distress instead of trying to solve it and reach their own goals. They may internalise this concept and believe the solution is beyond their control. Thus, they might become more passive, accepting the fact rather than seeking help and challenging it. However, Li et al. (2014) provide a different culture-based insight. They argue that Chinese people construct a different discursive pattern to protect them and lessen social stigma. In this case, Chinese people can avoid being othered by the 'normal world' (p. 78), and are able to create a safe space to talk about their lived experiences. This strategy does not reflect the submissive attitude towards fate but strongly demonstrate vivid protraits of resilience of people that carry Chinese cultural features in responding to mental health challenges.

Apart from the above forms of help-seeking patterns, Chinese people with a higher level of awareness of Western constructs of mental distress are more likely to access mainstream mental care practice (Green et al., 2006; Spencer & Chen, 2004; Tabora & Flaskerud, 1997). 'Pragmatism' (Tabora & Flaskerud, 1997) and 'medical pluralism' (Green et al., 2006; Kuo & Kavanagh, 1994) are used to describe consumers' preference for using both traditional Chinese therapies and mainstream mental health services in the Western countries.

Research conducted in New Zealand demonstrates that the under-representation of data on Chinese people in the mental health profession indicates issues of concern behind the low use of mental health services. Since Chinese people's general mental health situations are not obvious in the public data sets, related policies might not take these needs into account, which leads to less funding and policy support regarding the improvement of culturally sensitive services in current New Zealand mental health systems (Zhang et al., 2013). This situation might be relevant to that in the Australian context. In the next section, we will examine how Chinese people utilise mental health services in Australia.

Australian Chinese people

The low uptake of mental health services by people from Chinese cultural backgrounds has been widely reported in the Australian literature (Blignault et al., 2008; Chan & Ritchie, 2011; Kokanovic et al., 2006a; X. Lin et al., 2016; Lu et al., 2014; Minas, 2021; Poon et al., 2013; Uygur et al., 2011). This phenomenon is also reflected in the Australian Bureau of Statistics. The 2011 ABS data (including the country of birth and language spoken at home) showed that the proportion of using MBS-subsidised mental health-related services among people from Chinese cultural backgrounds was roughly half of that of the total CALD population, ranking nearly the lowest among all ethnicities (Appendixes 1 & 2). The low rate of service utilization by Chinese consumers does not imply that Chinese people are experiencing mental wellbeing; there are many possible explanations. It is to the point that, although this data dates back a decade ago, it is the only current officially released data in recent years for the specific inclusion of Chinese ethnicity.

Many studies have found that the most mentioned reasons for limited access to public mental care services include low mental health literacy, deeply-rooted stigma on mental issues, communication difficulties, lack of trust in Western medical techniques, and insufficient knowledge of available services and resources, especially the availability of culturally appropriate and discrimination-free services (Blignault et al., 2008; Chan & Ritchie, 2011; Fun Chan & Quine, 1997; Fung, 1997; Kokanovic et al., 2006a; X. Lin et al., 2016; Lu et al., 2014; Minas, 2021; Poon et al., 2013; Uygur et al., 2011). Recent research also found that financial difficulties became significant during the initial relocation to Australia, as immigrants might not be entitled to social security benefits and public healthcare (Poon et al., 2021). The increasingly intense political and economic situation between major Western countries and China also has impacts on Chinese people living in Australia. The political tension is a macroscopical factor that may negatively affect Australian Chinese people's sense of security and wellbeing (Minas, 2021).

There is a distinct theme in the literature of help-seeking behaviours in the past three decades. Earlier literature showed that Chinese people with mental distress had limited trust in medical treatment, and they would postpone seeking mental health professionals' help as possible. Instead, they relied primarily on their family and supportive others (Fung, 1997; Mak & Chan, 1995). They might apply different traditional Chinese therapies to overcome mental distress at this stage. The documented forms included food therapy, changing *fengshui*, *qigong*, religious worship, cupping, therapeutic massage, acupuncture, and so on (Fun Chan & Quine, 1997; Lu et al., 2014; Wong et al., 2017; Wong et al., 2010). However, there is a growing tendency toward medical pluralism in Australian Chinese people's help-seeking patterns. The literature suggests that family and friends are prioritised in the resource ranks and notes the compatibility of traditional Chinese therapies and Western mental health services (Lu et al., 2014; F. Martin, 2020; Poon et al., 2021; Wong et al., 2010).

It has been argued that, considering the large numbers of people from CALD social backgrounds, Australian mental health services to prioritise the provision of culturally safe, responsive and sensitive care with ongoing practices (Blignault et al., 2008; Hsiao et al., 2006a; Kokanovic et al., 2006b; Wong et al., 2017). In some studies, Chinese people pointed out the importance of a deep understanding and awareness of Chinese ethnicities and cultures in the mental health services (Cheng, 1985; Hsiao et al., 2006b; X. Lin et al., 2016; Poon et al., 2021). Moreover, mental health professionals with cultural sensitivity can bridge consumers' concerns, facilitate communication with consumers and work to provide satisfying and reciprocal service outcomes (Chan et al., 2004; Chan & Ritchie, 2011).

Some scholars pointed out the significance of improving Australian Chinese consumers' mental health literacy in response to the challenges of mental distress in their daily lives (Lu et al., 2014; Wong et al., 2010). According to Wong et al. (2010), mental health literacy as a Western concept refers to 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention.' (p. 2). Chinese people might initially report somatic symptoms to clinicians as they might not be clearly aware of the distress and overlook the necessity of interventions (Chan et al., 2004; Lu et al., 2014). However, in this study, which is committed to cultural awareness and sensitivity, I argue that mental health literacy should embrace cultural understandings despite its original Western definition. In this way, mental health literacy will not be limited to its Western construction, which does not reveal the amount, extent and visibility of mental distress among Australian Chinese consumers, and may deter consumers' help-seeking attitudes and behaviours in response to mental distress. Table 2.1summarises the studies mentioned above that specifically detail mental health service use among Australian Chinese consumers.

Author(s) (publication year)	Specific population subgroup	Sample size/gender	Study design/type	method	Key words of findings
Fun Chan and Quine (1997)	Adult	8 focus groups 45 females, 6 males	Qualitative Descriptive and explanatory	Focus group	Fact of service utilisation Help-seeking pattern Advice for further research
Fung (1997)	Female adult	2 females	Qualitative	Case study	Barriers to accessing and using services
Chan et al. (2004)	N/A	N/A	Literature review	N/A	Advice for further research
Hsiao et al. (2006a)	Adult	28 consumers with carers	Qualitative	Phenomenological study	Advice for further research
Kokanovic et al. (2006b)	Adult not only Chinese	12 females, 8 males	Qualitative	Interview	Challenges in using services Advice for further research
Chan (2007)	Adult not only Chinese	16 groups	Mixed	Survey and focus group	Advice for further research
Blignault et al. (2008)	Consumer, service providers and community members	8 females, 1 male; 7 females, 4 males; 9 females, 4 males	Qualitative	Interview	Barriers to accessing and using services Advice for further research
Wong et al. (2010)	Adult	139 females, 61 males	Quantitative	Survey questionnaire	Advice for further research Medical pluralism detected
Chan and Ritchie (2011)	Adult	16 groups	Qualitative	Focus group	Fact of service utilisation Advice for further research
Lu et al. (2014)	Adult	171	Quantitative	Survey questionnaire	Barriers to accessing and using services Help-seeking pattern Advice for further research

Wong et al. (2017)	Chinese Australians; Shanghai Chinese; Hong Kong Chinese; Taiwan Chinesee	200; 522; 572; 287	Quantitative	Survey questionnaire	Advice for further research
Minas (2021)	N/A	N/A	Literature review	N/A	Fact of service utilisation Barriers to accessing and using services

Table 1 2.1. Summary characteristics of the included studies

Early in 2007, Chan (2007)suggested that in addition to the grassroots lobbying of consumers and caregivers, it is necessary to support the concerns with research in order to push the government for greater funding for more people and resources. In recent decades, there have been very limited studies using interviews to collect qualitative data from consumers, which is the base of the methodology applied in this study. According to the above review, there is still considerable ambiguity about what improvements should look like, or whether improvements are being made. Additional studies of understanding Chinese consumers' attitudes toward mainstream mental health services and their help-seeking patterns should be conducted, as well as practical improvements and suggestions for mental health services.

2.4 Australian social work practice in mental health

A historical examination of the social work profession reveals that its participation in the mental health sector dates back to the earliest phases of its inception. Psychiatric social workers have been involved in mental health since the end of the 19th century and the first two decades of the 20th century, mainly involved in the after-care of discharged patients from psychiatric institutions. It is argued that social work knowledge and skills have a crucial professional role in applying a holistic and social perspective in caring for the mentally distressed (Aviram, 2002; Starnino, 2009). However, social work in mental health has been criticised for not challenging psychiatric dominance, which appears to have prevented social work from contributing its full potential to this area of practice and the people it serves (Aviram, 2002). Even though its potential for leadership in developing recovery-oriented practice has been highlighted, it still cannot shake off the dominant influence of psychiatry and clinical treatment (Khoury & Rodriguez del Barrio, 2015).

The situation in Australia is quite consistent with the development of social work in mental health in other Western countries, except that the cultural influence has a more significant position. At the beginning of the second half of the last century, there were only six qualified social workers in mental health settings with psychiatric education and training backgrounds, far less than other health services (Lawrence, 2016). Soon after, Australia witnessed a rapid development of social work in the mental health field. About 10 percent of social workers in the whole mental health workforce in Australia were actively practising social work values in hospital and community mental health services, non-governmental organisations, and private settings (Bland et al., 2021).

Early in 2003, Fook (2003) urged Australian social workers to take leadership foster inclusive practice-minded research and research-minded practice, as well as focusing on social justice and empowerment. Social work practice in mental health shall reflect the value foundation of the consumer movement. A logical extension of the traditional empowerment principles that currently guide mental health services is to search for ways to involve consumers in a wide range of professional tasks, from the education and training of social workers to the development of services, including the setting of standards for professional conducts (Bland et al., 2006).

The convergence of the recovery movement values and ideas with those of social work practice reflects the core spirits of the consumer-survivor movement and the significance of the recovery framework in social work mental health settings in Australia (Hyde et al., 2015). However, its uncritical embrace of neoliberalism, which focuses primarily on 'economic rationalisation, biomedicalisation, and individual responsibilisation, alongside rationalised practices that emphasise evidence-based and short-term efficiency-based models' is criticised (Brown, 2021, p. 644). It is contended that as a disempowered profession, social work is confronted with a crisis as it strives to reconcile its radical and critical commitment to more inclusive, social justice practice while frequently operating within environments that require the subordination to neoliberal biomedicalism (Brown, 2021; Morley, 2003). In Australian social work, there has been a solid determination to facilitate recovery approaches in mental health services and practice. Importantly, the significance of working with the lived expertise of consumers and families has been demonstrated, emphasizing social factors, primarily relationships, as the core of hope and recovery (Bland et al., 2021).

Australian social work is critiqued for having inherited the epistemological and ontological assumptions of whiteness, despite the agenda of respecting diversities within practice fields and universities. Social workers are required to reflect on their racial positions and the extent of white privilege in their mindset (Afrouz, 2022; Walter et al., 2011). Further, social workers need to be aware of CALD consumers' race, ethnicity, cultural background, upbringing-based belief systems, and personal prejudices related to their own cultural values that might influence their therapeutic relationships with practitioners (Wright & Van Der Watt, 2010). It is crucial for social workers to provide culturally sensitive, appropriate and safe services in working with people with mental distress and relevant families and caregivers (Khawaja et al., 2013; Poon & Lee, 2019; Poon et al., 2013). Therefore, scholars urge the necessity of providing cultural awareness-based education with 'ongoing professional development opportunities' to facilitate social work students' authentic cultural competence (Maidment et al., 2011, p. 13; Mlcek, 2013). Notably, in an outstanding contribution to studies on Australian Chinese people with mental issues, Poon et al. (2013) indicated the need to hire more social workers with Chinese cultural backgrounds to better meet service needs. The leadership of federal and state governments need to support this, so available resources and formal services can be extended to international students, immigrants and refugees (F. Martin, 2020).

While the recovery model and cultural influences on ethnic minorities are highlighted in the social work mental health field in Western transcultural societies, Australia is challenged to improve culturally responsive social work practice for the CALD population. Australian people from Chinese cultural backgrounds and their needs for social work services are not well represented in research, especially when the recovery model and cultural factors are taken into account. With an eye on the possible directions of social work research in the literature, the critical perspective of this study will bring together the core values of social justice and empowerment, the recovery perspective, and understanding and respect for the lived expertise of CALD consumers through exploring participants' lived experiences of mental distress.

2.5 Summary of the chapter

This chapter reviews the Australian literature that accentuates the sociocultural factors contributing to Australian Chinese people's lived experiences of mental distress. Migration experiences and the pressures of a new cultural context in the context of racism and Eurocentric approaches to mental health are two significant aspects of the social dimensions of Chinese people's mental wellbeing. Apart from an increasing focus on the relationship between the educational factor and mental wellbeing, the extant literature highlights the low mental health literacy of Australian Chinese people to explain the invisibility of the impacted population and the low uptake of mainstream mental health services. Australian studies have identified some barriers to the Chinese population's access to mental health services – their attitudes to seeking help and diverse help-seeking patterns. This study argues that despite its Western background, the understanding of mental health literacy among Australian Chinese people should embrace Chinese cultural understandings in a wider development of the CALD social context. TCM and Confucian cultural perspectives offer valuable backgrounds in this regard. However, given the limited exploration of social and structural dynamics, the subsequent chapter's theoretical discussions offer additional viewpoints.

This literature review identified a gap in qualitative research on mental distress and recovery in the contemporary Australian literature on the Chinese population. It acknowledges the lack of attention to demographical differences. Given the gaps in the Australian social work literature – that people from Chinese cultural backgrounds and their needs for social work practice in dealing with the distress challenges have not been well examined – this study argues an urgent need for recovery perspectives to be integrated into culturally responsive, sensitive and safe social work practice. The study argues that allowing people with lived experience of mental distress to construct their own unique experiences and understandings of recovery through a holistic, individual-context-based discourse is crucial to the development of effective interventions.

CHAPTER 3 Theoretical framework and methodology

Drawing on the literature review, this chapter starts by re-stating the research aim and questions. To answer the research question, the suitability for this study of qualitative methodology informed by social constructionism, critical race theory and a focus on recovery pathways is presented. After outlining the considerations of ethics and rigour, the chapter introduces how the data was collected, transcribed and analysed. The practising reflexivity is another important consideration throughout the process of the research.

3.1 Aim of the research and the research questions

This study explores the lived experiences of mental distress among people from Chinese cultural backgrounds in the Australian social context. The responses of people in mental distress to challenges and how they navigate their roles and identities during their recovery journey are explored. The literature review reveals that, although lived experiences of mental distress among overseas Chinese people have been discussed worldwide, the experiences of Australian Chinese people have rarely been examined, nor have their understandings of recovery and experiences of mental health services been sufficiently canvassed. Do they experience mental distress differently? What are their opinions concerning mental health services and support? How do their lived experiences construct their understanding of recovery? What knowledge might contribute to improving social work's support for them? To explore the first-hand experiences and voices of Australian Chinese people, the main research question underpinning this study is: What are the lived experiences of mental distress among people from Chinese cultural backgrounds living in Australia, and how do they understand their recovery journey?

3.2 Theoretical framework

Epistemology concerns the nature of knowledge; it relates to philosophical issues pertaining to the structure and origins of the knowledge (Rawnsley, 1998; Tuli, 2010). Like other social sciences, social work research is commonly associated with interpretivist or constructivist epistemologies. For most qualitative research, an interpretivist-constructivist perspective is taken to explore the world, with the premise that knowledge is produced by people in their interactions with others and within the broader social systems. Tuli (2010) argues that qualitative inquiry aims to uncover the interpretations of specific phenomena under a series of specific settings rather than to generate universal principles for a population. Researchers' viewpoints can vary widely, due to their unique cultural backgrounds, philosophical stances, and professional experiences. Researchers take different worldviews about the nature of reality and knowledge, which sets the base tone for the theoretical framework and answers the research questions in a chosen way. It is important for researchers to identify their epistemological positions regarding the paradigm or research tradition they apply, because it contributes to the rigour and credibility of qualitative research (Anastas, 2004; Becker, 1996; Gringeri et al., 2013; Tuli, 2010). Moreover, it provides a meaningful chance to examine 'our own knowledge formation processes' (Takacs, 2003) in achieving robust epistemological integrity by being open and transparent in discussing the reflexivity and the power within relationships with participants (Gringeri et al., 2013).

The epistemological position adopted in this thesis aims to be sensitive to diverse ways of understanding experiences based on different backgrounds, experiences, worldviews and values. This study is designed to investigate if different lived experiences of mental distress and different understandings of recovery exist among people from Chinese cultural backgrounds in Australia in comparison to Western knowledge. If so, how could these be described? By conducting qualitative research, I was privileged to have access to first-hand narratives from participants. Social constructionism and critical race theory are well-placed to provide the theoretical foundation for answering the question. More importantly, my role as a person with some similar experiences to the participants and as a doctoral student impacted each stage of the study, highlighting the necessity of examining my reflexive stance constantly and thoroughly exploring the trustworthiness of my data and findings.

Social constructionism emerged from 'the paradigm war' in the second half of the 20th century, during which debates on epistemology reached their unprecedented height, when a number of philosophers and social scientists joined the discussion led by French intellectuals Jacques Derrida and Michel Foucault. These scholars argued that the privilege and hegemony of scientific research strengthened power differentials for technocratic and corporatist elites (Lichtman, 2014c; Padgett, 2008). In contrast to scientific methods, social constructionism argues there is no objective truth that can be accurately mapped or understood. Facts are artefacts and products constructed within specific social and cultural settings. The way we understand the world is the product of the historically and socially interactive processes through which we interact and negotiate with different groups of people (Galbin, 2014). Meaning is seen as 'the product of the prevailing cultural frame of social, linguistic, discursive and symbolic practices' (Galbin, 2014, p. 84); language is not only the tool that we communicate with, but the matter we 'exist' in (Burr, 2019). Social constructionism is a significant theoretical challenge to the taken-for-granted 'realities' in the positivistic world (Bradley, 2022). It brings a critical attitude to the way we understand mental health. Social constructionism in mental health problematises the concept of mental illness as an 'independently existing nature or reality', arguing instead that it is 'the product of specific socio-historical periods' (White, 2017, p. 24). Within this setting, social constructionists question the idea that mental distress could be explained by objective natural science; the biomedical base of labeling an individual as 'mentally ill' reflects the values and prejudices of psychiatric professionals and the norms of society in a specific context and historical time (Galbin, 2014). Compared to the conventional conclusions about mental distress from professional perspectives, adopting a social constructivist position is likely to uncover the experiences of mental distress from a different perspective that challenges the predominant biomedical paradigm.

The key purpose of this study is to explore the lived experiences of surviving mental distress among the Australian Chinese population through their narratives rather than examining participants' 'illness' through professional perspectives. By applying the epistemology of social constructionism, this study opens a space not only for describing the 'facts' of mental distress experiences, but also for exploring the meanings of recovery from mental distress, and how participants navigated and negotiated their roles and power during these experiences.

Moreover, the critical perspectives in social constructionism cohere with the recovery-related lens to view participants' experiences in a hope-inspiring and empowering manner, and challenges the biomedical discourse that pathologises mental distress as an individual responsibility (Beresford, 2002; Mcdermott et al., 2012; Reavey et al., 2013) and considers only what are regarded as absolute facts (Bracken, 2012; Cohen, 2017b).

In the development of social constructionism, the urgency of critical work on mental health has been stated (Cohen, 2017a). In the *Routledge International Handbook of Critical Mental Health* (2017) publication, among other critical texts, richer and more nuanced perspectives that explore mental distress through class, gender, race, culture, etc., have been systematically introduced. In this study, critical race theory has much to offer in understanding factors in lived experiences of mental distress, such as race, sex, cultural backgrounds, power issues in familial and public societal settings, and so on. According to Moodley et al. (2017), critical race theory first grew out of the liberal and positivist views of law and the unfulfilled promise of civil rights legislation. As it developed, critical race theory has become a way to look at power dynamics in a culturally diverse and postcolonial context. Critical race theory accentuates the importance of delving into the sociocultural factors that affect how we and others experience, make sense of and respond to racism. It also explores how sociocultural factors construct lived realities and the intertwined social dynamics. In critical race theory, race is understood as a socially constructed product that is 'engrained in the fabric of existing power structures and the societal landscape,', where 'non-whites' are subject to overt and covert social, political and economic disadvantages with a higher risk of the perceptions of deviant and abnormal populations (Moodley et al., 2017, p. 81).

Critical race theory has its specific advantages in this study. It incorporates an intersectionality perspective to highlight the complexity and multidimensionality of oppression. It also examines how various forms of inequality and identity (e.g. race, gender and national origin) interact in different circumstances. Therefore, the use of critical race theory recognises that participants' lived experiences of mental distress vary across many intersections. And it also enables a more complex and nuanced analysis of the lived experiences of the participants who come from an ethnic minority group and might face various forms of inequalities in their recovery journeys.

Additionally, critical race theory encourages the construction of counter-narratives by marginalised individuals as a technique for challenging dominant discourses. According to Moodley et al. (2017), counter-storytelling is an approach to telling the marginalised and discriminated lived experiences that are not often told by disempowered populations. Therefore, critical race theory provides a strategy for examining participants' narratives from a perspective that counters the predominant biomedical discourse in mental health. Critical race theory again echoes and iterates the emphasis on the mainstream white-led language and power, which construct non-whites in marginalising and discriminating terms. Together with the social constructionist epistemological position applied in this study, this research approach enables a critical analysis of the construction of the meanings of participants' lived experiences of recovering from mental distress.

3.3 Qualitative methodology: Why is this the best way to answer the research question

After the 1980s, many critical theorists and feminist researchers pushed for research that took into account the experiences of marginalised groups (Fortune, 2013; Lichtman, 2014c; Patton, 2015). The essence of qualitative research is the exploration of meanings and interpretations of people and their contextual conditions. By treating people as active respondents, a qualitative study aims to deliver the silenced voices of the marginalised and the vulnerable and address social justice issues (Liamputtong, 2019; Lichtman, 2014c). Therefore, qualitative research is grounded on the notion of the social construction of realities, rather than the search for objective 'truths' (Flick, 2011). Fortune (2013) further explained:

> Qualitative research can be understood as an epistemological or paradigmatic stance, a statement of what can be known—constructions of the world—and how it can be known… Knowledge is thus understood as a social construction—a worldview for groups of people. (pp. xii-xiii)

Although diverse, qualitative research has some common elements. It emphasises the context where social interactions take place. It takes the position that realities and facts are socially constructed. It illuminates the details of the voices of participants, and it also interprets and explicates the meaning-constructing process of everyday practices and everyday knowledge in natural settings (Flick, 2011; Fortune, 2013; Lichtman, 2014c; Patton, 2015; Shaw & Holland, 2014b).

Two prominent roles in qualitative research are the participants and researchers. In some studies, the authors define participants as 'the researched' (Finlay, 2002, 2003; Gough, 2003; McKenna, 2007; Saldaña, 2011; Shaw & Holland, 2014b; Wilkinson, 1988), which I do not agree with because it might reflect a privileged and expert-superiority attitude which is not consistent with the language and terminology this research adopts. Participants who account for their unique experiences are 'active respondents' (Liamputtong, 2019, p. 11) rather than objects to study in a hierarchical relationship. Qualitative researchers are inquirers instruments who usually have extensive interactions with participants and have strong commitments to examine their narratives and perspectives, endeavouring to employ multiple theoretical frameworks and paradigms to explore diverse viewpoints. The methods that they select strongly reflect their epistemological stances. There is no doubt that their positionality and reflexivity will have impacts on the findings of the research. In other words, qualitative research is value-driven, and the researchers play a critical role in it (Flick, 2011; Fortune, 2013; Liamputtong, 2019; Lichtman, 2014c). In all, qualitative research is interpretive. It allows researchers to use theoretical frameworks in order to develop an understanding of the issues they examine. During this process, participants and researchers and their relationships and interactions answer the specific research questions through the collaborative construction of knowledge.

Therefore, a qualitative methodology focused on the recovery journey is a suitable approach to answer the research question in order to unearth the unnoticed stories of Chinese people who are in a unique position to discuss the lived experiences of and responses to mental distress in Australia. A qualitative research methodology focused on recovery pathways might find hopeful aspects of the lived experiences that make a difference to the context of distress.

It emphasises autonomy and self-determination, effective and supportive social connections, collaborative and meaningful engagement, strength and responsiveness to diversities. From a social work perspective, I aim to use language that is free of pathologisation and discrimination to minimize potential harm to participants during the research process and demonstrate an inclusive stance in the recovery-oriented approach (Australian Health Ministers' Advisory Council, 2013a, 2013b; Department of Health, 2011).

As mentioned in the literature review, qualitative data is needed to provide a more nuanced understanding of the lived experiences of mental distress among Chinese people living in Australia. In this context, a qualitative approach to this topic is justified as it wishes to explore a little-known and sensitive phenomenon with a certain emotional depth. It expects to give 'voice' to those who can provide lived experiences and to create meaning from it (Holosko, 2010; Sofaer, 1999).

In summary, the use of qualitative methodology suits the need to examine in a nuanced and subjective way how Australian Chinese people experience mental distress and how these people make sense of recovery, considering the intersections of personal, social, cultural and political factors. This approach acknowledges that realities are co-constructed by lived experience; the researcher's reflexive stance adds depth and echoes the epistemological considerations clarified in the former section.

3.4 Ethical considerations

Ethical considerations are essential in this research, especially when the group of studied people is disempowered and with perspectives that have been marginalised. Shaw and Holland (2014a) point out that it could be challenging for researchers to elicit the participants' experiences, feelings, and thoughts when the research topic is personally sensitive. Researchers should think about how their actions will affect participants and work to protect participants' safety and rights. To prioritise a safe and harmless research process, ethical conduct for researchers entails adhering to a set of moral principles, rules, or standards. This study was conducted within The University of Sydney ethical guidelines, Project Number:

2020/575. This study also considered the code of conduct from the National Association of Social Workers and the Australian Association of Social Workers. To ensure the ethical considerations are compatible, this study also learned from other books, for example, *Sage Research Methods* (Lichtman, 2014b; Reamer, 2010; Shaw & Holland, 2014a). The specific ethical considerations in this study are as follows.

Respect autonomy and self-determination. As the participants in this study are people with mental distress experiences from different Chinese cultural backgrounds, I demonstrated respect for their cultures, backgrounds and autonomy. For example, I purposefully avoided any potential start of a conversation that was sensitive to politics, cultural and geographical bias, based on my observation of such arguments on China's social media. Moreover, participants in this research were fully informed of their right to make independent decisions on stopping and/or pausing the interview if uncomfortable feelings were identified (AASW, 2010; NASW, 2017; Traianou, 2014).

Do no harm. This principle includes two aspects, one for participants, the other for researchers. First, the safety and wellbeing of participants are paramount, and doing no harm to participants is considered the cornerstone of ethical conduct (Lichtman, 2014b), especially since participants are particularly disempowered in this research. Researchers need to ensure that their agendas do not take precedence over participants' emotional and physical health (Reamer, 2013). When it comes to issues participants do not want to talk about any further, those decisions should be honoured as an indication that we have reached the borders of privacy and intimacy we have to respect (Flick, 2007b). It is assumed that qualitative researchers often have access to the most private corners of participants' lives, which means participants might feel overexposed or emotionally at risk when revealing details about private lives and wish they had not shared (Flick, 2007b; Reamer, 2013; Traianou, 2014). For example, when I noticed one participant crying while talking about his stories, I asked if he needed to take a break. It was obvious that the story he was talking about greatly saddened him. The participant insisted on continuing after drinking some water. I double checked with him again if we could continue the same topic, and we only started when he clearly confirmed.

Second, Shaw and Holland (2014a) stress that the emotional safety of researchers is also important. Researchers might sympathise when having interviews with participants, and participants' narratives may impact researchers. According to my experience, this was particularly obvious during the lockdowns of the Covid pandemic, when uncertainties and insecurity were all magnified. In order to distance myself from the emotional impact of the interviews, I wrote field notes every time after interviews, transcriptions, translations and reviews during the analysis. Moreover, regularly communicating with supervisors and peers helped me relieve the excessive emotions when immersed in the data for too long.

Confidentiality and anonymity. Confidentiality and anonymity are fundamental and vital requirements for credible research. Being identified may have an unexpected impact on participants' daily lives, which is unnecessary and can have many adverse consequences (AASW, 2010; Lichtman, 2014b; NASW, 2017; Oka & Shaw, 2003; Reamer, 2013; Shaw & Holland, 2014a; Traianou, 2014). Therefore, identifiable personal information was removed; each participant was also allocated a pseudonym. None of the interviews were saved as video recordings. The interviews were saved as audio recordings in the cloud provided by the University. To ensure sufficient information from interviews was captured, I took field notes of participants' body language, facial expressions and any changes of emotions in each interview.

Informed consent. Participants in this study were survivors of various forms of oppression, abuse and neglect. The consent form ensures that participants were aware of the necessary details of the research, including the aim of the interview, the process of confidentiality I would adopt and the potential benefits and risks before participants agreed to attend the interview (AASW, 2010; Flick, 2007b; Lichtman, 2014b; NASW, 2017; Shaw & Holland, 2014a). The University-approved Participant Information Statement and Participant Consent Form were distributed to each participant after the first contact initiated by participants. Participants received and signed the consent form before the formal interviews began.

Boundary issues. Building rapport and trustworthy relationships with participants will promote the quality of the data collected. But Lichtman (2014b) draws attention to the fact that there is a difference between developing rapport and being friends. Researchers are responsible for providing a safe environment for participants. They should be sensitive to their power over the participants, avoiding setting up situations where participants have unrealistic expectations and regard ongoing support as friendship. Although self-disclosure is encouraged for researchers to connect with participants (Shaw & Holland, 2014a), Lichtman (2014b) mentions a reasonable expectation that researchers should not be too intrusive with participants regarding their time, space and personal lives. These boundary issues were particularly paid attention to when I realised my participants would personally see me as a close stranger who knew more of their private thoughts and feelings than their friends but remained an uninvolved person in their social network. Although leaving participants was difficult to some extent, as there was a risk that this might hurt their feelings in contrast to offering an ongoing relationship, I explained the limitations of my role in a sincere manner. Participants understood and appreciated the transparency and honesty of this conversation.

3.5 Rigour

The concept of rigour in qualitative research has a relatively short history compared with quantitative research. Before the 1990s, a quantitative method had the predominant role in research fields, and criteria such as objectivity, reliability, and internal validity was accepted even in naturalistic enquiries. This situation continued until 1990-2000 when Guba's standards of rigour in naturalistic research were broadly embraced by qualitative researchers (Lichtman, 2014d).

Guba (1981) summarised trustworthiness in four naturalistic terms matching the four aspects of quantitative/scientific research, including credibility, applicability, consistency and neutrality. Credibility refers to the degree to which the findings represent the meanings of the research participants. Researchers, as the study instrument in qualitative research, should be aware of the potential impacts on their roles in the credibility of the research findings. Applicability refers to the degree to which the research could be conducted in similar/same contexts, settings or groups. It could also be understood as transferability, which does not imply generalisation but forms 'working hypotheses that may be transferred from one context to another depending upon the degree of fittingness' (Guba, 1981, p. 81). Consistency refers to the degree to which the findings could be consistently repeated within a similar or the same context and discipline. Under some circumstances, the terms dependability, stability, and trackability could be interchanged. Based on this understanding, Franklin et al. (2010) replace consistency with audibility – the degree to which research procedures are documented and could enable reviewers to follow and critique the whole process. The fourth is neutrality or confirmability, which allows reviewers to confirm or corroborate the findings and to ensure the findings are consistent with knowledge from research participants as far as possible, rather than being influenced by biases, motivations, interests and perspectives. Guba provides detailed suggestions to add to the rigour of qualitative research, such as member-checking, prolonged engagement, persistent observation, triangulation of data (cross-checking), peer debriefing, thick descriptions, audit trail and practising reflexivity (Lincoln & Guba, 1986). Lietz and Zayas (2010) also provide a summary of research strategies and questions worth asking, to increase the trustworthiness of qualitative research based on the work of Guba (p. 198–199).

Specifically, Patton (2014) encourages the following strategies to respond to the rigour of qualitative research in social construction and constructivism philosophical frameworks:

> -Subjectivity acknowledged (discuss and take into account inquirer's perspective);
> -Trustworthiness and authenticity (these are also mentioned in the work of *Lincoln and Guba (1986)*);
> -Interdependence: relationship-based (intersubjectivity);
> -Triangulation (capturing and respecting multiple perspectives);
> -Reflexivity;
> -Particularity (doing justice to the integrity of unique cases);
> -Enhanced and deepened understanding;
> -Contribution to dialogue;
> -Extrapolation and transferability;
> -Credible to and deemed accurate by those who have shared their stories and perspectives. (pp. 684–686)

Although the strategies for securing rigour in qualitative research might vary due to multiple factors, experienced researchers have suggested that there is no consensus on which criteria should be applied to identifying rigour in qualitative research, nor is the notion that the more criteria the better the research accepted by qualitative researchers (Poduthase, 2015). Nevertheless, according to the review of 100 articles drawn from social work journals, it is recommended that at least two of eight strategies – i.e. prolonged engagement and persistent observation, triangulation, peer review or debriefing, negative case analysis, reflexivity (clarification of researcher bias), member-checking, thick description, and external audits - should be applied in a qualitative social work research (Barusch et al., 2011). Moreover, qualitative researchers should treat the issue of rigour with depth, which should be built into the research process rather than evaluated at the very end of the enquiry (Cypress, 2017).

Based on the above review of the suggested strategies and the current contextual conditions of the research, this study applied thick description, peer debriefing and reflexivity to increase the trustworthiness and rigour. Thick description refers to the meticulous and rich details of qualitative data, which enable readers to immerse themselves in the descriptive context. By reconstructing the context, readers might be able to reflect on the process through which an analysis evolved, and examine the integrity of the translation and the logic of the conclusions (Creswell & Miller, 2000; Franklin et al., 2010; Guba, 1981). I achieved this goal by taking notes of subtle details I sensed during and after the interview. Also, I presented the vignettes of participants in an independent chapter (see Chapter Four) to introduce each participant's background and shape their unique images. At the end of the thesis, the appendixes demonstrate how this information was collected; and the following sections will also explain how the collection was conducted. Therefore, readers can notice this study's thick descriptions in many places.

Peer debriefing refers to the context where researchers can sever ties with the scene and seek out and communicate with other professionals who have insights or experiences and can and will serve in the debriefing capacity. The optimum way to employ this approach is over the course of an entire investigation (Creswell & Miller, 2000; Guba, 1981; Lietz et al., 2006). I did this by meeting with peers and supervisors regularly over the time when I was coding, generating themes and writing findings. I also discussed my findings with student colleagues from different social science disciplines who had interest in the research topics in forums held by the University. These were completed over a continuous length of time, which assisted me with ongoing reflections on analysis and writing.

As a study that critically challenges the biomedical paradigm in the mental health field, it is important to acknowledge the role of the researcher in the whole research process. For example, reflexivity involves thinking about how my identity, experience, epistemological beliefs, behaviours and decisions might impact interactions with participants and the research processes (Creswell & Miller, 2000; Lietz et al., 2006). Reflexivity is elaborated on in the next section.

3.6 Self-reflexivity: practice in the research process

In the 1970s, a growing methodological self-consciousness in the form of a 'confessional account' was valued amongst ethnographers and anthropologists. The discovery of reflexivity as the centre of methodological reflection was a new paradigm commonly accepted in the 1980s and 1990s, and exceedingly prospered in feminist studies (Wilkinson, 1988). In *A Dictionary of Gender Studies*, Griffin (2017) explains reflexivity as a capacity to think about the researcher's position critically, accepting the notion that knowledge is partial and dependent on the individual's position (gender, class, race, ethnicity etc.). Reflexivity is a stance that enables one to take account of this fact.

It is believed that findings in social science research are co-constructed products of researchers, participants and relationships (Finlay, 2002, 2003). The researcher's position, perspective and presence will impact how the findings will be presented. Researchers need to constantly reflect on the dynamics of subjective and intersubjective elements in the research process (Finlay, 2002). To maintain the rigorous nature of qualitative research, reflexivity is considered an evaluative tool to increase its integrity and trustworthiness.

It is important to clarify that there must be a distance between my participants and me. We shared something in common, such as similar lived experiences of mental distress, brought up within traditional Chinese cultures, or being of a similar age. Nonetheless, I am aware of the heterogeneous nature of Chinese people in Australia: each of them has a different life that led them to participate in this study.

I realised how my lived experience and academic knowledge shaped each research process, including how participants perceived me, based on their interpretations of my role as a researcher from the university. Based on such awareness, I came to understand the importance of establishing trusting relationships with participants, which could ensure the richness and depth of the stories those people would like to reveal. Disclosure of my lived experience of mental distress allowed participants to view me as a trustworthy ally whom they might feel safe confiding in. I was also careful not to share too much, as I did not want to take the focus away from participants' stories. Moreover, because I had similar experiences of mental distress, I was aware that by using everyday language free of problematising, the impact of stigma and the likelihood of distress after interviews could be reduced.

It was very difficult to recruit participants, but I was lucky enough, finally, to have nineteen participants who wanted to share their stories with me. Participants shared their most anguished, private and personal feelings and thoughts with me even though they might have concerns, such as that the Chinese community was small enough that others might recognise their presence in my study – this was well acknowledged as participants highly valued their privacy and anonymity. The interviews could provide a valuable space to reveal their personal emotions, raising self-awareness and self-reflection (Coombs et al., 2016; Hutchinson et al., 1994; Wolgemuth et al., 2015). I believe the experiences of getting involved in this study can be more than contributing to the lived experience in distress. After the interviews, some participants commented that the interview was such a relief that they eventually found a way to voice their genuine experiences, feelings and thoughts to someone they felt safe to speak to. Even more, these participants developed some new understandings about the recovery journey they had been experiencing. Some expressed an interest in helping others as peer supporters someday, when they felt strong enough to contribute.

As a researcher with a social constructionist view, I was aware of the power dynamics between participants and me, as we were the co-creators of the findings. The knowledge from participants constantly challenged and shaped my understanding of the research topic. While I had control of the design of the study, guiding the interview process and conducting the interpretations and analysis of the data, participants decided how the knowledge and experiences should be told. I learnt a lot from supervision, that I should never take binary perspectives to interpret participants' experiences and never attempt to evaluate the 'truth' of what I collected from the interviews. It was helpful to be involved in this study with a similar experience of distress, yet it did not mean that I possessed all the expertise or insights of all the lived experiences that could be. I was much more inspired by how participants' interpretations of the lived experiences challenged the predominant biomedical and white knowledge of mental distress.

To ensure the trustworthiness and rigour of the study, I regularly met with my supervisors and colleagues for advice. Also, I kept meticulous field notes and memos in the data collection and interpretation process, as these collected the intuitions, reflections, details of interviews, and early memories, which can be unexpectedly helpful, especially when researchers immerse themselves in data collection and analysis for months or years (Flick, 2007a; Galletta & Cross, 2013; Lichtman, 2014a; Nathan et al., 2019; Rubin & Rubin, 2005). The notes also helped me to be flexible and responsive in my approach to interviewing. For example, when participants specifically mentioned the impacts of Covid on their life, I adjusted my interview questions to include Covid-related topics, which was unexpected when I submitted my research proposal in 2019. It turned out that Covid-related topics led to some interesting and detailed discussions of racial issues in their lived experiences of mental distress. Further, it linked to the discussion of the different cultural backgrounds of mental health clinicians and the participants.

Again, acting as a social researcher who has personal background, culture and experience which hold the potential for shaping my interpretations, I also acknowledged the asymmetry of knowledge and information between the participants and me. I tried not to take an expert position; rather, I recognised my personal and professional experiences as a motivator of the reciprocal process of knowledge production, within which my understanding has developed in response to the knowledge from participants.

3.7 Data collection

To start talking about where and what kinds of participants can be recruited in this research, it is necessary to clarify that the representativeness of qualitative research is quite different from quantitative research. Quantitative research has the advantage of referring the study's findings to a larger population (Coyne, 1997; Flick, 2007c). However, qualitative sampling is not intended to ‘be representative when seeking to approximate known population parameters’ (Abrams, 2010, p. 537). The focus of qualitative research, particularly in the field of social science, is frequently placed on problems – such as actions, interactions, identities, and events – for which we do not have adequate knowledge of the distribution of phenomena to sufficiently inform sampling issues (Marshall, 1996; Rapley, 2013). Therefore, qualitative research does not aim to provide statistically representative findings or draw statistical inferences. In some ways, as Rapley (2013) argues, some generalisation is possible when qualitative samples have demonstrated representativeness of the population within a defined setting over a defined period of time. Therefore, while probability sampling provides representativeness to strengthen quantitative research, purposeful sampling– the most common form of non-probability sampling – is justified to strengthen qualitative research (Coyne, 1997; Emmel, 2013). Purposeful sampling, also known as purposive sampling, encourages researchers to apply their judgement in choosing samples that will provide the best perspectives on the topic of interest, and purposefully invite those opinions into the research (Abrams, 2010; Emmel, 2013). Patton’s detailed account of purposeful sampling was claimed to reverse the potential weakness of qualitative research into significant strengths (Emmel, 2013). Purposeful sampling aims to ensure the integrity of the research, the richness of data, the depth and scope of the conclusion, and most importantly, to increase credibility to convince the audience of the research (Abrams, 2010; Emmel, 2013).

Considering the following recruitment criteria, purposeful sampling was considered the best method for data collection. The intended participants were those with Chinese cultural backgrounds and those who emotionally or physically had connections to China, were living in Australia; had experienced mental distress and self-identified as being in a recovery process, and were over 18 years old. Inclusion of the grey data, having been diagnosed by a medical authority, was not necessary, as potential participants might not ever approach a mental health professional, given personal considerations or other contextual conditions. Considering that it might not be possible to recruit enough participants to complete the study, the caregivers and supportive others of the population were also welcome. Reimbursement was offered for time spent taking part.

In this research, participants were generally recruited from flyers distributed by mental health-related organisations and snowball sampling. As seen from the literature review, overseas Chinese people tend to be somewhat reserved about their experiences of mental distress because of limited access to mental health service systems. Therefore, I anticipated the population would be less likely to come forward so agencies might make access to the target group of people easier, which is common in mental health social work studies (de Jager et al., 2016; Hansen et al., 2019; Noble-Carr & Woodman, 2018; Nurser et al., 2018; Tang, 2016, 2019a). I contacted around ten organisations, multimedia platforms and social work agencies and asked if this recruitment could be advertised on their websites or bulletins. Only three agencies confirmed their help, and one social work agency wanted to help but didn’t get approval from their supervisors. Apart from that, I put flyers on the notice board in the university library and the flyers were distributed randomly to the general public from an organisation’s exhibition shelf. Recruitment through the relevant shelf in a community centre as backup plans. Eventually, five participants reached out to me through online bulletins of the organisations and social media, with one introduced by their networks. I recruited five participants through the university notice board, with eight more through their social networks. In order to make sure that there was no breach of privacy involved in accessing the contact details of potential participants, I only distributed the recruitment information and waited until participants proactively contacted me.

The sample size is another thing that needs to be clarified. An appropriate sample size for qualitative research is one that adequately answers the research question, which is often much smaller than that needed for quantitative research (Marshall, 1996). Ayres (2007) points out that participants in qualitative research are chosen to provide information-rich insights into the phenomenon under investigation, not for their representativeness of the related population. The sample size reaches its limit when new explanations, categories or themes stop emerging from the data, that is, data saturation (Marshall, 1996). Interestingly, core authors in reflexive thematic analysis argue for the flexibility of sample size because they are always sceptical about the usefulness of the saturation concept. These scholars consider sample size is often informed by ‘various contextual and pragmatic considerations, some of which cannot be (wholly) determined in advance of data collection’ (Braun et al., 2019b, p. 851). Based on the actual situation of recruitment, this research finally reached 19 participants. Detailed demographic information can be found in the next chapter. Nineteen participants turned out to be sufficient to collect narratives, as the key issues started to became repetitive when I was coding the last two to three participants’ interviews.

The study sample had its limitations. The composition of the participants demonstrated a noticeable proportion of students, which might be explained as the result of snowball sampling and the mention of reimbursement in the flyers. It also reflected that limited methods at that time were available to reach out to the potentially more diverse population, whose focus on managing the effects of mental distress might outweigh the attraction of the reimbursement and/or contribution to research.

Recruitment and interviewing were conducted simultaneously, which ensured an ongoing process to maximise time efficiency. To make participants feel comfortable and safe talking to me, a brief conversation between us prior to the interview was necessary, as it built rapport and sent out a friendly signal to participants, who would decide the way and the depth of the stories they intended to reveal. During this conversation, the Participant Information Statement and the Participant Consent Form (see Appendices 9 & 10) were read and signed by participants.

The in-depth semi-structured interview was the primary method to collect the narratives. Each participant was interviewed once. The anticipated length of an interview was 60 mins each, but some participants asked if they could speak longer with me, and I confirmed that such an extension would neither delay our arrangements afterwards nor do harm to their feelings during the whole process. All participants agreed that the conversations be audio-recorded. In case of any unforeseen issues with the recorder, I used two recorders together in every interview so that I had backups in case one broke down. Participants were also aware that they could decide to withdraw from the interview at any time without any adverse consequences, in the hope that this would relieve any potential tension raised by the perceived power imbalance between participants and me.

The semi-structured interviews involve a set of open-ended questions (Ayres, 2007; Harvey, 2020; Morris, 2015) approved by the Ethics Committee of the University, which enabled participants to reveal their expert insights into mental distress and recovery. I appended questions with the emerging topic of the ongoing impacts of the Covid-19 pandemic during the interviews, in this way, the study responded to the time-and-context-bound features of this study, increasing its rigour (Guba, 1981; Oka & Shaw, 2003; Rapley, 2013). I was committed to being flexible and innovative in collecting quality data. Since participants might speak different languages, I asked which language they would like to speak before the interview began. To provide the most comfortable environment for the interviews, I prepared the mentioned forms both in written English and Mandarin and confirmed the translations with one Chinese native speaker, who had signed the statutory declaration form as instructed by the guideline of human ethics of the University. In some circumstances, I applied the self-disclosure technique, revealing my experience, feelings and thoughts of distress to proactively create a safe environment for participants to talk freely. It turned out that this helped participants feel more affirmed and they even would speak about deeper aspects of their thoughts and feelings. To reach as many participants as possible, I invited every participant to share the interview information with their peers. Due to the satisfying quality of conversations, I received expressions of interest from their networks, which helped me recruit participants more effectively.

3.8 Data management

The recruitment, transcription and translation were conducted simultaneously. This is important, as Patton (2015) suggests themes, patterns or ideas might emerge during the data collection process, which could be hard to recall and are worth recording. Soon after the interview was completed, I uploaded these audio recordings onto the cloud platform nominated by the university ethics committee; all hard copies are digitised and stored in the same place. After that, the recordings were deleted from the recorders. The clearer recordings were chosen to conduct the transcription. I translated the recordings verbatim, including the paralanguage. Paralanguage sometimes does not appear in the quotes in the following three chapters (Chapters Five, Six and Seven)due to the translation, but it was mentioned in the analysis if relevant.

Since some participants spoke Mandarin (14) and Cantonese (1), I continued the translation process after the transcription. However, I found it challenging to complete the translation job myself because I lacked familiarity with translating written Chinese into English. Moreover, I was too immersed in the conversations such that, with the impacts of the Covid-related lockdowns in Sydney, I could not balance my mental condition and working load. Therefore, I asked the Mandarin native speaker who helped me proofread the flyers if they could help me again with the translation. Again, this procedure strictly followed the requirement of the guideline of human ethics of the University. Eventually, I independently translated five transcripts, and she completed the rest. She was also supportive in providing advice on the translation of slang and metaphors with regard to the Chinese lingual context. Except for the confidentiality concerns addressed in the national statutory declaration, I confirmed with her that the translation could stop at any time she felt overwhelmed to deal with it. However, she did not report anything and returned the translation at the scheduled time. After that, I reread 19 transcriptions, proofreading the translations and immersing myself again in the conversations. Most participants did not request the transcripts after the interview, except for one requested sent by email.

The Covid created uncertainty to every step of the study since 2020. This exceeded my expectation when I wrote my research proposal in 2019. I deeply reflected on my role as a researcher who might personally experience unanticipated circumstances when conducting the research and the necessity of embracing the experience as part of my life and, more importantly, a part of the research. Again, I committed to sorting out every challenge in this study in every flexible and innovative way that helped. After finishing the translation, these word documents were then uploaded to the cloud and deleted in the local drive. Analysis was conducted with the assistance of NVivo release 1.7.

With repetitive reading and immersion in the transcripts, the data continued to be thematically analysed. According to Clarke and Braun (2018), thematic analysis (TA) entails locating and analysing patterns of meaning in data and themes, providing interpretations and in-depth analysis, and ultimately making sense of what the data say in light of the researchers' theoretical precepts and epistemology. Therefore, TA is reflexive and theoretically flexible, fitting in a wide range of philosophical bases (e.g. constructionist and realist), approaches (e.g. inductive and deductive), data types (e.g. interview and focus group), datasets (small or big), samples (heterogenous or homogenous) and diverse qualitative research questions.

TA is ideal in this research as it fits a range of research questions, elucidating the specific nature of how people make sense of the particular phenomenon, including individual experiences, people's views and opinions, the reasons why people think or feel or do specific things and the factors or processes that underpin and shape such experiences or decisions (Braun et al., 2019a; Joffe, 2012). The core perspective from TA is also aligned with critical mental health theories, which argue that mental illness should not be simply diagnosed as biologically individual malfunctions without acknowledging the influence of experiences involved and other related economic, political and cultural contexts.

Braun and her colleagues have developed a six-phase reflexive thematic analysis process (Braun & Clarke, 2006; Braun et al., 2019b; Clarke & Braun, 2018), which are:

-Familiarising yourself with the data and identifying items of potential interest;

-Generating codes;

-Generating initial themes;

-Reviewing themes;

-Defining and naming themes;

-Producing the report.

Since I listened to each audio recording twice and read each transcript at least three times, the details of every interview deepened in my mind. I highlighted the most pertinent parts when I did the second reading – some metaphors were so impressive that I used them in the subheadings. The next step mainly involved the assistance of NVivo. I used descriptive codes to summarise the potentially important points and moved towards more abstract ones when some could be combined or categorised in different layers under one code. This step was done on a brainstorming board because I found it more productive and time-effective when using pins and pen to move whenever the themes came to wherever they could be placed. In this process, I strongly felt that reflexive thematic analysis was a data-driven inductive approach, from which the themes generated were subjective and interpretive. The researchers' disciplines, values, experiences and backgrounds would impact the process of developing themes and how the codes' layers could be constructed.

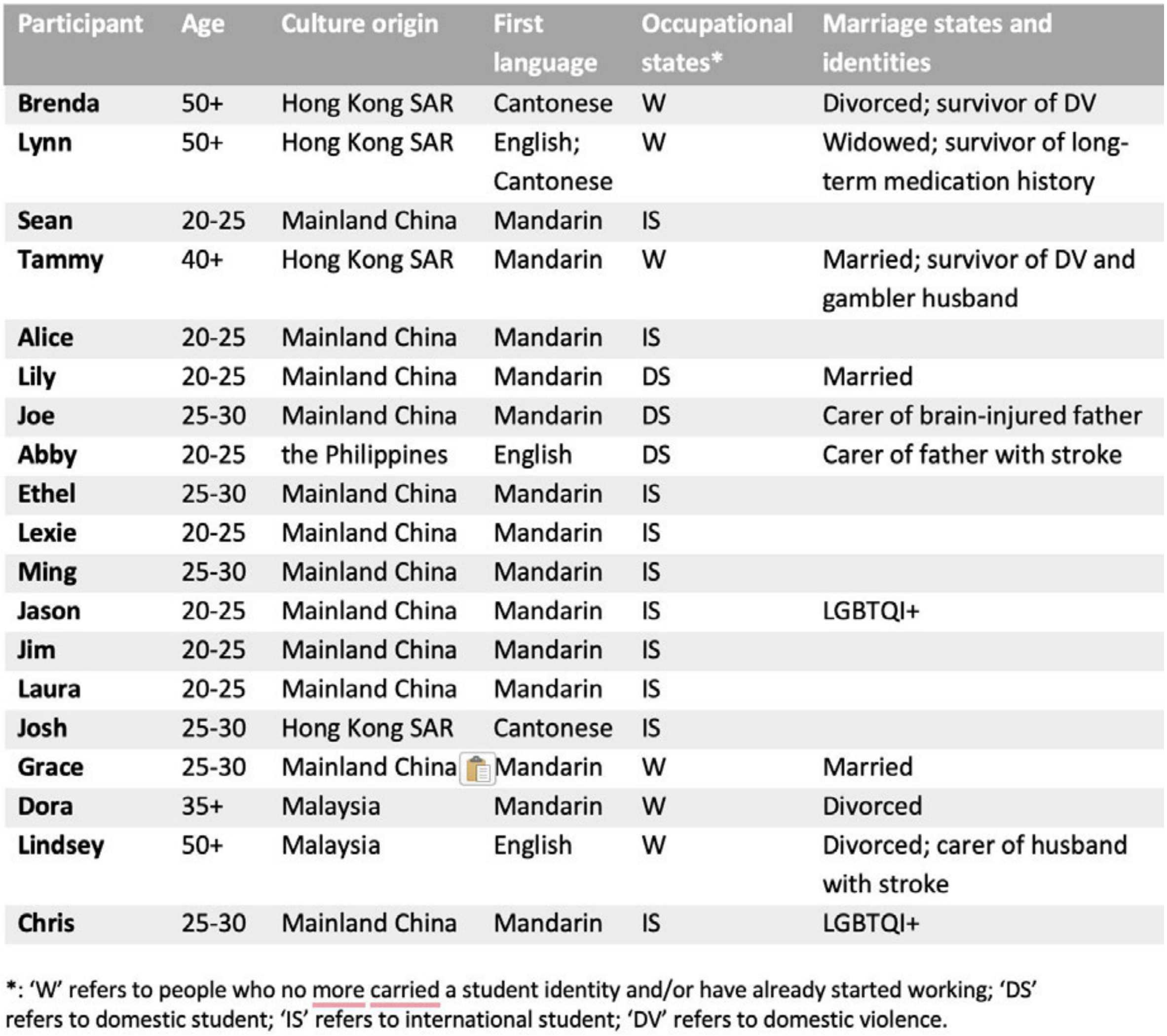
Reviewing themes occurred when I re-grouped the codes into new codes in NVivo. However, I found that not all codes could be grouped under certain themes in answer to the research questions, either because these were mentioned only by one or a few participants, or they seemed irrelevant to the research questions. To make space for the displaced codes, I reported them in the Discussion chapter wherever they related to the topics discussed. I had 19 participants who provided such a large amount of data for me to analyse that the word count was often exceeded. The themes eventually changed several times as the writing progressed.

3.9 Summary of the chapter

This chapter elaborates on the process of conducting the study in detail. The qualitative research method with a focus on the topic of recovery is considered the most suitable method in answering the research question and realising the research goal. A focus has been placed on delivering an in-depth account of the research process by describing each phase of the study I conducted, including the ethical considerations, rigour and self-reflexivity, prior to the detailed steps taken in data collection, transcription and analysis.

CHAPTER 4 Stories of participants

This chapter outlines the brief stories of participants in this study. To follow the recovery-oriented practice framework, these interviews were conducted with an awareness of using language free of pathologising terms except for the psychiatric diagnosis from participants' narratives. Interview questions were meticulously designed to ask participants' understanding of the experiences of having and recovering from mental distress. However, it should be clarified that the depth of each story might vary; these stories might not accurately portray the intricacies of participants' life. Table 4.1 lays the groundwork for further understanding their perspectives.



Participant	Age	Culture origin	First language	Occupational states*	Marriage states and identities
Brenda	50+	Hong Kong SAR	Cantonese	W	Divorced; survivor of DV
Lynn	50+	Hong Kong SAR	English; Cantonese	W	Widowed; survivor of long-term medication history
Sean	20-25	Mainland China	Mandarin	IS	
Tammy	40+	Hong Kong SAR	Mandarin	W	Married; survivor of DV and gambler husband
Alice	20-25	Mainland China	Mandarin	IS	
Lily	20-25	Mainland China	Mandarin	DS	Married
Joe	25-30	Mainland China	Mandarin	DS	Carer of brain-injured father
Abby	20-25	the Philippines	English	DS	Carer of father with stroke
Ethel	25-30	Mainland China	Mandarin	IS	
Lexie	20-25	Mainland China	Mandarin	IS	
Ming	25-30	Mainland China	Mandarin	IS	
Jason	20-25	Mainland China	Mandarin	IS	LGBTQI+
Jim	20-25	Mainland China	Mandarin	IS	
Laura	20-25	Mainland China	Mandarin	IS	
Josh	25-30	Hong Kong SAR	Cantonese	IS	
Grace	25-30	Mainland China	Mandarin	W	Married
Dora	35+	Malaysia	Mandarin	W	Divorced
Lindsey	50+	Malaysia	English	W	Divorced; carer of husband with stroke
Chris	25-30	Mainland China	Mandarin	IS	LGBTQI+

*: 'W' refers to people who no more carried a student identity and/or have already started working; 'DS' refers to domestic student; 'IS' refers to international student; 'DV' refers to domestic violence.

Table 2 4.1. Demographic information of participants.

4.1 Brenda

Brenda married her husband 23 years ago and settled in with her husband in Sydney. She soon realised that her life had significantly changed, since she was not used to the living environment in Sydney and she had become a mother of two babies. Brenda found it challenging to adapt to the new life, and later she was diagnosed with depression. Brenda’s husband did not show sufficient support for her situation as he expected Brenda to be an obedient housewife. They often had arguments over family decisions, during which Brenda found it unfair of him to deny her position in the family just because she made limited financial contribution to the family.

Brenda managed to seek help from her GP, psychologist and social worker but reported difficulties talking to clinicians from other cultures than her Chinese cultural background. By the time Brenda accepted the interview, she was doing a part-time job in a government department, which she found both meaningful and challenging. Brenda thought working enabled her to find her peace of mind and values in society; She expressed optimism and hope in her recovery journey, although the side effects of taking antidepressants still concerned her.

4.2 Lynn

Lynn lost her husband 20 years ago, and since then had to raise three children all under 13 years old on her own. Her children did not seem to become a supportive resource in her life after they became adults. Lynn had a lengthy history of taking psychiatric medications, but her attitude towards these medications was ambivalent. She thought the medications enabled her to make decisions, while she doubted the effectiveness of the medication in stopping her depression. Lynn had financial difficulty in maintaining regular meetings with mental health professionals. Also, she commented that the mental health professionals she met had not experienced similar situations or were not old enough to understand her experience. She would appreciate support from professionals from similar cultural backgrounds.

Lynn also talked about her willingness to speak to peers and friends in similar situations, but she mentioned that the support was limited because she thought people from Chinese cultural backgrounds were more inclined to be reserved about personal mental issues. Lynn denied social workers’ role as professionals or experts regarding her lived experience. Lynn thought full recovery was impossible; what she experienced could not be given up easily. Now she managed to accept the fact and move on.

4.3 Sean

Sean’s story started at the beginning of the Covid pandemic. Sean was a campus-oriented international student. Since the university imposed the social distancing policy, Sean had to adapt to the new online learning mode, which he claimed to be unproductive as he lost the competitive environment of face-to-face study, nor did he have the motivation to maintain social connections with his friend and classmates, due to his introvert personality. As a result, Sean did poorly in his courses, which affected his emotions and confidence. He was clearly conscious of his situation, but since he was distressed by the situation, he lost the motivation to make a change – he blamed himself for behaving so. Moreover, Sean was experiencing difficulties in his relationship with his girlfriend. He felt powerless under the national border control restrictions in 2020.

Sean commented that it would be less helpful if the clinicians were from different cultures than his Chinese cultural background. Instead of seeking help from mental health professionals, he would sort out the problem independently. Also, he thought he should not have wasted the resources as there might be someone who needed the mental health services more badly. Sean’s relationship with his family could not become a supportive resource, but he managed to do sports and keep in touch with a few friends to make him feel connected to his life. Sean had no idea of or interest in social workers' help.

4.4 Tammy

Tammy met her ex-husband (hereinafter referred to as *ex*) online when she was in China. She later married her ex and came to Australia when she was three months pregnant. Gradually, Tammy found that her ex was a gambler with tendencies to verbal violence. He would devalue Tammy by calling her useless. Tammy felt hopeless and tried to convince herself to bear with it for the children’s wellbeing. When Tammy became agitated more easily, her ex attempted to create tensions in her relationship with her children. Tammy tried to negotiate with her ex and take him to gambling treatment, but did not progress with this since she was diagnosed with depression. She mentioned having limited social connections in Australia due to language difficulties. And she could not work full-time with the successive pregnancies and ensuing depression.

Tammy has seen several mental health clinicians but did not continue seeing any of them. One of the concerns was that she lacked knowledge of the confidentiality of such support. Also, she was troubled by the side effects of the psychiatric medications. Tammy believed the key to solving the problem was to restore her relationship with her children.

4.5 Alice

Alice was a beloved daughter and was taken good care of by her parents. The first time she studied abroad worried her parents a lot as they could not imagine Alice managing her life without the assistance of her parents. Alice was required to report every activity to her mother within the promised time with photo or video evidence, even when Alice was in class. This kind of life lasted for two years until the days when she could not stop crying and could not sleep at night. Alice experienced so many physical dysfunctions at that time that she sought help from a psychologist. Alice had a very satisfying relationship with the psychologist, who helped Alice gradually sort out the causes of her distress and her relationship with her parents. Alice followed the psychologist’s suggestion and took action to reverse the unhealthy relationship with her parents.

Apart from the support from her psychologist, Alice spoke highly of support from her friends and boyfriend. However, she insisted that people cannot empathise with each other. The solution to her distress lay within herself. She was grateful for such an experience and appreciated her efforts to pull herself out of the distress. Alice did not know what social workers were or the support she could get from social workers. Alice regarded the Covid pandemic as a relief as others became less productive, as she was during her depression.

4.6 Lily

Lily came to Australia to marry her husband after graduating from university in America. But the Covid pandemic stopped her from reuniting with her parents, and most of her friends decided to return to China after the outbreak of the Covid pandemic. Lily thought her husband did not prepare enough for significant family changes, such as moving home and having babies. As her anxiety grew, so did their quarrels. Lily was strongly supported by her parents, who took a firm position on her side. Apart from that, Lily felt stressed about purposefully making friends.

Lily tried to seek help from mental health professionals. But, regarding confidentiality, she reported her unwillingness to reveal her lived experiences to strangers who might not have similar experiences or cultural backgrounds. Moreover, considering the amount of money, she would like to seek e-mental consultation with clinicians in China, and she sought divination (such as tarot card reading) for solutions. Lily was unclear about the process of recovery.

4.7 Joe

Joe's family's business went broke in the third year he was in Sydney. As a consequence, he had to make money for his tuition fee and living expenses by himself. During the following two years, he had a 'soulless' and meaningless life shuffling around the home –which fortunately was offered by his cousin – the internet café, the school and the workplace. This life was then interrupted by his father's accident back in China. He fell over the stairs and suffered a severe brain injury. Joe felt so distressed that he suspended his study and went back to China to take over the responsibility of caring for his father, and began to think about his relationship with his parents and preparing for the loss of his beloved father.

Joe had several close friends to talk to, but he knew he was too reserved to reveal his authentic feelings to friends or his family. He was profoundly impacted by the conventional notion that the male child in the family should not reveal his emotions, which might be interpreted as weakness to others. Joe said his way of expressing his distress was writing online fiction. Joe had never visited mental health professionals as he regarded his distress as experience and part of his life. The process of recovery began when he regained control over his life. He also commented that the financial support from his cousin meant the most to him during that period. Generally, Joe demonstrated an optimistic attitude in facing the challenge, although he was confused about what might happen in the future.

4.8 Abby

Abby was recruited for the study through a carer support organisation. Abby and her mother were the primary caregivers of her father, who had recently been diagnosed with dementia, depression and anxiety, partly due to disabilities and a stroke. She spoke of the effort of negotiating with her father, who was agitated and upset most of the time.

For Abby, recovery meant group support. Abby's supportive family met their challenges with the support of the NDIS plan and from behavioural clinicians and other professionals. She also mentioned the helpful carer program, from which she learned how to care for her father. She kept company with her father, reading, watching Kungfu movies, listening to Chinese songs, walking around the community and visiting friends. But since the outbreak of Covid and the lack of access to their community, her father no longer received sufficient support. More Chinese-specific services and activities would better suit Abby's father's needs. Abby did not know what support with mental health issues social workers could offer.

4.9 Ethel

Ethel had mental health problems before she came to Australia. She spoke about her loneliness in the early months of living in an unfamiliar city. She was eager to explore the city, and had support from her classmates, who took her to attend activities held by Christians. However, Ethel was confused, as she could not find the answer to her distress in the church, nor could she see signs that God blessed her. She finally refused to go to church when she was refused communion because she did not donate money to the church. During the Covid pandemic, Ethel had conflict with her agent and landlord, who she believed were bullying Chinese international students who did not dare to use the law to defend their rights. Later, her roommate left Australia but left her a mess to clean up. During that time, she had two experiences of racial discrimination.

Ethel acknowledged the importance of having companionship. She said that her parents' support helped her go through the difficult time during city lockdowns. She did not think visiting mental health professionals could be more helpful as she had unhappy memories of seeing psychologists in China.

4.10 Lexie

Lexie came to Australia when she was only 16. She lived with her homestay family until she moved to UniLodge with her friend. After that, Lexie experienced the difficulties of living alone. Things became better when she made new friends at uni. She had so many warm and happy memories that when everyone graduated and discontinued their studies, she felt heartbroken and depressed again. Lexie said that peer pressure and her sense of competitiveness in her faculty made her self-critical, feeling she was neither intelligent nor hardworking. She spoke about the cultural differences and the difficulty of fitting into either Australian society or Chinese society if she went back. This sense of alienation extended to her distressing experiences of racial discrimination, her work placement, and her relationships with family, friends and classmates. Lexie also experienced the grief of losing her family members and the serial impacts of Covid. On top of all these stresses, Lexie reported an alcohol problem.

Lexie considered friends and family as important supports in her time of depression. She had regular meetings with her psychologist, who had a similar cultural background and could empathise with her experiences, which was important to her. For Lexie, recovery meant she could accept the facts of her situation, live with the distress and find inner peace and balance. Lexie had limited awareness of the role of social workers.

4.11 Ming

The main issue of concern for Ming was the pressure of studying and his interpersonal relationships with others. Ming had trouble getting used to the teaching styles of a few tutors. And he had very limited social networks in Australia; he felt awkward about making friends with others even if he was given the opportunity of social intercourse. He valued friendship highly, but blamed himself most of the time for not being able to pull himself out of his social isolation from others. Ming was uncomfortable with one of his experiences of discrimination, which he believed related to his accommodation and his identity as a Chinese international student.

For Ming, the solution to recovery was to seek help from others. He wanted to seek help from mental health professionals and friends. He was more reserved about telling his family about the distress. Inherently, Ming tried to maintain rationality and positivity; he accepted that he was not good at keeping up his connections socially, but believed he would find a way to sort out the confusion.

4.12 Jason

Jason insisted on leaving his hometown and studying abroad alone. He soon found out that life was different than he had imagined. As he had difficulties managing his study and getting satisfactory grades, he became self-critical and conscience-stricken for being a burden on his parents, who supported his decisions and paid for his failures. Gradually, he became resigned to his introversion and subjectively isolated himself from others. Jason’s parents took him to visit a psychologist in China when he was back on holiday. Since then, Jason he has been taking medications.

Jason spoke about support from family and friends, who accepted that he was not always feeling well but still stood with him. He reflected on how to express his authentic self and what he wanted. Along with addressing his weakness in studies, recovery meant getting to know himself better and seeing his advantages while accepting his weaknesses. Jason mentioned that reading, watching movies and occasionally talking to a stranger relieved his distress to a certain extent. Jason stopped taking medications when he felt strong enough to manage his anxiety by himself.

4.13 Jim

Jim's distress mainly came from the pressure of studying and his relationship with his parents. He elaborated on differences in study mode, interpersonal relationships, social environment, and parental styles between Australia and China. Jim was aware that he had a sensitive and introverted personality and would overthink and overreact in anxious moments. Jim was eager to establish emotional independence with his parents, which, however, was impossible; he described his parents as controlling, unnegotiable, pushing him in all aspects of his life, lacking in empathy and not respecting their child as an equal. Jim felt uncomfortable about being required to keep a lowly and subservient position in accepting his parents' financial support. He identified this stressful relationship as the cause of his hostile attitude to others, digestive problems and inattentiveness. Jim decided to reduce the frequency of communicating with his parents.

Jim preferred to solve his problems by reflecting and exploring the causes on his own, because he thought he knew himself best. He would look for relevant information online and talk to peers on Facebook with similar experiences. Jim thought recovery meant knowing himself better and becoming stronger in responding to setbacks.

4.14 Laura

Laura has been annoyed by her weight for a long time. This was made much of by her parents, so that gradually, Laura came to blame herself for all her problems. The vicious cycle continued when she got stuck in a binge eating pattern. Apart from that, Laura spoke about the pressure of studying and her limited social circle. Laura thought she was depressed but did not know how severe it was, so she contained the distress herself most of the time. As a result, Laura became more self-isolated from others and procrastinated with her studies to escape from the distress.

This situation improved when Laura searched for information online and managed to regain control of her weight without being anxious. She accepted that her weight could not reach the range her parents expected, but she allowed herself to eat and lose weight in a regulated way. Laura was particularly thankful for her boyfriend's help to keep her meals regular. She was aware that, although friends might not empathise with her completely, they could support her and provide stable social networks. Recovery for Laura meant accepting the facts, regaining control, and finding the ability to escape from the vicious cycle of binge eating.

4.15 Josh

Josh spoke about his emotional connection with his mother. He thought they had similar distress before he came to Australia. The manifestation would be his abrupt emotional outbursts. It was not easy for Josh to concentrate and catch the topic of conversation all the time. He talked about his experiences of being rejected by girls, troubles getting along with others, and the stressful lifestyle in Hong Kong (where he came from). He knew his mental condition was not good all the time, but he did not know how to express it. Interestingly, Josh had his way of sorting out the distress. He could manage to express his emotions as they arose, and he did not mind if his expression troubled others. Generally, Josh commented that he had been optimistic most of the time.

Josh thought emotional problems were common among his peers. He spoke about the idea of helping others with similar distress patterns. Also, he thought there were many ways to sort out distress, and paying an expensive clinician was just one of them. Josh valued the support he had from friends and the chance to talk to me, as he thought it somehow helped him figure out his distress. Josh was not clear about the turning point of his recovery. He expressed high appreciation for social workers' work in supporting people.

4.16 Grace

The cause of distress in Grace's case was mainly her application for Australian permanent residency. Grace married her husband just before her student visa expired; after that they had to face separation in two countries. Grace found a dream job in China, but because they assumed that her husband’s application for permanent residency would soon be approved, Grace resigned and returned to Australia with a travel visa. However, their plan was significantly impacted by the Australian government’s changing immigration policy. Meanwhile, Grace confronted a career dilemma: she could neither have a full-time job nor could she get an illegal underpaid job. These issues affected her application for a PhD scholarship and her physical health. Grace felt aimless and hopeless; she often complained about her husband’s decision to stay in Australia.

Grace wanted to seek help from others but did not have sufficient information, such as how to find Chinese-speaking psychologists. She visited traditional Chinese medicine clinicians to adjust her bodily systems, but mentally she was still depressed. Grace got support from her parents and friends. She spoke about her mother-in-law as a source of her anxiety. Recovery meant less sense of powerlessness and feeling her contribution to others had more value. During her recovery, Grace expressed an interest in becoming a volunteer to help others.

4.17 Dora

Dora has been married to her husband for almost 20 years; she described him as a controlling person. After Dora resigned from her former company, she was required to start a new life in Australia – ‘for your good and our future, ’as her husband put it. Dora came to Australia alone and lived with her brother-in-law’s family, but soon she realised that she barely had any communication with her husband (less than five times a year), nor did she get any form of support from him. Dora became very distressed and was admitted to the emergency department, as no cause was found for her bleeding eyes, which she believed were related to her emotional distress. During that time, she did not receive any concern or support from her husband. They saw no hope in their marriage, so just one month before the interview, they decided to divorce.

Dora did not consider seeing a mental health clinician because she had no access to this information, nor could she afford the consultation. She had close friends to share her feelings with, but she remained reserved as she did want her family to get worried. Dora found that outdoor activities could be a way of relieving her distress. Dora thought recovery was a Western concept as it was commonly mentioned in Australia, but not Malaysia. Dora would have appreciated support from social workers if it had been available to her.

4.18 Lindsey

Lindsey participated in the study as a carer. She was looking after her ex-husband (Dan), who had been a heavy drinker; a stroke a few years ago resulted in his brain injury, with short-term memory loss and depression. Dan has been diagnosed with hoarding disorder. He hoarded things in his house, and the condition of the house and hygiene problem got worse. Dan needed significant care, but since Lindsey alone managed his daily routines and chores, she found it impossible to take care of every detail. Because of the hoarding in Dan's place, none of his friends visited him, and support workers only came occasionally. Dan and Lindsey had four children, and Lindsey reported that they all had unhappy relationships with Dan because of his Chinese parenting style.

Dan had regular meetings with his psychologist, but psychiatric medication seemed ineffective in soothing his distress. Lindsey and Dan had a disappointing experience with social workers in the hospital, and they were not referred elsewhere. Lindsey expressed the need for the carer pension and the disability pension to support her caregiving work. Lindsey thought recovery for Dan did not mean the reversal of his brain injury but having more contact with friends and his children, exploring life's goals and purposes and improving his living conditions. Lindsey reported her need to be respected and listened to as a carer by mental health workers.

4.19 Chris

Chris reported she had suffered emotional distress since she was a teenager. Ice skating was one way of releasing her depressed feelings. Chris did not consult mental clinicians until four years ago when she was severely injured in ice skating. She realised that the depression was out of her control when she had to rest in bed for months. Chris was advised to take medications because her psychiatrist thought counseling could no longer contain her depression. However, Chris had a strong sense of stigma and did not want her parents to worry about her, which might make her more anxious. Chris made plans to recover from the distress, but found herself in a more vicious cycle when she could not achieve the goals she had set. Chris reported a strong sense of self-blame and frustration. She also spoke about many somatic impacts of mental distress and her social phobia because of her body shame. Chris finally was admitted to a youth health centre with thorough services to improve her mental condition after she attempted suicide twice and called the suicide hotline. Chris did not think the different cultural backgrounds could be her primary concern when seeing a mental health professional. Still, she was concerned as to whether she could effectively build reciprocal connections without repeatedly telling her stories to people from a different cultural context.

Chris thought recovery meant building a supportive relationship with her parents and reconciling with herself. Chris commented that as strangers, it is important to be kind and non-judgmental to anyone who might be struggling. Chris thought recovery also meant facing challenges when she was strong enough to take the risk. Recovery was a signpost toward growing up, and the adversity caused by distress did not mean it was forever. Recovery also meant helping others with similar experiences. Chris wanted to be a volunteer or a YouTuber to share her knowledge of distress after she recovered. But due to her current situation, she could only care about her friends' and family's mental wellbeing for the moment.

4.20 Summary of the chapter

This chapter introduces the experiences of 19 participants with different lived experiences of mental distress. It delivers their unique perspectives on recovering from mental distress indifferent individual contexts. Participants' stories reveal the complexities of the factors intertwined and interacting within their lived experiences of mental distress; they formed specific and expressive group portraits. Following these vignettes that serve as an introduction to the participants, the following three chapters will examine and elaborate on the findings of the interviews.

CHAPTER 5 The challenges of mental distress

The following three chapters (5, 6 & 7) present the findings on how Australian Chinese people have experienced mental distress and negotiated their roles and identities during recovery. In order to explore the experiences contributing to participants' mental distress, this chapter considers three aspects: the dynamics in familial relationships, the social factors contributing to distress experiences, and the impacts of mental distress.

The findings adopt Rawsthorne (2009) convention, applying 'most' to more than three-quarters of participants, 'many' to around half of the participants, 'some' to less than half but more than a quarter of participants, and 'a few' and 'a small number' to refer to less than a quarter of the participants.

5.1 Dynamics in familial relationships

All participants reported family issues as a significant cause, directly or indirectly leading to their experiences of mental distress. The impacts of family dynamics were mainly demonstrated in two kinds of relationships. Violence and conflict generated from marital relationships were reported as the consequences of addiction to alcohol and other drugs, problem gambling, emotional neglect and unequal gender power relations, especially among married female participants. Negation, emotional distance and failed respect of individuality were identified within the parent-child relationships, especially among the young adult participants, who primarily identified as international students. Two detailed examples will elaborate on emotional abuse in parent-child relationships. In this context, culture's impact is complicated and worthy of more detailed interpretations.

5.1.1 Violence, conflicts and gender inequality in marital relationships

Female married participants reported experiences of domestic violence (DV) and conflicts with their partners. Violence and conflict came from alcohol and other drugs (AOD), problem gambling, emotional neglect and unequal gender power relations, significant stressors contributing to their mental distress.

Tammy particularly spoke about her ex-husband’s addiction history to AOD and problem gambling, which removed his focus and energy from the responsibilities of taking care of his family. Tammy got to know her husband online and left her home country to marry her husband decades ago. She did not have any prior experience of living with her partner. After she came to Australia pregnant and alone, she gradually realised her husband’s living pattern, which mainly was around bars and gambling machines: ‘He had a lot of bad habits that I had never known.’ Tammy recalled her effort to find her ex-husband after work:

> When he got off work, he was probably still playing slot machines at the bar, and a decade ago, there was no one on the train, just me on the platform after 11 pm. Other passengers looked at me strangely. They probably didn't know why I was outside with a big belly late at night. On the train, I thought, if I saw him, I'd hit him with a shoe or I would take a bottle of water and pour it on his head. I was angry because he didn't come home till late. He was gambling, leaving me, a pregnant woman, at home alone. (Tammy)

Tammy thought her distress started during the first pregnancy when she realised her husband could not resist the temptation of AOD and gambling, which brought huge risks to their economic security and family relationships. Tammy admitted her husband was verbally aggressive and disregarded her physical unwellness, such as lack of rest and overwhelming baby caring tasks. Having been raised in a traditional Chinese cultural context, Tammy did not have a notion that, as well as physical violence in the family, there is verbal violence. In the interview, she noted her realisation that ‘psychological violence is also a kind of violence.’ A lack of understanding of DV, to some extent, allowed it to exist in her life and resulted in her profound experience of mental distress.

To some other participants, emotional neglect contributed to a distressing experience. Dora was told by her husband to come to Australia and find a way to settle down, make a living and get prepared for a ‘happy future life.’ However, Dora said that she had been neglected by her husband since she settled in Australia. He did not want to leave Malaysia where he could earn a considerable income. There was also very limited communication and support between Dora and her husband.

> He thinks it's normal, so what's wrong with this? Everything is OK. I stay in his brother's house, he takes good care of me, and then he gives me food. I'm not supposed to feel stressed about anything. But for me, I have a husband, but it doesn't seem like I have a husband. I have to do everything myself. He didn't ask me anything. Sometimes a couple would send messages and ask, how are you? Are you good? Are you getting used to it? And something like that, but no, nothing. We barely text each other. Don't even communicate, yes, but maybe less than five times a year. (Dora)

Dora concluded that her loneliness in not being supported by her partner led to the distress experience, especially when she was married, away from home and loved ones. This finding echoes the literature reviewed in Chapter Two, which pointed out that neglect of a partner can be a form of DV. Dora's experience of neglect and lack of emotional support revealed gender inequalities in her marital relationship, as she was asked to comply with her husband's requirements and sacrifice the right to make independent decisions.

The third reported factor related to DV and participants' mental wellbeing was unequal gender power relations. This study defines gender inequality as unbalanced gendered expectations of roles in marriage and powerlessness in patriarchy-centred familial and social structures. Brenda talked about the experience of giving birth to her two children in a short time, during which she gave up her future career development because she was expected to take over most of the housework and duties of child care.

> My husband and I would always argue over money. He thought I had nothing to contribute to our family financially, so I just couldn't be decisive in so many family things. But it felt so unfair; I thought I've done a lot for my family. (Brenda)

The patriarchal expectation of Brenda's role in her family erased her value as an independent woman who can balance her roles of being a mother and a career woman. She was expected to take responsibility for family reproduction and taking care of the offspring. She missed the opportunity to achieve in her career when fulfilling the mother role and housewife duty.

However, Brenda felt it was discriminatory and unfair to be treated as a family member who was not contributing to the family financially. She commented that her husband's accusation that she did not contribute financially to the family attacked her self-worth and self-affirmation. Brenda's inferior position in her marital relationship significantly affected her mental wellbeing for years, and later in the interview, she emphasised her goal of becoming an independent woman with reliable financial circumstances.

Grace felt powerless to challenge her husband's power to make decisions when she had to sacrifice her career development in China. She believed that her sense of subordination and sacrifice of her self-value to fit into her husband's future goal put her in a menial situation where the power of patriarchy ruled.

> I: So you wanted to get into work right away and create income for your family, and then you tried to find your own value. But this policy changed and ruined everything.
> G: Right. I didn't understand why I had to give up so much. My ability was not improved. I had a gap in my heart because I once had an excellent job in China. I have worked for four years in China. I felt uncomfortable and didn't want to do some illegal work [without legal working rights]. But if I was really at home all the time, it could be painful just to sit around and do nothing.
> I: So you were facing the fact of leaving your career development in China and coming to Australia, where you hadn't yet been allowed to work full-time?
> G: Right. (Grace)

These stories of challenges and problems in participants' marriages reflect that culture is an important factor contributing to the root of DV and conflict. In Confucian family ideology, filial piety is an instrument that justifies patriarchal authority and constructs the public expectations of marriage and the roles and duties of husbands and wives. This phenomenon was also reflected among Chinese women in the UK (Tang & Pilgrim, 2017), and is echoed in the literature review of traditional Chinese culture and its impact on gender power relations (see Chapter Two). Through this lens, Confucian culture and filial piety are fundamental contexts for understanding and interpreting participants' distress.

This section reveals that AOD, problem gambling, emotional neglect, and unequal gender power relations were reported as contributing factors to DV and conflict within participants' marital relationships, which further contributed to their distress. Understanding the role that culture played in these lived experience of mental distress was complicated. As will be elaborated in the following finding chapters, culture can either be a factor that contributes to mental distress or a potential protective factor in participants' recovery (Kleinman, 2004). Therefore, the interpretation of the impacts of culture should remain multi-dimensional, context-based and fluid. Although culture interacts as a stressor to mental distress in this section, for many participants it was an important factor in developing successful strategies for responding to the difficulties and challenges of living with distress (see Chapter Six).

5.1.2 Negation, emotional distance and failed respect of individuality: emotional abuse in the parent-child relationship

Chinese international students make up a significant proportion of the participants in this study who mainly spoke about the problems and concerns in their parent-child relationships. These young adult participants reported the experience of being rejected in their attempts to negotiate equal parent-child relationships and being forced to submit to their parents. They also reported that their parents failed to acknowledge and respect their individuality and the psychological boundary between them. Parental rejection and emotional abuse impacted their parent-child relationships and levels of mental distress. Two typical experiences will illustrate these findings.

Jim spoke about his powerlessness in working out an equal relationship with his parents, who considered him a recipient of parental economic support and a submissive object to their absolute parental authority.

> The money they gave me was not enough, but they would emphasise that it was for me. It meant that they wanted me to accept the money with a menial status, which was one of the things that made me very uncomfortable…When I take the money, I feel like I owe them something…I tried to communicate with them, but there was no positive progress. And they would emphasise

> the fact that it was a large amount of money. I know that was a lot of money, but their attitude was unacceptable. (Jim)

As a full-time international student, Jim relied mostly on his parents' economic support to cover his academic expenses in Australia. However, Jim considered this forced him into a lowly position. He felt powerless to argue for a balanced relationship with his parents, who claimed they 'gave' more than they 'got.' This powerlessness exacerbated his distress. Jim expressed a defensively independent attitude toward his parents because of his uncomfortable situation. He mentioned that he maintained infrequent contact with his parents: 'Before I left China, I told them that I might not see them again in the future. I would just stay in Australia and not see them anymore.'

Similarly, some young male participants talked about their 'contractual parent-child relationships.' 'Contractual' was the word many participants applied when we had the interviews. They described such a relationship as involving some emotional neglect or misunderstandings between the parents and their adult children. Jim continued:

> I think it's difficult for them to give me some positive comments. All their comments were either negative or neutral. When I ran into problems, they never sympathised with me. When I told them things, except those with shared values, they only had two responses to everyday things or problems. One was negativeness; the other was it is not their business. They never responded positively, and they would accuse me of not understanding. They kept their distance. I wanted to build an emotional connection with my parents. Later I realised that it would never happen. So I had to figure it out myself, and I found it a little tricky. (Jim)

When Jim said he wanted emotional connection, he may have been articulating a contradiction between seeking recognition and affirmation from his parents on one hand, and grappling with the challenge of remaining indifferent when those desires went unfulfilled on the other. Jim recalled that his parents demonstrated very limited appreciation of his abilities and achievements while he was growing up. Also, it was difficult for Jim to empathise with his parents because they 'just understood my life in their way, using their judgement; they didn't really focus on the problems; neither would they admit that they were wrong or even apologise.' The experience of 'infinite negation from parents' and his sense of emotional distance supported the parental acceptance-rejection theory, which explains that children who experience rejection tend to be 'defensively independent,' 'impaired in self-esteem and self-adequacy,' and emotionally unstable (Rohner & Rohner, 1980, p. 189). This may also be a cultural reflection of how traditional Chinese culture constructs a filial piety-based hierarchy in the parent-child relationship (see Chapter Two). In this context, they present a self-defensive attitude regarding the 'contractual' relationships with their parents. Another student, Sean, commented that his parents mainly cared whether they could enjoy the 'show-off capital' of being able to show off his achievements to their peers. This 'win-win' model was developed to protect their sense of integrity. The interviews revealed that the students considered living in Australia was a strategy to pursue a higher education, stay away from parental control, and create broader choices for future development. While for parents, children's success satisfied their need to save 'face' and be envied by other family members, colleagues, and counterparts. However, the continuous negation from parents and the sense of emotional distance could be seen as a form of emotional abuse, and it could further impact participants' appreciation of self-worth, self-esteem and mental wellbeing (Glaser, 2011). Unlike Jim's experience, Alice reported overly intense surveillance from her parents, from which she had an intense sense of rebelling against parental control and resisting the accusation of not obeying filial piety. Alice's parents failed to acknowledge and respect their children's individuality and the psychological boundary between them.

> When I first came here, they would call me every night, and every night they would check up where I was, whether I was in the dorm, then why I spent two more minutes answering their call. And then, they would ask me to call them back on video if I was in the dorm, and they required me to show them my dorm… When I first went abroad, I understood that it might be for my own safety or that they were actually curious about what it was like here in Australia. So at first, I accepted that they could ask me for that… I was afraid or reluctant to blame my parents based on Chinese ethical and moral traditions. (Alice)

Alice was required to report everyday activities to her parents, who wanted to know everything that had happened in her life since she came to Australia alone and lived far away from them. In some ways, what Alice's parents did was understandable, given the geographical distance. However, Alice remarked that she did not realise how harmful such control could be to her sense of individuality. It only became clearer to her after she left her family and came to Australia alone. Alice struggled against her strong awareness of the Chinese tradition of filial piety, which centres on the concept of respecting and caring for parents and older people. She would not disobey her parents' demands because she was educated to comply with her parents. She said that she never doubted her parents' 'love and care' and never reflected on her true feelings and thoughts, such as what she wanted to do and at she wished to avoid.

The boundary between parents and children is particularly permeable (Chan, 2000). According to the FRAMEA categories of parental emotional abuse (Glaser, 2011), Alice's parents' failure to recognise, acknowledge and respect her individuality, independence, and the psychological boundary was a form of parental emotional abuse. Alice's experience reflected that her parents might fail to distinguish Alice as an independent individual, placing their expectations on the child who was used to fulfil their 'needs as a virtual extension of the parent.' (Alice's word). This emotional abuse became an important factor contributing to her distress.

The parent-child relationship is worthy of further attention. Parenting conflicts may become more pronounced when parents with a Chinese parenting style choose to educate their children in a Western/Australian social context. In this study, such conflicts appear to be a significant factor contributing to participants' mental distress. While Jim's and Alice's experiences are typical cases revealing that culture-informed parenting issues could contribute to their mental distress and limit available family support, it should also be highlighted that culture also features in the solutions to the difficulties and challenges of mental distress (see Chapter Six).

5.2 The absence of secure social bases

This section will demonstrate two main aspects regarding the absence of secure social bases. Changes of the external environment, such as the stress of studying in a new place, unequal work opportunities, housing disadvantages and the numerous lockdowns during the Covid pandemic, significantly impact on participants' experiences of distress. Resettling in a new social context requires an adaptation of social norms, social roles, languages, and a new culture for student participants. The process became more difficult when the new Covid pandemic broke out, leading to strict physical and social distance restrictions and further putting people in a more isolated and stressful context.

The second finding concerns the cultural differences, distance and concerns. The first part demonstrates the longstanding racial discrimination in Australian society and the heightened xenophobia and sinophobia against Asian/Chinese-looking populations that Covid caused. A more invisible, ostensibly non-racial, hidden form of racial hostility – covert racism – is further identified. This finding opens space for its possibly prolonged impacts on participants' mental wellbeing. The second part demonstrates concerns about cultural identity and the immense impacts of racial discrimination.

5.2.1 Changes in the external environment

There are four main external environment changes identified in the study: stress in being international students, unequal work opportunities, housing disadvantages, and numerous lockdowns during the Covid pandemic. By using the term 'change.' this section compares the original social context and the resettled Australian context. Australia is a multicultural society, where people come from different cultural backgrounds and have divergent understandings of prevailing discourses and phenomena. As stated before, Chinese overseas students (COSs) are a significant proportion of the Chinese population in Australian communities, which is reflected in this research sample size. Student participants spoke about their motivations for escaping the prejudice against sexual minorities in Chinese society, pursuing higher academic achievement, exploring new life experiences, and so on. Yet, adapting to a new living environment meant a process of reintegrating social norms, roles, languages and other socio-cultural adaptations. Participants reported the challenges and difficulties of fitting in with different social norms, negotiating social roles, and developing confident English proficiency.

Student participants reported three issues regarding their stress in their studies: different study patterns between China and Australia, cultural differences and misunderstandings among classmates, and the shift to online study during Covid lockdowns. Some participants felt overwhelmed when adapting to a study mode different from the one they followed in China. With the challenging course requirements, workloads and adaptation to the English language study environment, they had to make more efforts to avoid falling behind in their studies, which caused unexpected stress and pressure.

> When I was in China, the way we studied there was to memorise things. But here, we need to understand the concepts. We are provided with an outline, and we need to learn it ourselves. What's more, we have to pay more attention to exploring ourselves. But I didn't think we had that in China. So I had no guidance here. I was feeling lost at the beginning and was unable to adapt. Plus, the content was massive; I was lost without direction. (Jim)
>
> It's not me who set the high standards; it's that the whole thing is extreme. If you keep at it, you're always at the top, but if you let go, you will fail this course. This is how the course is set up. (Alice)

Apart from the difficulties of adapting to a different study pattern, participants also reported interpersonal challenges in the class due to different cultural backgrounds. Ming described his experience of having misunderstandings with his Korean classmates. This example does not mean that only people who share different cultural backgrounds would experience misunderstandings and conflicts. It suggests that conflictual interactions with classmates can be an additional burden to their existing study challenges.

> Because our English was not at the same level or maybe different communication habits, I never understood one of my Korean classmates when he was talking…Then when I told him that I couldn't understand him, he thought I was going against him and got upset with me… (Ming)

Moreover, teaching and study modes were ineluctably challenged during the Covid pandemic. An online learning mode was gradually applied as a major compensatory method to maintain the educational delivery, significantly challenging students who were used to the face-to-face study mode (Bahasoan et al., 2020; Dodd et al., 2021; Fyllos et al., 2021; L. Martin, 2020).

According to Lexie’s experience, online learning formed a new social occasion, where people might be more willing to group up with friends rather than ‘strangers’, creating a sense of safety and boosting Lexie's confidence. Someone who was not good at breaking the ice on such occasions might feel isolated from others. And since the study environment has changed, the strong motivation to get a higher grade meet more difficulties. For student participants, online study reduced not only the learning experience and quality but also the frequency and opportunities of getting connected socially.

> I was in a very competitive environment in our field and was very demanding of myself. But since that environment disappeared, since I studied from home, everything disappeared – I spent a lot of time watching games and videos, doing everything but studying. And then I failed one exam, which very much discouraged me. At that time, I began to feel like I couldn't do this anymore, or all my effort will be wasted. But I didn't take any action; I was so upset. I set a high and ambitious goal the first year, setting up what I was going to do when I graduated and how I would achieve it. After the failure of the exam, I started to wonder if I was ever going to get there. Then I got anxious, and I thought I might not get there, but I couldn't think of any solution to make it better. I didn't study very hard, and I was very anxious at the end of the semester because I knew that if I didn't study hard enough, I would basically get a lower grade. (Sean)

This finding is consistent with and supported by research, which finds that the compulsory shift to online study has had a significant negative impact on university students' mental wellbeing, with a higher chance of future anxiety among international students (Dodd et al., 2021). L. Martin (2020)provides detailed feedback on effects of the transition to online learning, including a sense of isolation, reduced interactions with academic staff and peers, lack of engagement, and diminished enthusiasm. Participants also spoke about how study stress increased their sense of self-blame, such as feeling guilty about ‘wasting’ parents' money through failing assignments. Compared to domestic students, such additional stressors might lead to distress and another vicious cycle of low self-worth and self-identity.

> I felt particularly frustrated on the one hand and felt sorry for my parents on the other hand. Then I began to question why I chose this major. Very guilty and having little confidence. I was

> quite lost at that time, and I even thought about taking a break from the university or transferring to another university… I have a younger brother at home, and my parents have to support his education and life. Hence, the regular expenses are quite high. I feel like I should ...can't say afford, but I must not add to their burden, but failing a course made me feel like a burden to them, which led to my emotional breakdown. (Jason)

For some participants, the external environment changes exposed them to a stressful situation with unequal work opportunities. Some participants considered working as a meaningful way to realise an individual's value and build up the connection to others and society, to reconstruct self-esteem and confidence, and help reduce the sense of isolation and depression.

> But working is very important to me – economically, and to my own value – it's vital for me… I am happy because helping people realises my value, which brings me income, which could make me financially independent. (Brenda)
>
> When I didn't work, I felt a little bit of depression. The more depressed, the longer I didn't work. There was no way to reverse the situation. (Grace)

The experience of inequality in work opportunities stood out. According to Lexie's experience, inequality in work opportunities mainly referred to identity concerns, especially among people who did not have the same right to work as local residents and citizens. Identity concerns around work eligibility are paradoxical. On the one hand, a qualification-related job is essential for applying for a political identity that secures working eligibility equivalent to that of local residents and citizens. On the other hand, some employers would look for unlimited work eligibility and even unlimited residency before considering the qualifications of applications, as Lexie remarks below. While Australian society embraces the value of workforce diversity regarding gender, cultural and linguistic differences, the current social and political environment still unconsciously practises discrimination and bias through filtering out a large number of the international workforce with unequal selection criteria (Blackmore & Rahimi, 2019). This is also reflected in Lexie's statement:

> I would say (the major subject of studies) is very stressful because everyone works extremely hard. It might be easier for local students or ABCs (Australian-born Chinese), but all my Chinese friends and I often found it stressful. The locals and ABCs already had part-time jobs

> when they were doing their undergraduate degrees. And then it's easier for them to find local law firms because the local law firms would prefer PRs (permanent residents) and citizens. Unless you're outstanding, you can't even pass the first interview. (Lexie)

Housing conditions were also reported as a concern of the external environment changes. Many participants revealed that the risk of worse mental health increased for them when housing problems became a primary concern in their daily lives. For participants who had already experienced depression, anxiety and/or isolation, the despondency caused by unsafe living conditions might further strengthen their depression and sense of hopelessness, which could create a vicious circle of mental distress.

> I lived in a loft. I was very excited when I first moved in there. But after some time, I felt like I was staying in jail because it only had a window on top. I had difficulty breathing and was depressed both mentally and physically every day. I couldn't see hope. I knew I couldn't stay like that. I felt like I was so sad that I was dying. So I told myself I need to find a place with an open view. That's why I moved to the seaside (She showed me the seascape outside of her window). Frankly, since I moved in here, my sleeping issues have gotten better. My former local roommates were very noisy. After lockdown, they lost their jobs and stayed at home to play games every day or partied till 3 or 4 am. I felt helpless and miserable, but I didn't want to ruin our relationship. I was often crying at that time, and I felt devastated. The worse thing was that they were smoking marijuana downstairs. Now that I have moved, I can finally have good night’s sleep. It's so quiet. And I get up around 7 in the mornings. My life became more regular. (Lexie)

Many student participants reported that bad housing conditions not only deprived their basic needs for cosiness, warmth, safety and relaxation in the ‘home’ but also expose them to greater risks of isolation, mental pressure and distress. This can also be found in other studies in other countries (Evans et al., 2000; Liddell & Guiney, 2015; Singh et al., 2019).

During the discussion of housing conditions, participants also revealed concerns about international travel limitations and city lockdowns, which created a tremendous sense of physical and mental isolation, loneliness and hopelessness during the Covid pandemic.

Structural pressures such as unpredictable lockdowns and durations were the cause of mental distress.

> I was kind of an outgoing person in my first year, and I had a lot of communication with my classmates and so on. But since Covid started, we've stopped taking offline classes. I stopped communicating with my classmates… I don't text anyone, I am basically socially isolated. (Sean)

International students became one of the most affected and vulnerable groups of people after the Australian government closed the national border. In my role as a member and an observer of this group of people, I perceive that those who stayed in Australia after the outbreak of Covid with limited social connections were vulnerable to loneliness and isolation. This discouraging situation was created in a particular period, affecting international students profoundly. Together, bad housing conditions and numerous long-term lockdowns have exposed participants to extraordinary physical and mental stresses.

When I proposed the study, I never expected the outbreak of Covid, but the pandemic and its impacts significantly changed our life and the world. While the stress on studies, inequality of work eligibility, housing disadvantages and numerous city/country lockdowns have contributed to participants' insecure social base, it is important to stress that different cultural and social contexts cannot be simply compared and defined as better or worse. The findings above only revealed the external challenges and difficulties when participants tried to fit into the Australian cultural and social context in a specific period.

5.2.2 Cultural differences, distance and concerns

Racial inequalities and injustices are always prevalent globally and in multicultural Australian society. Fuelled by the fear of Covid-19, unjustified, biased and misleading media coverage of COVID-19 inflamed pre-existing sinophobic propaganda towards Chinese people and people of Asian origins, while the resurgence of attitudes characterised by xenophobia, or a fear of foreigners, perpetuates racial discrimination against non-European migrants because of the fear of the disease. Concerns about COVID-19, online interactions, and media disinformation have increased the prevalence of sinophobic attitudes, actions, and racial insults among the Chinese diasporas (Litam, 2020). COVID-19 has inflamed the racial hatred that privileges white people and belittles migrants of colour indiscriminately, especially Asian-looking or people of colour.

The experiences of racism were all reported by young adults in their 20s. Although there is no clear explanation of this phenomenon, because the studied sample size might not be big enough, an Australian Research Council-funded research from the University of Melbourne also found that Chinese overseas students in their young adulthood reported racism in many areas in Australia (F. Martin, 2020).

> They were all locals, one was black, and one was European-looking. The first time was at my door. I was ready to open the door holding a bunch of things. There were four people, four English speakers saying all kinds of F words. I didn't listen clearly. But it was definitely some rude words. I didn't do anything, even bother to look at them. It was late and dark at 9 pm. I thought I might be weak if I chose to argue with the four big guys. The second time was on the elevator, two black people were there. Melbourne was in a very strict lockdown stage. They looked at each other and laughed when my roommate and I got on the elevator, and they didn't wear a mask. When they got off the elevator, they gave me a look and said 'coronavirus,' and then they scolded me. I couldn't hear clearly, but I was super angry. These two times made me feel that I didn't feel respected in Australia, really rare. (Ethel)

Chinese overseas students are part of the vulnerable population that observably confront racial discrimination from some Western multicultural mainstream societies. Ma and Miller (2020) find that COSs face a more complicated situation than the Covid pandemic alone. They are exposed to a significant risk of overwhelming anxiety and panic, as well as the worry of being unable to cope with the shifting circumstances. The COVID-19 pandemic has exacerbated long-standing problems for them, including racism and discrimination resulting from unfavourable stereotypes and geopolitical events, as well as disrupting their education, finances, social lives, and future plans (Weng et al., 2021).

In addition to overt racism, it is claimed that there is a ‘new racism’, more procedural, ostensibly non-racial, hidden and less blatant (Coates, 2011; Sniderman et al., 1991), in Australia (Gopalkrishnan, 2013), which is taking place in a noticeable way and can be difficult to identify and challenge. As mentioned earlier, the COVID-19 pandemic functions as a tool to operate the ‘boundary-keeping mechanism’ (Coates, 2011), to set the binary between ‘healthy and innocent whites’ and ‘virus-carrying and sinful Asians/Chinese.’ Covert racism, Coates argues, has the primary goal of maintaining the social divisions between racial majorities and minorities. And within the social contexts, these border mechanisms generally are implicit or even undetected. Covert racism is observed in this study but remains ambiguous.

> One of my teachers was troubling me a lot. It was the mid-semester assessment period, so I thought that even though the mark wasn't satisfying to me, I could improve from it and handle the final exam better. Because he wrote his comments with a pencil, many places weren't clear due to the eraser marks. So, there were places where a sentence wasn't finished and didn't make any sense to me. I felt like I couldn't learn anything from it. So I sent him an email, and asked if I could discuss it with him for 15 minutes when he was available. Then he told me to write down my questions; otherwise, he said, students were just doing this to complain about their marks. I think I wasn't complaining about my marks, and I only mentioned booking an appointment with him. And I clarified that I couldn't read some of his comments. So we only needed 15 minutes. I was so angry about his reply. I tried to write down the questions for him, but he replied in a standardised form. Maybe standardised is not the right word. He was once a student and then a teacher; he should've better known what the student could or could not do. But he's the kind of person who would turn around and become particularly critical and blame the student after dumping some information on you. I was not the only one who had to take that. I would think that as a teacher, he didn't explain things he needed to. Instead, he claimed that we didn't know how to learn or that we were lazy… Either way, he only gave me vague answers instead of focusing on my questions. I think this was also something you would call racism. (Ming)

The identification of covert racial discrimination can be subjective. Even though the performer does not identify the behaviour as racial, the impact is established when the receiver interprets it as racism. In Ming’s case, a possible explanation can be that the teacher had a relatively distanced attitude towards his students; it was about personality. However, when Ming sensed and concluded the whole thing was racism, he felt distressed by what he had experienced. Therefore, it is suggested that the subjective component in covert racism is significant, despite its ostensibly non-racial, hidden and less obvious nature. Noh et al. (2007) support the perception that such a form of racial discrimination can subtly cause mental distress. Although perceived racial discrimination is less blatant and overt, it did contribute to the participants’ distress.

This finding indicates that racial inequality might be significantly relevant to mental distress. With the rapid spread of Covid-19 worldwide, anti-Asian xenophobia and sinophobia threaten the physical and mental wellbeing of the Chinese communities (Chae et al., 2021; Cheng, 2020; Coates, 2011; Litam, 2020; Tan et al., 2021; Wu et al., 2021). Chinese international students in Australia have been considered one of the most vulnerable populations who confront the contagious and lethal Covid virus and the ‘racism virus.’ Moreover, the subtle forms of racial discrimination that negatively impact people’s wellbeing, especially those with cultural backgrounds other than Australian, should be cautiously and sensitively treated.

The second part of cultural differences and concerns concerned the dilemma of cultural identity recognition. Woodward (2018) claims that ‘identity’ and ‘identity crisis’ are concepts that emerged in contemporary or late-modern societies, where globalisation has become a significant trend, the traditional frameworks of nations and communities have been dismantled, and a growing 'transnationalisation of economic and cultural life' has occurred (p. 435). Kaul (2012) considers globalisation ‘a set of cultural interpenetration processes.’ (p. 13), which significantly impacts cultural identities. Immigration can be viewed as a form of the globalisation trend, a factor in the cultural identity crisis participants faced. Lexie recognised her identity as deeply rooted in Chinese culture while being torn apart between two social contexts:

> In the past, I usually went back home every two to three months. But even with that frequency, I still felt like it was hard to fit into the life in China every time I went back…This was something

> I felt difficult to accept after I got back home. Because I've gotten used to life here, I would sometimes face this dilemma. They would say hideous things like, ‘go back to YOUR Australia, don't be here, you can't get used to it anyway.’ But it's the same in Australia. They said if you can't get used to life in Australia, just go back to China… After I got home and experienced such a different environment… You can't be impolite to your boss; you must give bribe money to your coach when you learn to drive – you can't do anything without respecting its unwritten rules. And when you go to see a judge, there're rules about not doing something in front of the judge, but buying him dinner and being very respectful. I think it's ordinary for people to have mutual respect. But sometimes I needed to respect or even please him in an exaggerated way; I felt so strange. So I felt like I couldn't get used to either of them (two social contexts)… The feeling was very complicated. (Lexie)

The dual intertwined cultural identities confused Lexie’s sense of belonging and identity. Lexie identified herself as Chinese and had a sense of connection to her homeland and culture, but she could not be accepted as a ‘whole Chinese’ again because she had acquired ‘Australian traits.’ The rejection of full acceptance as a Chinese strengthened her identity concerns.

On the other hand, Lexie formed her values and understandings of the world during her young adulthood in the Australian context while always recognising her Chinese cultural identity. She felt challenged to fit back into the Chinese society, which was a well-acknowledged phenomenon in China, as expressed in the labels ‘nepotist society’ or ‘acquaintance society’ (Ding & Xu, 2015). The idea of acquaintance, expressed in the term Guanxi (关系), originates in familial ties of sentiment and obligation within kinship networks. It extends beyond kindred limits to control social interactions in society through the standards of face, favour, and reciprocity (Bian, 2018). It involves the thought that the individual is a member of a rigid social and economic hierarchy that precedes the individual's interests. Each individual has guanxi commitments to their familial, social, and business networks in this social system. In this environment, interpersonal connections emphasise trust, loyalty, reciprocity, and dedication, in addition to familial obligations (*What is ‘Guanxi’*, n.d.). Therefore, Guanxi is essential to maintain Chinese social production and social life. However, it is difficult for

Lexie to fit into the Chinese nepotist social context having lived in a different cultural context, and she was perplexed about her identity. This was also reported among Chinese people in the UK (Furnham & Li, 1993). Moreover, the racial hatred heated during Covid might strengthen the sense of being unsafe and the confusion of conflicting cultural identities.

5.3 The impacts of mental distress

This section demonstrates the impacts of mental distress, based on participants' understandings and descriptions of their distress experiences. The changes primarily involved three aspects: behavioural manifestations, bodily wellness and the mind and the self.

5.3.1 The understanding of having mental distress: 'You don't know when the black and white movie will stop.'

Before discussing how participants made sense of recovery, a few participants talked about their experience of not identifying mental distress. Participants' spontaneous conclusions about the experience of mental distress were negative. They described the sense of mental distress as being aimless, emotionless and hopeless. Grace spoke about losing the purpose to get up every day when experiencing depression. Joe thought his two-year life was stolen – 'I was a walking corpse doing everything mechanically repeated.' He mentioned that the experience was too painful and overwhelming to manage, so he chose to live a dull and repetitive life to avoid any risks of further harm. In such a paralysed state, he could not recall anything special.

Alice provided a detailed metaphoric description to help us understand the feeling of having mental distress:

> A: It's as if you don't know when the black-and-white movie will stop, and you're sitting alone in a movie theatre. You've been watching the movie, but you think it's really dull. It's really dull, but you don't know how long you have to put up with it, and you just can't leave.
>
> I: Why can't you leave?

> A: Because if you leave and the movie ends, it's like you're finishing your own life. That's the concept.
>
> I: It's kind of suffering. You never know when you will get to the end of it.
>
> A: Yes, it confirms a non-mainstream saying that 'To live is a kind of suffering,' and that was how I felt at that time. (Alice)

Alice vividly explained the suffering. She used the movie theatre as an entity of a state of passive isolation, representing her understanding of her world and her disconnection from the outside world. She compared her miserable life to the 'endless black-and-white movie' to describe her unbearable feeling of a colourless and joyless life. However, she could not leave her movie theatre because it meant giving up her life.

For some participants, experiencing mental distress indicated an unforeseen length of time and level of difficulty. Some participants reported that their depression had long-term and repeated features. The unpredictable distressed state might have existed for some time before they made sense of it. Because of the relatively invisible feature of their distress (participants mentioned their introverted characteristics and their self-protection mechanisms in the previous chapter), they reported a sense of loneliness, which others could not empathise with.

> I recall that the mood was like when I was in kindergarten; I was punished by a very strict teacher. He said he would let me go if I said sorry. But at the time, I was under the impression that I was innocent or that he misunderstood me. I didn't say anything, and I felt like I was doing the right thing, and then he took me to see the principal. I was scared of it when I was a child. I stood in the hallway in front of the principal's office for a long time, watching him talk to others. At that time, I felt like I was waiting in line to be shot. That was how I felt. There are times when you know you're not going to do well (taking exams) because you haven't reviewed a lot, but you think you might have a little bit of luck and you might do well, and then you take the exam, and you realise that you are not so lucky, you are going to fail. Even though you can't understand the question, you still pretend to write the answer, like waiting for the death sentence. (Josh)

Some participants found that the answers to their mental distress were unclear; they might not have had an experience of solving the puzzle. The causes of their distress could be complicated and multifaceted, even not easily detected. They pointed out that having mental distress was not ‘as simple as making up your mind and being more persistent.’ With his sense of powerlessness in changing the situation, Josh perceived mental distress as ‘waiting for an unpredictable punishment or sentence.’ The unforeseen difficulties challenged their experience, knowledge and ability to solve the problem.

However, the lessons learnt from mental distress might not only be depression and powerlessness; it could also deliver a sense of hope and self-improvement. At the beginning of this section, I used ‘spontaneous’ because the painful feeling was the quick first conclusion of the participants’ mental distress. From participants’ perspectives, recovery is a complicated concept; in this study, it emerged from the discussions around hope and reflection (see Chapter Seven). With the process of building up layers of communication, participants reported different perceptions of these experiences.

5.3.2 Manifestations of behavioural changes

Changes in participants’ behaviours included changes in interpersonal relationships in three different forms; problematic substance use and eating behaviours; sleeping issues, attentional difficulties and unstable emotional management.

Changes in interpersonal relationships

Participants reported three forms of changes in interpersonal relationships. The first was tension and conflicts in relationships. This could be reflected in marital relationships, parent-child relationships and general social relationships. Grace mentioned that when she was anxious and could not get enough sleep, her temper became worse and the arguments with her husband increased. Similarly, Dora found herself more controlled and less loved by her ex-husband. Not long before the interview, Dora decided to end her marriage with her husband as the relationship was no longer good for her mental health. Tammy reported difficulties in managing her son’s behaviour.

> I didn't know how to educate my children. For example, when we went out and saw those fliers, he would take a lot of them, all of them. I said we couldn't take them all, just one for each person, but he didn't listen to me. He didn't listen to me… he was hard to teach, he said no to everything I asked, and he would do everything opposite what you (I) asked him to. When I was depressed, I couldn't think of anything in my head... Whenever I was in trouble, I would be impatient, (couldn't) stay calm to deal with the problem, or (couldn't) try to communicate with him to solve the problem. I would lose my temper and get angry. That's why I had a weak relationship with him. He would say no to everything, and that would be discouraging to me. I know kids always make mistakes, but I punish myself for their mistakes, then I get upset and throw things. When I was in China, I was raised well. I never said something rude. But I would scold the child very badly, sometimes so harshly that I even felt very guilty myself. (Tammy)

Several mothers in the study reported that their relationships with their children worsened during times when they struggled to control their emotions or attempted to repair the relationship. These negative parent-child dynamics developed over an extended period rather than occurring suddenly. Tammy, for example, didn't know how to react when her child refused to comply with her requests, causing her to lose her temper and lash out verbally. This behaviour only exacerbated her feelings of guilt and perpetuated the harmful cycle.

Lynn reported serious problems with her relationship with her adult children.

> L: My children are not at home. They ignore me.
>
> I: They what?
>
> L: They left home…the children are… I'm not a good mother.
>
> I: You often have arguments?
>
> L: Yes. Because I'm by myself, just by myself. I deal with the things, and I don't say it. And they feel like I was cheating them.
>
> I: So what was your feeling about that?
>
> L: Very sad! Very sad and very unsupported.
>
> I: And then what did you do with that? You just let it be and do nothing, or you try to fix your relationship, or …?

> L: No…they didn't [want to] know me. They didn't take my phone calls. I'm more depressed than before… I have three children, one is 32 living at home with me, but we don't talk a lot. And the 23-year-old children left home and took off, and they don't have contact with me. I called them and texted them, and they just ignored me. I'm not worse than 20 years ago. How can the person be kept better, tell me? Worse than that. But then the way they treated me, the way I don't see them…
>
> I: So you haven't had a way to fix your relationships yet. And it makes you depressed more.
>
> L: They have ignored me. I don't have a way to talk to them. How can I fix it? ...They said I couldn't contact them. They asked me not to follow them. If …illegal, they are going to sue me… It's a nightmare. It's a life, though. (Lynn)

Lynn blamed herself for not being a good mother and recounted experiencing significant distress while raising three children alone after being widowed. Rather than placing the blame solely on the participants for the tensions and conflicts, it would be more beneficial to provide greater understanding and support, despite the challenges this may present. But when loved ones are going through distress, other family members might require additional support in order to maintain their resilience and be strong enough to face the challenges posed. Interestingly, while the mothers did not report having tensions with friends, they exhibited more moodiness towards their children.

Regarding general social relationships, Jim reported that he would become hostile toward people around him by overreacting or overthinking every word or behaviour of others. Communications with others would be complicated and he would maintain a negative attitude toward almost everything. When I enquired about a more detailed instance that might better explain this, Jim revealed:

> When someone says something in our WeChat group chat, I will misinterpret what he/she means and suspect that this person is judging me. I would sceptically overthink some simple thing; I would feel like people have certain feelings against me. This may just be fine. But when I have the impression that people may think of me negatively, I tend to overreact, which makes the others really start to think negatively about me and become hostile. (Jim)

While certain participants struggled with managing conflicts arising from interpersonal relationships, others sought more companionship from people around when they were on the brink of collapsing under the weight of loneliness and distress.

> I was so crazy about the dating app that I would like to talk to anyone I was matched up with. I didn't like typing, but I didn't even know what to talk about. I just talked and talked; sometimes, I just ended our talk without any signs. I didn't know what I was talking about, but I felt like repeating the same thing every day. Then I thought that the more I was obsessed, the emptier I felt. (Ethel)
>
> They thought I was actually depressed at that time, but they didn't know what to do. They might stay with me on the phone until two or three in the morning, but sometimes they just couldn't stay up too late and probably went to bed. (Alice)

All the participants who discussed their overwhelming desire for companionship were female international students. In their accounts, they did not report a particular preference for whom they spoke to, whether it was strangers or friends. However, these individuals may not have been ready to provide the necessary support. An excessive need for companionship could become burdensome for those who are not prepared to assist their friends.

Roughly half of the participants reported that they withdrew socially when they were feeling distressed. They experienced a decrease in their drive and enthusiasm for engaging in social activities, resulting in a perceived reduction in their daily interpersonal connections. Following is a striking story from Chris about her extreme fear of going out.

> C: I would choose home delivery. They would deliver things to me every week. Many Asian grocery shops provided delivery service. The food-delivery service was well-established too. So, I used the delivery service for a long time. To be honest, in the worst times, I didn't even see my friends. I felt fearful even when I was getting a phone call. So, I didn't answer any calls anymore. I stopped checking the email from Uni, refused to answer any phone calls or check any emails. It caused many problems in my study because I stopped checking the emails from school. My school required me back to work, but I would tell my psychiatrist that I failed another course. My psychiatrist suggested that I should tell my Uni about my condition. Uni might give me a

> refund of the tuition fee because of my health issue. For instance, I would miss many deadlines because I didn't check my emails. You know, it created a bad cycle for me. And because I couldn't do my work, I avoided seeing my classmates or teachers. I stood in front of the teaching building with my cat, who is the anchor of my heart. I stood there with my cat, and I was crying like crazy. I couldn't get in, so I called my friend, someone you just saw. I would ask if she could come out and keep me company.
>
> I: Why did you stand in front of the teaching building with your cat?
>
> C: Because I was supposed to go to class that afternoon, but I was so scared. I thought I might have more courage with my cat keeping me company… Sometimes I felt like I was pushing myself to class because I really needed to. But I couldn't. So I was seeking solutions that could make me go.
>
> I: That's why you brought a cat.
>
> C: Yes.
>
> I: And your friend came down to keep you company?
>
> C: Yes. She said she would walk in there with me, but I couldn't. I was breaking down at the front door. I actually didn't want my friend to come down for me. I thought I could go to the class with my cat. But I really couldn't. I was too scared and too anxious. So I was crying, with my cat on my back. It was stupid, and it sounded ridiculous. But I was really scared and had no idea what to do. (Chris)

Despite her fear of forming connections with others, Chris had to attend school to fulfil her academic obligations. Her account of bringing her cat with her demonstrated the level of distress she was undergoing, but also demonstrated her resilience in directly confronting the challenge, regardless of the outcome. Chris' decision to bring her cat to school may have been an attempt to achieve a goal, exerting her bravery and strength and tackling her worries.

Two caregivers shared how their elderly male care recipients experienced social exclusion due to worsening physical and mental health conditions. Both individuals had been living alone under the care of their caregivers for many years, with limited interaction with health workers and little opportunity to participate in community activities. Unfortunately, communities lack the necessary capacity, resources, and training to adequately support people with higher care needs. Moreover, the mental health of caregiver participants is not well looked after. Caregiver participants reported tiredness and powerlessness when taking over caring responsibilities. Participants needed more support in form of, for instance, peer support groups and education to help them find the necessary skills and abilities to continue the endeavour. And without the basic connections to the communities, aging participants with multiple health conditions were marginalised from basic daily social engagement.

Problematic substance use and eating behaviours

Lexie talked about her struggle with problematic substance use that involved the misuse of alcohol. She explained that when she found it difficult to cope with her academic goals in a new environment, she would consume a significant amount of alcohol daily. However, this habit resulted in weight gain and financial strain. Even more concerning, the alcohol did not provide any sense of happiness or motivation the following day, causing her to feel unmotivated and inactive.

Problematic eating behaviours include binge eating, vomiting and appetite loss. Certain participants consume copious amounts of a specific type of food as a coping mechanism during times of distress. Grace, for instance, had a preference for spicy foods, while Lily favoured desserts. Below is Chris's account of binge eating and vomiting.

> When you are depressed or in a bad mood, there is no way to meet any of your desires, or you have no desires at all. When your appetite is satisfied, this feeling of happiness or joy can lift your mood a little bit temporarily; that's why I was overeating. Then after you've overeaten, you would have a heavier sense of guilt. I actually have it all the time now. And then there was the vomiting, kind of passive vomiting, just overeating until I vomited. It was not so much the eating that made me vomit, but the guilt I felt afterwards. It's because you vomit after eating something, and you would feel okay if your stomach is empty now. You might not continue eating. But next time you are upset, you would think you can continue overeating because you can always just vomit all the food out. Do you see? That's why the behaviour of forced vomiting is so difficult to stop. People don't want to stop it subjectively. After all, nothing else but

> overeating can cheer them up when they are not happy. This is something many friends of mine are suffering. (Chris)

Chris reported that when she had depression and anxiety, the most straightforward approach to cheer herself up was food, because the unhealthy mental condition blocked her desire for everything but food – the most direct joyfulness she could acquire. Overeating could make her happy temporarily, but later on, she would feel guilty about it. To reduce her guilt, she would vomit the food until she emptied her stomach. However, vomiting could cause burning throughout her oesophagus and stomach – that was when the vicious cycle started. As well as escaping the guilty feeling of binge eating, Alice vomited after binge eating because she wanted to keep her weight unchanged.

> S: There was a time when I started to lose my appetite. Usually, when I had some kind of psychological stress reaction, I couldn't eat anything. Then I vomited, very seriously. I couldn't eat and had to vomit. I would feel nauseous when I saw food even if I'd been hungry for two days.
>
> I: Two days for eating nothing at all?
>
> S: No, nothing.
>
> I: Can you take it? Doesn't your stomach hurt?
>
> S: No. All my other functions are normal, but I can't eat. I try to force myself to eat some liquid food, but I can't help retching.
>
> I: Would you vomit?
>
> S: Yes, but I get used to it... This is where I reason… It's the desire to survive, I guess. Feed myself up with milk and cereal.
>
> I: But irrationally, your instinct is that you don't want to eat it.
>
> S: No, I don't.
>
> I: No desire to eat food?
>
> S: No… I'm not interested in food.
>
> I: Has it always been like this?
>
> S: I have no particular interest. I know what delicious food means. But when I think about my purpose in life, I can assure you that food is not on my list. (Sean)

A few participants spoke about appetite loss. Sean lost interest and motivation to eat. He described forced eating for health reasons and vomiting as the impacts of experiencing mental distress. Furthermore, he indicated that he had lost his capacity to derive pleasure from eating and viewed it as an unenjoyable activity during times of emotional hardship.

Sleeping issues

Nearly half of the participants reported sleeping issues. For some, this persisted for several years and negatively impacted their well-being. In addition, some participants experienced both excessive sleepiness and difficulty falling asleep at the same time. Irregular sleep patterns not only resulted in tiredness during the day and sleep through important tasks, but also brought the struggle to fall asleep at night. From participants' further descriptions, their sleep problems also increased the risk of cardiovascular problems and breathing difficulties, further hindering their ability to function in daily life. These sleeping issues also significantly impacted their mental health, increasing the risk of depression. Participants reported struggling to recover from difficult situations due to their sleeping issues.

Attentional difficulties

Nearly half of the participants reported experiences of attentional difficulties in their distress journey. They spoke about the challenges of directing and sustaining attention on tasks or situations. Some participants had to make extra efforts to focus on doing things. Some such traits were even observed during the interview. For example, Josh, Tammy and Lynn could easily be distracted and sidetracked if I did not repeat the question immediately. They could forget what they just said; overthrow the previous statement and insist they did not say anything about that; or sometimes, they just apologised for not being able to concentrate on the topic we talked about.

> I spent time reading topics and projects. I read alone, but I wasn't efficient. I read them mechanically, and my mind went blank. Then I was annoyed that I didn't remember anything after reading it. I thought I was studying very hard, but I didn't remember anything. In fact, when I think about it now, I realise I didn't have the right mindset at that time. I didn't put my

> mind to it. I felt that if I finished reading it, I finished learning it, and there must be a good result. But it was not, so I took it as my fault and wondered if it wasn't the thing for me to be studying. (Jason)
>
> I give myself excuses like I have about 100 pages of paper that I haven't read, and I urge myself to read it, but not really doing that. I might read it for like 10 seconds, and then I realise that my clothes are everywhere in my room. I would think about putting away all the clothes, and then I would get anxious about the 100-page unread paper. I always make excuses for not doing this and that, which could have been done in 5 minutes. And nothing was done in the end. (Sean)

The difficulty of concentration was a hard challenge for participants like Jason and Sean. They realised that they had primary tasks to do. Despite investing time and effort, they found it difficult to remain attentive. This further burdened their daily tasks, and the unproductive outcome left them more frustrated.

Changes in management of emotions

Several participants experienced a shift in their emotions and a sense of losing control over them. Some reported sudden feelings of anger and irritability, such as Ethel who noticed her anger became magnified during the Covid-19 pandemic. Another participant, Abby, shared that her father, who suffered from multiple health conditions including stroke, dementia, and depression, was emotionally unstable due to his mental distress and physical disability.

> He was very up and down those days. And sometimes he'll be sad, crying, just like looking outside the window, maybe thinking of something else, not sure. And other times, still crying but laughing at the same time. So you might be like, perhaps confused. You can feel confused sometimes. Yeah, sometimes he gets angry as well… Physical and verbal aggression. If he's angry or upset, he might slap you or hit you or whatever. (Abby)
>
> Then my GP introduced me to another psychologist whom I couldn't get along with. I didn't think he understood me. And then I got really depressed, I cried all the time, and I couldn't control my emotions… I felt like my life was meaningless every day, and then I went to see the GP and couldn't stop crying… Whenever I was in trouble, I would be impatient… I would lose

> my temper and get angry… then I'd get upset and throw things… I can't (control myself). I scold a lot. I would have never done that, but I couldn't control myself. (Tammy)

Tammy faced a challenging time with her children due to her husband's gambling addiction and her failure to educate her children properly. Tammy's behaviour towards her children became unmanageable as she exhibited bad manners and aggression towards them. During the interview, I noted guilt and remorse in Tammy's tone when she reflected on her behaviour. These participants experienced a period when they struggled to regulate their emotions. Lacking emotional control did not mean that the participants were the ones to be blamed. They were also the victims of the consequences of mental distress. However, this did not mean that they were unable to control their emotions, becoming unpredictable, dangerous or unstable. In the following chapter, we will delve into their resilience and explore how they regained control of their lives despite these challenges.

5.3.3 Changes in bodily wellness

The accounts provided by the participants regarding the changes in their physical conditions were divided into two categories: explicit and well-defined descriptions of bodily changes, and obscure and unclear descriptions of bodily changes.

Explicit descriptions

The explicit and well-defined manifestations of bodily changes included changes in weight, breathing problems, tiredness, stomach problems, menstrual irregularities, hair loss, cardiac issues and hand tremor, including two prominent experiences of somatisation.

Participants who reported weight changes were those who previously reported problematic substance use and eating behaviours. Some participants also gained weight from taking psychiatric medications. Apart from that, Lindsey reported severe malnutrition in Dan, the one she cared for.

> Then he lost so much weight, he lost 16 kilos weight; his clothes were just falling off him, and then mice-things are annoying through the clothes (I guess she was implying the hygiene of

> Dan’s clothes but she expressed in an unclear way. I recorded her original word.). So he wasn't looking neat and tidy, as if he was going off to work. And he hadn't worried about that, but he still had thin hair, long grey hair. I think he was sort of a bit… Sometimes he wasn't aware of it, but at the time, he didn't seem to have a perception of the way he was looking because, in the street, people would look at him. He doesn't look well when he was in the street. Generally, you look at someone and have a second thought, are they okay? Are they in danger? … Essentially, there's not anyone that's seen the full picture of what's happening in Dan’s life and looking at his things (I am aware that Lindsey expressed in an unclear way. I recorded her original word.). He has lost 16 kilos and even ended up in the hospital with malnutrition. it shouldn't be possible in Australia, to get to that point where there's no hope. (Lindsey)

Lindsey was the only caregiver for Dan. But based on the fact that Lindsey was aging and she was also the caregiver for one of her children, she had limited time and energy to cater for Dan’s high care needs. His mental distress and physical disability led to significant weight loss. Additionally, his appearance was a source of concern for those who were unaware of his condition and the struggles he faced.

Several individuals experienced breathing difficulties while experiencing high levels of pressure and anxiety. Specifically, Joe and Lily provided detailed accounts of their experiences with chest pain and tightness. Joe recounted an incident when he attempted to distract himself from his worries by playing online games with friends. However, he suddenly felt significant chest pain and a sense of mental paralysis. Lily reported experiencing regular episodes of chest tightness in the afternoons when she was noticeably tense and nervous over a period of time.

> I thought about my parents' affairs every day, and I couldn't sleep well. I had to go to work, worry about not having enough money and my studies. Everything bothered me, and suddenly I felt like I couldn't breathe, and I felt chest tightness. I usually went out to play online games with my friends on weekends… I sat in front of the computer, frozen, and the mouse didn't move, and I didn't want to move my fingers or breathe. Then there was a feeling of chest pain and freezing, my mind was frozen. (Joe)

> I had chest congestion every afternoon at that time, and I didn't know why. The other strange thing was I couldn't do anything when the teacher started to call the roll in class. I was so nervous that I couldn't listen to anyone talking about anything. I couldn’t only relax until the teacher called my name and I raised my hand. I didn't know why the state was that serious and strange… (Lily)

During the discussion, some participants shared their experiences of feeling fatigued and unable to tolerate a regular amount of physical activity. Grace explained that she perceived her tiredness as her body undergoing stress and trying to recover.

Jim and Laura both described their digestive issues. Jim experienced difficulty digesting food when he became anxious, while Laura struggled with binge eating and occasional bouts of uncontrollable vomiting. As a result, she developed gastritis and had to undergo a gastroscopy.

Other bodily changes including menstrual irregularities, hair loss, handshaking and heartache, not frequently mentioned, are listed here without additional quotes.

Following are two pertinent statements that significantly attributed physical dysfunctions to mental distress.

> Because of this distress, I was in hospital for 7 days, a year ago. The doctor told me…I'm not sure what happened. Still, because my eyes suddenly had some problems and something was blocking my eyesight, I went to the eye doctor. The eye doctor said it was bleeding inside my eyes, and they didn't know the cause. So they had to admit me to the emergency department in a hospital. I went to the hospital, and they needed to check everything because they couldn't find what was wrong. I was in the hospital for 7 days. Then they checked everything, even did a lumbar puncture. They checked the lumbar puncture, checked my breasts, and checked the whole body. My platelets, red blood cells, white bloods cell, neural fields - all the counts were very low. It was almost danger level count. It was a very dangerous figure… Everything is normal, but I need to go back to the hospital for review every week. After that, I tried to find out what happened in my body because it came on all of a sudden; it had never happened before. After that, I've approached many nutritionists, and I tried to find out what happened. But the

> doctors say they don't know what happened; they only can review. But I've found out it's the stress. It was so stressful that my body could not handle it. Yeah, I've found out that I have an immune system problem, but it's not a severe one. But if let's say, I can't balance my lifestyle or my stress, something will happen to my body. So that's one of the symptoms that happened. I was too stressed. (Dora)
>
> I had gallstone surgery this July because I did not rest well every day, so lots of these things added up, and I had an emotional breakdown. But I'm much better now… I found out in May this year when I went straight to emergency. I hadn't had a check-up in the last two years. We went straight to the hospital. I was in excruciating pain, and it was gallstones… Actually, I think emotional problems can have a severe impact on the body. When I really want to recover [from emotional distress], the hardest part is the body, because the less comfortable your body is, the harder it is to cheer you up. (Grace)

Dora tended to attribute the eye-bleeding incident and Grace the gallstone diagnosis to mental distress, when doctors were not able to identify other possible explanations for the diseases. Dora speculated that her weakened immune system was relevant to her distressed mental condition, which caused her body to react with eye bleeding. Similarly, Grace believed that the body and emotions were interconnected, and that when one was affected, the other was impacted as well. This perspective aligns with the holistic principles of Traditional Chinese Medicine (TCM), which does not view the body and mind as separate entities. These examples demonstrate how mental distress can be somatised, or manifest as physical symptoms.

Interestingly, these explicit descriptions of bodily conditions were primarily reported by female participants. It appeared that females were more attuned to their physical well-being, and they were more inclined to attribute these changes to the effects of mental distress.

Obscure descriptions

A couple of participants provided some unique interpretations of the impacts, which did not specifically name the physical unwellness like the descriptions above. However, this did not imply that they did not have a sense of what changes mental distress had brought to their bodily conditions.

> I: So you were facing both heavy stresses from study and cultural shock. What were your emotions like at that time?
>
> M: I felt a little uncomfortable every day. I didn't have a time when I felt entirely free from worry.
>
> I: Mentally uncomfortable?
>
> M: Yes. (Ming)

In the original Mandarin version of the interview, Ming was talking about his ‘xin,’ which, according to the literature review on mental distress from the Chinese mainstream cultural lens, indicated his heart, with a combined meaning of heart and mind, extending further to the notion of mentality. By saying, ‘I didn't have a time when I felt entirely free from worry,’ Ming revealed that he had been mentally uncomfortable during his period of distress without any specific physical disorders. Similarly, Lexie said, ‘I felt… depressed both mentally and physically every day… was in a state of torpor.’ This expression does not separate the relationship between mind and body. This differs from the biomedical perspectives that categorise the consequences of mental distress into disorders primarily located within the brain.

5.3.4 Changes in the Mind and the Self

In this section, participants talked about what their feelings were when they developed suicidal thoughts, how the challenges impacted their motivations and passions, and what their senses of self were in the journey of distress.

Changes in thoughts

A small number of young female participants reported depressing and dangerous life-threatening thoughts after being significantly affected by their mental distress in their early 20s. They provided detailed descriptions of their feelings at that time.

> It was probably in the early morning, and I felt that I had split into two parts. One part told me that it was really hard, death was the quickest way to get rid of it, and it really just felt like a radical idea. But the other part of me was thinking, 'I'm going to get help, I'm going to get someone to cut off this bad idea which would make me do something really dangerous.' I was… I often wanted to stand in a very high place. I might want to jump; I often ran up to the top of our dormitory and looked down on the city. Still, at that time, I felt that the whole person was in a very empty and ethereal state, melting into the ethereal world. There might be some very suicidal thoughts. One night I just couldn't take it anymore. It was so painful, and I searched the Internet for a psychological consultant. (Alice)
>
> I had a severe suicidal inclination. I attempted suicide twice, both of which failed. I used glass– it was more like self-harm – but my intention was suicidal; I tried to cut myself with glass. And I had a very strong impulse to go to the balcony. I wanted to jump down from it. So it was terrible... I didn't pick up my phone the whole day because I was afraid to talk to anyone. They were very concerned and just showed up at my place and rang the bell, asked me if I was okay. I tried to kill myself the night before they came to me. I wanted to harm myself with a piece of broken glass. Then I broke down. I tried self-help. I called the suicide helpline. (Chris)

Alice and Chris encountered a period of intense stress during which they contemplated the possibility of resorting to suicide as a means of resolving their distress. It is important to note, however, that participants experiencing suicidal ideation were not exclusively vulnerable individuals who lacked the capacity to regain control of their lives. In fact, the narratives of those who have undergone such difficult times revealed that they were able to confront their life challenges, reflecting their strength and resilience. Their journey towards recovery was marked by their capacity to summon the courage to seek effective support and reclaim agency over their lives.

Decreased motivation and directionlessness

Lacking motivation and feeling aimless can be a common experience for many people, and it can be challenging to overcome. Whether it's feeling uninspired at work, uncertainty of the next steps in life, or a general apathy towards everything, a lack of motivation can have a significant impact on our mental and emotional well-being. In this study, nearly half of the participants spoke about the feeling of having no motivation to do anything and feeling aimless. They could not focus or think of anything. If there were many things piled up to do and not taken care of, they might even choose to give up completely.

> I: How do you think this problematic experience is affecting your life right now?
>
> S: I piled up a lot of things I should have done, but I didn't.
>
> I: Academically?
>
> S: Both in academic and in life.
>
> I: Life, like what?
>
> S: I'm stacking my clothes in my room.
>
> I: Not washing It?
>
> S: No, it's just not dirty, it's worn once, it's not folded, and that's it. It wasn't like this before. I used to wash up, put away, and keep a clean environment because home used to be just a place for me to sleep, just to come home and feel comfortable. Now it's like a cage.
>
> I: So it doesn't bother you to live in a messy home?
>
> S: No, it bothers me. (Sean)
>
> I was just emotionless. When I recall the past two years, I felt like I was a walking corpse. I didn't remember what I have done in those two years, like memory loss, you know? Not that exaggerated, but many things were mechanically repeated… I didn't know what I had done… I usually went to work… But there was no goal in my life at all. Although there were not many goals in my life before this incident, I might not graduate or something, I could still rely on my family. But I found out I had nothing left; I knew I had nothing left… (Joe)

In Sean’s and Joe’s cases, the possible cause of lacking motivation was a lack of clear goals or purposes. Without a clear direction, it can be difficult to feel motivated to take action towards anything. Moreover, a few participants spoke about the feeling of being burnt out and overwhelmed as the cause of the lack of motivation and purposelessness.

> I had no desire for food. I was already numb… When they always took me out for hot pot and ramen, I was fine with it because there was nothing I especially wanted to eat or reject… I used

> to draw, but there was a time when I found it really painful to do such things, like drawing or playing the piano, which were my hobbies but later became painful things. (Alice)

Hobbies and interests might be two-sided. For some, engaging in hobbies and interests could serve as a positive outlet and assist in the management of negative emotions, thereby contributing to people's overall wellbeing (this is discussed in Chapter Six). This could be attributed to the fact that hobbies provide a sense of purpose and enjoyment and a distraction from the stresses of daily life. However, for people like Alice, hobbies and interests can become a burden. Even it is not hobbies or interests, doing something that requires effort and commitment might be overwhelming for those who lack the necessary drive.

Sense of low self-worth

In this study, self-worth refers to an individual's ability to acknowledge and appreciate their value. Participants' lived experiences explicitly revealed the significant impact of mental distress on their sense of self-worth. Low self-worth was a common topic among many participants, including the lack of self-affirmation and self-criticism.

> When a person closest to you always says that you have not contributed to the family, the money in the family is all from him, you hear about this a lot, and you will really doubt yourself. (Brenda)
>
> I couldn't figure it (study) out because I had a sense of trepidation. I felt scared that I couldn't understand it. And I was very inefficient because of the tight course schedule. I didn't think about going elsewhere for help either…I blamed myself, apologised a lot when I spoke with my parent, and expressed my regret and guilt…I hated myself; I thought I was not good, neither academically nor in any way. To put it mildly, I felt like I was rubbish compared to others. (Jason)

Some participants reported being discouraged by external judgements from affirming their self-value. Brenda was assailed by self-doubt about her value because she experienced long-term domestic violence and gender inequality in her marriage. Her husband's hasty dismissal of her contribution to their family prevented Brenda from seeing her self-value for a time. Jason had a relatively high expectation of academic achievement but was constantly discouraged by the difficulties in the study field. Jason devalued and ‘hated’ himself; he became overwhelmed at that time.

Some participants pointed out that they had sensitive and relatively introverted personality traits, which sometimes could lead to overreacting or overthinking. They concluded that the most obvious consequence of having such an introverted and sensitive personality was that they felt separated from others. Being aware of his reticence about building up a friendship and making social connections, Ming spoke about the sense of self-blame.

> I'm a passive person in making friends, so I usually don't actively communicate with others. I was never the one who initiated adding to someone's WeChat or WhatsApp…I felt like I wasn't willing to have deep communications with people. And I would keep some distance from everyone. Or even when people came to talk to me, I wasn't very friendly to them… I blame myself every time things like this happen. That's why I would be a little aggressive. (Ming)

Self-criticism was common among participants. It is characterised as the inclination to engage in negative self-evaluation, resulting in feelings of worthlessness, failure, and guilt; it was once thought to be particularly significant to the development of depression (Naragon-Gainey & Watson, 2012). These participants tended to attribute their distress to their personalities and characters. They blamed their limited social connectedness on internal factors rather than the dynamic changes in structural situations and external limitations. Characterological self-blame (CSB) is a self-reflective cognitive style in which individuals blame themselves and their character. CSB-responders are frequently self-critical, believing they are at fault or deserving of the negative consequences (Tilghman-Osborne et al., 2008). According to Janoff-Bulman (1979), self-blame as a maladaptive psychological process is often associated with harsh self-criticism and poor self-worth. In some of the participants’ experiences, CSB and self-criticism were strong concomitant of depression. This supports studies from Peterson et al. (1981). The followings are some self-criticism statements.

> I always wanted to make myself better. I made many plans… But I found that even if I had a good plan, my body didn't allow me to achieve it, and then my frustration was extreme. I blamed

> myself, feeling guilty and full of regret, all of which would aggravate my mental distress. (Chris)
>
> I would hate myself so much that the disgust would come out. Basically, when something was happening to me, I felt like 90% of it was my problem. It must be caused by something I didn't do, so my first instinct was to blame myself. I blame myself for not doing this or that, and then I get very frustrated and end up going to bed to sleep…I was aware of my depression, but I didn't do anything to make it better, for which I blamed myself very much. (Sean)

Many participants showed minimal appreciation of themselves. The awareness of depression had become a significant factor contributing to their self-criticism. They demonstrated some determination to resist their adversities, but the failure caused more severe distress issues, leading to a vicious cycle in the self-criticism maze. Low self-worth impacted participants' mental wellbeing. Body dissatisfaction appears to be a good example of the lack of self-affirmation and the self-blame tendency. Two female participants in particular spoke about their depressing experiences of perceived overweight body shape:

> When I was lonely in the first half of last year, I usually talked to a boy in China. We had a great chatting time. I felt like I was hiding behind a screen, and he couldn't see me, so I was relieved… Sometimes I skipped class because I didn't wash my hair and didn't want to put on my makeup. I felt like I was fat and ugly. I just didn't want to go out and meet people, like I lacked the motivation to socialise. I skipped classes because I had to meet many classmates, and I was ugly; I didn't want to see them… (Laura)

The impression Laura left was that she was a girl with a fit body shape, but she seemed unable to ignore her parents' trenchant comments on her body shape. To keep her fit and slim, her mother applied rigorous rules to her diet and appearance. As time passed, Laura became less confident in her body shape and appearance, lost motivation for socialising, and became more introverted. Laura reported that her parents' harsh standards for her body image gradually made her anguished, which led to a diagnosis of depression and anxiety. While Laura's depressing experience was related to her parents, Chris was sensitive to the cultural stereotype that females should be slim and fit. Even though she chose to stay away from these hostile comments, she became upset and developed a great sense of shame.

> I socialise online most of the time. And most people who do online social aren't very nice. Especially when I was a little fat… I actually always had body shame, even when I was fit, during which time I never really thought I was fit. The social environment creates these hidden rules, judging and valuing people by appearance. So when I realised that I was a little fat, especially when someone called out loud that I was fat, or how had I got that fat… so many people judged me by my appearance. This made me feel ashamed. I was upset. I wouldn't fight back against their judgement at the beginning. I knew I was fat; they didn't have to say it aloud. I would make an effort to lose weight. I would say things like that and accept their body shaming. But later, I would get mad when they repeated these terrible things. Eventually, I stopped getting in touch with some people. Especially when their words would give me a stronger sense of shame, I would feel upset. (Chris)

Chris's understanding of the unspoken online social rules is that kindness and friendliness is shown to people with a nice body image and appearance. Since she had been experiencing depression for a long time, which caused her irregular sleeping and eating habits, she had to cope with her emotional instability while fighting against the consequences of binge eating and vomiting, which she thought was the cause of her being overweight. Even though Chris tried to ignore the unfriendly comments on her appearance and later protected herself by staying away from the hostility, the words from the internet were so harsh that she eventually became more distressed after being criticised for her body image.

For some participants, it was challenging to develop a positive attitude toward unexpected body images while also experiencing mental wellbeing in a social and cultural context that judges people's values by criticising unfit body shape at the first impression. They might alter their behaviours in response to what they believed others thought of them, even if this was not always accurate.

Sense of powerlessness and disadvantage

The sense of powerlessness is closely related to social factors, such as gender inequality, economic inequality, emotional abuse, and structural oppressions (Deegan, 1996; Tew, 2013; Tse, 2004), which are reflected in the following findings. For example, Grace faced the challenge of powerlessness as she could not decide her future career development for herself. She lived in Sydney with her husband, who eagerly made plans to get a permanent residential identity in Australia. As a result, Grace gave up her career life in China and lived far away from her parents, family and hometown. But the application process was not as fast as they expected; Grace felt that she was constrained by her husband’s decision, the policies and the unclear future; she had no choice but to wait. And she felt powerless to own the right to decision-making.

> What does that mean to me…I don't know right now, but I can feel that if I had stayed the way I was, I would have been miserable. It's like I'm coming out of a place I really don't want to stay in. Because that situation was where I felt so powerless. (Grace)

As discussed before, gendered inequality could be a stressor for a sense of powerlessness and disadvantage, especially when participants are significantly internalised the superior power of patriarchy that acknowledged by traditional Chinese culture. It is worth highlighting that despite feeling voiceless in this situation, Grace exhibited a clear awareness of her ability to distance herself from the disadvantaged circumstances. The feelings of powerlessness and disadvantage may not always have a negative connotation; they can also contain the potential for resilience and bouncing back.

The structural stressors also brought a sense of powerlessness and disadvantage.

> I don't know how to describe that feeling, but when I saw him lying in a hospital bed, unable to open his eyes but dozens of tubes inserted all over his body, I couldn't help crying. I was in a state of shock when all my tears came out… When I took care of my dad, after a specific time, there is a saying that 'there is no filial son in front of a bed for a long time.’ (This proverb implies that true filial piety is often absent when someone is in a prolonged state of illness). I don't know if you have heard it before, but this saying is true. When I recall [that time], [I realise how] reality indeed has a significant impact on people's state and mindset. I had some thoughts I didn't say out loud and are so despicable when I think about it now… [like] if only my dad could leave us as he hurts so badly, our family would be less burdened and happier, and I have to stay here, doing nothing and going nowhere, just taking care of him. Then I thought, my mum didn't

> have to be like that [taking over such an overwhelming responsibility to care for his dad]; my sister and brother-in-law didn't have to be like that. Everyone in this family was deeply affected by his situation. And I was sorry for thinking these things [about our burden]. After all, my dad had done so much for our family… I feel that the hope is dim. I think these are tiny comparing to the whole world, and there is nothing we can do but take it… Everyone is a drop in the torrent of development. (Joe)

Joe’s life was torn apart when his father had a severe brain injury that disabled him and gave his family no hope of recovery. Joe had to take over responsibility for every aspect, including becoming financially independent as soon as possible, relieving his mother’s burden as much as possible, fighting against the growing sense of hopelessness and accepting the fact. He felt powerless and helpless because he was separated from his parents - they were back in China and he had to make money in Australia to support himself and his family - and was limited in what he could offer to help his family. Joe expressed the desire for social support to improve his father’s caring conditions, but such supports were rare. Moreover, deeply rooted in Chinese culture, the eldest son must carry the responsibilities when the family is experiencing a crisis. The tradition encourages males to present strength and masculinity and does not allow them to surrender to difficulties. Joe had to struggle to be strong in front of his family, but in an environment of insufficient social support and strong cultural influences, Joe had difficulties in developing his resilience.

During the COVID pandemic, social stressors became the primary source of reported mental health issues. For example, due to the Australian government’s decision to close the national border to foreigners, a few participants talked about their dilemma of whether to stay in Australia or return to China. Staying here could be vital to their study commitment and employment plan, but they might have limited social support to reach out to, experience isolation and loneliness, racial discrimination and hostility, and the fear of catching COVID with the risk of being excluded from sufficient medical treatment because of not having health care entitlements. Below is Lexie’s experience that demonstrates such a dilemma and her sense of powerlessness.

> Whenever I was walking on the street, I could feel the malice of the whole world against Chinese people. No matter what you did, after COVID-19, people were just so… You couldn't even debate with them. It was very annoying. And this year was challenging from start to end… Last Saturday I was having a drink with my friends. Suddenly a drunk white guy that no one knew joined us. He asked where we lived and where we were from. My friend answered that we were from China. He started to talk about Coronavirus without even thinking. I was furious when I heard that, because it was so challenging to make my return to Sydney earlier this year. If you wore masks, the locals would say that you were carrying the virus or sick. But if you weren't wearing a mask, your friends would ask why you were not wearing a mask and just refuse to see you. So it was so difficult to be in between, and I couldn't really blame anyone…Even though I'm not a foreigner (when I was back in China), as someone from Chongqing, when people from Wuhan fled overnight, I was angry and blamed them for spreading the virus. So I could understand how people must've felt about me. But in the meantime, I think we can't really argue about anything because everyone is like this. There is so much hatred on social media right now. They hate you for being Chinese, no matter what you say or do. (Lexie)

COVID triggered many unexpected and rapid social changes that cut off participants from their expected plans for their life. And it was difficult to reverse the situation as the individual-level adversities seemed insignificant to the macro social context. Alternatives were hard to figure out for them at that moment, and it was frustrating for those involved. Powerlessness to fight against the social and political uncertainties, thus, was another negative effect on participants' mental wellbeing.

5.4 Summary of the chapter

This chapter presents three sections on participants' lived experiences of mental distress. The first section points out that family does not act as a biological or genetic cause of mental distress, but as a vital social context to consider in the development of mental distress. In past studies, Hsiao et al. (2006a) found that the Confucianism-oriented family environment can impact Australian Chinese people's mental health. The discouraging facts within familial dynamics in this study added to the literature by revealing how Confucian ideology and filial piety became influential drivers in participants' distress experienced in the current context. However, culture may not only have a negative impact on the distress that participants involved, but also can be a protective factor in responses to distress and challenges (Kleinman, 2004; Lam et al., 2022)(also see Chapter Two and Chapter Six for findings on this point). Traditional Chinese culture could profoundly and subconsciously affect people's perceptions and behaviours when coping with mental issues, even in the Australian context, which will be elaborated on in the next chapter.

The second section elaborates on two main findings regarding the absence of secure social bases. Participants in this research were generally overseas-born with Chinese cultural backgrounds, most of whom found challenges and differences when relocating to Australian society and culture. The stress of study, unequal employment opportunities, housing conditions and numerous lockdowns increased the difficulty of readapting in a new social context. Moreover, Covid heated racial hostility towards Asian/Chinese-looking people, who were at risk of having Covid while being discriminated against. With the rapid spread of Covid-19 worldwide, anti-Asian xenophobia and sinophobia threaten the physical and mental wellbeing of Chinese communities. Cultural differences and distance also raised about participants' concerns about their cultural identity. Together, these formed an unsafe social base for participants and their mental wellbeing.

The third section provides some powerful descriptions of the impacts of experiencing mental distress, starting from participants' accounts of their feelings. The impacts primarily involved three aspects: behavioural changes, bodily changes and the development of negative thoughts and changes in the perceptions of the self.

Changes in interpersonal relationships took three different forms: tension and conflicts, excessive needs for companionship, and social withdrawal. Tension and conflicts were particularly found in marital relationships, parent-child relationships and general social relationships. Some participants reported excessive needs for friends, who, according to participants' narratives, might not be adequately prepared to meet the overwhelming needs.

Apart from that, participants spoke about the challenges of problematic substance use and eating behaviours; sleeping issues; difficulties in remaining attentive to their studies and other obligations and regulating emotions. These were all the behavioural changes found in this study.

Changes in bodily wellness included explicit and well-defined descriptions of the impacts on participants' physical wellness, as well as the obscure and unclear ones. Participants reported problems with weight, breathing, tiredness, stomach, menstrual irregularities, hair loss, cardiac issues, and hand tremor. Participants tended to attribute physical unwellness to mental distress, and described the physical dysfunctions as significant manifestations of their mental distress. Findings of changes in bodily wellness demonstrated how mental distress could be somatised, or interpreted as manifestations of physical symptoms. Participants did not necessarily separate the body and the mind, in accordance with the Chinese cultural conception of mental distress as described in the literature review chapter.

Changes in the mind and the self manifested in experiences of suicidal thoughts, and how participants' motivation and passions were impacted by mental distress. The impacts on self-perceptions and self-image stood out. Participants with lower self-worth seemed more reactive to their social environment; they cared more about external feedback in their self-perceptions. Also, self-blame and self-criticism could significantly diminish their sense of self-worth. An example of this finding is their emphasis on dissatisfaction with their body. Stressors that could lead to the feeling of powerlessness and disadvantage are presented in this section, including gender inequality, overwhelming family duty and unavoidable structural oppression during the Covid pandemic. A crucial purpose of reporting the impacts on participants' sense of self is to demonstrate their resilience, strengths and power in generating strategies for responding to such circumstances, which are elaborated on in the following chapters.

CHAPTER 6 The responses to mental distress

Alice specifically described the importance of responding to problems in distress:

> I was like a broken car engine core. You were driving the car, and it already smoked everywhere; everyone would leave you far behind if you tried to fix it and get back to the field. You might as well drag on here, as far as you can, anyway, the total distance was set. But I found out that it was not really like that. (Alice)

Decisions and actions aiming to change the distress might be seen as signs of the start of the recovery journey. In this second chapter on findings, I continue to explore how participants responded to the challenges of mental distress and navigated their roles and identities during their recovery journey.

The strategies for seeking external help will be presented in terms of informal and formal support. Informal mental care supports are defined as resources originating from an individual's support network, such as family and partners, friends, religious activities and leaders, community support programs, school resources, employment, acquaintances and other non-medical resources. Formal mental care supports, such as mental care service providers, practitioners and professionals, provide mainstream services to all individuals (Brown et al., 2014; Lauzier-Jobin & Houle, 2021).

Participants reported support from family, partners, friends, religions and other informal supporters. They also revealed their lived experiences of accessing formal mental health services. Within the conversations, they confirmed that there were concerns and challenges when they sought help from others. The 'seeking help from others' section demonstrates different strategies that participants applied based on their individual contexts and considerations; it does not divide informal or formal support into 'more helpful' or 'less helpful' conclusions. Self-support refers to leisure and recreational engagements, ongoing attempts to address struggles and self-empowerment, and self-acceptance.

6.1 Seeking help from others

Informal and formal supports were all reported by participants when they sought external help. Informal support included family and partners, friends, religion-related sources and other supporters. Family's and partners' supports were foreseeably weak, given the family tensions described in the previous chapter. Concerns were also raised regarding friends and religion. Formal support was mainly within the professional mental care fields, including service providers, practitioners and psychiatric medications. In this section, participants especially highlighted the importance of respecting their socio-cultural and economic backgrounds, which not only related to the stressors of their mental distress but also to their understandings and interpretations of mental distress as well as their help-seeking patterns.

6.1.1 Informal support

Family and partners

In this study, a few participants spoke about how support from family and their partners encouraged them to find hope and resilience when they had mental distress. However, family and partners were not without their challenges. The definition of the partner in this discussion includes married participants' spouses and unmarried participants' partners, with every possible sexual orientation.

Joe reported that his cousin provided essential help for him to go through the most difficult time. Joe's father had severe brain damage, and Joe was suddenly put into a crisis where he must live independently and support his family as soon as he could. The acute change in his family overwhelmingly challenged his mental condition. He realised that comfort and kindness were useless in the face of these extreme challenges. He considered the offer of free accommodation from his cousin the most imperative as it enabled him to go through the financial crisis and continue his study at the university.

> The most helpful thing for me is financial help. I have a clear vision that my cousin is the most helpful one on my way forward. My cousin is the one who has the most significant influence on

> me because his help actually changed my plan and everything I have for the future. When everything happened, I thought that if I came back, there was no place to live, I had no money, and I had nothing. I could only make money to pay for my accommodation, but no more for tuition fees. When my cousin gave me another chance, asking me if I needed help, I still yearned for the way forward. Now I can barely pay my living expenses and tuition fees, even with my cousin's help. But if I have to pay for accommodation, I might lose the chance to finish my study at uni. (Joe)

Lily identified that support from family was significant to her. She emphasised that family support could be expressed in an attitudinal form. The affirming attitude from her parents gave her a sense of security in solving her problems independently while knowing permanent support from her parents would always comfort her whenever she needed it.

> I was in depression. So one day, I told my mum that she couldn't step out of these things. If I quarrel with my husband, I need you to promise to be on my side as always. Even though I don't always tell you what happens, I need your confirmation. After saying this, my mum claimed that she just wanted us to solve the problems ourselves, but not avoid them. We had a long talk, and we both cried. Finally, I confirmed that my parents will always be behind me. They will always love me and will always help me. I don't really need them to do anything; just an attitude can be enough. (Lily)

However, many participants reported concerns about telling their families about their mental or emotional issues. Their reports mainly focused on the concerns that their frustration could make their parents worry. They would instead only tell parents the good sides of their life or pretend to be happy in front of parents while digesting the depressed emotions and thoughts themselves. And they further worried that their frustration could adversely affect their parents and cause secondary harm to them.

> A second ago I was worried about a thing, the next second I'd talk to my parents with a smiling face, saying that I'm fine, I'm going to have dinner, I'm having a good time. I put so much mental and financial pressure on my parents in previous years. I poured all the information that I shouldn't pour out to them, and I think they were a bit overwhelmed. They didn't express that,

> but I could feel it. Now I won't do childish things like that and I’ve stopped being so emotional. (Jason)
>
> I was worried that they might be worried. They couldn't come to me; it's meaningless for them to be worried. I didn't want them to be concerned. So there's a nasty cycle. I was anxious. If I told them, they would be worried. They would like to come to me, but they couldn't because of many reasons. Then they would be anxious. Their anxiety would reflect on me, which would make me more nervous. (Chris)

Traditional Chinese culture understands mental health issues in a different way from Western culture (see Chapter Two). It does not especially recognise mental health and distress or encourage revealing personal emotions and mental conditions. Emotion-revealing and help-seeking behaviour could be interpreted as showing weakness to others, admitting failure in one’s life and casting a shadow over the glory and reputation of one’s family, which highly dishonours Chinese culture with Confucianism as its core (Lian et al., 2020). Influenced by the Chinese cultural background, families in this study did not always respond supportively to the disclosure of distress.

Interestingly, some participants emphasised their experiences as the single-and-only-child in their families. There were 10 participants with a single-child background. Single-and-only child participants in this study may carry certain responsibilities in taking care of themselves and reducing the potential worries of parents. Not telling parents about their depression and the frustrating experiences was considered responsible, showing solicitude for parents who had already had pressures in their life.

> I didn't dare to make my family worry about me. I am a single child. After I was gone, there was only a Husky at home. I think he is the anchor of my family. For the most part, I didn't want them to worry about me. Because I've been overseas for so long, and I've always shown them my best side. I could be crying alone, and the next moment I could just smile at them on the video call. I don't want my family to worry about me. They’ve had a lot on their plate already. (Lexie)

The previous chapter pointed out that a problematic parent-child relationship was a significant stressor in some participants' mental distress. A lack of family support could also explain why they did not want to reveal their mental or emotional issues to their families. For example, Chris's parents could not accept her depression diagnosis for years until the severity of the mental distress developed into a life-threatening intention. Some participants had very tense relationships with their parents, who they believed were the primary reason for their mental issues.

> I: Have you told your family about this since you realised it?
>
> S: That's one of my problems. I don't like sharing my personal emotions with anyone.
>
> I: Even family?
>
> S: Especially family. My relationship with my family is like…I would tell them something that would make them proud, but nothing else. (Sean)
>
> My family pushed me very hard; I didn't dare tell them my problems. I tried once, but their reaction was exaggerated. They were even more devastated than I was, saying that they spent all their money to get me to study abroad, and then I told them that it was them that caused my mental problems. (Alice)

Although the current literature (see Chapter Two) highlights that family is an important factor in improving the mental wellbeing of people with distress, this study found less evidence to support it. Some participants revealed their concerns about seeking help from their families, based on their cultural interpretation of the consequences of asking for help from others, their single-child family background and the intense parent-child relationships. Interestingly, only female participants reported their opinions toward partners. Similar to familial support, most female participants attributed their distress to their partners to a certain extent. Only two participants expressed thankfulness for the support from their partners.

> Do you mean the process of feeling better? Actually, I think the most important factor is I had a boyfriend. I finally have someone to talk to, and he is a relatively self-disciplined person who makes my life much more regular. Because we would eat together, he would have regular meals. If he had all three meals, I didn't seem to want to eat anything else, and then we would have more time to study, which made me feel better. He didn't really understand it [Laura's concerns

> with body image], and he didn't really show any verbal support or anything, but the change in my life was fairly straightforward. (Laura)

Laura had an eating disorder and was anxious about her body image. She commented that her partner assisted her in regulating her eating behaviour and comforting her anxiety about her body shape even though he could not understand it. Alice revealed both the support from her partner and the challenges they faced. Alice had difficulties constantly maintaining stable emotions, which also affected her partner's emotions and the further development of a long-term intimate relationship. But Alice also pointed out that being accompanied by a partner stimulated positivity, from which she gained the motivation to step forward in her recovery.

> I was also accompanied by my boyfriend, so I think it was a lot better. Otherwise, I would have cried late at night and couldn't stop, which sounds really bad, especially when it lasts for years. He felt sorry for me, and he would hug me whenever I felt sad. Actually, my boyfriend and I had a hard time at first. Maybe it's because I was not emotionally stable. He was depressed, too. He didn't think he could handle staying up late at night or stand my weird temper. He said I couldn't control my emotions, and I didn't know why we were still together. I can't deny that being in a relationship is definitely very helpful; it has a positive effect. I'm sure it's better to have someone there. Having someone with you really helps a lot. (Alice)

This finding supports the studies on partners of people with mental distress, which demonstrated the crucial role partners can play in motivating resilience and strength (Harris et al., 2006; Mannion, 1996; Oomens, 2005). Moreover, gender did not seem to be significant in such lived experiences, since both male and female participants reported support from their families, and reported concerns and hesitations about seeking help from their families. A slight difference was that only female participants reported appreciation and gratitude for their partners. This may have been simply a feature of that particular sample, which was not significant gender-wise.

Friends – 'It's like lighting a match in a vast ice cellar…Just a few drops but it's still a big help.'

During the interviews, most participants mentioned the importance of support from friends. They confirmed that friends were generally supportive and helpful, strengthening and widening their social connections. Friends could become listeners and provide companionship, emotional support and practical advice. However, they also expressed concerns and some reported that help and support from friends was not the most helpful element in the solution to their adversities.

> Sometimes they came and asked me to go out. I went out with them, and sometimes I would be playing and talking and forget that I had something annoying in my mind. I would feel relaxed for a while. I would think that I didn't have to worry about things when hanging out with them. When I was with them, I felt like I didn't need to worry about things; I immersed myself in it. Sometimes I think it's nice to enjoy freely playing with my friends. I like my friends a lot, they are very lovely people, very innocent, and they are enjoying themselves. When I am with them, everyone is happy to express themselves. (Jason)

Jason thought he was relaxed and distracted from his distress when accompanied by friends, which was commonly reported by COSs, who had relatively weak social networks because of their short residency in Australia. Lexie said that emotional support was significant for her. Her mind could become clearer, and her emotions could be vented when talking with friends. Besides mentioning companionship and emotional support, Chris spoke about her friend who suggested she see a counsellor, who finally became the primary support during her distress.

> The first time I went to see a counsellor was because a friend told me about it. Because that friend was also experiencing trauma in her life. She was the first person who convinced me to see a counsellor. So I had my first meeting with a counsellor. And I never stopped seeing them afterwards. It was not that I chose not to stop. It was them who thought I should see them again. (Chris)

These confidants performed as a ‘safety net’ to protect participants from being more isolated or unsupported because of their unstable mental condition. Joe thought that if the safety net was strong enough, it could motivate people to ‘rebound.’

> I feel like if you're emotionally unstable and have a large circle of close friends – it's like a safety net, and if your safety net is strong enough, it can help you rebound. So I think that's what matters. The most important thing is whether the people around you can help you, that's my idea. (Joe)

However, participants also pointed out that sometimes, friends could not possibly be the most significant factor in resolving their problems. They explained that concerns and hesitations prevented them from revealing their inner thoughts to their friends. For example, Brenda said her friends were concerned about her, but they did not offer as much help as she needed, because her friends knew little about mental distress or did not have a clear concept of what it meant. The only help they could offer was being a listener, which Brenda appreciated but still struggled to fight against her distress alone. Other participants elaborated that all friends could offer was comfort, which was not enough for them –‘others would feel that you didn't have to worry about yourself, you could absolutely go through it, but I knew I couldn’t.’ Friends might not be able to fully empathise with their situations and the causes of their distress because their living contexts or lived experiences were different; ‘what I say to them is just like a story,’ Joe added. Lynn commented that rather than telling friends about her difficulties, she felt more accepted and understood when sharing her concerns with people with similar experiences.

> Yeah, we talk, but they are just friends. They can just listen to me; they cannot do anything better than that… I only talk to a friend who's got the same problem. I don't want to talk to a friend who has no problem. (Lynn)

Other concerns and hesitations included worrying about friends’ mental wellbeing and the different living contexts. They thought their experience might become a burden to friends who were busy with their daily lives or whose resilience was not strong enough.

> But I didn't usually talk to him about this stuff because I thought he was even more emotionally unstable than I was. He was more extreme, more erratic, and more impulsive. I couldn't talk to him about my sad things because I was worried I would make him more depressed. I often asked my friends out, telling them how miserable my life was. We talked about life and the meanings of life. And my friends would be depressed as well. (Lexie)

Despite the concerns, participants showed gratitude and appreciation for friends who supported and led them towards their recovery journey. This relationship capital offered them emotional support, companionship, and friendship, increased their mental capacity, stimulated hope, strength and resilience, and brought meaning and purpose to their lives. Moreover, participants understood the nature of friendship to be changing and dynamic. As time passed, friends who once helped them out of their distress might later become strangers. Participants viewed these pieces of friendships as part of their life. They still carried the courage and strength to live a hopeful life.

> The company of friends could make you feel less lonely and empty during that time, it was warm. It's like being in a vast ice cellar with a lot of ice; your friends' help is like lighting a match, which gives you very faint light and heat; the ice may melt a little bit... just a few drops of water, but it's still a big help. (Alice)
>
> I feel that I have been relying on friends for the last few years. Even though some of us didn't end up being friends anymore, I still am grateful for the experience we shared. I think I've learned to be thankful in the few years. After all, it's fate to be together. We'll meet so many different people in our lives, but it's not easy to meet someone like them. We left memories in each other's life, even though we might end up being strangers eventually. I began to respect the facts. I didn't want to reject it or something because this is a part of my life. (Lexie)

Religion-related support

Religion often positively impacts people's quality of life (Martinez, 2010). Several participants reported that religious activities and leaders distracted them from feeling isolated and excluded and provided patient and attentive care, especially to those who had weak social connections. For example, Abby's father was severely disabled by a stroke, with consequent lack of emotional control and depression. The church from Abby's community provided both essential support for daily living and spiritual support to their family during the most challenging time.

Interestingly, one female participant (Lily) reported that she used tarot divination and lighting candles to predict the unknown things within her marriage, which was the primary stressor of her anxiety. She claimed that the spiritual method was prevalent among young Chinese female adults because it provided a more affordable way to relieve their cluttered thoughts than paying a high hourly rate to see a psychologist. She believed her confusions were answered, and her mental condition improved after speaking with a person who claimed to be accurate in divination. But she also reflected that tarot might not be a realistic solution for others who had mental issues because, after all, 'you just need a stranger to tell you something you've already known.' I include her reflections here, not to argue whether tarot or divination belongs to religion or not, but to point out this interesting phenomenon, which appears to be prevalent, as I also witness my friends using this method to find answers for challenges they face. Soothsayers are not much seen in the scholarly literature, but could be explored as an alternative help-seeking preference.

Now we turn to unpleasant experiences with religion. Ethel reported that she felt disrespected and uncomfortable during religious interactions:

> I actually thought it was ok to donate money because every time I took part in their activities I ate something. I thought I should give some. But because I haven't been baptised yet when they had the Eucharist, they let me eat for the first time. And they ignored me the second time, leaving without talking to me, which made me very sad. I felt very sad because I thought they pushed me to do the baptism. They constantly asked if I would join the baptism, but I refused twice. I was embarrassed, but I didn't think it was the right time. If I had, I would have taken the initiative to ask for it. This made me very unhappy… I attended one baptism. They said that everyone had their unique language for speaking to God. But that day, I didn't. I didn't feel anything. I wondered if God didn't like me, and then they asked me to wait. I waited for half a year, and I felt God didn't occupy a prominent position in my life… The so-called sisters and

> brothers haven't really been in my life. I lack a sense of companionship without any more contacts beyond this relationship. They didn't help me understand the whole thing, so I decided to quit. I said I wanted to reconsider this matter. (Ethel)

Ethel was once encouraged by a church member to attend regular activities. She felt accepted and welcomed by a group of people in the new city she started living in. She was grateful to the church and the people who helped her build up her initial connection to the city, but then she was uncomfortable with the rituals, which she considered inappropriate for an unbaptised member.

This example does not mean that religion cannot be a strategy for those who look for spiritual guidance and inner peace, but it highlights that spiritual support might not be culturally appropriate for some people who hold different cultural concepts. It has various manifestations and core concepts, which might clash and create misunderstandings when two different cultures meet. From the above example, we can see that religious activities and leaders motivated participants to build and strengthen their social networks in the communities and provided emotional and spiritual outlets in response to their feelings and thoughts about their difficulties. But the different cultural concepts might also undermine the positive effects of religion. Religion-related support should respect people with different cultural backgrounds to avoid becoming a discouraging factor in their mental well-being and quality of life. Religion-related support should be carefully and appropriately conducted when people who receive support hold different cultural views.

Other informal supporters

Other informal supports were reported by a few participants, including casual acquaintances, community mental support programs and government-funded programs, and support from their educational institutions.

According to some participants, acquaintances could be significant when participants need particular or additional assistance in daily activities, even though the opportunity is random. Ming reported his experience of being taken care of by a Chinese dormitory manager, who sometimes brought him food and presents. Ming guessed the woman had a strong sympathy for Chinese students who lived abroad alone. He felt touched and grateful for her warmth when he was experiencing distress and loneliness. Jason reported an experience with an Uber driver who relieved his concerns and listened to his thoughts, which he commented was more helpful than consulting with a psychologist. Laura reported that her dietarian and fitness trainer relieved her body shape anxiety and overactive eating behaviour. Other participants spoke about acquaintances who helped them with specific problems they faced when experiencing mental distress. The informal help gave emotional and physical support to improving participants' wellbeing. These supports were casual and unplanned but, to some extent, were a hopeful step in their recovery journey.

For carer participants with healthcare entitlement, community care programs and government-funded care programs such as NDIS and other carer support projects provided significant support for people with mental distress and physical disabilities. According to Lindsey and Abby (carer participants), their communities offered activities for people with physical disabilities, and strengthened their social integration and connections to the communities. Government-funded projects provided carers with relevant skill training and emotional support. Carer participants also pointed out that their families might experience long-term impacts from mental distress and physical disabilities, such as the perpetual need for psychiatrists and nurses to support the complex needs of the cared-for family members. These social supports could also reduce their financial burden significantly while instilling hope and resilience towards their recovery.

As a consumer of the mental health care services given by the university and the psychological professionals, Alice claimed that the practical help from her university was inadequate. There might be a sizeable invisible group of people who had similar experiences and potentially needed support from their educational institutions.

> I wish our school could pay more attention to this aspect [mental health] of students. I know about [the name of her university's psychological consultation service]. But actually, I think they should give the students more substantial help. For example, they could send students a

> form for a depression test... because they send it to them, then they will know it would help, but don't know if they have it or not [before getting this information and tests]. Like me, if I hadn't done the test for a long time, I wouldn't have known it was severe depression or severe anxiety. People don't know whether they have it, right? Some people like me may be perplexed. But they put it off a long time before they knew they have mental issues. I thought it took a really long time for me [to figure out the situation], and I should have gotten out of it a long time ago. I wasn't told how to do it during that challenging period. I didn't think everyone could be that lucky (to recover), and I later found myself surrounded by friends with all sorts of causes of depression. That's why I think the uni should pay attention to such a group of people. (Alice)

According to Gale and Thalitaya (2015), mental support from educational institutions can help students continue their studies, improve their coping strategies for mental distress, and further improve their general well-being. Some participants showed minimal trust and interest in seeking help from their universities when they experienced mental distress. They considered the service too standardised and that it could not focus on the specific difficulties they faced (please see the following section). And they lacked confidence that service practitioners would spend sufficient time getting to know them in order to understand their situations. A few participants did not realise that their universities provided such services.

6.1.2 Formal support – professional mental care services

Service providers and practitioners

Formal support refers to paid services from mental care service providers, practitioners and professionals. Since some participants were unable to identify the specific roles psychologists or counselors played, I will refer to mental health professionals if no specific role is identified.

Many participants had seen a mental care practitioner at least once in their experience when they realised they could not cope with the distress by themselves. The catalyst for seeking formal help had two forms. Some participants met with a psychologist because they felt miserable and depressed. For example, Alice described how her experience with a psychologist started one night when she thought she had reached the limit of her mental condition: ‘I just couldn't take it anymore, it was so painful.’ Alice googled for a psychological consultant and wrote an email to the psychologist. Jason reported that he felt he might ‘have a psychological problem’ and asked his parents to take him to a doctor for a check-up and counseling. Other participants reported that they decided to see a psychologist when their friends or family members who had knowledge or experience of mental care treatment gave positive feedback. For example, Ethel was experiencing a difficult time, but she did not start psychological consultations until she accompanied her sister to a psychologist. Two carers (Lindsey and Abby) reported that they sought psychological assistance in improving the mental wellbeing of the person they cared for because of their irreversible physical disabilities.

Generally, participants gave both positive and negative feedback on their engagements with mental health professionals. Some participants reported they received significant help from psychologists during the treatment. They highly regarded the expertise shown by the psychologist, including the professional practice that helped them clarify the problems and relieve them mentally, emotionally and physically.

> He has been very helpful to me. He could understand me. And also, maybe there were just too many people who were just as troubled as me; he wouldn't judge me. He drew pictures for me, explaining what was happening in my mind. And he used theoretical knowledge to guide me, telling me how to arrange my emotions and thoughts. Every time I listened to him, I felt like I didn't understand, but what he said made sense. It was the power of theories. He analysed my situation systematically, telling me why I would have certain thoughts. Then he would divide them into different sections and tell me some theories about them. After that, he taught me how to breathe and other methods, which were quite convincing. Like recording my heartbeats to calm myself down, stop thinking about things, or tell me how to improve my focus. (Lexie)

> As for help, someone who really helped me was my counsellor and my psychiatrist. My psychiatrist referred me to a non-profit organisation called the XXX Service. They had a treatment team. The meeting with the psychologist was every week and

> had a perfect environment. I was treated there for a year and I believe I was on the recovery process. They only focused on a small group and small community to keep the safety of everyone. Everyone was very fragile, so they were very protective. They helped me a lot. I had my cat because my psychologist was very supportive of it. The psychologist supported me when no one else did. Now I'm back to the psychiatrist at Uni, who took me to a mental health nurse. I visited her quite often afterwards. The mental health nurse was not a counsellor but someone who assisted my psychiatrist's work. She had weekly talks with me. She might not be as professional as a psychologist, but she was even more helpful than the psychologist I visited. (Chris)

Compared with other participants I discuss below, several participants had a long-term relationship with their psychologist and received relatively systematic treatment from the services. Participants commented that they felt respected and were treated in an equal manner. Psychologists respected their lived experiences, supported their decision-making, and encouraged a hopeful and positive attitude towards their experience and recovery. They pointed out that this progress was based on preconditions of mutual trust, empathy and rapport. When discussing trust, Ming thought that given the professional training the psychologist had, he could finally accept proceeding with a professional mental health treatment with him in a gradual process:

> I need to talk to him. And he might have some ways to help me relax or build up mutual trust in some ways. But I would trust him in most of the things. Otherwise, I wouldn't go looking for them. (Ming)

However, it was not easy for some participants to build mutual trust and rapport with their doctors. They would show reluctance to reveal or recall their adversities, claiming that ‘tearing the wounds open again’ could be particularly harmful mentally and make them miserable. If some participants had a strong and sensitive character, reluctant to show their weakness to others, it could be more difficult to lower their defences and win their trust without causing any secondary harm.

> I went to see the psychologist, but after that, I didn't feel like I wanted to do it anymore. Because you have to tell a stranger about your inner world piling up with tons of unhappiness, it's like you're going to tear the wound again, which is pretty hurtful. (Brenda)
>
> I remember I cried so hard in front of him once. I felt like I was showing my vulnerable side to him, which I didn't want anyone to see. I usually tend to be strong in public and wouldn't show any weakness to anyone. I was sad and crying when I talked to him, and when I was done, I was even more depressed. This situation could last for a day or two. Well, I am very strong. Just that I have been through a painful experience. Every time I say it, I have to face it one more time. I would be in a sombre mood when recalling my past. (Tammy)

While some participants were very protective of their privacy and emotions, others showed concern that the mental health professionals might not get to know their whole self during several sessions and would not be able to empathise with their experiences. After the first few conversations, they doubted whether the clinician could effectively help them solve their problems. When the risk of revealing private feelings and skepticism about the treatment's effectiveness prevailed, participants would become more reserved during the therapeutic talks, which led to less effective interventions.

> I thought I needed to work on my problems because I knew myself better than anyone else. The [name of the service] can help with some problems because they are professional. But they didn't know me enough. And I thought I could solve the problems myself once and for all. (Jim)
>
> After all, psychiatrists can only provide some guidance. It doesn't mean you fully recover when you see them. I don't know how many times I would have to tell my story and build up the relationship until I finally find someone who can help me. I don't want to waste time and energy. It’s so much effort, I think I'd rather recover myself. So I feel that there is no need to see a psychiatrist. I believe that I can adjust myself slowly…This was my first psychological consultation and the first time I saw this person. I didn't know if I could trust him, so I didn't tell him everything. It is possible that the information I gave him is not complete. I might have only told him the problem I wanted to solve most, but I might not have opened my heart to tell him everything. It could be one of the reasons why he was not that helpful. But I can't talk about it like [I would to]a good friend at the first psychological consultation. I just can't do that. (Lily)

Building trust and rapport is not easy. Apart from the reluctance to recall past miserable memories and lack of confidence in effective treatment outcomes, several participants spoke of their concerns about working with psychologists from different cultural, social and economic backgrounds and with different demographic characteristics, such as gender, age, income, race and education level; they feared they might not be able to empathise with their clients.

> The psychologist was a Western woman, but I didn't think she understood it. These people, for me, are simply from a very privileged background. They just come from a perfect background, I think. (Brenda)
>
> One of the significant concerns I have about this kind of therapist is that they are not from the same culture. When you share your story, they respond with very Western answers. I don't think it's constructive at all. (Sean)

Brenda was a victim-survivor of domestic violence. Brenda had a relatively strong recognition of family in traditional Chinese culture. She could not agree with her psychologist’s suggestion of getting a divorce from her husband because she believed a ‘complete’ family could ensure her children’s healthy and prosperous future. She commented that her psychologist, with her different culture and background, could not help her solve the problem but suggested an unacceptable solution. Sean had similar concerns about the Western mental health care treatment, which applied a Western problem-solving method based on Western mental health theories. He thought that Western strategies applied to people from Eastern cultural backgrounds were not constructive.

Different ages might also work against trusting therapeutic relationships. Lily found it challenging to trust a psychologist of a similar age to her parents, because she inherently refused to ‘be disciplined or taught’ by parent-like professionals.

> I met a psychologist last time in her 50s, and I was terrified of her. Maybe I am used to not sharing my feelings with others, and I am afraid to tell them about my marriage. Young women may be better. Young women can understand me. But if we are not in the same generation, if I am the same age as her daughter, I think she is in a parent's position. She may persuade me to do

> or not do something but not understand me sufficiently. Even if she says the same thing as a younger female psychologist, I can't open my heart to the elder because I don't want to be disciplined or taught. (Lily)

Moreover, some participants reported difficulty in building trust and rapport with their psychologists because of their racial and lingual differences. Conversations in English might not sufficiently express their authentic feelings and emotions, and even the Western appearance could create distance between the psychologists and the participants.

> The whole process was in English because I forgot to tell them that I needed a Chinese-speaking counsellor. So when I talked to them in English, it was a little strange for me. So I wasn’t able to talk about it much. (Jason)
>
> But sometimes, even though we talked in English, I felt more sympathy talking to someone who has an Asian face or speaks my language and has a similar cultural background. I'm more willing to tell him what's happening. (Lexie)

In previous paragraphs, participants reported that trusting and accepting mental clinicians was based on the professional training they had received and their expertise. But for some other participants, this was the reason they found it difficult to accept clinicians as helpers. Standards of practice might ensure the professionalism of mental care treatment, which has been proven to generate relatively effective outcomes. But for some participants, this could mean distanced professional-client relationships – a lack of personalised and flexible therapeutic practice.

> I went to see a psychologist once, and I thought he was too mechanical. Everything he said was trained, very standard... his service was like the kind of things that have been prepared, even the answers. I felt it was very mechanical. He was professional, but I felt too standardised, too professional, which led to a sense of isolation. I didn't think he would be able to solve these problems or anything like that. He gave me advice which I can also find online. Like going out more often, you know, talking to your friends more often, doing more exercise or whatever, and I don't think it means that much to me. (Sean)

Additionally, there is a possibility that responding to the demands of standardised practice became a burden for participants, so that the effectiveness of services was weakened.

> I find it meaningless. There are many times I think I prepared the answers to her questions prior to our meeting. Maybe it helped me in the first few sessions, but then I knew she would ask me how my day and stuff were. Then I started to prepare what I would answer on my way to the counselling sessions. Things started to change from then. It became more like a psychological class, thinking about how to answer the questions she asked. (Jason)

Further, the stigma of mental distress and the limited accessibility of Chinese-speaking mental health services are issues that call for attention when improving and delivering culturally sensitive mental care services. A few participants reported that when they were unable to afford the cost of professional mental health services in Australia, they might consider looking for psychologists in China and do e-consultation to avoid the risk factors that they might face in Australia, with the bonus of competitively lower prices and presumably similar cultural backgrounds.

Participants generally expressed low intentions of using mental care services, especially the students, who reported the majority of concerns about seeing mental clinicians. This supported the previous studies cited in Chapter Two, which revealed Australian Chinese people's low intention of getting involved with the mental health service systems. Participants expressed their interest in seeking more tailored, culturally sensitive and empathetic support from formal services. Some participants with Chinese cultural backgrounds found Western formal mental health support helpful, but others perceived it as a complex and unfamiliar situation where their concerns and hesitations discouraged them from seeking formal help. Some participants recognised the expertise of their psychologists, believing that the professional knowledge and training they possessed could promise a respectful and empathetic practice attitude, build mutually trusting and equal practitioner-client relationships, and be reliably effective. However, several expressed concern that a lack of information on everything that contributed to their mental distress was complicated by the difficulty of building trust and rapport. Some participants responded that mental health professionals could not solve their problems because of different personalities and demographic backgrounds. Specifically, unmatched social, cultural and economic backgrounds could lead to an unempathetic and unequal treatment relationship between the helper and the helped. This was reflected in a previous Australian study (Chan, 2007). Moreover, if the standardised service provision had a one-size-fits-all inclination, it might be inadequate for participants who valued tailored, culturally sensitive formal services.

This finding does not indicate any preference for using or not using formal support, but highlights that the choice of whether to use formal mental support services is made considering multiple factors. Although the findings provide positive and negative opinions on formal mental health services, it is possible that participants' understanding of formal support is changeable, and might evolve further in a longer-term recovery experience and change of values.

Psychiatric medications

Nearly half of the participants reported their experiences of using psychiatric medication as prescribed, and the feedback turned out to be generally negative. Except for a few reports stating unclear impacts from medication treatment, several participants doubted the efficacy of the psychiatric medications as they rarely sensed an improved mental state. Alice had a biomedical academic background, and she contributed her insights and concerns about consuming medications based on her biomedical interpretations:

> I was worried about the side effects. The truth is that the mechanism of these drugs is something you could become anxious about after studying them. Let me explain: When I don't know whether I'm thinking in the right or the wrong direction, I can only understand this from a scientific perspective, like how does medication work. If you give me a medication, I might look at the chemical formula and see how it would react to my body. And then I really don't think these medications should be taken. I think it is useless if you are getting mentally better but are physically damaged because of the medications. (Alice)

Alice worried that there was a potential that the stated efficacy of medication prevailed over the actual benefits when treatment was prescribed. Several participants spoke of their worry about the drug's side effects. Jason felt sleepy after using some medication when he had a sleeping issue. He had to rely on the medication to ensure a certain amount of sleep time and sleep quality. However, he stopped using the medications after becoming aware of the possibility of addiction. The withdrawal phase was challenging, but he achieved a medication-free goal in his recovery.

> I think most of those medications made me very sleepy most of the time. So I usually wouldn't take the morning one. Instead, I would take the three-times-a-day medication. It was a Chinese patent medication, only for relieving the anxiety. And I would take the night medication on time, which was helpful for my sleep. There was a period when I couldn't sleep after I stopped taking that medication. Because I would be very excited after stopping it. Taking the medication would make me fall asleep instantly when I couldn't sleep, and the sleep quality was excellent. I told my psychiatrist that I seemed to become dependent on the medications. I didn't know if I should continue taking it. She said that I needed to continue taking it. At least after that, my condition became a little better. She reduced the amount around last year. I stopped taking it after I felt like I could sleep by myself. (Jason)

Grace also reported that when her GP could not find out the reasons for her body dysfunction, she then sought help from Chinese medicine:

> Because I was in a bad mood and couldn't sleep well, my body had many problems. I went for Western medicine first, but the doctor couldn't find any reason. He told me to relax emotionally and then go for a walk. After doing these things, I didn't get much better, so I went for traditional Chinese medicine. I'm not sure if it was emotional causes, but my body was not good for a couple of years. (Grace)

Grace interpreted her unhealthy physical conditions as the somatisation of her depressed mental condition. She did not show a preference for Chinese medicine. The possible explanation for her turning to Chinese medicine was because the available Western medical methods failed to identify her unwellness, and Chinese medicine has a relatively integrated medical concept and value (see Chapter Two), which might provide a more holistic approach to her general unwellness.

Even though this study generally found the participants gave negative feedback on Western psychiatric medication, they do not provide any definitive conclusions about the effectiveness of Western psychiatric medications. This section does reveal that participants were inclined to seek Chinese medicine to relieve their distress when they thought that the psychiatric medications might cause more harmful side effects on their bodies while the initial problems remained. This behaviour was also reported by Chinese people in the United States (Tabora & Flaskerud, 1997; U.S. Department of Health and Human Services, 2001).

6.1.3 Summary

This section reports that overall, informal support from family and partners, friends, religion and other sources, and formal support from mental health professionals and medications infused hope and strength and empowered participants to cope with the difficulties and adversities caused by the distress. The chapter also reports the concerns raised about family, partners and religions. It should be noted that cultural factors were both among the stressors of their mental unwellness and shed light on the solutions that should be considered, particularly within formal support forms. The findings also show that other support, such as educational institutions, need to be more responsible for advocating and providing mental care services for CALD students.

Some participants commented that professional mental care services were helpful, and believed the professional practices could effectively alleviate their mental distress, while other participants expressed concerns and hesitations about building trust and rapport with mental health professionals. They might feel uncomfortable recalling their miserable times, feel defensive about their privacy, and not trust the quality and effectiveness of the professional treatment relationships. Several participants showed a distant attitude toward professionals with a Western appearance, feeling wary of the different socio-cultural and economic backgrounds, unequal consumer-practitioner relationships, and expertise-based advice. Moreover, due to concerns about side effects of Western medicine, some participants sought help from traditional Chinese therapies, which they had more trust in. These findings indicate the importance of encouraging both formal and informal mental care support based on individual contexts and developing cultural sensitivity and competency within current mental care services provided to potential Chinese service users in Australia.

6.2 Self-support

The generation of strategies to support oneself was continuously evident in accounts of participants' experience of seeking help from others. The previous sections identified the limitations of informal support from family and partners, friends, religions, and other public support resources such as government, communities, and educational institutions. The limited accessibility of culturally sensitive, formal mental health services also contributed to self-help intentions. It is important to note that self-help responses do not deny the effectiveness and compatibility of the above formal and informal help from others. Some participants applied both patterns during their recovery journey.

Except for the above reasons, participants also mentioned that their estimation of the severity of their mental distress contributed to their motivation to use self-support strategies. Some participants could not identify their mental distress. Instead, they thought they were 'just unhappy,' 'felt depressed but didn't know how serious it was,' so they 'did not pay much attention to it.' Even when they could identify their distress, they thought their situations were not so bad that they had to be helped by others, especially when compared to someone with severe mental distress they knew.

> I had a high school classmate who started to suffer from depression in high school. He was so severe that he went to the hospital for treatment. I asked him what side effects this medication had. Because I clearly remembered that when he took those antidepressants in high school, sometimes his hands would shake, which he said was a side effect. Then he [the psychiatrist] told me that the medication might cause memory loss or something. After he told me this, I thought my case was not severe enough to take medication. (Ethel)
>
> Compared to other people, my problem is not a problem, such trivial emotional things. I think those who have problems are those whose lives are severely affected by those mental problems. My hard time is a specific short period; I can't say it will last long. However, some people's depression is long-term. Compared to other people's situations, mine seems not so serious. (Sean)

According to their statements, some participants seemed to stand back from their experiences, observing and comparing their situations with others who they witnessed were in severe distress. They intentionally avoided facing the difficulties and adversities of their distress directly and pretended to be fine. However, they pointed out that this strategy did not solve the problem but just temporarily provided relief. Almost every participant reported their lived experiences of seeking self-coping solutions. I categorise them into four patterns: leisure and recreational activities, self-distancing and 'smiling happy faces,'self-reconciliation, and ongoing attempts to address struggles and seek self-empowerment.

6.2.1 Leisure and recreational engagements

Many participants reported their preferences for distracting themselves from distressing emotions through various forms of leisure and recreational activities. Reading was one of the leisure activities that they applied to cope with their distress. By reading and getting information from media or books related to their mental distress or similar lived experiences, they could grasp more than basic knowledge of their distress. For example, Brenda said she did not want support from others but would like to read self-help books, which she claimed was 'a way to help myself.' Jim reported that reading and learning information from social media connected him to a group of peers who could support each other with similar lived experiences.

> I would read some methods or read something that other people wrote. I saw a group chat when I was browsing on Facebook, and the group consisted of Asian kids who were sharing their stories in that group. So I thought they had similar backgrounds as me because their mental issues were also caused by their parents' influence, which was a coincidence. The more I thought about it, the more I realised that my stories were similar to theirs. (Jim)

Some participants reported that watching TV shows and movies was an intentional tactic that could prevent them from sinking into their emotions and being controlled by them. For some participants, a reliable hobby such as watching a movie, doing physical activities and writing fiction was like a 'painkiller' for their negative mental experiences, which could relieve their depression and anxiety to some extent.

> Maybe it's also a lucky thing because I managed to get myself out of it. I try to find something interesting to do. I just go ahead so that I won't stay in the same situation for a long time. I found out that actually, I like adventures. I want to go outside rather than stay in the room. The first time I went to the beach alone, I felt like this could help me a lot. That's why now, I like to go out, and I try something I've never tried, and then I feel like this is what I want. Finally, I find what I want and what I like. (Dora)

The findings reflected in this study support the research that claims that leisure activities improve health on various levels, including reducing stress and fostering greater physical and mental well-being. Participating in personally meaningful leisure activities acts as a buffer against the stresses of life (Siegenthaler, 1996). Research also argues that regular physical activity may help alleviate depression and anxiety (Paluska & Schwenk, 2000; Taylor et al., 1985). It could also increase the global quality of life by improving self-efficacy and reversing mental health adversities (Paxton et al., 2010). Participants reported that leisure and recreational engagements could form a buffer protecting them from further harm from mental distress sources and provide an opportunity to re-practise their decision-making ability.

6.2.2 Self-distancing and 'smiling happy faces'

Some participants reported they kept their distance from others when they became distressed. 'Isolate' was the word they used in their narratives. This referred to a state in which either they refused to be socially involved or concealed their inner thoughts and feelings, pretending to be fine while being inwardly distressed.

> And I felt, for a long time, that my mind and my body were separated into two minds… They (Friends) recommended me some activities and helpers, but I didn't take any action. They've mentioned this to me, but I was kind of self-isolated. I did not go to any activities they suggested tome. (Alice)

Participants talked about their worries of being tagged as 'mentally ill'- 'I was reluctant to talk about it in the past, and I was afraid that people would judge me.' The self-distancing behaviour was understood as a strategy to protect them from being judged as crazy, insane and unreasonable. Jason reported that he tried to stay 'normal and ordinary' in front of others because he was afraid of being considered mentally abnormal or mad – even in front of his psychiatrist. Jason's concern about being recognised as having mental distress was so intense that he developed a self-distancing strategy to protect himself.

> I digest it myself. If I go out with friends, hang out, socialise and do other things like that, I won't express my emotions too much. It's not that they (family and friends) were not helpful to me. I just didn't want to trouble them most of the time. That's the reason. Sometimes I think I need help. But I hated bothering others, even if it was my doctor or my parents. Because I know when I'm explaining myself, I would be in a chaotic state, and I would tell them things they don't understand… Even if it's my psychiatrist, I still want to remain normal and ordinary to her. I don't want her to look at me as someone with mental problems. Frankly, I'm that kind of person who can go out with a mask on my face, I mean, an unreal face… Disguise is not hard for me. (Jason)

The subjective distancing strategy included wearing 'smiling happy faces' in front of others. Jason vividly described the situations where he digested his emotions by himself, wore a 'smiling mask.' pretending to be friendly and easy-going when he was out socialising. Inside, he was aware of the distance he deliberately kept from others. He refused to reveal his authentic feeling and thoughts to anyone. Many participants gave similar accounts in interviews I had with them, which they saw as a protective technique against the risk of being harmed or judged by others. Also, they explained that even though they felt safe and comfortable distancing themselves from others and never revealed their true feelings easily, they felt drained and weary of applying this approach. Overall, the lack of a supportive family and friends network, CSB behaviour (elaborated in the previous chapter) and subjective distancing strategies underscored the complexity of their social disconnectedness.

The above strategy differs greatly from the Western concept of disclosing mental distress and seeking help. Asian people tend to make internal attributions of their mental distress or may not even define it as mental distress, whereas Western culture identifies mental distress and provides psychiatric treatments to reverse both biochemical imbalances and deviant behaviours (see Chapter Two). Quiescence and stoicism are virtues derived from traditional Chinese culture (Parker et al., 2001), subtly affecting participants' coping attitudes and strategies towards the challenges of mental distress. In contrast, Australia has a range of services, such as helplines, websites and government mental health information services for people with emergent or chronic mental suffering. Awareness is raised through public activities such as promoting R U OK Day and Mental Health Month. However, people from non-Western cultural backgrounds may not feel comfortable with these solutions due to the lack of culturally safe, appropriate features (see Chapter Two). Therefore, from a sociocultural lens, subjective distancing and wearing ‘smiling happy faces’ can be understood as mediators to synthesise current Australian/Western perspective-based mental health services and unmet Chinese/Asian mental needs. It is important to highlight that the finding does not imply a hierarchical system that identifies Western cultures as better/developed or Eastern cultures as less good/underdeveloped, but rather, it is important to acknowledge the potentially different approaches and needs.

6.2.3 Self-acceptance

In this study, self-acceptance refers to a process of self-exploration to find solutions to mental distress. Participants made efforts to set a good relationship with themselves – they accepted who they were and what made them distressed, vulnerable and powerless without judging themselves. They tried to balance the facts and their expectations, the influence of others and their authentic feelings. They also embraced others with differences and contradictions even though it might feel difficult to figure out a comfortable way to achieve that.

The staying-alone strategy helped maintain inner peace and calm. Some participants pointed out that they preferred to stay alone when exploring possible solutions to their mental concerns. Due to many factors I mentioned in the previous paragraphs, they chose to ‘stay by myself for a while’ and ‘digest it myself, and I will figure it out.’ Below are some elaborations on how they managed to reconcile with their situations and mental distress.

> I didn't think it (overeating) was right, and then I read something on the Internet which said that we needed to know our desires, which was hard at first. Then I was onto it in December last year because I felt less stressed on holidays. I didn't push myself to go to the gym or on a diet; I just

> went on with my everyday life. And I've also been overeating sometimes, like one or two or three days. When I started binge eating, I would eat for three days without weighing myself. Maybe a week later, I realised I'd gained a lot of weight and would make a conscious effort to eat less. And then gradually, it became less and less of a problem, and I found that this thing was controllable. I can get my little mood swings under control in a few days. I admit I may overeat, but it's controllable. (Laura)

Laura reported her experience of self-forgiveness for remorse over her binge eating. Laura was significantly impacted by her parents' judgement of her body shape and got anxious about their overwhelming comments. However, she developed a binge eating issue when she could not balance the feedback from others and her authentic thoughts. These problems circulated and threatened her mental wellbeing. Laura later realised that she could forgive her binge appetite by investing more self-control. She no longer suppressed her binge desire and submitted to the pressure from her parents. When Laura realised she had the power of self-determination, she gradually regained control over her desire and body image. Self-forgiveness not only protected Laura from the health risks but also balanced her expectation of her body shape and her mental wellness.

Similarly, Ming and Jim talked about their ways of self-helping in confronting the challenges.

> M: I adjusted myself a bit as well. I tried to be inclusive of others because I'm not perfect.
>
> I: Was that how you make peace with yourself?
>
> M: Yes, it was pretty much how I did. I would constantly do some self-talk mainly because I tried to communicate with myself. I told myself that everyone had their shortcomings. I had mine too. Everyone had their shortcomings and strengths. So I shouldn't be too mean to people when we were together. (Ming)

Ming had limited social connections during the first few months in Australia. He had difficulties adapting to the study pattern. He and his classmates had misunderstandings because of different cultural backgrounds, and he reported a sense of emptiness and not belonging. Ming thought he was the kind of person who contained their emotions and thoughts deeply in themselves. He generated a self-talk method to respond to the cultural differences that led to the tension between him and his classmates. He showed respect for the differences and the way others were and accepted the imperfections in every individual. Ming made peace with his inner struggles and distress through this self-reflection method and fixed his relationship with others. According to Ming, such experience was constructive to his further social network development.

> I think the main thing is self-healing, which is self-regulation. I was just slowly exploring, slowly thinking, or slowly wondering in my mind – what is the root of these problems? I wanted to know which factors caused the results at that time and solve them bit by bit. I attempted to balance the relationship between my parents and me, but I realised it just didn't work. So I think it's more about reconciling with myself. I tried to remove the problems from me and cut down the impacts I got from my original family. To be honest, I thought it was pretty helpful. I gradually figured it out by myself. (Jim)

Jim had a tense relationship with his parents, especially about financial problems. Jim felt uncomfortable presenting a submissive position to his parents, who constantly required him to be grateful for accepting money from them. When Jim tried to balance the unequal parent-child relationship, he found it difficult to reach a satisfactory outcome. So he changed his strategy to regulate his emotions and thoughts and gradually found way to protect himself from possible harm from them.

The above reports demonstrate self-reconciliation responses to the causes of participants' distress. These participants chose to cope with their adversities themselves and applied strategies such as regaining the power of self-control by embracing the expectations and facts, promoting self-reflection by accepting differences, and focusing on self-improvement by protecting themselves from risky factors. These responses are significantly related to their understandings and interpretations of recovering from mental distress, which will be discussed in the next chapter.

6.2.4 Ongoing attempts to address struggles and self-empowerment

Several participants reported that their helplessness in the face of the problems related to their mental distress was overwhelming; they made tremendous efforts to fight hopelessness and self-doubt. They also reported the struggle to open a crack of hope.

> All the feelings were still there; they didn't just disappear after visiting psychologists. I slowly learned to control my emotions, even though more sad and unfortunate things were happening in my life. I had no choice. I needed to find a way to solve these problems. (Lexie)

A specific struggle participants reported was with questioning their ability to cope with their distress. For example, Lynn lost her husband decades ago and forced herself to ‘JUST constantly face the fact,’ focusing on sheltering and taking care of her children. Lexie thought she should control her recovery with help and support from others. Things she interpreted as ‘sad and unfortunate’ would not solve themselves, neither could help from others permanently solve her primary problems. She realised she had to face the challenges herself. Otherwise, recovery seemed vague and unattainable. Jason also struggled with the assumption that he was mentally troubled and needed help. He finally decided to change his situation of his own accord.

> Every day I asked if I was suitable for this (study) major. I felt so tired, and I didn't want to learn. I was particularly restless; I felt like I was going blind writing codes; I didn't want to write. Then I heard them say that if you don't understand, there are actually school forums you can go to and ask questions, and you can also go out and find a teacher. Then, I bought two programming books, found some teachers and asked for help, asked my seniors for help, and gradually got over it. After becoming familiar with studying here, no learning things can stump me. I felt that I was not getting used to it at that time. After getting used to it, I did not think I would be troubled anymore. Now I don't get frustrated when things happen and will find a way to get over them. (Jason)

Jason shared an impressive experience of combating self-doubt and the sense of failure, gaining confidence and self-empowerment. He struggled in an unfamiliar academic field and had limited sources to find his path towards academic achievement, which put much pressure on his mental state. During the process of seeking solutions, he managed to take action to respond to the problems. He learned not only how to respond to the study challenges, but how to maintain hope, strength, self-empowerment and resilience.

All these participants emphasised the significance of ‘self,’ pointing out that ‘self’ controlled their responses. Also, their motivation to seek help from others was boosted mainly by self-support.

> It's still up to you. Really, no one else can help, others can give you some advice, but it's really up to you to reverse the good and the bad. I can tell you a bit about how my journey has changed and how I have these thoughts. The first is my view of my parents. I know I have to change my opinion of them as well as my dependence on them. I can't get out of it if I am internally in agreement with their suppression. After that comes self-adjustment. It was probably in the early morning, and I felt that I had split into two parts. One part told me that it was really hard, death was the quickest way to get rid of it, and it really just felt like a radical idea. But the other part of me was thinking, 'I'm going to get help, I'm going to get someone to cut off this bad idea which would make me do something really dangerous.’(Alice)

Apart from the challenges of self-doubt and empowerment, other participants mentioned the importance of time. Given enough time, an answer would come. This concept will be re-visited in the next chapter when I elaborate on what recovery meant to the participants.

6.2.5 Summary

This section explores participants’ self-supporting responses to mental distress and their difficulties. The coping methods of leisure and recreational engagements, self-isolation, self-reconciliation and self-empowerment significantly improved their mental wellbeing, even though the ongoing struggle when they independently explored self-support strategies was challenging.

Among the diverse coping strategies chosen by participants, there were specific considerations around self-support. The self-support method was compatible with other forms of support. Some participants commented that when they sought help by themselves, they did not reject support from family, friends, mental health professionals and other supporters. But the core solutions were ultimately located within themselves in combination with the broader social contexts.

6.3 Summary of the chapter

Both external support and self-support were reported as strategies that responded to the difficulties and challenges that led to mental distress. These supports generally infused hope and strength and encouraged self-determination and empowerment by improving participants' mental wellbeing.

External help included informal support from family, partners, friends, religion, and other informal supporters, and formal support from mental health professionals, service providers and medications. Participants generally had a positive attitude towards using informal support. This finding corresponds to the existing discussions of informal mental health support, which claim that informal help-seeking seems to be a very effective and widely used approach among people from different generations and ethnic backgrounds, whether on its own or combined with formal support (Brown et al., 2014; Findlay & Sunderland, 2014; Weng & Spaulding-Givens, 2017). This finding also suggests that there were limitations within informal support. For example, the lack of professional knowledge-informed practice, unequal power relationships in families, partners and structural contexts, different cultural backgrounds, and so on, could complicate and work against recovery.

The experiences with mental health professionals and medications tended to be discouraging, because participants reported a distance between themselves and Western mental health services. It should be highlighted that there was no standard effective solution to mental distress. Although cultural differences contributed to the lack of effectiveness of different support strategies, it also shed light on potential solutions when improving family and partner support, religion-related support and formal support. The choice of strategies depended on specific individual contexts, such as their different cultural, social and economic backgrounds, personality types and other demographic characteristics.

The role of self-support improved the quality of both types of external support and led to a more effective recovery experience. Particularly, self-distancing behaviour was widely reported as an internal strategy when participants protected themselves from the potential risks of being harmed and judged. This finding reflects how culture impacts people's interpretation of mental distress and their attitudes and behaviours. At a sociocultural level, the participant's ability to distance themselves might be a mediator in synthesising the current Western perspective-based mental health supports and unmet Chinese/Asian mental needs. Individuals' experiences with mental distress are unique and located within a cultural context; understanding individual and cultural attitudes about mental distress is critical for more inclusive and effective mental health care practice. In all, self-support responses were strongly tied to participants' perceptions and interpretations of recovering from mental distress, which will be examined in the following chapter.

CHAPTER 7 Understandings and interpretations: recovery, social work and social workers

This is the third chapter exploring the findings of participants' understandings and interpretations in two aspects: recovering from mental distress, and social work and the roles of social workers. In the first aspect, participants reported their general understandings of recovery, and particularly demonstrated that the signs of hope and self-empowerment could be seen as the start of their recovery journey, which might not be smooth and linear as concerns and hesitations might push them away from recovery goals. However, participants showed their strength in overcoming the challenges, which echoed their initiatives of self-support reported in the previous chapter. The generally weak understanding of social work and social workers is demonstrated in the second half of this chapter.

7.1 Understandings and interpretations of recovery

In order to explore how participants understood and interpreted their recovery journey, this section answers the research question: 'what does recovering from mental distress mean to participants?' The first section explores participants' understandings of their recovery experiences. The second and third sections narrate their interpretations of their recovery journey. Findings in this chapter argue that hope can be seen as a significant signpost of recovery, serving as a linchpin that connects lived experience of mental distress with the meaning-making process of recovery. Notably, it should be highlighted again that mental distress and recovery are Western concepts. Participants' interpretations of recovery were culturally impacted by their particular socio-cultural contexts. Their recovery was also subject to individual interpretations alongside cultural understandings. However, some participants profoundly internalised the biomedical understanding of distress and described themselves as intrinsically damaged. Self-criticism of the causes of their distress outweighed an awareness of the potential structural oppressions and inequalities, resulting in a negative self-evaluation and low sense of self-efficacy. This potentially reflected the cultural impact of their exposure to Western mental health constructions.

7.1.1 ‘No matter if it's good or bad, it will pass or change somehow.’

Many participants preferred using ‘recovering’ over ‘(fully) recovered’ because they disagreed with the possibility of a recovered state in the bio-psychological discourse. According to their statements, recovery was something that they would describe as a process of recovery.’ Like painfulness, sadness and happiness, recovery was a part of their experiences and lives. They considered recovery a task of growing up, and they had to accept the challenge and experience it because the recovery journey was a unique experience symbolising their growth. Challenges and difficulties would not defeat them as they gradually developed resilience and strength during the hardship.

> I think it means growing up. I've never resented what I've been through; I've never felt resentment, like why am I the only one who got depressed but not the ones around me?... It really wasn't until I got depressed that I started doing a lot of reflection and growing up. I sometimes felt quite proud of myself; I'm definitely a lot different now than I was before. (Chris)

Discussions in the interview provided participants with a chance to slow down and reexamine their past lives and the process of growing up. In the previous chapters, I categorised some social factors that contributed to their mental distress, such as the dynamics in their familial relationships with partners, children and parents. Participants spoke about their experiences of being so profoundly impacted by the distress and difficulties in their lives that sometimes they wanted to find a solution to the problem without asking themselves how the distress had become such an influential stressor in their lives. Alice reported:

> I've been pushing myself to get better, and I haven't really gotten better during that time. I was cheating myself. (Alice)

Alice was deeply involved in the distress and could not see through the adversity she confronted. But with support, she came to understand the broader social context related to the pressure from her family and her inherently embedded submission to the power inequality between her parents and herself. Similar to Alice’s experience, Ethel remarked that she rarely reflected on her authentic thoughts and feelings. When she confronted distress, she was busy adjusting to a ‘normal’ state. She did not accept that she had lost the strength to overcome the challenges in her life because she was always proud of her ability under pressure. Ethel added:

> I think this experience is a test of my life, so I have to get through it. Before that, I thought I had a very strong heart. I rarely looked into my inner self; I didn't clean up my mind. I didn't have such a feeling before, but at that time, I found that I probably needed time to calm down and reflect on what I had done. Am I in a good mental state? Am I happy when doing this? Am I mentally healthy? I just need to reflect on myself constantly, and I think the more I grow up, the more critical this matter is. (Ethel)

Slowing down and reflecting on authentic thoughts and feelings when confronted with mental distress might be seen as a sign pointing toward recovery. This reflection allowed participants to ‘change their mind.’ Rather than feeling scared and fearful of recalling their distressing experience, many participants expressed gratitude and pride in finding the strength and power to respond to the challenges and adversities even though they had been discouraged by failed attempts. They also pointed out that recovery took a certain time, and the process was not easy as the outcome would not be linear. Chris reported her recovery experience with many failed attempts:

> The hardest thing was not just that you stayed that way for a long time, but that you emotionally wanted to resist because you know you've been taught and told that this was wrong and unhealthy. Those kinds of thoughts tortured you. You wanted to correct them, but then you failed every time. There was a very long-term vicious cycle. I always wanted to make myself better. I made many plans. I looked for a lot of ways, but these plans and these solutions hardly led to a good result. For example, I would write many day plans in my diary. I would make a clear plan of what I would do at a particular time. But I found that even if I had a good plan, my body didn't allow me to achieve it. (Chris)

Recovery does not have a unified pattern, since everyone has different lived experiences of mental distress. As I emphasised in the previous chapter, there is no one strategy better than another in responding to mental distress and adversities. For example, family relationships could be supportive or detrimental, given different personal contexts. Chris's case further explained this finding, as she could hardly achieve her recovery expectation by herself. Chris's life 'was very smooth and well-protected… didn't go through any immense sadness or setbacks.' She had limited experience in solving unfamiliar and extremely challenging problems when she realised that she needed support in addition to her individual efforts. She experienced powerlessness when her multiple recovery attempts were defeated by her physical conditions (she had non-cardiogenic heartache and narcolepsy), which frustrated her attempts to get better. Therefore, the recovery journey is non-linear; it might contain the possibility of failure and the risk of getting back to a distressing state when there is not sufficient support or access to multiple modes of recovery. According to participants' reflections, recovery is one aspect of experience in an individual's lifespan. The nonlinear, highly taxing features of recovery do not mean that the distress will last endlessly, as Chris put it:

> My recovery also made me realise that any stage in life is not permanent. Whether you're at your worst or your best, even if you're at an awful time – and this is a quote from my psychiatrist – even if you're at your downturn, you think it might be forever; you believe you're never going to be okay – at this moment, you're really very committed to believing that, but it really isn't forever; you must tell yourself this really isn't forever. I mean it. Even if I become really terrible and even worse and more devastated than in the past, I know firmly that this thing that causes these emotions won't be permanent. The emotions I might be going through won't be endless. Whether good or bad, it will pass or change somehow. Therefore, the emotions won't stay forever. The statement 'not forever' will let you know that you can change, and you will have hope. That's how I think. (Chris)
>
> I think the process is like I can feel better than yesterday. When I wake up today, things that bothered me yesterday don't seem the same anymore. They can't trouble me like before. Or I can take some time to think about things that still trouble me, and I can explain them to myself. (Jason)

One key factor that distinguishes recovery from the distressing mental condition is the manifestation of hope-and self-empowerment. The above statement suggests that hope can be a starting signpost for the recovery journey. Even though hope and strength are hidden beneath the surface of seemingly everlasting distress, it is essential to highlight that the experience of mental distress is a temporary experience and process in life. The following section will elaborate on hope and self-reflection to describe the multiple interpretations of recovery that were discussed by participants.

7.1.2 Hope

Hope is the sub-theme in participants' understanding and interpretations of recovery. This section argues that hope, as one of the main interpretations of recovery, is a complicated concept. It encompasses not only positive and optimistic features but also hesitations and concerns. Its optimistic side refers to the redefinition of roles and the redirection of self-expectations. However, it echoes the previous section, pointing out the non-linear and taxing features of recovery, revealing that hope is a complicated concept with challenges and concerns.

'I still hope that I am open to improvements; I still hope to do better than yesterday.'

Participants spoke about hope as the confidence of redefining roles and redirecting self-expectations in their roles.

> I really want to get out of the situation. I'm still working very actively, improving myself and never forgetting to upgrade myself. I still hope that I am open to improvements; I still hope to do better than yesterday. I don't want to spend my time on tea, coffee and gossip. I feel like I've been caring for my children for years without having my career. I think it is time; I want to get my life back. I want to do my job well, and I know I will not be that successful, but I hope to improve myself. (Brenda)

Brenda's strong desire to 'get my life back' transferred her role from being a victim-survivor of domestic violence to an enabler of life improvement. Her life goals used to be carrying out a responsible mother role, which limited her self-development. As she saw it, unlike other women of her age, Brenda reoriented her ability with great enthusiasm, getting involved in work and value-making. She was confident that her efforts would create many possibilities for her future. Similarly, Jason’s self-blame and sense of imperfection had damaged his self-image and mental condition. Now, he insisted on the advantages he had and was not disheartened by the abilities he did not have. Jason knew, ‘I'm not the best at everything, but I'm still good at a lot of things.’

Grace saw recovery as ‘regaining a direction, like restarting my career, feeling better physically, and communicating with my family.’ She emphasised that the sense of being disoriented was terrible and aimless. She stressed the importance of motivation when responding to mental distress, and felt it was important to ‘take the initiative to send out a signal to the outside world for help.’ Jim focused more on ‘what kind of life I want to live in the future’ rather than how he was disempowered in his relationship with his parents.

Participants recognised their individual abilities and established goals and motivations for improvement in the recovery process. Four reasons emerged to explain the motivation for redefining roles and redirecting self-expectations in the roles. Some participants reported positive and open attitudes toward more options when sorting out challenges and difficulties. A generally positive attitude towards difficulties was a critical factor contributing to their subsequent help-seeking behaviours.

> I concluded that I couldn't get myself into a dead end. I shouldn't be confined to my emotions and unwilling to come out. I had to let go of myself and walk out of the place I was used to. (Ethel)
>
> I'm telling them now that I will try my best to graduate, and if I can't, I'll go back for another six months. You can do whatever you want, right? There are so many ways to live. (Alice)

Some participants realised that they were on the verge of danger if they did not take any actions to change the situation. Participants with such thoughts generally had been troubled by mental distress for some time. Predictably, they could not afford the consequences and possible risks if they let the worst things happen. Therefore, looking for alternatives seemed practical and likely to address the adversities and challenges.

> Maybe it's a lucky thing as well because I managed to get myself out of it. I try to find something interesting to do. I just go ahead so that I won't stay in the same situation for a long time. I think we still have a chance to change. If it doesn't work, then we just switch to another way. There would be a way that's suitable for us, I think. I wasted too much time on someone who wasn’t even worth it. Too much time, 10 years. This is a very long time, and I wasted 10 years doing nothing. So I just think I don't want to waste another 10 years and another 10 years. I will regret it, and say why I do this. (Dora)
>
> I was willing to go [to see a clinician] because I knew I was a bit off myself. A lot of people would think that they are just too lazy to do certain things. But I am very introspective; I asked why I could be like this? Was I a lazy person? Or did I lose my enthusiasm or something? I just figured out that if the doctor said I was really lazy, I would admit it. But maybe there really are times when you realise that you're starting to be different from before and getting sluggish; you might really be sick. (Chris)

The above participants were significantly impacted by their distress. Dora reported that she had been confused about her previous marital relationship, within which she experienced neglect and emotional abuse from her husband and family. She pointed out that it was not easy to stop a ten-year marriage, but she felt lucky and hoped to have a second chance to start over when she found a way out. Chris was uncomfortable accepting being ‘a lazy person’ as an excuse to escape from the distress she faced. She finally engaged with her professional mental care team to help her maintain mental stability and positivity, regain hope and strength, and confirm her self-worth. Other participants mentioned that mental distress caused significant emotional and physical issues, and emphasised the necessity of seeking available solutions and help. Compared with other participants with an inherently positive attitude towards challenges and difficulties, these participants encountered more profound problems and conflicts before overcoming the obstacles and moving on in their recovery journey.

Other participants indicated the need to stay rational. Some participants remarked that self-control and being rational were important to avoid being controlled by emotions or being easily impacted by external factors. They tended to make decisions based on rational thinking and facts, knowing that mental distress would, to some extent, challenge their practice of rationality and disturb their mental wellbeing.

> I lived my life as scheduled, studying and avoiding problems by doing that. I want to escape from these problems gradually. Sometimes, I would distract myself with other things, like watching TV dramas, to get out of it and prevent myself from sinking into it. I didn't want to let myself be controlled by emotions. (Jim)

The above experiences are more inclined to be motivated by individual explanations. Out of the four motivations for redefining roles and redirecting the expectation of the roles, one social aspect emerged. Participants reported that commitments and responsibilities to family, friends and work were their motivations for recovery, which became the socially-driven motivation to overcome the challenges and consequences of mental distress. Participants who were mothers emphasised the commitment and responsibility of caring for their children even when they experienced domestic violence and mental distress. Participants with solid social connections reported that these helped them to stay motivated, positive and resilient in coping with mental distress and its consequences.

> I don't want to be angry with my family all the time. It's not good for the children. It will negatively influence and even hurt my sons if they live in this environment. He doesn't get to choose his family, but it is my responsibility to learn how to minimise the harm to them; it is very important. (Tammy)

> But because I had more and more commitment, I couldn't just disappear. I couldn't make my family worry, and there would always be someone looking for me, especially after I had this job. I couldn't just cut off all the contacts because it's irresponsible. I wanted to follow my heart and find peace for myself. In the meantime, all my responsibilities restrained me. I couldn't just disappear because connections in students' clubs, my colleagues, study, and friends all needed me. (Lexie)

In the narratives of participants' recovery journeys, hope was described as confidence in redefining roles and redirecting self-expectations in their roles. In discussing motivation, participants reported four influences on their motivation for recovery: the underlying optimism of becoming better, self-awareness, the need to stay rational, and life and work commitments. It is surprising that participants spoke about the motivation of hope mainly in an individual context. And there was very limited discussion of support or connections or the importance of the social resources they might rely on.

Hesitations and concerns

In this study, hope is a complicated concept with not only positive features, but also hesitations and concerns. Two main challenges were reported in the interviews: the fear of unexpected or disappointing outcomes and the profoundly internalised taboo of mental distress.

Some participants reported that hope was experienced alongside despair. They worried that they might not be sufficiently prepared to accept an unexpected or disappointing outcome in their recovery process. As I pointed out in the first section of this chapter, recovery is a non-linear process which takes effort and time. Hope could be defeated when efforts do not find suitable approaches to recovery.

> At that time, I began to feel like I couldn't do this anymore, or all my effort would be wasted. I set a high and ambitious goal the first year, like what I am going to do when I graduate and how I will achieve it. After failing the exam, I started to wonder if I was ever going to get there. Then I got anxious, and I thought I might not get there. (Sean)

Jason spoke about his experience of seeing a mental health professional. Close to his appointment with the clinician, he decided to cancel the meeting without a clear explanation. Getting someone to help him seemed to be a hopeful solution to his depression, but Jason was not confident this would help him on his recovery journey:

> I didn't want to talk to him all of a sudden. I can't quite explain why, but suddenly I didn't want to go and talk to him. It was a counselling clinic near my house. But when they sent me a message before I went, I read this text message for a long time, they said REPLY YES OR NO, then I replied with a NO. I don't know why; I think the most reasonable explanation is that I was too tired. I really didn't want to move. I just wanted to lie in bed at that time. I didn't want to go out. I didn't even want to chat. (Jason)

Jason’s explanation was not clear, but it was evident that he somehow worried that seeing a mental clinician would not address his distress and difficulties. Jason’s experience further illustrates the complicated experience of hope and recovery, which was not always positive and satisfying.

The second aspect was the profoundly internalised taboo of mental distress. A few participants reported or witnessed the phenomenon that if the possible solution was seeing a psychologist or mental health professional, the behaviour might be interpreted in stigmatising or biomedical language that identified them as ‘crazy’ and that it was dangerous to ‘have a mental illness.’ The stigma and stereotype of mental distress are deeply embedded in Chinese culture and society. When I did my placement in a mental hospital and felt proud of my work, the first impression from others was to question me about working with dangerous people and ‘murderers.’ I do not justify the prevalence of such thoughts in Chinese communities (see cultural interpretations of stigma in Chapter 2). This judgement is also reflected in participants’ comments:

> I felt like I had emotional problems and wanted to see a doctor, but I didn't. I've heard some people on TV say that many people with emotional problems knew they had emotional issues, which was a pretty accurate statement in my case. Perhaps because the concept that emotional illness is also an illness is not very deep in my mind, I think I can just ignore it. Maybe I need to see a clinician; maybe not, I don't know. I probably never will because I didn't have that idea before. (Josh)

> I know my husband is stressed a lot because of the family, his mom and everything. But if I ask him to go for some consultations or anything, he wouldn't. Because it's the mindset – ‘I'm not a crazy person, only crazy persons need to see doctors, and then they will be sent to the mental hospital.’ I'm not that kind of person, I can accept it myself. (Dora)

In the previous chapter and the first section of this chapter, I pointed out that mental distress or mental illness is a Western concept, and Chinese culture might interpret and understand the experience of mental distress differently. Findings in this section reflect that participants have deeply rooted cultural understandings of mental distress. They may subjectively distance themselves from the risk of being labelled as ‘dangerous people with mental illness’ based on their cultural knowledge and interpretation of mental distress. This provides a possible explanation to the low rate of mental care service utilisation among Australian Chinese people (see Chapter Three).

7.1.3 Self-reflection explorations: ‘I feel more comfortable being myself and getting along with myself.’

Many participants have confirmed that they could accept their genuine selves, constructed by their lived experiences and the social contexts they lived within. As mentioned in the former chapter, participants tried to achieve a balanced relationship with themselves by accepting who they were and what made them distressed, vulnerable and powerless, without judging themselves. They aimed to accept the differences between the past and the current circumstances. By exploring their authentic feelings, thoughts and behaviours, they generally showed appreciation for themselves and became more self-accepting of their emotional experiences. Their personal reflections also revealed the interpretation that participants viewed the self as both the cause and the core solution of mental distress.

> As for recovery, I think things have happened already. The pain you’ve suffered has already had its effect. For me, recovery means letting go. It means that with things I once saw as big as the sky falling, I've now accepted them. For instance, something used to occupy 100% of my emotions. I couldn't do anything while it was there. But now it wouldn't be as important to me as before. Maybe it only takes 10%. It's still there, but it doesn't get to me as much. It won't be my whole life. And it can't dominate me. Then I think, just let it go. We can't deny that things have happened. (Lexie)

Participants pointed out that the lived experiences of mental distress had happened and formed a part of their lives, which could not be denied or forgotten. They would accept their past and the distress, which they realised could exist for a prolonged period. Recovery meant they were in process of regaining control of their lives, and the comprehensive impacts of distress would gradually lessen. By acknowledging their current situation, they were able to remain relatively hopeful and maintain inner strength and positive attitudes despite hardships.

> It depends on what you experience in your life. Something that you experienced in your life can never be given up, you know. I just move on and try to accept it. It's not easy to let go and move on. I've been living like this for 20 years, and now I'm fine. (Lynn)
>
> The most significant change in my life is accepting that I'm not perfect, and that's how I feel. I learn to admit that I am not good enough. I don't blame myself for overeating or some unhappy parts of my life, not being fit and not looking good enough. I don't think that way now. I accept that I am an average person with a good appetite. I still think I'm fat and not good-looking, but I think I can live with that. (Laura)

Lynn lost her husband two decades ago, and she has been struggling to overcome her distress. She has had many achievements in this process, including becoming a responsible and strong mother who supported three children to adulthood and an active community member in a peer support program. Lynn accepted the facts and made great efforts to overcome the challenges, even though she admitted the process was not easy. Laura had a binge eating disorder and was very anxious about her body shape, which was over-emphasised by her parents. She gradually learned to accept her eating needs and became less critical of her body shape, less influenced by others' judgements.

Like Laura, some participants valued regaining the power of control as a critical component of their recovery journey. They considered the ability to stabilise their emotions an obvious sign of recovery, because they had had profound experiences when the emotions were uncontrollable and the emotional breakdowns were spontaneous and sudden. They commented that the ability to maintain emotionally stability provided 'a sense of security.'

> I think the process is like I can feel better than yesterday. When I wake up today, things that bothered me yesterday seem not the same anymore. They can't trouble me like before, or I can take some time to think about things that still trouble me, and I can explain it to myself. In the past, anything that happened would make me nervous and anxious, and sometimes it would make me feel like it was the end of the world. Then my sleep would be ruined. I definitely

> couldn't fall asleep at night. Now, I just lie in bed and fall asleep. I don't allow things to stay on my mind for too long. (Jason)

As well as regaining the power of emotional control, participants also talked about the ability to maintain an appropriate boundary in the parent-child relationships. Alice was experiencing life-threatening depression when she could not refuse her parents' over-monitoring for at least two years. She talked about her guilt when she refused to pick up her mother's phone calls at first, saying:

> I wanted to call them back, or I would have many intense psychological activities. I had this strong feeling at first. I panicked and thought I would be in trouble if I didn't call them back. They would be outraged or yell at me or something like that.

She struggled for some time, but then realised that:

> the picture in my mind was far more exaggerated than it actually was. So it seemed like nothing terrible would happen even if I didn't answer their calls.

With the help of her psychologist, she gradually reconsidered the boundary in their relationship, so that she had the freedom to accept or reject her parents' requirements without feeling remorseful or guilty.

Participants' experiences of managing their appetite, emotions and interpersonal relationships revealed improved self-agency and self-efficacy, which indicate their progress in recovery. This supports the research of Chiu et al. (2013), which identifies self-agency as a component of recovery (hope, empowerment, resilience, self-responsibility and self-mastery).

Accepting and living with distress does not mean that participants compromised or surrendered to the difficulties and challenges, but reflects their ability to regain hope, strength, power and courage to embrace the 'new' and 'genuine' self constructed through their lived experiences. As Joe said,

> This sadness can't affect my plans. Do you stop working when you're sad? No, you still have to look ahead, right? It will be painful to think of it once in a while, but you still have to carry on with your plan.

Participants also spoke about self-appreciation and self-affirmation while embracing their authentic feelings, thoughts, emotions and behaviours. For example, Jim had an alienated relationship with his family because his unequal economic status made him submissive to parental authority. By re-identifying his role in the family structure and his attitude towards his parents, Jason had a profound awareness of his resilience, improved problem-solving ability, and hopeful expectations of future life.

> I had a deeper understanding of myself. It meant a lot, getting out of there [distressing experience]. Firstly, I became very resilient mentally. My ability to deal with problems became better. Secondly, I had a deeper understanding of the relationship between the other people and me, like the relationship with my parents, my friends, and my partner… And I had more understanding of my life. I started to think about what kind of life I want to live in the future and what attitude I have toward them [his parents]. (Jim)

Rather than struggling with the limitations of their abilities and personalities, many participants discovered they had advantages and their experiences were unique. For example, Jason commented that he felt "'more comfortable being myself and getting along with myself, rather than changing myself.' By 'not changing myself,' Jason referred to his strengths and weakness. He did not force himself to do things beyond his abilities, which, he recalled, was a significant stressor to the distress he once experienced.

Alice concluded her process was 'a reinvention of self.' Recovery does not mean one becomes a 'mentally normal' person but refers to relearning the self with the experience learnt from the past; realigning one's life, rebuilding the understanding of relationships, things and people, rebuilding the values and goals of life; and seizing the right opportunity to start a new life. Some participants pointed out that maintaining self-balance and inner peace were also important in the process.

However, some participants underlined that they were not only the core solution but also the cause of their distress. The characterological self-blame (CSB) phenomenon in Chapter Five revealed their self-blaming tendency to attribute the adversities and difficulties of mental distress to themselves. When discussing the understanding of recovery, some participants also spoke about the self-attribution of their distress experiences. For example, Laura acknowledged her power of control over the direction of her problems but also emphasised that ‘I am the initiator of these problems.’ Joe had a similar attitude to his experience of recovery from mental distress:

> I didn't say that I should recover by myself, but I always know that this is just my life; this is just one of my experiences, which is very normal. It has already appeared, which means I must experience it, so I experience it. This is how I see these things. (Joe)

Joe’s life was significantly impacted by his father’s severe brain injury, which aggravated the overwhelming physical, mental and economic burden on his life. Joe wished to seek help and become mentally better, but he held a hidden and firm belief that he was destined to accept the difficulties and adversities. And he should accept everything that had already happened. It seemed that Joe normalised the whole experience that had happened to him, particularly in ascribing his distress to himself rather than reflecting on the oppressive social factors. He understood his role in the world in the terms: ‘everyone is a drop within the torrent of development’ and passively accepted the adversities as ‘one of my experiences.’

This finding indicates that participants’ self-exploration had nuanced implications as it was not always an entirely positive attitude, embracing their authentic feelings, thoughts, emotions and behaviours. In some cases, their self-criticism surpassed the accusations of structural oppressions and inequalities, forming a problematic self-evaluation and lower self-efficacy. This reflects that participants were significantly exposed to the risk of self-stigma and possible harm from the biomedical discourse of mental distress. Nevertheless, their bravery and strength stood out in this difficult and challenging self-exploration process.

7.2 Understanding of Social Work and social workers

This section explores how participants made sense of social work and the roles of social workers in their recovery process. The majority of the participants had no or limited knowledge of the roles of social workers. They understood the roles of social workers in a simplified way, based on their lived experiences, interpretations and/or assumptions about social workers. For example, they might see the social workers as the protector of abused children, a way to release emotions and receive possible advice or compensation for government public responsibilities. Some participants did not know mental support services for people with distress as one of the functions of social workers as they thought social workers only provide care to people with physical problems or severe mental issues.

This study found that only a few participants had experiences with social workers and these experiences were relatively negative. They reported that their cultures and customs were not respected by social workers with Western cultural backgrounds, cultural values and working methods. They also reported a lack of empathic and non-judgemental working attitude during their interactions with the social workers. These experiences caused secondary harm to their situations, which further led to their negative comments on social workers. However, most other participants expressed their interest and willingness to include social workers as one of the supportive social resources in their recovery journey.

7.2.1 'I've heard about them, but I don't really know much about them.'

Compared to the fast development of social work services all over Australia, participants reported relatively narrow understandings of social workers and their roles. A small number of the participants reported no knowledge of the roles of social workers. They might be aware of the existence of social workers but knew nothing further about this role. Or they had never heard of social workers before the interview took place.

> Not really. I've heard about them, but I don't really know much about them. (Alice)
>
> I don't know any social organisations that can help us. I really don't know. I didn't have an idea before you told me. (Joe)

Other participants had limited or single understandings of social workers. For example, when Jason was asked about social workers' work, he replied with his experience of seeing social workers in Redfern, Sydney, looking for people to fill out forms and make donations. Jason's understanding of social workers was limited to a particular form, and he did not know social workers could also provide support for people with mental health challenges; as he put it, ‘I didn't even know there were groups like this that existed.’

Similar to Jason’s report, many participants understood the roles of social workers based on their lived experience, interpretations and/or assumptions about social workers. For example, Abby considered social workers’ roles as looking for responsible guardians for children. Dora found social workers as the last option when other people who could share her thoughts with were unavailable. She thought the role of a social worker was to ‘give some advice.’ Brenda also viewed social workers as someone with whom to release emotions, talk and receive possible advice. But she understood social workers as an alternative for other psychiatric interventions.

> She might be good at helping people with marriage and family issues. I didn't think she was accommodating. But at that time, I really wanted to grab someone and pour out my bitterness, hoping they could give me some suggestions. I was in grave despair, but I stopped seeing her as soon as I got occupied by work. (Brenda)

Brenda was a mother participant who confronted an unbalanced marital relationship with her husband. She had limited access to supportive social networks and reliable financial income because of her commitment to the mother’s role in their family. Brenda desperately wanted to be provided with any possible solution to relieve her depression, and she found a social worker an alternative. She highly valued the importance of being connected to a social worker who would like to listen to her troubles. However, Brenda did not maintain a long-term relationship with the social worker. She left once she found work could be a substitute for the social worker’s role. For Brenda, social workers’ support could be replaced by other options, such as work, which could distract her from becoming more anxious and worried.

The notion of social workers as substitutes revealed doubt about its professionalism and distinction from other mental health-related professions. Participants may not have seen social workers as being able to make a difference regarding the social contexts of distress, as Lynn put it:

> They're not a professional, not professors or experts. I think they are just solving problems. (Lynn)

The flexibility of social work methods does not suggest other alternatives can be substituted. Social work and the roles of social workers have their unique core values and methodology for assisting, supporting and empowering people who confront individual challenges, social inequalities and oppressions. Participant perspectives that social work is a substitute for professional services might be generated from individual contexts, specific lived experiences with social workers, and the biomedical model of distress that does not look at social contexts.

Some participants saw social workers as a secondary compensation for limitations in the government or local community's public responsibilities. They thought the social work services were far from relevant to their lives because the mission of social workers was 'seeking the benefit of society.' Furthermore, social workers were understood as supporters who provided help to people with physical disabilities, irrelevant to mental health wellbeing and care.

> I thought social workers help people who are more likely to have some physical difficulties, such as financial or physical disabilities. So I don't know if they could help people with mental things. Social work is a social resource, but it depends on the severity. I think my problems are too small by comparison. I can take care of myself. I feel like I don't deserve it because I didn't suffer a devastating strike or whatever. (Sean)

Sean interpreted the role of social workers as helpers for people with severe physical or financial challenges. Sean thought social workers would not be his option for recovery because he did not have any physical problems, and he disagreed that his mental condition was severe enough to consume 'the social resource.' Sean explained 'severity' as, 'I think the people who really have problems are those whose lives are severely affected by those mental problems.' Sean's understanding of the severity of mental distress might be influenced by his existing knowledge of mental health, lived experience of mental distress and the specific individual context, within which his understanding reflected his cultural background.

Therefore, in this study, some participants' limited understandings of social work and the role of social workers reflected specific individual contexts, including their socio-cultural backgrounds and lived experiences of mental distress.

7.2.2 The experiences and expectations of social workers

Even though most participants did not have experiences with social workers, a few participants reported their interactions and comments with social workers. Interestingly, participants who had settled in Australia for a short time (generally less than five years) reported no knowledge and/or experience with social workers. Participants who reported their interactions with social workers generally had been living in Australia for more than 15 years. This might be because participants with temporary residency in Australia had limited access to social support resources. For Chinese people unfamiliar with social work and social workers, social work support might be a less relevant resource among other social support capital.

Brenda met a social worker who could not empathise with her experience of gender inequality and marital challenges. She commented that communication in English was not the primary concern, but that the cultural backgrounds could significantly impact the effectiveness of the intervention. Brenda recalled:

> I didn't think they could understand our issue because we are from different cultural backgrounds – those social workers are Westerners. They suggested something I couldn't accept or do. I don't think Chinese people can generally take the solution they offer. As for me, they suggested we divorce, relatively easy, wasn't it? But I didn't think I could do that. At that stage, divorce was not the best solution. And the kids were too young. Then I started pretending I was OK and didn't want to argue with them anymore. I said I was better; everything was OK. (Brenda)

Brenda showed her frustrating experience with the social worker, who simply encouraged her to seek a divorce. Brenda might fit the profile of a woman who strictly followed the mother role in a family defined and constructed by Confucian culture and traditional Chinese ethical ideology. She could not accept such advice because she assumed her children were too young to accept growing up in a divided family. She felt little respect from the social worker for her cultural background and value, so she pretended to be better to avoid seeing her again.

According to Brenda, this happened many years ago. It is reasonable to assume that social work services were not culturally sensitive when Brenda came to Australia with an early generation of Chinese migrants. But her experience also highlights the importance of respecting people's backgrounds. Factors such as gender, age, ethnicity, culture, educational and economic level could significantly influence equal social worker-client relationships. In particular, being respected culturally is an essential component of an equal and professional support relationship.

Lindsey was the carer of her ex-husband, Dan, who had experienced significantly challenging physical and mental difficulties. Lindsey was a middle-aged woman who could not drive; it was difficult for her to take care of Dan every day, having to travelling on foot for half an hour each visit. Lindsey pointed out that 'essentially, no one else sees the full picture of what's happening in his life and looking at his circumstances.' Due to the limited ability that Lindsey had to care for Dan and limited social support resources that she could access, Dan 'lost 16 kilos and even ended up in the hospital with malnutrition.' Lindsey was disappointed and commented, 'it shouldn't be able (to happen) in Australia.'

However, Lindsey and Dan's situation did not change much after Dan was admitted to the hospital. She commented that the social worker she met in the hospital did very little to improve Dan's living conditions or link him to available social support resources. Aside from the complex situation of Lindsey and Dan's divorce, Lindsey found the social worker's language offensive:

> I know that they've got a lot of people to see, but this particular social worker, he felt that…because I was around, I could do things. And he didn't think that he needed to be doing anything. So he said to me that I come across as confident and resourceful. He said to me that I speak English, I speak English well, I speak with an Aussie accent. He said, 'you can do the looking into help for him, so I don't need to help you then.' And he also said to Dan 'your wife';

> I just find it absolutely unbelievable that he would say that. He was from Africa, somewhere… He was just really, really poor at his job in terms of knowing what helps us out there for one thing. (Lindsey)

According to Lindsey's experience, the triaging process created conditions that allowed harmful care and racial discrimination. A carers' responsibility might be viewed as more beneficial for the person being cared for and complex than the services that hospital social workers could provide. But Lindsey sought help from social workers because of her limited ability to assist Dan with his daily tasks. She felt her divorce fact was not respected because she was called 'your wife.' Unhelpful assumptions about a person's context could lead to disappointing service outcomes that do not match people's current needs. Care that did not meet Dan's needs could cause secondary damage to his health, as Lindsey reported regarding his malnutrition. It is not appropriate to assume that people from different language backgrounds other than English can be 'resourceful' when they become proficient in English. Assumptions about language proficiency and non-Western/English cultural backgrounds may reveal racial bias and discrimination in the hospital setting.

The role of social workers was not clearly understood by participants who had interactions with social workers. Lindsey continued her report:

> I actually had to speak to the social worker manager in the hospital, and they tried to block me. They said they would put me through to the manager, but they put me through to someone else that was like at a Junior level. And because I volunteer at that hospital, I know a bit about the management structure. I know I wasn't speaking to the manager there. When I went to Centrelink, their social workers were very busy; I couldn't access one at the local Centrelink. And then, when I spoke to one on the phone, she said, 'do you have something to eat and do you have somewhere to stay tonight?' I said yes. She said there was limited time for me; she had to help those who didn't [have food and places to stay]. I'm not a social worker. I just try to put things together. But I consider that a social worker would have been able to do something a lot more quickly than I could get things in place. (Lindsey)

Lindsey's exclusion experience illustrates problems that arise when clients are not sufficiently informed of the service that hospital social workers can offer. The structure of hospital social work might undermine the social workers who want to develop meaningful relationships to support the people they work with, because the shortage of funding in the hospital restricts the resources and the time during which consumers can stay and receive complete services. It is vital for social workers to maintain an empathic and non-judgemental attitude when working with clients from CALD backgrounds, as Gibbons and Plath (2009) pointed out in their research.

This section explores participants' concerns about their interactions with social workers. In this research, participants came from different social, cultural and economic backgrounds. Brenda's experience implies that when there is a lack of respect for clients' backgrounds, such as gender, age, ethnic origin, culture, educational attainment, and economic status, the quality of social worker-client relationships is substantially impacted. Lindsey's experience reveals the importance of social workers maintaining an empathic and non-judgemental professional attitude toward their clients.

7.3 Summary of the chapter

This chapter explores participants' understandings and interpretations of recovery from mental distress and the roles of social workers. The first section found that participants understood recovery from mental distress as experiences of their lifespan, a task of growing up, a chance to slow down and reexamine the past, and a chance to re-empower themselves. Recovery needed massive time and effort, as it was not a linear process. That is, it did not have a unified pattern; the recovery processes were different between people with different lived experiences. And during this process, participants often confronted challenges and difficulties.

According to the participants, the importance of hope was central when difficulties and adversities happened, and was a contributor to the positive experience of recovery. Throughout participants' reports, hope refers to recognising their individual abilities, redefining their roles and reestablishing goals and motivations for recovery. It is worth noting that for participants, hope was quite an individual thing – many individual aspects of narratives of hope emerged, rather than an emphasis on the importance of the social aspect. Except for commitment and responsibilities for family, friends and work, participants rarely linked their hope of recovery with their social contexts. They believed the hope was primarily motivated within themselves. Moreover, recovery is not a smooth and linear process. Hope and motivation not only have positive and optimistic features but also challenges, risks and concerns, such as the lack of confidence in the outcome of recovery and culturally-informed understandings of mental distress, which labelled mental distress with negative and stigmatised meanings and became a challenge to holding a positive and hopeful attitude towards their recovery.

Self-reflection was another interpretation of recovery that featured in participants' reports. Generally, participants accepted and embraced the distress experience as part of their life**.** They considered regaining the power of control as a significant competency. Accepting and living with distress did not imply that participants compromised or were resigned to the obstacles and challenges. Rather, they clarified their ability to reclaim hope, strength, power, and courage in embracing their authentic selves through their lived experiences. During the self-exploration process, not only self-appreciation and affirmation but also the problematic tendency to self-criticism was reported, which echoed the self-criticism experienced when they confronted mental distress in Chapter Five. Self-criticism might outweigh awareness of the impacts of institutional oppression and inequity, suggesting a problematic self-blaming tendency and a negative self-evaluation. This finding may reflect the cultural influence of the prevailing emphasis on Western, biomedical mental health literacy in this society.

The second section found that different lived experiences and backgrounds could reflect different understandings of social work and the roles of social workers regarding their mental support and recovery from mental distress. People from Chinese cultural backgrounds might not have a general understanding of social work and the roles of social workers compared to people living in an environment where social work agencies and information could be frequently sighted. In this study, this finding was pronounced among participants who had not been settled longterm in Australia. Apart from negative experiences with social workers, many participants expressed their interest in including social workers as one of the supportive resources in their recovery journey.

Therefore, this study argues that although the concepts of social work and social workers might not be prevalent among Australian Chinese people – especially those with relatively short residency – there is considerable potential to develop social work mental care services among Chinese communities. Social work and the supportive roles that social workers play in the mental health field might not be recognised by Chinese people in a short period of time. However, it is hopeful that people’s understandings and attitudes towards social workers might change when they become more informed. Moreover, social work practice may need to improve and become more relevant to Chinese people through more thorough cultural knowledge and not making assumptions based on a white social work lens. With the development of culturally sensitive interventions among Chinese communities, social work mental health service is expected to become a significant social resource in improving Australian Chinese people’s social integration, self-empowerment and mental wellbeing.

CHAPTER 8 Conclusion and discussion

This study aimed to explore the lived experiences of mental distress among people from Chinese cultural backgrounds in the Australian social context. As the recovery experiences and perspectives of this group have been rarely investigated in past studies, this study also delved into how Chinese people in Australia respond to challenges in mental distress and navigate their roles and identities on their recovery journey. One of the key strengths of this study is that it provides the most recent first-hand accounts of mental distress from a range of demographically diverse Chinese people in Australia. It included as many definitions of Chinese people in Australia as possible and highlighted the importance of culture in understandings and experiences of mental health. The other key strength is that by applying a social rather than diagnostic perspective, this study challenges the predominant biomedical paradigm in mental health and the expert-based knowledge of ‘patients,’ establishing a de-pathologising approach to understanding the lived experience of mental distress and recovery.

The previous three chapters demonstrate the main themes identified in the analysis of rich data from 19 participants’ interviews. These participants’ lived experiences of mental distress and recovery have been explored in relation to the research question: What are the lived experiences of mental distress among people from Chinese cultural backgrounds living in Australia, and how did they understand the recovery journey? Based on the findings, this study provides some helpful information to enable a better understanding of what mental distress and recovery mean to Chinese people in Australia and how professionals and services could better respond to their needs.

This chapter evaluates the findings of the study and discusses the connections with previous research and the new insights it contributes. It will also discuss the implications for practice in regard to social policies, social workers and other mental health practitioners and service providers. Limitations and suggestions for future research are also discussed.

8.1 Main findings of the study

8.1.1 Finding 1

Conflicts and clashes in familial relationships, together with the challenges and inequalities in the social environment, contributed to the lived experiences of mental distress. Such experiences became more complicated when Covid amplified the impacts of the multiple inequalities and power imbalances, adding unexpected complexity to many aspects of the above challenges.

Although past studies revealed a tradition of describing mental distress as physical problems – somatisation – in Chinese people's narratives (Wu, 1982; Yip, 2003, 2016), this study found that in addition to attributing the lived experiences of mental distress to physical manifestations, participants specifically spoke about the social determinants of distress, among which the topics of gender, social status and race were most outstanding.

Gender inequality was primarily reported in marital relationships, in which unequal power relationships between husband and wife were a significant stressor that led to some female participants' mental distress. Such dynamics reflect the descriptions of submission to patriarchal authority and suppression of personal emotions among women in traditional Chinese families based on the concept of filial piety in Confucianism (Han, 2012). This study, therefore, reveals that gender power inequality is informed by cultural factors. To the Chinese participants, domestic violence and conflicts were possible consequences of cultural understandings of norms within intimate partner relationships, which contributed to mental distress for women. Moreover, although gender power inequality did not stand out in parent-child relationships, the fulfilment of cultural expectations of filial piety consolidated the imbalanced power relationship between parents and children, acting as an important factor in participants' mental distress. Similar findings have been reported in previous research (Hsiao et al., 2006a).

Although not commonly spoken about, women living with suicidal thoughts should not be ignored or dismissed. Past research found that Australian men were more vulnerable to the impact of mental distress and had higher rates of suicide than women, particularly in the 65+-year-old range (Kiely et al., 2019; Wilhelm, 2014). However, there has been a noticeable increase in suicide among Australian women (Stefanac et al., 2019). This is also reflected in the latest statistics of the 2021 Census, which show that women have a higher rate of exposure to risk factors for mental distress in all age sections (Australian Bureau of Statistics, 2021; Australian Institute of Health Welfare, 2022). In this study, only young female participants expressed suicidal thoughts. Although the underlying reasons were not always discussed in detail, these participants were young Chinese females who were experiencing powerlessness and insufficient resources. Given the lived experience of gender power inequality that female participants experienced, it should also be clear that distress among young Chinese women in Australia should be taken seriously.

The study has identified some new social factors contributing to Chinese people's mental health in the Australian social context, including issues relating to gender, and social stressors including racism, as well as the dual role of parent-child relationships in both triggering distress and serving as supportive elements in the recovery process.

In accordance with past studies of the factors that contribute to Australian Chinese people's mental distress. Migration and the challenges of acculturation are major causes of distress. Previous studies found that changes in socioeconomic status – primarily downward mobility – could significantly impact migrants' mental health (Das-Munshi et al., 2012; Tang et al., 2007). This was also reported in this study. For example, Grace and Brenda talked about the confusion about their career development as they gave up their planned career development to take care of the family, as required by their husbands. When finding a similar job that matched their abilities in the past became unrealistic, the disappointing downward mobility of socioeconomic status became one of the major stressors that contributed to their distress.

As stated in the literature review, the growing Australian literature identifies the relationship between educational factors and mental wellbeing (Leung, 2001; Pan & Keung Wong, 2011). It was also reflected in this study, as Chinese overseas students participated in the research. Tang and Pilgrim (2017) argued that overseas educational experiences reflected the assumption that upward social mobility is achieved through academic success. The pressures to achieve upward mobility became a stressor contributing to distress for the participants. Although the duration of residency in Australia has been considered a factor related to the severity of mental distress among other ethnic minority groups (du Plooy et al., 2019; Hosseini et al., 2017), this study did not find that a clear relationship between the two aspects. However, the motivation behind the change in social status and the upward routine of social mobility might add deeper layers to explaining the experiences of distress reported by international students who participated in this study.

Seeing the construction of lived experiences of mental distress through a race lens could provide more critical information. The methodology chapter illustrated that critical race theory incorporates an intersectionality perspective to highlight the complexity of social oppressions and other sociocultural factors. Participants in this study, as less visible and marginalised Chinese people, gave counter-narratives to dominant mental health discourses (Moodley et al., 2017), revealing how oppression and racialisation shaped their lived experiences of mental distress. This was not only reflected in the discussion of causes of mental distress, but also particularly emerged in the discussion of covert racism. However, covert racism exists in a way that rarely and hardly raises the public's attention (Nadal et al., 2015; Sue et al., 2007). Its impact on CALD people's mental wellbeing is worthy of further exploration. From this point of view, the race lens brings understanding of the multidimensionality and intersectionality of lived experiences of distress, and further challenges the biomedical paradigm that understands mental distress through internal deficits and medical pathologised discourse.

Covid was an unexpected yet significant incident that has significantly and completely changed our lives and the world since the outbreak in 2019. Participants in this study highlighted how their social connections, daily lives and experiences of distress related to Covid. Covid-related anti-Asian xenophobia and sinophobia also extensively and powerfully affected some participants who have already confronted massive challenges contributing to their distress. This was primarily reported by student participants, which are becoming an increasingly influential part of the demographically diverse Chinese population in Australia in the post-Covid era. The wellbeing of Chinese international students needs further exploration when looking deeper into the diversity of the Australian Chinese population and their lived experiences of mental distress. Fortunately, Chinese overseas students' mental health has already been noted in some recent Australian literature (F. Martin, 2020).

8.1.2 Finding 2

Depending on individual contexts, participants' help-seeking patterns could be supportive to some while unconstructive for others. There were no ultimately 'correct' solutions that divided formal and informal forms of support into helpful or unhelpful categories. The strategies employed by participants in response to challenges of mental distress were based on individual contexts within which cultural backgrounds played an important role.

Findings in this study support the 2011 ABS data (see Appendixes 1 & 2) that the utilisation of MBS-subsidised mental health-related services among people from Chinese cultural backgrounds in Australia is low. Although this is the most recent data from the Australian Bureau of Statistics, it is decade-old data that may reflect an ongoing pattern. This study adds more detailed explanations to the statistics from the first-hand accounts of participants' help-seeking experiences. From the interviews, cultural factors played an important role in this part. They not only impacted the way in which participants decided to respond to the distress, but also impacted the specific strategies for response to the distress – mostly negative views relating to mental clinicians. Other studies have explored different cultural beliefs between professionals and consumers as the cause of the under-utilisation of mental health services among Chinese people (Meeuwesen & Ingleby, 2013). Participants believed the current Australian mental health services need a shift to culturally responsive and sensitive practices toward its large CALD population. Compared with seeking help from formal mental health services, participants were welcoming to informal support from family, friends, religious resources and so on. Again, while these factors could be beneficial for someone to sort out the challenges of distress, they could also be risky for other participants with unsupportive interpersonal relationships.

Self-support in this study reflects its complexity and heterogeneity as a response to distress. Unlike other studies that see withdrawal behaviour as a negative sign of mental health, participants from this study tended to describe it as a subjective distancing strategy that protected them from the potential risks of secondary traumatisation. In his 2003 and 2016 work, Kam-Shing Yip named this strategy 'passive ego (centric) preservation.' Influenced by Confucianism, passive ego preservation refers to a form of self-protection responding to social inequality, harmful exploitation and possible confrontations and conflicts (Yip, 2003, 2016). A New Zealand study pointed out that the notion of fatalism in Chinese culture may positively impact the search for help through therapeutic interventions. On the other hand, the notion of fatalism can act as a protective factor that secures the sense of self and finds the most harmonious way to reconcile with the distress (Tse, 2004). In this study, participants reported wearing 'smiling happy faces' as a subjective distancing strategy to protect themselves. Considering the other social factors underpinning distress, subjective distancing and 'smiling happy faces' can be understood as strategies to synthesise current Australian/Western perspectives, and to manage within the context of Western mental health services and Chinese/Asian social expectations. Moreover, although some traditional Chinese therapies such as Qigong, cupping, acupuncture and so on have been documented as popular forms of mental interventions (Fun Chan & Quine, 1997; Lu et al., 2014; Wong et al., 2017; Wong et al., 2010), this study did not find them popular. There was no one distinct strategy that was relevant to all participants in relieving distress. In this respect, this study suggests that the multiplicity of potential supports should be recognised, and the literature should be more cautious. However, it should also be noted that this study has its limitations regarding the diversity of the participants, which could hinder the complete exploration of the self-support strategies– this will be discussed later in this chapter.

This study revealed a variety of strategies applied by participants with lived experiences of mental distress. It is argued that culture-based individual contexts impacted the way in which participants decided to respond to the distress and the way they chose to recover. Existing research in relation to overseas Chinese people, their mental distress and their help-seeking behaviours also confirms the powerful influence of culture in shaping people's attitudes and behaviours in response to mental distress (Kleinman, 2004; Na et al., 2016).

Moreover, the findings demonstrate the complexity and relativity of supportive resources, as these could also be unhelpful factors in recovery. For example, resources such as family, friends, religion-related support, mental health services and service practitioners were all found helpful in some narratives while unhelpful in others. Also, participants did not tend to deny the compatibility of traditional Chinese medicine. Embracing Western treatments and traditional Chinese medicine were emerging trends, which echoed the finding of 'medical pluralism' in major Western countries (Green et al., 2006; Kuo & Kavanagh, 1994; Tabora & Flaskerud, 1997; Wong et al., 2010). This could be explained by the existing studies of Chinese people in bicultural or multicultural societies, which elaborated that when Chinese people are caught in dilemmas arising from the bicultural or multicultural contexts, they might internalise different cultural frames to understand and explain different cultural icons with different meanings (Yip, 2003, 2016). A higher level of acculturation might increase the acceptance of the host culture, getting easier access to mental health services and receiving more satisfying therapeutic outcomes (Abbott et al., 2003; Spencer & Chen, 2004; Tabora & Flaskerud, 1997). According to Green et al. (2006), the acknowledgement and embrace of medical pluralism might also help to close the gap of difficulties in accessing mainstream mental health services and the unmet needs for culturally appropriate practice.

Therefore, this study acknowledges and respects any choices of strategies people applied to respond to the challenges of distress. It is not interpreted that among the many forms of supportive resources, one is better and more effective than another, considering the heterogeneity and complexity of individual contexts. Since each form of support has its possibly unhelpful aspect, the most suitable recovery strategy should be the one in that people feel comfortable and confident in acting out.

8.1.3 Finding 3

The perspectives on recovery varied based on different lived experiences. Only a few participants credited the importance of their social context in their recovery journey. During the process of recovery, hope and self-reflection emerged as primary approaches, but the difficulties and challenges further complicated the process of recovery. Social work practices were viewed as potentially helpful in assisting Australian Chinese people's mental health recovery in the foreseen future, but at this point of time participants were not familiar with the roles social workers can play in supporting Australian Chinese people's recovery.

The understandings and interpretations of mental distress and recovery differed among Australian Chinese people based on their different cultural backgrounds. This could explain why some participants were less likely to report mental distress, and why the uptake of mental health services remained low. The notion of mental health literacy is a concept derived from Western culture. The assessment of mental health literacy of Australian Chinese people is likely to reflect the level of their acculturation to Westernised mental health literacy (Tabora & Flaskerud, 1997). This study found that while distress and recovery were ably discussed by participants, participants also used different terms to describe their experiences. Mental health is not a well-known concept in Chinese society. In its absence, people from Chinese cultural backgrounds might not be able to describe their experiences in these terms (Mui & Kang, 2006). Instead, their recognition of mental distress from a Western perspective might be irrelevant and the facts might be interpreted in terms of body dysfunction, unemployment, and lack of family love (Li et al., 2014; Yang & Wonpat-borja, 2012). Traditional Chinese culture encourages emotional suppression and endurance (Tabora & Flaskerud, 1997). It prioritises the reputation and benefit of the larger family over the individual's feelings, thoughts and experiences (see Chapter Two). Shame is intimately associated with the pervasive influence of stigma and discrimination toward individuals with mental health difficulties. Having mental distress can be stigmatised as 'losing face' and interpreted as "weakness is a shame" in Chinese traditional notions (Meeuwesen & Ingleby, 2013) (see Chapter Two). People diagnosed with mental illness might be excluded from equal opportunities for adequate housing, education, employment, daily social interactions, financial loans and even drivers' licenses (Tse, 2004). Therefore, seeking help from services might be seen as a loss of face; the stigma becomes one of the significant barriers to accessing mental care services (Tieu & Konnert, 2014).

Therefore, the low uptake of mental health services by participants does not necessarily reflect that access to and information about the services are limited. However, this does not mean that Australian Chinese people have low mental health literacy (Uygur et al., 2011; Wong et al., 2010). Instead, personal reports of participants' lived experiences reflect rich, culturally-patterned understandings and interpretations of mental distress and recovery.

The participants described their understandings of recovery as an active process of reconstructing identity and making meaning of their lives. Participants also provided rich perspectives of recovery impacted by Chinese culture on a day-to-day basis. Specifically, participants concluded that the generation of hope and self-empowerment were the signposts of their recovery journey. However, layered descriptions of mental distress and recovery from biomedical perspectives profoundly prevailed in their personal interpretations. This finding supports Tang's studies on UK Chinese people's mental health, which pointed out that in some cases, the concept of hope might not be sufficient for understanding what propels recovery. Other than the positive influences it brings, hope could also limit people's autonomy and prevent them from becoming capable of leading the lives they want. The challenges in leading a hopeful life might also lead to inequality in a broader context (Tang, 2017, 2019b).

However, the impacts of the biomedical discourse and Chinese culture created a situation where some participants were found caught in shame, self-blame and more covert forms of stigma. The notion of mental health based on mainstream Chinese culture perpetuates the shame culture that primarily blames individual weakness, deepening self-stigma and self-blame, which formed a significant barrier to their recovery. As discussed, participants rarely linked the importance of the social context to their recovery experiences. Although they discussed some supportive resources based on their social networks, the additional importance of these factors on the recovery journey was often discounted. Participants talked much more about how they managed to negotiate their self-worth and regain the power of control and decision-making**.** From this point of view, a possible explanation is that generally, participants lacked sufficient social support. However, an emphasis on self-empowerment may be regarded as a significant initial step in facilitating the recovery of Chinese people, in combination with the thoughts, emotions, and behaviours influenced by Chinese cultural contexts.

In analysing the participants' interviews, it was apparent that participants were profoundly impacted by the biomedical discourse, but this was combined with the cultural interpretations of mental health. Participants were both the victims and survivors of the social stigma and shame culture. The study made space for their voices and perspectives to be heard. Therefore, it again demonstrated that people with lived experiences of mental distress should be allowed to describe their authentic experiences, feelings, thoughts and attitudes through holistic first-person accounts (Leete, 1988; Wallcraft, 2004).

This study found that participants were largely unfamiliar with the roles that social workers could play in supporting recovery. The current need for social work services to be more accessible and culturally responsive was therefore reflected in the narratives. This finding provides contemporary qualitative evidence that reflects the primary critiques of current Australian social work practice in the review of literature, which pointed out that Australian social work practice has invisibly inherited the epistemological and ontological assumptions of whiteness, and there is a need to carry out cultural awareness-based social work education and practice. Despite their limited familiarity with social work, participants had a generally welcoming attitude to social work responses to Chinese people’s mental needs. This is a positive sign for future work in developing culturally sensitive, safe and responsive social work practices with Chinese people in Australia.

8.1.4 Summary

The present study has made a valuable contribution toward addressing the gap in the literature by providing knowledge of direct lived experience and including Chinese people across diverse social locations in Australia. In the exploration of mental distress among people from Chinese cultural backgrounds in the Australian social context and how people respond to challenges in mental distress and navigate their roles and identities during their recovery journey, the importance of acknowledging intersectionality and heterogeneity stood out significantly.

Other than the biomedical explanation of mental distress, participants with different social identities provided detailed descriptions of how they were caught in the adversities of distress from multiple social contexts. Firstly, based on different personal contexts, factors such as family relationships, social environments and the following impacts in the post-Covid-19 era acted or interacted as stressors contributing to the lived experiences of mental distress. Secondly, the heterogeneity of the help-seeking patterns was reflected in the different choices of the combination of supportive resources. In this part, participants contributed complex descriptions of the same factors that could be helpful or unhelpful in different personal contexts and lived experiences. Thirdly, participants brought different understandings and interpretations of mental distress and recovery according to their unique lived experiences and different cultural backgrounds. Although this study applied a constructive sociocultural lens that critically explored the recovery pathways of mental distress, it cannot deny how significantly participants were impacted by and internalised both the biomedical perspectives and cultural interpretations of mental distress and shame. Furthermore, these themes offer an opportunity to compare and contrast, allowing us to examine the shared and distinctive aspects of the lived experiences of mental distress among other ethno-cultural groups, whether they are within or beyond the Australian context. In general, there is much to do in to planning and supporting Chinese people experiencing distress, whose voices have rarely been heard.

8.2 Implications for policies and mental health care systems

It was after the Fourth National Mental Health Plan (2009-2014) that the mental wellbeing of Australian people from culturally and linguistically diverse backgrounds (CALD) was explicitly included in the mental health policies. Cultural competence means that an individual's cultural background, cultural beliefs, and cultural values are respected and taken into account in a system of behaviours, attitudes, and culture that is integrated into the way healthcare is provided (Department of Health and Aged Care, 2008). Along with the critiques of the lack of data on service outcomes in the CALD population, and the lack of inclusion of the CALD population in the study design and reporting (Minas et al., 2013a), the Australian states and territories, governments, and organisations have put significant effort into working towards culturally responsive and competent mental health policies and practice for the CALD people (Department of Health and Aged Care, 2018; Embrace Multicultural Mental Health, 2014; Lived Experience Workforce Program, 2016; Mental Health in Multicultural Australia, 2014; NSW Mental Health Commission, 2014). Over recent years, we have witnessed an emergence of higher political commitment to ensure access and equity in engaging with the mental resources (Department of Home Affairs, 2018; Khatri & Assefa, 2022).

Although the well-stated policies have acknowledged the significance of cultural factors with respect to the CALD people, in general, insufficient attention has been paid to specific ethnic groups in these policies. The Australian mental health policies for the CALD population developing so far adopt a universalised understanding of culture despite the diverse cultural traits of each ethnic group. All CALD people are cursorily regarded as having the same lived experiences of distress and recovery; therefore, services for these people tend to follow the same approaches. However, this study found that Chinese people presented unique culturally-patterned interpretations of distress and recovery experiences. For example, while sufficient information for mental help, such as free consultation, helpline, and many psychological resources and information are available online, participants in this study demonstrated an untrusting and reluctant attitude to these resources. Participants were in general unwilling to talk about their distress to anyone that might not be helpful, preferring other forms of support outside mainstream mental health approaches. Impacted by the Confucian understanding of the development of mental distress, they tended to attribute their distress to personal weakness and fragility. Participants also reported the ultimate stressor of distress was from the family. This differs from some policies which regard family as one of the important resources of mental support. However, for many of these participants, family was not necessarily a better choice for supporting their recovery, Moreover, while some participants tended to seek peer support or Chinese medicine, rather than using Western psychiatric treatments and medications, the relevant support and services were not sufficient to reach its population. Drawing on the experiences of the participants, this study argues that there is a lack of in-depth policies or documents that specifically take the lived experiences and mental needs of Australian Chinese people into account.

Furthermore, in mental health funding nationwide in the past couple of years, neglect of funding to support the CALD population and their mental wellbeing is of great concern, despite the declared commitment to improve Australians' mental health and improve suicide prevention. For example, the 2021-22 Federal Budget made a 2.3 billion commitment to establishing 'a foundational shift in the national response to mental health, wellbeing and suicide prevention.' But this expensive budget plan did not answer the political call for a higher commitment to CALD people. People from CALD backgrounds were excluded from the specified priority population in this context. This oversight was clearly reflected in this study. Participants reported an absence of sufficient information for access to related services, nor did they feel comfortable in using the so-claimed culturally sensitive and appropriate, recovery-oriented services. The promise of culturally responsive policies for CALD people and an increasing body of research, practice and programs created a stark contrast to the real sum of funding for the CALD population's mental wellbeing, which illustrated that no meaningful engagement with CALD or even Chinese people with lived experiences of distress had been practically established on the political level. The political commitment to improve CALD services and Chinese people's mental health remained very small.

Policies can be just pieces of paper if they exist only on the written level. Led by policymakers and politicians, the government should have an unswerving commitment to putting policies into practice. And these policies should be in dialogue with related service provision systems, including service providers, practitioners and any relevant others. Below are some practical implications for this purpose.

The implementation of policies should be promoted among service providers to motivate the structural and service transition within the service providers and organisations. With the emerging need to support CALD people with lived experiences of mental distress, service providers should consider an improved distribution of labour, with a sector working collaboratively in an integrated way to provide ethnic groups with culturally appropriate and safe services.

The culturally responsive and competent practice promised is not apparent in clinical settings. Many participants expressed their concerns about talking to mental health clinicians with Western appearance, thinking modes, sense of values, worldviews and problem-solving patterns. This is understandable, as it can be challenging for Anglo mental health workers with their English orientations to embrace and accept a culture that is completely different. Therefore, the power and importance of a multilingual/bilingual workforce must not be overlooked. This study argues that the provision of multilingual/bilingual service practitioners – including attracting students from CALD backgrounds into the education systems – seems possible and more practical in the foreseen future, considering that, as participants explained, practitioners from similar cultural backgrounds have cultural advantages over their counterparts. Overseas students are becoming an influential part of Australian Chinese communities, and are a potential labour force in this field. It is worth considering how to attract overseas graduate students to live and work as multilingual/bilingual mental health workers. Scaling it up to the employment environment of the whole multilingual/bilingual health workforce, policymakers, governments, states and territories should maintain an inclusive attitude to the CALD workforce by increasing employment opportunities for the CALD workers and improving policies to attract a highly skilled CALD workforce. At specific organisational levels, governments and leaders can help to build a strong and united work culture by improving the proportion of the CALD workforce across the sectors. More importantly, it is challenging but essential to promote effective collaborations and interactions within each department sector.

Relevant policies should also support the research projects and plans at the government-led, institutional and university-led levels. This study took the opportunity to explore participants' narratives through a critical race lens and the social constructionist perspective that counters the predominant biomedical discourse in mental health. With this approach, this study has recorded and interpreted profound narratives that describe the diverse and nuanced lived experiences of mental distress and recovery. As such, it contributes to the knowledge base with the voices of Chinese participants that have rarely been heard. The related existing research and findings from this study create a possible space to investigate more deeply the social determinants of distress and the intersectionalities of those factors with Chinese people's lived experiences of distress and recovery. As indications of gender violence, race, older people, people with both mental and physical disabilities, LGBTQ+ groups, children and young adults, and so on, feature in the interviews, a significant space is presented for further research on specific vulnerable people within the Australian Chinese ethnicity. Australian studies can be extended and drawn on to explore Chinese people's lived experiences of mental distress in other social and cultural contexts.

Since participants reported limited knowledge of the related mental support policies, this study suggests policy popularisation and advocacy in Chinese communities. Nowadays, there are some major multimedia internet platforms that connect the Australian Chinese communities well. Governments and mental health services could actively use these resources to engage with the Chinese community. According to the participants' narratives, it was not easy for them to accept and understand the mental health policies and services. The internet platforms that they are familiar with could act as a mediator to break the ice between the Chinese communities and the government.

To secure the success of policy implementation, it is essential to have funding granted and ensure a relatively comprehensive and specific supervision and management mechanism at all levels. However, funding for mental health services in Australia comes from a wide variety of sources, including the Australian government, state and territory governments, individuals, and private health insurers (Cook, 2019). The complex mix of funding sources might challenge the clear allocation of funds and lead to overlapping funding for one group or sector and overlook less powerful groups. For example, this study found that people who were less able to speak out about their adversities were among those who were not eligible for health care entitlements– for example, international students. Some participants were not able access mental health support because of financial concerns attendant on their temporary resident status. Whereas Australia is now launching free, convenient and private HIV and STI testing for anyone regardless of their visa or residency status, prevention and treatment for people with mental distress has not been made broadly available yet, even though the consequences of mental distress are wide-reaching. Therefore, funding for the provision of basic mental health support to those who are excluded by the system is important. There is a need to listen deeply to the voices of different groups of people from CALD backgrounds, in order to meaningfully address health inequalities.

This study finds that a stigma perpetuates discriminatory attitudes towards people experiencing mental distress. In Australia, the presence of structural stigma undermines the enactment of policies and distribution of funding, with detrimental effects on individuals with mental distress (Griffiths et al., 2015). This study argues for a more inclusive response, not only for Australian people with mental distress but also for those sub-groups that carry multiple cultural and social identities. Although there is an increasing emphasis on cultural responsiveness and competence in mental health policies, the lack of funding for Chinese people demonstrates ongoing inequalities.

In view of shame and more covert forms of stigma from biomedical perspectives and mainstream Chinese culture, this study suggests that inclusive and holistic mental health policies and avoidance of the use of pathologising and problematising terminology in recovery-oriented practice will strengthen the wellbeing of service users. Mental health policies have a critical role in providing structural and political support for CALD people with mental distress, and should grasp the opportunity to achieve policy transformation at this point in the post-Covid world.

8.3 Implications for service providers and practitioners

This study offers recommendations for improving culturally sensitive and responsive practice with recovery-oriented principles based on participants' lived experiences with mental health professionals and practitioners.

This study found that Chinese people were less likely to seek help from mental health services. If people change their minds and turn to look for help from professionals, it is important for professionals to identify the diverse perspectives and interpretations of mental health and distress of Chinese consumers through ongoing inquiry into their cultural background, values and beliefs. This study has demonstrated that the deep-rooted stigma and stereotype of mental distress within Chinese culture and society has significant impacts on the attitude of participants toward seeking professional help. Participants might be hesitant to seek help due to fears of being stigmatised or perceived as weak by their families and society. Furthermore, the cultural emphasis on collectivism over individualism leads individuals to prioritise the well-being of their family or community over their own mental health needs. Accordingly, mental health services need to consider the cultural context in which they operate and develop strategies that are sensitive to the cultural beliefs and values of the community. Services should make the best effort to proactively encourage people to live out their culture and values, not to deny them.

Participants reported the practices of mental health clinicians could lead to distanced professional-client relationships. The utilisation of standardised psychological treatment protocols that are rooted in Western professional backgrounds may not effectively establish rapport and foster trust among Chinese clients, due to a failure to accommodate participants' cultural, social, and economic backgrounds. Considering that cultural responsiveness and competence vary among professionals, especially those from non-Asian cultural backgrounds who are less likely to identify with Asian cultures, it would be helpful if professionals acknowledge their biases, beliefs and attitudes toward the consumers and demonstrate humility and inclusiveness in establishing safe, supportive and equal relationships with them.

This study identified obvious heterogeneity in the social identities of participants with distress. Stressors and supportive factors in recovery varied due to the different individual lived experiences. For example, for some, family was the major cause of participants' distress, while others reported a significant improvement in their mental state with support from the family. By applying recovery-oriented values in clinical practice, practitioners should ensure their practice is sensitive to heterogeneity such as gender, sexuality, age, language background and so on.

In this context, it is important for mental health workers to work collaboratively with others who can promote the most suitable recovery support for the people they care about. For example, some participants revealed that they were more likely to seek help from non-professional others, such as family, friends and supportive others. Caregiver participants especially expressed the urgent need to support their family members and protect their own mental status. Therefore, it would be helpful if professional knowledge is provided to support these people and equip them with the basic knowledge and skills to take care of their loved ones. For example, mental health practitioners can inform these people of what the experiences of mental distress are, what is the recovery process, and what they can do to support their cared ones in recovery. However, mental health practitioners should also be humble about the limitations of professional knowledge and open to new understandings. Further discussion is warranted regarding potential collaborations with peer experts with lived experiences of mental distress, multilingual/bilingual colleagues, social workers, traditional Chinese medicine practitioners and other mental health-related workers. Moreover, it is important to improve the referral pathways to maximise the integration and optimal use of available resources. If opportunities are provided, it shall be helpful to learn from other workers' experiences and professional knowledge through ongoing communication and sharing.

This study found that participants had very limited support and information on access to services through their communities. Therefore, it is time to enhance the quality and relevance of support in collaboration with Chinese communities. Nowadays, a growing number of social media are becoming increasingly influential among Australian Chinese people, so mental health professionals should take the opportunity to share resources and information on mental health and recovery – especially those with bilingual advantages and with hope and strength-based recovery values–through the internet platforms.

Although very few participants mentioned the experiences of e-consulting with mental health professionals located in China for economic and cultural reasons, it might be time to consider the possibility of working with mental health professionals from China. This not only facilitates professional knowledge and experience sharing, but also can help optimise the referrals and the effectiveness of service outcomes with cooperative interventions. Be that as it may, this kind of collaboration needs further discussions, studies and policy-focused research to prove its feasibility.

8.4 Implications for informal supportive others

Governments and services are not the single and only entities responsible for the improvement of the Australian Chinese people's mental health. Policies and services are often not a core component of supporting participants. The significance of informal supportive others was highlighted more by participants. According to participants' narratives, the related informal supportive others could be categorised as family, friends, peers, universities (referring to all educational institutions but not limited to universities), religious groups and communities.

Family is an important factor that may support recovery. The findings show that participants' families from Chinese cultural backgrounds might be impacted by the stigma of mental distress, which would hinder their potential in supporting participants to respond to the challenge. It is important for the family to release the stereotyped notion of mental distress and to be the first ones not to feel shameful about having a family member with mental distress. To achieve this goal, it is necessary to explore the role that mainstream Chinese culture plays in this regard. This study argues that Confucian culture and filial piety are not just stressors that can contribute to distress, but can strengthen family cohesion with careful thought given to relationships and balances of power. Collectivism in the family means seeing the family as a whole entity. But this should not privilege familial prosperity and harmony at the expense of individual wellbeing, with personal submissiveness and emotional suppression as essential conditions. Drawing upon the experiences of some female participants, it becomes evident that issues such as addiction to alcohol and other drugs, problem gambling and emotional neglect are complex factors that can contribute to domestic violence. Such issues cannot be addressed by one party alone through suppression of their emotions and acquiescence in the attempt to achieve a temporary and illusory harmony. Rather, it is a challenge that requires joint efforts by both spouses to resolve the disharmony. In this regard, female participants could be supported to safely assert their roles and powers within the family unit, negotiate their positions, and demand respect equal to that accorded to male members of the family. This study argues that understandings of the collective are sometimes overly simplistic and miss this point: the achievement of collective harmony should be based on the acknowledgement and respect of each member as an equal individual.

To be specific, this study provides some advice for support within the relationships of intimate partners and parents and children. Participants frequently reported imbalanced power relationships in the gendered roles in intimate partner relationships. This study suggests that both husband and wife should acknowledge and respect each other’s equal rights in family issues, such as working opportunities, decisions in family issues, and the duty of caring for children and aged family member, the duty of household chores and so on. If positive negotiation does not work for both, it is possible to seek related professional consultations or any other third parties that might be helpful as a mediator, especially when this relates to domestic violence, problem gambling, alcohol and other drug issues, and similar problems.

In parent-child relationships, this study argues that we need to have a more complex understanding of filial piety. Filial piety does not mean that children have to be completely submissive to their parents. A commitment for children to obey their parents’ requirements should be reciprocated in the parents’ commitment to the proper use of power with mutual respect; rights come with obligations. In some contexts, children can believe that their family is the most trustworthy ally in their recovery journey. However, it is not easy to have full trust in their parents. Therefore, it is important to facilitate effective communication between parents and children. This is also important in cases where adult children do not care enough about aging parents, their needs and concerns. Adult children's supportive roles mean a lot to their parents. But if negotiations and communication do not work well, both parents and children can a seek support from others, such as other family members, friends, mental health professionals, social workers, the community, or supportive others. In all, the central principle of understanding and respect should prevail when mental distress affects loved ones.

The effect of friends' support did not stand out in many participants' narratives, but did in some. This study suggests that it is helpful if friends provide companionship and emotional support. For some participants, it was easier to speak to their friends than to their families. Friends who are emotionally available can use their empathy to provide emotional support. This relies on the non-stigmatised view of mental health and distress through a recovery-oriented lens. Friends can also provide other supports such as advice for employment opportunities, study skills, housing, interpersonal relationships, and so on. If the support is beyond a person's ability, help can be sought from mental health professionals, social workers, communities, religious groups, peer support workers, and so on. Friends should be careful of their own emotions. If they feel too involved and impacted, they should stop and enquire about professionals and other support workers.

Peer support workers with cultural advantages were hypothetically welcomed by participants. However, because of the expansive scope and frequently informal nature of peer workers' involvement in providing mental health support, there is a dearth of statistics concerning the overall count of workers with lived experience in Australia (Australian Institute of Health and Welfare, 2022). Few statistics relate to peer workers' cultural backgrounds. A report from NSW data demonstrated a very small proportion (7.4%) of peer workers identified as culturally and linguistically diverse (Mental Health Coordinating Council, 2021). Therefore, a plausible assumption is that a significant proportion of peer workers originate from Anglo-Celtic backgrounds and possess personal lived insights, but frequently lack sufficient cultural knowledge. Consumers from Chinese cultural backgrounds might have great unmet needs in obtaining pertinent information and gaining access to peer workers who share the same cultural backgrounds. There is an urgent need to expand the workforce of peers who can bring their Chinese cultural knowledge into mental health services. Other than developing supporting skills and experiences informally, it is important for peer workers to get involved in peer support programs led by mental health-related organisations, communities and government departments. The current workforce of peer workers from Chinese cultural backgrounds is unclear. However, peer workers and their allies and managers should keep advocating for policies, research and public attention to the significance of lived experiences of mental distress and recovery, and also the supportive roles peer workers can provide for the Australian Chinese people with distress.

The universities (referring to all educational institutions but not limited to universities) can support students in safe and progressive process in adapting the learning and teaching environment. Participants reported different levels of difficulty in getting used to studying at Australian universities. The universities can provide assistance to help students have a successful start. Other than improving more adaptable teaching modes, universities can recruit student peers to assist new students with their new school life. For students with a short residency in Australia, the universities and student peers can provide information for daily living, such as accommodation, transportation, groceries, and advice for city exploration. Moreover, peers can support students to find relief from interpersonal pressures.

The universities should actively disseminate recovery-oriented notions of mental health and provide an inclusive environment for students with mental distress from Chinese cultural backgrounds. This not only relates to reducing stigmatised attitudes towards students with mental distress school-wide, but also pertains to the racial discrimination that can happen in every possible scenario in the universities. Therefore, universities should provide training for teachers to be more culturally inclusive and responsive. By calling for more attention to students' mental wellbeing, it is important to identify racism and social exclusion; these were identified as social determinants leading to mental distress in some student participants' narratives. Participants reported that universities should be more attentive to students and their mental health, not just rely on standardised administration routines. Participants mentioned that regular self-assessment of mental health should be included in the university administration’s routines, because it provides a way for students to seek assessment of their mental status if that is what they need.

This study also argues for improvement in collaboration with mental health sectors inside and outside of the universities. For example, universities can work collaboratively with general practitioners, mental health professionals, mental health organisations and social workers on early intervention, suicide prevention and consultation to assist Chinese students in culturally appropriate ways.

Religious communities provided social connections, essential living support and spiritual support for participants. In this context, religious groups and Chinese communities can function as information and resource exchange hubs, providing information and support for their members with mental distress. Religious groups and communities can be resourceful, as they gather different people and information from different fields. They could work with social welfare organisations, Chinese-led organisations, social workers and other mental health workers and professionals to provide extra help. For example, religious groups can work with mental health professionals who can bring their cultural competence and provide consultations for their Chinese members who are confronted with issues such as domestic violence, parent-child relationships, alcohol and other drugs, problem gambling and so on. The religious groups could also provide language services and peer support for accommodation, housing conditions, food, employment and so on. They can collaborate with local communities to reach out to some individuals who feel the need to be more involved in local activities and social lives.

However, from participants’ narratives in this study, religious support and community support were generally weak and more likely to be threatening factors in participants’ quality of life. It is important for religious groups and Chinese communities to bear in mind the recovery-oriented notions of mental health and be dedicated to reducing stigma and stereotypes of mental distress in Chinese communities, and encouraging people to ask for help if they feel unable to deal with the difficulties caused by distress. Religious groups and Chinese communities should also be aware of finding a culturally appropriate way in which they could support people from Chinese cultural backgrounds with mental distress without causing any additional harm due to cultural differences. According to participants' experiences with religious groups, the differences between Chinese etiquette and religious ritual customs could be a source of unease and distress. This warrants further attention. Much work needs to be done by the government and the Chinese communities to collaborate and disseminate a non-discriminatory attitude towards people with mental distress. Since participants did not report much regarding this aspect, this study suggests that whether community leaders and cultural advisers are good points to start such work requires further exploration. Also, since the reported influence of mental health support from Chinese communities remained small, this study argues that Chinese communities should make full use of the internet platforms to ensure that mental health information becomes more accessible among the Chinese population.

8.5 Implications for social work practices

This study demonstrates that participants had a very limited understanding of social work and the supportive roles that social workers play in the mental health field. This situation was more common among participants with a relatively short residency in Australia. Participants' experiences of taking medicine and their descriptions of shame and self-blame in understanding their recovery journey might indicate that biomedical perspectives have a profound impact among people from Chinese cultural backgrounds. This not only indicates the dominance of other medical professionals in the mental health space, but also hinders participants from being more knowledgeable about social workers and the roles they can play in their recovery process.

Although not many experiences with social workers were reported, findings in this study indicate that respect for clients' backgrounds, such as gender, age, ethnic origin, culture, educational attainment, and economic status, is pertinent to the equality of social worker-client relationships. They also indicate that it is important for social workers to maintain an empathic and non-judgemental, professional attitude toward their clients. In order to achieve these goals, this study argues for the cultural competence and responsiveness of social workers, the importance of detecting inequality and oppression through an intersectionality lens, and acknowledging the heterogeneity of Chinese people in different personal contexts.

Being culturally competent and responsive requires a look back at the notions in traditional Chinese medicine (TCM) and Confucianism. The Ying-Yang principle and the five universal elements from TCM suggest that mental distress does not necessarily separate an individual's mind from their body. The mental health literature on Chinese people has already pointed out a somatisation feature within the descriptions of lived experiences of mental distress. Participants also reported that binge eating issues and sleeping issues significantly reflected the quality of their mental status. In this case, it is reasonable to assume that some Chinese people might describe how their physical health has changed rather than directly recognising their distress. Being aware of such notions might help identify someone with mental distress who describes their distress in a Chinese culturally-patterned way. This might be particularly helpful in referring consumers to early prevention and alleviation of mental distress or related services.

Confucianism believes that an individual is never expected to be a separate, self-contained entity apart from their collectivity. In the context of collective culture, one's worth is reflected as a part of attaining collective prosperity. It is expected that individuals will strive to meet the demands of collective objectives, ultimately contributing to the prosperity and competitiveness of their respective families, groups, and broader society. However, under such social norms, the individual is required to control any sign that could 'expose weakness' by admitting they are experiencing distress. The requirement for self-restraint becomes a barrier to the participants expressing their distress and accessing support for themselves from the micro-social level to broader social levels. In this case, this study argues for an exploration of how Chinese participants are located in the complex situations of intertwinement of the Australian social context and the Chinese cultural context in their lived experiences of mental distress, and how they navigate and negotiate their recovery from mental distress through both Western and Confucian perspectives. Under such circumstances, this study argues for a reconstruction of the notions of self-control, collective harmony and the relationship between these two concepts.

Collective harmony does not imply covering up the unhealthy side of society but admitting and facing mental distress directly. It indicates a non-stigmatised and non-discriminatory social environment where people can express their distress experiences, perspectives and feelings freely, get sufficient support to recover and most importantly, regain the power to sort out the challenges. In this redefined context, self-control does not mean pretending to be mentally 'healthy' and suppressing one's emotions, but taking the power to control one's life and believing in oneself in solving problems. Self-worth is reflected in acknowledging the capacity to deal with mental distress challenges and contribute one's self-empowerment spirit to the collectivity in this regard.

However, in the Australian social context, participants confronted the situation where they were caught between cultural differences regarding aspects of their daily lives that could lead to distress. For example, participants who experienced a power imbalance in relationships with their parents found it challenging to maintain individuality and boundaries with their parents under the moral restraints of filial piety, which directly triggered the distress. Married female participants reported a gender power imbalance caused by the conflicting expectations of women's independence in the Australian social context and submissiveness in Confucian family moral ethics. An upbringing in Chinese cultural contexts and living in the Australian social context impacted upon how Chinese people negotiate their power and identity in interpersonal relationships and how they respond to mental health challenges. Depending on their unique lived experiences and social conditions, their perspectives on mental health and recovery might vary considerably in the negotiation between the two cultures.

Social work practice that respects the Chinese mainstream culture should take a critical role in the cultural interpretations of mental health but also in developing societal understandings of mental distress. Moreover, social work practitioners need to identify and acknowledge their biases, beliefs and attitudes toward the consumer in the first place. It is also important to be more attentive to the consumers' personal contexts rather than acting on preconceived ideas and trying to offer help through an established white lens. Based on participants' descriptions of not being sufficiently informed of the services that the social workers could provide, this study argues that social workers may also need to confront the organisational and institutional forces that can undermine their capacity to perform culturally-informed practice in some settings –the hospital, in this study. Under such circumstances, social workers shall play a critical role in advocating for more inclusive spaces to embrace people's diverse cultural backgrounds and the capacity to provide culturally competent and responsive services for people with distress.

Intersectionality is a powerful tool to help explore the various social, economic and political processes through which inequality and oppression were experienced by participants (Lane et al., 2010; Morrow & Weisser, 2012). The critical racial lens applied in this study examined the mental distress experiences of participants and emphasised the intricacy and multidimensionality of oppression by incorporating an intersectionality perspective. By encouraging the construction of counter-narratives from the marginalised and less visible narratives of Chinese people, this study unearthed how the complex interactions of social determinants (race, gender inequality, sexual orientation, social class, etc.) gradually evolved into various forms of inequality and influenced participants' perspectives on mental distress and their help-seeking attitudes and behaviours. The various demographic features made space for heterogeneity in the Australian Chinese population. By acknowledging and exploring the different social and cultural identities Chinese participants carried, distress could be understood as the outcome of structural inequality and oppression in combination with personal narratives. This study shall enable social workers and educators to recognise how Chinese people are positioned in complex and intertwined social identities, how cultural backgrounds and their lived experiences impact the perspectives on mental distress, and the attitudes and behaviours employed in navigating difficulties in their recovery journey. No matter whether they sought help from others or were self-supported, participants remained in the core position of taking the control of their lives, including deciding the directions of their recovery processes.

Therefore, the lived experience is never simply contained within the biomedical discourse. The values and core thoughts of social justice and empowerment in social work practice resonate closely with recovery-oriented perspectives. Progressive social work practice and education should recognise opportunities to make a radical and critical commitment to addressing inequitable power relationships (Brown, 2021; Morley, 2003).

The study offers several practical suggestions. Social work practice might help Australian Chinese consumers with mental distress deal with issues involving family tensions (violence, neglect and abuse), equal work opportunities, housing conditions, racial discrimination experiences, confusion in sexual orientation, interpersonal relationships, caregiving skill training, and so on. It is also important to bear in mind the recovery-oriented practice values while acknowledging that there are no ultimate correct recovery processes or patterns. By embracing the heterogeneity of the consumers, respect is afforded for each individual context that will lead to different understandings and decisions on people's recovery processes. Moreover, social work practitioners should explore ways to connect with Chinese communities and potential clients by improving the accessibility of mental health-related resources and information. For example, a few participants mentioned that there are possibilities to engage with internet platforms that are popular among the Australian Chinese people, and work with other Chinese-led organisations or mental health organisations to disseminate information and support through such platforms. Indeed, since the time of data collection, there has been a vast increase in the availability and use of apps among Chinese people in Australia.

Being mindful of cultural biases and any risk of racial discrimination in practice is important. This study argues for the training of social work students with education based on Chinese experiences that can help to identify any biases and assumed superiority of race, whiteness, and reduction of mental distress based on the biomedical paradigm. In this study, it is suggested that social work practices respect and acknowledge collectivist thoughts and filial piety in Confucianism and the complexities of these, avoiding stereotypical thinking about these concepts. While these were reported as the cultural reasons that related to participants' distress, social work research, practice and education should engage with the reconstruction of these cultural concepts by Chinese people living in the current Australian social context to develop culturally competent, appropriate and safe practices. It is noteworthy that participants expressed a greater level of receptiveness towards social workers who shared similar cultural backgrounds. Expanded recruiting of social workers from Chinese cultural backgrounds is an issue for consideration in the development of the future social workforce in Australia.

Faster and more effective pathways for educating social workers from Chinese cultural backgrounds should be studied in the effort to enlarge the entire workforce.

8.6 Strengths and limitations of the study

A key strength of this study lies in its determination to explore the experiences of a diverse group of Chinese people with mental distress. To include the heterogeneous groups of Australian Chinese people, this study considered people from all Chinese cultural backgrounds and geographical origins. This study also welcomed caregivers and supportive others as an important part of the participant pool. As well as maximising the heterogeneity of the Chinese participants, I, as a multilingual researcher, have made a great effort to minimise the language barriers that participants encountered. This is especially important when conducting qualitative research with CALD people who might speak languages other than English. I found it much easier to build trust and rapport with participants in the first place when we shared the same cultural identity.

However, this study confronted several challenges and limitations. The most prominent challenge was the issue of gatekeeping. It was particularly difficult to get support from organisations and agencies regarding recruitment. Most of the time, they did not reply to the requested email or did not state the reasons for refusal. It was understandable, as assisting recruitment might breach their work regulations. On the other hand, it not only challenged my capability to look for other possible ways to attract potential participants but also excluded potential participants from making their own decision to participate. The other challenge was related to the recruitment method I applied. Since I was only allowed to distribute the flyers and wait until people reached out to me, I lost some potential participants that might have contributed some unique voices to this study. The concerns about taking part in the interviews were also reflected among the final participants. One concern was that they might not identify or recognise the experiences as mental distress. The other was that they worried about the risk that the so-called 'very small Chinese communities' might know that they took part in 'mental illness research,' even though confidentiality was clarified the first time they approached me. Apart from those who were not initially interested in the interview, this study missed some unique voices of some who did not respond proactively, and of those who were unable to get to know about this study. Regarding the limitations to the principle of heterogeneity, these unincluded people might include senior male adults and a certain number of older people.

In order to address the limitation posed by a narrow potential participant pool, snowball sampling was employed to supplement recruitment efforts. The approach was deemed particularly efficacious and comparatively less challenging in light of the resourcefulness of participants' respective networks. Therefore, it is recommended that snowball sampling may constitute a viable strategy for participant recruitment, provided that the initial pool of participants exhibits a diverse range of characteristics and that the networks of potential participants satisfy the established criteria for recruitment.

Finally, it should be noted that this study is limited by the geographic scope of its participant pool, which might not be able to be generalised to the other parts of Australia, especially rural and remote regions. However, it is important to clarify that generalisability was not a priority of this study. Considering the limited sample size, rather than generalising its findings to the entire Chinese population in Australia, this study aimed to open a space to deliver voices that were rarely heard by the public. The inclusion of various participant narratives and perspectives has contributed to enhancing an understanding of the richness and complexity of mental distress and recovery experiences. This, in turn, has provided valuable, culturally sensitive insights for practitioners and educators.

8.7 Implications for further research

The current study proposes that the following seven points be integrated in future research endeavours.

Firstly, the heterogeneity of the Australian Chinese population enables further research on specific subgroups sharing the same cultural and ethnic labels. This study suggests further research on the lived experiences of Chinese people with specific social identities: women, senior male adults, aging people, LGBTQ+ people, teenagers, overseas students, disabled people, people with different residential identities, people living in rural and remote areas and so on. Moreover, it is possible to consider the lived experiences of people at the intersections of the above identities. For example, women in intimate partner relationships and their lived experiences of mental distress, young adults' mental health and their relationships with parents, or the mental health of elderly people who migrated to Australia to live with their children.

Secondly, given that certain participants attributed their recovery experiences to the utilisation of self-support strategies, it would be worthwhile for future research to investigate the self-empowerment of the Chinese population within the Australian social context and the Chinese cultural context.

Thirdly, social work studies should examine how social work practice can best support Australian Chinese people in their mental health and recovery. Further exploration of this topic may yield valuable insights into culturally responsive care practices and strategies that enhance the effectiveness of mental health interventions within this population.

Fourthly, the provision of community support to Chinese people experiencing mental distress has been found to be inadequate. This highlights the need for further investigation into potential avenues for community support. One promising approach is to engage community leaders and cultural advisers in developing and implementing supportive measures. Further research is required to determine the feasibility and effectiveness of such strategies.

Fifthly, the idea of e-mental health services came up as an important issue among a few participants. Subsequent discourse may explore a range of subjects concerning e-mental health services, including their implementation in clinical settings, their integration into social work practice, and their potential impact on mental health policy-focused research.

Sixthly, this study identified covert racism as a less discernible manifestation of racial discrimination, characterized by a potent subjective element that can overshadow its ostensibly non-racial, concealed, and less apparent nature. A more nuanced exploration of the covert forms of racial discrimination and its impact on the mental health of Chinese individuals is imperative. Furthermore, it is critical to examine how individuals respond to such forms of inequality and negotiate their self-identity in the face of these challenges, particularly in the aftermath of the COVID-19 pandemic.

Lastly, building upon the developing foundation laid by qualitative studies, it is anticipated that future quantitative studies may be conducted on a larger sample of Chinese individuals to explore their lived experiences and coping strategies in response to mental distress. Such studies hold the potential to yield findings that can be generalised to a wider range of the Chinese population, thereby informing policy advocacy and facilitating social progress.

8.8 Conclusion of this study

A 2015, Australian research claimed that the healthy immigrant effect (HIE) – that immigrants are generally healthier than native-born people – was commonly cited across a multitude of social science literature in major Western countries that receive immigrants, and was strongly supported by the Australian data (Kennedy et al., 2015). However, this study unearthed the deeper facts that – taking the Chinese population as an example – Chinese people are a less visible group and therefore, their experiences of distress might be generally underestimated. This study found that the unclear and low official statistics did not indicate that Chinese people commonly maintained higher levels of mental wellbeing. Based on the first-hand accounts of the lived experience, this study provides more details of how Chinese people have experienced mental distress. More importantly, it reveals the resilience, strength, power and ability of participants who navigated their roles and identities to survive the challenges. This study indicates that the factors that support or exacerbate distress are multiple, complex, and nuanced. The lived experiences of mental distress of Chinese people could not be definitely concluded without clarifying the individual contexts combined with cultural and social contexts.

References

AASW. (2010). Code of Ethics.

Abbott, M. W., Abbott, M. W., Wong, S., Giles, L. C., Wong, S., Young, W., & Au, M. (2003). Depression in Older Chinese Migrants to Auckland. *37*(4), 445-451. https://doi.org/10.1046/j.1440-1614.2003.01212.x

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review*, *31*(6), 934-948. https://doi.org/https://doi.org/10.1016/j.cpr.2011.05.003

Abrams, L. S. (2010). Sampling 'Hard to Reach' Populations in Qualitative Research: The Case of Incarcerated Youth. *Qualitative Social Work*, *9*(4), 536-550. https://doi.org/10.1177/1473325010367821

Ådnøy Eriksen, K., Arman, M., Davidson, L., Sundfør, B., & Karlsson, B. (2014). Challenges in relating to mental health professionals: Perspectives of persons with severe mental illness. *International Journal of Mental Health Nursing*, *23*(2), 110-117.

Afrouz, R. (2022). Developing inclusive, diverse and collaborative social work education and practice in Australia. *Critical and Radical Social Work*, *10*(2), 280-296. https://doi.org/10.1332/204986021x16553760671786

AIHW. (2022). *Culturally and linguistically diverse Australians: Overview*.

AIHW. (2023). *Prevalence and impact of mental illness*.

Anastas, J. W. (2004). Quality in Qualitative Evaluation: Issues and Possible Answers. *Research on Social Work Practice*, *14*(1), 57-65. https://doi.org/10.1177/1049731503257870

Andresen, R., Oades, L., & Caputi, P. (2003). The Experience of Recovery from Schizophrenia: Towards an Empirically Validated Stage Model. *Australian & New Zealand Journal of Psychiatry*, *37*(5), 586-594. https://doi.org/10.1046/j.1440-1614.2003.01234.x

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*(4), 11-23. https://doi.org/10.1037/h0095655

Australian Bureau of Statistics. (2021). *National Study of Mental Health and Wellbeing*. ABS. https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release.

Australian Health Ministers' Advisory Council. (2013a). A national framework for recovery-oriented mental health services: guide for practitioners and providers. https://www.health.gov.au/sites/default/files/documents/2021/04/a-national-framework-for-recovery-oriented-mental-health-services-guide-for-practitioners-and-providers.pdf

Australian Health Ministers' Advisory Council. (2013b). *A national framework for recovery-oriented mental health services: Policy and theory*. Retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra

Australian Institute of Health and Welfare. (2022). *mental health workforce* https://www.aihw.gov.au/mental-health/topic-areas/workforce#Lived_experience_workers

Australian Institute of Health Welfare. (2022). *Mental health: prevalence and impact.* https://www.aihw.gov.au/reports/mental-health-services/mental-health

Aviram, U. (2002). The Changing Role of the Social Worker in the Mental Health System. *Social Work in Health Care*, *35*, 615-632. https://doi.org/10.1300/J010v35n01_15

Ayres, L. (2007). Qualitative Research Proposals—Part III: Sampling and Data Collection. *Journal of Wound, Ostomy and Continence Nursing*, *34*(3), 242-244. https://doi.org/10.1097/01.WON.0000270816.99318.3b

Bahasoan, A. N., Ayuandiani, W., Mukhram, M., & Rahmat, A. (2020). Effectiveness of online learning in pandemic COVID-19. *International journal of science, technology & management*, *1*(2), 100-106.

Barusch, A., Gringeri, C., & George, M. (2011). Rigor in Qualitative Social Work Research: A Review of Strategies Used in Published Articles. *Social Work Research*, *35*(1), 11-19. https://doi.org/10.1093/swr/35.1.11 %J Social Work Research

Becker, H. S. (1996). The epistemology of qualitative research. *Ethnography and human development: Context and meaning in social inquiry*, *27*, 53-71.

Beresford, P. (2002). Thinking about'mental health': Towards a social model. *Journal of Mental Health*, *11*(6), 581-584.

Beresford, P., Perring, R., Nettle, M., & Wallcraft, J. (2016). From mental illness to a social model of madness and distress. *London: Shaping Our Lives*, 1-72.

Bian, Y. (2018). The Prevalence and the Increasing Significance of Guanxi. *The China Quarterly*, *235*, 597-621. https://doi.org/10.1017/S0305741018000541

Bird, V., Leamy, M., Tew, J., Le Boutillier, C., Williams, J., & Slade, M. (2014). Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers. *Australian & New Zealand Journal of Psychiatry*, *48*(7), 644-653. https://doi.org/10.1177/0004867413520046

Blackmore, J., & Rahimi, M. (2019). How 'best fit' excludes international graduates from employment in Australia: a Bourdeusian perspective. *Journal of Education and Work*, *32*(5), 436-448. https://doi.org/10.1080/13639080.2019.1679729

Bland, R., Drake, G., & Drayton, J. (2021). *Social Work Practice in Mental Health: An Introduction (3rd ed.)*. Routledge. https://doi.org/https://doi.org/10.4324/9781003148913

Bland, R., Laragy, C., Giles, R., & Scott, V. (2006). Asking the Customer: Exploring Consumers' Views in the Generation of Social Work Practice Standards. *Australian Social Work*, *59*(1), 35-46. https://doi.org/10.1080/03124070500449762

Blignault, I., Ponzio, V., Rong, Y., & Eisenbruch, M. (2008). A Qualitative Study of Barriers to Mental Health Services Utilisation Among Migrants From Mainland China in South-East Sydney. *International Journal of Social Psychiatry*, *54*(2), 180-190. https://doi.org/10.1177/0020764007085872

Bonney, S., & Stickley, T. (2008). Recovery and mental health: a review of the British Literature. *Journal of Psychiatric and Mental Health Nursing*, *15*(2), 140-153. https://doi.org/10.1111/j.1365-2850.2007.01185.x

Bracken, P. (2012). Psychiatric power: A personal view. *Irish Journal of Psychological Medicine*, *29*(1), 55-58. https://doi.org/10.1017/S0790966700017638

Bradley, M. (2022). The social construction of mental illness in contrast to medical models. *Mental Health and Social Inclusion*(ahead-of-print).

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019a). Answers to frequently asked questions about thematic analysis. https://cdn.auckland.ac.nz/assets/psych/about/our-research/documents/Answers%20to%20frequently%20asked%20questions%20about%20thematic%20analysis%20April%202019.pdf

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019b). Thematic Analysis. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences* (pp. 843-860). Springer Singapore. https://doi.org/10.1007/978-981-10-5251-4_103

Brown, C. (2021). Critical Clinical Social Work and the Neoliberal Constraints on Social Justice in Mental Health. *Research on Social Work Practice*, *31*(6), 644-652. https://doi.org/10.1177/1049731520984531

Brown, J. S. L., Evans-Lacko, S., Aschan, L., Henderson, M. J., Hatch, S. L., & Hotopf, M. (2014). Seeking informal and formal help for mental health problems in the community: a secondary analysis from a psychiatric morbidity survey in South London [Article]. *BMC Psychiatry*, *14*.

Burr, V. (2019). Social Constructionism. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences* (pp. 117-132). Springer Singapore. https://doi.org/10.1007/978-981-10-5251-4_57

Carpenter, J. (2002). Mental Health Recovery Paradigm:Implications for Social Work. *Health & Social Work*, *27*(2), 86-94. https://doi.org/10.1093/hsw/27.2.86

Casadi, K., Marino. (2014). To belong, contribute, and hope: first stage development of a measure of social recovery. *Journal of Mental Health*, *24*(2), 68-72.

Cauce, A. M., Domenech-Rodríguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and Contextual Influences in Mental Health Help Seeking: A Focus on Ethnic Minority Youth. *Journal of consulting and clinical psychology*, *70*(1), 44-55. https://doi.org/10.1037/0022-006X.70.1.44

Chae, D. H., Yip, T., Martz, C. D., Chung, K., Richeson, J. A., Hajat, A., Curtis, D. S., Rogers, L. O., & LaVeist, T. A. (2021). Vicarious Racism and Vigilance During the COVID-19 Pandemic: Mental Health Implications Among Asian and Black Americans. *Public Health Reports*, *136*(4), 508-517. https://doi.org/10.1177/00333549211018675

Chan, B. (2007). Depression through the Chinese eyes. A window into public mental health in Multicultural Australia [journal]. (University of New South Wales, Sydney. Accessed on)

Chan, B., Parker, G., Chan, B., & Parker, G. (2004). Some Recommendations to Assess Depression in Chinese People in Australasia. *Australian & New Zealand Journal of Psychiatry*, *38*(3), 141-147. https://doi.org/10.1080/j.1440-1614.2004.01321.x

Chan, B., & Ritchie, J. (2011). Perceptions of Chinese Australians on seeking help for mental health problems: a qualitative study. *International Journal of Mental Health Promotion*, *13*(4), 36-45.

Chan, Y.-K. (2000). Privacy in the Family: Its Hierarchical and Asymmetric Nature. *Journal of Comparative Family Studies*, *31*(1), 1-17.

Chen, A. W., Kazanjian, A., Wong, H., & Goldner, E. M. (2010). Mental health service use by Chinese immigrants with severe and persistent mental illness. *The Canadian Journal of Psychiatry*, *55*(1), 35-42.

Cheng, H. L. (2020). Xenophobia and racism against Asian Americans during the COVID-19 pandemic: Mental health implications. *Journal of Interdisciplinary Perspectives and Scholarship*, *3*(1), 3.

Cheng, S. K. K. (1985). Cultural Explanation of a 'Psychosis' in a Chinese Woman Living in Australia. *Australian & New Zealand Journal of Psychiatry*, *19*(2), 190-194. https://doi.org/10.3109/00048678509161319

Cheng, Z., Tu, M.-C., & Yang, L. (2016). Experiences of Social Support Among Chinese Immigrant Mental Health Consumers with Psychosis. *Community Mental Health Journal*, *52*(6), 643-650. https://doi.org/10.1007/s10597-016-0008-4

Cheng, Z. H., Tu, M.-c., Li, V. A., Chang, R. W., & Yang, L. H. (2015). Experiences of Social and Structural Forms of Stigma Among Chinese Immigrant Consumers with Psychosis. *Journal of Immigrant and Minority Health*, *17*(6), 1723-1731. https://doi.org/https://doi.org/10.1007/s10903-015-0167-3

Chiu, M. Y. L., Davidson, L., Lo, W. T. L., Yiu, M. G. C., & Ho, W. W. N. (2013). Modeling Self-Agency among People with Schizophrenia: Empirical Evidence for Consumer-Based Recovery. *Psychopathology*, *46*(6), 413-420. https://doi.org/http://dx.doi.org/10.1159/000345834

Clarke, V., & Braun, V. (2018). *Thematic analysis - an introduction* [Video]. YouTube. https://www.youtube.com/watch?v=5zFcC10vOVY

Clement, B., & Sumeet, J. (2017). Problematising Global Mental Health. In *Routledge International Handbook of Critical Mental Health*. Routledge. https://doi.org/10.4324/9781315399584.ch25

Coates, R. D. (2011). *Covert racism theories, institutions, and experiences*. Brill.

Cohen, B. M. Z. (2017a). Introduction: The importance of critical approaches to mental health and illness. In B. M. Z. Cohen (Ed.), *Routledge International Handbook of Critical Mental Health*. Routledge. https://doi.org/10.4324/9781315399584

Cohen, B. M. Z. (2017b). Marxist theory In B. M. Z. Cohen (Ed.), *Routledge International Handbook of Critical Mental Health*. https://doi.org/10.4324/9781315399584.ch5

Cohen, B. M. Z. (2017c). *Routledge International Handbook of Critical Mental Health* (First edition. ed.). Taylor and Francis.

Cook, L. (2019). Mental health in Australia: a quick guide. *Parliament of Australia*, *14*.

Coombs, M. A., Parker, R., & deVries, K. (2016). Research: Can qualitative interviews have benefits for participants in end-of-life care research? *European journal of palliative care*, *23*(5), 227-231.

Coppock, V., & Dunn, B. (2010a). Understanding Mental Health and Mental Distress. In *Understanding Social Work Practice in Mental Health* SAGE Publications Ltd. https://doi.org/10.4135/9781446288276

Coppock, V., & Dunn, B. (2010b). What Works in Promoting Recovery? Evidence-Based Practice and the Dynamics of Power

in Mental Health Research. In *Understanding Social Work Practice in Mental Health*. SAGE Publications Ltd. https://doi.org/10.4135/9781446288276

Coyne, I. T. (1997). Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? , *26*(3), 623-630. https://doi.org/10.1046/j.1365-2648.1997.t01-25-00999.x

Creswell, J. W., & Miller, D. L. (2000). Determining Validity in Qualitative Inquiry. *Theory Into Practice*, *39*(3), 124-130. http://www.jstor.org.ezproxy2.library.usyd.edu.au/stable/1477543

Cromby, J., Harper, D., & Reavey, P. (2013). *Psychology, mental health and distress*. Macmillan International Higher Education.

Cypress, B. S. (2017). Rigor or Reliability and Validity in Qualitative Research: Perspectives, Strategies, Reconceptualization, and Recommendations. *36*(4), 253-263. https://doi.org/10.1097/dcc.0000000000000253

Dalal, A. K., & Misra, G. (2011). *New Directions in Health Psychology*. SAGE Publications. http://ebookcentral.proquest.com/lib/usyd/detail.action?docID=835844

Das-Munshi, J., Leavey, G., Stansfeld, S. A., & Prince, M. J. (2012). Migration, social mobility and common mental disorders: critical review of the literature and meta-analysis. *Ethnicity & Health*, *17*(1-2), 17-53. https://doi.org/10.1080/13557858.2011.632816

Davidson, L. (2005). Recovery, self management and the expert patient – Changing the culture of mental health from a UK perspective. *Journal of Mental Health*, *14*(1), 25-35. https://doi.org/10.1080/09638230500047968

Davidson, L. (2016). The recovery movement: Implications for mental health care and enabling people to participate fully in life. *35*(6), 1091-1097.

de Jager, A., Rhodes, P., Beavan, V., Holmes, D., McCabe, K., Thomas, N., McCarthy-Jones, S., Lampshire, D., & Hayward, M. (2016). Investigating the lived experience of recovery in people who hear voices. *Qualitative Health Research*, *26*(10), 1409-1423.

Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric rehabilitation journal*, *19*(3), 91.

Deegan, P. E. (2005). The importance of personal medicine: A qualitative study of resilience in people with psychiatric disabilities. *Scandinavian Journal of Public Health*, *33*(66_suppl), 29-35. https://doi.org/10.1080/14034950510033345

Department of Health. (2011). *Framework for recovery-oriented practice*. the Mental Health, Drugs and Regions Division, Victorian Government

Department of Health and Aged Care. (2008). National Mental Health Policy.

Department of Health and Aged Care. (2018). Mental health services for people of culturally and linguistically diverse (CALD) backgrounds.

Department of Home Affairs. (2018). The Multicultural Access and Equity Policy Guide

Department of Immigration and Citizenship. (2014). Community Information Summary

China-born [report]. https://www.dss.gov.au/our-responsibilities/settlement-services/programs-policy/a-multicultural-australia/programs-and-publications/community-information-summaries/the-china-born-community

Devon Partnership Trust and Torbay Care Trust. (2008). Putting recovery at the heart of all we do: What does this mean in practice? In.

Ding, M., & Xu, J. (2015). Social Circles. In *The Chinese way* Routledge. https://doi.org/https://doi-org.ezproxy.library.sydney.edu.au/10.4324/9781315818917

Dodd, R. H., Dadaczynski, K., Okan, O., McCaffery, K. J., & Pickles, K. (2021). Psychological Wellbeing and Academic Experience of University Students in Australia during COVID-19. *International Journal of Environmental Research and Public Health*, *18*(3), 866. https://www.mdpi.com/1660-4601/18/3/866

Dong, X., Chang, E. S., Wong, E., & Simon, M. (2012). Perception and negative effect of loneliness in a Chicago Chinese population of older adults. *Archives of Gerontology and Geriatrics*, *54*(1), 151-159. https://doi.org/https://doi.org/10.1016/j.archger.2011.04.022

Drake, R. E., & Whitley, R. (2014). Recovery and severe mental illness: description and analysis. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *59*(5), 236-242. https://doi.org/10.1177/070674371405900502

du Plooy, D. R., Lyons, A., & Kashima, E. S. (2019). Predictors of Flourishing and Psychological Distress Among Migrants to Australia: A Dual Continuum Approach. *Journal of Happiness Studies*, *20*(2), 561-578. https://doi.org/10.1007/s10902-018-9961-7

Ellison, M. L., Belanger, L. K., Niles, B. L., Evans, L. C., & Bauer, M. S. (2018). Explication and Definition of Mental Health Recovery: A Systematic Review. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(1), 91-102. https://doi.org/10.1007/s10488-016-0767-9

Embrace Multicultural Mental Health. (2014). Rationale: Why is cultural responsiveness important for mental health services? *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery* http://mental.dev-box.com.au/sites/default/files/framework/rationale_factsheet.pdf

Emmel, N. (2013). Purposeful Sampling. In *Sampling and Choosing Cases in Qualitative Research: A Realist Approach*. SAGE Publications Ltd. https://doi.org/10.4135/9781473913882

Emrich, L. (2018). *Recovery from psychosis: a mental health inpatient perspective* University of Essex].

Evans, G. W., Wells, N. M., Chan, H.-Y. E., & Saltzman, H. (2000). Housing Quality and Mental Health. *Journal of consulting and clinical psychology*, *68*(3), 526-530. https://doi.org/10.1037/0022-006X.68.3.526

Fardella, J. A. (2008). The Recovery Model: Discourse Ethics and the Retrieval of the Self. *Journal of Medical Humanities*, *29*(2), 111-126. https://doi.org/10.1007/s10912-008-9054-4

Fawcett, B., & Hearn, J. (2004). Researching others: epistemology, experience, standpoints and participation. *International Journal of Social Research Methodology*, *7*(3), 201-218. https://doi.org/10.1080/13645570210163989

Ferdinand, A. S., Paradies, Y., & Kelaher, M. (2015). Mental health impacts of racial discrimination in Australian culturally and linguistically diverse communities: a cross-sectional survey. *BMC Public Health*, *15*(1), 401. https://doi.org/10.1186/s12889-015-1661-1

Findlay, L. C., & Sunderland, A. (2014). Professional and informal mental health support reported by Canadians aged 15 to 24. *Health Reports*, *25*(12), 3-11.

Finlay, L. (2002). "Outing" the Researcher: The Provenance, Process, and Practice of Reflexivity. *12*(4), 531-545. https://doi.org/10.1177/104973202129120052

Finlay, L. (2003). The Reflexive Journey: Mapping Multiple Routes. In L. Finlay & B. Gough (Eds.), *Reflexivity: a Practical Guide for Researchers in Health and Social Sciences* (pp. 3-20). https://doi.org/10.1002/9780470776094.ch1

Flick, U. (2007a). Analyzing Qualitative Data. In *Designing Qualitative Research*. SAGE Publications, Ltd. https://doi.org/10.4135/9781849208826

Flick, U. (2007b). Ethics in Qualitative Research. In *Designing Qualitative Research*. SAGE Publications, Ltd. https://doi.org/10.4135/9781849208826

Flick, U. (2007c). Sampling, Selecting and Access. In *Designing Qualitative Research*. SAGE Publications, Ltd. https://doi.org/10.4135/9781849208826

Flick, U. (2011). What Is Qualitative Research? In I. Shaw & S. Holland (Eds.), *Designing Qualitative Research*. SAGE. https://doi.org/https://dx.doi.org/10.4135/9781849208826

Foo, K. H. (2019). *Intercultural parenting how Eastern and Western parenting styles affect child development*. Routledge.

Fook, J. (2003). Social work research in Australia. *Social Work Education*, *22*(1), 45-57. https://doi.org/10.1080/02615470309134

Fortune, A. E. (2013). *Qualitative research in social work*. Columbia University Press.

Foucault, M. (1967). *Madness and civilization : a history of insanity in the age of reason*. Tavistock.

Franklin, C. S., Cody, P. A., & Ballan, M. (2010). Reliability and Validity in Qualitative Research. In B. A. Thyer (Ed.), *The Handbook of Social Work Research Methods* (Second Edition ed.). SAGE Publications, Inc. https://doi.org/10.4135/9781544364902

Friedman, S. H., Stankowski, J., & Sajatovic, M. (2009). Health and Wellness. In S. Loue & M. Sajatovic (Eds.), *Determinants of Minority Mental Health and Wellness* (pp. 1-14). Springer New York. https://doi.org/10.1007/978-0-387-75659-2_1

Fullagar, S. (2017). Foucauldian theory In B. M. Z. Cohen (Ed.), *Routledge International Handbook of Critical Mental Health*. https://doi.org/10.4324/9781315399584.ch4

Fun Chan, Y., & Quine, S. (1997). Utilisation of Australian health care services by ethnic Chinese. *Australian Health Review*, *20*(1), 64-77. https://doi.org/https://doi.org/10.1071/AH970064

Fung, Y. (1997). Lived experiences of Chinese migrants with mental illness in Australia. In Behavioural & H. Social Sciences In (Eds.).

Furnham, A., & Li, Y. H. (1993). The Psychological Adjustment of the Chinese Community in Britain: A Study of Two Generations. *The British Journal of Psychiatry*, *162*(1), 109-113. https://doi.org/http://dx.doi.org/10.1192/bjp.162.1.109

Fyllos, A., Kanellopoulos, A., Kitixis, P., Cojocari, D.-V., Markou, A., Raoulis, V., Strimpakos, N., & Zibis, A. (2021). University students perception of online education: Is engagement enough? *Acta Informatica Medica*, *29*(1), 4.

Galbin, A. (2014). An introduction to social constructionism. *Social research reports*, *26*, 82.

Gale, J., & Thalitaya, M. D. (2015). Mental Health Support Service for University Students. *Psychiatria Danubina*, *27 Suppl 1*, S115-S119.

Galletta, A., & Cross, W. E. (2013). Ongoing and Iterative Data Analysis. In *Mastering the Semi-Structured Interview and Beyond* (pp. 119-146). NYU Press. http://www.jstor.org.ezproxy1.library.usyd.edu.au/stable/j.ctt9qgh5x.9

Gibbons, J., & Plath, D. (2009). Single Contacts with Hospital Social Workers: The Clients' Experiences. *Social Work in Health Care*, *48*(8), 721-735. https://doi.org/10.1080/00981380902928935

Glaser, D. (2011). How to deal with emotional abuse and neglect—Further development of a conceptual framework (FRAMEA). *Child Abuse & Neglect*, *35*(10), 866-875. https://doi.org/https://doi.org/10.1016/j.chiabu.2011.08.002

Goemans, R. (2012). A consideration of the nature and purpose of mental health social work. *Mental Health and Social Inclusion*, *16*(2), 90-96. https://doi.org/10.1108/20428301211232504

Good, B. J., & Good, M.-J. D. (1982). Toward a Meaning-Centered Analysis of Popular Illness Categories: “Fright Illness” and “Heart Distress” in Iran. In A. J. Marsella & G. M. White (Eds.), *Cultural Conceptions of Mental Health and Therapy* (pp. 141-166). Springer Netherlands. https://doi.org/10.1007/978-94-010-9220-3_5

Gooding, P. (2016). From deinstitutionalisation to consumer empowerment: mental health policy, neoliberal restructuring and the closure of the ‘Big bins’ in Victoria. *Health Sociology Review*, *25*(1), 33-47. https://doi.org/10.1080/14461242.2015.1134261

Gopalkrishnan, N. (2013). From covert to overt: The role of crisis in transforming racism.

Gopalkrishnan, N. (2018). Cultural Diversity and Mental Health: Considerations for Policy and Practice [Review]. *Frontiers in Public Health*, *6*. https://doi.org/10.3389/fpubh.2018.00179

Gough, B. (2003). Deconstructing Reflexivity. In L. Finlay & B. Gough (Eds.), *Reflexivity: a Practical Guide for Researchers in Health and Social Sciences* (pp. 21-35). https://doi.org/10.1002/9780470776094.ch2

Gould, N. (2016). Perspectives on mental health. In N. Gould (Ed.), *Mental health social work in context* (2nd ed.). Routledge. https://doi.org/10.4324/9781315695785

Green, G., Bradby, H., Chan, A., & Lee, M. (2006). “We are not completely Westernised”: Dual medical systems and pathways to health care among Chinese migrant women in England. *Social Science & Medicine*, *62*(6), 1498-1509. https://doi.org/https://doi.org/10.1016/j.socscimed.2005.08.014

Griffin, G. (2017). reflexivity. In: Oxford University Press.

Griffiths, K. M., Mendoza, J., & Carron-Arthur, B. (2015). Whereto mental health reform in Australia: is anyone listening to our independent auditors? *Medical Journal of Australia*, *202*(4), 172-174.

Gringeri, C., Barusch, A., & Cambron, C. (2013). Epistemology in Qualitative Social Work Research: A Review of Published Articles, 2008–2010. *Social Work Research*, *37*(1), 55-63. https://doi.org/10.1093/swr/svs032 %J Social Work Research

Guba, E. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *ECTJ*, *29*(2), 75-91. https://doi.org/10.1007/BF02766777

Gungwu, W. (2004). A single Chinese diaspora? . In (pp. 157-177). RoutledgeCurzon Taylor & Francis Group. https://doi.org/10.4324/9780203392515

Gwinner, K., Knox, M., & Brough, M. (2013). Making sense of mental illness as a full human experience: Perspective of illness and recovery held by people with a mental illness living in the community. *Social Work in Mental Health*, *11*(2), 99-117.

H. Richard Lamb, M.D. , and, & Leona L. Bachrach, Ph.D. (2001). Some Perspectives on Deinstitutionalization. *Psychiatric Services*, *52*(8), 1039-1045. https://doi.org/10.1176/appi.ps.52.8.1039

Han, Q. (2012). An overview of Traditional Chinese family ethics. *Quarterly Journal of Chinese Studies*.

Hansen, H., Stige, S. H., Davidson, L., Løberg, E.-M., & Veseth, M. (2019). "Needing different things from different people"–a qualitative exploration of recovery in first episode psychosis. 1-21.

Harris, T. J. R., Pistrang, N., & Barker, C. (2006). Couples' experiences of the support process in depression: A phenomenological analysis. *Psychology and Psychotherapy*, *79*, 1-21.

Harvey, L. (2020). Researching the Real World. www.qualityresearchinternational.com/methodology

Higgins, A. (2008). A recovery approach within the Irish mental health services: A framework for development.

Holosko, M. J. (2010). An Overview of Qualitative Research Methods. In B. A. Thyer (Ed.), *The Handbook of Social Work Research Methods* (Second Edition ed.). SAGE Publications, Inc. https://doi.org/10.4135/9781544364902

Holschuh, J., LeCroy, C. W., & Holschuh, J. (2012). *First Person Accounts of Mental Illness and Recovery*. John Wiley & Sons, Incorporated. http://ebookcentral.proquest.com/lib/usyd/detail.action?docID=995746

Holttum, S. (2012). Research watch: recovery as a personal journey: how mental health services are trying to support it. *Mental Health and Social Inclusion*, *16*(4), 169-174. https://doi.org/10.1108/20428301211281014

Hosseini, A., Kakuma, R., Ghazinour, M., Davern, M., Evans, W. P., & Minas, H. (2017). Migration experience, resilience and depression: a study of Iranian immigrants living in Australia. *International Journal of Culture and Mental Health*, *10*(1), 108-120. https://doi.org/10.1080/17542863.2016.1270977

Hsiao, F.-H., Klimidis, S., Minas, H., & Tan, E.-S. (2006a). Cultural attribution of mental health suffering in Chinese societies: the views of Chinese patients with mental illness and their caregivers. *Journal of clinical nursing*, *15*(8), 998-1006. https://doi.org/10.1111/j.1365-2702.2006.01331.x

Hsiao, F.-H., Klimidis, S., Minas, H. I., & Tan, E. S. (2006b). Folk concepts of mental disorders among Chinese-Australian patients and their caregivers. *Journal of advanced nursing*, *55*(1), 58-67. https://doi.org/10.1111/j.1365-2648.2006.03886.x

Hu, Y., & Scott, J. (2016). Family and Gender Values in China: Generational, Geographic, and Gender Differences. *Journal of family issues*, *37*(9), 1267-1293. https://doi.org/10.1177/0192513X14528710

Hutchinson, S. A., Wilson, M. E., & Wilson, H. S. (1994). Benefits of Participating in Research Interviews. *Image: the Journal of Nursing Scholarship*, *26*(2), 161-166. https://doi.org/https://doi.org/10.1111/j.1547-5069.1994.tb00937.x

Hwang, W.-C., Myers, H. F., Abe-Kim, J., & Ting, J. Y. (2008). A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model. *28*(2), 211-227.

Hyde, B., Bowles, W., & Pawar, M. (2015). 'We're Still in There'—Consumer Voices on Mental Health Inpatient Care: Social Work Research Highlighting Lessons for Recovery Practice. *British Journal of Social Work*, *45*(suppl1), i62-i78. https://doi.org/10.1093/bjsw/bcv093

Ip, D., Lui, C. W., & Chui, W. H. (2007). Veiled entrapment: a study of social isolation of older Chinese migrants in Brisbane, Queensland. *Ageing and Society*, *27*(5), 719-738. https://doi.org/10.1017/S0144686X07006083

Jacob, K. S. (2015). Recovery model of mental illness: a complementary approach to psychiatric care. *Indian journal of psychological medicine*, *37*(2), 117-119. https://doi.org/10.4103/0253-7176.155605

Jacob, S., Munro, I., & Taylor, B. J. (2015). Mental health recovery: lived experience of consumers, carers and nurses. *Contemporary nurse*, *50*(1), 1-13.

Jaeger, M., & Hoff, P. (2012). Recovery: conceptual and ethical aspects. *Current Opinion in Psychiatry*, *25*(6), 497-502. https://doi.org/10.1097/YCO.0b013e328359052f

Janoff-Bulman, R. (1979). Characterological versus behavioral self-blame: Inquiries into depression and rape. *Journal of personality and social psychology*, *37*(10), 1798-1809. https://doi.org/10.1037/0022-3514.37.10.1798

Jenny Secker , Helen Membrey , Bob Grove , & Seebohm, P. (2002). Recovering from Illness or Recovering your Life? Implications of Clinical Versus Social Models of Recovery from Mental Health Problems for Employment Support Services. *Disability & society.*, *17*(4), 403.

Joffe, H. (2012). *Thematic Analysis*. John Wiley & Sons.

Johnstone, L. (2006). The Limits of Biomedical Models of Distress. In D. B. Double (Ed.), *Critical Psychiatry: The Limits of Madness* (pp. 81-98). Palgrave Macmillan UK. https://doi.org/10.1057/9780230599192_5

Kalathil, J. (2014). An exploratory note on discrimination and race in relation to mental health in the west. *Medico Friend Circle Bulletin*, (357-360), 375–378.

Karban, K. (2016). Developing a health inequalities approach for mental health social work. *British Journal of Social Work*, *47*(3), 885-992.

Kaul, V. (2012). Globalisation and crisis of cultural identity. *Journal of Research in International Business and Management*, *2*(13), 341-349.

Kennedy, S., Kidd, M., McDonald, J., & Biddle, N. (2015). The Healthy Immigrant Effect: Patterns and Evidence from Four Countries. *Journal of International Migration and Integration*, *16*(2), 317-332. https://doi.org/10.1007/s12134-014-0340-x

Khatri, R. B., & Assefa, Y. (2022). Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges. *BMC Public Health*, *22*(1), 880. https://doi.org/10.1186/s12889-022-13256-z

Khawaja, N. G., McCarthy, R., Braddock, V., & Dunne, M. (2013). Characteristics of culturally and linguistically diverse mental health clients. *Advances in Mental Health*, *11*(2), 172-187. https://doi.org/10.5172/jamh.2013.11.2.172

Khoury, E., & Rodriguez del Barrio, L. (2015). Recovery-Oriented Mental Health Practice: A Social Work Perspective. *The British Journal of Social Work*, *45*(suppl_1), i27-i44. https://doi.org/10.1093/bjsw/bcv092

Kiely, K. M., Brady, B., & Byles, J. (2019). Gender, mental health and ageing. *Maturitas*, *129*, 76-84. https://doi.org/https://doi.org/10.1016/j.maturitas.2019.09.004

Kleinman, A. (1978). Clinical relevance of anthropological and cross-cultural research: concepts and strategies. *The American Journal of Psychiatry*.

Kleinman, A. M. (1977). Depression, somatization and the “new cross-cultural psychiatry”. *Social Science & Medicine (1967)*, *11*(1), 3-9.

Kleinman, A. M. D. (2004). Culture and Depression. *The New England Journal of Medicine*, *351*(10), 951-953.

Kokanovic, R., Petersen, A., & Klimidis, S. (2006a). 'Nobody Can Help Me...I am Living Through it Alone': Experiences of Caring for People Diagnosed with Mental Illness in Ethno-Cultural and Linguistic Minority Communities. *Journal of Immigrant and Minority Health*, *8*(2), 125-135. https://doi.org/http://dx.doi.org/10.1007/s10903-006-8521-0

Kokanovic, R., Petersen, A., & Klimidis, S. (2006b). ‘Nobody Can Help Me...I am Living Through it Alone’: Experiences of Caring for People Diagnosed with Mental Illness in Ethno-Cultural and Linguistic Minority Communities. *Journal of Immigrant and Minority Health*, *8*(2), 125-135. https://doi.org/10.1007/s10903-006-8521-0

Kolstad, A., & Gjesvik, N. (2014). Collectivism, individualism, and pragmatism in China: Implications for perceptions of mental health. *Transcultural Psychiatry*, *51*(2), 264-285. https://doi.org/10.1177/1363461514525220

Kung, W. W. (2016). CULTURE- AND IMMIGRATION-RELATED STRESS FACED BY CHINESE AMERICAN FAMILIES WITH A PATIENT HAVING SCHIZOPHRENIA. *Journal of Marital and Family Therapy*, *42*(3), 409-422. https://doi.org/http://dx.doi.org/10.1111/jmft.12145

Kunitoh, N. (2013). From hospital to the community: The influence of deinstitutionalization on discharged long-stay psychiatric patients. *Psychiatry and Clinical Neurosciences*, *67*(6), 384-396. https://doi.org/https://doi.org/10.1111/pcn.12071

Kuo, C.-L., & Kavanagh, K. H. (1994). Chinese Perspectives on Culture and Mental Health. *Issues in Mental Health Nursing*, *15*(6), 551-567. https://doi.org/10.3109/01612849409040533

Lam, J. S. H., Links, P. S., Eynan, R., Shera, W., Tsang, A. K. T., Law, S., Fung, W. L. A., Zhang, X., Liu, P., & Zaheer, J. (2022). "I thought that I had to be alive to repay my parents": Filial piety as a risk and protective factor for suicidal behavior in a qualitative study of Chinese women. *Transcultural Psychiatry*, *59*(1), 13-27. https://doi.org/10.1177/13634615211059708

Lane, P., Tribe, R., & Hui, R. (2010). Intersectionality and the Mental Health of Elderly Chinese Women Living in the UK. *International Journal of Migration, Health and Social Care*, *6*(4), 34-41. https://doi.org/10.5042/ijmhsc.2011.0152

Lauzier-Jobin, F., & Houle, J. (2021). A comparison of formal and informal help in the context of mental health recovery. *International Journal of Social Psychiatry*. https://doi.org/10.1177/00207640211004988

Law, S., Andermann, L., Chow, W., Luo, X. W., & Wang, X. (2021). Experiences of Family Burden in Caring for the Severely Mentally Ill in a Foreign Land: A Qualitative Study of Chinese Immigrant Families in Toronto, Canada. *Transcultural Psychiatry*, *58*(6), 745-758. https://doi.org/10.1177/13634615211000552

Lawrence, R. J. (2016). *Professional social work in Australia*. ANU Press.

Leamy , M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*(6), 445-452.

Leete, E. (1988). A consumer perspective on psychosocial treatment. *Psychosocial Rehabilitation Journal*, *12*(2), 45.

Leona L. Bachrach. (1978). A Conceptual Approach to Deinstitutionalization. *Psychiatric Services*, *29*(9), 573-578. https://doi.org/10.1176/ps.29.9.573

Leung, C. (2001). The psychological adaptation of overseas and migrant students in Australia. *International Journal of Psychology*, *36*(4), 251-259. https://doi.org/10.1080/00207590143000018

Leung, C. (2002). Factors Related to the Mental Health of Elderly Chinese Immigrants in Australia. *Australian Journal of Primary Health*, *8*(2), 48-53. https://doi.org/10.1071/PY02026

Li, S., Hatzidimitriadou, E., & Psoinos, M. (2014). "Tangled wires in the head": older migrant Chinese's perception of mental illness in Britain. *Journal of Aging Studies*, *30*, 73-86. https://doi.org/https://doi.org/10.1016/j.jaging.2014.04.001

Li, W. W., & Chong, M. D. (2012). Transnationalism, social wellbeing and older Chinese migrants. *Graduate journal of Asia-Pacific studies*, *8*(1), 29-44.

Liamputtong, P. (2019). Qualitative Inquiry. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences* (pp. 9-25). Springer Singapore. https://doi.org/10.1007/978-981-10-5251-4_53

Lian, Z., Wallace, B. C., & Fullilove, R. E. (2020). Mental Health Help-Seeking Intentions Among Chinese International Students in the U.S. Higher Education System: The Role of Coping Self-Efficacy, Social Support, and Stigma for Seeking Psychological

Help. *Asian American journal of psychology*, *11*(3), 147-157. https://doi.org/10.1037/aap0000183

Lichtman, M. (2014a). Drawing Meaning from the Data. In *Qualitative Research for the Social Sciences*. SAGE Publications, Inc. https://doi.org/10.4135/9781544307756

Lichtman, M. (2014b). Ethical Issues in Qualitative Research. In *Qualitative Research for the Social Sciences*. SAGE Publications, Inc. https://doi.org/10.4135/9781544307756

Lichtman, M. (2014c). Introduction. In *Qualitative Research for the Social Sciences*. SAGE Publications, Inc. https://doi.org/10.4135/9781544307756

Lichtman, M. (2014d). Judging the Research Process and Product. In *Qualitative Research for the Social Sciences*. SAGE Publications, Inc. https://doi.org/10.4135/9781544307756

Liddell, C., & Guiney, C. (2015). Living in a cold and damp home: frameworks for understanding impacts on mental well-being. *Public Health*, *129*(3), 191-199. https://doi.org/https://doi.org/10.1016/j.puhe.2014.11.007

Lietz, C., & Zayas, L. (2010). Evaluating Qualitative Research for Social Work Practitioners. *Advances in Social Work*, *11*(2), 188-202. https://doi.org/10.18060/589

Lietz, C. A., Langer, C. L., & Furman, R. (2006). Establishing Trustworthiness in Qualitative Research in Social Work:Implications from a Study Regarding Spirituality. *Qualitative Social Work*, *5*(4), 441-458. https://doi.org/10.1177/1473325006070288

Lin, X., Bryant, C., Boldero, J., & Dow, B. (2016). Psychological well-being of older Chinese immigrants living in Australia: a comparison with older Caucasians. *28*(10), 1671-1679.

Lin, X., Haralambous, B., Pachana, N. A., Bryant, C., LoGiudice, D., Goh, A., & Dow, B. (2016). Screening for depression and anxiety among older Chinese immigrants living in Western countries: The use of the Geriatric Depression Scale (GDS) and the Geriatric Anxiety Inventory (GAI). *8*(1), 32-43.

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Program Evaluation*, *1986*(30), 73-84. https://doi.org/10.1002/ev.1427

Litam, S. D. A. (2020). " Take Your Kung-Flu Back to Wuhan": Counseling Asians, Asian Americans, and Pacific Islanders with Race-Based Trauma Related to COVID-19. *Professional Counselor*, *10*(2), 144-156.

Liu, A. S. F. (2014). Voices of recovery: what helps in the recovery of people with lived experiences of mental disorder. *China Journal of Social Work*, *7*(1), 26-38. https://doi.org/10.1080/17525098.2014.882785

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

Liu, C. M. (2018). *The Impact of Individual and Parental Confucian Attitudes on Mental Illness Stigma and Help Seeking Attitudes among Asian Americans from Confucian Cultures* (Publication Number 10786730) [Ph.D., University of Massachusetts Boston]. ProQuest One Academic. Ann Arbor.

Lived Experience Workforce Program. (2016). NGO CALD MENTAL HEALTH LIVED EXPERIENCE WORKFORCE STANDARDS AND GUIDELINES: SELF ASSESSMENT TOOL. .

Loumpa, V. (2012). Promoting Recovery Through Peer Support: Possibilities for Social Work Practice. *Social Work in Health Care*, *51*(1), 53-65. https://doi.org/10.1080/00981389.2011.622667

Lu, S. H., Dear, B. F., Johnston, L., Wootton, B. M., & Titov, N. (2014). An internet survey of emotional health, treatment seeking and barriers to accessing mental health treatment among Chinese-speaking international students in Australia. *Counselling Psychology Quarterly*, *27*(1), 96-108. https://doi.org/10.1080/09515070.2013.824408

Ma, G. X. (1999). Between Two Worlds: The Use of Traditional and Western Health Services by Chinese Immigrants. *Journal of Community Health*, *24*(6), 421-437. https://doi.org/10.1023/A:1018742505785

Ma, H., & Miller, C. (2020). Trapped in a Double Bind: Chinese Overseas Student Anxiety during the COVID-19 Pandemic. *Health Communication*, 1-8. https://doi.org/10.1080/10410236.2020.1775439

Maeshima, L. S., & Parent, M. C. (2022). Mental health stigma and professional help-seeking behaviors among Asian American and Asian international students. *Journal of American College Health*, *70*(6), 1761-1767. https://doi.org/10.1080/07448481.2020.1819820

Maidment, J., Egan, R., & Wexler, J. (2011). Social work with older people from culturally and linguistically diverse backgrounds: Using research to inform practice [Other Journal Article]. *Aotearoa New Zealand Social Work*, *23*(3), 3-15.

Mak, A. S., & Chan, H. (1995). Chinese family values in Australia. In R. Hartley (Ed.), *Families and cultural diversity in Australia*. Allen & Unwin in association with the Australian Institute of Family Studies.

Malla, A., Joober, R., & Garcia, A. (2015). "Mental illness is like any other medical illness": a critical examination of the statement and its impact on patient care and society. *Journal of Psychiatry & Neuroscience : JPN*, *40*(3), 147-150.

Mannion, E. (1996). Resilience and Burden in Spouses of People with Mental Illness. *Psychiatric rehabilitation journal*, *20*(2), 13-23. https://doi.org/10.1037/h0095389

Marino, C. M. (2016). The Development and Validation of the Social Recovery Measure [dissertation and theses]. *Portland State University*. https://doi.org/10.15760/etd.2921

Marsella, A. J., & White, G. (2012). *Cultural conceptions of mental health and therapy* (Vol. 4). Springer Science & Business Media.

Marsella, A. J., & Yamada, A. M. (2000). Chapter 1 - Culture and Mental Health: An Introduction and Overview of Foundations, Concepts, and Issues. In I. Cuéllar & F. A. Paniagua (Eds.), *Handbook of Multicultural Mental Health* (pp. 3-24). Academic Press. https://doi.org/https://doi.org/10.1016/B978-012199370-2/50002-X

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice*, *13*(6), 522-526. https://doi.org/10.1093/fampra/13.6.522 %J Family Practice

Martin, F. (2020). *Chinese International Students' Wellbeing in Australia: The Road to Recovery*. http://hdl.handle.net/11343/240399

Martin, L. (2020). Foundations for Good Practice: The Student Experience of Online Learning in Australian Higher Education during the COVID-19 Pandemic. *Australian Government Tertiary Education Quality and Standards Agency*.

Martinez, N. M. (2010). *The influence of formal and informal support on the quality of life of individuals with a severe mental illness* (Publication Number 1492955) [M.S.W., California State University, Long Beach]. ProQuest One Academic. Ann Arbor.

McCabe, R., Whittington, R., Cramond, L., & Perkins, E. (2018). Contested understandings of recovery in mental health. *Journal of Mental Health*, *27*(5), 475-481. https://doi.org/10.1080/09638237.2018.1466037

Mcdermott, F., Meadows, G., Epstein, M., Olsen, A., & Fossey, E. (2012). Society, mental health and illness. In G. Meadows, J. Farhall, E. Fossey, M. Grigg, F. McDermott, & B. S. Singh (Eds.), *Mental Health in Australia : Collaborative Community Practice*. Oxford University Press. http://ebookcentral.proquest.com/lib/usyd/detail.action?docID=4389038

McKenna, S. (2007). Deconstructing a personal "academic"/"practitioner" narrative through self-reflexivity. *Qualitative Research in Organizations and Management*, *2*(2), 144-160. https://doi.org/http://dx.doi.org/10.1108/17465640710778539

McNally, R. J. (2011). *What Is Mental Illness?* Harvard University Press. http://ebookcentral.proquest.com/lib/usyd/detail.action?docID=3300897

Mead, S., & Copeland, M. (2000). What Recovery Means to Us: Consumers' Perspectives. *Community Mental Health Journal*, *36*(3), 315-328. https://doi.org/10.1023/A:1001917516869

Meeuwesen, L., & Ingleby, D. (2013). Beliefs about mental illness among Chinese in the west. *International Journal of Migration, Health, and Social Care*, *9*(3), 108-121. https://doi.org/10.1108/IJMHSC-07-2013-0020

Mental Health Coordinating Council. (2018). Recovery Oriented Language Guide - Second Edition Revised. In M. H. C. Council (Ed.).

Mental Health Coordinating Council. (2021). Mental Health Workforce Profile: Community Managed Organisations Mental Health Workforce Report 2021 NEW SOUTH WALES.

Mental Health in Multicultural Australia. (2014). Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery.

MHCC. (2018). Recovery oriented language guide - Second edition.

Minas, H. (2021). Mental Health of Chinese Immigrants in Australia. In H. Minas (Ed.), *Mental Health in China and the Chinese Diaspora: Historical and Cultural Perspectives* (pp. 225-243). Springer International Publishing. https://doi.org/10.1007/978-3-030-65161-9_16

Minas, H., Kakuma, R., San Too, L., Vayani, H., Orapeleng, S., Prasad-Ildes, R., Turner, G., Procter, N., & Oehm, D. (2013a). Mental health research and evaluation in multicultural Australia: developing a culture of inclusion. *International journal of mental health systems*, *7*(1), 23.

Minas, H., Kakuma, R., San Too, L., Vayani, H., Orapeleng, S., Prasad-Ildes, R., Turner, G., Procter, N., & Oehm, D. J. I. j. o. m. h. s. (2013b). Mental health research and evaluation in multicultural Australia: developing a culture of inclusion. *7*(1), 23.

Mlcek, S. (2013). Are We Doing Enough to Develop Cross-Cultural Competencies for Social Work? *The British Journal of Social Work*, *44*(7), 1984-2003. https://doi.org/10.1093/bjsw/bct044

Moodley, R., Mujtaba, F., & Kleiman, S. (2017). Critical race theory and mental health. In B. M. Z. Cohen (Ed.), *Routledge International Handbook of Critical Mental Health*. https://doi.org/10.4324/9781315399584.ch9

Morley, C. (2003). Towards Critical Social Work Practice in Mental Health. *Journal of Progressive Human Services*, *14*(1), 61-84. https://doi.org/10.1300/J059v14n01_05

Morris, A. (2015). *A practical introduction to in-depth interviewing*. Sage.

Morrow, M., & Weisser, J. (2012). Towards a Social Justice Framework of Mental Health Recovery. *Studies in social justice*, *6*(1), 27-43. https://doi.org/10.26522/ssj.v6i1.1067

Mui, A. C., & Kang, S.-Y. (2006). Acculturation Stress and Depression among Asian Immigrant Elders. *Social work (New York)*, *51*(3), 243-255. https://doi.org/10.1093/sw/51.3.243

Mulvany, J. (2000). Disability, impairment or illness? The relevance of the social model of disability to the study of mental disorder. *Sociology of Health & Illness*, *22*(5), 582-601. https://doi.org/https://doi.org/10.1111/1467-9566.00221

Na, S., Ryder, A. G., & Kirmayer, L. J. (2016). Toward a Culturally Responsive Model of Mental Health Literacy: Facilitating Help-Seeking Among East Asian Immigrants to North America. *American Journal of Community Psychology*, *58*(1-2), 211-225. https://doi.org/https://doi.org/10.1002/ajcp.12085

Nadal, K. L., Wong, Y., Sriken, J., Griffin, K., & Fujii-Doe, W. (2015). Racial Microaggressions and Asian Americans: An Exploratory Study on Within-Group Differences and Mental Health. *Asian American journal of psychology*, *6*(2), 136-144. https://doi.org/10.1037/a0038058

Naragon-Gainey, K., & Watson, D. (2012). Personality, Structure. In V. S. Ramachandran (Ed.), *Encyclopedia of Human Behavior (Second Edition)* (pp. 90-95). Academic Press. https://doi.org/https://doi.org/10.1016/B978-0-12-375000-6.00275-5

NASW. (2017). Code of Ethics.

Nathan, S., Newman, C., & Lancaster, K. (2019). Qualitative Interviewing. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences* (pp. 391-410). Springer Singapore. https://doi.org/10.1007/978-981-10-5251-4_77

Neufeld, A., Harrison, M. J., Stewart, M. J., Hughes, K. D., & Spitzer, D. (2002). Immigrant Women: Making Connections to Community Resources for Support in Family Caregiving. *Qualitative Health Research*, *12*(6), 751-768. https://doi.org/10.1177/104973230201200603

Ng, C. H. (1997). The Stigma of Mental Illness in Asian Cultures. *Australian and New Zealand Journal of Psychiatry*. https://doi.org/10.3109/00048679709073848

Ng, S. M., Chan, C. L. W., Leung, P. P. Y., Chan, C. H. Y., & Yau, J. K. Y. (2008). Beyond Survivorship: Achieving a Harmonious Dynamic Equilibrium Using a Chinese Medicine Framework in Health and Mental Health. *Social Work in Mental Health*, *7*(1-3), 62-81. https://doi.org/10.1080/15332980802072405

Niaz, U., & Hassan, S. (2006). Culture and mental health of women in South-East Asia. *World Psychiatry*, *5*(2), 118.

Noble-Carr, D., & Woodman, E. (2018). Considering Identity and Meaning Constructions for Vulnerable Young People. *Journal of Adolescent Research*, *33*(6), 672-698. https://doi.org/10.1177/0743558416684952

Noh, S., Kaspar, V., & Wickrama, K. A. S. (2007). Overt and subtle racial discrimination and mental health: preliminary findings for Korean immigrants. *American Journal of Public Health*, *97*(7), 1269-1274. https://doi.org/10.2105/AJPH.2005.085316

Nora Jacobson, Ph.D. , and, & Dianne Greenley, M.S.W., J.D. (2001). What Is Recovery? A Conceptual Model and Explication. *Psychiatric Services*, *52*(4), 482-485. https://doi.org/10.1176/appi.ps.52.4.482

NSW Mental Health Commission. (2014). Living Well: A Strategic Plan for Mental Health in NSW 2014-2024.

Nurser, K. P., Rushworth, I., Shakespeare, T., & Williams, D. (2018). Personal storytelling in mental health recovery. *The Mental Health Review*, *23*(1), 25-36. https://doi.org/10.1108/MHRJ-08-2017-0034

O’Donnell, A., & Shaw, M. (2016). Resilience and resistance on the road to recovery in mental health. *Concept*, *7*(1), 18-18.

Oka, T., & Shaw, I. (2003). Qualitative Research in Social Work. In. https://doi.org/10.13140/2.1.2794.4641

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: a review of the literature. *Psychiatric rehabilitation journal*, *31*(1), 9-22. https://doi.org/10.2975/31.1.2007.9.22

Oomens, P. C. J. (2005). *The social context of mental illness. Individual, partner and parental resources*. [Sl: sn].

Padgett, D. (2008). *Qualitative methods in social work research* (2nd ed. ed.). Sage Publications.

Paluska, S. A., & Schwenk, T. L. (2000). Physical Activity and Mental Health. *Sports Medicine*, *29*(3), 167-180. https://doi.org/10.2165/00007256-200029030-00003

Pan, J.-Y., & Keung Wong, D. F. (2011). Acculturative Stressors and Acculturative Strategies as Predictors of Negative Affect Among Chinese International Students in Australia and Hong Kong: A Cross-Cultural Comparative Study. *Academic Psychiatry*, *35*(6), 376-381. https://doi.org/10.1176/appi.ap.35.6.376

Parker, G., Chan, B., Tully, L., & Eisenbruch, M. (2005). Depression in the Chinese: the impact of acculturation. *Psychological Medicine*, *35*(10), 1475-1483. https://doi.org/http://dx.doi.org/10.1017/S0033291705005623

Parker, G., Gladstone, G., & Chee, K. T. (2001). Depression in the Planet's Largest Ethnic Group: The Chinese. *The American Journal of Psychiatry*, *158*(6), 857-864. https://doi.org/10.1176/appi.ajp.158.6.857

Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and practice*. Sage publications.

Patton, M. Q. (2015). *Qualitative research & evaluation methods : integrating theory and practice* (Fourth edition. ed.). SAGE Publications, Inc.

Paxton, R. J., Motl, R. W., Aylward, A., & Nigg, C. R. (2010). Physical Activity and Quality of Life-The Complementary Influence of Self-Efficacy for Physical Activity and Mental Health Difficulties. *International Journal of Behavioral Medicine*, *17*(4), 255-263.

Peterson, C., Schwartz, S. M., & Seligman, M. E. (1981). Self-blame and depressive symptoms. *Journal of personality and social psychology*, *41*(2), 253-259. https://doi.org/10.1037//0022-3514.41.2.253

Piat, M. (1992). DEINSTITUTIONALIZATION OF THE MENTALLY ILL: Theory, Policy, and Practice. *Canadian Social Work Review / Revue canadienne de service social*, *9*(2), 201-213. http://www.jstor.org/stable/41669491

Pincus, H. A., Spaeth-Rublee, B., Sara, G., Goldner, E. M., Prince, P. N., Ramanuj, P., Gaebel, W., Zielasek, J., Großimlinghaus, I., Wrigley, M., van Weeghel, J., Smith, M., Ruud, T., Mitchell, J. R., & Patton, L. (2016). A review of mental health recovery programs in selected industrialized countries. *International journal of mental health systems*, *10*(1), 73. https://doi.org/10.1186/s13033-016-0104-4

Poduthase, H. (2015). Rigor in Qualitative research: Promoting quality in Social Science Research. *Research Journal of Recent Sciences*, *4*, 25-28.

Poon, A. W. C., Cassaniti, M., Sapucci, M., & Ow, R. (2021). Wellbeing and experiences of Chinese and Vietnamese carers of people with mental illness in Australia. *Transcultural Psychiatry*, *58*(3), 351-364. https://doi.org/10.1177/1363461520952629

Poon, A. W. C., & Lee, J.-S. (2019). Carers of People with Mental Illness from Culturally and Linguistically Diverse Communities. *Australian Social Work*, 1-13.

Poon, W. C., Joubert, L., & Harvey, C. (2013). Experiences of Chinese Migrants Caring for Family Members With Schizophrenia in Australia. *Social Work in Health Care*, *52*(2-3), 144-165. https://doi.org/10.1080/00981389.2012.737907

Price, M. (2013). Defining mental disability. *The disability studies reader*, *4*, 292-299.

Price-Robertson, R., Obradovic, A., & Morgan, B. (2017). Relational recovery: beyond individualism in the recovery approach. *Advances in Mental Health*, *15*(2), 108-120.

Provencher, H. L., & Keyes, C. L. M. (2011). Complete mental health recovery: bridging mental illness with positive mental health. *Journal of Public Mental Health*, *10*(1), 57-69. https://doi.org/https://doi.org/10.1108/17465721111134556

Ramon, S., Healy, B., & Renouf, N. (2007). Recovery from Mental Illness as an Emergent Concept and Practice in Australia and the UK. *International Journal of Social Psychiatry*, *53*(2), 108-122. https://doi.org/10.1177/0020764006075018

Rapley, T. (2013). Sampling Strategies in Qualitative Research. In U. Flick (Ed.), *The SAGE Handbook of Qualitative Data Analysis*. SAGE Publications. http://ebookcentral.proquest.com/lib/usyd/detail.action?docID=1707694

Rawnsley, M. M. (1998). Ontology, Epistemology, and Methodology: A Clarification. *11*(1), 2-4. https://doi.org/10.1177/089431849801100102

Rawsthorne, M. L. (2009). Just Like Other Families? Supporting Lesbian-parented Families. *Australian Social Work*, *62*(1), 45-60. https://doi.org/10.1080/03124070802626885

Read, J., & Dillon, J. (2013). Creating evidencebased, effective and humane mental health services: Overcoming barriers to a paradigm shift. In J. Read & J. Dillon (Eds.), *Models of madness psychological, social and biological approaches to psychosis* (Second edition. ed.). Routledge.

Reamer, F. G. (2010). Ethical Issues in Social Work Research. In B. A. Thyer (Ed.), *The Handbook of Social Work Research Methods* (Second Edition ed.). SAGE Publications, Inc. https://doi.org/10.4135/9781544364902

Reamer, F. G. (2013). Ethics in Qualitative Research. In A. Fortune, W. J. Reid, & J. R. Miller (Eds.), *Qualitative Research in Social Work*. Columbia University Press. http://ebookcentral.proquest.com/lib/usyd/detail.action?docID=1103411

Reavey, P., Cromby, J., & Harper, D. (2013). *Psychology, Mental Health and Distress*.

Repper, J. (2003). *Social inclusion and recovery : a model for mental health practice*. Baillière Tindall.

Ridgway, P. (2001). ReStorying Psychiatric Disability: Learning from First Person Recovery Narratives. *Psychiatric rehabilitation journal*, *24*(4), 335-343. https://doi.org/10.1037/h0095071

Rohner, R. P., & Rohner, E. C. (1980). Antecedents and consequences of parental rejection: A theory of emotional abuse. *Child Abuse & Neglect*, *4*(3), 189-198. https://doi.org/https://doi.org/10.1016/0145-2134(80)90007-1

Rosen, A. (2006). The Australian experience of deinstitutionalization: interaction of Australian culture with the development and reform of its mental health services. *Acta Psychiatrica Scandinavica*, *113*(s429), 81-89. https://doi.org/https://doi.org/10.1111/j.1600-0447.2005.00723.x

Rubin, H. J., & Rubin, I. S. (2005). The First Phase of Analysis: Preparing Transcripts and Coding Data. In *Qualitative Interviewing (2nd ed.): The Art of Hearing Data* (2nd ed.). SAGE Publications, Inc. https://doi.org/10.4135/9781452226651

Saldaña, J. (2011). *Fundamentals of qualitative research*. Oxford University Press.

Samaha, A. M. (2007). What Good Is the Social Model of Disability? *The University of Chicago Law Review*, *74*(4), 1251-1308. https://doi.org/10.2307/20141862

Shaw, I., & Holland, S. (2014a). Ethics in Qualitative Research. In *Doing Qualitative Research in Social Work*. SAGE Publications, Ltd. https://doi.org/10.4135/9781473906006

Shaw, I., & Holland, S. (2014b). Qualitative Research and the Social Work Context. In I. Shaw & S. Holland (Eds.), *Doing Qualitative Research in Social Work*. SAGE.

Siegenthaler, K. L. (1996, 1996/01//). Leisure and the elderly. *Parks & Recreation*, *31*(1), 18+. https://link.gale.com/apps/doc/A17853667/ITOF?u=usyd&sid=bookmark-ITOF&xid=1b738611

Singh, A., Daniel, L., Baker, E., & Bentley, R. (2019). Housing Disadvantage and Poor Mental Health: A Systematic Review. *American Journal of Preventive Medicine*, *57*(2), 262-272. https://doi.org/https://doi.org/10.1016/j.amepre.2019.03.018

Sjöström, S. (2017). Labelling theory In B. M. Z. Cohen (Ed.), *Routledge International Handbook of Critical Mental Health*. https://doi.org/10.4324/9781315399584.ch1

Slade, M. (2009). The contribution of mental health services to recovery. *Journal of Mental Health*, *18*(5), 367-371. https://doi.org/10.3109/09638230903191256

Slade, M. (2010). Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC Health Services Research*, *10*(1), 26-26. https://doi.org/10.1186/1472-6963-10-26

Slade, M., Amering, M., Farkas, M., Hamilton, B., O' Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, *13*(1), 12-20. https://doi.org/10.1002/wps.20084

Slade, M., Amering, M., & Oades, L. (2008). Recovery: an international perspective. *Epidemiologia e Psichiatria Sociale*, *17*(2), 128-137. https://doi.org/10.1017/S1121189X00002827

Slade, M., Leamy, M., Bacon, F., Janosik, M., Le Boutillier, C., Williams, J., & Bird, V. (2012). International differences in understanding recovery: systematic review. *Epidemiol Psychiatr Sci*, *21*(04), 353-364.

Slade, M., & Longden, E. (2015). Empirical evidence about recovery and mental health. *15*(1), 285.

Sniderman, P. M., Piazza, T., Tetlock, P. E., & Kendrick, A. (1991). The New Racism. *American Journal of Political Science*, *35*(2), 423-447. https://doi.org/10.2307/2111369

Sofaer, S. (1999). Qualitative Methods: What Are They and Why Use Them? *Health Services Research*, *34*(5), 1101.

Spector, R. (2002). Cultural diversity in health and illness. *Journal of Transcultural Nursing*, *13*(3), 197-199.

Spencer, M. S., & Chen, J. (2004). Effect of Discrimination on Mental Health Service Utilization Among Chinese Americans. *American Journal of Public Health*, *94*(5), 809-814. https://doi.org/10.2105/ajph.94.5.809

Starnino, V. R. (2009). An Integral Approach to Mental Health Recovery: Implications for Social Work. *Journal of Human Behavior in the Social Environment*, *19*(7), 820-842. https://doi.org/10.1080/10911350902988019

Stefanac, N., Hetrick, S., Hulbert, C., Spittal, M. J., Witt, K., & Robinson, J. (2019). Are young female suicides increasing? A comparison of sex-specific rates and characteristics of youth suicides in Australia over 2004–2014. *BMC Public Health*, *19*(1), 1389. https://doi.org/10.1186/s12889-019-7742-9

Strickland, C. M., & Patrick, C. J. (2015). Biomedical Model. In *The Encyclopedia of Clinical Psychology* (pp. 1-3). https://doi.org/https://doi.org/10.1002/9781118625392.wbecp476

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: implications for clinical practice. *American psychologist*, *62*(4), 271.

Tabora, B. L., & Flaskerud, J. H. (1997). Mental Health Beliefs, Practices, and Knowledge of Chinese American Immigrant Women. *Issues in Mental Health Nursing*, *18*(3), 173-189. https://doi.org/10.3109/01612849709012488

Takacs, D. (2003). How does your positionality bias your epistemology?

Tan, X., Lee, R., & Ruppanner, L. (2021). Profiling racial prejudice during COVID-19: Who exhibits anti-Asian sentiment in Australia and the United States? *Australian Journal of Social Issues*, *n/a*(n/a). https://doi.org/https://doi.org/10.1002/ajs4.176

Tang, G. W.-G., Dennis, S., Comino, E., & Zwar, N. (2009). Anxiety and Depression in Chinese Patients Attending an Australian GP Clinic. *Australian family physician*, *38*(7), 552-555.

Tang, L. (2016). Barriers to recovery for Chinese mental health service-users in the UK: a case for community development. *Community Development Journal*, *53*(2), 358-374.

Tang, L. (2017). *Recovery, Mental Health and Inequality : Chinese Ethnic Minorities as Mental Health Service Users* (First edition. ed.). Taylor and Francis. https://doi.org/10.4324/9781315725086

Tang, L. (2019a). The double hazard in recovery journey: The experiences of UK Chinese users of mental health services. *International Journal of Social Psychiatry*, *65*(4), 271-278. https://doi.org/10.1177/0020764019840059

Tang, L. (2019b). Recovery, Hope and Agency: The Meaning of Hope amongst Chinese Users of Mental Health Services in the UK. *The British Journal of Social Work*, *49*(2), 282-299. https://doi.org/10.1093/bjsw/bcy033

Tang, L., & Pilgrim, D. (2017). Intersectionality, mental health and Chinese people in the UK: a qualitative exploration. *Mental health review journal*, *22*(4), 289-299. https://doi.org/10.1108/MHRJ-03-2017-0014

Tang, T. N., Oatley, K., & Toner, B. B. (2007). Impact of Life Events and Difficulties on the Mental Health of Chinese Immigrant Women. *Journal of Immigrant and Minority Health*, *9*(4), 281-290. https://doi.org/10.1007/s10903-007-9042-1

Taylor, C. B., Sallis, J. F., & Needle, R. (1985). The Relation of Physical Activity and Exercise to Mental Health. *Public health reports (1974)*, *100*(2), 195-202.

Tew, J. (2002). Going social: Championing a holistic model of mental distress within professional education. *Social Work Education*, *21*(2), 143-155. https://doi.org/10.1080/02615470220126390

Tew, J. (2004a). Core Themes of Social Perspectives. In *Social perspectives in mental health : Developing social models to understand and work with mental distress* (pp. 13-31). Jessica Kingsley Publishers. http://ebookcentral.proquest.com/lib/usyd/detail.action?docID=290651

Tew, J. (2004b). Social Perspectives Towards a Framework for Practice. In J. Tew (Ed.), *Social perspectives in mental health: Developing social models to understand and work with mental distress* (pp. 216-227). Jessica Kingsley Publishers.

Tew, J. (2013). Recovery capital: what enables a sustainable recovery from mental health difficulties? *European Journal of Social Work*, *16*(3), 360-374. https://doi.org/10.1080/13691457.2012.687713

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: a review of the evidence. *The British Journal of Social Work*, *42*(3), 443-460.

Tieu, Y., & Konnert, C. A. (2014). Mental health help-seeking attitudes, utilization, and intentions among older Chinese immigrants in Canada. *Aging & Mental Health*, *18*(2), 140-147. https://doi.org/10.1080/13607863.2013.814104

Tilghman-Osborne, C., Cole, D. A., Felton, J. W., & Ciesla, J. A. (2008). RELATION OF GUILT, SHAME, BEHAVIORAL AND CHARACTEROLOGICAL SELF-BLAME TO DEPRESSIVE SYMPTOMS IN ADOLESCENTS OVER TIME. *Journal of Social and Clinical Psychology*, *27*(8), 809-842. https://doi.org/http://dx.doi.org/10.1521/jscp.2008.27.8.809

Timander, A.-C., Grinyer, A., & Möller, A. (2015). The study of mental distress and the (re)construction of identities in men and women with experience of long-term mental distress. *Disability & Society*, *30*(3), 327-339. https://doi.org/10.1080/09687599.2014.999911

Timimi, S. (2017). Critical cultural theory. In B. M. Z. Cohen (Ed.), *Routledge International Handbook of Critical Mental Health*. https://doi.org/10.4324/9781315399584.ch6

Tobert, N., & Cornwall, M. (2016). *Cultural Perspectives on Mental Wellbeing : Spiritual Interpretations of Symptoms in Medical Practice*. Jessica Kingsley Publishers. http://ebookcentral.proquest.com/lib/usyd/detail.action?docID=4653287

Tooth, B., Kalyanasundaram, V., Glover, H., & Momenzadah, S. (2003). Factors Consumers Identify as Important to Recovery from Schizophrenia. *Australasian Psychiatry*, *11*(1_suppl), S70-S77. https://doi.org/10.1046/j.1440-1665.11.s1.1.x

Topor, A. (2001). *Managing the contradictions: Recovery from severe mental disorders* Department of Social Work, Stockholm University].

Topor, A., Borg, M., Di Girolamo, S., & Davidson, L. (2011). Not Just an Individual Journey: Social Aspects of Recovery. *International Journal of Social Psychiatry*, *57*(1), 90-99. https://doi.org/10.1177/0020764009345062

Traianou, A. (2014). The Centrality of Ethics in Qualitative Research. In P. Leavy (Ed.), *The Oxford Handbook of Qualitative Research*. Oxford University Press, Incorporated. http://ebookcentral.proquest.com/lib/usyd/detail.action?docID=1657789

Tse, S. (2004). Use of the Recovery Approach to Support Chinese Immigrants Recovering from Mental Illness: A New Zealand Perspective. *American journal of psychiatric rehabilitation*, *7*(1), 53-68. https://doi.org/10.1080/15487760490464997

Tuli, F. (2010). The basis of distinction between qualitative and quantitative research in social science: Reflection on ontological, epistemological and methodological perspectives. *Ethiopian Journal of Education and Sciences*, *6*(1).

Turner, T. (2004). The history of deinstitutionalization and reinstitutionalization. *Psychiatry*, *3*(9), 1-4. https://doi.org/https://doi.org/10.1383/psyt.3.9.1.50257

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the surgeon general*. US Department of Health and Human Services.

Ussher, J. M. (2017). A critical feminist analysis of madness: Pathologising femininity through psychiatric discourse. In B. M. Z. Cohen (Ed.), *Routledge International Handbook of Critical Mental Health*. https://doi.org/10.4324/9781315399584.ch8

Uygur, H., Yi, T., & Miao, M. (2011). Chinese Australians. *Population*, *71*, 1.

Walker, M. T. (2006). The social construction of mental illness and its implications for the recovery model. *International Journal of Psychosocial Rehabilitation*, *10*(1), 71-87.

Wallcraft, J. (2004). Recovery from mental breakdown or illness. In J. Tew (Ed.), *Social Perspectives in Mental Health : Developing Social Models to Understand and Work with Mental Distress* (pp. 242). Jessica Kingsley Publishers.

Walter, M., Taylor, S., & Habibis, D. (2011). How White is Social Work in Australia? *Australian Social Work*, *64*(1), 6-19. https://doi.org/10.1080/0312407X.2010.510892

Warner, R. (2009). Recovery from schizophrenia and the recovery model. *Current Opinion in Psychiatry*, *22*(4), 374-380. https://doi.org/10.1097/YCO.0b013e32832c920b

Weng, E., Halafoff, A., Barton, G., & Smith, G. (2021). Higher Education, Exclusion, and Belonging: Religious Complexity, Coping and Connectedness Among International Students During the COVID-19 Pandemic in Australia. *Journal of International Students*, *11*(S2), 38-57.

Weng, S. S., & Spaulding-Givens, J. (2017). Informal Mental Health Support in the Asian American Community and Culturally Appropriate Strategies for Community-Based Mental Health Organizations. *Human Service Organizations: Management, Leadership & Governance*, *41*(2), 119-132. https://doi.org/10.1080/23303131.2016.1218810

What is 'Guanxi'? Understanding reciprocity in Chinese culture. (n.d.). http://www.business-circle.com.au/en/?p=3218

White, K. (2017). The social construction of mental illness In B. M. Z. Cohen (Ed.), *Routledge International Handbook of Critical Mental Health*. https://doi.org/10.4324/9781315399584.ch2

Wilber, K. (2001). *Sex, ecology, spirituality: The spirit of evolution*. Shambhala Publications.

Wilhelm, K. A. (2014). Gender and mental health. *Australian & New Zealand Journal of Psychiatry*, *48*(7), 603-605. https://doi.org/10.1177/0004867414538678

Wilkinson, S. (1988). The role of reflexivity in feminist psychology. *Women's Studies International Forum*, *11*(5), 493-502. https://doi.org/https://doi.org/10.1016/0277-5395(88)90024-6

Wolgemuth, J. R., Erdil-Moody, Z., Opsal, T., Cross, J. E., Kaanta, T., Dickmann, E. M., & Colomer, S. (2015). Participants' experiences of the qualitative interview: considering the importance of research paradigms. *Qualitative research : QR*, *15*(3), 351-372. https://doi.org/10.1177/1468794114524222

Wong, D. F. K., Cheng, C.-W., Zhuang, X. Y., Ng, T. K., Pan, S.-M., He, X., & Poon, A. (2017). Comparing the mental health literacy of Chinese people in Australia, China, Hong Kong and Taiwan: Implications for mental health promotion. *Psychiatry Research*, *256*, 258-266. https://doi.org/10.1016/j.psychres.2017.06.032

Wong, D. F. K., Lam, A. Y. K., Poon, A., & Chow, A. Y. M. (2012). Gender differences in mental health literacy among Chinese-speaking Australians in Melbourne, Australia. *International Journal of Social Psychiatry*, *58*(2), 178-185. https://doi.org/10.1177/0020764010390431

Wong, F. K. D., Lam, Y. K. A., & Poon, A. (2010). Depression literacy among Australians of Chinese-speaking background in Melbourne, Australia. *BMC Psychiatry*, *10*(1), 7. https://doi.org/10.1186/1471-244X-10-7

Woodward, K. (2018). Concepts of identity and difference. In Sheila Watson, Amy Jane Barnes, & K. Bunning (Eds.), *A Museum Studies Approach to Heritage*. Routledge.

Wright, B., & Van Der Watt, G. (2010). Transcultural or Multicultural: What best defines our work? *Advances in Mental Health*, *9*(3), 215-218. https://doi.org/10.5172/jamh.9.3.215

Wu, C., Qian, Y., & Wilkes, R. (2021). Anti-Asian discrimination and the Asian-white mental health gap during COVID-19. *Ethnic and Racial Studies*, *44*(5), 819-835. https://doi.org/10.1080/01419870.2020.1851739

Wu, D. Y. H. (1982). Psychotherapy and Emotion in Traditional Chinese Medicine. In A. J. Marsella & G. M. White (Eds.), *Cultural Conceptions of Mental Health and Therapy* (pp. 285-301). Springer Netherlands. https://doi.org/10.1007/978-94-010-9220-3_12

Yang, L. H., Chen, F.-p., Sia, K. J., Lam, J., Lam, K., Ngo, H., Lee, S., Kleinman, A., & Good, B. (2014). “What matters most:” A cultural mechanism moderating structural vulnerability and moral experience of mental illness stigma. *Social Science & Medicine*, *103*, 84-93. https://doi.org/https://doi.org/10.1016/j.socscimed.2013.09.009

Yang, L. H., & Wonpat-borja, A. J. (2012). Causal Beliefs and Effects upon Mental Illness Identification Among Chinese Immigrant Relatives of Individuals with Psychosis. *Community Mental Health Journal*, *48*(4), 471-476. https://doi.org/http://dx.doi.org/10.1007/s10597-011-9464-z

Yip, K.-s. (2003). Traditional Confucian Concepts of Mental Health: Its Implications to Social Work Practice with Chinese Communities. *Asia Pacific Journal of Social Work and Development*, *13*(2), 65-89. https://doi.org/10.1080/21650993.2003.9755929

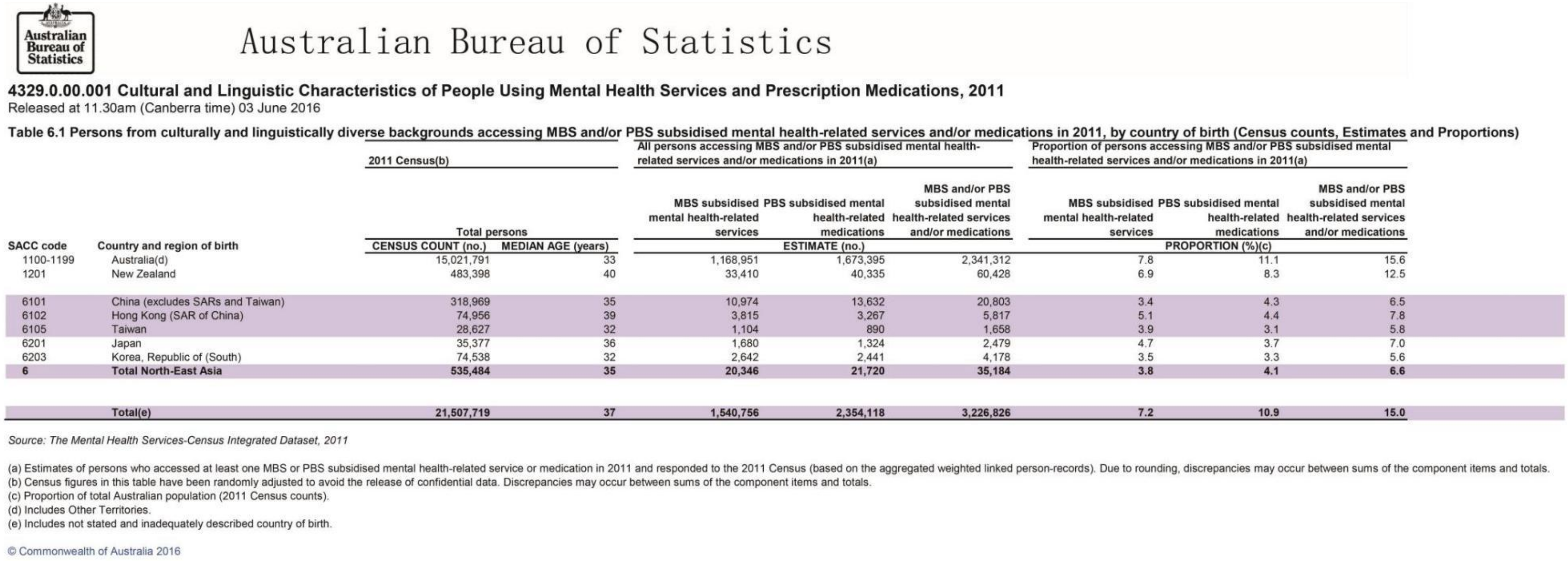
Yip, K.-s. (2004). Taoism and its impact on mental health of the Chinese communities. *Int J Soc Psychiatry*, *50*(1), 25-42. https://doi.org/10.1177/0020764004038758

Yip, K.-s. (2016). Chinese concepts of mental health. *International Social Work*, *48*(4), 391-407. https://doi.org/10.1177/0020872805053462

Zhang, Q., Gage, J., & Barnett, P. (2013). Health provider perspectives on mental health service provision for Chinese people living in Christchurch, New Zealand. *Shanghai archives of psychiatry*, *25*(6), 375. https://doi.org/10.3969/j.issn.1002-0829.2013.06.006

Appendices

Appendix 1 People from Chinese cultural backgrounds accessing formal mental health services and medications in 2011, by country of birth (with some unrelated data deleted, please see the full appendix in another attachment files).



Australian Bureau of Statistics

4329.0.00.001 Cultural and Linguistic Characteristics of People Using Mental Health Services and Prescription Medications, 2011

Released at 11.30am (Canberra time) 03 June 2016

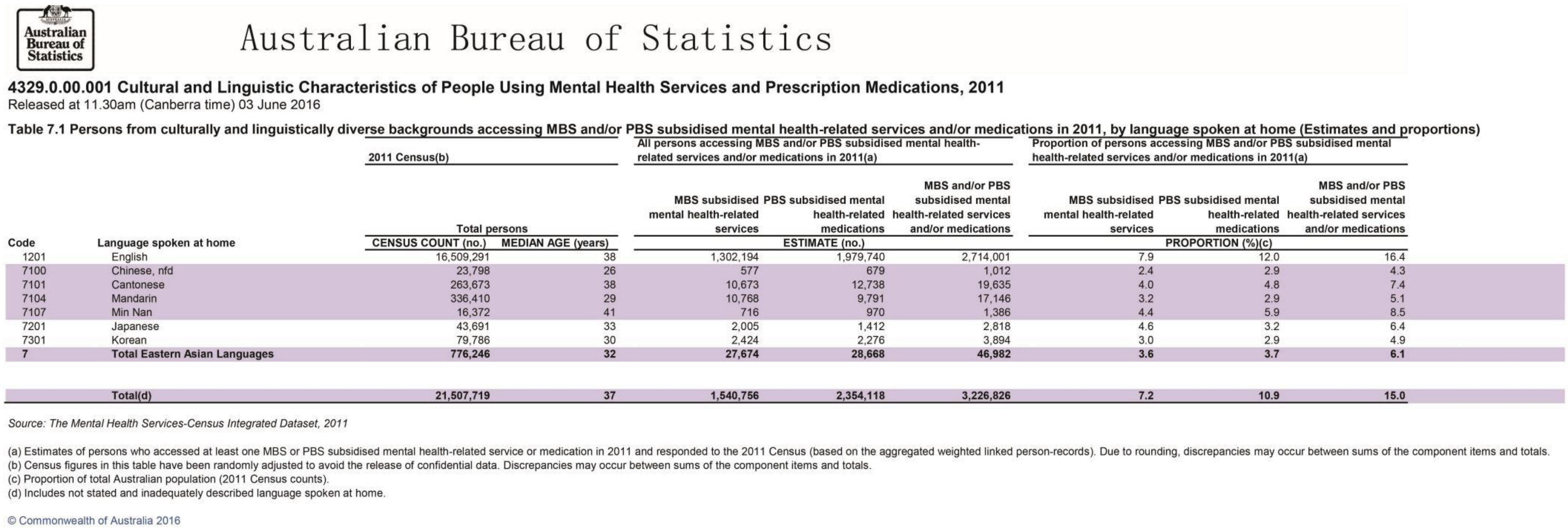
Table 6.1 Persons from culturally and linguistically diverse backgrounds accessing MBS and/or PBS subsidised mental health-related services and/or medications in 2011, by country of birth (Census counts, Estimates and Proportions)

		2011 Census(b)		All persons accessing MBS and/or PBS subsidised mental health-related services and/or medications in 2011(a)			Proportion of persons accessing MBS and/or PBS subsidised mental health-related services and/or medications in 2011(a)		
		Total persons		MBS subsidised mental health-related services	PBS subsidised mental health-related medications	MBS and/or PBS subsidised mental health-related services and/or medications	MBS subsidised mental health-related services	PBS subsidised mental health-related medications	MBS and/or PBS subsidised mental health-related services and/or medications
SACC code	**Country and region of birth**	**CENSUS COUNT (no.)**	**MEDIAN AGE (years)**	**ESTIMATE (no.)**			**PROPORTION (%)(c)**		
1100-1199	Australia(d)	15,021,791	33	1,168,951	1,673,395	2,341,312	7.8	11.1	15.6
1201	New Zealand	483,398	40	33,410	40,335	60,428	6.9	8.3	12.5
6101	China (excludes SARs and Taiwan)	318,969	35	10,974	13,632	20,803	3.4	4.3	6.5
6102	Hong Kong (SAR of China)	74,956	39	3,815	3,267	5,817	5.1	4.4	7.8
6105	Taiwan	28,627	32	1,104	890	1,658	3.9	3.1	5.8
6201	Japan	35,377	36	1,680	1,324	2,479	4.7	3.7	7.0
6203	Korea, Republic of (South)	74,538	32	2,642	2,441	4,178	3.5	3.3	5.6
6	**Total North-East Asia**	**535,484**	**35**	**20,346**	**21,720**	**35,184**	**3.8**	**4.1**	**6.6**
	Total(e)	**21,507,719**	**37**	**1,540,756**	**2,354,118**	**3,226,826**	**7.2**	**10.9**	**15.0**

Source: The Mental Health Services-Census Integrated Dataset, 2011

(a) Estimates of persons who accessed at least one MBS or PBS subsidised mental health-related service or medication in 2011 and responded to the 2011 Census (based on the aggregated weighted linked person-records). Due to rounding, discrepancies may occur between sums of the component items and totals.
(b) Census figures in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.
(c) Proportion of total Australian population (2011 Census counts).
(d) Includes Other Territories.
(e) Includes not stated and inadequately described country of birth.

Appendix 2 People from Chinese cultural backgrounds accessing formal mental health services and medications in 2011, by language spoken at home (with some unrelated data deleted, please see the full appendix in another attachment files).



Australian Bureau of Statistics

4329.0.00.001 Cultural and Linguistic Characteristics of People Using Mental Health Services and Prescription Medications, 2011
Released at 11.30am (Canberra time) 03 June 2016

Table 7.1 Persons from culturally and linguistically diverse backgrounds accessing MBS and/or PBS subsidised mental health-related services and/or medications in 2011, by language spoken at home (Estimates and proportions)

		2011 Census(b)		All persons accessing MBS and/or PBS subsidised mental health-related services and/or medications in 2011(a)			Proportion of persons accessing MBS and/or PBS subsidised mental health-related services and/or medications in 2011(a)		
		Total persons		MBS subsidised mental health-related services	PBS subsidised mental health-related medications	MBS and/or PBS subsidised mental health-related services and/or medications	MBS subsidised mental health-related services	PBS subsidised mental health-related medications	MBS and/or PBS subsidised mental health-related services and/or medications
Code	**Language spoken at home**	**CENSUS COUNT (no.)**	**MEDIAN AGE (years)**	**ESTIMATE (no.)**			**PROPORTION (%)(c)**		
1201	English	16,509,291	38	1,302,194	1,979,740	2,714,001	7.9	12.0	16.4
7100	Chinese, nfd	23,798	26	577	679	1,012	2.4	2.9	4.3
7101	Cantonese	263,673	38	10,673	12,738	19,635	4.0	4.8	7.4
7104	Mandarin	336,410	29	10,768	9,791	17,146	3.2	2.9	5.1
7107	Min Nan	16,372	41	716	970	1,386	4.4	5.9	8.5
7201	Japanese	43,691	33	2,005	1,412	2,818	4.6	3.2	6.4
7301	Korean	79,786	30	2,424	2,276	3,894	3.0	2.9	4.9
7	**Total Eastern Asian Languages**	**776,246**	**32**	**27,674**	**28,668**	**46,982**	**3.6**	**3.7**	**6.1**
	Total(d)	**21,507,719**	**37**	**1,540,756**	**2,354,118**	**3,226,826**	**7.2**	**10.9**	**15.0**

Source: The Mental Health Services-Census Integrated Dataset, 2011

(a) Estimates of persons who accessed at least one MBS or PBS subsidised mental health-related service or medication in 2011 and responded to the 2011 Census (based on the aggregated weighted linked person-records). Due to rounding, discrepancies may occur between sums of the component items and totals.
(b) Census figures in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals.
(c) Proportion of total Australian population (2011 Census counts).
(d) Includes not stated and inadequately described language spoken at home.

Appendix 3 Population change and percentages of people from Chinese cultural backgrounds in the recent 10 years, by country of birth.

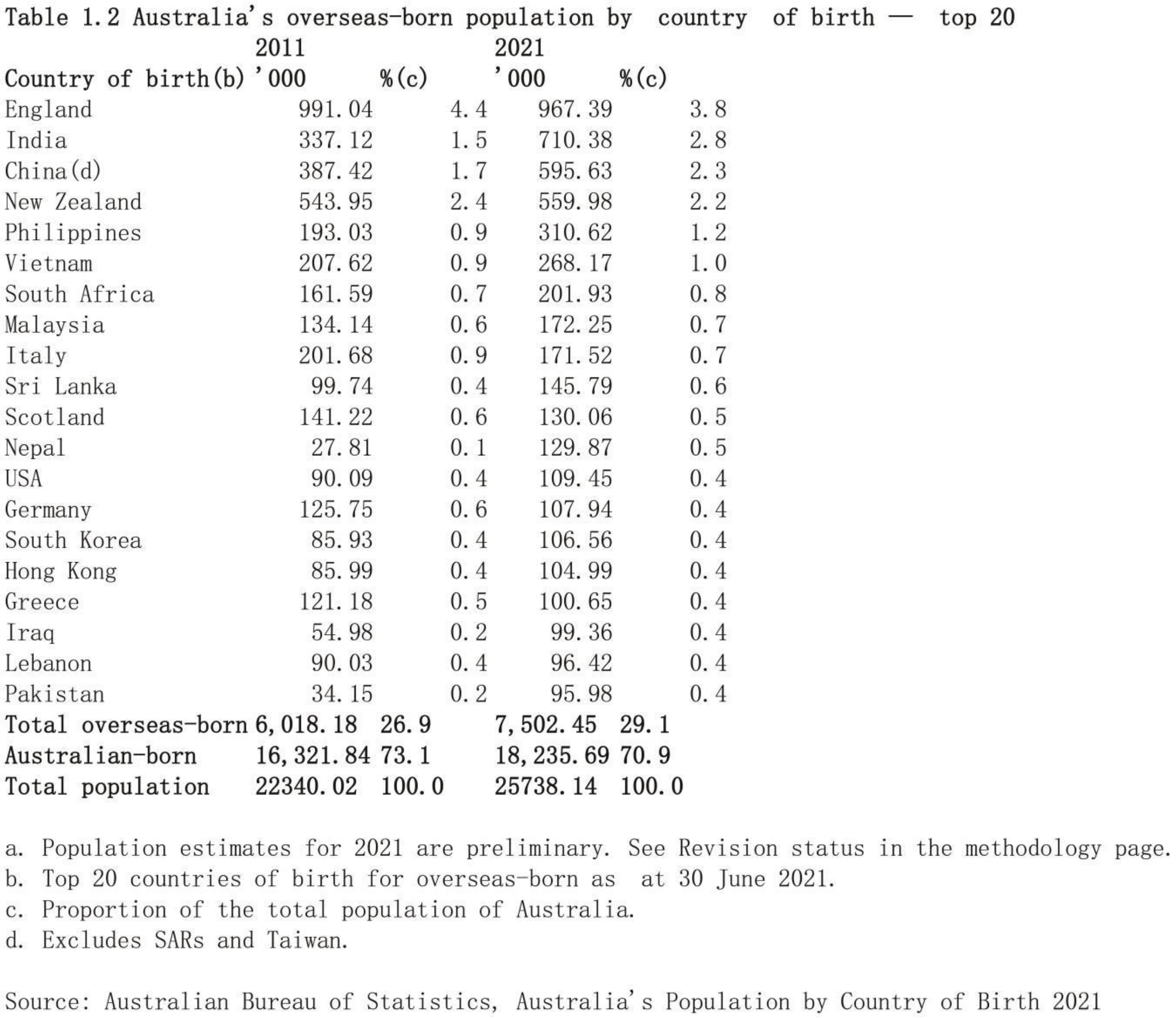


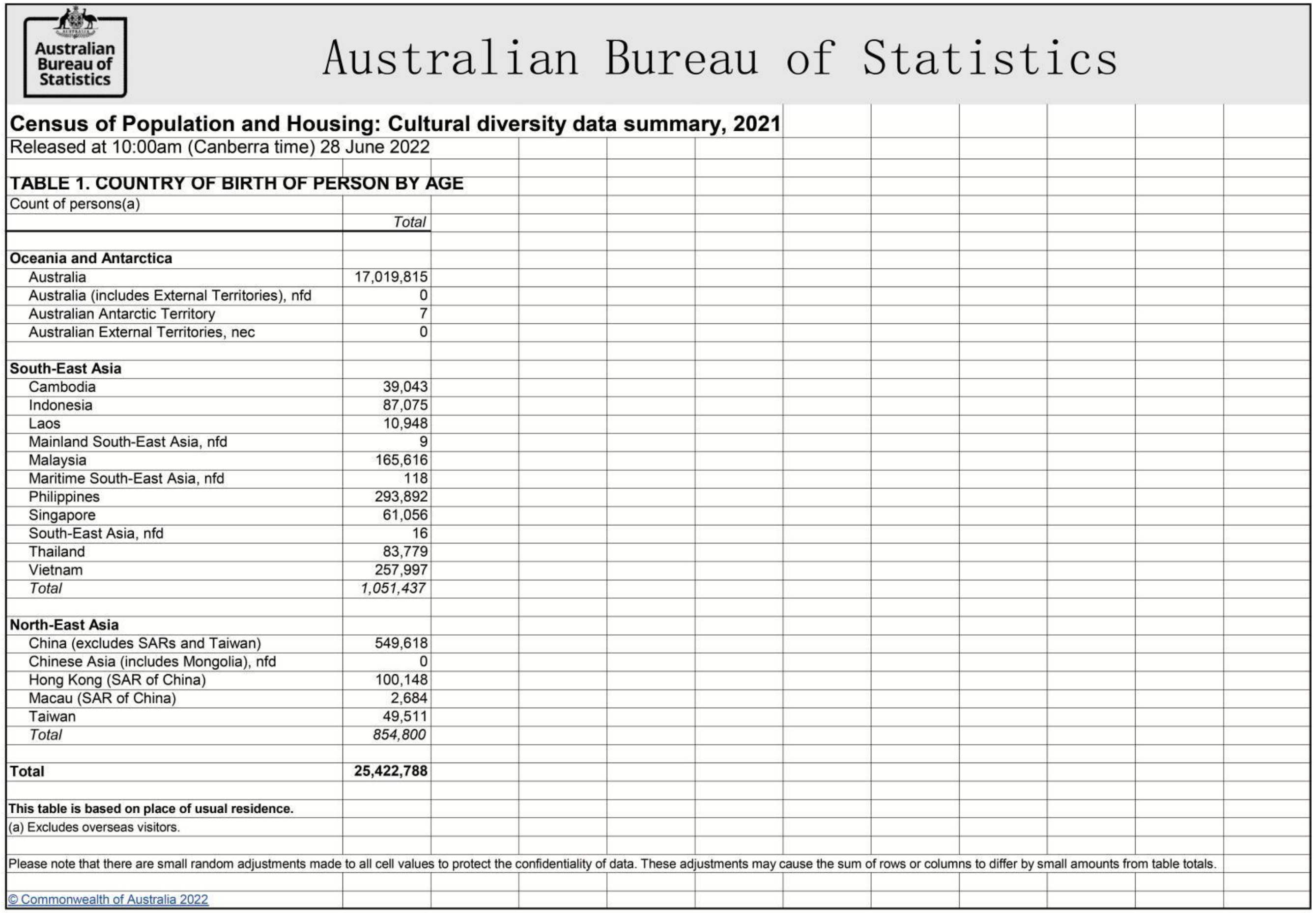
Table 1.2 Australia’s overseas-born population by country of birth — top 20

Country of birth(b)	2011 ’000	%(c)	2021 ’000	%(c)
England	991.04	4.4	967.39	3.8
India	337.12	1.5	710.38	2.8
China(d)	387.42	1.7	595.63	2.3
New Zealand	543.95	2.4	559.98	2.2
Philippines	193.03	0.9	310.62	1.2
Vietnam	207.62	0.9	268.17	1.0
South Africa	161.59	0.7	201.93	0.8
Malaysia	134.14	0.6	172.25	0.7
Italy	201.68	0.9	171.52	0.7
Sri Lanka	99.74	0.4	145.79	0.6
Scotland	141.22	0.6	130.06	0.5
Nepal	27.81	0.1	129.87	0.5
USA	90.09	0.4	109.45	0.4
Germany	125.75	0.6	107.94	0.4
South Korea	85.93	0.4	106.56	0.4
Hong Kong	85.99	0.4	104.99	0.4
Greece	121.18	0.5	100.65	0.4
Iraq	54.98	0.2	99.36	0.4
Lebanon	90.03	0.4	96.42	0.4
Pakistan	34.15	0.2	95.98	0.4
Total overseas-born	**6,018.18**	**26.9**	**7,502.45**	**29.1**
Australian-born	**16,321.84**	**73.1**	**18,235.69**	**70.9**
Total population	**22340.02**	**100.0**	**25738.14**	**100.0**

a. Population estimates for 2021 are preliminary. See Revision status in the methodology page.
b. Top 20 countries of birth for overseas-born as at 30 June 2021.
c. Proportion of the total population of Australia.
d. Excludes SARs and Taiwan.

Source: Australian Bureau of Statistics, Australia’s Population by Country of Birth 2021

Appendix 4 Population of people from Chinese cultural backgrounds in Australia in 2021, by country of birth (with some unrelated data deleted, please see the full appendix in another attachment files).



Australian Bureau of Statistics

Census of Population and Housing: Cultural diversity data summary, 2021

Released at 10:00am (Canberra time) 28 June 2022

TABLE 1. COUNTRY OF BIRTH OF PERSON BY AGE

Count of persons(a)

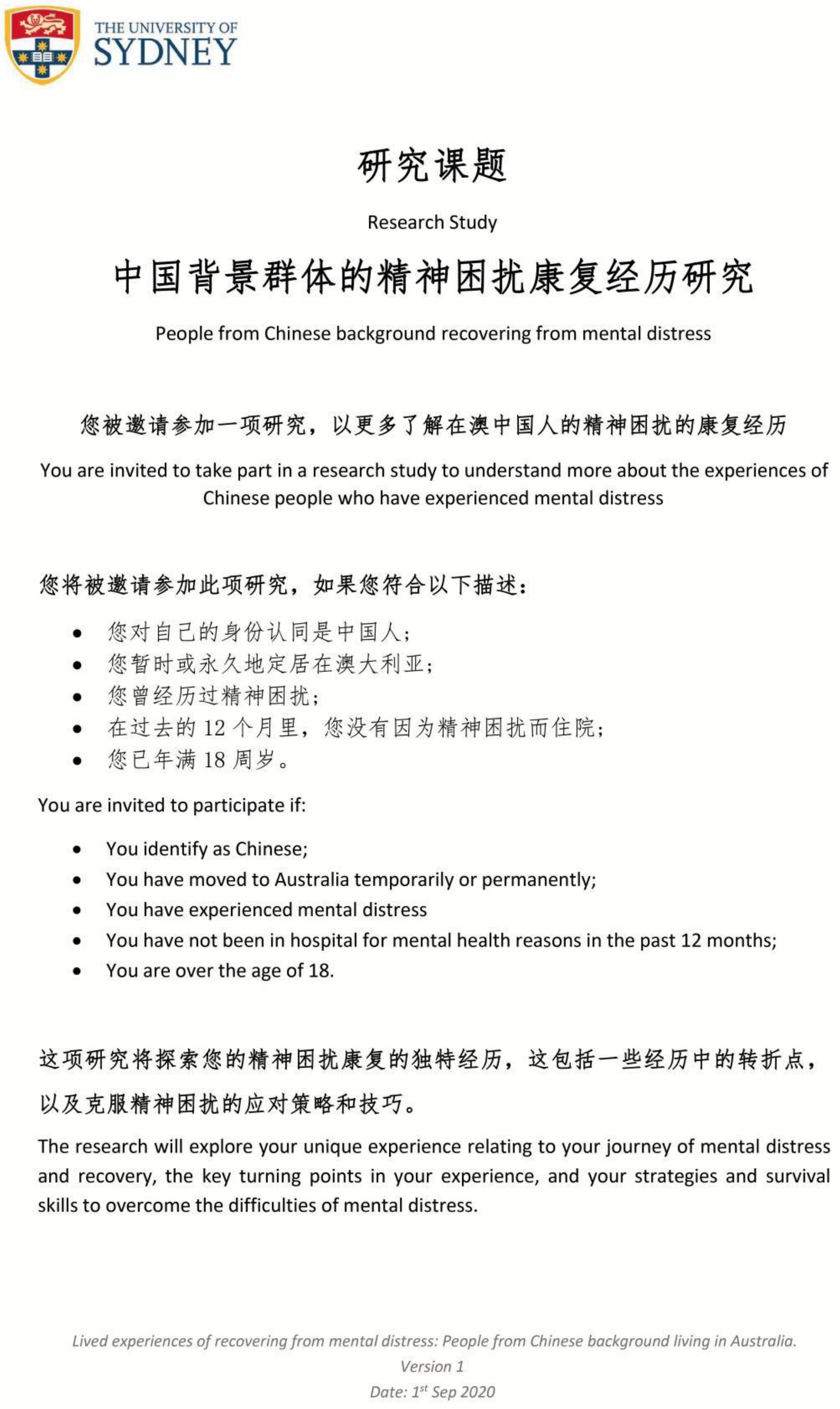
	Total
Oceania and Antarctica	
Australia	17,019,815
Australia (includes External Territories), nfd	0
Australian Antarctic Territory	7
Australian External Territories, nec	0
South-East Asia	
Cambodia	39,043
Indonesia	87,075
Laos	10,948
Mainland South-East Asia, nfd	9
Malaysia	165,616
Maritime South-East Asia, nfd	118
Philippines	293,892
Singapore	61,056
South-East Asia, nfd	16
Thailand	83,779
Vietnam	257,997
Total	*1,051,437*
North-East Asia	
China (excludes SARs and Taiwan)	549,618
Chinese Asia (includes Mongolia), nfd	0
Hong Kong (SAR of China)	100,148
Macau (SAR of China)	2,684
Taiwan	49,511
Total	*854,800*
Total	**25,422,788**

This table is based on place of usual residence.

(a) Excludes overseas visitors.

Please note that there are small random adjustments made to all cell values to protect the confidentiality of data. These adjustments may cause the sum of rows or columns to differ by small amounts from table totals.

Appendix 5 Recruitment advertisement for individual participants.



THE UNIVERSITY OF SYDNEY

研究课题

Research Study

中国背景群体的精神困扰康复经历研究

People from Chinese background recovering from mental distress

您被邀请参加一项研究，以更多了解在澳中国人的精神困扰的康复经历

You are invited to take part in a research study to understand more about the experiences of Chinese people who have experienced mental distress

您将被邀请参加此项研究，如果您符合以下描述：

- 您对自己的身份认同是中国人；
- 您暂时或永久地定居在澳大利亚；
- 您曾经历过精神困扰；
- 在过去的 12 个月里，您没有因为精神困扰而住院；
- 您已年满 18 周岁。

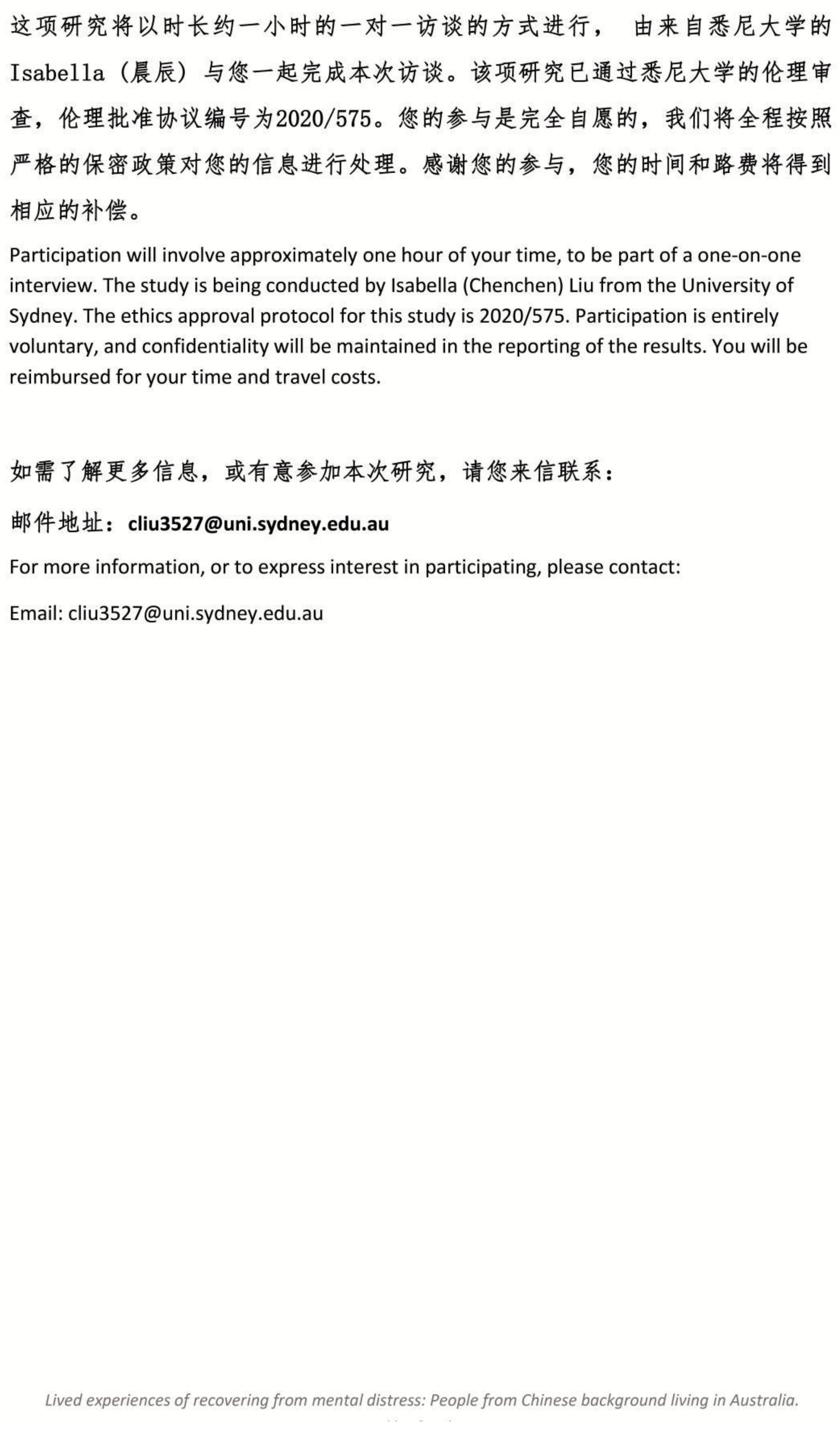
You are invited to participate if:

- You identify as Chinese;
- You have moved to Australia temporarily or permanently;
- You have experienced mental distress
- You have not been in hospital for mental health reasons in the past 12 months;
- You are over the age of 18.

这项研究将探索您的精神困扰康复的独特经历，这包括一些经历中的转折点，以及克服精神困扰的应对策略和技巧。

The research will explore your unique experience relating to your journey of mental distress and recovery, the key turning points in your experience, and your strategies and survival skills to overcome the difficulties of mental distress.

Lived experiences of recovering from mental distress: People from Chinese background living in Australia.
Version 1
Date: 1^{st} Sep 2020



这项研究将以时长约一小时的一对一访谈的方式进行， 由来自悉尼大学的Isabella（晨辰）与您一起完成本次访谈。该项研究已通过悉尼大学的伦理审查，伦理批准协议编号为2020/575。您的参与是完全自愿的，我们将全程按照严格的保密政策对您的信息进行处理。感谢您的参与，您的时间和路费将得到相应的补偿。

Participation will involve approximately one hour of your time, to be part of a one-on-one interview. The study is being conducted by Isabella (Chenchen) Liu from the University of Sydney. The ethics approval protocol for this study is 2020/575. Participation is entirely voluntary, and confidentiality will be maintained in the reporting of the results. You will be reimbursed for your time and travel costs.

如需了解更多信息，或有意参加本次研究，请您来信联系：

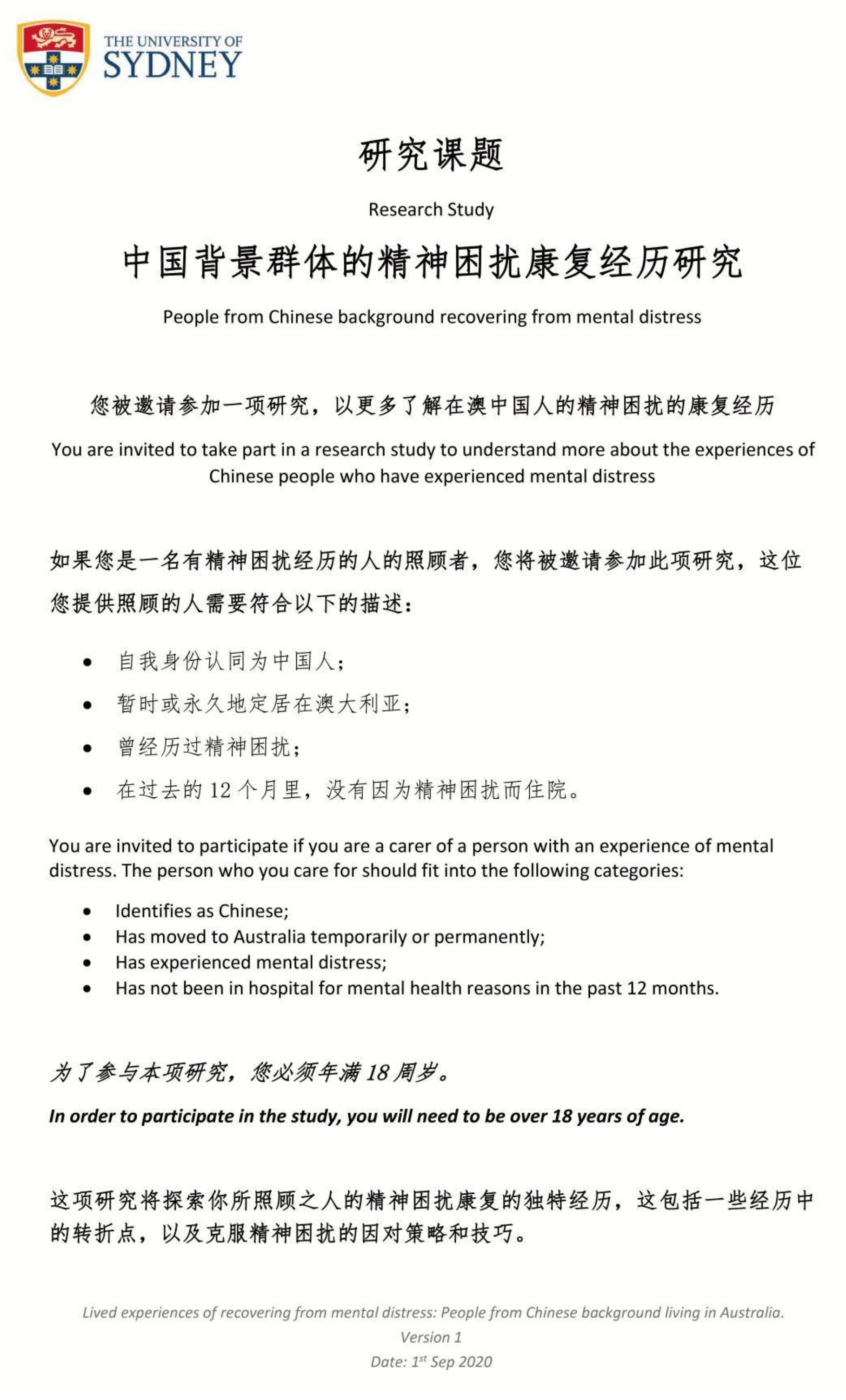
邮件地址：**cliu3527@uni.sydney.edu.au**

For more information, or to express interest in participating, please contact:

Email: cliu3527@uni.sydney.edu.au

Lived experiences of recovering from mental distress: People from Chinese background living in Australia.

Appendix 6 Recruitment advertisement for family members and/or caregivers.



THE UNIVERSITY OF
SYDNEY

研究课题

Research Study

中国背景群体的精神困扰康复经历研究

People from Chinese background recovering from mental distress

您被邀请参加一项研究，以更多了解在澳中国人的精神困扰的康复经历

You are invited to take part in a research study to understand more about the experiences of Chinese people who have experienced mental distress

如果您是一名有精神困扰经历的人的照顾者，您将被邀请参加此项研究，这位您提供照顾的人需要符合以下的描述：

- 自我身份认同为中国人；
- 暂时或永久地定居在澳大利亚；
- 曾经历过精神困扰；
- 在过去的 12 个月里，没有因为精神困扰而住院。

You are invited to participate if you are a carer of a person with an experience of mental distress. The person who you care for should fit into the following categories:

- Identifies as Chinese;
- Has moved to Australia temporarily or permanently;
- Has experienced mental distress;
- Has not been in hospital for mental health reasons in the past 12 months.

为了参与本项研究，您必须年满 18 周岁。

In order to participate in the study, you will need to be over 18 years of age.

这项研究将探索你所照顾之人的精神困扰康复的独特经历，这包括一些经历中的转折点，以及克服精神困扰的因对策略和技巧。

Lived experiences of recovering from mental distress: People from Chinese background living in Australia.
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The research will explore the unique experience of person you take care of relating to her/his journey of mental distress and recovery, the key turning points in her/his experience, and her/his strategies and survival skills to overcome the difficulties of mental distress.

这项研究将以时长约一小时的一对一访谈的方式进行， 由来自悉尼大学的Isabella（晨辰）与您一起完成本次访谈。该项研究已通过悉尼大学的伦理审查，伦理批准协议编号为2020/575。您的参与是完全自愿的，我们将全程按照严格的保密政策对您的信息进行处理。感谢您的参与，您的时间和路费将得到相应的补偿。

Participation will involve approximately one hour of your time, to be part of a one-on-one interview. The study is being conducted by Isabella (Chenchen) Liu from the University of Sydney. The ethics approval protocol for this study is 2020/575. Participation is entirely voluntary, and confidentiality will be maintained in the reporting of the results. You will be reimbursed for your time and travel costs.

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邮件地址：**cliu3527@uni.sydney.edu.au**

For more information, or to express interest in participating, please contact:

Email: cliu3527@uni.sydney.edu.au

Appendix 7 Interview schedule - for participants.

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Lived experiences of recovering from mental distress: People from Chinese background living in Australia

Interview schedule

Introduction

Thank you for volunteering your time and agreeing to speak with me today. I have received a signed consent form from you. This research is about the experiences and perceptions of Chinese people who once experienced mental distress and now are making progress on the journey of recovery. We acknowledge that recovery should not be defined by an expert's perspective but those who have experienced it directly. Therefore, your point view of recovery matters a lot in this research.

I would like to remind you that what you tell me is confidential and will only be used for the reasons specified in the consent form that you signed. If at any time you wish to stop the interview, please let me know and the interview will end, with no adverse consequences for you.

In the event that you feel upset or distressed by the material we speak about, is there anything that would be helpful for me to do? For example, I can pause the interview, you can take a break outside, we can move onto the next question. I will check in with you a couple of times during the interview that you are happy to keep answering questions. Following the interview, if you would like, I can also discuss support options with you.

Do you have any questions before we begin?

Interview Guide

Can you tell me your experiences of mental distress?

What happened when you first had mental distress? What did you do with that? How was your feeling about that? Since then, what's been happening?

How does your distress have an influence on your life now?

Where did you get help and support? What kinds of things enabled you to feel stronger? How did that make you feel stronger?

In your opinion, what kind of supports are helpful? What has not been helpful? What kind of support do you wish was available?

What stories in your mental health journey do you remember the most? Why?

What does mental health ‘recovery’ mean to you?

What types of professional people have you spoken to? Have you seen a social worker? What was your experience with them?

Is there anything else that you would like to share about your story?

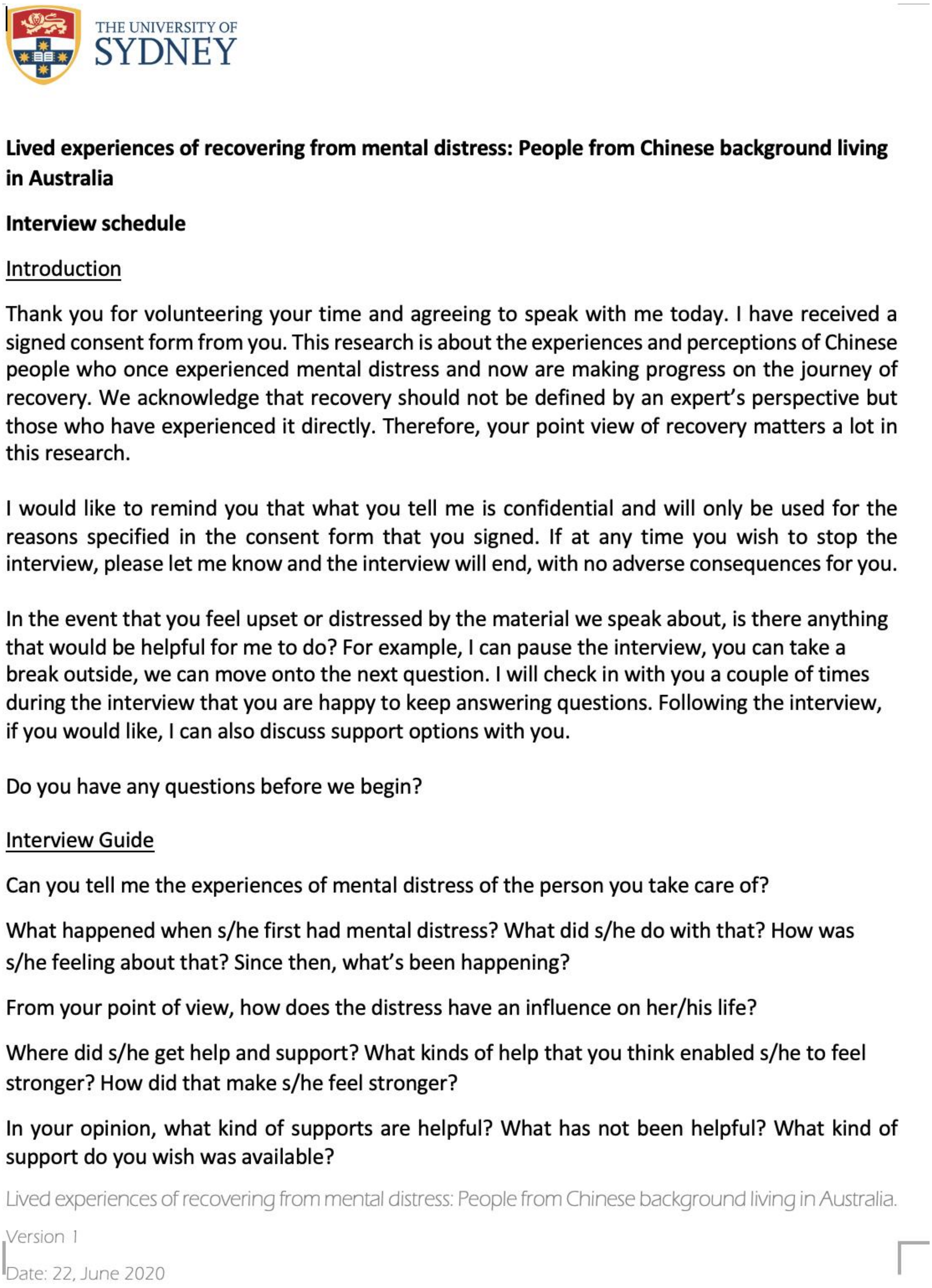
Conclusion

That concludes the interview. Thank you for volunteering your time and sharing your experiences with me.

How are you feeling following the interview? Would you like to discuss support options? [If so, discuss participants’ chosen supports, or if no chosen supports, the options to access Transcultural Mental Health Centre, Beyond Blue and Lifeline]

Provide gift voucher.

Appendix 8 Interview schedule - for family members and/or caregivers.



THE UNIVERSITY OF SYDNEY

Lived experiences of recovering from mental distress: People from Chinese background living in Australia

Interview schedule

Introduction

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I would like to remind you that what you tell me is confidential and will only be used for the reasons specified in the consent form that you signed. If at any time you wish to stop the interview, please let me know and the interview will end, with no adverse consequences for you.

In the event that you feel upset or distressed by the material we speak about, is there anything that would be helpful for me to do? For example, I can pause the interview, you can take a break outside, we can move onto the next question. I will check in with you a couple of times during the interview that you are happy to keep answering questions. Following the interview, if you would like, I can also discuss support options with you.

Do you have any questions before we begin?

Interview Guide

Can you tell me the experiences of mental distress of the person you take care of?

What happened when s/he first had mental distress? What did s/he do with that? How was s/he feeling about that? Since then, what's been happening?

From your point of view, how does the distress have an influence on her/his life?

Where did s/he get help and support? What kinds of help that you think enabled s/he to feel stronger? How did that make s/he feel stronger?

In your opinion, what kind of supports are helpful? What has not been helpful? What kind of support do you wish was available?

Lived experiences of recovering from mental distress: People from Chinese background living in Australia.

Version 1

Date: 22, June 2020

What stories in her/his mental health journey do you remember most? Why?

What does mental health 'recovery' mean to you?

What types of professional people has s/he spoken to? Has s/he seen a social worker? What was her/his experience with them? What do you think of these helpers?

Is there anything else that you would like to share about her/his story?

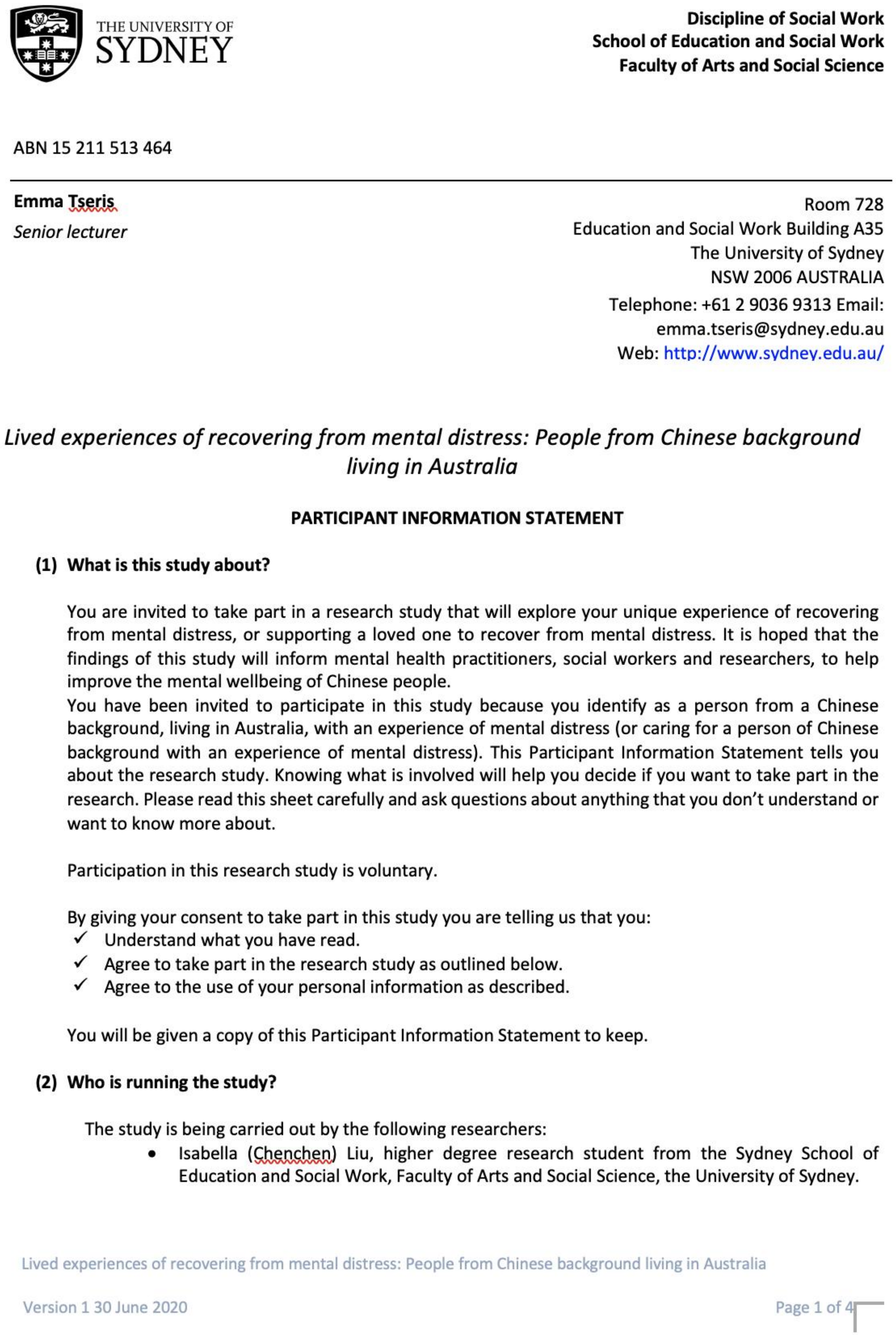
Conclusion

That concludes the interview. Thank you for volunteering your time and sharing your experiences with me.

How are you feeling following the interview? Would you like to discuss support options? [If so, discuss participants' chosen supports, or if no chosen supports, the options to access Carer Gateway, Beyond Blue and Lifeline]

Provide gift voucher.

Appendix 9 Participant information statement.



THE UNIVERSITY OF SYDNEY

Discipline of Social Work
School of Education and Social Work
Faculty of Arts and Social Science

ABN 15 211 513 464

Emma Tseris
Senior lecturer

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NSW 2006 AUSTRALIA
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emma.tseris@sydney.edu.au
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Lived experiences of recovering from mental distress: People from Chinese background living in Australia

PARTICIPANT INFORMATION STATEMENT

(1) What is this study about?

You are invited to take part in a research study that will explore your unique experience of recovering from mental distress, or supporting a loved one to recover from mental distress. It is hoped that the findings of this study will inform mental health practitioners, social workers and researchers, to help improve the mental wellbeing of Chinese people.

You have been invited to participate in this study because you identify as a person from a Chinese background, living in Australia, with an experience of mental distress (or caring for a person of Chinese background with an experience of mental distress). This Participant Information Statement tells you about the research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary.

By giving your consent to take part in this study you are telling us that you:
- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.

You will be given a copy of this Participant Information Statement to keep.

(2) Who is running the study?

The study is being carried out by the following researchers:
- Isabella (Chenchen) Liu, higher degree research student from the Sydney School of Education and Social Work, Faculty of Arts and Social Science, the University of Sydney.

Isabella (Chenchen) Liu is conducting this study as the basis for the degree of Doctor of Philosophy at The University of Sydney. This will take place under the supervision of Professor Fran Waugh and Senior Lecturer Emma Tseris.

(3) What will the study involve for me?

If you decide to participate, the study will involve an interview with Chenchen (Isabella) Liu. The interview will take approximately one hour and the place and timing of interview will be your choice. You can choose to meet in a room around the Camperdown Campus in the university of Sydney if you are able to come. Otherwise, an online interview or phone interview is also possible. In the interview, questions will ask about your thoughts and experiences relating to the journey of recovering from mental distress.

With your consent, I would like to audiotape the interview to ensure what you say is accurately captured. You can feel free to speak Cantonese, English or mandarin without worrying about anyone else (e.g. a translator) will be present. The tapes will be transcribed and will be stored in a locked cabinet on university premises in a building which is fully secured and alarmed as well as in secure data management software. At the conclusion of the study, the audiotapes and interview notes will be stored for five years; after this the audio tapes will be erased, all notes shredded, and all secure electronic files deleted.

(4) How much of my time will the study take?

The interview will take approximately one hour.

(5) Who can take part in the study?

This research study aims to explore the experiences of people with Chinese background recovering from mental distress. Participants in this study must be over 18 years old; have one year or more since hospitalization for any mental health reason; and not currently a person with a Guardianship Order or Community Treatment Order.

Participants also need to be from a Chinese background. Participants will have moved to Australia for a temporary or permanent settlement; identify as Chinese, and have physical and emotional connections to China.

Family carers and friends of those with mental distress and Chinese background to are also invited to participate in the research study.

(6) Do I have to be in the study? Can I withdraw from the study once I've started?

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of Sydney or your relationship with any mental health services.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time. You can do this advising the researcher before, during and after the interview by contacting Isabella Liu through the contact details on page 4. There will be no consequences if you want to withdraw from the study.

You are free to stop the interview at any time. Unless you say that you want us to keep them, any recordings will be erased and the information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the interview.

(7) Are there any risks or costs associated with being in the study?

Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study. However, in some circumstances talking about your experiences may elicit distress. If the interview does raise any concerns for you, please speak with the interviewer so that options for support can be discussed with you. These will include Lifeline (131114) and Beyond Blue (1300 22 4636) and the Transcultural Mental Health Service (02 9912 3850).

(8) Are there any benefits associated with being in the study?

Participants will be financially compensated for their time and effort with a $50 gift voucher.

(9) What will happen to information about me that is collected during the study?

An audio recording will be taken to facilitate reporting the results of the study. We will transcribe the audio recording to a written transcript, to enable analysis. If you prefer speaking in a language other than English (i.e, Mandarin or Cantonese), we will then translate it into English and the transcript will be verified by 1 Chinese-and-English-fluently-speaking person bound by a confidentiality agreement. Access to the data collected at any stage during or after the study will be limited to the researcher. Personal information will be kept confidential. Study findings may be published, but you will not be individually identifiable in these publications.

Your information will be stored securely and your identity/information will be kept strictly confidential, except as required by law. All electronic files will be stored on the password-protected desktop computer of the researcher. All hard copies of consent forms and other project documentation will be stored in a locked filing cabinet on University of Sydney premises. To comply with University guidelines, data will be stored for five years, however access will be restricted to the researchers. After this period, electronic documents and audio files will be securely deleted from the hard drive. Hard copies will be securely disposed.

By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise.

(10) Can I tell other people about the study?

Yes, you are welcome to tell other people about the study.

(11) What if I would like further information about the study?

When you have read this information, Isabella (Chenchen) Liu will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact Isabella (Chenchen) Liu, higher degree research student, via email: cliu3527@uni.sydney.edu.au or phone number: [REDACTION].

(12) Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback by ticking the relevant box on the consent form. This feedback will be in the form of a one-page lay summary. You will receive this feedback after the study is finished.

(13) What if I have a complaint or any concerns about the study?

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of the University of Sydney [2020/575]. As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in Human Research (2007).* This statement has been developed to protect people who agree to take part in research studies.

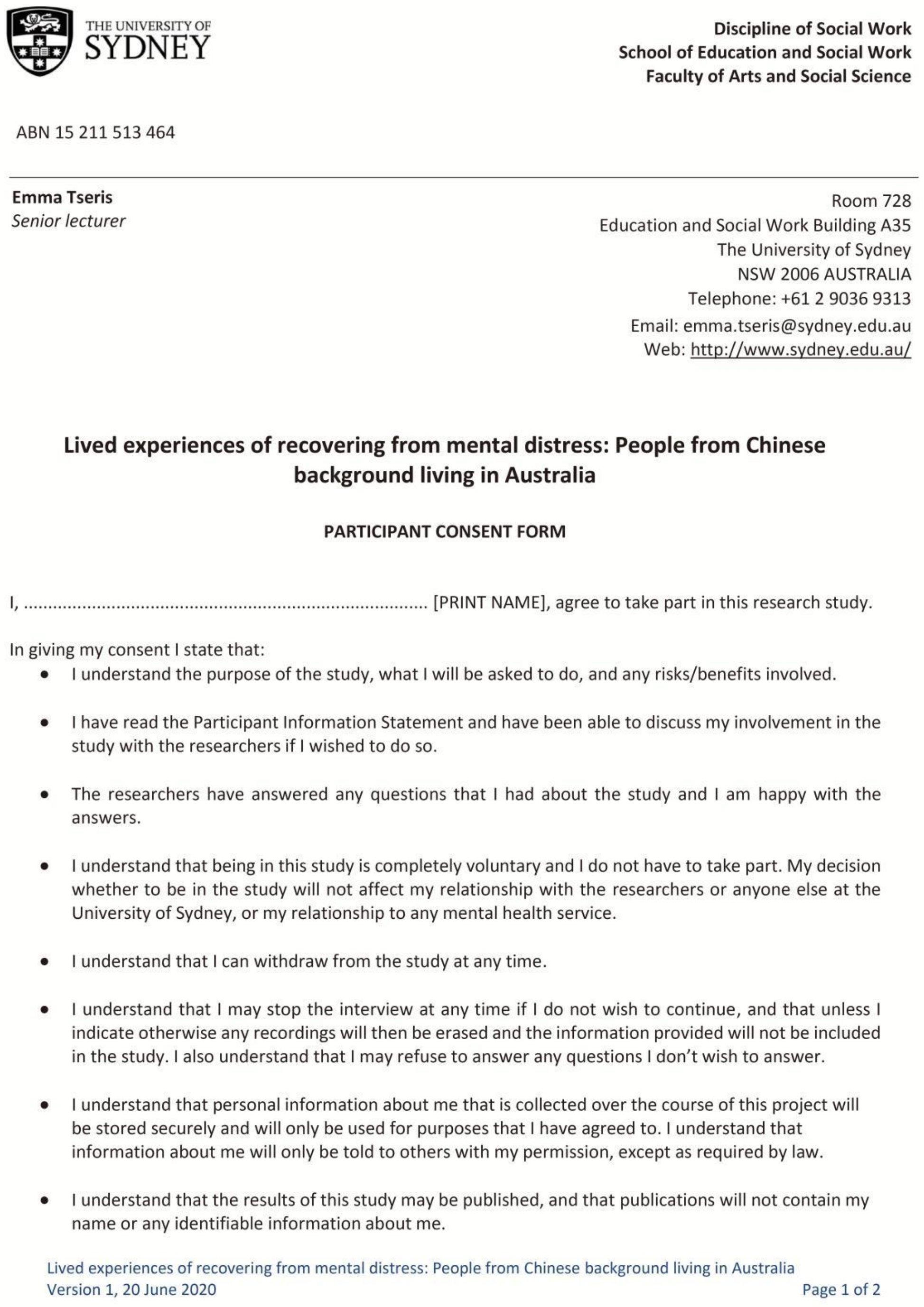
If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university using the details outlined below. Please quote the study title and protocol number.

The Manager, Ethics Administration, University of Sydney:

- **Telephone:** +61 2 8627 8176
- **Email:** human.ethics@sydney.edu.au
- **Fax:** +61 2 8627 8177 (Facsimile)

This information sheet is for you to keep

Appendix 10 Participant consent form.



THE UNIVERSITY OF SYDNEY

Discipline of Social Work
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ABN 15 211 513 464

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Senior lecturer

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NSW 2006 AUSTRALIA
Telephone: +61 2 9036 9313
Email: emma.tseris@sydney.edu.au
Web: http://www.sydney.edu.au/

Lived experiences of recovering from mental distress: People from Chinese background living in Australia

PARTICIPANT CONSENT FORM

I, ... [PRINT NAME], agree to take part in this research study.

In giving my consent I state that:

- I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- The researchers have answered any questions that I had about the study and I am happy with the answers.
- I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of Sydney, or my relationship to any mental health service.
- I understand that I can withdraw from the study at any time.
- I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise any recordings will then be erased and the information provided will not be included in the study. I also understand that I may refuse to answer any questions I don't wish to answer.
- I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.
- I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.

I consent to:

Audio-recording YES ☐ NO ☐

- **I would like to receive feedback about the overall results of this study**
  YES ☐ NO ☐

- **I would like to take part in the interview online via Zoom technology?**
  YES ☐ NO ☐

If you answered **YES**, please indicate your preferred form of feedback and address:

☐ Postal: ____

____

☐ Email: ____

....
Signature

....
PRINT name

....
Date