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**Double Minority Youth Mental Health**

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An investigation of challenges and opportunities to  
support Chinese sexual/gender minority young people in  
New Zealand

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A thesis submitted in fulfilment of the requirements for the degree of  
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## Abstract

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**Objectives:** Most research on sexual and gender (SG) minority mental health has been conducted with European (White) populations in the United States. Very little is known about the mental health needs and challenges faced by young people who are both ethnic and SG minorities (i.e. those who are not exclusively heterosexual or cisgender) in Western nations. With a focus on Chinese SG minority youth ('double minority youth') in New Zealand (NZ), I explored what might affect their mental health and wellbeing, and opportunities to improve therapeutic practice including psychological therapies, counselling or talking therapies (hereafter 'therapies') for Chinese SG minority youth.

**Methods:** I adopted a three-phase mixed-methods research approach and conducted four studies. In Study One, a secondary analysis of nationally representative Youth2000 survey data was conducted to examine the mental health status of double minority youth, including Chinese SG minority young people. In Study Two, I embarked on a systematic search of 29 international databases to identify the best evidence-based therapeutic practice for Chinese and other East Asian minorities. Study Three involved qualitative interviews with 11 Chinese SG minority youth to explore their views on mental health challenges and support. Study Four involved qualitative interviews with 8 therapists to gather their views on working effectively with these youth. I adopted a general inductive approach to analyse the data of both Study Three and Study Four.

**Results:** SG minority status, minority ethnicity, and female sex were independently associated with a higher risk of depression, suicidality, and poor wellbeing in NZ. Double minority youth reported higher risk than their SG majority peers of the same ethnicity, whereas double minority youth reported lower risk than their NZ European SG minority peers. The review of international literature highlighted the scarcity of published studies in the field. Challenges

associated with various forms of oppression, including those relating to their intersecting identities were explored. Culture and community connections, in addition to family and peer support were described as resilience factors. However, stigma and fear of ‘losing face’, and the lack of cultural competency in therapeutic practice were reported by both youth and therapist participants as barriers to effective mental health support. A range of recommendations to improve mental health support were identified.

**Conclusion:** A set of ‘Chinese-SG-minority-specific’ recommendations for therapeutic practice emerged, with a strong emphasis on youth development. Holistic clinical assessment, culturally attuned relationship building, and growth in cross-cultural competency as well as supporting healthy identity management are the main tenants of these recommendations for practice. Further research is required which aims to: address the oppression experienced by Chinese SG minority youth and seeks to enhance therapy for Chinese SG minority young people.

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## Glossary

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Terms/phrases	Definitions used in this thesis
Youth/Young people	Used here to describe those aged between 10 and 29 years old, in accordance with Chinese traditions.
Sexual and/or gender (SG) minority, or sexual/gender minority	Refers to individuals who do not identify as exclusively heterosexual, or cisgender (i.e., someone whose gender identity matches their sex assigned at birth). Both groups face unique issues, while some individuals can be both sexual and gender minority. However, as both share some common challenges associated with cis-/hetero- normative oppression, and in Chinese, they are sometimes collectively referred to as Tongzi. They are addressed as a collective in this thesis.
Double minority	Although this term can describe anyone with dual minority status, in some recent academic texts, it has referred to people who are members of both ethnic and non-White SG minorities (e.g., Wong & Menkes, 2018; Duran, 2018; Eaton & Rios, 2017; Hayes, Chun-Kennedy, Edens, & Locke, 2011; Zamboni & Crawford, 2007).
Mental health challenges	Refers to any psychological experiences, issues, concerns, difficulties, or needs that young people may find distressing. In Chinese culture, mental health challenges, particularly emotional distress (e.g., depression and anxiety) often imply a certain degree of relational problems.
Psychological therapies	Psychological treatment, intervention, consultation, talking therapy, counselling or psychotherapy that aims to treat or prevent mental ill-health or promote mental health.



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# Chapter 1: Introduction

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In this thesis, I explore the mental health and wellbeing of young people who are both sexual and/or gender (SG) minority and ethnic minority in New Zealand, with a particular focus on Chinese SG minority youth. I discuss the challenges as well as opportunities to improve psychological therapies, counselling or talking therapies (hereafter ‘therapies’) to better meet the needs of Chinese SG minority young people who are suffering from stress, distress or mild to moderate mental ill-health in English-speaking Western nations such as New Zealand. As many such nations are multicultural, there is ongoing debate over whether the current practice of psychological therapies can meet the mental health challenges commonly faced by ethnically and SG diverse minorities (Arnett, 2008; Chan, 1992). My thesis is a response to this question. The current chapter provides readers with an overview of my work and its theoretical background.

## 1.1 Background

Chinese people make up one of the largest ethnic and cultural groups on earth, and Chinese migrants form a substantial portion of the population in the English-speaking Western world (Wang & Liu, 2006; Parker, Gladstone, & Chee, 2001). In New Zealand, about 4% of the national population can be considered Chinese, with the percentage higher (i.e., up to 6%) among young people (Adolescent Health Research Group [AHRG], 2015; Ip, 2016).

Research evidence shows that many Chinese migrants tend to adhere to their cultural roots (Chiu, 1987; Sue & Sue, 1971). However, as a discipline, modern psychology has its roots in Western society, and much of the research into treatment has been developed using White American samples (Arnett, 2008). Consequently, psychology can be critiqued as being culturally blind, under-attending to the influence of culture in shaping the cognitions and behaviours of Chinese immigrants (and other ethnic minorities as well) (Berry, 2013a; Berry, 2013b; Berry, 2015), and thus hindering scholars and practitioners from working well with young migrant Chinese people.

The contemporary literature dedicated to the understanding of SG identity development among young people has been criticised for its fixed and linear views of development (Bilodeau & Renn, 2005; Carrera, DePalma, & Lameiras, 2012). Although youth development is tied to physical maturation (e.g., the changes due to hormones and neural activity) (Lerner, Easterbrooks, Mistry, & Weiner 2013), psychosocial and cultural influences also shape the path of development (Bronfenbrenner, 2001; Erikson, 1968; Eser & Çeliköz, 2009). Recent studies have revealed distinct mental health and developmental challenges among cultural or ethnic minority youth (Besnoy, Maddin, Steele, & Eisenhardt, 2015; Cardemil, 2015; Murray, 2015), but the challenges commonly faced by those who are both ethnic and SG minorities remain largely uncharted. Faulty notions of SG identity formation and inappropriate therapeutic practice can still, unfortunately, be found in a relatively recent survey of licensed or highly qualified psychologists (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991).



### 1.1.1 Rationale for the research

Multiculturalism expands the definition of culture to encompass a myriad of social identities beyond ethnicity, including gender and sexuality status (Jackson, 2006; Reid, 2002). Multiculturalism posits that some foundational psychological experiences are shared across the human race, while other experiences can be context-dependent (i.e., unique to certain culture/s) (Berry, 2015; Jackson, 2006; Poortinga, 2015). The perspective of intersectionality further appreciates the unique experiences associated with the interactions of multiple social identities (Crenshaw, 1991). Based on this perspective, I propose that some adjustments are required to the Western approaches of mental health practice in New Zealand to better support migrant Chinese SG minority youth. However, to determine the form of such adjustments in approach and practice to consider culturally unique experiences, researchers need to have a process for sampling from under-represented populations, a research focus that deviates from the interests of the dominant population, and a research method that captures psychological experience within its appropriate cultural context (Berry, 2013b; Poortinga, 2015; Reid, 2002).

In addition, while some scholars may advocate for the total adoption of indigenous healing approaches (Pe-Pua, 2015), Western therapies are actually gaining popularity in China and many Chinese-speaking Eastern regions (Qian, Smith, Chen, & Xia, 2001). As Tsuei (1978, p.551), a renowned medical researcher, has pointed out, “The Western approach tends to change the environment and the Eastern way is to prefer to adapt to the environment.” Both

approaches are required in psychological medicine. Recent evidence also shows that culturally attuned therapies using a combination of both Western and Eastern approaches can be more effective in terms of treatment adherence and outcomes for Asian cultural minorities (Chan, Ying Ho, & Chow, 2002; Griner & Smith, 2006).

I have utilised a post-positivist mixed-methods research methodology (MMRM) with a focus on the intersection of identities (Crenshaw, 1991; Creswell, 2015). My choice of research methodology and questions was influenced by the New Zealand Psychological Society's Code of Ethics (New Zealand Psychologists Board [NZPB], 2002) and Guidelines for Cultural Safety (NZPB, 2009). MMRM typically has a philosophical underpinning of critical realism, which appreciates both the cultural context and scientific soundness of findings, as well as a pragmatic emphasis on addressing societal inequity to promote social inclusion (Houston, 2001; McEvoy & Richards, 2006; Ponterotto, 2010). I have designed a series of studies using Chinese SG minority youth residing in New Zealand as my primary focus. They serve as a window to reveal some therapeutic principles that can benefit migrant Chinese SG minority youth in general.

Several terms and phrases used in the thesis are listed in the Glossary, and they are further explained in the main text of the thesis. One term that requires immediate attention is "double minority". Although the term double minority can be used to describe anyone with two minority identities, for instance women of colour (McKay, 1983), it is often used in relation to SG minority persons of ethnic minority (e.g., Wong & Menkes, 2018; Duran, 2018; Eaton &

Rios, 2017; Massaquoi, 2015; Hayes, Chun-Kennedy, Edens, & Locke, 2011; Zamboni & Crawford, 2007; Boykin, 1996; Wooden, Kawasaki, & Mayeda, 1983). Some scholars note that double minority, as with any other label, can oversimplify the complexity of this population, reinforcing a false assumption of sameness among all non-European SG minority people (Huang & Fang, 2018) when this population in fact encompasses groups of highly heterogeneous individuals. Additionally, I would like to acknowledge that other types of double minority status (e.g., age, disability, and poverty) are equally important as research topics. However, I use double minority to describe persons who are both SG and ethnic minority, as this term has gradually become popular in the academic literature to describe such individuals for the purpose of academic communication (Wong & Menkes, 2018). Also, this usage helps in highlighting some common needs among non-European SG minority youth in general. In addition, wherever possible, I have opted for a more specific alternative (e.g., Chinese SG minority in English-speaking Western nations, or African American SG minority people).

## **1.2 Research questions**

The research reported in this thesis was designed to investigate **‘mental health challenges and therapeutic supports for Chinese SG minority young people in New Zealand’**.

The overarching research question can be broken down as follows across the three phases of the research process, as follows (see Figure 1): What is the overall mental health status of double minority young people in New Zealand, and are there significant differences compared

to their NZ European SG minority peers? What are the peer-reviewed therapeutic recommendations for Chinese and other East Asian SG minorities in Western nations? According to the views of migrant Chinese SG minority youth, what are their mental health challenges and how can they be better supported, including via psychological therapies? According to the views of psychological therapists, what is their understanding of migrant Chinese SG minority young people's challenges and ways to support them?

### 1.2.1 The focus of each research phase

In Phase I, the mental health status of double minority youth in New Zealand was examined via the nationally representative youth 2000 surveys, which included 1,306 double minority youth. Given the small sample sizes of ethnic-specific groups, the Adolescent Health Research Group who owns the survey data did not permit ethnic-specific comparisons. However, I carefully reviewed opportunities and limitations regarding the use of the survey data with my co-authors on the article reporting this phase of the research and was able to report several Chinese (and other ethnic minority) SG minority youth findings, as shown in the relevant tables in Chapter 4. In contrast to some of the U.S. based studies with larger populations that can allow for more detailed ethnic comparisons, the overall focus of Study One is the mental health status of double minority youth as a whole. This focus is particularly useful as it addresses a gap in the literature exploring these topics based on population-based studies outside the U.S.

In Phase II, the literature regarding the experiences of therapy for Chinese and East Asian

SG minorities was reviewed. The broader grouping was selected due to the lack of literature focusing solely on Chinese SG minorities. The East Asian ethnic grouping (including Chinese, Taiwanese, Japanese, and Korean) is reasonable based upon their historical links and shared culture and customs, and is commonly used by scholars in the field (Reischauer, 1974; Wang, Yuchen et al., 2018).

When exploring the views of youth and therapists in Phase III, I focused specifically on my core area of research interest – Chinese SG minority youth. Semi-structured interviews were conducted to explore the mental health challenges and therapeutic support for Chinese SG minority youth in New Zealand. A general inductive approach was selected to analyse the interview data.

### **1.3 The structure of the thesis**

This thesis is presented in accordance with the 2016 University of Auckland regulations for including publications in a thesis. The current thesis has eight chapters in total, and reports a three-phase research design based on four separate studies. I have adopted a ‘focus-down’ model, which is a popular approach for PhD research in the field of Social and Health Sciences involving a balanced consideration of both the breadth and depth of a research topic (Dunleavy, 2003). Following this model, the PhD student begins by researching the topic of interest from a broad angle. The scope of focus then gradually narrows down to an in-depth study of the topic of interest (see Figure 1). The shift in my research scope from broad ethnic

groupings (double minority in general) in Phase I, down to Chinese SG minority youth in Phase III, thus reflects the focus-down approach.

### Phase I

Chapter 4: Study One:  
Overview of double minority youth mental health  
Data source: Nationally representative youth 2000 surveys  
Sample: New Zealand high school students



### Phase II

Chapter 5: Study Two:  
Systematic review of psychological therapy for Chinese and other East Asian SG minorities  
Data source: Contemporary academic literature from international databases  
Sample: Peer-reviewed articles



### Phase III

Chapter 6: Study Three:  
The views of Chinese SG minority youth  
Data source: Interview data  
Sample: Chinese SG minority youth in New Zealand

Chapter 7: Study Four:  
The views of psychological therapists  
Data source: Interview data  
Sample: Psychological therapists experienced in working with Chinese SG minority youth in New Zealand

Figure 1. Structure of the research.

### 1.3.1 Introductions to each chapter

Chapter 1 provides a brief background and introduction to the whole thesis. Chapter 2 reviews the current literature in relation to the mental health of double minority young people, with a focus on those of Chinese descent living in English-speaking Western countries. Chapter 3 describes the methodology, including the reasons for using an MMRM approach that draws on aspects of intersectional approaches.

In Chapter 4, I begin by exploring the mental health status of double minority high school students in New Zealand, using nationally representative and cross-sectional data from the National Youth2000 Health and Wellbeing Survey Series (“Youth2000” for brevity) (Study One). Chapter 5 is a systematic review of therapeutic recommendations for Chinese and other East Asian SG minorities in English-speaking Western nations (Study Two). Chapter 6 describes a subsequent qualitative study focusing solely on the views of Chinese SG minority young people on mental health challenges and supports in New Zealand (Study Three). Chapter 7 reports another qualitative study exploring the views of mental health providers about working with Chinese SG minority young people in New Zealand (Study Four). The two qualitative studies help explain the findings of the quantitative study and fill in the gaps identified in the literature review. Chapter 8 is where I conclude the thesis with the integrated findings of the four studies and discuss their potential implications for theoretical and practical knowledge in the field of mental health. Implications for the future research and practice are



also considered.

I am the lead author on all four papers included in the thesis. With the support of my PhD research supervisors, I planned and carried out the studies on which they are based, wrote the papers, and then reviewed them with my co-authors. If the papers have been published or accepted for publication, the accepted manuscripts are included in the thesis. Where the outcome of peer review is not yet known or they have been rejected, the manuscripts are included as submitted. All the papers have been reformatted so that the numbering of pages, tables and figures is continuous throughout the thesis.

---

## Chapter 2: Literature Review

---

In this chapter, I review the current literature regarding the mental health and wellbeing of double minority young people. The chapter consists of three parts. Firstly, I discuss concepts and theories about young people, youth development and mental health. Due to the unique purpose of my thesis, I specifically focus on the areas relevant to SG minority, ethnic minority, and double minority youth. Secondly, I provide an overview of the mental health challenges of double minority youth. I pay particular attention to the challenges Chinese SG minority young people may face. Thirdly, I explore opportunities for psychological therapists to better support the mental health and wellbeing, as well as healthy development, of SG minority youth of Chinese descent in English-speaking Western nations, including the USA, UK, Ireland, Canada, Australia, and New Zealand. These countries share traditions from Rome and Greece, Christianity, and modern enlightenment (Kurth, 2003), and have significant Chinese minority populations (Ip, 2003). Finally, I conclude with a summary of key issues.

### 2.1 Young people and development

The United Nations Department of Economic and Social Affairs (UNDESA) (2013; 2011) defines “youth” as individuals from 15 to 24 years of age, with those aged between 10 and 24 years classified as “young people”. However, these two terms are often used interchangeably

in the literature to define a culturally loaded concept (Hamilton & Hamilton, 2004; Keniston, 1970; Patel, Flisher, Hetrick, & McGorry, 2007; Skelton & Valentine, 2005). As well as youth and young people, other similar terms such as adolescents, teens, and teenagers refer to individuals going through a stage of rapid biological development (i.e., puberty, or the development of secondary sexual characteristics) (Lerner et al., 2013; Shaffer & Kipp, 2007).

In many English-speaking Western nations, the term youth typically describes a period of transition from parental dependence to independent adulthood (UNDESA, 2013). The older phase of this period can also be termed “emerging adulthood” (Arnett, 2000; Arnett, 2007; Bynner, 2005). During this time, young people are usually completing their formal education and entering employment (Lerner et al., 2013).

In China and many other Chinese-speaking regions, young people are commonly viewed as those aged between 15 and 29 years (Xi & Xia, 2006) who still live with their families of origin and have not yet entered marriage (Ip, 2003). In general, these young people are subject to family expectations and responsibilities, such as choosing educational plans and career paths, and entering into dating and relationships toward marriages that will further the prosperity of their families, whereas young people in English-speaking Western nations may be given more space for self-actualisation (Xi & Xia, 2006). It is therefore important to adopt a broad age range to fully grasp the expected developmental trajectory and cultural implications Chinese SG minority youth may have to deal with. Accordingly, in this thesis, I have defined youth or young people as individuals between 10 and 29 years of age.

### 2.1.1 Youth development

When viewed as part of developmental processes, youth development reflects a series of systemic changes due to biological maturation, life experiences, and concurrent changes in social and other environmental contexts (Bronfenbrenner, 2001; Hamilton & Hamilton, 2004; Lerner et al., 2013). In part, the maturing of cognitive capacity typically allows more complex stimulus processing and hypothetical reasoning by young people (De Ribaupierre, 2015; Shaffer & Kipp, 2007). Hence, for young people, social and environmental interactions can become more important than biological maturation (Erikson, 1968; Karpov, 2015; Keller, 2015). Youth development should thus be viewed as a complex and reciprocal process of growth, closely tied into surrounding influences including family, peers, school, and other factors in the youth context.

#### Approaches to positive youth development

The perspective of *Positive Youth Development* (PYD) refers to psychological approaches that aim to optimise youth development. PYD scholars investigate the potential strengths of young people with a focus on developing their abilities to meet their needs (Damon, 2004). A PYD approach is informed by contemporary theories of developmental systems such as Bronfenbrenner's bioecological theory, and appreciates the bidirectional interactions between young people and their surroundings (Lerner, Almerigi, Theokas, & Lerner, 2005). In this

perspective, development is viewed as a growing process where young people develop self-identity, goals, and roles or position in society and connect with important others (Damon, 2004). PYD approaches aim to cultivate youth initiative and motivation for growth (Larson, 2000) in areas such as competence, confidence, connection, or character (Lerner et al., 2005; Park, 2004; Park, 2009). Practices to support positive youth development, for instance, may include the elements: building supporting relationships with parents, teachers, and peers, seeing opportunities not problems, mentorship, and learning, as well as engaging with caring communities (Hamilton & Hamilton, 2004). The emergence of PYD approaches signals a paradigm shift from the highly individualistic and deficit-focused approaches to relationship- and strengths-building in contemporary Western models of mental health practice (Larson, 2000). In this thesis, I consider the mental health and wellbeing needs of dual minority youth within the context of a PYD perspective. This paradigm connects well with the relational nature of Chinese mental health perspectives, and promotes strength and wellbeing while at the same time addressing developmental challenges and important mental health needs.

### 2.1.2 Youth development and mental health

Challenges to healthy youth development are intertwined with mental health and wellbeing (Bowman, McKinstry, & McGorry, 2017; McGorry, Purcell, Hickie, & Jorm, 2007). According to the World Health Organization (WHO) (2004, p.12), mental health is “a state of well-being in which every individual realizes his or her own potential, can cope with the

normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.

Estimated lifetime prevalence for mental ill-health ranges from 12% to 47% worldwide (Kessler et al., 2007). For nearly half of those people, mental ill-health begins in adolescence or young adulthood (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015; Bowman et al., 2017; Kessler et al., 2005; Patel et al., 2007). A recent study has suggested that mental health among young people in New Zealand may be worsening (Clark et al., 2013a). Further, studies from a range of English-speaking Western countries suggest that over two-thirds of young people in significant mental distress do not utilise mental health services for reasons such as cost, stigma, and lack of awareness and education to help negate stigma (Bowman et al., 2017; Muller, 2017; McDermott, Hughes, & Rawlings, 2018; Vermeir, Jackson, & Marshall, 2018).

The development of identity is among the important areas covered in the youth development literature. In the 1960s, the well-known developmental psychologist, Erik Erikson placed a spotlight on integral self-identity and satisfying interpersonal relationships as essential for young people’s wellbeing and mental health (Erikson, 1968). Delays, frustrations or problems in achieving the psychosocial developmental needs for identity development and relationship building can contribute to mental ill-health and behavioural problems later in life (Hamilton & Hamilton, 2004; Kessler et al., 2005; Patel et al., 2007b; Steinbeck & Kohn, 2013). Conversely, those who have a stable and secure sense of identity will likely be more competent in developing positive relationships, dealing with stress and contributing towards

their own lives as well as others.

## **2.2 Identity development for minority youth**

Identity development for members of a minority group/s can sometimes be challenging. The term “minority” typically refers to a group of individuals sharing a social identity that differs from the corresponding majority identity in a society. Differentiating minority identities is often based on easily identifiable physical or psychological human characteristics, including ethnicity, culture, sexuality, and gender (Barzilai, 2010). There is still a lot to be learned about how minority young people navigate through their developmental challenges. In this section, I will discuss key concepts and theories relating to ethnic, cultural, sexual, and gender minority youth. These concepts underpin my thesis research.

### **2.2.1 Sexual and/or gender minority youth**

The term sexual and/or gender (SG) minority, or sexual/gender minority, refers to individuals whose sexual and/or gender identity does not conform to cis-heteronormative ideals (Mayer et al., 2008). In this thesis, I have considered issues and opportunities for SG minority youth as a combined group rather than emphasising the differences between the two minority groups. In Chinese and other East Asian contexts where individualistic values are less significant (King & Bond, 1985), sexual minority and gender minority are not always considered as two separate categories. For example, the commonly used Chinese term “Tongzi”

does not distinguish between gender minority and sexual minority individuals. Furthermore, scholars in the U.S. recognise that SG minorities face some common challenges in relation to cis-/hetero-normative oppression from mainstream society (Toomey, Ryan, Diaz, Card, & Russell, 2013). However, it is important to acknowledge that combining sexual and gender minorities does risk making their differences invisible. This is a particular issue for gender minority youth, who face additional issues and specific challenges (Bradford, Reisner, Honnold & Xavier, 2013; Levitt & Ippolito, 2014), and remain relatively under-researched compared to sexual minority youth.

While acknowledging some significant differences, SG minority can nevertheless be used as an umbrella term to include lesbian, gay, bisexual, trans-gender/-sexual, and questioning (LGBTQ) individuals. These labels are commonplace in English-speaking Western nations (Barrett, 2015). The acronym LGBTQ covers the following groups: Lesbian/ Gay refers to females/ males who identify their romantic attachments as being with persons of the same sex; Bisexual refers to individuals who identify their romantic attachments as being with persons of both sexes; Questioning refers to individuals who are not sure about (or still in the process of defining) their sexual identity; and Transgender, or more broadly gender diverse/non-binary, refers to individuals whose internal gender identity is incongruent with the sex assigned to them at birth (Cheney, LaFrance, & Quinteros, 2006).

In China and other Chinese-speaking regions, the term “Tongzhi” (i.e., comrades) is the term preferred by SG minorities to identify themselves, as the word emphasises comradeship



rather than indicating sexuality or gender orientation (Coleman & Chou, 2013). Although Chinese gay men are sometimes called “Duanxiu” (i.e., cutting sleeve), and lesbian women “Mojing” (i.e., rubbing mirror), these are less commonly used traditional Chinese terms (Hinsch, 1990; Wu, 2003). Similarly, “Bianxingren” literally means someone who changes their gender (梁明玉, 2012).

As the focus of this thesis is migrant Chinese youth residing in New Zealand, I use SG minority as an inclusive term to describe persons who are not exclusively heterosexual and/or cisgender.

#### Contemporary stage models of sexual or gender minority identity development

Due to the cis- and hetero-normative nature of English-speaking Western societies, mental health organisations such as the American Psychological Association (APA) (2011; 2015) suggest that psychological therapists should be aware of the issues around SG identity development, stigma, discrimination, minority stress and intersectionality for young people who sit outside the hetero- and cis- norms. The development of a SG minority identity has been hypothesised to move through a series of coming-out phases (D'Augelli, 1994; Floyd & Stein, 2002; Garnets & Kimmel, 2003; Savin-Williams & Diamond, 2001). Cass's Homosexual Identity Formation Model, proposed in 1979, describes a step by step unidirectional stage-like process, starting from the initial awareness of being different in terms of one's SG orientation, and moving through self-denial and self-exploration, self-acceptance,

disclosure of SG minority identity, and then establishment of appropriate relationships congruent with this identity (Cass, 1979; Floyd & Stein, 2002; McCarn & Fassinger, 1996; Morgan & Stevens, 2008; Savin-Williams & Diamond, 2000).

More recent models critique this linear process. For bisexual youth, for example, identity development can be a particularly ambiguous process filled with uncertainty, as they often struggle with pressure to fit in with either identity group while trying to come to terms with their bisexual identity (Brown, 2002; D'Augelli, 1994).

For gender minority youth, their gender identity is based on gender experiences not traditionally associated with the sex they were assigned at birth (Mayer et al., 2008). Transgender youth often experience gender dysphoria, a chronic feeling of mind-body dissonance with regard to their gender (American Psychiatric Association, 2013). Scholars suggest that for transgender youth, a stage-like process of identity development may involve experimentation with alternative gender identities as they recognise a gender mismatch (between mind and body), followed by gender incongruence, and later transition to a life aligned with their gender identity (Levitt & Ippolito, 2014; Morgan & Stevens, 2008).

#### Minority stress theory and sexual/gender minority mental health

Overall, previous research shows that many SG minority young people can achieve an integrated and coherent sense of identity by early adulthood (Consolacion, Russell, & Sue, 2004; Rosario, Schrimshaw, & Hunter, 2004), although for some, their identity status may

remain diffused, foreclosed or in a state of moratorium for protracted periods of time (Lerner et al., 2013). Others may also experience life challenges beyond identity development, including discrimination for example.

Many SG minority youth choose to conceal (or counterfeit) their SG minority identity to appear heterosexual cisgender so as to blend into the mainstream (Chrobot-Mason, Button, & DiClementi, 2001). Concealment serves as a strategy in identity management to avoid dealing with homo-/bi-/trans-phobia, as these negative feelings, attitudes, speech, thoughts, views or behaviours from others may disadvantage SG minority youth (Mohr & Fassinger, 2000). The literature consistently suggests that SG minority youth are at elevated risk of mental ill-health (Lucassen, Stasiak, Samra, Frampton, & Merry, 2017; Mayer et al., 2008), with depression and anxiety and associated problems common (Marshall et al., 2011; Mayer et al., 2008).

Minority stress theory has been used to explain the disparities in mental health between SG minority and heterosexual/ cisgender young people. This theory is the updated version of social causation theory, and suggests that the mental ill-health of minority groups is the result of the difficult social environments they face and not, by default, their inherent failures (Dohrenwend, 1966). Accordingly, the elevated risk of mental ill-health is seen as the result of encountering various forms of homo-/bi-/trans-phobic mistreatment derived from an oppressive environment (Dentato, 2012; DiPlacido, 1998; Hendricks & Testa, 2012). These are termed “minority stressors”. The core tenet of minority stress theory is that being a member of a minority group greatly increases exposure to minority stressors, which in turn leads to

elevated risk of mental ill-health (Dohrenwend, 2000). Scholars have identified two types of minority stressors (Meyer, 2003). Distal stressors typically include: anti-gay harassment and micro-aggressions; negative responses, tensions and conflicts related to disclosure of SG minority identity to friends or family members; and experiences of bullying and victimisation at school or in the workplace (Li, Thing, Galvan, Gonzalez, & Bluthenthal, 2017; Sue, 2010). Proximal stressors are the psychological processes that occur after exposure to distal stressors, such as the anticipatory fear of rejection. Studies (DePalma & Jennett, 2010; Eliason, 1997; Ochs, 1996; Shidlo, 1994; Szymanski & Gupta, 2009a) have shown that the experience of homo-/bi-/trans-phobic victimisation can become internalised into a self-derogatory belief of the self as inferior and worthless. Internalised homo-/bi-/trans-phobia has been identified as one of the most damaging forms of minority stressor in the mental health and identity formation of SG minority young people (Bockting, 2008; Meyer, 2003; Newcomb & Mustanski, 2010; Williamson, 2000).

### 2.2.2 Ethnic and/or cultural minority youth

In English-speaking Western nations, the term ethnic minority commonly refers to individuals who are immigrants, and/or non-European White (Berthoud, 1998; Bonnett, 1998). Although “race” and “ethnicity” are often used interchangeably, human race is a genetic designation that subsumes all ethnicities together as one species (Berry, 2013a; Quintana et al., 2006). In psychology, ethnicity is defined as a sense of belonging to a certain ancestry, familial

origin, or cultural heritage, and individuals with the same ethnicity can be bound together by the shared beliefs, values, or customs derived from this common origin (Berthoud, 1998; Connor, 1978). Culture, a closely related term, can be described as a “mental software” (Hofstede, Hofstede, & Arrindell, 1998). It underscores the shared values, norms, and customs that have become a habitual way of living followed by an ethnic group (Geertz, 2008). Culture not only provides norms but also creates a context against which the self is defined in relationship to others, as well as guiding appropriate behaviours for people in this cultural context (Berry, 2005; Betancourt & López, 1993; Segall, 1986).

In spite of the numerous ethnic cultures across the world, Kluckhohn (1962) suggested there should be a universal way of categorising cultural groups because all need to answer some common questions about humanity, such as how to show love and respect. Hofstede (1980) further simplified culture into six dimensions: large-/small-power distance, high-/low-uncertainty avoidance, individualism/collectivism, masculinity/feminism, long-/short-term orientation, and indulgence/restraint. Among these, individualism/collectivism has been the focus of much cross-cultural research (Hofstede, 2011). A set of scoring systems has also been developed to determine whether a culture is individualistic or collectivistic (Hofstede, 2011). According to this model, many Asian nations are grouped into the collectivistic culture category, and generally English-speaking Western nations are categorised as more individualistic (Hofstede, 2011).

However, I have only used these categorisations selectively in the thesis for two major

reasons. Firstly, Hofstede (2011) himself pointed out the philosophical flaw of this categorisation model as the term “culture”, by definition, already has collectivistic implications (i.e., shared customs among a *group* of people). Secondly, critics have argued that this model is overly simplistic, as cultures are richly diverse (Jones, 2007). Important cultural nuances (e.g., filial piety as a unique Chinese cultural feature) can easily be lost in the process of categorisation. Instead of using individualism/ collectivism to categorise cultures, I have opted to use these terms to describe a tendency or commonly held value (e.g., being collectivistic is used in the sense of valuing the inter-dependent relationships), rather than as a definitive category. This usage is in line with the current trend in the cross-cultural literature (Hofstede, 2011).

#### Stage models of Asian identity development in the Western world

Ethnic minorities with an Asian heritage represent culturally heterogeneous groups (Chae & Larres, 2010; Feng, 1994; Salant & Lauderdale, 2003). Asian cultures can be roughly divided into six groupings by region (i.e., North, Central, East, West, South, and Southeast Asian). However, Chinese ethnicity is one of the largest ethnic groupings globally (Parker et al., 2001), and Chinese culture one of the most influential among Asian people (Reischauer, 1974). It is, therefore, important to note that most of the theories described here were developed on the basis of, or normed with this population.

Stage-like models of ethnic identity formation have been proposed for ethnic minority

young people in the English-speaking Western world. Similarly to the SG identity models, the development of a minority ethnic identity can be challenging (Boykin, 1996). The process of colonisation often enforces the sole legitimacy of dominant cultural views that may marginalise or even pathologise indigenous or minority cultural views of mental health and development (Revilla, 1997; Berry 2013a; Berry, 2013b; Thompson & Neville, 1999). The stage approach to ethnic identity development includes three main phases: diffusion/foreclosure (not yet beginning to think about ethnicity), moratorium (in the process of exploration), and identity achieved (committed to an ethnic identity) (Bernal, Knight, Garza, Ocampo, & Cota, 1990; Phinney, 1989; Phinney & Alipuria, 1990). For migrant Asian young people, scholars have developed specific models of ethnic identity development (Chae & Larres, 2010; Herring, 1995; Nadal, 2004; Poston, 1990; Sue, Mak, & Sue, 1998). These models can be summarised into five broad stages. In the first stage, Asian young people naïvely believe in the superiority of the customs and values of Western culture and devalue their Asian culture. Accordingly, they usually comply with Western customs without question. In the second stage, Asian young people start to develop feelings of not fitting in with Western culture, and become confused about whether its values suit them. In the third stage, young people begin to enthusiastically reject Western values and embrace Asian culture. In the fourth stage, they gradually develop a balanced view of the strengths and limitations of Asian and Western cultures. In the final stage, young people can appreciate the strengths and weaknesses of both cultures and identify themselves as integrated cultural beings without experiencing

internal conflict. Some scholarly models of Asian identity development include more stages. For example, in his Filipino American identity model, Nadal specifies a stage where young Filipino people need to gradually differentiate their unique ethnic heritage from “pan-ethnic” Asians. (Nadal, 2004). Other scholars draw more attention to the transformation of identity as an Asian youth, from feeling “less than” White to “self-love” (Revilla, 1997). In a nutshell, despite the minor differences between these scholarly models, a central theme is the psychological journey that calls for young people to move from naïvely believing in the mainstream and rejecting their own ethnic heritage, to self-exploration and acceptance in the process of achieving a bicultural identity.

#### The application of minority stress theory to ethnic/cultural minority mental health

Similarly to SG minority identity, the development of a minority ethnic identity in the Western world can sometimes be difficult for ethnic minority young people (Phinney, 1991), who are also more likely to experience mental distress (Hall, 2010; Pieterse, Todd, Neville, & Carter, 2012). Minority stress theory (Dentato, 2012) has been applied to explain the elevated risk of mental ill-health among ethnic minority youth (Russell, Mallinckrodt, & Liao, 2008). As most social environments are not designed to accommodate these young people, they can often face challenging situations involving neglect, prejudice, racial discrimination, mistreatment or other obstacles that can marginalise their developmental and mental health needs (Cauce et al., 2002; Hamilton & Hamilton, 2004; Lerner et al., 2005). The findings of a



New Zealand survey support this understanding (Johnstone & Read, 2000). Of 247 psychiatrists surveyed nationally, a significant number (11%) erroneously believed that indigenous people are biologically and genetically prone to mental ill-health. In addition to experiencing racism or discrimination from others, ethnic minority youth are reported as likely to internalise the ethnocentric views of dominant societies (LeVine & Campbell, 1972). According to the framework for minority stress, the experience of racist attacks can be identified as a distal stressor, while perceived and internalised racism in particular are documented as one of the most damaging forms of proximal stressor (Graham, West, Martinez, & Roemer, 2016; Pieterse et al., 2012).

### 2.2.3 Double minority youth

The term double minority was introduced and discussed in Chapter 1. In this section, I discuss relevant theories and concepts in relation to identity development in double minority youth.

#### Double minority identity theories and the emergence of intersectionality

Identity development can be complex for double minority young people due to the coexistence of SG and ethnic minority identities and the interaction between them (Greene, 1994). While the stage models of identity may work for single minority youth, these models have been severely critiqued for their limited application to double minority populations

(Bilodeau & Renn, 2005; Ikizler & Szymanski, 2014; Morris, 1997). They are seen as simplistic and linear, neglecting the multiple aspects (e.g., socio-economic status) of life that may intersect with identity development (Bilodeau & Renn, 2005). In order to accurately depict identity development as an ongoing process embedded in various contexts, a growing body of literature in the field has discarded linear models, instead emphasising the adoption of *multi-dimensional* perspectives to understand the development of identity and its relationship with youth mental health (Bilodeau & Renn, 2005; Diamond, 2006; Konik & Stewart, 2004; Morris, 1997). Compared to linear stage models, this recent perspective pays particular attention to the “*ecological*” (Bronfenbrenner, 1977) nature of the developmental process (Bilodeau & Renn, 2005). It recognises that identity development can occur throughout the entire life span of young people, and focuses on the interactions between young people and their psychosocial contexts. As previously suggested by Bronfenbrenner (2001; 1986), young people’s daily experiences in dealing with their surroundings can significantly shape the path and make-up of identity formation. In this thesis, I embrace both linear and multi-dimensional approaches to produce a more comprehensive understanding of Chinese SG minority young people.

Drawing on Bronfenbrenner’s theory (1986) (as well as other systemic, multicultural and feminist theories), Crenshaw (1991) wrote an influential paper on *intersectionality*. She suggested that although the recent feminist movement in America has led to recognition of social oppression against women, it is centred on the experiences of middle-class, White

American women and falsely assumes that their experiences are representative of all women. Crenshaw (1991) argues that this assumption has unfortunately led to further exclusion or marginalisation of African American women, both within and outside social equality groups. The premise for intersectionality is that multiple aspects of one's identity can interact to form an experience completely distinct from its singular parts (Cole, 2009). Compared to middle-class White American women, the experience of marginalisation for African American ('Black') women can be very different, and much more intense.

I have adopted this premise to investigate the experiences of double minority youth, with the aim of exploring their unique experiences in the process of identity development. As Chung and Katayama (1998) describe, the journey involves balancing the development of ethnic and SG minority identities as two "parallel" and yet "interactive" processes. Even though they appear to have two independent developmental trajectories, the two often intertwine to create unique intersectional challenges linked to double minority status (Jaspal, 2015). Take Asian SG minority youth as an example. Some scholars have found that double minority young people may experience a sense of psychological incongruence or tension because of the incompatibility between their ethnic/cultural and SG minority orientations (Jaspal & Cinnirella, 2010). In the next section, I explore what is documented in the literature with regard to the mental health challenges often faced by double minority young people.

## 2.3 The mental health challenges of double minority youth

To begin with, it is important to acknowledge there is no universal understanding of the concept “mental health”. In English-speaking Western nations, mental health has connotations of self-efficacy and individualisation (Thompson & Neville, 1999). On the other hand, in more collectivistic nations such as China, mental health is generally defined in a broad and relational perspective. For example, in Chinese traditions, a sense of good mental health is achieved through a balanced lifestyle maintaining harmonic relationships between self and others, as well as upholding social morals and harmony (Santee, 2007). Among Maori in New Zealand, mental health is also seen as strongly relational and as a critical component of wellbeing, alongside other critical components such as family and spiritual wellbeing. Partly due to these cultural differences in the way mental health is viewed, there have been inconsistent or even conflicting reports in the double minority literature regarding mental health and wellbeing. Issues around the use and interpretation of mental health measures for double minority youth have been documented (DeBlaere, Brewster, Sarkees, & Moradi, 2010). I next summarise the two main hypotheses used by scholars and explain the conflicts in the literature.

The hypotheses for double jeopardy or resiliency

According to minority stress theory, double minority young people are at greater risk of mental ill-health because of combined effects of social oppression. Scholars have termed these

combined effects variously as “double whammy”, “double jeopardy”, “triple jeopardy”, “triple oppression”, “super threat”, “gay racism”, or “racialized homophobia” (Diaz, Bein, & Ayala, 2006; Greene, 1996; Hayes, ChunKennedy, Edens, & Locke, 2011; Jaspal, 2015; Strayhorn, 2014). These terms signify the unique intersectional challenges often faced by these young people, and the cumulative negative impact on their mental health and wellbeing. Some scholars have tested and found only partial support for the *double jeopardy hypothesis* (Dowd & Bengtson, 1978; Ferraro & Farmer, 1996; Hayes et al., 2011), noting that the intersection of ethnic and SG minority identities may also be associated with some reverse or positive effects on youth mental health and wellbeing.

Among other possible explanations, *the hypothesis of resiliency* has recently drawn a lot of attention in the literature (Li et al., 2017; Meyer, 2010; Reicherzer & Spillman, 2012; Rios & Eaton, 2016; Wolitski, Stall, & Valdiserri, 2008). This hypothesis proposes that for double minority young people, their early experience of racism may help them deal with homo-/bi-/trans-phobic attacks later on. Further, double minority young people may have more opportunities to develop and practice resilience skills for dealing with discrimination through learning from the experiences of their families. According to social learning theory (Bandura, 1962), the skills they learn in their families can be transferred into resources to combat other adversity later in life. Moreover, the literature provides illustrations of important coping skills, such as identity management and selective coming out for example (Chrobot-Mason et al., 2001; Jaspal & Williamson, 2017; Szymanski & Sung, 2013). A successful coming-out

experience can help reduce internalised homo-/bi-/trans-phobia, as positive feedback from important others may help foster a good sense of self (Hunter, 2007). However, the potential harms associated with coming out, such as rejection by others, can drastically increase the risk of mental ill-health (Hegna, 2007). Therefore, advanced skills for prioritising salient aspects of their identity as appropriate for the social context may be beneficial for double minority young people (Szymanski & Sung, 2013). In a number of the empirical studies presented in the next section, the resiliency hypothesis helps explain why double minority youth can sometimes be more resistant to mental ill-health.

### 2.3.1 Overview of current double minority populations

Having explained the possible mechanisms that can affect the mental health of double minorities, I now provide a population overview of their mental health status as reported in the literature. Most of the studies were conducted in the U.S. with non-rural regional samples of double minorities of predominantly African (Black), Latino, or Asian American ethnicity.

Generally speaking, double minorities are less likely to disclose their sexual minority status than their White counterparts. Sexual minority persons across all ethnic groups typically report a higher rate of eating disorders than heterosexuals. For Black sexual minority men and women, depression is associated with internalised homophobia, low self-esteem, and risky sexual behaviours (men only). Black sexual minority women often report greater discrimination and poorer psychological wellbeing than sexual minority Black men and White

women (Loiacano, 1989; O'Donnell, Meyer, & Schwartz, 2011; Walker & Longmire-Avital, 2013; Washington & Thomas, 2010). In terms of age comparisons, older Black gay men report much higher degrees of perceived ageism, racism, and internalised homophobia than older White and young Black gay men (David & Knight, 2008). Young Black lesbians between the ages of 16 and 20 appear to successfully achieve identity integration despite multiple minority stress (David & Knight, 2008; Follins, 2011; Potoczniak, Crosbie-Burnett, & Saltzburg, 2009; Robinson, 2010; Wilson, Okwu, & Mills, 2011). For Latino sexual minority persons, disordered eating, body image disturbance (De Santis et al., 2012), poverty, and perceived racism (Diaz et al., 2006; Diaz, Ayala, Bein, Henne, & Marin, 2001; Sun et al., 2016) are among the reported problems contributing to depression, however higher social support is related to lower levels of depression (Zea, Reisen, & Poppen, 1999).

Several studies have discussed Asian Americans sexual minorities in comparison to their Black, Latino, and White American peers (Aranda et al., 2015; Bryn Austin, Nelson, Birkett, Calzo, & Everett, 2013; Calzo, Blashill, Brown, & Argenal, 2017; Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; Mereish & Bradford, 2014; Meyer, Dietrich, & Schwartz, 2008; Wilson & Yoshikawa, 2007). Although double minorities 'on average' report a lower lifetime prevalence of mental disorders than White sexual minority people, certain specific ethnic (i.e., Black, Asian and Latino) sexual minority participants in all these studies showed a slightly elevated risk for depression and suicidality. A wide range of mental health service needs are reported among ethnic minority transgender persons (Kahn, Alessi, Woolner, Kim, & Olivieri,

2017; Nemoto, Cruz, Iwamoto, & Sakata, 2015; Reyes et al., 2015; Yang, Manning, Van Den Berg & Operario, 2015), including mental health counselling, treatment for alcohol and drug addiction, sex work and immigration issues, violence and abuse, HIV related issues and gender-transitioning psychological and medical assistance. However, very few supporting resources are available for them.

#### Overview of the mental health status of double minority youth

For double minority young people specifically, only a few population-based studies have examined their mental health challenges in comparison to their White peers. I have summarised these studies in Table 1.



Table 1. Overview of the mental health status of double minority youth

Authors	Year	Location	Methods	Sample	Findings
Balsam et al.	2015	U.S. based social networking sites	Quantitative (Online Survey)	1,106 sexual minority women	Sexual Minority Women (SMW) of colour did not report elevated rates of discrimination, compared to White SMW. Asian SMW reported lower trauma exposure and Post Traumatic Stress Disorder (PTSD) severity than White SMW.
Shadick et al.	2015	New York (USA)	Quantitative (Survey)	4,345 first year college students	LGB students had a higher suicide risk than their heterosexual peers. LGB students of colour had an elevated suicide risk relative to their heterosexual peers, but White LGB students had the greatest suicide risk.
Bostwick, et al.	2014	Massachusetts (USA)	Quantitative (Youth risk survey)	6,245 sexual minority youth	Compared to White sexual minority youth, Asian and Black peers had lower odds of sadness, suicide, self-harm, but American Native/Pacific, Hispanic, and multicultural peers had higher odds.
Lytle et al.	2014	National Health Assessment (USA)	Quantitative (Survey)	4,321 LGB college students	LGB students reported more risks than heterosexuals. Within the LGB sample, Asian, Black, and Latino students reported lower depression; Black and Multicultural students reported more suicide attempts; Latino students reported lower suicidal ideation than White peers.
LeVasseur et al.	2013	New York (USA)	Quantitative (Youth risk survey)	5,541 LGB youth	LGB youths had higher rates of attempting suicide (4.39) and experiencing bullying (1.9), compared to non-LGB youth. The effect of bullying on suicide was strongest in White males (vs Latino).
Mustanski et al.	2011	Chicago (USA)	Quantitative (Survey)	425 LGB youth	Ethnic minority (mostly Black and Latino, some Asian and Pacific) participants reported lower disclosure and self-acceptance (females in particular); 94% of participants reported being victimised; social/family support had a protective effect.

Hayes et al.	2011	66 university counseling centers (USA)	Quantitative (Survey)	1,596 LGB youth	Ethnic and sexual minority clients had greater psychological distress than White or heterosexual clients respectively. Among ethnic minority students, sexual minority status was associated with heightened distress. Among sexual minority students, ethnicity was not associated with added sources of distress.
Mustanski et al.	2010	Chicago (USA)	Quantitative (Survey)	246 LGBT youth	LGBT youth reported higher rates of mental disorder diagnosis, but ethnic minority LGBT youth did not show additional distress. Bisexuals had low rates of all diagnoses. Depression in this population may have been over-estimated.

As shown in Table 1, these studies yielded mixed results, with some supporting the double jeopardy hypothesis and other supporting the resiliency hypothesis. In summary, double minority youth from various cultural heritages report different rates and types of mental health risk. Overall, young people with either ethnic or SG minority status report elevated risk for mental ill-health compared with cisgender and heterosexual White youth. However, as previously discussed, being a double minority youth is not always linked to a further elevated level of risk. The intersectional effects of double minority status on the mental health and wellbeing of youth of different ethnicities seem to vary widely according to their cultural heritage. I will next focus on Chinese culture and explore its impact on Chinese SG minority young people.

### 2.3.2 The mental health challenges of Chinese sexual/gender minority youth

Prominent features of Chinese culture typically reflect the philosophies of Confucianism, as well as Buddhism and Taoism (Santee, 2007), with an emphasis on the virtues of contentment with one's current circumstances and engagement in harmonic and respectful family relationships (Chinese Culture Connection, 1987; Fan, 2000). Partly due to this cultural value, many SG minority young people in modern China still live 'in the closet' and/or maintain apparently heterosexual relationships (Wong, 2015). For instance, in a large online survey in China ( $n = 41,878$ ), up to 90% of men who have sex with men (MSM) reported they had either entered, or intended to enter into a heterosexual marriage of convenience (Zhang & Chu, 2005). Further, participants in a small qualitative study of 22 Chinese sexual minority men and women interviewed across five cities in China reported they were in 'fake' marriages in order to 'save face' (Wang, 2015). Such is the demand for these marriages that online platforms including 'iHomo' have been developed to enable connections between Chinese SG minority persons who wish to enter a 'heterosexual marriage' (Mistreanu, 2015).

Concealing SG minority status can also be understood in the context of repression and persecution of SG minorities in China. Homosexuality was not declassified as a mental disorder until 2001, and the Chinese Psychiatric Association only did so after coming under pressure from international professional authorities (Wu, 2003). In contrast, the American Psychiatric Association officially stopped considering homosexuality a mental disorder almost thirty years earlier, in 1973 (Mayes & Horwitz, 2005). However, exceptions to this pattern of repression have occurred in certain Chinese-speaking regions. In Taiwan, for example, the rights of same-sex attracted Tongzhi were recently acknowledged by the legalisation of same-sex marriage in 2017 (Capell & Elgebeily, 2019; Cheng, Wu, & Adamczyk, 2016). However, the recognition of Tongzhi has not been extended to other SG minorities. Transgender people, in particular, remain one of the most stigmatised populations in Chinese-speaking regions, where they can even experience marginalisation from Tongzhi groups and organisations (Wong, 2015).

Even in a time of reduced repression, hiding or being discreet about one's SG minority identity remains important in Chinese cultural and social contexts. In Chinese traditions, individualisation is not encouraged and there is an emphasis on the virtues of collectivism and conforming to cultural norms and values such as avoiding conflict, respecting elders, acceptance and being in harmony. Among such Chinese cultural values, Hu and Wang (2013) further suggest that filial piety plays an important role in the identity formation of Chinese sexual minority youth.

While migrant Chinese SG minority youth in English-speaking Western countries such as New Zealand may have more exposure to individualistic culture and values, many still retain their Chinese cultural roots (Eyou, Adair, & Dixon, 2000; Ip, 2003). This phenomenon has seldom been explored in the literature. However, a small convenience sample of young Asian (including Chinese) American lesbian women, Singh, Chung, and Dean (2007) compared those who endorsed more individualistic Western values with those endorsing more

collectivistic values. Those with more individualistic values appeared more ‘out’ in public, yet suffered from more internalised homophobia. Hence, it is important to explore the elements of Chinese culture to understand how they shape mental health and wellbeing.

#### Chinese culture and mental health challenges

Of the three backbones of Chinese culture, Confucianism, Buddhism and Taoism, Confucianism is the central foundation (Bond, 2010). The values imbued in the Confucian philosophy have important implications for the mentality of Chinese SG minority young people. Confucianism sees humans as relational beings and values the growth of human potential (Ames & Rosemont Jr, 2010). It emphasises education, honour and respect for authority, and self-perfection towards better relationships (Ames & Rosemont Jr, 2010; King & Bond, 1985). Confucianists believe in five cardinal relationships, termed “Wu Lun”, as critical to human wellbeing (Fan, 2000; King & Bond, 1985). These are the master-follower relationship, father-son relationship (or filial piety), husband-wife relationship, elder-younger relationship, and friendship. In terms of education, Confucianists believe that everyone is capable of learning, and should be given the opportunity to learn and improve regardless of social status (Fan, 2000; Leung, 2010). In parallel with the pursuit of harmonic and respectful relationships, Buddhists value self-control and emotional moderation, as strong feelings and desires are believed to be the causes of interpersonal conflict and human misery (Leung, 2010; Lin, 1981) Meanwhile, Taoists embrace harmonic relationships between human beings and nature, suggesting that people should always follow the ways of nature and not inflict themselves onto their surrounding contexts (Leung, 2010; Lin, 1981). Shaped by these values, Chinese people can typically be quite flexible in their approaches. Rather than consistently bringing a unitary personal or individualistic identity to each social situation, they can often conduct themselves in a context-specific way, which is termed a “pragmatic” way of living (Leung, 2010; Tseng & Wu, 2013).

It seems likely these Chinese philosophies contribute to the mental health challenges of Chinese SG minority youth. Although Chinese history is rich with cut-sleeves (Hinsch, 1990), revealing an SG minority orientation or SG minority identity is still socially stigmatising for the majority of Chinese young people. Several features of Chinese culture in particular are documented as frequently misused to reinforce cis/hetero-normativity, and can be very challenging for Chinese SG minority youth to cope with. For instance, the notion of Yin-Yang has often been used to uphold the normalcy of a relationship between a man and woman and ostracise other possible forms of romantic relationship (Greene, 1996; Lin, 1981). The notion of filial piety has also been misused to accuse Chinese SG minority men of causing loss of “face” (i.e., the collective honour and reputation of the family) (King & Bond, 1985) by not producing a male heir (Wang, Bih, & Brennan, 2009). Last but not least, Confucianism or Taoism can sometimes be used as means to maintain social norms and limit SG expression in Chinese SG minority youth (Chan, 1997; Greene, 1994; Greene, 1996; Kwok, 2018).

In addition to mental health challenges associated with Chinese cultural values, migrant Chinese SG minority youth can also suffer from other challenges related to mixing in predominantly White SG minority communities (Ayres, 1999; Davidson & Huenefeld, 2002). In contrast, a few articles have found that many of these young people demonstrate mental resiliency in coping with these challenges (Huang & Fang, 2018; Ocampo & Soodjinda, 2016). These scholars have pointed out, for example, that some Chinese SG minority youth learn invaluable coping skills for combating racism from their parents, who are also migrants. These skills can then be transferred to help these youth deal with other similar forms of oppression such as sexism or homophobia later in life.

## **2.4 Mental Health Practice Supporting Double Minority Youth**

The previous section reviewed the literature regarding identity development and mental health challenges for double minority young people. This section will provide a broad review

of youth mental health practice as discussed in the literature.

“Mental health practice” in English-speaking Western nations such as New Zealand typically describes interventions and approaches to help deal with psychological distress and support psychosocial functioning, wellbeing and mental health (Stickle, & Basset, 2008). Practice can be considered in a range of intensities or layers as shown in Figure 2. At the population level, social and contextual approaches such as preventive care or community outreach to reduce social stigma and homo-/bi-/trans-phobia in schools or local communities can be used as a broad approach to improve wellbeing for SG minority youth. Interventions at a slightly more intensive or personalised level can include programmes to support wellbeing or positive youth development. More intensively, *mental-health-focused* support mainly involves talking therapies, including specific forms of psychological counselling, treatment, consultation or psychotherapy to address emotional distress and/or behavioural problems. These approaches are commonly carried out by trained therapists, counsellors and psychologists. This level of intervention can also include the use of medications for common forms of mental distress (e.g., anxiety or depressive symptoms) (Cushman, 1992). Finally, the most specialised *mental-illness-focused* interventions include inpatient treatment, or intensive psychotherapy and biological treatment, such as the use of psychoactive medications and other medical procedures. Of note, although most forms of psychological therapy rely on verbal communication, they can also be delivered via other mediums, for example painting or music (Pelton-Sweet & Sherry, 2008; Whitehead-Pleaux et al., 2012).

When implementing these various levels of intervention, practitioners are strongly advised to adopt an “evidence-based” approach (Drake, Merrens, & Lynde, 2005). This approach emphasises the role of best scientific evidence for mental health practice, suggesting that all interventions applied to a certain area of practice should be based on evaluations of currently available evidence derived from relevant empirical research (Wampold & Imel, 2015). As a scientific exercise, this thesis aims to make a contribution to the area of “moderate

intensity or specialist interventions”. As such, I will next review the available evidence-based practice, with a particular focus on psychological therapies.





This figure demonstrates the common model of mental health practice in English-speaking Western nations such as New Zealand. The intensity of care is generally determined by the severity of mental distress. The details of this model can vary slightly between nations.

Figure 2. Various levels of mental health practice

## The unique bi-cultural context of mental health practice in New Zealand

It is important to highlight that this thesis was conducted in a country that is distinct from other English-speaking Western nations. New Zealand as a society is grounded in colonial assumptions that favour the perspectives of NZ European (or White) people (Ip, 2003). Its mental health practice is similarly founded on Western traditions, and, as such, may struggle to appreciate culturally diverse views (O'Hagan, Reynolds, & Smith 2012). Historically, mental health care in New Zealand has primarily adopted a medical model, and accordingly a “recovery” approach (New Zealand Ministry of Health, 2012). The term “recovery” is an adaptation of Western medical terminology and implies that mental distress, like physical injury, is an individualistic matter for which the patient is mostly responsible (O'Hagan, 2004).

However, unlike other English-speaking Western nations, New Zealand has a uniquely bicultural basis in the form of the Treaty of Waitangi (the Treaty hereafter) (Barrett & Connolly-Stone, 1998). The Treaty (or Te Tiriti o Waitangi) was initially signed in 1840 by representatives of the British Crown and the indigenous Māori people to outline the political relationship between the two parties and protect the rights of indigenous people under British rule (Orange, 2015). The Treaty is New Zealand's “founding document” and its influence is seen in various domains of New Zealand society including social policy, health, and research development (Barrett & Connolly-Stone, 1998; Brannelly, Boulton, & te Hiini, 2013; Hudson & Russell, 2009; Kingi, 2007).

Hence, Māori (and sometimes Pacific) cultural perspectives emphasising holistic, collectivistic, community- and family-oriented, and spiritual values are salient in New Zealand mental health practice (Kerekere, 2015; Tamasese, Peteru, Waldegrave, & Bush, 2005; Durie, 1999; Durie, 1985). There is also cultural tradition of acceptance of sexual diversity among Māori, despite the influence of Christianity dating from the time of British colonisation (Aspin

& Hutchings, 2007; Doyle, 2011, Durie, 1997; Wallace, 2003). Moreover, Māori conceptualisations of health contrast sharply with the individualistic Western model. As described in Durie's (1985) Te Whare Tapa Whā model, the four dimensions of health are mental (te taha hinengaro), spiritual (te taha wairua), physical (te taha tinana) and family wellbeing (te taha whanau). Pere's (1982) Te Wheke or the octopus model of health also represents the inter-connectedness of different elements of health: spirituality (wairuatanga), individuality (mana ake), life force (mauri), traditions (hā a kui ma a koro ma), physical wellbeing (taha tinana), family connectedness (whanaungatanga), emotional wellbeing (whatumanawa) and the mind (hinengaro) (McNeill, 2009). Just as an octopus relies on all eight tentacles, the eight elements of Te Wheke are interwoven with overall health and wellbeing – for the individual and their whānau. These models highlight the influence of broader and communal contexts and their relationship to mental health.

There is very limited published empirical research on the links between Māori culture and mental health, however culturally specific behaviours (e.g., allocentrism) appear to be associated with healthy psychological adjustment for Māori youth (Jose & Schurer, 2010; Webber, 2012; Reid et al, 2016). Although the potential crossover between traditional Māori cultural beliefs and those of migrant Chinese SG minority youth in New Zealand is unknown, there seem to be some similar features across these two cultures.

#### Youth mental health practice and psychological therapies

In comparison to the symptom-focused approach of adult mental health practice, contemporary mental health practice for young people generally has a slightly different emphasis (Hamilton & Hamilton, 2004). The “all youth thrive” philosophy of positive youth development (Hamilton & Hamilton, 2004) emphasises de-pathologisation, de-stigmatisation, diversity and “youth initiatives” (Larson, 2000). Important functions to encourage PYD are integrated into its practice, and include: youth centric design, training or curricula with a clear

objective, ongoing and constructive feedback, and a caring and accepting community (Hamilton & Hamilton, 2004). At the broader levels of practice (see Figure 2), youth mental health agencies can develop mass media or social media programmes, educational workshops or training classes that promote public awareness of youth mental health, as typified by the WHO (2004, p.11) slogan: “Mental health is everyone’s business”. Further, governmental agencies and organisations can implement mental health policies that promote the use of non-discriminatory and non-biased language. In local communities and schools, specific mentorship or peer support programmes can be adopted to foster the development of youth competence. Parents, teachers, or other people involved in youth care can receive training to raise their awareness of the diverse issues in youth populations (Lalor, O’Dwyer, & McCrann, 2006). Community outreach is also a useful approach to transforming the attitudes of the local communities surrounding young people (Simmons et al., 2008).

At the more intensive level of mental health practice, psychological therapies become salient. As one of main research questions in the thesis focuses on therapy, it is important to explore the literature in this area in more detail. The development of psychological therapies is rooted in Western traditions, including Christian theology and religious practice. However, the contemporary practice of psychological therapies in the health and medical fields only emerged in the late 19<sup>th</sup> century (Cushman, 1992). Starting with psychoanalysis and behaviorism, and later the birth of cognitive therapy, psychological therapy has become a pivotal part of the healing process for clients within Western mental health practice settings (Cushman, 1992).

There are currently many approaches to psychological therapy available for people who live in the English-speaking Western world (Norcross, VandenBos, & Freedheim, 2011; Wampold & Imel, 2015), including psychodynamics, interpersonal psychotherapy, narrative therapy, expressive therapy, and cognitive behavioural therapy (CBT). Each of these approaches can take a variety of different forms as well. Among these, CBT has the best evidence of effectiveness for treating of depression or anxiety (Strupp & Howard, 1992;

Wampold & Imel, 2015). The premise of CBT is that when a negative environment triggers distress in individuals, their distress is often exacerbated (and maintained) by negative thoughts and associated maladaptive behaviours (Southam-Gerow & Kendall, 2000). Psychological therapists working with these clients aim to change negative thoughts and develop adaptive coping behaviours to better deal with the environment, so that their emotional distress will eventually be reduced (Southam-Gerow & Kendall, 2000).

As mentioned above, scholars have expressed concern that the symptom-focused approach of psychological therapies has a narrow focus on deficits that does not acknowledge psychosocial or cultural contexts and youth developmental needs (Hamilton & Hamilton, 2004). Many psychological therapists working with young people therefore embrace the PYD approach (Larson, 2000) in considering youth developmental needs as part of the treatment (Hamilton & Hamilton, 2004). Accordingly, therapy needs to not only address the distress and difficulties experienced by young people, but also cultivate their strengths and assets to promote the growth of their abilities, competencies, and qualities (termed the *build-on-strengths approach*) (Park & Peterson, 2008; Park, 2009). The aim of such psychological therapies is to create value-oriented, motivated, and resilient youth who can make positive contributions to their communities in the long term (Park, 2004).

Moving on from the general discussion of youth psychological therapies, I now explore psychological therapies for SG or ethnic minority young people as very specific skill sets and knowledge are required to work effectively with these populations. In addition, it is important to note that all the competencies outlined below are discussed *as if* psychological therapists are members of the dominant population, namely White, cis-gendered and heterosexual adults, with no or minimal exposure to minority experiences, as this is usually the case in the English-speaking Western world (Collins & Arthur, 2010). It is important to note that psychological therapists implementing Western therapeutic models in China are not the focus of this thesis. This section provides the foundation for the Phase II Systematic Review Study

(see Chapter 4), which will focus on evidence-based therapeutic guidelines supported by peer-reviewed papers.

### 2.4.1 Psychological therapies for sexual/gender minority youth

A focus on SG minority people is evident in only a small proportion of the literature on psychological therapies. Overall, the literature suggests that psychological therapists who wish to work with this population should be competent in three major areas: knowledge of SG minority concerns; an accepting and open attitude towards SG minority people; and skills in working with SG minority clients (APA, 2011; Burnes et al., 2010; Israel, Gorcheva, Burnes, & Walther, 2008; Lev, 2013; McCann & Sharek, 2016; McNair & Hegarty, 2010; Vermeir et al., 2018). At the very least, knowledge should include an understanding of SG identity and social stigma and oppression in relation to cis-genderism, heteronormativity, as well as homo-/bi-/trans-phobia. Mental health studies suggest that issues related to SG identity formation, coming out, and relationships are often highlighted as important aspects of therapeutic work to improve the mental health of SG minority youth (Mayer et al., 2008; McCann & Sharek, 2016; Satterfield & Crabb, 2010; Whitehead-Pleaux et al., 2012). With regard to attitudes, therapists need to have a non-judgmental and/or affirmative approach that acknowledges and respects the possible differences between the therapist and client. The skills requirement refers to the ability to conduct psychological assessment and interventions based on current evidence-based therapeutic modules.

#### Basic ingredients for therapies with SG minority youth

I next summarise a few key ideas for therapies with SG minority young people. Firstly, current treatment guidelines require mental health providers to understand that SG orientation and identity are two different concepts. For example, an individual who likes to cross-dress may not necessarily identify with members of the opposite sex. Furthermore, current evidence

suggests that gender identity can be non-binary (APA, 2015), meaning that an individual can identify as anywhere between male and female. A possible approach for psychological therapists in tackling this issue is to assist SG minority youth to differentiate between these concepts during the early phase of their identity exploration when they may be curious about their minority SG orientation. This may allow SG minority youth the freedom to decide how to comfortably identify themselves in the future. Secondly, as discussed earlier, psychological therapists need to acknowledge the well-documented link between social oppression of SG minority youth and their mental health and wellbeing. A possible area of therapeutic work may be supporting the process of recovery from psychological trauma caused by victimisation (Balsam, Huang, Fieland, Simoni, & Walters, 2004). Thirdly, psychological therapists can help SG minority youth express and appreciate their experiences in a creative way to build their inner strength (Bonet, Wells, & Parsons, 2007; Pelton-Sweet & Sherry, 2008; Whitehead-Pleaux et al., 2012). Most importantly, apart from the specialised knowledge and attitudes required of psychological therapists working with SG minority youth, the evidence shows that good basic counselling skills determine the quality of therapy experiences for LGBT clients in general (Israel et al., 2008). As reported by Israel et al. (2008), the majority of clients in their study responded positively to therapists who listened, were empathetic and warm, could help in reframing adversity, and provided useful feedback.

#### 2.4.2 Psychological therapies for ethnic/cultural minority youth

As discussed previously, the current practice of psychological therapies in the English-speaking Western world is generally tailored for members of the ethnic majority (e.g., Europeans or White Americans) (Arnett, 2008; LoSchiavo & Shatz, 2009). This ethnocentric trend also prevails in New Zealand, resulting in inadequate psychotherapeutic services and contributing to poor (mental) health outcomes for ethnic minorities (Māori people in particular), although there are some Māori focused mental health services and programmes in

place (Doyle, 2011; Harris et al., 2006; Johnstone & Read, 2000).

Primarily due to the application of Treaty principles in mental health practice, New Zealand therapists are now required to be culturally competent in relation to Māori and diverse cultures, which includes understanding and respect for differences in minority ethnicity and cultural beliefs, as well as the ability to address the barriers when working with an ethnic minority client (NZPB, 2002). New Zealand (mental) health services also appear to be increasingly aware of the mental health needs of migrant Chinese and other Asian populations, with language and cultural differences identified as common challenges for migrants, creating barriers to accessing mental health support (Ho & Ho, 2003).

Recent advances in psychological therapies have incorporated ways to work with SG minority youth. However, in order to appreciate the mental health challenges of non-White SG minority youth, it is important to first understand the cultural heritages of these young people and potential acculturation issues they often face. In this section, I explore academic discussion about all these issues. My aim is to provide foundational knowledge for the systematic review of therapeutic recommendations for Chinese and other East Asian SG minorities in English-speaking Western nations reported in Chapter 5.

From acculturation or enculturation, to culturally attuned therapies

Historically, China and a few areas of East Asia have never come under the influence of English colonisation. Further, many Asian migrants continue to hold on to their own cultural customs and beliefs, even after living in an English-speaking Western nation for many years (Ip, 2003). Hence, the idea of psychological therapy often seems foreign and unfamiliar to them (Atkinson & Gim, 1989). The evidence shows that this often leads to under-utilisation of psychological therapy by Asian migrants, premature dropout from therapy, or poor outcomes from therapy (Atkinson & Gim, 1989; Kung, 2004; Leong & Lau, 2001).

Earlier scholars in this area (Atkinson & Gim, 1989; Eyou, Adair, & Dixon, 2000; Salant



& Lauderdale, 2003; Yu, Huang, Schwalberg, Overpeck, & Kogan, 2002) therefore stressed the importance of acculturation for Asian young people. Psychological therapists, in particular, were advised to assist these young people in adopting the language and culture of the dominant society (Phinney, 1991). It was commonly understood that the more migrants could assimilate or integrate into the mainstream (i.e., Western customs), the better their mental health and wellbeing would be. For example, one study found that those who were highly acculturated and could speak English well generally reported fewer obstacles in life and were less afraid of utilising mental health services when in distress (Atkinson & Gim, 1989). However, more recently, emergent approaches in cross-cultural psychology have placed less emphasis on acculturation and more on fostering the development of own ethnic identification (termed *enculturation*) and skills to cope with the mainstream (Miller, 2007; Yoon et al., 2013). Recent evidence (Yoon et al., 2013) shows that enculturation is equally important to the mental health and wellbeing for ethnic minority young people as acculturation. As discussed in relation to the development of ethnic identity in youth, appreciating and taking pride in their own cultural heritage is important to their overall adjustment. Some studies specifically point out that minority ethnic identity including a “collective” aspect of self (termed “inter-dependent” self) can mitigate the damaging impact of racism on mental health (Ai, Nicdao, Appel, & Lee, 2015; Lam, 2005; Lam, 2007; Liu, 2015). A sense of connecting or belonging to families and communities thus serves as a powerful protector (Elizur & Ziv, 2001).

Recognising the potential importance of cultural connection, guidelines and recommendations (Deng et al., 2016; Guzman, 1993; Hwang, 2016b; Tseng, 1999) has encouraged psychological therapists in the English-speaking Western world to learn about ways to provide *culturally attuned therapies*. Culturally attuned therapies are Western psychological therapies that include adaptations relevant to the cultural contexts and values of their ethnic minority clients (or the process termed “bentuhua” if in China) (Hwang, 2016a;

Qian et al., 2001; Zheng, Zhang, Li, & Zhang, 1997). While the core of these Western therapies remains, they are infused with important features of Chinese culture (Kang, 1990; M. Li, Duan, Ding, Yue, & Beitman, 1994; Qian et al., 2001). The evidence suggests that culturally attuned therapy can greatly extend the application of the original Western therapies to effectively serve diverse Asian clients (Beach et al., 2005; Griner & Smith, 2006).

#### Basic ingredients for therapies with migrant Asian/ Chinese youth

Similarly to working with SG minority youth, psychological therapists who wish to work with ethnic minority youth should be competent in the areas of attitude, knowledge, and skills (Guzman, 1993). Attitudinal competencies typically include appreciation of, and respect for, the ethnic and/or cultural backgrounds of clients, the use of non-biased language and non-judgmental approaches, and willingness to learn about cultural diversity (Guzman, 1993). Knowledge refers to understanding the differences between Chinese and Western worldviews in terms of mental health and wellbeing (Guzman, 1993; Hwang, 2016b). In contrast to the highly analytic Western medical traditions (e.g., mind-and-body split), traditional Chinese medicine generally has a holistic and relational view of (mental health and) wellbeing (Hwang, 2016a). Chinese people generally believe that maintaining a balanced, moderate and harmonic relationship (termed “Guanxi”) with their surroundings reflects and promotes good mental health (Lin, 1981). Yin-Yang (or Wu-Hsing), for instance, highlights the dynamic balance between each of the inter-connected, contradictory, and complementary elements in a living system (e.g., day and night serve as a full day cycle) (Fan, 2000; Leung, 2010).

Similarly, in Chinese traditions, mental distress is often viewed as resulting from imbalance in the relationship between mind, body, family, social and spiritual or other broad contextual factors. As the mind and body are connected, bodily intervention can improve the function of mind. To restore balance, Chinese medicine therefore encourages the exercise of mind-and-body connections (Lin, 1981). The popular psychological interventions of Chinese

medicine include acupuncture, Qi-gong or Taiji Quan (which involve with a sequence of complex breathing and gymnastics) (Hsuan-Ying, 2018). Additionally, family and other relationship factors are viewed as important for mental health. As Lin and Lin (1981) describe, families (and extended families) are considered the cornerstones of Chinese society, and the adult children of Chinese families continue to receive their loving care and support. Thus, Lin and Lin (1981) stress that mental health services need to incorporate consideration of family contexts. Although Chinese people have become more open to Western influences, Chinese medicine is still the most common means of treating emotional distress or mental ill-health in China (Qian et al., 2001).

In terms of skills, psychological therapists can engage in *cultural bridging*, where they bring some Chinese cultural elements into psychological therapies and explicitly link aspects of Western psychological theories with Chinese cultural beliefs and practices (Amundson, Westwood, & Prefontaine, 2007). Since the beginning of the new millennium, the different approaches of Western psychological therapies have flourished in China and other Chinese-speaking Eastern regions (Deng et al., 2016; Sathya Devan, 2001). Possible approaches to cultural bridging are described in the literature (Chan et al., 2012; Chang, Tong, Shi, & Zeng, 2005; Chen & Davenport, 2005; Foo & Kazantzis, 2007; Hwang, Wood, Lin, & Cheung, 2006; Kang, 1990; Lin, 2002; Qian et al., 2001; Shen, Alden, Sochting, & Tsang, 2006; Varvin & Gerlach, 2011; Zhang et al., 2002).

First, regardless of their choice of therapeutic modalities, psychological therapists are encouraged to embrace the relational, integrative, holistic, and pragmatic nature of Chinese worldviews. Second, as previously noted, clients' relationship patterns can be included as part of treatment. Further to this, the relationship between therapists and their clients may follow Confucian teaching, whereby therapists are seen as the experts in, or teachers of mental health and clients are seen as the experts on their own cultures and experiences (Hodges & Oei, 2007). Third, psychological therapists are encouraged to provide pragmatic, hands-on, and

step-by-step suggestions to guide their clients in forming a harmonious life with their surroundings. Homework and behavioural activities, termed “doing” to change thoughts, are encouraged (Foo & Kazantzis, 2007; Rong et al., 2006). Fourth, a lot of Chinese metaphors are apt in psychological therapies. These metaphors align with the philosophy underlying Taoism, “Shun Qi Zi Ran” (i.e., let nature takes its course), a peaceful and harmonic state of acceptance to whatever life can bring (Kang, 1990; Rong et al., 2006; Zhang et al., 2002), which can eventually lead to the reduction of emotional distress.

### 2.4.3 Psychological therapies for double minority youth

Because intersectionality is a newly developed theory, only a limited literature has acknowledged the intersectional mental health challenges of double minority youth. An even smaller portion of the literature (Bridges, Selvidge, & Matthews, 2003; Greene, 1994; Greene, 1996; Perry, 2014; Wynn & West-Olatunji, 2009) has addressed the unique issues of therapeutic work with double minority young people. This scholarly work is, unfortunately, written mainly based on the experiences of White SG minority populations as the norm (Moradi et al., 2010). Although these papers show an appreciation of the intersectional challenges of double minority youth, a common assumption is that these young people need to take the same path for identity development as White SG minority youth. There is also a prevailing belief in a “clash of cultures”, where the culture of origin is described as an obstacle to healthy identity development and mental wellbeing (Wynn & West-Olatunji, 2009, p.205).

On a positive note, this clash-of-cultures metaphor may work to signal the important therapeutic task of cultivating bicultural competency in working with double minority youth. Because Chinese SG minority young people straddle between two cultures, they often experience tensions when trying to meet two sets of cultural expectations, namely Chinese values associated with filial piety and Western values that see coming out as important to self-individualisation (Wang et al., 2009). As discussed earlier, psychological therapists are

encouraged to become familiar with the perspectives of intersectionality and gain proficiency in both Chinese and Western cultures, especially in the areas of SG expression and identity. Chapter 5 presents an exhaustive systematic review of the existing evidence-based literature, undertaken to determine recommendations for best therapeutic practice to appropriately support double minority people of Chinese and other East Asian descent. This review study provides more detail as to what culturally attuned therapies might look like for these young people.

## **2.5 Conclusion**

In the current chapter, I introduced important concepts from PYD and identity development theory as applied to SG and ethnic minority youth development. Further, I utilized minority stress theory to explain the elevated mental distress experienced by SG and ethnic minority youth. I then introduced a more recent perspective called intersectionality to explain the unique intersectional mental health challenges of double minority youth (mainly Chinese SG minority youth), and also their potential for developing resiliency. I also presented a quick overview of the mental health status of double minority youth as reported in the literature. In the last section, I discussed what mental health practice and psychological therapies might look like for SG minority, ethnic minority, or double minority youth in the course of describing some specific requirements for therapeutic work with these groups.

This chapter serves as the backdrop to support the other components of my research. In the next chapter, I describe the methodology used to carry out the studies aimed at exploring how to improve existing mental health practice to better support migrant Chinese SG minority youth in New Zealand.

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## Chapter 3: Methodology

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Chapter 3 describes the overall research methodology used in my thesis and the rationale for this methodology. Informed by concepts from intersectional inquiry, my thesis uses a mixed methods research methodology (MMRM) comprising four discrete but inter-related studies. Specific details of the methods for each of the studies are discussed in the corresponding chapters (chapters 4–7).

### 3.1 Rationale

The literature review indicated that double minority young people are often marginalised (Wilson & Neville, 2009). Further, concepts and terms from psychology tend to be culturally blind as they are based on the false assumption that all people share a unitary definition of mental health and normal behaviour, and do not acknowledge the inherent bias of psychological and health sciences largely formulated in English-speaking Western nations (or ‘Western psychology’ for brevity) (Arnett, 2008; H. Betancourt & López, 1993; Gordon, 1988; Segall, 1986). However, the evidence suggests that cultural and social identities are important in shaping the psychological development and health of growing individuals (Harris et al., 2006; Quintana et al., 2006). Due to the highly analytical nature of Western psychology, issues of complex identities are seldom a main focus. Further, quantitative methodologies, although popular in health sciences, may not adequately describe the experiences of ethnic minorities, and may not appeal to double minority youth (DeBlaere et al., 2010; Moradi, Mohr, Worthington, & Fassinger, 2009; Moradi, DeBlaere, & Huang, 2010; Wilson & Neville, 2009). My thesis therefore required a methodology that would allow their voices to be heard and valued.

There are inevitable limitations in using a single method (either qualitative or quantitative) in research. Given that any method needs to build on its prescribed philosophical underpinnings

and programmatic steps (Ponterotto, 2010; Trochim, 2006), this can naturally ‘imprison’ the interpretation of research data within a certain methodological angle at the potential risk of sacrificing other meaningful information (Tobin & Begley, 2004). Because it is difficult to access marginalised populations, single-method research is sometimes criticised as a waste of precious research effort, or for offering only limited insights into complex issues (DeBlaere et al., 2010).

On the other hand, multi-methods research approach usually describes any combination of multiple methods derived from the same philosophical underpinning (Teddlie & Tashakkori, 2003). This approach applies several different methods in a logical way to generate better answers to a research inquiry, and thus allows researchers to look at a target population from multiple angles (Teddlie & Tashakkori, 2003). For example, researchers can either use a questionnaire to assess the outcome of an experiment, or use clinical observation in addition to in-depth interviews to better capture the experiences of participants. However, the tension between the philosophical underpinnings of broader qualitative and quantitative research paradigms can make it difficult for researchers who wish to combine quantitative and qualitative studies in their research. In recent years, mixed-methods research methodology (MMRM) has evolved to denote research ‘across-paradigms’ (Creswell, 2015). However, there is ongoing debate about defining the term more exactly. For example, Johnson et al. (2007) identify 19 definitions of mixed methods research in the literature, and argue that MMRM is a third research paradigm.

In addition, research in the health sciences often places a strong emphasis on a pragmatic approach that allows a research method to be utilised in conjunction with other methods via a unified scientific philosophy (Carter et al., 2014; Drake, Merrens, & Lynde, 2005; Green & Thorogood, 2018; Neergaard et al., 2009; Taylor, 2013). As such, MMRM as a scientific methodology is currently gaining popularity in the health sciences (Taylor, 2013).

The MMRM for this thesis consisted of a survey, systematic review of the literature, and

expert and youth qualitative interviews. None of these methods on their own were adequate to answer my research questions. Take expert interviews as an example. Previous research has reported that most young people do not access professional support, even when needed (Curtis, 2010; Hanrahan, Stuart, Delaney, & Wilson, 2013). According to a recent systematic review (Gulliver, Griffiths, & Christensen, 2010), the stigma associated with mental ill-health and concerns about the trustworthiness of professionals are the primary reasons given for not reaching out to mental health professionals. It is therefore reasonable to conclude that expert-centric methods alone, such as soliciting the opinions of mental health providers, would not have sufficed for my research. Providers will also see only a small number of young people who are unlikely to represent the overall youth population. Similarly, even though surveys can potentially reach marginalised populations (Andrews, Nonnecke, & Preece, 2003), this method on its own would not have been suitable for the purposes of this research into double minority young people. I therefore developed an MMRM framework that integrates: 1) a cross-sectional survey with a nationally representative sample of young people; 2) a systematic literature review of evidence-based therapeutic recommendations; 3) expert interviews to explore the views of mental health providers; and 4) youth interviews to explore young people's experiences. This combination of methods was used to achieve the following objectives:

1. Obtain an overview of the mental health and wellbeing of double minority youth in New Zealand.
2. Interrogate the current literature to determine the mental health challenges and supports for Chinese and other East Asian SG minorities living in English-speaking Western nations. In particular, I wanted to extract some therapeutic recommendations that are supported by empirical studies.



3. Explore the views of Chinese SG minority youth living in New Zealand in terms of their mental health challenges and support needs.
4. Explore the views of mental health providers in New Zealand about the mental health challenges faced by Chinese SG minority youth and their therapeutic work with this unique sub-population.
5. Provide insights into culturally attuned mental health practice appropriate for those working with Chinese SG minority youth in New Zealand.

### **3.2 Utilising a Mixed-methods Research Methodology**

While an MMRM framework combines the advantages of qualitative and quantitative methods (Onwuegbuzie & Leech, 2005), there are challenges in assessing the quality of MMRM research (Teddlie & Tashakkori, 2003). Further, an MMRM research framework will contain various combinations of different methods, and each retains its own limitations and requirements (Creswell, 2015; Patton, 2002). As a result, researchers may find it challenging to determine what form of MMRM research will best suit the aims of their study. After reviewing the MMRM research literature, Johnson et al. (2007) summarised three major types of MMRM research for future researchers to consider: 1) Qualitative-dominant MMRM research with a primarily qualitative and social constructionist underpinning; 2) Quantitative-dominant MMRM research where a quantitative and post-positivist underpinning prevails; and 3) Pure mixed or Equal status MMRM research in which both philosophical underpinnings co-exist and compete.

Current principles for quality assessment of MMRM research inquiries suggest that researchers provide a sound umbrella rationale to justify the use of an MMRM framework; coherent philosophical underpinnings and theories; correct execution of each of the included

methods according to their specific requirements; and well-integrated research outcomes from the included studies (Creswell, 2015; O'Cathain & Thomas, 2006; O'Cathain, Murphy, & Nicholl, 2008; Teddlie & Tashakkori, 2003; Yin, 2006). I was guided by these principles while designing my MMRM research.

In line with a pragmatic and scientific focus common in health sciences research, my thesis is based on a 'quantitative-dominant' MMRM design. While qualitative studies are incorporated into my research, the main philosophical underpinning relies on a quantitative, realist and post-positivist perspective (Johnson et al., 2007). For example, while I identify the importance of participants' voices and contexts, I prioritise scientific constructs such as causality, sample generalisation, reliability and validity. In contrast, a strongly qualitative, relativist and constructivist approach would emphasise meaning, live narratives, truthfulness or credibility (Johnson et al., 2007; Patton 2002).

In the health sciences, MMRM is frequently situated in the ontology of critical realism and the epistemology of post-positivism (Creswell, 2015; Zachariadis, Scott, & Barrett, 2013). Critical realism emerged in the 1970s from social science scholars seeking to develop a post-positivist paradigm to sit between positivism (e.g., research focusing on causalities) and constructionism (e.g., descriptive interpretation) (Archer et al., 2016). Critical realism posits that psychosocial reality (e.g., sexism), although subjective and abstruse, can exist independently of human thinking. It has a real impact on human life via the interconnected chains of associated causal mechanisms embedded in the social world (Clark, 1998). However, critical realists believe that due to their limited capacities, researchers can only have a 'transitive' view of psychosocial realities, and this view is often affected by the researcher's personal background (e.g. values or beliefs) (Archer et al., 2016; Houston, 2001; Zachariadis et al., 2013). Accordingly, the study of psychosocial realities requires multiple reliable and evidence-based processes. Methodological pluralism and triangulation across different data sources are therefore used to gain a more accurate understanding of the reality (Olsen, 2004; Ponterotto,

2010; Trochim, 2006; Zachariadis et al., 2013).

Arguably, in the health sciences, MMRM often achieves scientific rigor via the application of various empirical practices to a research topic (Carter et al., 2014; Drake, Merrens, & Lynde, 2005; Green & Thorogood, 2018; Neergaard et al., 2009; Taylor, 2013). This process is termed ‘triangulation’. It describes the use of multiple methods to study the same psychosocial reality for the purpose of evaluating the trustworthiness of research outcomes (Jick, 1979). In other words, if three different methods converge to the same reality, this reality is likely to be trustworthy. Scholars have outlined several types of triangulation, of which methodological, data and interdisciplinary triangulation (Tobin & Begley, 2004) were applied in this research. I have used them to provide ‘confirmation’ (or validation), ‘completeness’ (or explanation), and ‘enlargement of perspectives’ (Padgett, 2011) in my research outcomes. Given the potential generalisability of quantitative methods and the in-depth exploratory power of qualitative methods, used in combination they can potentially validate each other and provide a breadth and depth far beyond what a single method can offer (Clark, 1998; Creswell, 2015; Jick, 1979; McEvoy & Richards, 2006; Morse, 1991). Further, the plural views of psychosocial reality stemming from different methods can certainly help in extending understandings provided by the research findings (Clark, 1998; Olsen, 2004).

Last but not least, critical realists’ emphasis on pragmatic values reflects their appreciation of the impact of social oppression on human life and pursuit of positive social changes (Houston, 2001). As such, they support the use of scientific, evidence-based practice to generate practical knowledge for the marginalised (Houston, 2001; McEvoy & Richards, 2006; Onwuegbuzie & Leech, 2005). This approach also aligns with the notion of intersectionality (Crenshaw, 1991). Although I did not adopt a fully intersectional methodology, it was important to incorporate the essence of intersectional inquiry into my research.

### 3.2.1 Key concepts of intersectional inquiry

Intersectionality has its origins in multicultural and feminist studies. It is a relatively new form of research inquiry that explores the interaction between various social identities (e.g., ethnicity, gender, sexuality, and social class) in human experiences (Cole, 2009; Crenshaw, 1991; Hancock, 2007; McCall, 2005). While multiculturalism appreciates the plural views and experiences of people from different social backgrounds (Hall, 2015), intersectionality further acknowledges the complexities in how social oppression and privilege can manifest at the intersections of these identities (Cole, 2009). Intersectional inquiry allows researchers to carefully examine the unique circumstances of double minority people, who may otherwise be overlooked due to their minority status (Balsam et al., 2015; Harris et al., 2006).

Although scholars have outlined a range of commonly adopted methodologies in intersectional scholarship, there is no well-defined methodology dedicated to intersectional research (Guittar & Guittar, 2015). There is ongoing debate in the literature about appropriate methodologies for intersectional inquiries, with many intersectional scholars refraining from the use of quantitative methods due to their fear of reducing the complexity of intersecting identities into labels or numbers (Cole, 2009; McCall, 2005). To date, good intersectional research is generally recognised as including two methodological criteria (Cole, 2009; Hancock, 2007; McCall, 2005). Firstly, researchers should acknowledge the complexity of the intersecting identities in psychosocial experience, such as by describing the intersectional effects between multiple social identities using quantitative methods. Secondly, researchers have a mission to not only make the voices of the oppressed heard, but also to make recommendations about how to support them (Houston, 2001; Pansiri, 2005; Rorty, Putnam, Conant, & Helfrich, 2004). I have adopted these two aspects of intersectionality in this MMRM research because they resonate with my professional commitment as a clinical psychologist to promote safe mental health practice for the marginalised. In light of longstanding gap between research and practice (Fouché, 2016), this MMRM thesis demonstrates an appreciation of the values of intersectional

research in seeking practical knowledge that can be applied to improve the mental wellbeing of double minority young people (Pansiri, 2005; Rorty et al., 2004).

The following sections of this chapter move on to describe how I designed each of my four studies based on this framework, as well as how these studies fit together to serve the research inquiry.

### 3.3 Research design

A multi-phase convergent design was crafted to investigate **‘the mental health challenges of, and therapeutic supports for, Chinese SG minority young people in New Zealand’**. This design expanded on *explanatory sequential MMRM design*, where a quantitative analysis is prioritised to provide an overview of a psychosocial reality, with a follow-up qualitative analysis further exploring elements related to the outcomes of the quantitative study (Creswell & Plano Clark, 2011; Creswell, 2015).

As shown in Figure 2, this design had three phases. The Phase I quantitative study examined the mental health status of NZ double minority young people (including Chinese and East Asian, Indian and other Asian, Māori and Pacific youth). In Phase II, a systematic review of therapeutic recommendations identified the peer-reviewed, empirical literature on therapeutic support for Chinese and East Asian SG minorities in English-speaking Western nations. Phase III comprised two qualitative studies with an in-depth focus on the mental health challenges and therapeutic support needs of Chinese SG minority young people. Although these phases utilise differing reference points or groups, the four studies help answer the overarching research question, as highlighted in the Section 1.2 of Chapter 1.

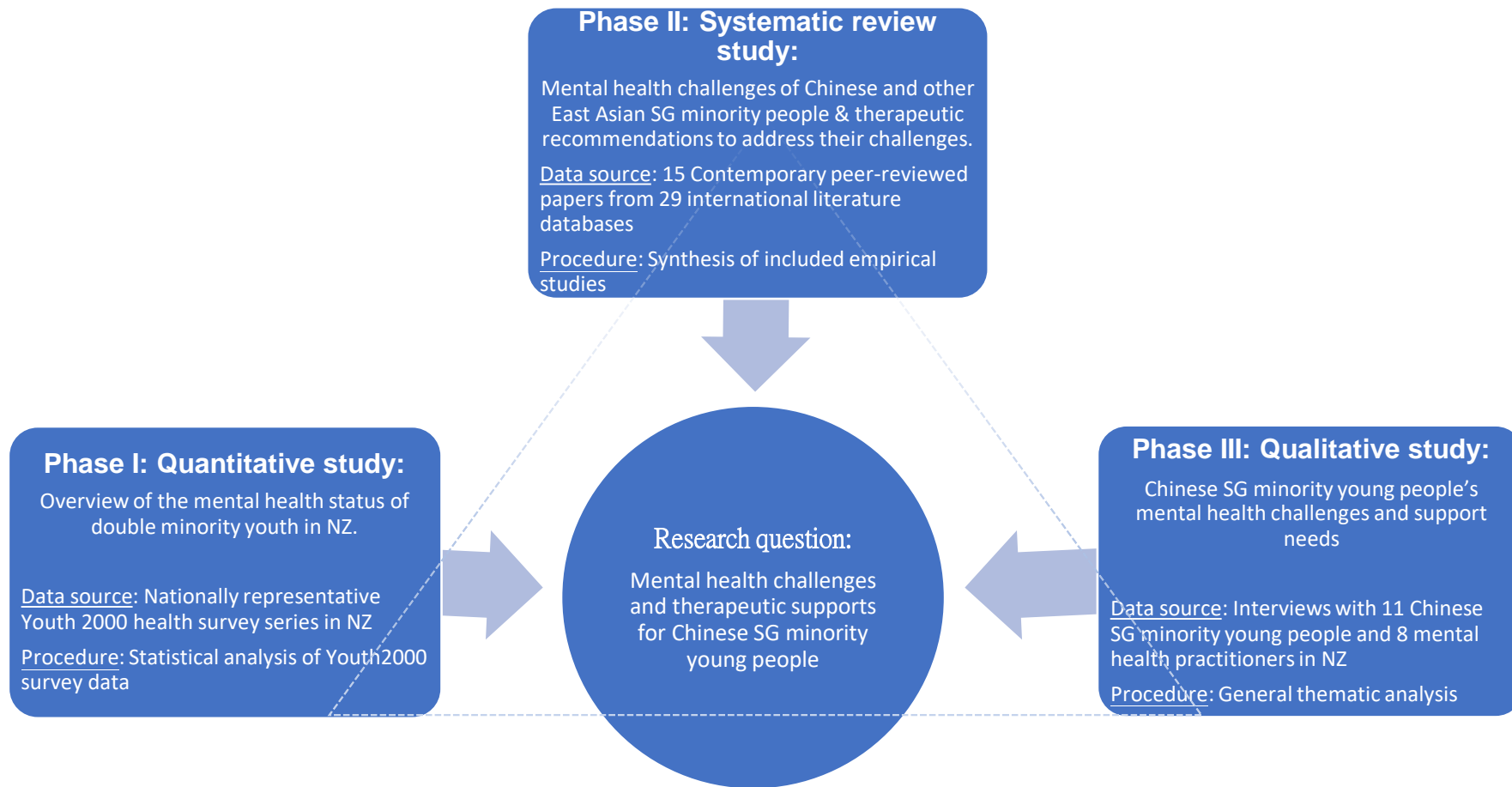


Figure 3. Research design

### 3.3.1 Phase I: Quantitative study

Quantitative research methods are commonplace in post-positivist research (Trochim, 2006). For the introductory study, I signed an agreement (see Appendix A) allowing me to use the Youth2000 dataset to provide a population-based overview of the mental health status of New Zealand's double minority young people. The Youth2000 survey series currently includes three nationally representative, cross-sectional, population-based youth health and wellbeing survey waves. Each survey includes between 3–4% of secondary school students nationwide in New Zealand, and surveys have been carried out in 2001, 2007 and 2012 (i.e., Youth'01, Youth'07, and Youth'12) (Adolescent Health Research Group, 2015). However, only the latter two survey waves, Youth'07 and Youth'12, were utilised in this study because of compatibility issues (i.e., the lack of certain key outcome measures in Youth'01). Summary information about the two survey waves is provided below.

For the Youth'07 survey, 115 schools were invited and 96 (84%) took part. Of the 12,355 students invited, 9,107 (74%) participated. The Youth'12 survey invited 125 schools to participate and 91 schools (73%) took part. Of the 12,503 students invited to participate, 8,500 (68%) did so. Ethics approval for both surveys was obtained from the University of Auckland Human Subject Ethics Committee. Written consent to conduct the surveys was obtained from each participating school, as well as from individual students. Specific details about the measures used, characteristics of participants, and data analysis for this study can be found in Chapter 4.

Drawing on some aspects of intersectional inquiry, I was able to use Youth2000 study data to explore the interaction of sexual/gender (SG) and ethnic minority status in youth mental health and wellbeing. However, a major limitation was that the data could not provide detail as to *how* the intersection influenced mental health outcomes, as survey design and statistical

analysis are usually established based upon researchers' pre-determined theories, not participants' understandings of what underpins correlations (Trochim, 2006).

### 3.3.2 Phase II: Systematic literature review study

A systematic review is a very specific method of literature review that has evolved from the post-positivist research paradigm of clinical and health sciences to reach the top of the 'evidence-based-practice' pyramid (Lichtenstein, Yetley, & Lau, 2008; Tranfield, Denyer, & Smart, 2003). Systematic review is regarded as highly scientific because it exposes the literature to a rigorous, systematic, transparent, and replicable process of scrutiny with the aim of selecting, evaluating, and synthesising 'high-quality' empirical literature in answer to a research inquiry (Chalmers, 1993; Khan, Kunz, Kleijnen, & Antes, 2003; Lichtenstein et al., 2008; Van Tulder, Furlan, Bombardier, & Bouter, 2003). Including a systematic review in the research helped demonstrate the scientific process expected by critical realism in terms of selecting the best therapeutic recommendations documented in the literature (Lichtenstein et al., 2008; Popay, Rogers, & Williams, 1998).

There are several rationales for conducting systematic reviews, and two in particular were prioritised in this thesis. Systematic reviews can be used to summarise the current state of empirical knowledge in the field, including theoretical gaps or areas for future research (Lichtenstein et al., 2008; Popay et al., 1998; Tranfield et al., 2003). In so doing, systematic reviews collect empirical studies to develop evidence-informed guidelines and recommendations for therapeutic interventions (Cook, Mulrow, & Haynes, 1997; Cook, Greengold, Ellrodt, & Weingarten, 1997; Smith, Devane, Begley, & Clarke, 2011; Tranfield et al., 2003).

In this review study, I searched 29 international databases. Only 15 peer-reviewed



empirical papers were identified that had a focus on the mental health challenges and therapeutic support needs of Chinese and other East Asian SG minority people living in English-speaking Western nations. A detailed description of the keywords and phrases, Boolean search strings, and selection strategies is provided in Chapter 5. The systematic review was limited to exploring the peer-reviewed literature indexed in databases, and as such could only demonstrate what has been documented as empirically appropriate treatment for Chinese and East Asian SG minorities.

### 3.3.3 Phase III: Qualitative studies

As previously described, an exploratory qualitative method can enhance the richness and depth of quantitative data (Wisdom, 2013). Given the dearth of literature in this field (as demonstrated in Phase II), this method was used to provide deeper understandings from the research. I developed two qualitative studies to explore the views of Chinese SG minority young people in New Zealand (Chapter 6) and NZ mental health providers (Chapter 7) on mental health challenges and supports for Chinese SG minority youth.

In a post-positivist paradigm, qualitative methods typically utilise a bottom-up approach in collecting and analysing research data (Ponterotto, 2010; Popay, Rogers, & Williams, 1998). This approach generally aims to gather a ‘transitive’ view of the reality without using a preconceived theoretic lens (Sandelowski, 2000), and interview is a common way to collect such data (Braun, 2013). Hence, after obtaining ethics approval from the University of Auckland Human Participants Ethics Committee (Appendix B), recruitment flyers (Appendix C) were used to attract potential participants. Participant information sheets (Appendix D) and consent forms (Appendix E) were given to those who expressed interest in taking part in the research.

I used semi-structured interviews (Appendix F) as this interview format has the advantage of allowing flexible probing of sensitive data and clarification of answers while maintaining the focus of research (Louise Barriball & While, 1994). While group interviews (e.g., focus groups) can provide potentially meaningful data through the interactions between participants, one-on-one interviews were selected in both qualitative studies for their greater assurance of confidentiality given the sensitive topics discussed.

Interviews were transcribed by two native speakers (one of English, one of Chinese), who were professional transcribers and had signed the confidentiality form (Appendix F). To analyse the interview transcripts, I used a general inductive approach (GIA), a form of thematic analysis (Braun & Clarke, 2006; Thomas, 2006) suitable for analysing qualitative responses to specific research questions. Inductive analysis generates understanding by identifying the common patterns and themes of raw interview data, rather than according to predetermined conceptualisation by the researcher (Thomas, 2006). Inductive analysis is useful for describing psychosocial reality and developing theoretical models based on the voices of participants (Braun & Clarke, 2006). A general inductive analysis is a version of inductive analysis and is suitable for identifying themes within specific research or evaluation questions (Thomas, 2006). Finally, the format for reporting data followed the consolidated criteria for reporting qualitative (COREQ) research (Tong, Sainsbury, & Craig, 2007). As previously mentioned, a systematic and transparent procedure for reporting data is required as part of the scientific process for conducting research. Specific details about the characteristics of participants, the summarised interview guides, and data analysis were written up in the corresponding papers (see Chapter 6 and Chapter 7).

### 3.4 Integrating findings

Integrating research findings is part of the mixing process in MMRM research. According to Johnson and colleagues' (2007) summary, the mixing process can take place in any stage of the research, including when formulating research questions, and during data collection, analysis, and interpretation. In the current research, I utilised various methodological approaches, data sources, as well as interdisciplinary supervision to achieve convergent methodological triangulation (Padgett, 2011). The mixing process in this research mainly occurred during the stage of data interpretation, and in the planning stage when I considered how the two qualitative studies could be used to support some of the findings from the quantitative study. Although each of the four studies was analysed individually and reported independently, they were designed to address various elements of the overarching research question for the purposes of confirmation, completeness, and enlargement of perspectives (Jick, 1979; Morse, 1991).

Integrating findings from the four studies in the MMRM was a thinking process, drawing on my judgement as the researcher to search for a logical pattern and place the “pieces of puzzle” (Morse, 1991, p.122) into a coherent and meaningful whole (Jick, 1979; Morse, 1991; Tobin & Begley, 2004). In this process, I firstly outlined the individual findings of each study (see Chapter 8). I then looked for ways these findings validated each other, in particular exploring how the qualitative studies explained some of the key statistical outcomes in the quantitative study. I also identified the strengths and limitations of the studies. The integrated results, as well as inconsistent findings between the studies, are explored and discussed in Chapter 8.

In conclusion, this chapter has outlined the reasons for using MMRM. The research focus on the intersectional experiences of double minority youth required multiple angles stemming

from different methods. The philosophical framework and assumptions of this type of research also align with my own passion and commitment to promoting the mental health and wellbeing in double minority youth. The scene is now set for the following chapters, which present the results of the four studies forming my thesis.

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## Chapter 4: (Study One) Mental health status of double minority adolescents: Findings from national cross-sectional health surveys

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### 4.1 Preface

As previously discussed, almost all of the empirical work on double minority mental health and wellbeing uses youth populations in North America, and there is some UK research. Most of the studies are qualitative in nature. It is difficult to determine whether these studies properly reflect the overall experience of double minority youth in general, as very little is known about double minority youth who live in any other part of the English-speaking Western world, including New Zealand. Since my thesis is among the first of its kind, it was imperative that I get a population-based overview of the mental health status of double minority youth in this country.

I have therefore utilised data from the nationally representative Youth2000 survey series to help me get a *bird's eye* view of the overall mental health and wellbeing of double minority youth in New Zealand. I used measures of both distress and wellbeing with the aim of gaining a better understanding of the mental health outcomes for this group. Although some Chinese (and other ethnic) specific findings were presented in tables and figures of the published paper, we focused on reporting overall trends. By doing so, I (and my coauthors) avoid the low statistical power and ethnical risks associated with having a small sample in certain ethnic groups. Despite this, a general trend for Chinese youth (i.e., the focus of this thesis) is obvious and interesting to highlight: 1) There are similar levels of depression and attempted suicide for Chinese SG majority as NZ European SG majority youth, and 2) There is increased risk for Chinese SG minority (compared to Chinese SG majority) youth, however this increase in risk was smaller than that for SG minority NZ European youth.

Of note, it is critically important to highlight that this general trend may not represent the broader New Zealand Chinese youth population as stratifying and analysing the Youth2000 data by small numbers of specific ethnicities would increase the chances of producing misleading information and were therefore not supported by the AHRG. However, as an introductory study, this research served as a gateway for me to consider what I will need to do in sequential studies.

The current chapter contains a published paper reporting secondary analysis of Youth2000 data. The write-up of this study was peer-reviewed and later accepted for publication in the *Journal of Immigrant and Minority Health*.

## 4.2 Peer-review status

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**Mental health status of double minority adolescents: Findings from national  
cross-sectional health surveys**

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Simon Denny

(Accepted version)

### **4.3 Abstract**

**Background:** Little population-based work has been published about the mental health of adolescents with both sexual/gender (SG) and ethnic minority (i.e. double minority) status. This study aimed to provide an overview on their mental health.

**Method:** Analysis of data from a total of 17,607 high school students in New Zealand's 2007 and 2012 cross-sectional nationally representative Adolescent Health Surveys, including a total of 1,306 (7.4%) SG minority participants, of whom 581 (3.3%) were also an ethnic minority.

**Results:** SG minority status, minority ethnicity, and female sex were associated with higher mental distress and poorer well-being. Generally speaking, double minority students reported poorer mental health than SG majority students of the same ethnicity, but reported better mental health than SG minority European students.

**Discussion:** Explanations and future directions for research were suggested to further explore how double minority students negotiate mental health in the context of their communities/cultures in New Zealand.

**Keywords:** Ethnic minority, Intersectionality, Youth/adolescence, LGBT, Mental health,

## 4.4 Introduction

Depression and other forms of mental distress are common among young people and are often under-treated (Burns, Ryan, Garofalo, Newcomb, & Mustanski, 2015; McGorry et al., 2007; Patel et al., 2007). Sexual minority young people (i.e. youth who are not exclusively opposite-sex attracted) form approximately between 2.3% and 15.5% of the youth population (Denny et al., 2016). Less is known about gender minority young people. One of the first population-based studies addressing this issue estimated that 1.2% of high school students identified as transgender, with 2.5% ‘not sure’ of their gender (Clark et al., 2014). Sexual and gender minority youth have been reported to have at least 1.5 times the rates of depression, suicidality and elevated rates of other mental health problems than their heterosexual or non-transgender (cisgender) peers (Chakraborty, McManus, Brugha, Bebbington, & King, 2011; Clark et al., 2014; M. King et al., 2008; Lucassen et al., 2011). This phenomenon may be due to disproportionate ‘minority stress’ from heteronormative (i.e., heterosexuality is the only ‘normal’ or acceptable sexual orientation) and cis-normative (i.e., the assumption that all people are cisgender and/or should be cisgender) challenging environments and discrimination (Clark et al., 2014; Denny et al., 2016; Marshal et al., 2011; Meyer, 2003).

In addition, ethnic minority groups form an important, and often substantial, population in high-income nations. New Zealand (NZ) is made up people of a European heritage (referred to as New Zealand Europeans/NZE domestically), forming about 68% of the overall population; as well as indigenous Māori (14.9%); Pacific (6.6%); Chinese (4.3%); Indian (3.9%) and other (2.3%) ethnicities (Stats NZ, 2015). There are disparities in rates of mental health needs across specific ethnic groups, depending on age and the particular measures used. The specific needs of ethnic minority youth are sometimes overlooked due to racism and other barriers (Harris et al.,



2006; LoSchiavo & Shatz, 2009). Māori and Pacific youth report higher rates of suicidality, violence, and use of substances than NZ European youth (Crengle et al., 2013; Helu, Robinson, Grant, Herd, & Denny, 2009). Chinese and Indian youth are less likely to report behavioural problems, but are more likely to show symptoms of depression (Parackal, Ameratunga, Tin Tin, & Wong, 2011). Notably, despite high rates of distress, Pacific and Māori youth also demonstrate higher levels of resilience, relative to NZ European youth (Sanders & Munford, 2015).

Even less attention is given to understanding the mental well-being of adolescents who are both an ethnic and SG minority (i.e. ‘double minority’<sup>1</sup> youth) (Boykin, 1996; Guittar & Guittar, 2015). Based on the minority stress hypothesis, they would experience more compromised mental health, because of the additional stressors they faced, when compared to those who are only from a single minority category (Jaspal, 2015). However, studies on intersectionality<sup>2</sup> suggest a more complex interaction than a linear or additive one (Guittar & Guittar, 2015), and there is considerable debate regarding the factors associated with double minority populations’ risk and resilience. We identified only eight quantitative studies (all conducted in the U.S.) directly focused on double minority adolescents or college students, using either a convenience or regional sample to compare them with their White counterparts. These studies yielded mixed and conflicting findings, which are briefly summarized as follows:

Low self-acceptance for double minorities was reported in a survey of 425 lesbian, gay, and bisexual (LGB) youth (Mustanski et al., 2011). In contrast, three larger surveys which did not collapse all minority ethnicities together, reported increased risk for some but not other ethnic groups. Specifically, one with 6,245 LGB sample reported increased risk for Latino, Native American, Pacific and Multi-cultural but not for Black or Asian youth (Bostwick et al., 2014).

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<sup>1</sup> Although double minority can refer to anyone with dual-minority status, this term has gradually evolved to describe people who are an ethnic and sexual/gender minority.

<sup>2</sup> Intersectionality addresses an integrated understanding of how multiple social constructs interact.

Also in a survey of 4,321 college students, findings were mixed, with increased risk of suicide attempts among Black and Multi-cultural students but decreased risk of depression for Asian, Black, and Latino students (Lytle et al., 2014). Other research has identified no additional or even lower risk for double minorities over White counterparts. A survey of 1,596 LGB students in university counseling centers shown that ethnic minority status was not an added source of distress (Hayes et al., 2011). The same pattern emerged in two other surveys: one with 246 LGB and Transgender (i.e. LGBT) youth reporting no additive distress (Mustanski et al., 2010) and the other with 1,106 young LG females reporting lower PTSD severity for Asians in particular (Balsam et al., 2015). Surprisingly, a study including 5,541 LGB youth, suggested greater negative impact from victimization among White GB males (LeVasseur, Kelvin, & Grosskopf, 2013). Another surveyed 4,345 university students, indicating greater suicide risk for White LGB peers (Shadick et al., 2015).

In the face of this complexity, we aim to provide a population-based overview of the mental health and wellbeing of double minority youth from a nationally representative sample. This adds to the literature in important ways: it avoids the sampling bias inherent in convenience samples (Sousa, Zauszniewski, & Musil, 2004), and it provides the first analysis of this population from outside the US. Finally, we aim to consider not only the needs of double minority youth but also their assets and strengths.

## **4.5 Method**

Youth2000 is a series of national, cross-sectional, population-based youth health and well-being surveys, carried out with representative samples (3-4%) of New Zealand secondary school students in 2001, 2007 and 2012 (Youth'01, '07, and '12). Data from the Youth'07 and Youth'12 were merged to maximize the number of participants, with a statistical adjustment for

the cohort effect. Youth'01 was excluded as it lacks the use of the main ethnicity method and the wellbeing measure.

#### 4.5.1 Participants

In 2012, 125 schools were invited to participate and 91 schools (73%) took part. Of the 12,503 students invited to participate 8,500 (68%) did so. In 2007, 115 schools were invited, and 96 (84%) of them took part. Of the 12,355 students invited, 9,107 (74%) participated. Ethics approval was obtained from the University of Auckland Human Subject Ethics Committee, and written consent was also obtained from each participating school as well as from the students. Their common reasons for non-participation included: not attending the school on the day of survey; being unwilling to participate; or being unavailable when the survey was administered (further details about the surveys' methodology can be found at our website (AHRG, 2015) or written reports (AHRG, 2008; Clark et al., 2013b)).

The combination of data from Youth'07 and Youth'12 gave us a total sample of 17,607 participants, including 14,706 sexual and/or gender majority and 1,306 minority students of various ethnic backgrounds, with a remainder of participants (1,595) who cannot be placed into either group due to certain responses (e.g. attracted to neither sex). Approximately 40% of participants could be categorized into more than one ethnicity (Clark et al., 2013b), so the main ethnicity method (Kukutai & Callister, 2009) was used to allocate each participant into only one ethnic group.

#### 4.5.2 Measures

The surveys were anonymous, self-report, branched questionnaires, with a comprehensive range of questions related to many aspects of health and wellbeing. Core questions remained the

same across both survey waves except for small adjustments. The questions extracted for this analysis were:

*Demographics.* Sex (male or female), age (dichotomized into 15 years old or less, or 16 years old or more) ethnicity and New Zealand Deprivation Index (NZDI) scores. Participants were asked to choose one ethnicity that they identified with the most, i.e. “Which is your main ethnic group?” Responses were categorized as: NZ European; Chinese and other East Asian; Indian and other Asian; Māori; Pacific; and ‘other ethnicity’. NZDI is an indicator of neighbourhood socioeconomic deprivation derived from the NZ census, encompassing eight dimensions of deprivation (AHRG, 2012). We grouped participants into three levels of deprivation: high, medium, and low.

*Sexual attractions and gender identity.* We dichotomized the students into those who were sexual minority (i.e., they were sexually attracted to people of the “same sex”, “both sexes”, or they were “not sure” of their sexual attractions), versus sexual majority students (i.e., young people who were exclusively sexually attracted to the “opposite sex”) based on the question “Who are you sexually attracted to?” Students who reported being attracted to “neither sex” or who did not know how to answer this question were excluded from this analysis, as prior studies have indicated that they do not appear to experience the same sort of issues experienced by sexual minority participants (Lucassen et al., 2011; Lucassen et al., 2015). Students in Youth’12 were also asked “Do you think you are transgender. This is a girl who feels like she should have been a boy, or a boy who feels like he should have been a girl (e.g., Trans, Queen, Fa’afafine, Whakawahine, Tangata ira Tane, Gender queer)?” Those students who reported being transgender, and those not sure about their gender, were assigned into the ‘sexual and/or gender minority’ category. Students who did not understand this question were excluded from the analysis. The combined sexual and/or gender minority category are referred to as ‘SG minority’ for brevity. The remainder of students were categorized into the ‘sexual and gender majority’

group, referred to as ‘SG majority’ for brevity.

*Mental health outcomes.* The Reynolds Adolescent Depression Scale-Short Form (RADS-SF) was used to measure symptoms of depression. Previous studies have suggested that the RADS-SF has acceptable reliability and validity for NZ adolescents, and a cut-off score of 28 was used to identify those with clinically significant depressive symptoms (Fleming et al., 2014; Milfont et al., 2008). Attempted suicide was identified by an affirmative response to the question, “During the last 12 months have you tried to kill yourself?” The WHO-5 Well-being Index was used to measure the reported general psychological well-being of participants. This five-item scale has a maximum score of 25, with a cut-off point of 13 or higher used to indicate “good well-being” (WHO 1998).

#### 4.5.3 Data analyses

All analyses utilized the combined data from Youth’07 and Youth’12. Data were weighted by the inverse probability of selection and accounted for the clustering of students from the same schools using survey procedures in SAS 9.4. Sample size, adjusted percentages, odds ratios, and 95% confidence intervals were reported. Logistic regressions were conducted to look for significant interactions between sex, ethnicity, and SG status. A p-value equal or less than 0.01 was considered as an indication of statistical significance. Odds ratios (OR) were used to determine the comparisons between SG majority and minority groups, as well as between ethnic majority and minority participants within the SG minority group, while controlling for age, wave and NZDI.

### 4.6 Results

SG minority students were more likely to be female and Chinese and East Asian, Pacific or

another ethnicity (see Table 2). Also, 78.7% of Pacific and 57.3% of Māori students were living in neighborhoods with a high level of deprivation (see Table 3). As shown in Table 4, being a female or SG minority student was associated with an elevated risk of mental distress. The two-way interactions between SG status and ethnicity were significantly associated with depression, attempted suicide, and wellbeing. The two-way interaction between SG status and sex was only significant for attempted suicide, indicating an overall greatest risk of suicidality for female SG minority students.

Since the interaction terms were statistically significant, further data reports and interpretations were stratified by sex, SG status, and ethnicity (see Tables 5, 6, & 7). SG minority students consistently reported higher rates of depressive symptoms, suicide attempts, and a lower rate of good well-being (although this was far less pronounced for the Pacific and Māori groups), compared to SG majority students from the same ethnic group. Unadjusted figures have been used to report the data trends (see Figures 4, 5, 6, 7, 8, & 9).

Among SG majority students, females consistently reported higher rates of depressive symptoms, suicide attempts, and lower rates of good well-being than males across all ethnic groups. However, sex differences for SG minority students were often less pronounced or did not exist for selected outcomes (e.g. for Chinese and East Asian SG minority students in relation to suicide attempts). In comparing SG minority students according to ethnicity, NZ Europeans (both male and female) consistently reported higher rates of depressive symptoms and suicide attempts, than did their Chinese and East Asian, Indian and Other Asian, Māori, or Pacific peers. Moreover, SG minority NZ Europeans also reported low rates of good well-being relative to Chinese and East Asian (except for male), Indian and Other Asian, Māori, or Pacific peers.

Table 2. Demographics of Youth2000 participants (n,%)

	<u>SG majority</u>	<u>SG minority</u>	Chi-Sq
<u>Sex</u>			p<.0001
Male	7325 (50.14)	530 (40.92)	
Female	7380 (49.86)	775 (59.08)	
<u>Age</u>			p=0.1671
15 or less	9449 (64.20)	863 (66.07)	
16 or more	5249 (35.80)	442 (33.93)	
<u>Ethnicity</u>			p<.0001
NZ European	9776 (65.17)	725 (55.47)	
Male	4847	278	
Female	4929	446	
Unidentified	0	1	
Chinese and East Asian	759 (5.22)	139 (10.89)	
Male	435	57	
Female	324	82	
Unidentified	0	0	
Indian and Other Asian	779 (5.32)	68 (5.20)	
Male	410	28	
Female	369	40	
Unidentified	0	0	
Māori	1446 (9.79)	116 (8.73)	
Male	726	54	
Female	719	62	
Unidentified	1	0	
Pacific	1259 (8.54)	181 (13.82)	
Male	578	82	
Female	681	99	
Unidentified	0	0	
Other Ethnicity	687 (4.72)	77 (5.90)	
Male	329	31	
Female	358	46	
Unidentified	0	0	

Table 3. Youth2000 socioeconomic deprivation level by ethnicity (n,%)

<u>Ethnicity</u>	<u>Level of Deprivation</u>			Chi-Sq p<.0001
	Low	Medium	High	
NZ European	4554 (41.68)	4507 (40.94)	1940 (17.38)	
Chinese and East Asian	414 (41.56)	415 (41.33)	175 (17.11)	
Indian and Other Asian	213 (23.18)	426 (46.13)	286 (30.69)	
Māori	187 (10.99)	542 (31.73)	992 (57.28)	
Pacific	60 (3.58)	298 (17.72)	1341 (78.70)	
Other Ethnicity	254 (30.55)	329 (35.16)	256 (30.29)	
Column Total	5682	6517	4990	
			Missing	418

Table 4. Testing the main effects and interactions on the mental health outcomes

P<0.01

<u>Predictor</u>	<i>Depressive symptoms</i>		<i>Attempted Suicide</i>		<i>WHO-5 Well-being</i>	
	<u>P-Value</u>	<u>Significance</u>	<u>P-Value</u>	<u>Significance</u>	<u>P-Value</u>	<u>Significance</u>
<b>wave</b>	0.0243	No	0.0171	No	0.0287	No
<b>age</b>	0.3299	No	0.0057	Yes	<.0001	Yes
<b>NZDI</b>	0.0003	Yes	0.016	No	0.001	Yes
<b>sex</b>	<.0001	Yes	<.0001	Yes	<.0001	Yes
<b>ethnicity</b>	<.0001	Yes	0.0124	No	<.0001	Yes
<b>SG status<sup>3</sup></b>	<.0001	Yes	<.0001	Yes	<.0001	Yes
<b>SG status*ethnicity</b>	0.0009	Yes	0.0003	Yes	<.0001	Yes
<b>sex*ethnicity</b>	0.3201	No	0.733	No	0.0201	No
<b>SG status*sex</b>	0.3067	No	0.0035	Yes	0.3999	No
<b>SG status*ethnicity*sex</b>	0.4785	No	0.6372	No	0.3315	No

<sup>3</sup> Dichotomized into SG majority and minority categories.



Table 5. Associations between ethnicity and depressive symptoms in New Zealand secondary school students

**Rates of significant depressive symptoms**

		<u>SG majority</u>	<u>SG minority</u>	<u>OR (95% CL)</u>	
		<u>% (n/N)</u>	<u>% (n/N)</u>	<u>SAGI comparison</u>	<u>Ethnicity comparison</u>
NZ European	Male	6.67 (318/4741)	22.93 (62/266)	3.99 (2.95-5.39)	
	Female	13.40 (659/4873)	35.29 (151/427)	3.54 (2.88-4.35)	
Chinese and East Asian	Male	8.77 (38/430)	16.65 (9/54)	2.09 (1.10-3.97)	
	Female	13.43 (43/320)	21.78 (17/79)	1.61 (0.99-2.62)	
Indian and Other Asian	Male	6.64 (26/399)	15.80 (4/26)	3.18 (1.36-7.44)	
	Female	15.16 (55/364)	36.12 (14/39)	2.74 (0.89-8.50)	
Māori	Male	4.69 (34/693)	9.95 (5/51)	2.23 (0.87-5.71)	
	Female	15.38 (107/700)	18.31 (11/57)	1.30 (0.63-2.70)	
Pacific	Male	5.85 (33/554)	18.38 (14/77)	3.49 (1.68-7.27)	
	Female	15.54 (103/664)	16.57 (16/94)	1.04 (0.60-1.79)	
Other Ethnicity	Male	9.25 (29/316)	23.11 (6/27)	3.02 (0.99-9.23)	
	Female	18.38 (65/354)	33.28 (15/45)	2.07 (1.05-4.08)	

SAGI<sup>4</sup> comparison was for the difference between SG majority and minority students within the same ethnicity.

Reference category (OR=1) was SG majority students in each ethnic grouping, adjusted for wave, age, and NZDI

Ethnicity comparison was for the ethnic difference amongst SG minority students

Reference category (OR=1) was NZ European sexual minority students, adjusted for wave, age, and NZDI

All OR comparisons were matched with sex

(i.e. SAGI comparison: Pacific SG majority female / Pacific SG minority female = 1 : 1.04;

Ethnicity comparison: NZE SG minority male / Māori SG minority male = 1 : 0.35)

<sup>4</sup> SAGI stands for sexual attractions and gender identity

Table 6. Associations between ethnicity and attempted suicide in New Zealand secondary school students

**Rates of attempted suicide**

		<u>SG majority</u>	<u>SG minority</u>	<u>OR (95% CL)</u>	
		<u>% (n/N)</u>	<u>% (n/N)</u>	<u>SAGI comparison</u>	<u>Ethnicity comparison</u>
NZ European	Male	1.62 (77/4805)	11.93 (33/272)	8.25 (5.61-12.13)	
	Female	4.11 (202/4915)	16.45 (74/444)	4.58 (3.41-6.14)	
Chinese and East Asian	Male	1.94 (9/433)	5.68 (3/55)	3.47 (0.93-12.92)	0.46 (0.17-1.30)
	Female	3.10 (10/322)	5.19 (4/82)	1.66 (0.50-5.49)	0.29 (0.12-0.70)
Indian and Other Asian	Male	1.71 (7/407)	11.29 (3/27)	7.46 (1.81-30.77)	0.97 (0.29-3.21)
	Female	6.49 (24/367)	10.95 (4/40)	1.75 (0.60-5.16)	0.60 (0.21-1.67)
Māori	Male	4.43 (32/713)	7.98 (4/52)	2.02 (0.67-6.02)	0.58 (0.20-1.67)
	Female	9.94 (70/712)	17.81 (12/62)	1.98 (1.02-3.84)	0.97 (0.47-1.97)
Pacific	Male	3.40 (19/568)	8.99 (7/80)	2.74 (1.23-6.12)	0.62 (0.27-1.42)
	Female	12.61 (85/678)	13.31 (13/96)	1.06 (0.57-1.96)	0.65 (0.33-1.28)
Other Ethnicity	Male	2.15 (9/399)	20.12 (7/35)	10.16 (2.65-38.94)	1.82 (0.64-5.20)
	Female	5.93 (25/417)	16.41 (8/51)	3.32 (1.44-7.66)	1.08 (0.52-2.24)

SAGI<sup>5</sup> comparison was for the difference between SG majority and minority students within the same ethnicity

Reference category (OR=1) was SG majority students in each ethnic grouping, adjusted for wave, age, and NZDI

Ethnicity comparison was for the ethnic difference amongst SG minority students

Reference category (OR=1) was NZ European SG minority students, adjusted for wave, age, and NZDI

All OR comparisons were matched with sex

(i.e. SAGI comparison: Pacific SG majority female / Pacific SG minority female = 1 : 1.06;

Ethnicity comparison: NZE SG minority male / Māori SG minority male = 1 : 0.58)

<sup>5</sup> SAGI stands for sexual attractions and gender identity

Table 7. Associations between ethnicity and well-being in New Zealand secondary school students

**Rates of good psychological well-being**

		<u>SG majority</u>	<u>SG minority</u>	<u>OR (95% CL)</u>	
		<u>% (n/N)</u>	<u>% (n/N)</u>	<u>SAGI comparison</u>	<u>Ethnicity comparison</u>
NZ European	Male	84.69 (4044/4783)	68.26 (184/269)	0.40 (0.31-0.50)	
	Female	72.99 (3568/4890)	51.91 (229/440)	0.40 (0.33-0.49)	
Chinese and East Asian	Male	76.92 (329/428)	68.63 (38/55)	0.61 (0.31-1.19)	0.98 (0.49-1.93)
	Female	56.75 (211/321)	67.84 (54/80)	1.12 (0.57-2.18)	2.07 (1.23-3.48)
Indian and other Asian	Male	87.31 (356/407)	78.16 (22/28)	0.51 (0.22-1.18)	1.73 (0.75-3.99)
	Female	74.22 (271/365)	52.53 (21/40)	0.38 (0.21-0.67)	1.07 (0.58-1.95)
Māori	Male	83.83 (594/710)	81.89 (43/52)	0.83 (0.38-1.80)	2.11 (0.98-4.55)
	Female	70.36 (495/706)	70.29 (43/62)	1.02 (0.59-1.77)	2.35 (1.35-4.10)
Pacific	Male	86.37 (487/564)	87.43 (70/80)	1.05 (0.52-2.11)	3.27 (1.67-6.43)
	Female	77.25 (520/673)	71.21 (66/93)	0.72 (0.45-1.15)	2.46 (1.51-4.00)
Other Ethnicity	Male	81.64 (326/399)	55.78 (20/35)	0.30 (0.14-0.67)	0.50 (0.24-1.05)
	Female	67.73 (282/418)	60.56 (31/51)	0.74 (0.37-1.47)	1.44 (0.76-2.73)

SAGI<sup>6</sup> comparison was for the difference between SG majority and minority students within the same ethnicity

Reference category (OR=1) was SG majority students in each ethnic grouping, adjusted for wave, age, and NZDI

Ethnicity comparison was for the ethnic difference amongst SG minority students

Reference category (OR=1) was NZ European SG minority students, adjusted for wave, age, and NZDI

<sup>6</sup> SAGI stands for sexual attractions and gender identity

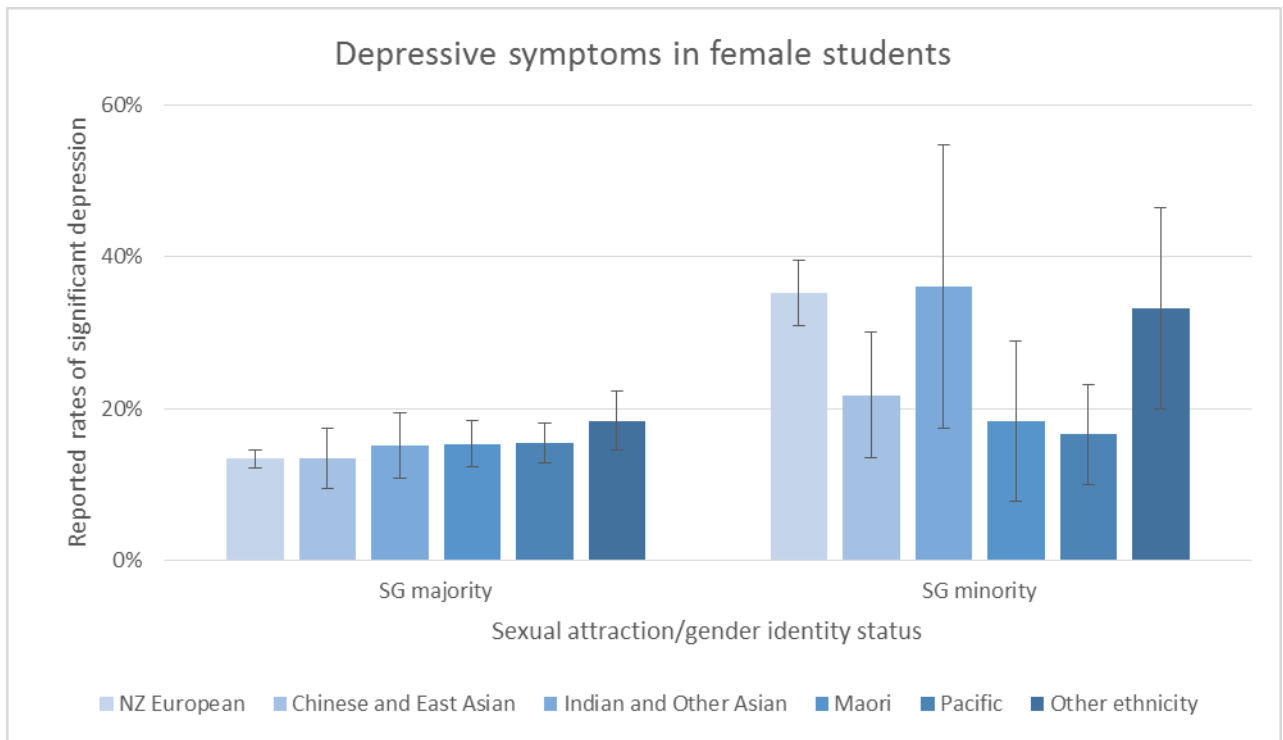


Figure 4. Reported rates of depressive symptoms in female students

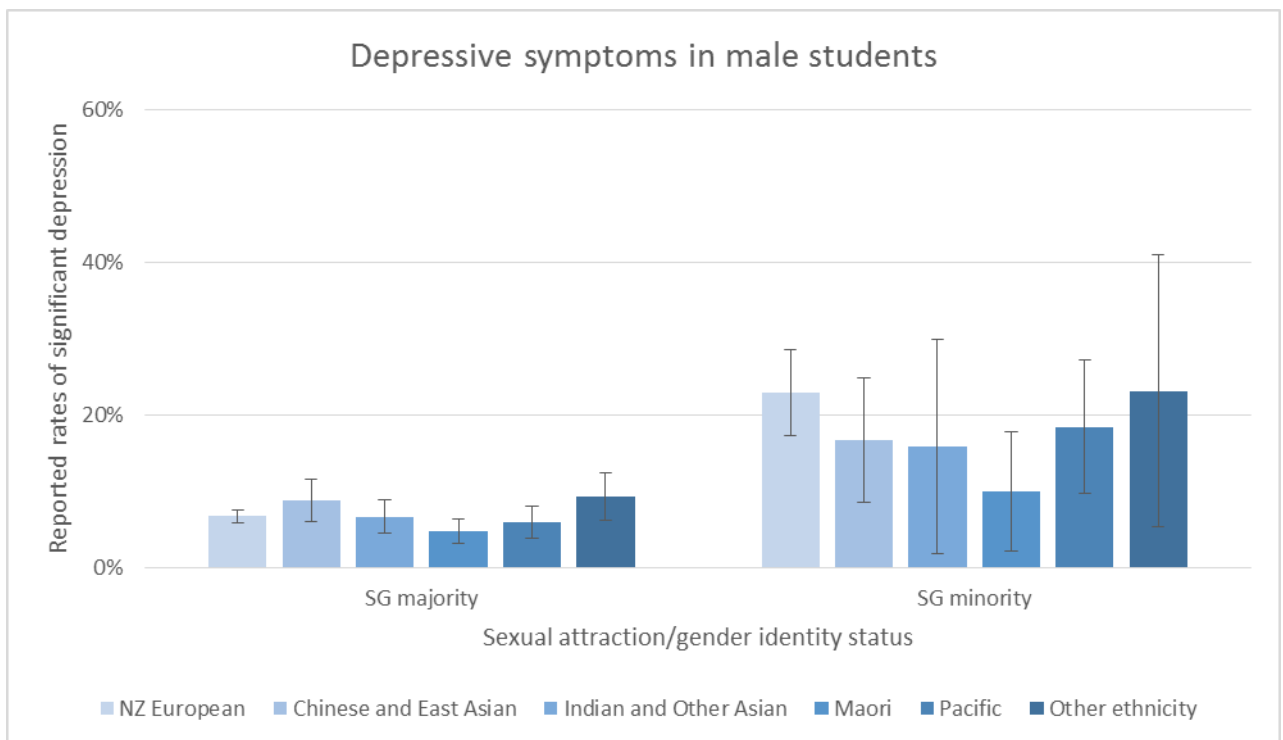


Figure 5. Reported rates of depressive symptoms in male students

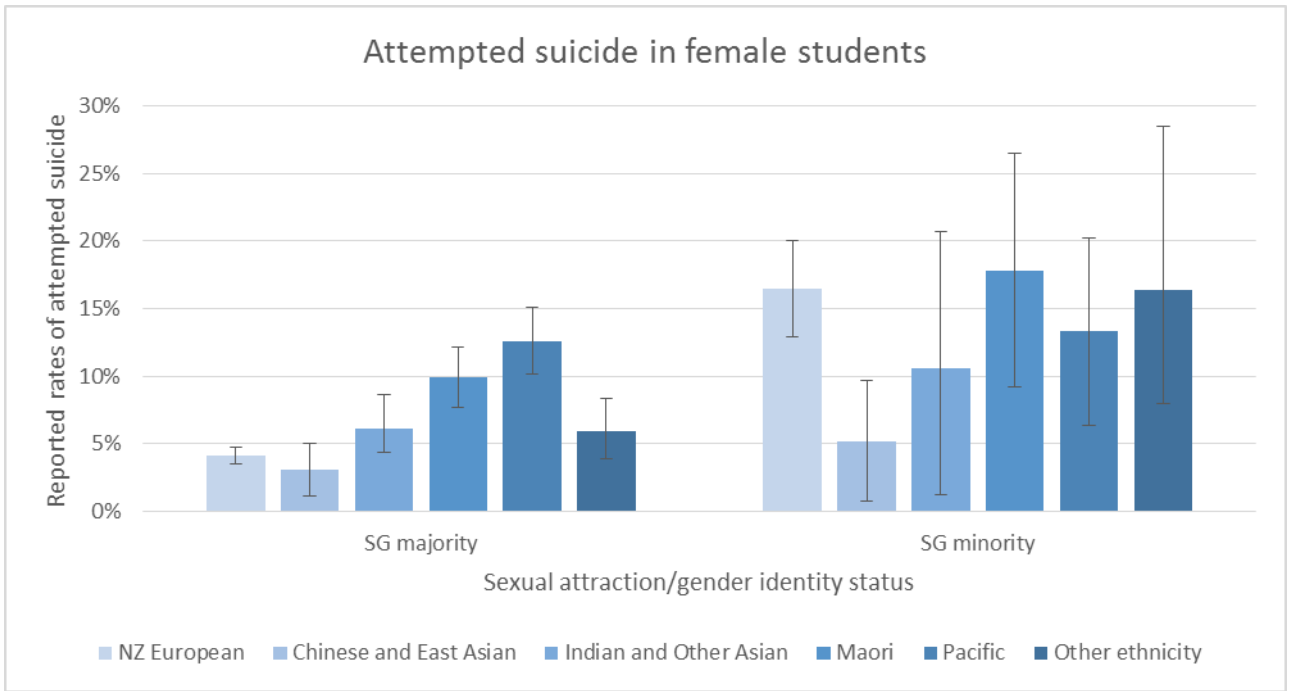


Figure 6. Reported rates of attempted suicide in female students

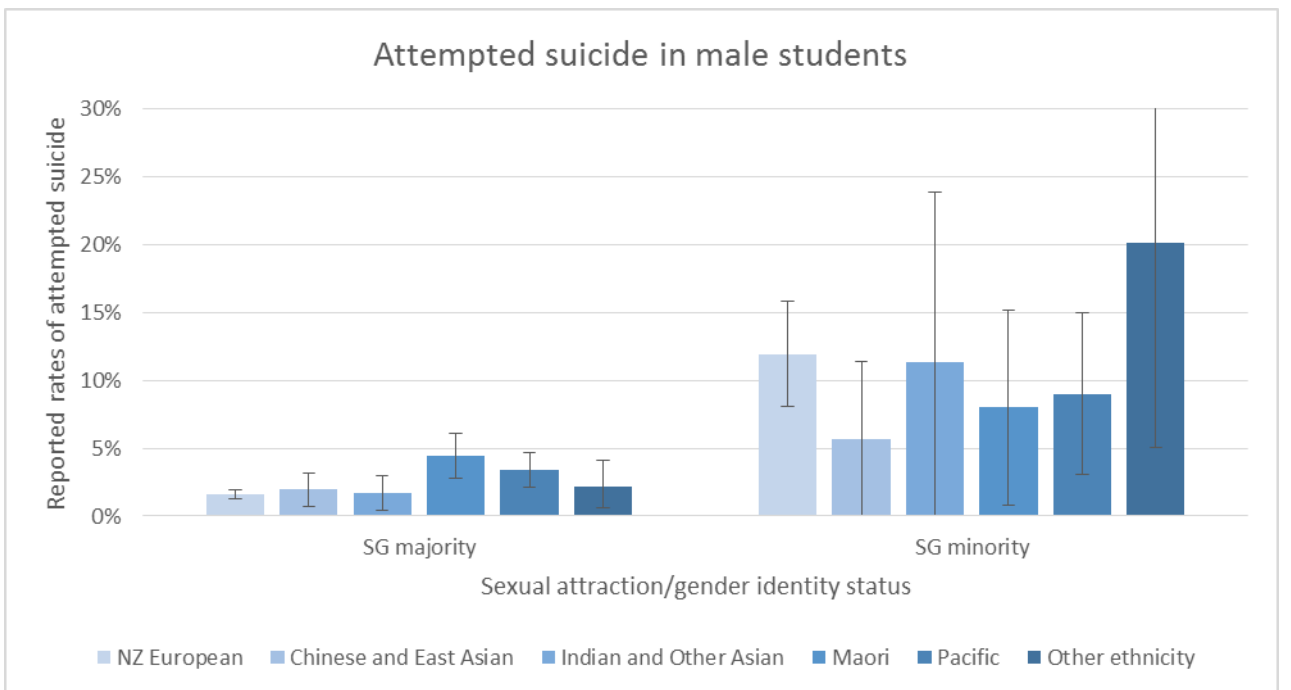


Figure 7. Reported rates of attempted suicide in male students

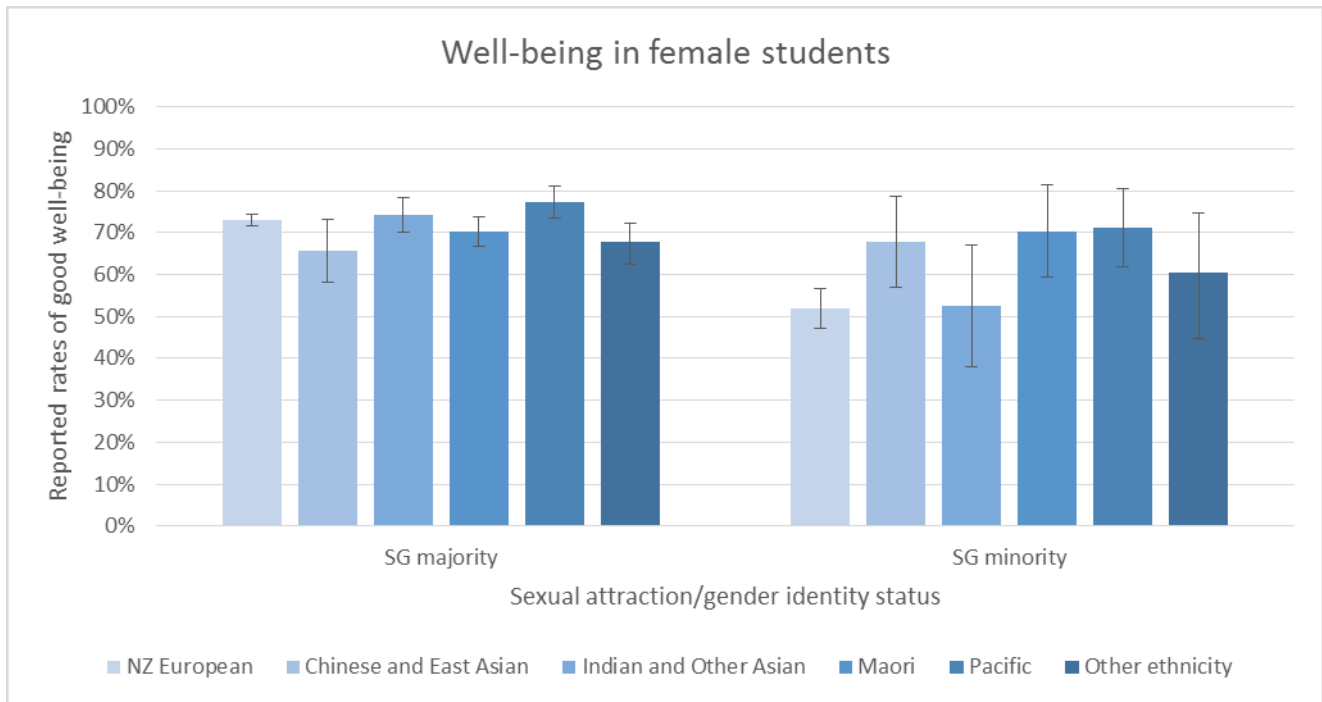


Figure 8. Reported rates of good well-being in female students

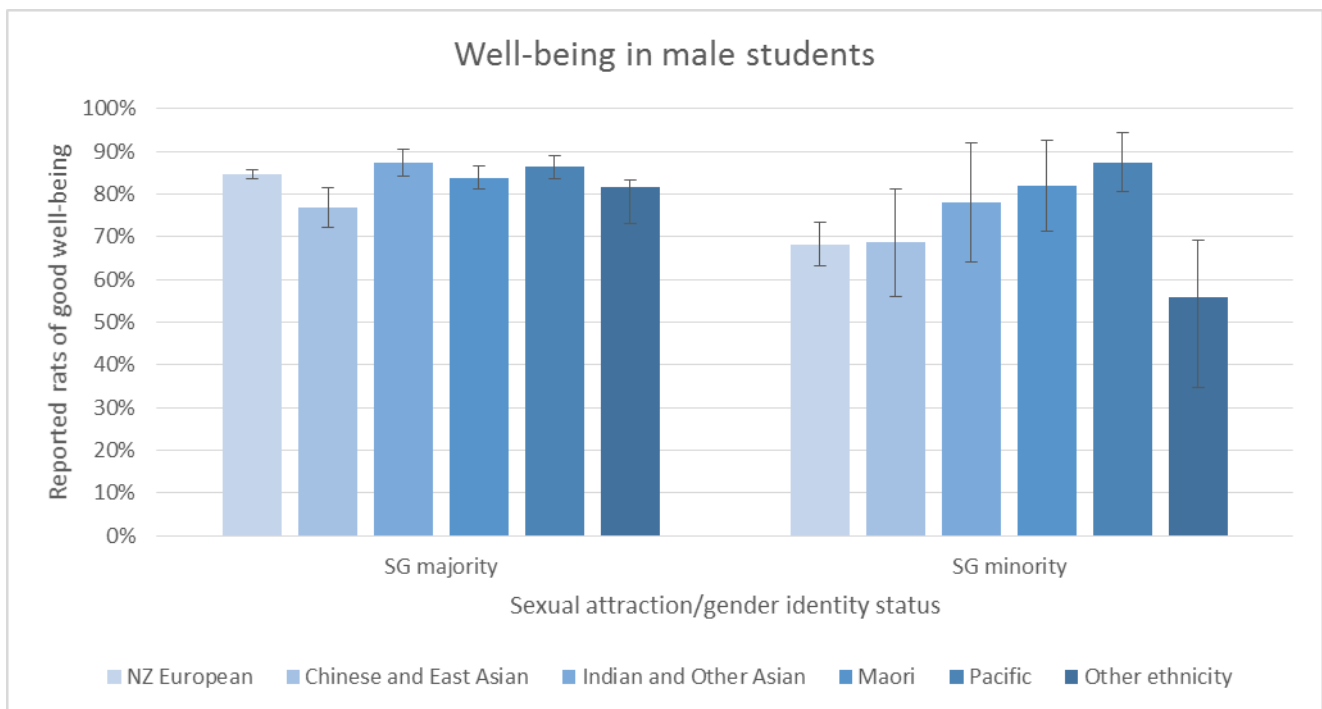


Figure 9. Reported rates of good well-being in male students

## 4.7 Discussion

### 4.7.1 Summary of the findings

In these cross sectional, nationally representative surveys, we observed a general trend regarding mental health problems: 1) SG majority NZ European youth showed the lowest risk; 2) SG majority youth who were an ethnic minority had a slightly elevated risk; 3) Double minority youth reported a moderate risk; and, 4) SG minority NZ European youth demonstrated the highest risk. Overall, female students reported higher rates of mental distress, and lower rates of well-being than male students. However, this distinction was less pronounced amongst SG minority students.

Our findings add to prior research highlighting that having either ethnic or SG minority status signifies an increased risk of mental ill-health, however dual-minority status does not further elevate the risk (LeVasseur et al., 2013; Meyer et al., 2008; Mustanski et al., 2010). Resiliency theorists proposed that ethnic minority youth may develop psychological hardiness by drawing upon appropriate resources (e.g. social/community support, family traditions, and cultural beliefs/values) (Sanders & Munford, 2015; Yu, Chang, Yang, & Yu, 2016), to help reduce the negative impact of dominant culture discrimination, racism and prejudice on mental health (Mustanski et al., 2011). Furthermore, social evaluation theory suggests that the sense of community experienced by belonging to a minority ethnic group may act to provide a more meaningful and supportive comparison than a dominant culture (Pettigrew, 1967). For Māori sexual/gender minority communities in New Zealand, identity can transcend traditional Western labels of gender, sexuality and ethnicity “claiming takatāpui enables us to bring all of the parts of ourselves together – to be all of who we are” (Kerekere, 2015, p.8).

#### 4.7.2 Potential implications

The present study was a response to the debate over whether students who are sexuality and gender diverse, as well as being from a non-majority ethnic group, would experience accumulative mental distress pertinent to their dual-minority status. Contrary to what was initially speculated, double minority students generally reported higher rates of good well-being and lower rates of mental distress than their NZ European peers. According to a resiliency perspective, two possible implications may be drawn from this:

*Tolerance of non-European cultures towards sexual and gender diversity.* The significance of the interaction may indicate that non-European SG minority students' cultures of origin may act as a buffer against mental health threats in New Zealand. Chinese and other East Asian cultures are found to be more tolerant of sexual/gender non-normative behaviours or presentations than Western cultures (Chan, 1997; Fann, 2003). Similarly, Māori and Pacific cultures in pre-European times were found to be inclusive of the same-gender relationships and gender diverse identities (Aspin & Hutchings, 2007; Wallace, 2003). Some double minority students may thus have an additional set of culturally anchored resources to draw upon as protection against a substantial decline of mental well-being, relative to their NZ European peers.

*Enhanced coping linked to challenging environments.* The adversity of certain social environments may sometimes stimulate young people to become resilient in relation to handling mistreatment (Egeland, Carlson, & Sroufe, 1993). Double minority students may have developed coping skills for positive adaptation, as many grew up in an environment that was challenging (e.g. they have had to manage racism and micro-aggressions<sup>7</sup> to do with their ethnicity from a very young age) (DeAngelis, 2009; Della, Wilson, & Miller, 2002; Moradi et al.,

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<sup>7</sup> Micro-aggression is described as a variety of minor verbal/ non-verbal treatments to ethnic minority persons delivered by well-intentioned White persons unaware of its hidden discriminatory messages.



2010). Although many may suffer from serious socioeconomic setbacks, Māori and Pacific students generally reported high rates of good well-being and their SG minority peers did not show a significant decline in reported rates of good well-being.

#### 4.7.3 Strength and limitations

To the best of our knowledge, the current study is amongst a very small number of studies to examine ethnic diversity among SG minority youth in terms of their mental health and well-being, and is the first study to do so in Australasia. However, the study has some limitations. First of all, the cross-sectional nature of the surveys means that a causal relationship cannot be drawn. Second, the main ethnicity method may suffer from criticisms of over-simplifying ethnic complexities, even though this method can signify which aspect of their cultural heritage a young person felt most strongly connected with (Kukutai & Callister, 2009). Third, a potential for bias due to the self-reported nature of the outcome measures utilized may occur. It may be argued that non-European students are accustomed to under-reporting their mental distress (Yeung et al., 2004). Past studies suggested that Chinese people may be less likely to report severe symptoms of mental distress, and not to seek professional help as often as Westerners because of certain barriers, such as the stigma associated with mental disorders, and a limited knowledge of mental health (Choi, Andrews, Sharpe, & Hunt, 2015; Georg Hsu et al., 2008; Li, Logan, Yee, & Ng, 1999). Fourth, the small number of SG minority students in particular ethnic groups resulted in some small cell sizes for certain analyses. However, we have provided the 95% confidence intervals (CI), so that readers can evaluate the degree to which one can be confident that differences are meaningful (e.g. for some analyses these 95% CI are wide ranging). Fifth, despite that there was no detectable difference in mental health outcome between Youth'07 and Youth'12 (see Table 4), an analysis of all three Youth2000 survey waves

(Lucassen et al., 2015) indicated generally no improvement regarding suicidality as well as a worsening trend of depressive symptoms for sexual minority students during the time period of these surveys (from 2001 to 2012). Finally, certain questions were missing between the two surveys. Most notably, students were not asked if they were transgender in the Youth'07 survey. Students were also not asked whether they were intersex (i.e. when one's biological sex does not fit the male/female sex binary) (Hofman, 2012).

## **4.8 Conclusion**

Our study provides a nationally representative and population-based snapshot of the mental health and wellbeing of double minority youth in New Zealand. Possessing ethnic or SG minority status is associated with increased risk of compromised mental health. We found that double minority students generally have increased risk over SG majority students of their own ethnicity. However, SG minority European students demonstrate increased risk relative to double minority students. In fact, overall double minority students appear to report better mental health than SG minority European students. Further research is needed to investigate the operation of the intersected identities (i.e. ethnicity, sexuality, gender diversity, and social class) in young people. In particular, in-depth qualitative research could be very useful to understand how potentially complex identities can be construed by young people, so that we can better support and further bolster them.

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## Chapter 5: (Study Two) Psychological therapies for Chinese and other East Asian sexual/gender minority people in English-speaking Western nations: A systematic review

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### 5.1 Preface

Based on the findings of Study One, it seems very likely that Chinese SG minority young people experience distinct mental health challenges and supports associated with their double minority status. I speculate that these experiences may be uniquely linked to the characteristics of Chinese culture. For example, the low suicidality of Chinese SG minority youth may be associated with certain Chinese beliefs including a strong work ethic and ‘not-give-up’ mentality.

However, Study One does not provide support for any differences in mental health between double minority youth and NZ European SG minority youth, nor can it explain how to support Chinese SG minority youth. In Study Two, I embarked on a systematic review of the empirical literature in the English-speaking Western world to identify research that might address these missing aspects. My aim was to identify peer-reviewed reports of research that contain therapeutic recommendations. Secondly, this review study would help me (and readers) identify the knowledge gaps in the literature.

I initially focused only on migrant Chinese SG minority youth but this focus resulted in an almost empty review. As a result, I removed the restriction on age and expanded my target population into migrant Chinese and other East Asian SG minority people. The rationale for this grouping has been provided in the Section 1.2 of Chapter 1.

The current chapter comprises a paper reporting the findings of this systematic review study. The paper was peer-reviewed but subsequently rejected by the *Journal of*

*Homosexuality.*

## 5.2 Peer-reviewed status

Peer-reviewed but rejected by this journal: I have completed updating the paper in February, 2019. The initial review study contained 9 eligible papers from the search of 26 international databases on May, 2017. The updated study has extracted 15 eligible papers (including the 9 papers in the initial study) from 29 international databases on November, 2018. Of note, my own Studies Three and Four have also been included as they have met the selection criteria. The paper below is the updated version. I will re-submit it to a different journal.

**Psychological therapies for Chinese and other East Asian sexual/ gender minority people  
in English-speaking Western nations: A systematic review**

Szu-Ying Chiang, Theresa Fleming, John Fenaughty, Kylie Sutcliffe, Mathijs F.G. Lucassen

(Updated version)

**5.3 Abstract**

**Purpose:** Sexual and/or gender (SG) minority individuals with an ethnic minority background (i.e., double minorities) often face unique intersectional challenges. It is unclear how extensively mainstream psychological interventions, counselling, talking therapies, or other forms of psychological services (termed ‘therapies’ for brevity) currently address these multifaceted challenges. Thus, we aimed to review the literature regarding therapies for Chinese and other East Asian (CEA) SG minority people living in English speaking Western nations.

**Method:** We conducted a systematic search of 29 databases. Peer-reviewed papers published in English were included if they addressed therapies for CEA SG minorities in English-speaking Western nations. The results of the included studies were summarized in a narrative synthesis.

**Results:** Fifteen articles met the inclusion criteria. The synthesis of these articles highlighted the intersectional challenges of this population. Challenges related to: 1) the development and expression of SG minority identity, 2) mental distress, and 3) interpersonal difficulties as a result of oppression and mistreatment. Based on our synthesis of the literature we devised four recommended areas of professional development for psychological therapists in order to improve therapy content and/or progress: 1) the willingness to self-reflect and receive further education on intersecting identities; the abilities to 2) conduct culturally adequate assessment

attuned to intersectional concerns, and 3) intervene to promote the therapeutic potential bi-culturally; and 4) address the pertinent treatment barriers.

**Conclusion:** This systematic review synthesizes the literature about therapies for CEA SG minorities and develops therapeutic recommendations for those working with this population. The relative scarcity of available peer-reviewed literature highlights a need for more research that can explore and enhance the therapeutic supports available for CEA SG people.

**Keywords:** Chinese; East Asian; Ethnic minority; LGBT; Sexual and Gender minority; Double minority; Gay, Lesbian, Bisexual, Transgender; Intersectionality; Psychotherapeutic counselling; Treatment guidelines; Systematic review

## 5.4 Introduction

Chinese and other East Asian (CEA) immigrants to Western nations<sup>8</sup> include people from Chinese, Taiwanese, Korean, and Japanese backgrounds. Together there are more than 5 million overseas Chinese people (Shi & Yu, 2010), and they form sizeable minorities in English-speaking Western nations (e.g., up to 6% of the American population and 8% of the Canadian population) (United States Census Bureau, 2017; Statistics Canada, 2011). Scholars have previously attempted to adapt Western psychological counselling or therapies and other forms of psychological practice (hereafter therapies) to address the distinct needs of minority populations (Kirmayer, 2001). Available literature on therapy for members of ethnic minorities suggests that cultural adaptations can be made to therapies, in terms of both treatment process and content. Process adaptations can include psychoeducation to demystify or destigmatise mental ill-health (Shen et al., 2006) or to clarify treatment goals and progress (Foo & Kazantzis, 2007). Content adaptations can include linking psychological theories with CEA cultural beliefs (Shen, et al., 2006), or exploring issues commonly associated with underlying differences in values between CEA and dominant cultures in English-speaking Western nations (Lee et al., 2000).

Attention has also been given to providing appropriately sensitive therapies for SG minority individuals (i.e., lesbian, gay, bisexual, transgender, and queer or questioning/LGBTQ). Process adaptations for these populations typically involve a SG minority affirmative perspective, acknowledging that the elevated rates of mental distress experienced by SG minority people stem from social oppression (Balsam, Martell, & Safren, 2006). Accordingly, content adaptations usually address aspects of minority stress (i.e., the unique stressors experienced by minority people in relation to potential conflicts between

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<sup>8</sup> Specifically the United Kingdom, Ireland, Canada, New Zealand, Australia, and the United States of America.

minority and dominant societal values). Thus, therapeutic work may include ways to manage discrimination, internalised homo-/bi-/trans-phobia, coming out, and developing a positive SG identity (Israel et al., 2008; Safren & Rogers, 2001).

Specific ethnic or SG minority identities can intersect to form unique identities distinct from their component parts (Guittar & Guittar, 2015). Thus, SG minorities with CEA cultural backgrounds can have mental health experiences different from those of dominant cultures in English-speaking Western nations. However, to the best of the authors' knowledge, there are currently no published therapeutic guidelines related to the needs of CEA SG minorities in English-speaking Western nations. We therefore sought to systematically review the peer-reviewed literature regarding the therapies considered appropriate and culturally sensitive for CEA SG minorities living in English-speaking Western nations and subsequently develop recommendations for therapists' professional development.

## 5.5 Methods

The method of systemic review represents a scientific way of assessing current literature and minimizing risk of bias (Beelmann, 2006; Cook, Mulrow, & Haynes, 1997). Assisted by an academic subject librarian, we completed an electronic search of 29 databases from their inception to November 2018, using relevant subject headings and key search terms (e.g., Asia) with the relevant truncation (i.e., \*), see Table 8 for details.

The search generated a total of 1,256 articles (i.e., 1228 + 28). After duplicates were removed, S.C. and T.F. scanned the titles and abstracts of the remaining 830 articles for relevance. S.C. then read the full articles of the 64 potentially relevant papers to determine if they met the inclusion criteria, specifically:

- The paper focused on CEA SG minority people living in an English-speaking



Western nation in which they were an ethnic minority (the United Kingdom, Ireland, Canada, New Zealand, Australia, and the United States of America, as these countries have English as an official language and share the cultural traditions of Christianity and the Modern Enlightenment; Kurth, 2003). Papers that did not focus solely on CEA SG minority people were included if CEA SG minority participants constituted over one third of the total sample, as findings were deemed potentially applicable to CEA SG minority people.

- The paper contained original qualitative or quantitative data (i.e., opinion pieces and commentary articles were excluded).
- The paper either addressed the psychological issues of CEA SG minority people and explicitly discussed therapeutic implications, or it contained case studies of CEA SG minority people receiving a form of psychological therapy.

Figure 10 provides a flowchart (in PRISMA format) and Table 8 outlines the key terms searched, databases used and inclusion criteria.

An assessor (a PhD candidate familiar with systemic review method) checked the titles and abstracts of a random sample of the screened articles (n=126) and read a random sample of the full text papers (n=41) deemed potentially eligible (i.e. 15% of the 830 papers being checked). The assessor queried S.C.'s decision to exclude 10 abstracts during the screening phase. Also, the assessor questioned whether the full text of 6 of the potentially eligible articles should be included. S.C. These 16 articles were reviewed again and we (the assessor and S.C.) eventually determined that they either 1) had no clearly stated therapeutic implications or 2) were unclear regarding the exact number of CEA SG minority participants included. Hand-searching the reference lists of the 64 eligible articles generated no further new articles for review. This process of data selection is preferred for systematic review

studies conducted in the discipline of “soft” sciences where a significant amount of qualitative research exists in the literature and therefore the involvement of professional peers is often needed to assist researchers in assessing the literature (Tranfield, Denver, & Smart, 2003).

A general inductive approach was used to analyse the data (Aronson, 1995; Braun & Clarke, 2006) into a “meta-synthesis” (Tranfield, Denyer & Smart, 2003) or narrative synthesis<sup>9</sup> with a focus on 1) the intersectional mental health challenges commonly faced by Chinese and other East Asian SG minority immigrants and 2) psychotherapeutic implications or recommendations proposed by these articles for working with this population.

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<sup>9</sup> According to the views of Tranfield, Denver, & Smart (2003), a systematic review study that contains a number of qualitative research naturally gives rise to the results of “agreed” or “consensual” narratives and perspectives across papers. This is in sharp contrast to the meta-analysis of systemic review studies that are often conducted in traditional medical sciences.

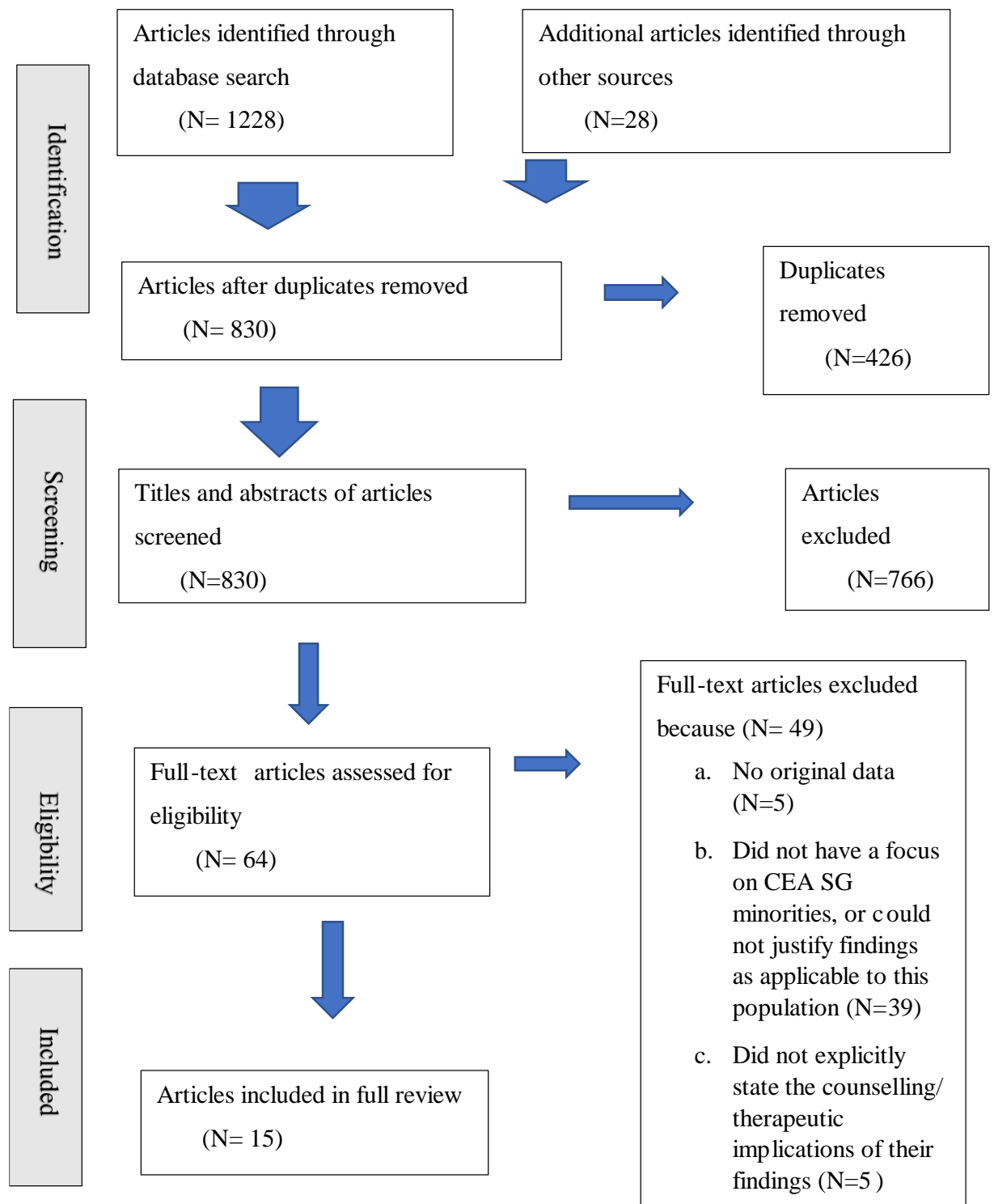


Figure 10. Systematic review PRISMA flow chart for data selection

Table 8. Selection criteria for systematic review

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**Key-terms searched**

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(chinese OR asia\* OR taiwan\* OR korea\* OR “hong kong” OR japan\* OR macau OR macanese OR singapore\*) AND

(lgbt\* OR gay OR gays OR homosexual\* OR “homo sexual\*” OR lesbian\* OR bisexual\* OR “bi sexual\*” OR transgender\* OR “trans gender\*” OR queer OR tongzhi OR “sexual minori\*” OR “gender minori\*”) AND

(counsel\* OR psychotherap\* OR “psycho therap\*” OR therap\*)

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**Databases used**

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1. ABI/INFORM Collection, 2. Academic Search Premier, 3. Australia & New Zealand Database, 4. CINAHL Plus, 5. Embase, 6. ERIC, 7. Education Research Complete, 8. Family Health Database, 9. Gender Watch, 10. Gender Studies Database, 11. Health Business Elite, 12. Health & Medical Collection, 13. Health Management Database, 14. MEDLINE®, 15. Nursing & Allied Health Database, 16. PsycInfo, 17. PsycArticles 18. Psychology Database, 19. Psychology and Behavioral Sciences Collection, 20. Public Health Database, 21. PTSDpubs, 22. Scopus, 23. Social Science Database, 24. Sociology Database, 25. Social Services Abstracts, 26. Sociological Abstracts, 27. Social Work Abstracts, 28. International Bibliography of the Social Sciences, 29. Journal@Ovid

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**Inclusion criteria**

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Articles were included if they met the following eligibility criteria:

1. The paper was peer-reviewed and published in English.
  2. The paper focused on CEA SG minority people residing in an English-speaking Western nation where they were an ethnic minority.
  3. The paper contained original qualitative or quantitative data. Case reports and small scale studies were included.
  4. The paper met at least one of the following two conditions:
    - a) It addressed the psychological issues of CEA SG minority people and explicitly discussed the therapeutic implications, OR
    - b) It contained case studies of CEA SG minority people receiving a form of psychological therapy.
-

## 5.6 Results

Fifteen papers were found to meet the inclusion criteria, with thirteen American studies and two from New Zealand. Most of the participants in the included papers were Chinese, Japanese, and Korean youth or young adults (between 17 and 30 years old) who identified as gay, bisexual, or lesbian. Exceptions included qualitative studies with 1) Chinese lesbian women over 40 years of age (Dibble, Sato, & Haller, 2007) and 2) psychological therapists working with Chinese SG minority youth (Chiang et al, 2018a; McConnell, 2018; Shen, Chiu, & Lim, 2005; Davidson & Huenefeld, 2002). Only two studies included one or more potentially gender-diverse Chinese youth (Chiang et al, 2018b; McConnell, 2018). See Table 9 for a summary of the characteristics of the 15 studies.

We assessed the quality of these papers based on the *strength of evidence* guidelines (Sackett et al., 1996; USPSTF, 2012), whereby studies carried out with a large, representative and randomised sample are thought to deliver stronger evidence. Using this quality assessment, the strength of evidence is categorised into three levels: high, medium, and low. For example, a systematic review of studies with representative samples is usually considered to be stronger (i.e. higher-level evidence) than a review of studies with small sample sizes. Most of the papers considered in the current review had very few participants, and were based on case reports ( $n = 1$  to 11, five papers) or other small-scale studies ( $n < 30$ ) of American CEA SG minority participants (6 papers). Therefore, the *individual* strength of evidence for each study is considered low. However, as we synthesised convergent evidence from multiple articles, we may increase the strength of the overall findings.

From our narrative synthesis, we identified two overarching themes: 1) intersectional mental health challenges faced by SG minorities of CEA descent (as summarized in Table 10) and 2) therapeutic recommendations described as improving treatment content and/or progress

(as summarized in Table 11).

### 5.6.1 Intersectional mental health challenges

There appeared to be a consensus among the reviewed papers that *CEA cultural values* can significantly interact with SG minority status to influence a SG CEA person's 'mental health experience'. We have grouped these potential influences into the intrapersonal and interpersonal aspects of the 'mental health experience'.

#### Intrapersonal aspects

*The development of SG minority identity.* Almost all the papers reviewed indicated that the process of developing a Western SG minority identity can be challenging for CEA SG minorities, as some CEA cultural values (e.g., saving face or the obligation to marry a member of the opposite sex and produce offspring) may prohibit the progression of LGBTQ identity formation. Various identity styles were discussed, for example segmentation or separation of identity (Choi et al., 1996; Chung & Szymanski, 2007; Davidson & Huenefeld, 2002; Ohnishi, Ibrahim, & Grzegorek, 2007; Shen et al, 2005; Singh, Chung, & Dean, 2007; Szymanski & Sung, 2013). Some SG minority CEA youth, for instance, were described as minimising their CEA characteristics by bleaching their hair or exclusively dating SG minority White partners. Others were reported to defensively conceal their SG minority status. Both approaches to identity management were theorised to be associated with unfavourable mental health outcomes for CEA SG minorities.

*The presentation of mental distress of an intersectional nature.* Although we found no clear pattern among reviewed papers regarding the behaviours and expression of mental distress commonly experienced by CEA SG minorities, various presentations of distress

uniquely related to intersecting experiences were reported. For example, one paper identified a variation of Post-Traumatic Stress Disorder (PTSD) due to a participant experiencing *intersectional trauma*, which was described as multi-dimensional and relationship-based psychological injury with symptomology entirely different from that associated with ‘classic PTSD’ (McConnell, 2018). Further papers reported challenging forms of psychological injury due to the aggregation of racism, sexism, and cisgenderism/heterosexism<sup>10</sup> (Chiang et al., 2018; Matteson, 1997; Tan et al., 2016). In addition, several papers reported various emotional disturbances and risky behaviours (e.g., depressive moods, unprotected sex or the use of illegal substances) among CEA SG minorities (Chiang et al., 2018; Chiang et al., 2018; Choi et al., 1996; Matteson, 1997). These negative mental health indicators were described as being associated with: Asian-specific body image concerns (e.g., negative self-views due to not meeting the Western standards of attractiveness in local LGBTQ communities); a lack of assertiveness linked to a false assumption about Asian submissiveness in LGBTQ communities; or a lack of HIV knowledge and education among CEA gay and bisexual men. In addition, two papers had a perspectives in relation to some CEA SG minority individuals’ adherence to the ‘*Asian model minority myth*,’ (i.e., an idealised social image about all Asian immigrants being overachievers in career, academic and moral aspects of life) (Dibble et al., 2007; Matteson, 1997). These papers described participants as painstakingly striving to meet socially prescribed “model-minority” images.

#### Interpersonal aspects

*Mistreatment and discrimination.* All included papers reported that SG minority CEA people are frequently subject to various forms of mistreatment, such as discrimination, abuse,

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<sup>10</sup> Cisgenderism refers to the prejudice of viewing the binary of male and female as the only legitimate and healthy gender identities. Similarly, heterosexism refers to the prejudice of viewing that heterosexual identity is the only legitimate and healthy sexual identity.

or racism (e.g., ‘no Asians’ as an exclusion criteria on LGBTQ dating Apps.). Mistreatment has been theorized to account for much of the mental distress experienced by SG minority CEA people. Several papers reported the use of strategic identity management by some SG minority CEA people in order to feel safer in their communities (Chiang et al., 2018; Davidson & Huenefeld, 2002; Ohnishi et al., 2007; Strayhorn, 2014; Szymanski & Sung, 2013). Some individuals, for example, were described to prioritise salient parts of self (e.g., being a ‘straight-A’ student, or ‘building up muscles’ for SG men) in an attempt to negate some aspects of mistreatment.

*Coming out and identity disclosure.* Most papers were consistent in highlighting that, compared with White SG minority individuals, CEA SG minority people tend to face additional challenges related to coming out and gaining acceptance due to the intersection of their ethnicity and sexuality and/or gender identity. The process of coming out can involve a high degree of discretion to avoid rejection from both CEA people (who are mostly heterosexual) and SG minority individuals (who are mostly non-Asian White). Therapy papers specifically highlighted the experience of SG minority CEA people feeling torn between both communities, and what psychological therapists can often describe as a bi-cultural therapeutic potential whereby they strike a balance between the CEA cultures and predominately White SG minority cultures (Chiang et al., 2018; Davidson & Huenefeld, 2002; McConnell, 2018; Shen, H. et al., 2005; Strayhorn, 2014).

### 5.6.2 Counselling/therapeutic recommendations

We extracted all the possible therapeutic elements from the included papers despite their heterogeneity. Through data synthesis we identified some shared themes regarding how to best work therapeutically with CEA SG minority people: These themes can be grouped into four



areas of recommendations for therapists to consider: 1) the willingness to self-reflect and receive further education on intersecting identities; the abilities to 2) conduct culturally adequate assessment attuned to intersectional concerns, and 3) intervene to promote the therapeutic potential bi-culturally; and 4) address the pertinent treatment barriers. Of note, among the included papers we observed an unspoken assumption that their intended readership was ‘mainstream therapists’ (i.e., White, cisgender and heterosexual therapists).

#### Continuing education about intersecting identities

The majority of reviewed papers discussed the need for therapists to learn about intersectionality and be aware of their own potential racial or heterosexist (and presumably cis-genderist) biases, acknowledging that therapists’ attitudes and assumptions influence treatment content and progress (Chiang., 2018; Chiang et al., 2018; Choi et al., 1996; Davidson & Huenefeld, 2002; McConnell, 2018; Ohnishi et al., 2007; Shen et al., 2005; Singh et al., 2007; Tan et al., 2016). For therapists, gaining self-awareness of their own limitations and continued training are the first steps required towards increased clinical sensitivity for identifying and addressing the intersectional challenges experienced by CEA SG minority people, according to these papers.

#### Culturally adequate assessment attuned to intersectional concerns

Most papers indicated that therapists need to be capable not only of addressing their clients’ presenting clinical problems (e.g., depression), but also of assessing multi-dimensional issues of intersectional concerns, typically involving a client’s sexuality, gender identity, ethnicity, and culture (Chiang et al., 2018; Davidson & Huenefeld, 2002; McConnell, 2018; Ohnishi et al., 2007; Shen et al., 2005; Strayhorn, 2014; Tan et al., 2016). These social

identities were described as more than simple background information or details. Rather identities (and their interactions) were seen as central and as influences on the symptomology of mental distress. McConnell (2018) reported the unique symptomology of intersectional trauma (e.g., leading to chronic and repetitive relationship difficulties).

The results also suggested that through culturally attuned assessment, therapists can correctly identify the core issue underlying their clients expressed symptoms. Four papers explicitly outlined the cultural frameworks of assessment that can help therapists achieve this aim (Davidson & Huenefeld, 2002; Ohnishi et al., 2007; Shen, H. et al., 2005; Tan et al., 2016).

#### Clinical interventions to promote the therapeutic potential bi-culturally

There was a high level of consistency among included papers highlighted that SG minority CEA people often struggle with the tensions between collectivist and individualist cultures. While accepting and disclosing a LGBTQ identity may be perceived as an endorsement of self-expression and individualism, privileging collectivism by honouring family and community (e.g., obeying the instructions of parents) may pose challenges to SG identity exploration. Several papers indicated that the main focus of clinical interventions should be on managing these particular tensions and/or developing the ability to navigate them (Chiang et al., 2018; Davidson & Huenefeld, 2002; McConnell, 2018; Ohnishi et al., 2007; Shen et al., 2005) under a holistic and relational therapeutic framework (Chiang et al., 2018; McConnell, 2018; Tan et al., 2016). In this way, therapists were seen as being able to support their clients to cultivate self-acceptance and a sense of acceptance that their parents or other family members may not change their negative views on sex, sexuality and gender diversity, whilst deepening family connectedness by accentuating the aspects of identity that are culturally valued by their families (Chiang et al., 2018; McConnell, 2018; Ohnishi et al., 2007;

Szymanski & Sung, 2010). Specific cases mentioned in two papers are that therapists worked with CEA SG minority youth clients to proactively negotiate relational boundaries in their families (Chiang et al., 2018; McConnell, 2018). Although familial conflicts and disagreements were described as inevitable, authors reported that it was important that clients be encouraged to find a middle ground (e.g., caring for other familial needs) to stay connected with (and supported by) their families.

Addressing barriers to progress.

Reviewed papers included discussion of the potential barriers to engaging in therapies faced by CEA SG minority people who have experienced mental distress (Chiang, et al., 2018; Choi et al., 1996; Davidson & Huenefeld, 2002; Dibble et al., 2007; Shen, et al., 2005). These barriers included lack of knowledge or motivation, shame, fear of taking psychotropic medicine as part of a therapeutic regime, and cultural stigma around SG diversity issues, mental ill-health, and psychological trauma.

Table 9. Characteristics of the included papers for systematic review

Study	Selection criteria			
	CEA SG focused?	Type of data?	Explicit counselling/clinical implications?	Counselling/ clinical interventions?
Choi et al., (1996)	No, but 102 (40 %) of 258 Asian and Pacific Islander (API) American gay male participants (Mean age=30) identified as CEA in brief group counselling for HIV risk reduction.	Quantitative/ Randomised control study	Yes, it is a study that addressed therapeutic interventions	Yes, it is a study that addressed therapeutic interventions
Chiang et al., (2018)a	Yes, interviewed 11 Chinese SG minority young people in New Zealand	Qualitative	Yes, Abstract, "...mental health service providers'..."	No
Chiang et al., (2018)b	Yes, focused on therapies with Chinese SG minority youth in New Zealand	Qualitative	Yes, it is a study that addressed therapeutic interventions	Yes, it is a study that addressed therapeutic interventions
Chung & Szymanski, (2007)	No, but 5 (50%) of 10 Asian American gay men in Study 2 were Chinese or Korean.	Mixed research/ quantitative and qualitative studies	Yes, page 90, "A counselor's ability to work with Asian American gay..."	No
Davidson & Huenefeld, (2002)	Yes, a 23-year-old Chinese American lesbian university student seeking career counselling	Case study	Yes, it is a study that addressed therapeutic interventions	Yes, it is a study that addressed therapeutic interventions

Dibble et al., (2007)	No, but 11 (38%) of 29 API American lesbian midlife (>40 years old) participants identified as having Chinese heritage in this study of their health status including body composition, coming out, smoking, alcohol, and history of abuse.	Quantitative/ Survey study with convenience sample	Yes, page 138, “To summarize, psychotherapists may...”	No
Matteson, (1997)	No, but 38 (54%) of 70 Asian American gay or bisexual men were Chinese or Korean.	Quantitative/ structured interview	Yes, page 102, “Recommendation for prevention...telephone counseling...”	No
McConnell, (2018)	Yes, reviewed a therapy case of a Chinese American adolescent who was questioning her SG identity.	Case study	Yes, it is a study that addressed therapeutic interventions	Yes, it is a study that addressed therapeutic interventions
Ohnishi et al., (2007)	Yes, a 19-year-old Korean American gay university student seeking counselling support for his depressed mood	Case study	Yes, it is a study that addressed therapeutic interventions	Yes, it is a study that addressed therapeutic interventions
Shen et al., (2005)	Yes, a 17-year-old Taiwanese American gay high school student seeking psychiatric and psychotherapeutic support for depression	Case study	Yes, it is a study that addressed therapeutic interventions	Yes, it is a study that addressed therapeutic interventions
Singh et al., (2007)	No, but 12 (44%) of 27 Asian American lesbian or bisexual women (Mean age=30) identified as CEA in this study examining the relationship between levels of acculturation and internalised homophobia.	Survey study with convenience sample	Yes, page 13, “Counselling and Advocacy Implications...”	No

Strayhorn, (2014)	Yes, interviewed 4 Korean American gay university students (Mean age=20) regarding their lived experiences as CEA gay men in college	Qualitative		Yes, page 593, “Counselling and mental health professionals may use these findings...”	No
Szymanski & Sung, (2010)	No, but 76 (53%) of 144 Asian American SG minority respondents (Mean age=30) identified as CEA in this study examining the relationship between minority stress and psychological distress	Yes	Quantitative/ Survey study with convenience sample	Yes, page 10, “Clinical Implications..., ...counselling psychologists might...”	No
Szymanski & Sung, (2013)	No, but 76 (53%) of 143 Asian American SG minority respondents (Mean age=30) identified as CEA in this study examining the relationship between Asian cultural values, internalised heterosexism, and coming out.	Yes	Quantitative/ Survey study with convenience sample	Yes, page 269, “Clinical Implications..., ...the need for counsellors to...”	No
Tan et al., (2016)	No, but 1 (33%) of three API American SG minority participants is CEA	Yes	Case study of three	Yes, page 327, “Recommendation for clinical practice...”	No

Table 10. Mental health challenges identified in systematic review

Study	Psychological experiences
Choi (1996)	<ul style="list-style-type: none"> <li>● Many of the Asian and Pacific Islander (API) SG minority respondents grew up in households in which homosexuality (and sex more generally) was not openly discussed (because of the characteristics of many API cultures), with implications for skills or knowledge in practicing safe sex and elevated risk of HIV infection for API gay men.</li> </ul>
Chiang (2018)	<ul style="list-style-type: none"> <li>● Four major categories of psychological experiences were identified: 1) experiences that apply to all youth (i.e., needs for love and acceptance), 2) experiences related to managing migrant Chinese youth needs (e.g., dealing with racism or acculturation), 3) experiences of being SG minority youth (e.g., coming-out), and 4) intersectional needs of being migrant Chinese SG minority youth.</li> </ul>
Chiang (2018)	<ul style="list-style-type: none"> <li>● Several challenging psychological experiences were reported, including those linked to racism, sexism, cis- heteronormativity and those related to intersectional identity (e.g., stress of managing rejections from both Asian and mostly White gay communities).</li> </ul>
Chung (2007)	<ul style="list-style-type: none"> <li>● Four different styles of racial/SG identity attitudes were identified among Asian American gay men: Assimilationists, Marginalists, Separationists, and Integrationists. These styles were described to be associated with internalised homophobia.</li> <li>● Themes of psychological experiences related to the developmental process of racial/SG identity were identified: 1) immigration and education issues, 2) coming out and SG expression concerns, 3) being Asian in America, and 4) issues related to intersecting identity (such as interracial dating and gay Asian stereotyping in America).</li> </ul>
Davidson (2002)	<ul style="list-style-type: none"> <li>● Chinese cultural factors may have influenced the experience of the Chinese lesbian participant. These include close ties to family and a collectivistic orientation, leading to limited expression of gender and sexuality, and limited career options for females.</li> <li>● The participant also experienced a tension/division between the Chinese (mostly heterosexual) and lesbian (mostly White) communities, which may have increased the difficulties she faced in integrating both her ethnic and sexual identities.</li> </ul>

Dibble (2007)	<ul style="list-style-type: none"> <li>● A third of the Asian, Native Hawaiian, or Other Pacific Islander (A-NHOPI) midlife lesbians were completely out to their families, co-workers, and health-care providers.</li> <li>● Although a significant percentage of participants reported a history of child abuse, they generally maintained a healthy lifestyle, including high rates of smoking cessation and low rates of smoking and alcohol abuse. 57% were in the healthy weight range (i.e., the hypothesized linkage between childhood trauma and unhealthy living unsupported).</li> <li>● Some cultural explanations for participants' health behaviours were discussed. For example, there is a "model minority" stereotypical perception of Asians as being well-behaved. These women may have subconsciously conformed with this myth.</li> <li>● Asian bodies may be particularly sensitive to alcohol and other substances. This could explain some participants' unwillingness to abuse substances to avoid experiencing "Asian flushing (i.e. face turning embarrassingly red after a small amount of alcohol intake)" and other physical discomfort.</li> </ul>
Matteson (1997)	<ul style="list-style-type: none"> <li>● Asian American gay men were found to more likely comply with safer sex than their bisexual peers. Acculturation to Asian cultures further enhanced this compliance.</li> <li>● Westernisation, lack of education about HIV transmission, no trusted sexual partner, poor interpersonal skills, and feelings of guilt were reported to be associated with sexual risk-taking.</li> </ul>
McConnell (2018)	<ul style="list-style-type: none"> <li>● A unique presentation of intersectional trauma-related symptoms was identified in a Chinese American SG minority youth. This cluster of symptoms was described as very different from classic PTSD. Intersectional trauma tends to be multifaceted, relational, structural and ongoing. Accordingly, symptoms were described to include emotional dysregulation, dissociation and reduced ability of self-awareness, and interpersonal issues.</li> <li>● The authors implied that intersectional trauma can lead to serious impairment, such as dysfunctional personality styles leading to chronic relationship difficulties.</li> </ul>
Ohnishi (2006)	<ul style="list-style-type: none"> <li>● The participant reported struggling against social stereotypes of Asian people (e.g. being submissive) and European standards of attractiveness (e.g. being tall with large muscles, for males) in order to gain acceptance.</li> <li>● Some Chinese cultural factors were discussed, for example, the complementarity of yin and yang, stigma and prejudice against homo-/bi-/trans-sexuality, collectivism and shame, the importance of family obligations, and proper career choice.</li> <li>● Issues around acculturation, internalised homophobia, internalised racism, and racism in the gay community were discussed.</li> </ul>
Shen (2005)	<ul style="list-style-type: none"> <li>● Essential Chinese cultural influences (mainly Confucianism, Taoism, and Buddhism) were discussed, including an emphasis on interpersonal harmony, high achievement orientation, high level of collectivism and interdependence, authoritarian parent-child relationship, and indirect communication style. Chinese culture also has different views on homosexuality, the expression of mental distress, and beliefs in traditional treatment.</li> </ul>



	<ul style="list-style-type: none"> <li>● The authors suggested that 1) Chinese immigrant youth often need to deal with acculturation issues, schooling, negative peer influences and isolation, and 2) Asian people may be more sensitive to psychotropic medicine. This may lead to side effects and poor treatment adherence.</li> </ul>
Singh (2006)	<p>The paper highlighted that:</p> <ul style="list-style-type: none"> <li>● The values of family and community affect Asian lesbian and bisexual women’s coming out process. Family expectations often outweigh individual needs, and Asian women are particularly encouraged to minimise potential conflicts for the sake of interpersonal harmony in the family.</li> <li>● Western models of sexual identity development often view coming out to others as a sign of mental health. This individualistic view may not reflect the tension experienced by these women living between individualism and collectivism.</li> <li>● Among participants, the Asian-identified women had lower levels of internalised homophobia than the Western-identified women. In general, the Western-identified and bicultural women were more “out” to their families and at work than the Asian-identified women.</li> </ul>
Strayhorn (2014)	<ul style="list-style-type: none"> <li>● Korean gay participants expressed the desire to come out and explore their homosexuality while in college, as this may be their first opportunity to live away from home. Prior to college, participants would maintain a divided identity because of CEA cultural barriers.</li> <li>● Participants experienced gay racism during the journey of coming out in college. They reported various forms of derogatory remarks or racial microaggressions from gay peers and on dating sites.</li> <li>● As a result, participants often reported a careful process of “picking and choosing” who they could come out to. No participants had come out to their parents at the time of study.</li> </ul>
Szymanski (2010)	<ul style="list-style-type: none"> <li>● This study explicitly adopted minority stress theory. It assumed that Asian LGBTQ individuals experience additional stress due to living in a heterosexist and racist context. This minority stress is unique to these individuals and is situationally based.</li> <li>● This study examined the relationships between various external (i.e. heterosexist or racist events and racism in gay communities) and internalised (i.e. internalised homophobia, coming out, and race-related dating issues) minority stressors and mental health. Heterosexism in Asian communities, race-related dating issues, internalised homophobia, and outness to the world were found to be significantly related to mental health. Coming out was not found to have a moderating or a mediating role in the relationship between internalised homophobia and mental health.</li> <li>● Potential cultural conflicts between individualism and collectivism were discussed, such as the Chinese notion of yin and yang.</li> </ul>

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Szymanski (2013)	<ul style="list-style-type: none"> <li>● This study also adopted minority stress theory to examine the relationships between Asian cultural values, internalised homophobia, and coming out among Asian sexual minority persons.</li> <li>● Some specific Asian cultural values, such as conformity to the traditional norms of gender role, collectivism, achievement orientation, emotional self-control, humility, and filial piety were discussed, as these may limit the expression of sexuality.</li> <li>● Identity concealment as both a protective and a risk factor was discussed. While identity concealment reduces the likelihood of homophobic attacks, it increases the sense of social isolation.</li> <li>● This study found that among Asian sexual minority persons, adhering to Asian values was positively related to internalised homophobia and negatively related to coming out to others. Internalised homophobia moderated and mediated the relationship between adhering to Asian values and coming out. This means that some specific Asian values may contribute to internalised homophobia, leading to these persons' unwillingness to come out.</li> </ul>
Tan (2016)	<ul style="list-style-type: none"> <li>● Possible experiences that can affect the Shared Decision Making (SDM) process between clinicians and Asian American SG minority clients were discussed, including systemic and intrapersonal experiences (e.g., immigration, language barriers, or socioeconomic status), interpersonal experiences (e.g., fear or experience of rejection and discrimination), and intersectional experiences (e.g., isolation from both Asian and SG minority communities).</li> </ul>

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Table 11. Therapeutic recommendations in systematic review

Study ID	Therapeutic recommendations/ guidelines for therapists and clinicians
Choi (1996)	<ul style="list-style-type: none"> <li>● Culturally sensitive brief group counselling in HIV risk reduction for API gay men was evaluated for its efficacy. Chinese men specifically benefited from participating in this group.</li> <li>● The intervention lasted about three hours and was run by two facilitators. It included four parts: development of positive self-identity and social support, safer sex education, eroticising safer sex, and negotiating safer sex.</li> </ul>
Chiang (2018)	<ul style="list-style-type: none"> <li>● Elements of psychological therapy that can support Chinese SG minority youth were described to include relationship-oriented, individual-tailored, and holistic approaches.</li> <li>● The authors proposed an alternative path of identity development for Chinese SG minority youth, from a secretive sense of hidden identity to segmented but well-managed identities.</li> </ul>
Chiang (2018)	<ul style="list-style-type: none"> <li>● Therapists' levels of experience were endorsed by two participants as a potential factor contributing to therapeutic outcome.</li> <li>● Other relevant elements, such as Chinese cultural connection, family and social support, and role modeling, may be general supporting factors of youth mental health.</li> </ul>
Chung (2007)	<ul style="list-style-type: none"> <li>● The authors proposed that counsellors can assess the racial/SG identity styles of their Asian American gay clients to help determine appropriate counselling interventions. For instance, it may not be appropriate to refer all Asian American gay clients to gay Asian support groups or Asian counsellors. A gay White (or European American) counsellor may work well with Assimilationist clients as these clients may wish to adopt a Western style of SG identity development.</li> <li>● Other interventions were recommended, including coping skills in dealing with racism and discrimination, coming out to families, and managing the feelings of being marginalised by both Asian and (predominately-White) gay communities.</li> </ul>
Davidson (2002)	<ul style="list-style-type: none"> <li>● An ecological model was employed to conceptualise the client's issues into three levels: macro-system, micro-system, and individual micro-system. At the macro-system level, the client's cultural context defined the appropriate career paths for her. At the micro-system level, she struggled between her family and rainbow communities (as well as with expectations from both Chinese and Western cultures). At the individual level, she was trying to develop a sense of harmony between her ethnic and sexual identity.</li> <li>● The proposed intervention was to first work through the client's identity as a Chinese American lesbian woman, then explore her career considerations and some specific career plans. Particular assessment tools were suggested as potentially helpful in identifying the client's career interests and personality styles.</li> <li>● Some barriers to therapies were discussed, including the therapist's own limitations and bias.</li> </ul>

Dibble (2007)	<p>The authors suggested that:</p> <ul style="list-style-type: none"> <li>● Inquire if there is a history of childhood trauma and assess its potential impact on API lesbian and bisexual women’s mental health.</li> <li>● Develop a do-able plan with clients to cut down substance use and promote health behaviours.</li> <li>● Find ways to facilitate disclosure, given these women do not usually come out to their health-care providers.</li> </ul>
Matteson (1997)	<ul style="list-style-type: none"> <li>● As an alternative to face-to-face intervention, the authors proposed that educational information about HIV and safer sex should be provided to Asian communities through online educational materials or interactive media. Described advantages of these alternative interventions included allowing privacy and reducing a sense of shame and guilt.</li> <li>● As most participants were reported as having negative views of Asian bodies and homosexuality, clinicians were encouraged to promote clients’ acceptance of their bodies and the positively affirm healthy homosexual behaviours.</li> </ul>
McConnell (2018)	<ul style="list-style-type: none"> <li>● The authors proposed the use of an affirmative psychotherapeutic approach with an emphasis on the understanding of trauma treatment and the potential impact of social oppression on mental health. This approach suggests that clinicians need to be aware of their own biases and learn to incorporate the theories of multiculturalism, SG minority identity, and intersectionality into their clinical practice.</li> <li>● The authors also highlighted the importance of considering the perspectives of youth development and family systems when working with young people.</li> </ul>
Ohnishi (2006)	<p>Multi-dimensional assessment was proposed using the Racial/ethnic and Sexual Orientation Identification Chart (RSIC) to help clinicians identify the current phase of identity development in LGBT Asian-American clients. RSIC describes four distinct phases of identification: high racial/high sexual, high racial/low sexual, low racial/high sexual, and low racial/low sexual identity development. Based on this framework, it is assumed that individuals with both high racial and sexual identification may present with low levels of psychological distress. Conversely, individuals with both low racial and sexual identification may present with higher levels of distress. The authors made the following recommendations to clinicians working with CEA SG minority clients:</p> <ul style="list-style-type: none"> <li>● Take an affirming stance to counteract the negative impact of societal oppression and help clients develop positive ethnic and sexual identity.</li> <li>● Understand clients’ ethnic and sexual orientation issues in the context of both Asian-American and LGBT communities.</li> <li>● Demonstrate linguistic expression free of heterosexual/racial biases.</li> <li>● Help clients identify and integrate both aspects of identity (i.e., achieving a state of high Asian-American/high LGBT identity).</li> <li>● Help clients navigate dual cultural paradigms and develop coping skills to be bicultural.</li> </ul>
Shen (2005)	<p>Multi-dimensional assessment of cultural formulation from DSM-4TR was adopted to conceptualise the case. The dimensions are cultural identity of the individual, cultural explanations for the individual’s illness, cultural factors related to psychosocial environment and levels of functioning, cultural elements of the relationship between the individual and clinician, and overall cultural assessment for</p>

	<p>diagnosis and care.</p> <ul style="list-style-type: none"> <li>● Be aware of a number of cultural subtleties/barriers and learn to overcome them.</li> </ul>
Singh (2006)	<p>The following recommendations were provided:</p> <ul style="list-style-type: none"> <li>● Focus on acculturation level and internalised homophobia or shame.</li> <li>● Develop knowledge and intervention skills in helping Asian lesbian and bisexual women combat racism, sexism, and homophobia.</li> <li>● Receive continuing education and use the latest treatment guide for SG minority clients with mental health needs.</li> <li>● Break the silence that commonly exists about sexuality in Asian communities.</li> <li>● Provide education and advocacy for the rights of this population.</li> <li>● Establish culturally-specific resources for these clients.</li> </ul>
Strayhorn (2014)	<p>Therapists were advised to help CEA gay men to prepare for coming out challenges in college, and to their families. This includes the development of coping strategies. Counsellors are also recommended to partner with other staff on campus to confront racism and homophobia, and diffuse anger.</p>
Szymanski (2010)	<p>The paper suggested therapists to:</p> <ul style="list-style-type: none"> <li>● Ask Asian SG minority clients about their experiences with racism in the gay community and homophobia in the Asian community, as well as their struggles between the two cultures.</li> <li>● Assess the various ways that internalised homophobia can manifest, as well as ways to reduce it.</li> <li>● Fully discuss a plan for, and issues about, coming out to others appropriately and safely.</li> </ul>
Szymanski (2013)	<p>Therapists were advised to:</p> <ul style="list-style-type: none"> <li>● Facilitate the discussion of the external and internal conflicts associated with minority cultural and SG identity, decrease internalised homophobia, and develop a sense of congruence in self, worldviews, and social relationships.</li> <li>● Be aware that the process of coming out is likely to be more complex for Asian SG minorities than for their European peers. There may be alternative ways to develop a sense of self-acceptance and come out in a relatively private manner.</li> </ul>
Tan (2016)	<ul style="list-style-type: none"> <li>● The authors proposed two practical ways to help clinicians minimize the potential bias when treating Asian American SG minority clients: 1) establishing a safe clinical environment by adopting an open and non-judgmental attitude, using appropriate terms to address the clients, or hiring professional interpreters; and 2) understanding the intersection of the clients' SG identities and cultures by asking and allowing them to freely express themselves, being mindful of potential stereotypes and stigma, and inquiring about the use of Chinese or other alternative therapies.</li> </ul>

## 5.7 Discussion

In this systematic literature review we identified 15 papers addressing the intersectional challenges of, and therapeutic supports for, SG minority CEA people living in Western, English speaking nations. Although there are many CEA SG minorities living in these nations and scholars demonstrate an increasing interest in intersectionality research, our included studies were generally small scale and exploratory with less methodological rigor. However, the high level of agreement across these papers made it possible for us to extract key themes regarding mental health challenges and opportunities for psychological therapists to consider. The results highlighted that partly due to intersecting minority identities, CEA SG minorities are often required to manage expectations from CEA cultures and predominately White SG minority cultures. Also, they need to cope with various forms of social oppression, both of which can have a negative impact on their mental health and wellbeing. Intersectional impact emerged in both the intrapersonal and interpersonal aspects of their lives. Our synthesis of the literature further suggests four important areas of therapeutic recommendations: 1) the willingness to self-reflect and receive education on intersecting identities; the abilities to 2) conduct culturally adequate assessment attuned to intersectional concerns, and 3) intervene to promote the therapeutic potential bi-culturally; and 4) address the pertinent treatment barriers. These four areas correspond with part of the guidelines of core competencies for psychologists (Kaslow, 2004). These include the abilities to perform self-assessment or self-reflective thinking, diagnostic formulation or assessment of clients, cultural adaptations on both therapeutic content and process to reduce foreseeable treatment barriers (Kaslow, 2004).

In terms of therapeutic goals, as a combination of external acculturation and internal enculturation seems to promise the most favourable impact on mental health (Yoon et al.,

2013), we recommend that therapists consider a holistic and relational approach in helping their SG minority CEA clients balance their ‘Western ways’ whilst being proud of their CEA identity and connections with their family of origin.

This systematic review adds to the existing literature in several meaningful ways. First, as there are currently no therapeutic guidelines available for therapists working with CEA double minorities in Western nations, this review consolidates the current evidence and offers a set of recommendations for therapists. Second, we demonstrate the relative scarcity of research addressing therapies for SG minority CEA people, despite their distinct needs (Chiang et al., 2016). Most importantly, due to the complex intersectional challenges reported in these papers and the fact that adequate therapeutic support for this population is lacking, further investment in developing culturally adapted therapies for double minorities is urgently needed.

This systematic review has several limitations. First, most of the reviewed literature is from the USA, therefore the findings may not reflect the experiences of SG minority CEA people living elsewhere. Second, most of the included studies had a small number of participants (i.e., less than 11 for the qualitative studies and less than 76 for the quantitative ones), with a focus on the issues faced by gay and bisexual males. The experiences of these participants may not adequately represent those of other SG minority people, or of other sex, gender, and sexuality diverse CEA people. Third, as some of the included studies (n=7) grouped Asian and Pasifika participants together without acknowledging the diversity within this combined group, the findings of this review may not meet all the unique needs of CEA SG minority people. Finally, as this review is based on a number of studies that only have very limited strength of evidence. The results of this review should therefore be considered exploratory to stimulate further research in the field.

## **5.8 Conclusion**

This study can be seen as a starting point for exploring how psychological therapies can be made more culturally appropriate for CEA SG minority people. It identifies some unique intersectional challenges and outlines a summary of relatively consolidated therapeutic recommendations for the consideration of therapists working with CEA SG clients.

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## Chapter 6: (Study Three) Navigating double marginalisation: Migrant Chinese sexual and gender minority young people's views on their mental health challenges and supports

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### 6.1 Preface

According to the findings of Study Two, there is a gap in the empirical literature regarding psychotherapeutic support for Chinese and other East Asian SG minority young people in English-speaking Western nations. It is clear that this group of young people have long been overlooked or even neglected by international scholars. In addition, the findings of Study One led me to hypothesize that double minority youth may have additional resiliency. For example, this may be linked to tolerance of some non-European cultures towards SG diversity. The resiliency may be also due to enhanced coping linked to participants' prior life experiences in managing racism (more discussions regarding this can be found in "4.7.2. Potential implications" of Study One). As mentioned previously, the alternative explanation may be that the double minority youth participants in Study One were under-reporting their psychological distress. Considering the findings and limitations of Studies One and Two, I undertook qualitative studies of an exploratory nature in the next phase of research to explore such themes in more depth.

An exploratory qualitative study is useful in areas of research such as this where gaps are evident in the literature. In-depth interviews can generate rich research data. It was also my intention to address some of the questions arising from Study One (e.g., the group differences in mental health status I observed).

I therefore designed a comprehensive interview guide for migrant Chinese SG minority young people in New Zealand. This guide explored not only mental health challenges, but also

potential support for resiliency. The resulting qualitative study explored the strengths and challenges reported by Chinese SG minority youth.

The current chapter comprises a paper reporting this qualitative study. This paper has been accepted for publication in the *Journal of Culture, Health, and Sexuality*. Based on the feedback from this peer-reviewed journal, this paper contributes new knowledge in two significant ways. First, although migrants can learn a new language or adopt different behaviours relatively quickly, their cultural roots tend to linger across generations. This study showed that some unique Chinese cultural features, such as saving face and filial piety, may still prevail among Chinese immigrant youth in English-speaking Western countries. Second, although most young people did not get professional support for their mental health and wellbeing, the study found that some of them can draw strength from their cultural assets, which supports the findings in Study One demonstrating their good wellbeing relatively to NZ European SG minority youth.

## 6.2 Peer-review status

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**Navigating double marginalisation: Migrant Chinese sexual and gender minority  
young people's views on mental health challenges and supports**

Szu-Ying Chiang, John Fenaughty, Mathijs F.G. Lucassen, and Theresa Fleming

(Accepted version)

### **6.3 Abstract**

Sexual and/or gender minority young people who are also members of an ethnic minority can experience unique challenges. Limited research draws directly on the mental health experiences of these 'double minority' youth. This study focused on Chinese sexual/gender minority youth in New Zealand. It sought to explore features they found challenging for, or supportive of, their mental health and wellbeing. Semi-structured interviews were conducted with 11 Chinese sexual/gender minority participants aged between 19 and 29 years old and residing in Auckland, New Zealand. An inductive approach to qualitative data analysis was used. Two major domains of findings emerged. Firstly, participants described mental health challenges linked to racism, sexism, cis-heteronormativity and challenges in relation to intersecting identities. Secondly, Chinese culture and community connections, family and peer support, and role models seemed to facilitate resiliency. However, the fear of 'losing face', unwillingness to disclose distress when unwell, and mental health service providers' lack of cultural and linguistic competency were described as barriers to effective mental health support. In conclusion, Chinese and sexual/gender minority identities were integral parts of participants' sense of self, and this was associated with their mental health and wellbeing. Further research is required to explore ways to reduce barriers and promote resiliency.

**Keywords:** Chinese, mental health, LGBT, sexual and gender minority, youth, psychological services, counselling, New Zealand

## 6.4 Introduction

Sexual and gender minority<sup>11</sup> youth are more likely to experience mental ill-health compared with other young people in a range of English-speaking Western nations (Lucassen et al. 2017; Mayer et al. 2008; McDermott, Hughes & Rawlings 2018). Similarly, minority ethnic young people report disproportionate mental ill-health compared to their majority ethnic peers (Paradies 2006; Tobler et al. 2013). The minority stress hypothesis (Meyer 2003; Kelleher 2009) has been used to explain the increased rates of mental ill-health experienced by members of these groups. The minority stressors of cis-heteronormativity (Ansara & Hegarty 2012; Konik & Stewart 2004; Jackson 2006), in addition to homo-, bi- and trans-phobia (Ochs 1996; Shidlo 1994; Norton 1997), as well as ethnocentrism (DeAngelis 2009; LeVine & Campbell 1972) and racism (Baratz & Baratz 1970; Speight 2007), can expose these young people to deleterious discrimination and oppression (Sue 2010; Meyer 2013; Newcomb & Mustanski 2010; Velez, Moradi & DeBlaere 2015).

The minority stress hypothesis posits that the more minority stressors a person experiences, the greater the chance of a negative impact (Meyer 2003). Young people who are members of sexual/gender and ethnic minorities (termed “double minority youth” for brevity) (Wooden, Kawasaki & Mayeda 1983; Boykin 1996) are theoretically more likely to experience greater challenges, due to the increased stressors of their double marginalisation (Jaspal 2015; Strayhorn 2014). However, studies have demonstrated that some interactions of minority positions can in fact be ameliorative to young people’s health and wellbeing (LeVasseur, Kelvin & Grosskopf 2013; Hayes et al. 2011). Such research suggests that the intersection of *particular* minority identities may produce positive outcomes, despite the

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<sup>11</sup> The term sexual and gender minority refers to all gender diverse people who are not cisgender (i.e. a cisgender person is someone whose gender identity aligns with the sex they were assigned at birth) and all those people who are not heterosexual, as well as those that identify as lesbian, gay, bisexual, or transgender (LGBT) (Mayer et al. 2008).

theoretical prediction of increased minority stress. For instance, the strong family connectedness of many minority ethnic communities (Scott, Wallander & Cameron 2015; Snowshoe et al. 2017; Reid et al. 2016), may in fact be protective as it may gradually encourage the familial acceptance (Ryan et al. 2010) of double minority youth.

Recent studies in the USA and UK indicate that double minority youth can develop coping strategies for resiliency in the face of double marginalisation (Li et al. 2017; Rios & Eaton 2016; Jaspal & Williamson 2017). These strategies include skills in identity management, whereby double minority youth learn to selectively prioritise aspects of their identity that are less stigmatised and seen as appropriate to the given social context (Wang, Bih & Brennan 2009; Szymanski & Sung 2013; Jaspal & Williamson 2017). Other resilience practices include developing assertiveness and self-advocacy when facing mistreatment and oppression, and the development of alternative social support networks (Li et al. 2017; Rios & Eaton 2016). Indeed, our recent New Zealand study (Chiang et al. 2017) found that while sexual/gender and ethnic minority status were singularly more likely to be associated with mental ill-health, double minority youth were overall *less* likely to report mental ill-health than their ethnic-majority (i.e., New Zealand European) sexual/gender minority peers.

However, the empirical research in this developing field has limitations. Minority ethnic communities and groups are usually treated as homogenous in terms of their experiences and ethnicity (Veenstra 2011; Lytle, De Luca & Blosnich 2014; Seitz 2018; Greene 1994; Bridges, Selvidge & Matthews 2003). Moreover, the majority of the published research is based in North America, which has its own unique context of racism and cis-heteronormativity (Jordan 1974; Durham 2003) that may differ from that of other English-speaking nations.

The current study seeks to extend the literature by exploring Chinese sexual/gender minority young people's experiences of mental health challenge and resiliency in New Zealand. In so doing, this study resists homogenising various ethnicities into one 'Asian' or

‘East Asian’ label. We feel that such homogenisation overlooks the potential influences of the many religions, cultures and languages that span the world’s largest continent, as well as Asian nations’ diverse histories of oppression.

Chinese immigrants form a substantial minority in many Western countries (Wang & Liu 2006) and represent the largest single migrant group in New Zealand (Ip 2003). A handful of qualitative studies (Chan 1995; Davidson & Huenefeld 2002; Shen, Chiu & Lim 2005) touch on the intersecting experience of Chinese sexual/gender minority youth in America. These studies note that aspects of Chinese culture (for instance, Confucianism, filial piety, Yin-Yang and ‘saving face’) may regulate expressions of emotionality, sexuality, and gender according to a socially prescribed norm, which often reinforces cis-heteronormativity (Chan 1995; Leung 2010). Opportunities (with their accompanying challenges) hence exist to explore whether aspects of Chinese culture can provide some protective features for double minorities.

In addition, since many Asian ethnicities share common concepts with Chinese culture (e.g., collectivism) (Reischauer 1974), we anticipate that these findings may have broader implications. As such, examining the mental health experiences of Chinese people in New Zealand may offer specific insights for deconstructing culturally specific cis-heteronormative norms. This may, in turn, provide insights into other ethnic groups that share aspects of Chinese culture.

In view of these considerations, the current study was designed to explore the views of Chinese sexual/gender minority youth regarding what has challenged and supported their mental health, including their views on how mental health services might be improved. We were particularly interested in exploring how a “double minority” status potentially enabled opportunities to resist the stigma and minority stress of cis-heteronormativity and/or ethnocentrism.

## 6.5 Methods

### 6.5.1 Participants

Following ethics approval from the University of Auckland's Human Participants Ethics Committee, 11 self-identified Chinese sexual/gender minority young persons aged between 19 and 29 years old and residing in Auckland, New Zealand, were interviewed (see Table 12 for demographic details). Participants were recruited via social media and internet advertisements. Participants had either migrated after their teenage years ( $n = 6$ ), or had spent all or most of their life in New Zealand ( $n = 5$ ).



Table 12. Characteristics of youth participants

<b>Pseudonym<sup>12</sup></b>	<b>Age</b>	<b>Sex assigned at birth</b>	<b>Country of birth</b>	<b>Ethnicity</b>	<b>Gender Identity</b>	<b>Sexuality/ relationship status</b>	<b>Occupation</b>
‘Abby’(E) <sup>13</sup>	20	F	China/ Moved to NZ at 17	Chinese	Cisgender F	Lesbian/ Recent break-up from a same-sex relationship	University student
‘Adda’ (C)	22	F	China/ Moved to NZ at 17	Chinese	Cisgender F	Lesbian/ Currently in a same- sex relationship	University student
‘Camille’ (C)	26	F	China/ Moved to NZ at 23	Chinese	Cisgender F	Undecided/ Currently in a same-sex relationship	In paid employment
‘Dada’ (E)	21	F	China/ Moved to NZ at 3	Chinese	Cisgender F	Bisexual/ Currently in a same-sex relationship	University student
‘Jack’ (E)	24	M	China/ Moved to NZ at 3	Chinese	Cisgender M	Gay/ Currently in a same-sex relationship	In paid employment/ University student
‘Jael’ (E)	22	F	China/ Moved to NZ at 2	Chinese	Gender non-binary	Asexual (‘Allergic to boys’)/ Single	University student
‘Laney’ (C)	19	F	China/ Moved to NZ at 15	Chinese	Transgender M	Heterosexual man/ Single	University student
‘Mary’ (E)	19	F	NZ born	Chinese/ NZ European	Cisgender F	Questioning (‘Experimenting’)/ Single	University student
‘Nash’ (E)	29	M	Thai/ Moved to NZ at 26 (was in Canada)	Chinese/ Thai	Cisgender M	No label (declined to comment)/ Single	University student
‘Randy’ (C)	29	M	China/ Moved to NZ	Chinese	Cisgender M	Gay/ Currently in a	In paid

<sup>12</sup> Each participant’s pseudonym was created to ensure confidentiality. Participants reported their sexual/gender minority status in their own words.

<sup>13</sup> E means that the interview was primarily conducted in English, and C in Chinese.

			at 3			same-sex relationship	employment
'Susan' (C)	26	F	China/ Moved to NZ at 24 (was in UK)	Chinese	Cisgender F	Bisexual/ Currently in a same-sex relationship	University student

### 6.5.2 Data collection

The first author (SC) conducted confidential face-to-face semi-structured interviews in private locations convenient to participants. SC is a cisgender gay man who is Taiwanese and registered as a clinical psychologist in New Zealand. He is fluent in both English and Mandarin Chinese. The interview guide (summarised in Table 13) was sent to participants at least one week prior to their interview so that they could consider the questions in advance.

The interviews lasted approximately 90 minutes. Interviews were conducted in participants' language of choice; six interviews were conducted in English and five in Mandarin Chinese. All the interviews were audio-recorded and professionally transcribed by native speakers.

Table 13. Youth interview guide

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Introducing yourself:

- Personal identity and background.
- What does being Chinese, a sexual/gender minority, and a Chinese sexual/gender minority youth mean for you? How are these identities linked to your mental health and wellbeing (explore more details based on the responses of participants)?

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Identity-associated experiences regarding your mental health and wellbeing

- Please tell me any significant experiences/ challenges you have had in the areas of personal, family, peer, school, work, and community, which (you think) may contribute to your mental health and wellbeing?
- In these experiences, what got you down (perceived risk) and what lifted you up (protective factors)?

Any other aspects of your identity you feel important to talk about, even though they are not the focus of this project?

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#### Regarding counselling & therapy

- Have you sought any form of counselling or therapy? If so, was it helpful? Please explore the aspects of therapy you found helpful and aspects of it you felt not so good?
  - If you have never sought help from a counsellor/ therapist even when distressed, please explore the possible reasons why?
- 

### 6.5.3 Data analysis

Interview data were analysed using a general inductive approach (Campbell et al. 2013; Thomas 2006). Three coders (SC, JF, and TF) were involved in the analysis, which included the following steps: 1) reading through the transcripts to consider the meaning; 2) identifying the potential units of meaning; 3) clustering similar units of meaning together; and 4) reviewing them to identify potential themes. JF and TF independently reviewed a selection of transcripts and units of meanings to confirm themes. Verbatim quotes (or their English language translations if in Mandarin Chinese) that best represent themes were identified. The consolidated criteria for reporting qualitative research (COREQ) (Tong, Sainsbury and Craig 2007) was used to guide the reporting of the findings.

## 6.6 Findings

Two major domains of findings emerged regarding how Chinese sexual/gender minority young people navigate their mental health experiences. Table 14 clarifies the relative pervasiveness of the themes across the interviews. As described by participants, these themes influenced their mental health and wellbeing. The order in which the themes are discussed below is determined by their pervasiveness in the domain.

Table 14. Summary of the youth study findings

<b>Domain</b>	<b>Themes (and the pervasiveness of each theme)</b>
<b>Reported Mental Health Challenges</b>	<p><b>Challenges potentially related to being a migrant Chinese youth (100%, N=11)</b></p> <ul style="list-style-type: none"> <li>• Various forms of reported racist incidents (91%, N=10)</li> <li>• Unintentionally subscribing to (or the internalisation of) racism, leading to shame (45%, N=5)</li> <li>• Misguided Chinese cultural features can also become challenging (55%, N=6)</li> </ul> <p><b>Challenges potentially related to being a Sexual/gender minority youth (100%, N=11)</b></p> <ul style="list-style-type: none"> <li>• Various forms of reported homo- bi- trans- phobic incidents (100%, N=11)</li> <li>• Unintentionally subscribing to (or the internationalisation of) cis-heteronormativity, leading to shame (36%, N=4)</li> </ul> <p><b>Challenges potentially related to being a young woman (73%, N=8)</b></p> <ul style="list-style-type: none"> <li>• Various forms of reported sexist incidents (45%, N=5)</li> <li>• Restricted gender role and expression (e.g. dress code) (27%, N=3)</li> </ul> <p><b>Intersectional challenges (100%, N=11)</b></p> <ul style="list-style-type: none"> <li>• Reported being rejected as a 'proper' Kiwi Chinese <i>women</i> (55%, N=6).</li> <li>• Reported generally not fitting in both Kiwi and Chinese cultures (45%, N=5)</li> <li>• Reported being rejected by both Chinese community and predominately White LGBT community (45%, N=5)</li> </ul> <p><b>The reported impact of the mental health challenges on youth mental health (55%, N=6)</b></p> <ul style="list-style-type: none"> <li>• Reported social isolation, loneliness, sadness, and emotional discomfort (27%, N=3)</li> <li>• Serious depression and anxiety disorders that required psychological and psychiatric treatment (18%, N=2)</li> <li>• Unbearable emotional distress leading to attempted suicide (9%, N=1)</li> </ul>
<b>Supporting and resiliency factors</b>	<ul style="list-style-type: none"> <li>• Helpful Chinese cultural features, including strong cultural and familial ties, the unconditional love of parents, and good work ethics (100%, N=11).</li> <li>• Support from peers, inspiration of role models, personalised coping strategies, as well as professional help (82%, N=9).</li> </ul>
<b>Barriers to accessing mental health supports</b>	<ul style="list-style-type: none"> <li>• Misguided Chinese cultural features, associated with mental health stigma, shame, the fear of gossips and the needs to 'save face,' leading to the denial of distress and the reluctance of seeking support (64%, N=7).</li> <li>• The lack of cultural/linguistic and sexual/gender diversity competency of New Zealand mental health services (64%, N=7)</li> </ul>

### 6.6.1 Reported mental health challenges

Challenges potentially related to being either migrant Chinese youth, sexual/gender minority youth or a young woman

Encountering racism of various kinds was common amongst all the participants. Examples of racism included three participants' accounts of hostile racist remarks and/or micro-aggressions from complete strangers. Susan, for instance, shared her experience of being shouted at when walking down the street: *'A White man was riding a bike towards us, and shouting out loud at us "Fucking Chinese," We were very angry at the time.'* Particularly among female participants, a common issue was that of racist and sexist stereotyping (which including an element of objectification). Through the use of sexualised slang, for example, the use of terms such as *'Chinese doll'* or *'dragon lady'*, participants described some White men as having *'yellow fever'*.

Racialised sexual stereotyping was upsetting for participants, as this objectification was not only demeaning but also demonstrated a prejudice that reduced the breadth and value of their Chinese culture to a narrow trope. Dada explained: *'Because like you're not a person, you're just a vessel for a culture that they think they know but they don't.'* Nearly half of the participants described an internalisation of racism. There was a sense of shame for not being White enough, because of the racist view that limits *'Kiwi [i.e. a New Zealander]'* to exclusively being and acting *'White, like Pākehā [i.e. a European New Zealander]'*. Mary stated:

*In terms of New Zealand society, there is a shame at not being fully White.... Yeah, or I don't want people to come to my house because my mum doesn't speak very good English*

*or something and I don't want them to judge her for that or be judged because sometimes my English is bad as well.*

In contrast, internalised racism might also be evident where some participants felt that they were superior because they appeared 'Whiter' than their peers. Nash, for example, stated: *'We prefer people to have fairer skin, right? So that's why, even for native Thai, they think that Sino-Thai [Chinese-Thai] are more attractive because most Chinese-Thai have fairer skin.'*

In addition, various themes of homo/bi/trans-phobia (including cis-heteronormativity) were discussed. Such mistreatment often began at school. For instance, Jack recounted verbal abuse at school that mostly targeted gay males: *'Just everyone [school mates] calling each other, faggot!'* Most participants who had come out to parents also experienced challenges in their families. Some parents argued with the participants about their sexual/gender minority status in the hope that they would stop being 'naïve' and eventually 'return to being normal'. As Laney commented below, his mother tried to 'correct' his being transgender by forcing him to adopt female attire. There was a deep-rooted belief among parents that being a sexual/gender minority was a choice, which could simply be unmade: *'Although my mother is a doctor with some understanding about this [i.e. transgender people], she would still intentionally buy me skirts, but I did not want to wear them.'* Other participants described a degree of invisibility (i.e., 'never-talk-about-it [LGBTQ identity]') and shame about their 'hidden' sexual/gender minority status at home.

A related sub-theme was that some participants themselves could (unconsciously or not) subscribe to cis-heteronormativity. Camille, for example, explained why she and her same-sex partner decided to break off their relationship: *'My partner has decided that she will want a heterosexual marriage and family for sure...she feels that it will be better for her children to grow up in a family with both a father and mother.'*

## Intersectional challenges

Chinese and sexual/gender minority identities were described as integral parts of participants' sense of self, as Nash illustrates: '*I identify myself as chocolate milk, I mean, you cannot just bring out chocolate and change my identity because these [i.e. the chocolate flavouring and milk] are smoothly blended.*' Here, participants reported navigating intersectional challenges. Three sub-themes emerged from the analyses, including 'double or triple rejection' from Chinese as well as New Zealand culture and communities:

**Rejected by both cultures as a woman.** Female-identified participants highlighted their struggles with sexism that was reinforced by both Chinese and New Zealand cultures. This experience of 'double sexism' was associated with the '*male-dominant*' nature of the two cultures, which customarily view women in sexist terms. Mary, for instance, gave a glimpse of these cultural views: 'I guess mostly both of them [Chinese and NZ cultures] want me to identify as a woman and stick to the social codes or wear dresses, wear skirts, flirt with boys, not be loud or anything and have long hair.'

**Rejected by both cultures as a Chinese Kiwi.** Five participants struggled to conform to both Chinese and NZ cultural expectations; their peers expected them to act 'like a Kiwi', but their family expected them to be Chinese. Hence, the participants described a tension about being like a "banana ['Chinese' on the outside 'Pākehā' on the inside]", meaning '*not Kiwi enough but also you're not quite Chinese enough.*' Jael summarised the challenges this issue can present when attempting to create a positive sense of belonging: '*I don't identify as Chinese or New Zealand... like I'm falling between the cracks.*'



**Rejected by both cultures as a sexual/gender minority person.** Several participants came to the realisation that ‘I can’t be Chinese in the queer community because I don’t fit the queer archetype.’ As well as experiencing the disapproval of their Chinese families in relation to their sexual/gender identity, participants could also face criticism about their looks or behaviours from the local, predominantly New Zealand European, sexual/gender minority culture. Nash detailed how both his Chinese family and White gay men had rejected him, ironically for the same reason – a body that was perceived to be too slender and feminine. In Chinese culture, big, solidly built bodies are associated with leadership and power; this body type is also seen as an ideal in Western gay male culture.

*[My grandmother] always says that I’m too thin, because in her perception men should be bigger, have bigger bodies, have larger bodies to show that he’s strong enough to be the leader of the family or something like that... Being male....Many gay guys say that I’m too thin, I’m too small, why don’t I go to [a] fitness [centre] to do build some muscles? My voice is too high. My face is too feminine or something like that.*

#### Potential impact on mental health

More than half of the participants reported psychological distress in relation to experiencing mental health challenges. One participant reported a suicide attempt; others suffered from self-blaming, shame, confusion, loneliness, isolation, anxiety and depression. Experiencing multiple challenges and forms of oppression seemed to exacerbate mental health challenges. Mary’s example illustrates how these challenges can amass cumulatively, and in this instance resulted in her first depressive episode.

*It was around the time I was [in] love with that girl. I didn't know how to deal with that and I stopped talking with my dad [who was sexist towards Asian women] and I was really confused and feeling guilty and feeling alone. And, yeah, my mood just crashed and I was just really, really depressed.*

## 6.6.2 Reported mental health supports and barriers

### Supporting factors

A shared view emerged among all participants regarding the importance of connecting with Chinese culture and local Chinese communities. Such connection can be practical, for example some participants found support from a local Chinese community important when first arriving in New Zealand. Susan stated: *“I initially lived in a Chinese neighbourhood, and they gave me a lot of support.”* Participants also stated that connecting with Chinese culture could make them feel good about themselves, as Adda commented: *‘Chinese culture makes me really proud. I very much identify with my Chinese heritage.’* Participants nominated specific cultural features, such as a strong family orientation (*‘blood ties’* or kinship), an emphasis on a strong work ethic and an education, as protective factors for their wellbeing. Jack, for example, detailed how Chinese parents are committed to their children’s success and encourage them not to give up: *‘...I think for Chinese parents, I think that they believe that their children are quite capable and everything is possible with a lot of hard work...And I think there’s a strong value on education, for what it is.’*

Participants endorsed the importance of family support, which provided them with not only financial assistance, but also emotional warmth and a sense of security. A loving family was described as *‘home’* and a place of refuge. As Randy put it, *‘Having the support of my*

*family is really important. Because it doesn't really matter how upset I am dealing with the outside world, I am happy as long as I can come home to my supportive family.'* Meanwhile, nine participants reported that peer support could be helpful. Having someone of a similar age or background listen and share their experiences made these participants feel that they were not alone. Here, Dada shared her excitement when first finding out about a local support group: *'I found [a local Asian sexual/gender minority social club], and that was really, really cool because there were so many people who were just like me!'* Several participants were inspired by 'witnessing' a Chinese sexual/gender minority person who had become 'mature and successful' in life. They saw this as an important message that they could still be successful despite being a double minority person. Adda said: 'When you have got some role model to look up to, those worries [about the future] are gone.'

Most participants employed some strategies or a particular mind-set to deal with minority stress. Some would '*take the first step*' in preparing themselves for possible discrimination (or other challenges) in advance, so that they could handle it in a respectful way. Others, such as Jael, processed their concerns by reading, creating artwork, using social media, and writing about their challenging experiences: *'Sometimes making these sorts of like annoying experiences into like actual writing and something I can craft and like spend time on is actually powerful.'* Only two participants had sought professional support. Therapists' level of professional experience was the only factor that both participants identified as having a possible impact on the quality of therapy. As Dada put it: 'She'd [therapist] seen other people like me [i.e. other Chinese sexual/gender minority young people] before. And she like told me what my options were.'

#### Barriers to accessing support

Most participants reported a cultural belief that mental ill-health is the result of a poor

work ethic. They can sometimes get accused of being lazy or ‘weak’ for having depression. As Dada commented: ‘...*It’s like super hush hush, like taboo.... it’s like if you’re mentally not well, you should work hard and fix it.*’

‘Pride’ in reluctance to admit to having a mental health problem was also discussed by many. Seeking counselling was thought to impact pride as it was thought to reflect poorly on one’s ‘face’ or personal image. As Jack explained: ‘*I felt like it was frowned upon to seek help for counselling...Like just kind of something that you only do if you’re kind of weak.*’ A strong focus on ‘saving face,’ could become a barrier to accessing professional help. Randy used a classic Chinese idiom to illustrate a deep-rooted cultural mentality that can prevent young people in distressing situations from accessing mental health services: ‘*Family shames must not be spread abroad.*’

Most participants could identify gaps in mental health service provision for Chinese sexual/gender minority youth. As Abby stated, some Chinese students (and families) may have problems communicating with mental health professionals in New Zealand due to language barriers and cultural differences: ‘This [English] is never my first language, you know, because I have really a difficulty expressing myself and some type cultural background thing.’

Three participants commented on the elements of therapy they thought were unhelpful, including unethical conduct (e.g. offering career advice when psychiatric referral was asked), and a lack of empathy. Importantly, being dismissive of a participant’s cultural heritage and/or sexual/gender minority status was highlighted as breaking therapeutic trust: ‘The counsellor was kind of dismissive of it [Asian student clients’ desire to pursue academic success]. Like, “*Oh, it’s a cultural thing,*” that sort of attitude.’ Jael

## 6.7 Discussion

This study examined the mental health experiences of New Zealand Chinese sexual/gender minority youth with a focus on factors that supported or challenged their mental health and wellbeing. Two major domains of findings emerged. Firstly, participants reported mental health challenges due to social oppression and the unique challenges related to their intersecting identities. Among participants, women faced additional challenges owing to the pervasive nature of sexism. Secondly, connecting to one's ethnic culture and community seemed to be beneficial, along with family and peer support, role models, and personal resilience. Some barriers to accessing services, including the fear of losing face and an attempt to preserve personal pride, were identified.

As detailed previously, the presence of strong cultural and family ties (Snowshoe et al. 2017; Reid et al. 2016), as well as personal resilience (LeVasseur, Kelvin & Grosskopf 2013) developed over many years, could help to explain why Chinese sexual/gender minority youth in New Zealand may be more equipped to manage psycho-social challenges than their New Zealand European counterparts (Chiang et al. 2017). Similar findings emerged from studies on Taiwanese and Hispanic sexual minority men in the USA (Rios & Eaton 2016; Wang, Bih & Brennan 2009), indicating that these men may develop an alternative path to obtain parental support and create additional supporting social networks while being marginalised.

In line with the literature, while adopting the language/s and behaviours of a host culture is generally thought to improve wellbeing, our study shows that retaining a bond with one's own ethnic culture appeared to assist participants in fostering a strong sense of self (Yoon et al. 2013). Mental health organisations, educators and other service providers who work with ethnically diverse youth may have an important opportunity to invest in diversity programmes that can support young people to explore and utilise their own cultural resources for resilience.

Also, as role models can become “a source of pride, inspiration, and comfort” (Gomillion & Giuliano 2011, p.330) for Chinese sexual/gender minority youth, mental health managers and policy makers could consider ways to train more culturally diverse and sexual/gender minority professionals in the field.

An over-emphasis on cultural features such as saving face was identified as a potential barrier to accessing mental health support by participants in this study. A possible explanation for this may be mental health stigma associated with a limited understanding of mental health, cultural perceptions of certain symptoms, and language barriers in the Chinese community (Lam et al. 2010; Li et al. 1999). Mental health professionals and those working in the education sector may need to engage in community outreach, psycho-education, or television/social media programmes to help demystify the mental health stigma in migrant communities.

Two pertinent options appear to exist to support mental health service provision for these young people. Some scholars (Zhang et al. 2002), for example, have developed culturally attuned therapies that infuse Western psychotherapeutic or counselling models with Chinese philosophies. These may address participants’ dissatisfaction with the cultural competence of practitioners. Furthermore, as many participants reported accessing the internet, free online self-help tools (e.g., Rainbow SPARX for sexual/gender minority youth) (Merry et al. 2012; Lucassen et al. 2015), may be helpful and mitigate the potential barriers of shame and fears about confidentiality that are discussed by participants.

### Limitations

There are limitations to the current study, such that the sample mainly comprised university students from a single city in New Zealand. Participant responses may not be

representative of Chinese sexual/gender minority youth in other English-speaking regions within New Zealand or elsewhere, or of those without access to a tertiary education. In this way there may be unforeseeable class benefits for these participants given their access to tertiary education, and rural-urban differences that are unexplored. Furthermore, the sample did not include self-identified bisexual men and transgender women. Alternative issues and themes are likely to emerge for subgroups within the wider sexual/gender minority communities, which are often under-represented (Lucassen, Fleming & Merry 2017). Further research with a sample inclusive of more bisexual and gender diverse youth is required to address this limitation.

## **6.8 Conclusion**

Study findings offer insight into the mental health experiences of a group of Chinese sexual/gender minority young people living in New Zealand. The reported challenges and impact on mental health due to mistreatment and oppression may signal the need for action. Cultural connection and the unique values of Chinese culture can provide fruitful opportunities to support sexual/gender minority youth and their families to foster wellbeing. Future research can work towards developing programmes and interventions that will strengthen the connections of both cultural and sexual/gender minority identities. Finally, further investigations are needed to reduce the barriers for sexual/gender minority youth to access mental health services.

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## Chapter 7: (Study Four) From secrecy to discretion: The views of psychological therapists on supporting Chinese sexual and gender minority young people

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### 7.1 Preface

As described in the current chapter, Study Four is also an exploratory qualitative study. Study Three provided space for the voices of Chinese SG minority young people. The findings of Study Three mostly describe various forms of mental health challenges the young people experience, as well as how they support themselves without seeking professional help. Study Three highlights key reasons as to why the majority of young people in New Zealand do not obtain professional help for their mental health needs. Some of these are consistent with reasons for New Zealand youth in general, for example, lack of mental health understanding and access due to issues about funding or referrals (Goodyear-Smith et al., 2017; Mariu et al., 2012). Study Four, on the other hand, explored the views of psychological therapists who have worked with SG minority, migrant Chinese and/or double minority young people of Chinese descent in New Zealand. A group of therapists were recruited for interview from a range of counselling or clinical settings including: secondary school guidance counselor who specialised in academic counselling, youth counselors who work both on the phone and in their private practices, psychiatrist and general practitioner experienced in working with gender diverse youth, psychotherapist at a university, social worker and substance abuse treatment clinicians working with SG minority youth. All reported having more than one year of experience working with Chinese youth and/or Chinese SG minority youth in New Zealand.

Study Four demonstrated that these therapists have well-developed therapeutic styles for

working effectively with migrant Chinese SG minority youth based on their years of professional experience. I explored their experiences to extract a culturally safe therapeutic approach for migrant Chinese SG minority youth. This therapeutic approach can be viewed as the practice of Western psychological therapies infused with elements of Chinese philosophies.

The current chapter comprises a paper reporting this qualitative study. This paper was peer-reviewed and accepted for publication in the journal of *Children and Youth Services Review*.

## 7.2 Peer-review status

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## **From secrecy to discretion:**

# **The views of psychological therapists on supporting Chinese sexual and gender minority young people**

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(Accepted version)

### **7.3 Abstract**

**Objective:** Little is known about how to best meet the mental health needs of sexual and/or gender (SG) minority young people who are also an ethnic minority (i.e., double minority youth). We aimed to explore the views of mental health providers (hereafter ‘therapists’ for brevity) on the needs of Chinese SG minority youth in a Western nation (New Zealand) and the therapeutic approaches to best address these needs.

**Method:** Semi-structured interviews were conducted with eight therapists (including medical practitioners, counsellors, a psychotherapist, and a social worker). All were providers of talking therapies or counseling, experienced in working with Chinese and/or SG minority youth. A general inductive approach to qualitative data analysis was used to identify themes.

**Results:** Four categories of mental health needs emerged. These were needs for love and acceptance; migration and Chinese cultural needs; managing cis-heteronormativity and coming-out needs; and intersectional needs of ‘double rejection’. A ‘double-minority-specific’ therapeutic process was identified. This process suggests therapists successfully engage young people through three phases of therapeutic engagement: from exploration of a SG minority orientation; via segmentation of identity and cautious coming out practice; to a sense of accepted and managed, but often discrete identities. Dimensions of therapy to support Chinese

SG minority youth prioritized relational, individual-tailored, holistic approaches that attend to potential barriers.

**Conclusion:** The results suggest that therapists perceive intersectional challenges for Chinese SG minority youth in a Western context. Tailored therapeutic approaches are advocated to support double minority young people.

**Keywords:** Chinese, Asian, mental health practitioner, counsellor, therapist, LGBT, sexual minority, gender minority, young people, adolescents

## 7.4 Introduction

*In some schools, coming out as being gay or having different gender orientation is dangerous. It's still dangerous, and they may be harassed, they may be teased.* Jade

As Jade, a senior school counsellor, commented, sexual and/or gender (SG) minority young people are at an elevated risk of mental ill-health due to social oppression (Barrett, 2015; Lucassen et al., 2017). Similarly, ethnic minority young people often suffer from mental ill-health due to challenges associated with racism, discrimination, minority stress and acculturation (Berry, 2005; Pyke & Dang, 2003; Tobler et al., 2013). ‘Double minority’ youth are those of both SG minority group (i.e. lesbian, gay, bisexual, transgender, and queer or questioning/LGBTQ) and an ethnic minority group or groups (Boykin, 1996; Wooden, Kawasaki, & Mayeda, 1983). Double minority youth may face complex challenges in identity formation and other aspects of life; influencing their mental health and wellbeing (Chan, 1995; Icard, 1986; Phinney, 1991). As suggested by “minority stress” hypothesis (Meyer, 2003), the accumulation of minority stress has been linked to the elevated risk of mental ill-health for certain ethnic groups of double minority youth in some studies (Bostwick et al., 2014; Lytle et al., 2014; B. Mustanski et al., 2011), but others have reported contradictory results (Moradi et al., 2010; Sanders & Munford, 2015). To date, the limited evidence of peer-reviewed literature mainly consists of US-based samples and often conflates results from diverse minority groups.

The conflicting evidence in literature may be, in part, due to the complex interaction of identities. The perspective of “intersectionality” suggests (Crenshaw, 1991; McCall, 2005) that multiple social identities can integrate to form a unique entity completely different its original parts. This indicates that dual minority youth may also have specific therapeutic needs unique

to their intersecting identity. Conventionally, providers of psychological intervention, counselling, or talking therapies (hereafter ‘psychological therapists’) worked with ethnic or SG minority youth to promote the development of identity from a sense of confusion to that of self-acceptance and identity integration (Cass, 1979; Morgan & Stevens, 2008; Phinney, 1989; Troiden, 1989). Critics, however, argue that these models do not reflect the fluidity and intricacy of self-identity in real life (Floyd & Stein, 2002; Yeh & Huang, 1996), and that they are mainly derived using samples of lesbian and gay White Americans (Bilodeau & Renn, 2005; McCarn & Fassinger, 1996). Chung and Katayama (1998) described the process of developing an intersecting identity as being “parallel” and yet “interactive”, requiring an ongoing negotiation between multiple aspects of cultural values from both minority ethnic culture/s and pervading Western worldviews (Greene, 1996). Meanwhile, several scholars proposed a life-span developmental approach where identity development is seen as a multi-dimensional processes interacting with various aspects of experience (e.g., discrimination and mistreatment) (Bilodeau & Renn, 2005; D’Augelli, 1994; Floyd & Stein, 2002; Mohr & Fassinger, 2000). Based on this view, we consider: 1) what a healthy identity formation for double minority youth is; and 2) how therapists can foster such an identity formation while working with these youths.

Therefore, we set out to explore the mental health and therapeutic needs of Chinese SG minority youth in New Zealand (NZ). Chinese immigrants are a substantial ethnic minority group in the Western world (Wang & Liu, 2006). In NZ, Chinese people settled in waves of migration, starting in the early days of colonial history with an upsurge in arrivals the 1990’s (Ip, 2003). Currently, Chinese people make up 4.3% of NZ’s total population and a greater proportion of the youth population (Stats NZ, 2013). Evidence shows that many minority groups can experience oppression and mistreatment while living in NZ (Adams, Braun, & McCreanor, 2007; Came, McCreanor, & Simpson, 2017). Aspects of minority stress, including

racism and acculturative stress (e.g. language acquisition) might impact on the mental health of migrant Chinese youth (Chiang et al., 2016; Han, 2008; Szymanski & Gupta, 2009b). Various accounts of racial discrimination within predominately White LGBTQ community in NZ were reported in the daily life of Chinese SG minority youth (Adams & Neville, 2018).

In addition, despite that Chinese immigrants generally integrate into mainstream NZ societies well, common features of Chinese culture, such as Confucianism, the importance of blood ties, filial piety, Ying-Yang balance, and the notion of ‘saving face’, may impact on their youngsters’ mental wellbeing and identity development (Bridges et al., 2003; Ip, 2003; Leung, 2010) and this could be particularly complex for Chinese SG minority youth. Very little has been published about therapeutic approaches to support migrant Chinese SG minority youth. Available literature (Chen, Roberts, & Aday, 1998; Greene, 1994; Shen et al., 2005) suggests that therapists for these young people should be informed of the common Chinese features and should consider how various forms of minority stress can interact to affect youth mental health. Therapists’ competence to address the tensions between two distinct cultural expectations in the face of double marginalization was highlighted as major therapeutic challenges.

Because of the limited evidence available, we adopted a qualitative approach to explore experienced therapists’ views on the therapeutic approaches that can best support Chinese SG minority youth.

## **7.5 Method**

### **7.5.1 Participants**

Experienced mental health and social care providers (including medical practitioners, school guidance and youth counsellors, a psychotherapist, and a social worker) offering psychological therapies (or termed ‘therapists’) were recruited via purposive sampling. We

used flyers, internet advertisements, and postings on social media to attract potential participants. We confirmed participants who had worked with Chinese and/or SG minority youth in a range of capacities in Auckland to take part in this study. Auckland is NZ's largest city, which has more than two-thirds of the nation's Chinese population (Stats NZ, 2013).

Eight therapists aged between 35 and 65 years old participated (See Table 15). All had completed professional education, including training in psychological therapies, in either NZ or Australia. Participants had worked in the mental health field at least 1 year prior to the interview taking place, and four of them had more than 10 years of experience. Five participants had special interests in youths and/or emerging adults (mainly between the ages of 10 and 24 years old). One participant specialized in working with tertiary students, with two others servicing older adults as well.

The majority of participants were NZ European, with two reporting being bi-ethnic (i.e., Chinese/European) and one being Taiwanese. Half of the participants were SG minority persons. All were fluent in English, although one used Mandarin Chinese in the interview. This study was approved by the University of Auckland Human Participants Ethics Committee.



Table 15. Characteristics of therapist participants

Pseudonym	Ethnicity	Sex	Years of practice	Current position	Workplace/servicing population
Thomas	Taiwanese	M	2+	Social worker	Community mental health/ Mainly work with migrant Asian youth, adults, couples, and families.
Josh	Chinese/ NZ European	M	9+	Addiction counsellor	Alcohol or drug (AoD) treatment program/ Ethnically diverse youth suffering from substance abuse (mostly between the ages of 12 and 21).
Brad	NZ European	M	20+	Psychotherapist	Counselling center/ Work with college and university students, as well as international students (mostly between the ages of 16 and 30).
Natalie	NZ European	F	6+	Counsellor	Mental health agency. Also in private practice/ Ethnically diverse adolescents, youth, and young adults who present with emotional distress (between the ages of 10 and 24).
Simon	NZ European	M	5+	Addiction counsellor	AoD treatment program/ Ethnically diverse adolescents and youth suffering from substance abuse (between the ages of 12 and 21).
David	Chinese/ NZ European	M	5+	Psychiatrist; Psychotherapist	Psychiatric hospital. Also in private practice/ Mostly work with children, adolescents, youth, and adults with a range of mental disorders.
Jade	NZ European	F	20+	School counsellor	Secondary school population/ Mostly work with students (from 10 to 16 years old) in a school where a third of student body has an Asian heritage.
Judy	NZ European	F	10+	General practitioner	Public hospital/ Work with adolescents and young people who were considering a medical intervention for gender transitioning (mainly between the ages of 12 and 24).

Pseudonyms were altered by SC to ensure confidentiality. 4/8 participants identified as a SG minority individual.

### 7.5.2 Data collection

One-to-one semi-structured interviews were conducted by the first author (SC), who is a registered clinical psychologist in NZ, and a cisgender gay male originally from Taiwan. Interviews lasted between 1 and 1.5 hours, and were conducted in the private offices of the participants. Participants received the semi-structured interview guide (See Table 16), one week prior to their interview. All the interviews were audio-recorded and professionally transcribed by a native speaker of the language used. Transcripts were carefully checked for accuracy by SC. The recruitment of participants was stop once we achieved the state of saturation (i.e., no new theme can be generated from an interview transcript).

Table 16. Therapist interview guide

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Introductions:

- Professional background and experience.

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Common mental health needs and concerns reported by Chinese SG minority young people?

- Explore any major issues in areas of personal, family, peer, school, work, and community that has an impact on their mental health.

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Regarding therapeutic & counselling recommendations for Chinese SG minority young people:

- What would be your therapeutic orientations and preferred treatment modules?
- Can you please identify what has been working and not working in providing treatment?
- In your opinions, what format of therapy can best encompass these therapeutic dimensions and work well?
- Some therapeutic dimensions **unique** to them?

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What are the gaps/ barriers in these services you are aware of?

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### 7.5.3 Data analysis

A general inductive approach was used to analyze data (Campbell, Quincy, Osserman, & Pedersen, 2013; Thomas, 2006). The analytic process utilized two coders (i.e. SC and TF) and

included these steps: 1) reading through the transcripts to consider the meaning in text without any prior expectations; 2) identifying the potential units of meaning in the text; 3) clustering similar units of meaning together; 4) reviewing them for relevance and differences to identify potential themes. These steps were repeated several times to finalize each of the themes. Verbatim quotes (or their English translations if in Mandarin Chinese) that represent themes were identified. The consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007) were used as a guideline to summarize this study. All the participants' names are pseudonyms.

## **7.6 Results**

The data were grouped into two main over-arching parts reflecting the two key research questions: the mental health needs of Chinese SG minority young people in NZ, and therapeutic approaches with this population.

### **7.6.1 Mental health needs of Chinese sexual and gender minority young people**

Four major categories of mental health needs emerged, including: a)'needs for love and acceptance'; b)'migration and Chinese cultural needs'; c)'managing cis-heteronormativity and coming-out needs'; and d)'intersectional needs of double rejection,' as shown in Table 17.

Table 17. Therapists reporting mental health needs of Chinese sexual/gender minority youth in New Zealand

<b>Reported mental health needs/</b> Participants' conceptualization of themes (Significance, indicated by the number of participant's endorsement)	
Needs for love and acceptance (100%, 8)/ <ul style="list-style-type: none"> <li>Described as the core needs that will promote youth mental health and wellbeing. These are fundamental needs that apply to all youth.</li> </ul>	
Migration and Chinese cultural needs (100%, 8)/ <ul style="list-style-type: none"> <li>Described as central needs for Chinese youth. These are needs shaped by features of Chinese cultures (e.g., saving face) as well as issues about migration, such as racism.</li> </ul>	
Managing cis-heteronormativity and coming-out need (100%, 8)/ <ul style="list-style-type: none"> <li>Described as central needs for SG minority youth. These are needs caused by social oppression</li> </ul>	
Intersectional needs of double rejection (100%, 8)/ <ul style="list-style-type: none"> <li>Described as being caught between both Chinese and mainstream NZ cultures</li> </ul>	
<b>Participants described the potential impact on youth mental health when these needs were not met.</b>	<b>Participants identified the key factors that can be linked to mental ill-health</b> (based on the six areas of life in the interview guide)
Their youth clients reported suicidality, social isolation, and/or other emotional disturbances (e.g., anger, sadness, guilt, or shame) (100%, 8)	<ul style="list-style-type: none"> <li>Self-acceptance (100%, 8)</li> <li>Family acceptance (100%, 8)</li> <li>Peer acceptance (100%, 8)</li> </ul>
Their youth clients were to present with any form of mental health issues that may be diagnosed as clinical depression or anxiety disorders (25%, 2).	<ul style="list-style-type: none"> <li>School acceptance (25%, 2)</li> <li>Workplace acceptance (12.5%, 1)</li> <li>Community acceptance (12.5%, 1)</li> </ul>
Their clients were identified to have behavioural problems, including unsafe sex, gambling, alcohol and drug abuse or addiction (50%, 4).	

a) Needs for love and acceptance

Participants considered that Chinese SG minority youth have needs universal to all young people, including love and acceptance from their family, as expressed by Jade: *There are somethings that are universal, like being loved by your parents; and accepted by your parents.* Social connection outside the family was also regarded as universal: *Connection is a massive, massive thing* [for all youth] (Simon), as was the need to develop a personal identity: *The whole “Who am I and what is my place in the world? What are my beliefs, what are my morals? What are my values?”* (Natalie)

b) Migration and Chinese cultural needs

Participants generally considered that Chinese SG minority youth have needs common to Chinese youth in the NZ context, regardless of their gender or sexual identity. Needs involved addressing experiences of racism, as indicated by Thomas: *Others expect you to speak English, so sometimes they give you a nasty look when they think that your English is not good enough.* Needs can also arise in relation to misguided Chinese culture, such as an over-emphasis on saving face, ‘*keeping up a good image*’. Associated with mental health stigma, most participants stated that the need to save face and please others can be so strong that the young person in distress may not seek support: *There was a sort of stigma of what counselling is, sharing your problems, or burden other people with your problems.* (Natalie)

Further to this, a number of participants reported that young people can sometimes be expected to fulfill familial duties and responsibilities at the expense of individual satisfaction: *Traditional Chinese cultures look at children as having a lot of duty and responsibility but not having a lot of rights or character of their own...the rights of the family or the rights of the*

*society are more important than the rights of [the] individual.* (David)

c) Managing cis-heteronormativity and coming-out needs

Participants were unanimous in the view that some needs are common to SG minority youth of all ethnicities. They considered that these needs, stemmed from harmful cis-heteronormative environments, often get internalized into chronic psychological stress, termed by some as internalized homo-/bi-/trans- phobia. As Simon described it: *What I see quite often is self-doubt. I do see self-loathing or what we've called internalized homophobia. There is a lot of blaming self, questioning themselves, and there is a lot of [self] hatred here.*

Two conflicting themes emerged in discussions of coming out from nearly all participants. One was Chinese SG minority youth's need for secrecy due to homo-/bi-/trans-phobia. As Brad commented, this fear may also be a reflection of internalized homo-/bi-/trans-phobia: *We come back to that internalised homophobia. I would say, "Do your flatties (flatmates) know that you're gay?" ... "No way," sort of stuff.*

The other theme emerged was related to the desire to disclose a SG minority identity and live authentically in the social world: *If ... you're able to present to the world as who you are, then that makes a big difference with your peer groups.* (Judy). For older adolescents and emerging adults, this need to come out was also associated with forming genuine relationships or dating. Jade, for example, shared her experience supporting a transgender student who recently completed his high school degree: *He's [this student] negotiated telling mum, telling dad, telling his friends, being accepted by his friends, being respected by his friends, being totally included socially.*

d) Intersectional needs of double rejection

Two main themes emerged among participant regarding the needs unique to Chinese SG minority young people. The two can be viewed together to form what we have termed ‘double rejection’: rejected by SG minority people for being Chinese and rejected by Chinese people for being SG minority.

***Rejected for being Chinese***

Many participants were concerned about racism in the LGBTQ communities. Negative comments were made about LGBTQ groups dominated by people of ethnic majority (White), which can often neglect or even mistreat double minority youth. Josh, for example, commented about gay racism against Asian (including Chinese) SG minority people: *There’s a lot of prejudice against Asians within the LGBT community...Like a lot would speak to me about seeing the ‘No Asians’ kind of tagline on dating profiles and stuff like that.*

***Rejected for being SG minority***

Participants were also concerned about homo-/bi-/trans-phobia in Chinese communities, referring to cis-heterosexuality and patriarchal traditions. A recurrent theme was that Chinese SG minority youth were often ashamed because they fear failing their cultural traditions (e.g. having a heterosexual marriage and potentially a male heir) and fear that they will disappoint their families of origin. Brad demonstrates the shame and isolation such experience can produce and the needs for Chinese SG minority youth: *Finding a way to end that isolation, so to create a sense of belonging and acceptance...But the risk is the shame, though, isn’t it?...They’re intrinsically bad because they can’t meet what their parents require of them, expect of them at all....They’ll never be good enough.*

Having explored the four categories of mental health needs for Chinese SG minority

youth, we will now move on to discuss therapeutic work with them.

### 7.6.2 Therapeutic work with Chinese sexual and gender minority youth

A process of supporting culturally safe identity development emerged, including 3 main phases. As shown in Figure 11, each of these phases has its associate therapeutic tasks. Also, important dimensions of therapeutic practice throughout the process were identified.



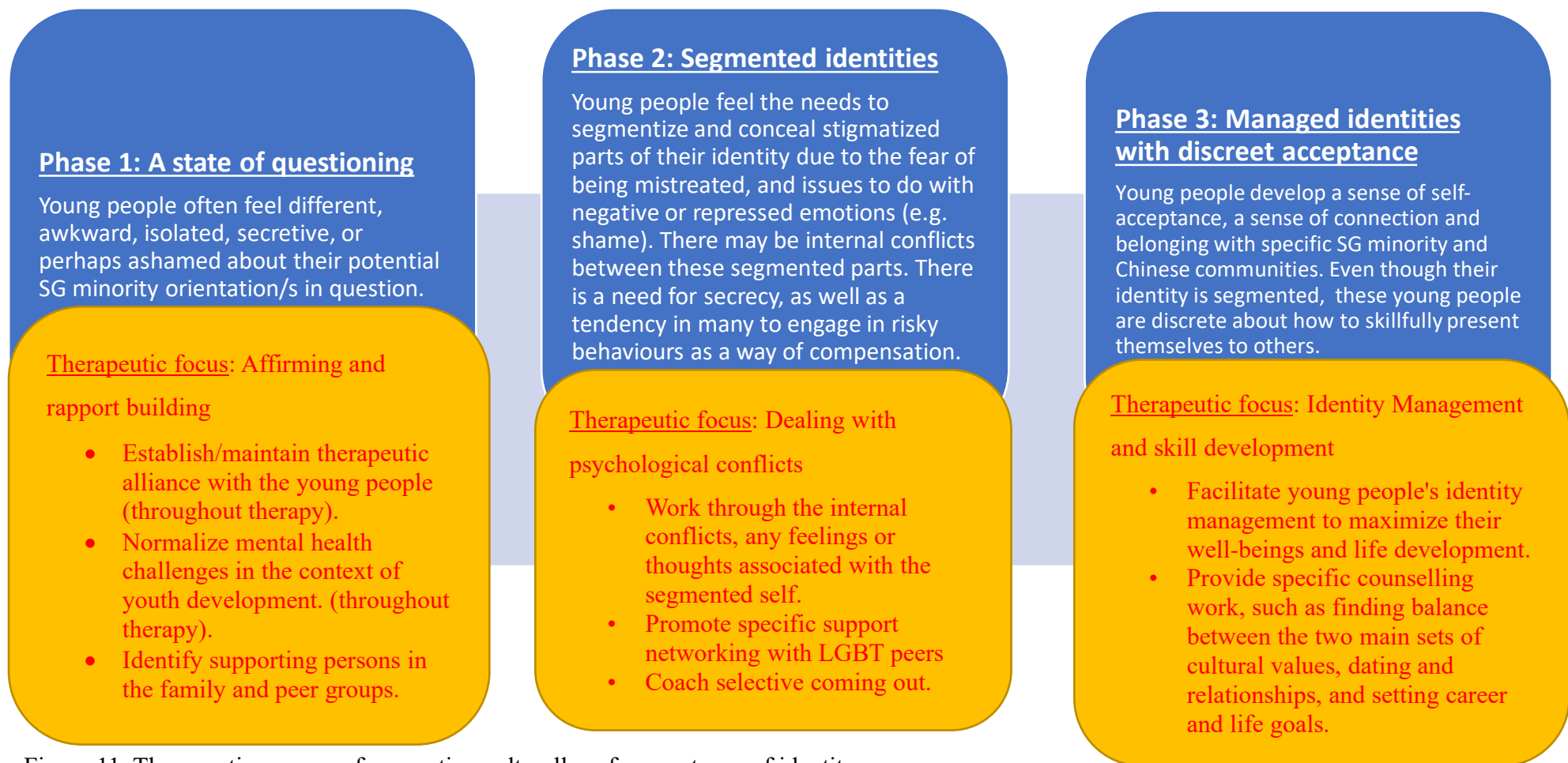


Figure 11. Therapeutic process of supporting culturally safe acceptance of identity

Participants described that Phase 1 often occurs in early adolescence and Phase 3 in late adolescence or emerging adulthood. They, however, did not explicitly specify the age range for each of these phases.

a) Supporting culturally safe acceptance of identity

Participants commented on therapeutic work with Chinese SG minority young people that enables them to develop, accept and express their identities in safe ways, as summarized by Julia:

*So they'd be bringing that to counselling, usually self-referred and saying, "I think I might be gay?" And then it's a long journey after that of the counsellor supporting that child to explore their own sexuality and own ideas about that, and certainly steering them away from shame towards self-acceptance...for example, with Chinese or other ethnic minorities, negotiating things like how they tell their parents, how they share this with their parents while staying safe.*

We have named this process, "the journey from secrecy to discretion." As described by different participants, the process begins with the initial contact, where young people are often ashamed, uncertain, or secretive about their unexplored SG minority orientation. The process then advances via safe and well-managed coming out practice, to supporting a sense of self-acceptance, often with discrete expression of their SG minority identity (See Figure 1).

**Phase 1: A state of questioning**

A shared view among most participants was that young people often start counselling with a question about their SG orientation. This is regarded as the first phase in the therapeutic process, which usually seen among younger adolescents. As Judy commented below, youth in this phase can present as highly stressed: *Young people are very focused on body changes, particularly in early adolescence. And for young transgender people, when that doesn't match with who you are, that's a very distressing time.*

Participants were unanimous that establishing and maintaining a therapeutic alliance with

an affirming stance was critical at all stages of therapeutic work, with a particular need for this at the beginning of treatment. This was about engaging with young people in a “*willing alliance*” using an open, ‘curious’, and genuine approach, so that they can trust their therapists. Natalie commented on this approach as follows: *That kind of relational-, being really curious, being developing that relationship where they would hopefully feel trust, they can trust me and that they would feel safe to share.*

Additionally, participants prioritized supporting young people to normalize their state of questioning as part of normal youth development. Several participants also alluded to the notion that it may be necessary to find ways to engage with Chinese families (e.g. parents) or other important support persons (e.g. close friends) when treating Chinese SG minority young people as this may improve treatment adherence. As Judy explained: *Sometimes we can support families to understand that [SG diversity] once they can get some support from us and understanding, then they’re happy to support their young people.*

## **Phase 2: Segmented identities**

Participants highlighted a second phase requiring discussions about a segmented identity. A recurring theme in the interviews was that young people’s experience of double rejection often leads to identity segmentation and a strong need for secrecy to save face. Nearly all participants noticed a trend where young people may try to ‘*ignore/ push away/ segment*’ the stigmatized part/s of self and take on certain socially acceptable personas. They were concerned that young people can, thus, become ‘*numb*’ and ‘*detached*’, resulting in a deficiency in articulating their thoughts and feelings around SG minority orientation. A few participants also reported that young people are more likely to engage in risk behaviors, such as alcohol and drug abuse.

*When you have somebody who has repressed their emotions because they're scared of how they feel; they're scared of their attraction to their best friend who is the same sex or scared of how they feel about their body, and they've repressed their emotions, I think you can get a blunted affect in terms of their ability to articulate or name feelings. Simon*

Participants shared common perspectives on helping young people work through psychological conflicts associated with their 'segmented self.' Participants addressed the segmentation by providing young people a space to talk through any 'repressed' emotion and thoughts. Furthermore, most participants found that strengthening the connection with other LGBTQ peers can facilitate disclosure of a segmented identity and cultivate self-acceptance. Josh, gives a glimpse of his intervention to address segmentation:

*They've got that segmented part of who they are, of their identity, but it becomes a little bit easier to speak about it in metaphors, speak about it in third person, so they can actually come to terms with some aspects of that or explore it in more detail, because it's almost detached from them, so they can do that externalized processing and stuff like that, take what they want back into their identity....*

Finally, views on 'selective coming out' also emerged among participants. They considered that issues of coming out can be complex for double minority youth. Participants described a key therapeutic task as supporting young people to neither be completely secretive nor share their identity with all (be completely out). Rather they utilized coaching approaches, supporting young people to carefully 'pick and choose' their social network to optimize positive support and to be discrete about their minority status to avoid sudden exposure to the overwhelmingly negative impacts of discrimination. Brad used a gay mentorship program to

coach ‘inexperienced’ gay men about self-acceptance and ways to connect with LGBTQ peers: *I did run at [a particular university] a gay mentoring program, so older gay -- more comfortably out gay guys could mentor baby gays.*

### **Phase 3: Managed identities with discreet acceptance**

The third phase that emerged from participants’ views on the therapeutic process with double minority youth, focused on supporting a sense of accepted, but often discreet and somewhat segmented, identity. Participants were unanimous that there is an urgent need to address social oppression so that SG minority youth can live authentically. However, they also appreciated that young people rely heavily on the support of their families, schools, and communities who might be rejecting of sexual and gender minorities. A theme prevailing among participants at this later stage of the therapeutic journey was to help young people find ways to safely navigate and thrive within ‘*unfair systems*’.

Participants aimed to assist young people in maximizing external support for optimal youth wellbeing and growth. The development of sophisticated skills in identity management (including ‘*selective coming out*’) and other practical life skills surfaced among most participants as a major therapeutic goal. Young people in this phase were usually either older adolescents or emerging adults. Therapists coached them to negotiate their identities wisely and present themselves in a context-dependent way to ensure a sense of safety and to allow for future opportunities. A typical example was where young people decided not to come out because of their concerns for their families, as Judy mentioned: *Although young people know their options, they’re not prepared to do something which they know is right for them, out of respect for their families’ viewpoints.*

In addition, many participants felt that they sometimes acted as a cultural bridge to cultivate young people’s competence in balancing the differences between Chinese and NZ

cultural values surrounding SG issues. Several participants expressed that young people can be more Westernized and individualistic than their Chinese parents. Young people may need to learn to strategically navigate different cultural paradigms so that they would know how to manage their SG identity according to the given context. David commented on the importance of this balancing act:

*I think it's often about finding a balance between more traditional Chinese values and more modern Kiwi [NZ European] values and finding a balance between the two, rather than the child trying to be very individual and very Kiwi and the family trying to be very traditional and Chinese, getting the whole family to find a compromise perhaps.*

#### b) Dimensions of therapeutic work

A second set of themes emerged from the interviews, namely a number of critical therapeutic dimensions. Participants considered that overall therapeutic practice should reflect a normalizing, holistic, individually-tailored, and relationship-oriented approach, with an emphasis on social relationship building and managing potential barriers.

A critical view among most participants was the cultural stigma about '*needing mental health support*', whereby young people were often afraid of being seen as '*abnormal*.' Our participants, thus, focused on helping young people verbalize as well as normalize their mental health challenges and support seeking. As Josh put it, normalization can help reduce some of the mental struggles with stigma: *If we're normalizing that, actually it doesn't have to be an issue...., "Okay, yes, I am normal and that puts words to some of what I found really challenging [The general response of Josh's clients]."*

The need for a '*holistic*' view was expressed by participants. They mentioned that young people are embedded in multiple layers of systems, and therefore recommended to not only

focus on the presenting problem, but also consider it in its broader context. Natalie, for example, described the importance of “*viewing the young person as somebody who exists within their environment; that has a connection and is influenced by their culture, by their community, by their physical health, and their mental health; by maybe religion or spiritual views, by their family or whanau [a Māori term meaning extended or wider family] and by relationships that they have.* Also, a client-centric approach was emphasized. Participants expressed an appreciation that therapeutic interventions needed to be specific to the issues that each young person brings. Simon stated this clearly: *A lot of the time it’s tailoring it to the individual. It is, what are the needs of the individual when they walk through the door?*

Another common view emerged across participants was their investment in coaching young people to build a supportive relationship with others in the future. As Natalie commented: *It would be the relational way of counselling; that for me means being focussed on the fundamentals of what it means to build a relationship with somebody.* Further to this, most participants supported Chinese SG minority young people to make friends. While some participants suggested young people try out several peer support groups, other participants directly referred young people to certain types of mentorship programs. As Josh explained: *If there is a supportive group that they could be in that could help... Develop some of their social skills, build their social capital, build their social networks.*

Possible barriers to treatment were identified. Nearly all the participants commented on the needs for Chinese cultural and/or linguistic capacity in mental health services. Brad pointed out the severe imbalance between the number of Chinese students and lack of Chinese therapists: *My team is all European [NZ European] ...We’ve got a high percentage of these numbers of students but we don’t have a single Asian face in our team. And trying to get a good Asian therapist isn’t easy.*

In addition, many participants viewed stigma and lack of educational information around

mental health (services) as barriers. Thomas commented: *The lack of information is also a risk factor. We were not given much chance to do school outreach so students did not have an opportunity to learn about this. And, there is still a stigma around mental health among Chinese people.*

Participants identified two ways to manage these barriers. Firstly, proactive psycho-education (including more clarification about confidentiality in therapy) can help reduce some mental health misconceptions and stigma among young people. Secondly, hiring bi-cultural/lingual and SG diverse persons on staff can increase the cultural competence of the workforce.

## 7.7 Discussion

This study explored mental health providers' views on therapeutic practice that can effectively support Chinese SG minority young people in NZ. The findings highlighted four categories of mental health needs for Chinese SG minority youth: needs for love and acceptance; migration and Chinese cultural needs; managing cis-heteronormativity and coming-out needs; and intersectional needs of 'double rejection'. A therapeutic process of supporting a 'double-minority-specific' youth journey across three phases emerged: from a state of questioning; via segmentation of identity and safe coming out practice; to a sense of accepted and managed, yet discrete identities. In contrast to what has been suggested previously (Chen & Davenport, 2005; Hodges & Oei, 2007), no consensus among participants was found to support any specific therapeutic approach (e.g. Cognitive Behavioral Therapy). Rather, critical dimensions of therapeutic practice throughout the journey were highlighted: namely a normalizing, holistic, individually-tailored, and relationship-oriented approach with ways to manage barriers to mental health services.



Contrary to many Western models of SG minority identity development (Bilodeau & Renn, 2005), a high level of identity integration/synthesis was not described as an essential part of participants' therapeutic work with Chinese SG minority youth. There are three possible explanations for this result. Firstly, the complexity of these client's needs and challenges may contribute to differences in identity development (Rosario, Schrimshaw, & Hunter, 2004). We found that the participants spent significant amount of time on addressing social mistreatment and oppression, as well as dealing with mental health issues as coming out is "*still dangerous*" in Western nations. Secondly, Chinese culture views a youth as an integral part of relational webs, and the emphasis on self-interdependence and family harmony can shape a youth's behavior and mentality (and mental health) accordingly (Gao, Bian, Liu, He, & Oei, 2017; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Szymanski & Sung, 2013). In particular, family ties are usually regarded as important for familial success within the Chinese communities in Western nations (Chung, 1997) and are protective for youth mental health (Scott, Wallander, & Cameron, 2015). Our participants, when applicable, reportedly invited support persons (e.g. parents, siblings, or close relatives) of the young people to be involved in therapy. However, we also found that familial and cultural expectations can be a barrier to developing an integrated SG minority identity (Greene, 1996). Thirdly, an emerging theme in identity management shows that participants mostly assisted Chinese SG minority youth through strategically navigating Chinese and NZ cultural paradigms, and supporting the youth to manage segmented identities for resilience.

As became clear from the findings, the journey of healthy identity growth and its corresponding therapeutic tasks can help scholars and practitioners better understand the culturally safe therapeutic practice that may be of value in working with double minority youth, as there are ways to be happy and self-accepting while navigating a variety of cultural expectations (Bridges et al., 2003; Ohnishi et al., 2007). For example, compared to White SG

minority youth, the link between coming out and mental health for double minority youth may be much more complex (Moradi et al., 2010). As the respect for cultural heritage and family of origin are often important for Chinese SG minority youth (Hu & Wang, 2013; Hu, Wang, & Wu, 2013), their SG orientation may need to be interpreted into a spiritual comradeship, “Tong-Zhi,” which can then be appreciated in Chinese culture (as a strongly relationship-oriented culture) (Wang et al., 2009). Therapists can promote the youth’s ability to be bi-cultural (Ohnishi et al., 2007), and to prioritize the salient parts of their identity within a given context for resilience (Szymanski & Gupta, 2009a; Szymanski & Sung, 2010). In addition, youth educational and mental health services may need to develop specific programs to train or hire more bi-cultural/lingual and SG diverse persons on staff to increase the cultural competence of NZ mental health workforce. Finally, the lack of identity synthesis has implications for relevant governmental sectors and policy makers in addressing oppression in NZ to ensure all SG minority youth can live authentically and safely.

There are several limitations to the current study. The study consisted of a small convenience sample from single country, NZ. Three of the participants in the sample are Chinese persons themselves, while the others are NZ Europeans. As is clear in the literature, a therapist’s background may possibly influence their therapeutic work (Ibaraki & Hall, 2014). Different findings may have emerged if we included other therapists.

## 7.8 Conclusion

This research is among the first studies that explore the views of experienced therapists on how to carry out therapeutic work with Chinese SG minority young people living in a Western nation other than America. Given the complex nature of their intersectional needs and of youth development more generally, contemporary Western identity formation and psychotherapeutic

models may need to be reconsidered for double minority youth. The findings of our study advocate for a ‘double-minority-specific’ youth development journey with an inclusive therapeutic approach. Also, our findings suggest that promoting cultural competence in mental health services is a priority. Further research is needed to explore how this inclusive approach can be developed and tested for its efficacy in promoting the wellbeing of double minority young people.

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## Chapter 8: Discussion

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Using a three-phase, quantitative-dominant, mixed-methods research methodology, I designed four studies to explore the mental health and wellbeing of double minority youth in New Zealand, with a focus on those of Chinese descent. The overarching research aims were to investigate: **‘Mental health challenges of, and therapeutic supports for, Chinese SG minority young people in New Zealand’**.

As discussed in Chapter 3, the trustworthiness of mixed-methods research outcomes can be determined based on the degree to which the component studies confirm (i.e., verify) and complete (i.e., explain) each other. Although each of the four studies was carried out separately and independently, they do verify and/or explain each other to extend understanding of the research inquiry (Padgett, 2011). In terms of confirmability, the findings of all four studies support the theories of minority stress and intersectionality. Three support the hypothesis proposing the relevance of strengths-based resiliency for double minority youth including Chinese SG minority youth, while all acknowledge the possibility of the double jeopardy hypothesis. All four studies indicate opportunities to improve current mental health practice in New Zealand, with three studies identifying that certain cultural features can complicate the mental health and wellbeing, and/or identity development of Chinese SG minority young people. In terms of completeness, the two qualitative studies provide possible explanations for the apparent protective intersectional effects I observed in the quantitative study. Further, the emphasis on cultivating the bicultural competency identified in the systematic review resonates well with the views of the therapist participants.

The constellation of findings is reviewed and considered in the overview of findings.

## 8.1. Overview of findings

### 8.1.1 Phase I

In Study One (Chapter 4), I investigated the mental health and wellbeing of double minority youth in New Zealand, using nationally representative Youth2000 Health survey data. About 3% of the New Zealand high school student respondents to the surveys were double minority youth. As shown in Table 18, an overall trend was observed where ethnic minority youth of SG majority report slightly elevated risk of mental distress compared to NZ European SG majority youth. Based on the same measures, double minority youth overall are at moderate risk, however NZ European SG minority youth report the highest risk. There may be a protective effect among double minority youth, who report less severe mental distress compared to NZ European SG minority youth.

Table 18. Observed overall trend of mental health risk

<b>Major grouping</b>	<b>Overall level of risk</b>
NZ European SG majority youth (SG majority refers to individuals who are exclusively heterosexual and cis-gender)	Low
Ethnic minority youth of SG majority	Slightly elevated
Double minority youth (including Chinese and other East Asian, Indian and other Asian, Maori and Pacific SG minority youth)	Moderate
NZ European SG minority youth	Highest

Mental distress indicators include: increased rates of depression and suicidality; reduced rates of wellbeing. More information can be found in Chapter 4.

To explore the outcomes of Study One in more detail, I included data from different ethnic minority groups. The AHRG, which granted me the access to the survey data, requested that differences between SG minorities from different ethnic minority groups not be

statistically tested due to the possibility of misleading conclusions associated with the small numbers from several ethnic groups in the sample. However, even without testing, some important differences are apparent. For example, Chinese and other East Asian SG minority youth appear to have particularly low rates of suicidality. There are important findings for Maori and Pacific SG minority youth (e.g., this group appear to have particularly high rates of wellbeing as well as high risk). In addition, females in each of the ethnic groups are consistently at higher risk compared to males. These findings warrant further investigation by appropriate researchers

### 8.1.2 Phase II

Study Two involved a systematic review of 29 international databases for peer-reviewed, scientific, and empirical papers addressing the mental health needs and therapeutic support for Chinese and other East Asian SG minority people residing in an English-speaking Western nation. The review indicated very limited research and guidance for such practice. Only 15 eligible papers were identified, most reporting studies conducted in the United States of America. These papers suggest that the mental health and SG identity development of Chinese and other East Asian SG minority people can be significantly complicated by negative experiences related to their intersecting identities. However, a range of features that can support therapeutic practice for Chinese and other East Asian SG minority people were noted (discussed below in Section 8.3).

### 8.1.3 Phase III

In the face of the surprising findings from Study One and the limited literature, two exploratory qualitative studies were developed. The therapist and youth participants in Study

Three and Study Four described some damaging effects of intersectional challenges on Chinese SG minority youth, while also identifying features that are protective and possible ways to better support Chinese SG minority youth health and wellbeing.

In Study Three (Chapter 6), I interviewed 11 Chinese SG minority youth to explore experiences they have found challenging for and supportive of their mental health and wellbeing. A range of mental health challenges were reported, including those associated with social oppression and mistreatment, as well as unique challenges related to their intersecting identities. Chinese culture and community connections, family and peer support, role models, as well as personal resilience appeared to be protective factors. In contrast, factors such as fear of “losing face”, an unwillingness to disclose distress when unwell, and mental health service providers’ lack of cultural and linguistic competency were all reported as barriers to effective mental health support.

In Study Four (Chapter 7), I interviewed eight therapists with professional experience of working with Chinese and/or SG minority young people in counselling or clinical settings. Four categories of mental health challenge emerged, specifically: needs around love and acceptance; needs related to migration and Chinese culture; needs related to managing cis-/heteronormativity and coming out; and intersectional needs relating to ‘double rejection’. The findings from this study suggest a “double-minority-specific” therapeutic process is required to support young people through three phases: from exploration of a SG minority orientation, via cautious and well-managed coming out practice, to supporting a sense of accepted, but often discreet and segmented identities.

The findings from all my studies are summarised in Table 19, which provides an overview on how study contributes to understanding the challenges and therapeutic support for Chinese SG minority youth mental health.

Table 19: Overview of findings

	Study 1	Study 2	Study 3	Study 4
Methods/ data source	Quantitative/ Youth2000 survey	Analysis of literature/ 29 international databases	Qualitative/ Chinese SG minority youths' voices	Qualitative/ Mental health providers' views
The focus of the study	Double minority youth	Chinese and East Asian SG minority people in English speaking nations	Chinese SG minority youth	Chinese SG minority youth
Mental health challenges	<b>Social oppression:</b> Ethnic and/or SG minority youth, especially females, were found to have elevated risk of depression, suicidality, and low wellbeing.	<b>Social oppression:</b> Racism, sexism, and homo-/bi-/trans-phobia were documented as causing a wide range of mental distress.	<b>Social oppression:</b> Racism, sexism, and homo-/bi-/trans-phobia were described as causing depression, anxiety, shame, and suicidality.	<b>Social oppression:</b> Homo-/bi-/trans-phobia and racism were described as causing depression, shame, anxiety, segmented identity, and risky behaviour.  Sexism was not mentioned.
	<b>Ethnic minority culture:</b> Ethnic specific analyses were not carried out due to sample size limitations	<b>Ethnic minority culture:</b> Chinese and East Asian cultural features, such as saving face, Yin-Yang, and Confucianism were documented as impacting SG minority expression.	<b>Ethnic minority culture:</b> Mental health stigma and the fear of losing face were reported as cultural barriers, while strong family ties and good work ethic were described as cultural assets.	<b>Ethnic minority culture:</b> Mental health stigma, the fear of losing face, and the lack of Western educational information in minority ethnic communities were described as cultural barriers.
	<b>Intersecting effects:</b> The overall risk of mental ill-health for double minority youth was not as elevated as for NZ European SG minority youth.	<b>Intersecting effects</b> Damaging effects (e.g., gay racism and racialised homophobia) were documented among Chinese SG minority youth with some resiliency factors noted, but protective effects were not otherwise clearly discussed	<b>Intersecting effects</b> Both protective and damaging effects were described. Chinese SG minority youth often experienced unique intersectional challenges, but they also reported advanced coping and resiliency.	<b>Intersecting effects</b> Both protective and damaging effects were described. Chinese SG minority youth reported experiencing unique intersectional challenges, but some were also noted to possess advanced skills in identity management.



Recommendations for mental health support	<p><b>Social oppression:</b> Oppression appeared to impact youth mental health negatively nationwide. Governmental and systemic interventions may be required.</p>	<p><b>Social oppression:</b> Oppression in mainstream society, LGBT communities, and even therapeutic settings needs to be addressed through community outreach and education.</p>	<p><b>Social oppression:</b> Oppression in mainstream society, LGBT communities, and professional/ therapeutic settings needs to be addressed.</p>	<p><b>Social oppression:</b> Oppression in mainstream society and LGBT communities needs to be addressed through policy making, community/ school outreach, and psychoeducation.</p>
	<p><b>Mental health practice:</b> Resiliency hypothesis may be supported. When working with double minority youth, therapists are encouraged to utilise the strength and assets of these youth.</p> <p>Other explanations are possible, including under-reporting or the denial of mental health concerns in ethnic minority youth who are also members of sexual and/or gender minority.</p>	<p><b>Mental health practice:</b> Mainstream clinicians are recommended to enhance their self-awareness and training for cultural sensitivity and SG diversity. Multi-dimensional and comprehensive assessment skills are recommended.</p> <p>Clinical interventions are recommended to focus on fostering self-acceptance and bicultural competency of double minorities.</p> <p>Some minority clients were documented to be unwilling to see clinicians with a similar background.</p>	<p><b>Mental health practice:</b> Connecting to one’s ethnic culture and communities was described as a way of boosting youth mental health and wellbeing, as Chinese cultural features such as familial tightness, blood ties and the unconditional love of parents, and a strong work ethic can provide some resiliency. Such cultural and community connections can also provide the youth with some pragmatic support (e.g., making friends) and a sense of psychological belonging.</p> <p>In addition, the personal coping skills and strength of the youth were noted, such as a secure sense of self, flexibility in self-identification, and the use of creative outlets for emotional soothing.</p> <p>Institutional changes (e.g., hiring</p>	<p><b>Mental health practice:</b> Holistic, relational, and all-round youth developmental therapeutic practice was recommended as a way of providing culturally safe therapy to help Chinese SG minority young people achieve a sense of self-acceptance and well-managed identities.</p> <p>The need to utilise the cultural and personal strengths of the youth in psychological therapies and other forms of mental health practice was recognised. These can include identity management associated with bicultural competency and the use of Chinese cultural and community assets for support.</p> <p>The need to develop plans (e.g., training or hiring more minority therapists) to address the lack of</p>

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more minority clinicians or increasing the cultural competency of mainstream clinicians) are required to ameliorate the lack of cultural/linguistic competency in NZ mental health services as these were reported as primary barriers to accessing treatment.

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cultural/linguistic competency in NZ mental health services identified as the primary barrier to accessing treatment.

## **8.2 Answering the research questions**

In this section, I integrate the findings from all four studies and consider how they respond to my research aims, as well as how they sit in the literature. This section is divided into two sections: 8.2.1 mental health challenges of, and 8.2.2 therapeutic supports for, Chinese SG minority youth who live in New Zealand.

### **8.2.1 Common mental health challenges of Chinese sexual and gender minority youth in New Zealand**

Consistent with earlier research (Lucassen et al., 2017; Mayer et al., 2008), I found that SG minority youth are at higher risk of mental distress than the cisgender/heterosexual youth population. This increased risk is thought to be associated with minority stress caused by sexism and cis-/hetero-normativity (Hendricks & Testa, 2012; Kelleher, 2009; Meyer, 2003). Likewise, ethnic minority (or migrant) youth often suffer from minority stress related to acculturation and racism (Baratz & Baratz, 1970; Berry, 2005; Harris et al., 2006; Pyke & Dang, 2003). Chinese SG minority youth also reported an elevated risk of mental distress in the Youth2000 surveys, although, interestingly, their NZ European SG minority peers reported considerably higher risk of mental ill-health.

The original contributions of my thesis reside in the exploration of complex intersectional effects on youth mental health. Drawing on the concepts of intersectionality (Crenshaw, 1991; Greene, 1994), I have explored the potential impacts of their double minority identity on the mental health and wellbeing of Chinese SG minority youth. In the literature, these intersectional challenges have been identified as gay racism (i.e., racism in SG minority communities) and racialised homophobia (i.e., homo-bi-trans-phobia in minority ethnic

communities) (Boykin, 1996; Diaz et al., 2006; Loiacano, 1989; Strayhorn, 2014). However, the youth participants also revealed intersectional challenges involving double or even triple rejection based on the interplay between forms of social oppression. Many of the Chinese SG minority youth experienced depressive moods, anxiety, and suicidality. Some also reported engaging in risky behaviours (e.g., alcohol/drug abuse, random and unprotected sex) to cope with their negative feelings related to such rejections.

Gender differences in levels of mental distress were salient. As the existing body of research on gender and mental health suggests (Busfield, 2010; Rosenfield, 1999; Rosenfield & Mouzon, 2013; WHO, 2002), various forms of social oppression, such as male-dominant cultures, sexist practices, or gender-based harassment and mistreatment, can have a damaging impact on females. It was thus not surprising that female (including transgender) youth participants reported additional challenges in relation to what they described as “double sexism”, a phenomenon where Chinese and New Zealand cultures, both patriarchal, form an alliance to press undue expectations upon these individuals.

In contrast to the deficit-based perspective represented in a lot of the literature (as shown in Chapter 5), this thesis investigated both the challenges and strengths of Chinese SG minority young people. Although the possibility of under-reporting emotional distress among ethnic minority youth has been noted (see Chapter 2), the cross-sectional findings can be also interpreted as supporting the resiliency hypothesis. Further to this, some “Chinese-SG-minority-specific” resilience factors were identified in relation to why the youth reported better mental health than their NZ European SG minority peers, namely: having strong connections to, and capability for, drawing strength from one’s own ethnic cultural assets (e.g., diligence, blood ties, or work ethic) and the support of families; advanced personal coping strategies; and skills in identity management. According to the work of other scholars (LeVasseur et al., 2013; Sanders & Munford, 2015; Scott et al., 2015; Yoon et al., 2013), these

factors may account for the difference in levels of distress found between Chinese SG minority and NZ European SG minority youth. Similar findings were reported in a New Zealand study that highlighted the importance of ethnic cultural connection (Webber, 2012). For Māori youth living in Auckland, having a strong Māori connection was found to help in securing their sense of self and making them more resilient to racism (Webber, 2012). Another study from the USA showed a strong sense of collective self promotes psychological belonging and resiliency in sexual minority youth (DiFulvio, 2011). Further, Anae, Barnes, McCreanor, and Watson (2002) found that good relationship-building skills and bi-cultural competence can serve as protective factors for the mental health and wellbeing of Māori youth. These considerations may also be important for the Chinese SG minority youth in this thesis as well.

With regard to inconsistencies between my studies, I note that provider participants did not mention sexism as a potential challenge for their female clients at all (as shown in Chapter 7), while participants in the other two studies (as seen in Chapter 4 and Chapter 6) both described the negative impact of sexism on women's mental health and wellbeing. A possible explanation for this discrepancy, as suggested in other research (Barreto & Ellemers, 2005; Gillborn, 2016), is that people tend to overlook discrimination if not outwardly hostile, even though minor discrimination can be just as harmful (Nielsen, 2002). Furthermore, I did not explicitly ask questions linked to sexism, as this research mainly focuses on the intersection of Chinese ethnic and SG identity. The area of sexism may therefore have been under-explored.

In addition, a number of youth participants in Study Three preferred to identify themselves in their own way rather than adopt Westernised SG minority identities (e.g., LGBT) (Chapter 6). Self-identification of this nature may be pathologised as "identity segmentation" or "delays in identity development" as appear to occur in the literature (Study Two) and among therapists (Study Four), however alternatively it can be seen as a brave act of self-assertion. Two possible explanations may apply to this finding. In my opinion, the

therapist participants could have unintentionally pathologised variations of identity development that do not fit into mainstream identity theories. This explanation is consistent with an identified trend toward over-diagnosis among mental health professionals in the medical field (Aragones, Pinol, & Labad, 2006; Whitaker, 2005; Woolgar & Scott, 2014). An alternative explanation is that provider participants could have overlooked cultural adaptations in identity development, consistent with findings that minority patients can be subject to stereotypical assumptions and bias in the process of clinical assessment (Betancourt, Green, Carrillo, & Ananeh-Firemong, 2016; Campinha-Bacote, 2002; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Sue, 1998).

Finally, it is concerning that most youth participants reported not seeking professional support when in distress (see Chapter 6). This finding is highly consistent with the literature for other youth populations (Curtis, 2010; Hunt & Eisenberg, 2010; Rickwood, Deane, & Wilson, 2007). Possible explanations include: young people's lack of understanding about mental health; social stigma or fear of losing face; lack of awareness and denial of illness; and service providers' lack of competency in working with youth, ethnic and/or SG diverse populations (Cauce et al., 2002; Curtis, 2010; Gulliver et al., 2010; Hernan, Philpot, Edmonds, & Reddy, 2010; Hunt & Eisenberg, 2010; Lalor et al., 2006; McGorry et al., 2007). Most of these explanations resonate well with the narrative reports of my participants. However, an alternative and noteworthy explanation that emerged from the interviews with youth participants is that strong cultural and familial connectedness, as well as personalised coping strategies, may provide some resiliency for Chinese SG minority youth, meaning there is less need to seek professional help. This explanation also finds support in other studies (Reid, Varona, Fisher, & Smith, 2016; Scott et al., 2015; Snowshoe, Crooks, Tremblay, & Hinson, 2017).

## 8.2.2 Adapting current psychological therapies to better support Chinese sexual and gender minority young people

Based on the outcomes of my research, this thesis proposes that current psychological therapies can be refined in relation to four aspects of therapeutic practice: self-reflection, clinical assessment, clinical interventions, and therapeutic aims.

### Self-reflection by therapists

A cycle of reinforcement exists whereby therapists' own issues, values, personality, and life experiences can influence their therapeutic work with clients, and the clients' reactions can in turn shape clinicians' therapeutic work (Gaume, Gmel, Faouzi, & Daepfen, 2008; 林淑君 & 陳秉華, 2002). As previously discussed, the majority of therapists in the English-speaking Western world are members of the ethnic and SG majority (i.e., White, cisgender, and heterosexual). Accordingly, some assumptions and unconscious biases in their practice of Western psychological therapies may hinder the therapeutic progress of Chinese SG minority young people in distress.

The systematic review and interview study with therapists indicate that self-reflection and self-learning are an important means for mainstream therapists to ensure the effectiveness of treatment delivered to Chinese SG minority clients. In the literature, the term cultural competency generally refers to mainstream therapists' capacity for working with people from diverse backgrounds in an effective way (Beach et al., 2005; Sue et al., 1982; Sue, Arredondo, & McDavis, 1992; Sue, 1998). Self-reflection and cultural competency are, in fact, important for *all* therapists. There are currently multiple similar terms to describe cultural competency, such as cross-/bi-cultural sensitivity, cultural appropriateness, cultural adaptation, and cultural awareness. These terms are often used interchangeably and without precision (Hwang, 2016).

Some scholars suggest mainstream therapists should first reflect upon their own lived experiences in individual, familial, social, and cultural spheres, and consider how these experiences can take root in their therapeutic work (陳金燕, 2003). Therapists' understanding of the differences between their own and client-specific cultural knowledge is a key aspect of cultural competency, as well as the flexibility to apply such understanding to therapeutic work with their diverse clients to maximise therapeutic rapport and the effectiveness of the treatment delivered (Sue, 1998).

For therapists interested in working with double minorities, the systematic review reported in Chapter 5 highlights that further reflective thinking on their own beliefs regarding diverse ethnic and SG issues is recommended. Mainstream therapists should also take advantage of any local multicultural and SG minority workshops, programmes, and lectures for their own learning. Importantly, a collaborative therapist-and-client relationship is advocated as the optimal therapeutic relationship, where youth clients are viewed as experts on their own cultures, and therapists learn from them. Recent systematic reviews of scientific evidence show that treatment adherence and effectiveness are greatly enhanced if mainstream therapists are reflective about their own interventions and can tailor them to match the specific cultural and social backgrounds of their clients (Beach et al., 2005; Griner & Smith, 2006; Lebolt, 1999).

### Holistic clinical assessment

A “*holistic*” assessment of the presenting problems of Chinese SG minority youth clients is highlighted as an important aspect of therapeutic work. The assessment should cover the various contexts of issues, including clients' families, schools, peers, workplaces, and neighbourhoods, as well as how these can interact with each other to affect youth clients. In



contrast to the often highly analytical and reductionist nature of Western therapeutic paradigms (Gordon, 1988; Mantri, 2008), therapist participants in Study Four (Chapter 7) described a comprehensive approach as responding better to the complexity of Chinese sexual and gender minority youth's experiences.

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) provides a useful formulation for culturally inclusive assessment that includes: cultural identity of the individual; cultural conceptualisation of distress; psychosocial stressors and cultural features of vulnerability and resilience; cultural features of the relationship between the individual and clinician; and overall cultural assessment. To expand this formulation for Chinese SG minority youth, the findings of this thesis indicate that therapists consider at least three more areas: 1) social oppression, 2) the intersecting of cultures, and 3) youth development.

First, as the impact of social oppression on youth mental health appears to be pervasive, social oppression may need to be considered as part of cultural conceptualisation. As discussed previously (Chapter 2), the latest APA (2015) guidelines for working with SG minority people address the oppressive nature of English-speaking Western societies for SG minority people. Therapists are encouraged to consider the contributing role of minority stress, discrimination, and intersecting identities in the psychopathology of their SG minority clients.

Second, in individualistic cultures, coming out reflects a self-healing process of repairing self-esteem and relationship building, because hiding one's identity often makes it difficult to feel good about oneself and to maintain genuine interpersonal connections (Hunter, 2007). However, this idea of coming out does not necessarily fully appreciate the inter-dependent nature of self-identity in collectivistic cultures (Wang et al., 2009). The notion of filial piety dictates ongoing attachment to family of origin (King & Bond, 1985; Sathya Devan, 2001). As a consequence, self-identity for many Chinese youth is very intertwined with the views and

honour of their families (Bond & Cheung, 1983; Chang, McBride-Chang, Stewart, & Au, 2003). In this context, coming out may be detrimental to their sense of self. Therefore, the complex interaction between cultures may also need to be considered as part of cultural conceptualisation.

Third, consideration of the youth development or PYD perspective was strongly recommended by the therapist participants (as described in Chapter 7). Contemporary stage models of SG minority identity formation usually view SG expression as a fixed trait (Cass, 1979; Troiden, 1989). However, my research suggests this view does not accurately reflect the experiences of Chinese SG minority youth. In fact, some youth respondents refused LGBT identification (Chapter 6). A youth development perspective, on the other hand, holds great promise as it implies a flexible process of growing competency in multiple domains of life (Hamilton & Hamilton, 2004). This perspective encourages clinicians to consider skills in SG identity management as part of therapeutic work to help youth negotiate their mental health challenges.

#### Guanxi-oriented clinical interventions

Societal and cultural expectations can influence people's views on mental health (Kleinman, 1980; Kleinman, Anderson, Finkler, Frankenberg, & Young, 1986). In Chinese culture, balanced and harmonious relationships are typically viewed as the basis of good mental health and wellbeing (Kuo & Kavanagh, 1994; Reid, 1981). The term Guanxi in Mandarin Chinese literally means relationship, but Guanxi often has further implications for one's ties with family and community, as well as the cultural obligations pertaining to these ties (Wen, 2008).

In this cultural context, the relational aspects of self often override needs for individuation (King & Bond, 1985). For the Chinese youth participants, how they relate to themselves, their

families and peers, and communities emerged as having a critical impact on their mental health and wellbeing. This was congruent with the views of mental health providers who placed strong emphasis on the relational aspects of therapy as well as building “*social capital*” (Chapter 6).

As previously discussed (Chapter 2), Chinese culture values five cardinal relationships. Filial piety, in particular, describes the respectful relationship children have with their parents that can limit sexual expression and non-traditional gender role expression. The systematic review (Chapter 5) suggests that coming out as an LGBT-identified person can often shock families, resulting in friction and conflict. Therapists may therefore need to assist Chinese SG minority youth with not only navigating both Chinese and ethnic majority cultures, but also with developing alternative identities according to the cultural context. For example, the Tongzi identity in Mandarin Chinese may provide a culturally safe re-interpretation of gay relationships as spiritually deep comradeships that can be appreciated in Chinese communities (Wang et al., 2009). Instead of necessarily adopting a LGBT label, therapists could encourage the youth to consider an identity label that avoids any sexual connotations when speaking to their parents.

In sum, clinical interventions with double-minority youth that focus on developing bi-cultural competence and relationship building, such as skills in identity management, for example “*Being Chinese at home and Kiwi at school*” (as seen in Chapter 6), may be useful in developing harmonious relationships in Chinese families and fostering parental acceptance.

#### All-round youth development as a therapeutic aim

The therapist participants promoted the value of all-round youth development, or “*feeding back to youth development*”, as a therapeutic aim (Chapter 6), rather than focusing on simplistic models of identity synthesis.

Some Chinese SG minority youth respondents also expressed a lack of interest in a synthesised SG minority identity. Many youth participants simply rejected Western identity labels, thereby throwing identity synthesis models into question. Importantly, diversity in identity and labels may therefore also be common among ethnic majority SG minority youth, suggesting a paradigm shift is needed in the current practice of mental health services. Instead of focusing mainly on self-individualisation, identity integration, and the reduction of mental distress, therapists are encouraged to utilise PYD approaches embracing cultural and familial contexts.

As previously mentioned (Chapter 2), the PYD perspective has positive implications for growth and increased competency in life skills. Departing from the deficit-focused traditions of Western therapeutic paradigms (Carrera et al., 2012; Gordon, 1988; Mantri, 2008), therapists may need to embrace a strengths-based and youth-centred therapeutic approach that emphasises youth initiative (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2004; Hamilton & Hamilton, 2012; Larson, 2000) and attends to both youth developmental needs and the unique challenges arising at the intersection of social statuses (Hamilton & Hamilton, 2012). The literature details therapeutic aims for cultivating youth growth in the areas of confidence and competence in relationship building (Lerner et al., 2005). As the youth participants reported using their own cultural resources to build resilience, mainstream therapists could incorporate the personal strengths and cultural resources of Chinese SG minority youth as part of treatment to promote youth mental health and wellbeing.

In addition, therapists are encouraged to engage with not only the youth client, but also their supporting others to maximise support from families, friends, schools, and workplaces for positive youth development. Instead of using LGBT community involvement as an identity growth marker on its own (Bilodeau & Renn, 2005), youth and provider participants viewed investment in strengthening Chinese cultural/ familial connections and alternative peer support

(e.g., *goths*) as a rewarding approach.

### **8.3 Implications and Recommendations**

This thesis is among the first scholarship to tackle the mental health challenges of double minority young people (mainly Chinese SG minority youth) in English-speaking nations outside the U.S. (Arnett, 2008; LoSchiavo & Shatz, 2009). It is also an appreciation of the inherent cultural strength and resilience of Chinese SG minority youth, which have been largely overlooked in the peer-reviewed literature on psychological therapies. As the findings of Study One imply, SG minority youth who are members of ethnic minority groups may become resilient for a number of reasons. These youth may develop additional supporting resources from their ethnic cultures. Coping skills learned by the youth to combat the negative effects of racism may also help them to manage heteronormativity later in life (Jaspal, 2015). In addition, because Study One is based on the analysis of representative national surveys, its findings may reflect the unique bi-cultural context in New Zealand. Future research could investigate this further. The systematic literature review for Study Two revealed the serious lack of academic literature attending to the mental health needs of Chinese and other East Asian migrants in many English-speaking Western nations. More research in these nations is therefore recommended to better understand the needs of this population so that therapists in these Western nations can better support them.

Study Three and Study Four also add to the literature in meaningful ways. The findings of Study Three imply that many Chinese cultural features, such as saving face and filial piety, may also be present in Chinese youth living in English-speaking Western regions other than North America. The implications of this finding highlight the ubiquitous influence of certain cultural roots on migrant youth.

The findings of Study Four suggest a holistic and relationship-orientated therapeutic approach that prioritises bi-cultural competency and strategies in identity management. This poses the question whether full identity integration should always be a preferred treatment goal in psychological therapies. Alternatively, it is recommended that therapists holistically assess their youth clients to tailor their treatment focus (as suggested in Study Four).

Although therapist participants in Study Four tended to take a pathological view of the segmented identity of Chinese SG minority youth, Studies Three and Four together contribute a comprehensive view of challenges and resiliency of the youth. It is therefore important to consider the implications of Studies Three and Four in tandem. In Study Three, the youth's recollections of their high school experience suggested that many of them remained in the closet or refused to take on LGBT identities. This corresponded with the findings of Study Four, implying the importance of identity management and discretion for young people. Considering the findings of Study One on resilience, I can reasonably hypothesise that having a discreet identity should not necessarily be viewed as inherently pathological for all young people; rather in some social settings it might be considered culturally adaptive. After all, as some scholars suggest, coming out, LGBT community involvement, and pride celebration are the products of highly individualistic English-speaking Western cultures (Henga, 2007; Wang, 2009). These pathways may therefore not be the highest priorities for all SG minority persons. As such, the *therapeutic journey from secrecy to discretion* described by New Zealand therapist participants in Study Four perhaps indicates an alternative pathway that might be considered for Chinese SG minority youth in New Zealand.

The outcomes of the research reported in this thesis suggest an urgent need to take action to address the social oppression, knowledge gaps, and inadequate cultural competency evident in various sectors of mental health practice. Next, I make a few recommendations for future mental health services and research.

### 8.3.1 For future mental health services

The discrepancies evident between the narrative reports of the youth and therapist participants may indicate possible gaps in mental health services in terms of not adequately addressing the serious impacts of racism and sexism on youth mental health. This omission could be an indication of mental health providers' lack of cultural sensitivity. It is therefore recommended that the New Zealand mental health workforce improves its cultural competence in the areas of ethnicity, sexuality, and gender. Here, I list some practical recommendations for mental health services in New Zealand that may be worthy of consideration:

#### More training and education in diversity

Training programmes (or staff education) should be implemented to improve providers' sensitivity for identifying and appreciating the potential impact of social oppression and mistreatment on youth who are members of ethnic and/or SG minorities. Training programmes to improve clinicians' capacity for engaging with families and whānau (i.e., extended family members) are also recommended. Holistic and relationship-orientated therapies, such as family therapy, ecological therapy, systemic therapy or attachment therapy, may be particularly useful in prioritising the interpersonal context or relational nature of psychological distress as the focus of treatment.

While recruiting more ethnic and/or SG minority clinicians or the development of dual minority focused approaches may be ideal solutions (Cabral & Smith, 2011; Maramba & Nagayama Hall, 2002; Rochlin, 1982), it is also important to train mainstream therapists in how to deliver their services in responsive ways, so that more young people can benefit from professional mental health services.

### More diversity in staff and services

Hiring (and training) more culturally and SG diverse providers is recommended, as they can be role models for Chinese SG minority youth (Chapter 6). A further recommendation to reduce some cultural barriers and mental health stigma is implementing PYD-oriented mental health services, including peer-support interventions, mentorship programmes, psychoeducation groups, tutoring, or community outreach programmes in ethnic and/or SG minority communities. In addition, as most of the young people said they do not like to engage in conventional (i.e., face-to face) therapy, I suggest that alternative forms of therapeutic services may need to be considered, such as computerised therapy, gaming therapy, telephone counselling, and/or internet counselling. These options may be more attractive to youth than conventional therapy.

### 8.3.2 For future research

Although the thesis has successfully illustrated the unique mental health challenges and therapy needs of Chinese SG minority youth, more research is required to explore whether the current findings are applicable to other double minority youth in different geographic locations in New Zealand, and internationally. In spite of some degree of similarity across collectivist ethnic groups, very little is known about how ethnic and/or cultural differences can shape the challenges young people may face. I propose that the following areas for further research:

#### Causality

In critical realist perspective, causality refers to the relationship between an action (or social mechanism) and its outcome, and it takes time to establish causality (Maxwell, 2004a;



Maxwell, 2004b; Wynn & Williams, 2012). Although a consistent pattern was observed regarding the impact of social oppression on youth mental health and wellbeing across the studies, the cross-sectional nature of the Youth2000 surveys prevented me from establishing any causal link between social oppression and youth mental health from the survey data. However, the follow-up qualitative studies do provide a sense of causal direction based on the detailed explanations of Chinese SG minority youth participants and therapists working with them. In contrast to the scientific approach that only permits quantitative research (i.e., experiments) to address causality, scholars have started to advocate the use of qualitative research for causal investigations (Dellinger & Leech, 2007; Maxwell, 2004a; Maxwell, 2004b). According to these scholars, field observations, and the meanings and contextual information derived from qualitative research can play significant role in determining a causal relationship. Therefore, longitudinal research is recommended to: 1) determine the causal link between social oppression and youth mental health; and 2) to explore the severity of social oppression for New Zealand youth nationwide. In particular, as McConnell (2018) has observed, the causal relationship between youth mental health and social oppression can be established through a qualitative study if clinical observations of the therapeutic process are carried out over time.

### Generality

As the qualitative part of the research focused solely on Chinese SG minority young people, more research is recommended to explore the unique needs of non-Chinese double minority youth in New Zealand. It would be valuable to explore cultural differences and also pay attention to fundamental psychological experiences shared among people of different cultures, as discussed by Berry (2015) and others (Jackson, 2006; Poortinga, 2015). Some Chinese cultural dimensions discussed here are relatively specific to Chinese cultures – for

example, filial piety in Confucianism is a powerful Chinese cultural feature (King & Bond, 1985). Other features such as the emphasis on family and collectivity are shared by many minority groups. Future research could explore whether the “identity management” finding applies to other NZ double minority youth whose cultures may or may not have an emphasis on filial piety.

As most of the research data were collected in Auckland, the largest and most diverse city in New Zealand, the findings of this thesis may be skewed toward diverse urban contexts. One may reasonably hypothesise that social oppression will be different, and perhaps worse in other, less diverse and more rural regions of the country, as ethnic minority communities are usually smaller and tighter knit in these regions. Similar research projects are therefore encouraged in various New Zealand settings.

### Resiliency

Some unique resilience factors have been described in this thesis, however more research is recommended to further explore how these factors support youth mental health, and how to incorporate them into current practice in mental health services. For example, as cultural and family connections appear to be important protective factors, future research is recommended to explore how these connections work. Based on the overall findings of the thesis, several important reasons for this protective effect can be hypothesized. First, cultural connection can strengthen self-identity and provides a sense of psychological belonging. Second, family connections provide a lot of material and social support associated with resiliency.

### Validation

Some key therapeutic approaches and practices for Chinese SG minority youth emerged

from this research. More research is thus recommended to validate these key elements, which include cultural connections, relationship-building, and bi-cultural perspectives. In particular, the “holistic and relational therapeutic approach that focuses on identity management” requires validation. I propose that a two-phased research project be developed. First, researchers could investigate the effectiveness of therapeutic approaches that integrate these key elements into regular Cognitive Behavioural Therapy (CBT). Second, a Randomized Controlled Trial (RCT) could be developed with youth who experience (mild to moderate levels of) depressive moods to examine whether holistic and bi-cultural relationship-focused CBT is more effective than regular CBT.

#### **8.4 Strengths and limitations**

This thesis research has a number of strengths. The well-integrated multi-phase/-method/-data exploratory research provides a deeper and broader understanding of the mental health challenges and supports for Chinese SG minority youth. Further, the convergence established between the four studies supports the overall trustworthiness of the research outcomes (Creswell & Plano Clark, 2011; Creswell, 2015). Building on the outcomes of the literature synthesis (Chapter 5), the two qualitative studies (Chapter 6 and Chapter 7) were successful in providing some explanations for the findings of the quantitative study (Chapter 4). The research findings also suggest ways for enhancing culturally safe therapeutic practice for psychological therapists to consider in their future work.

As well as the above-mentioned strengths, this research also has some limitations that must be considered. Although a mixed-methods research methodology is highly valued because it combines the strengths of qualitative and quantitative research methods (Creswell,

2015), it can, however, also inherit the weaknesses of both paradigms, especially if they are not integrated effectively (Yin, 2006). The limitations of each study were described in the corresponding chapters, and included measurement errors, under-reporting of mental distress associated with social desirability, and sample and participant bias.

In this section, I discuss some broader issues. All the findings are self-report and cross-sectional in nature. It is therefore possible that the reported correlations between social oppression and mental health could be due to unknown factors (Hayes, 2017). Sample size issues were also challenging. Although Study One was based on the the analysis of the nationally representative Youth2000 surveys that contained 17,607 youth in total, only 1,306 were non-European SG minority youth. Hence, the low number of certain ethnic minority SG minority youth prohibited further statistical analyses for different ethnic groups.

In Study Two, I initially systematically reviewed the peer-reviewed publications considering the mental health needs and support for Chinese SG minority youth but found only 3 publications. Therefore, I re-did the study focusing on Chinese and other East Asian SG minorities, resulting in a higher number of publications. As discussed previously in Chapter 1 and Chapter 5, this grouping is reasonable. The Confucian views shared among East Asians was the theoretical frame that facilitated their aggregation into a single category. Even with these adjustments, Study Two identified a limited number of peer-reviewed papers for analysis. The small number of papers identified limited generalisability for countries outside of North America. In spite of the search of 29 international databases, almost all the papers identified reported studies conducted in the USA. This may limit the contribution of this study in relation to psychological therapeutic work with Chinese SG minority youth living in other English-speaking Western nations. However, this limitation is a finding in itself, highlighting the scarcity of literature on psychological therapies for this population and underscoring the value of Studies Three and Four.

As exploratory qualitative studies, Studies Three and Four drew from small numbers of participants in Auckland. This is a fairly specific sample. However, this limitation is not unreasonable. Generally speaking, qualitative research aims to understand the meanings and experiences of its participants in depth and is less concerned about proving generalisability (Mason, 2010). The achievement of data saturation (Taylor, 2013; Marshall, 1996) in these analyses suggests these data were reliable, as the repeated occurrence of themes usually indicates their significance (Boddy, 2016; Mason, 2010; Francis, Johnston, Robertson, Glidewell, Entwistle, Eccles & Grimshaw, 2010). Also, as mentioned with regard to Studies Three and Four, Auckland is the most culturally and ethnically diverse city in New Zealand.

The validity (or trustworthiness) of qualitative studies in MMRM research can be achieved via the process of triangulation, whereby data integration across multiple sources strengthens the trustworthiness of research findings (Carter et al., 2014; Creswell & Plano, 2011). Even though the individual studies making up this research had small sample sizes, the integrated findings across the four studies confirm the research represents the key experiences of Chinese SG minority youth residing in an English-speaking Western urban region such as Auckland.

As noted in Chapter 6, the fact that the Study Three and Four findings were mainly generated with regard to urban and sexual-minority youth participants limits their generalisability for rural and gender-minority young people. The literature on rural SG minority youth, and on gender minority youth, suggests that such populations may face additional challenges such as limited access to services (Poon, 2009), and sexism for transgender people (Griffin, 2007; Jefferson, Neilands, & Sevelius, 2013). As these challenges were not able to be assessed in this research, the extent of the changes required to adequately support the full range of double minority young people may have been underestimated.

The final point is with regard to the age difference between youth participants across

studies. Youth participants in Study One were secondary school students while those in Study Three were university students. University students may differ from secondary school students as they have more opportunities for resiliency given the more inclusive environments in higher education and better access to mental health services. University students may also have increased cognitive ability due to maturity. However, despite the differences in age, almost all participants (10 out of 11) were full-time students, living at home and financially dependent on their parents. In Chinese cultural traditions both school students and university students living at home can be seen as youth or young people (Xi & Xia, 2006).

## **8.8 Concluding remarks**

This exploratory research highlights the mental health needs of Chinese SG minority young people and ways for mental health services to better support them. I have shown that Chinese SG minority youth face specific intersectional challenges associated with their cultural or ethnic heritage, SG minority status, and other aspects of their identity. Aspects of Western psychotherapeutic theories and models appear to fail considering these fully. I have identified ways that therapists might increase or advance their knowledge and practice. This thesis poses a difficult question that needs further research, namely whether therapists should support youth clients to attain a fully integrated ‘out’ identity, or whether for some clients being discreet about their SG minority identity may be a positive option. Given that current practice among psychological therapists focuses on working on client priorities, this is an important question as it suggests a shift from contemporary Western identity integration approaches may need to be considered.

Chinese SG minority young people face unique mental health challenges due to multiple forms of social oppression associated with their intersecting minority statuses. However, they

often do not access professional support. Their low utilisation of mental health services may be associated with mental health stigma and some cultural barriers. However, it may also reflect their ability to draw support from their own cultural and family connections, or to prioritise various aspects of their identity for resiliency. Policy makers, educators, and youth mental health professionals who wish to effectively support double minority youth may need to pay more attention to social oppression and its impact on youth mental health. A holistic, normalising, and relationship-focused, therapeutic process appears to be better suited to Chinese SG minority youth. Clinical interventions also need to incorporate the unique cultural and familial features and personal strengths of these youth.

In light of the research findings reported in this thesis, future researchers and practitioners are encouraged to consider ways to enhance the quality of mental health services for diverse young people in nations such as New Zealand.

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## **Appendices**

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# Appendix A: Signed agreement for the use of the Youth 2000 Survey data



School of Nursing  
The University of Auckland  
Private Bag 92019  
Auckland, New Zealand  
[www.youthresearch.auckland.ac.nz](http://www.youthresearch.auckland.ac.nz)  
Telephone: 64 9 923 7414  
Facsimile: 64 9 923 7620  
Email: [t.clark@auckland.ac.nz](mailto:t.clark@auckland.ac.nz) (Principal Investigator)  
Email: [t.fleming@auckland.ac.nz](mailto:t.fleming@auckland.ac.nz) (Chair)

## Memorandum of Understanding between the Adolescent Health Research Group and Associate investigator

### INTRODUCTION:

This Memorandum of Understanding (MOU) addresses the responsible use, interpretation and dissemination of data from the Youth2000, Youth'07 and Youth'12 datasets. This will require communication and collaboration between yourself and the members of the Adolescent Health Research Group.

### PRINCIPLES:

1. The data will be used under the guidance of your designated AHRG members.
- ✓2. Any analysis and interpretation of data must be in collaboration with AHRG members and biostatistician/data manager.
- ✓3. Any ethnic specific data must be interpreted and analysed with the guidance of Māori, Pacific or Asian AHRG members.
3. Information will be shared in a timely manner.
4. Any publications, presentations and conference abstracts must be agreed to by the Adolescent Health Research Group prior to submission.

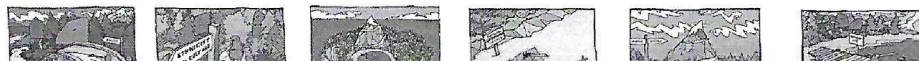
### Disagreements and complaints

Every effort will be made to find a solution and preserve a respectful working relationship. When disagreements occur the following process will apply:

1. Address the concern directly with the appropriate staff member. Most disagreements can be resolved in this way. Disagreements are best dealt with in person and this is recommended. If this is not possible they may be addressed by telephone.
2. Where disagreements cannot be resolved directly they will be referred to the AHRG chair or Principal Investigator, who will address the issue promptly.

I agree to this Memorandum of Understanding

Name of Associate Investigator Szu-Ying Chiang Name of AHRG member Simon Penny  
Signed Szu Ying Chiang Signed [Signature]  
Date ~~27/03/2014~~ 8/9/2015 Date 8/9/15



Appendix B: Ethics approval  
**Office of the Vice-Chancellor**  
Finance, Ethics and Compliance



The University of Auckland Private Bag 92019  
Auckland, New Zealand

Level 10, 49 Symonds Street  
Telephone: 64 9 373 7599  
Extension: 87830 / 83761  
Facsimile: 64 9 373 7432

**UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE**

(UAHPEC) 15-Apr-2016

**MEMORANDUM TO:**

Ms Theresa Fleming  
Psychological Medicine

**Re: Application for Ethics Approval (Our Ref. 016909): Approved**

The Committee considered your application for ethics approval for your project entitled **Rainbow Chinese Wellbeing Project / Mental Health Needs and Therapeutic Recommendations for Chinese Sexual/ gender Minority Young People: The Views from Young People and Clinicians.**

We are pleased to inform you that ethics approval is granted for a period of three years.

The expiry date for this approval is 15-Apr-2019.

If the project changes significantly, you are required to submit a new application to UAHPEC for further consideration.

If you have obtained funding other than from UniServices, send a copy of this approval letter to the Research Office, at [ro-awards@auckland.ac.nz](mailto:ro-awards@auckland.ac.nz). For UniServices contracts, send a copy of the approval letter to the Contract Manager, UniServices.

In order that an up-to-date record can be maintained, you are requested to notify UAHPEC once your project is completed.

The Chair and the members of UAHPEC would be happy to discuss general matters relating to ethics approvals. If you wish to do so, please contact the UAHPEC Ethics Administrators at [ro-ethics@auckland.ac.nz](mailto:ro-ethics@auckland.ac.nz) in the first instance.

Please quote reference number: **016909** on all communication with the UAHPEC regarding this application.

*(This is a computer generated letter. No signature required.)*

UAHPEC Administrators

University of Auckland Human Participants Ethics Committee

c.c. Head of Department / School,

Psychological Medicine

Mr Szu-Ying Chiang

**Additional information:**

1. Do not forget to fill in the 'approval wording' on the Participant Information Sheets and Consent Forms, giving the dates of approval and the reference number, before you send them out to your participants.
2. Should you need to make any changes to the project, please complete the online proposed changes and include any revised documentation.
3. At the end of three years, or if the project is completed before the expiry, please advise UAHPEC of its completion.
4. Should you require an extension, please complete the online Amendment Request form associated with this approval number giving full details along with revised documentation. An extension can be granted for up to three years, after which a new application must be submitted.
5. Please note that UAHPEC may from time to time conduct audits of approved projects to ensure that the research has been carried out according to the approval that was given.





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## Your experiences and ideas can help us improve 'rainbow' Chinese mental health and wellbeing...

We are researchers at the University of Auckland who are interested in improving mental health and wellbeing of 'rainbow' (LGBTIQ and Questioning) Chinese young people. We are interested in your thoughts, experiences, and ideas about what helps young people to thrive and what causes them stress or strain, as well as what can be done to support rainbow Chinese young people in counselling or therapy situations.

If you are a **Chinese sexual/ gender minority person between 16 and 29 years old**, with or without experience with or understanding of mental health services...

### **We would like you to participate in a confidential interview.**

This will be held at the University of Auckland, or a private location convenient to you. The interview will usually last about 1 hour. Some food will be provided and a \$30 voucher will also be given to you at the end of discussion as a thanks.

All information you provide in the discussion will be confidential and no identifying information will appear in any reports or publications out of this study.

If you would like to participate, please contact Szu-Ying (Xavier) using the details below and he will send you further information and arrange a time for the interview with you.

**Visit our research website:** <http://csgmyp.webnode.com/>

#### **Researcher**

Mr. Szu-Ying (Xavier) Chiang  
The University of Auckland  
Faculty of Medical and Health Sciences  
Private Bag 92019, Auckland 1142  
**Phone:** (09) 923 1640  
**Email:** sx.chiang@auckland.ac.nz

Approved by the University of Auckland Human Participants Ethics Committee, on 19/04/2016 for 3 years, Reference Number: 2016/016909

## Would you like to help improve therapy & counseling?

- Counseling and therapy need to embrace diversity.
- We would like to draw on your work experiences to improve counseling and therapy for ‘rainbow’ (LGBTIQ and Questioning, or sexual/gender minority) Chinese young people.

We are researchers at the University of Auckland.

If you are a **mental health practitioners (e.g. nurses, social workers, therapists, counsellors, psychologists, or psychiatrists)** experienced working with rainbow, Chinese, or rainbow Chinese young people,

**We would like to invite you to participate in a confidential interview about how to improve counseling & therapy.**

This will be held at the University of Auckland, or a private location convenient to you. The interview will usually last about 1 hour. Some food will be provided during discussion as a thanks.

All information you provide in the discussion will be confidential and no identifying information will appear in any reports or publications out of this study.

If you would like to participate, please contact Szu-Ying (Xavier) using the details below and he will organise a time for the interview with you.

**Visit our research website:** <http://csgmyp.webnode.com/>

### **Researcher**

Mr. Szu-Ying (Xavier) Chiang  
The University of Auckland  
Faculty of Medical and Health Sciences  
Private Bag 92019, Auckland 1142

**Phone:** (09) 923 1640

**Email:** sx.chiang@auckland.ac.nz

Approved by the University of Auckland Human Participants Ethics Committee, on 19/04/2016 for 3 years, Reference Number: 2016/016909

## Appendix D: Participant information sheet

Faculty of Medical and Health Sciences  
The University of Auckland  
Private Bag 92019  
Auckland, New Zealand  
Phone: (09) 923 5496



**MEDICAL AND  
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SCHOOL OF MEDICINE

### Rainbow Chinese Wellbeing Project

#### Information Sheet for Young People

To: Participants

#### Who are we?

We are researchers from the University of Auckland. Our details can be found on the next page of this sheet. **We are inviting Chinese rainbow young people to participate in a study to help make counseling and therapy better.**

#### About this study

We would like your views to help us improve counseling and therapy for rainbow Chinese young persons (i.e. Chinese Queer, GLBTI and Questioning, or sexual/gender minorities). We are running interviews in the department of Psychological Medicine at the University of Auckland. Alternative locations can be arranged upon your request. The topics of interview cover life experiences in relation to being a rainbow Chinese person in New Zealand (and/or Australia). You don't need to have prior experience with or understanding of mental health services to take part. As a follow-up, a brief survey will be emailed to you along with a draft of therapeutic recommendations for you to comment on at the ending stage of this study.

#### What would be involved?

Self-identified rainbow Chinese persons aged between 16 and 29 years

- We hope to talk to a wide range of young people.
- The interviews will take about one hour (less if needed to fit your timetable) to complete and will be held at a time that is convenient for you.
- You will have an opportunity to view a summary of the research. You will be invited to comment on the recommendations arising from the research.
- You can request a summary of the final results once the study is completed.

#### Arranging the interview

- You can register your interest by contacting us directly via website, email or telephone (www.csgmyp.webnode.com, [xs.chiang@auckland.ac.nz](mailto:xs.chiang@auckland.ac.nz) in New Zealand call (09) 923 1640).
- The interview will usually take place within two weeks of confirmation.

We will invite your help with:

- Sharing the poster and research website at <http://csgmyp.webnode.com/> with other people who may be interested.
- Suggesting some appropriate time slots that are convenient for you.
- Providing your feedback on a draft of therapeutic recommendations by completing the survey.

There will be snack and drinks offered during the interview as well as a voucher worth NZ \$30 as a thanks.

### Confidentiality matters?

Participants can choose to use English or Mandarin Chinese to conduct the interview. The discussion in the interview will be transcribed, and translated, (if not in English). The transcripts will be treated confidentially (i.e. transcriber/ translator will sign a confidentiality agreement). Transcripts and information obtained in writing will be kept securely in a locked cabinet in the department of Psychological Medicine at the University of Auckland and all electronic files will be stored on password protected computers. Signed consent forms will be stored separately from the data. No identifying information will appear in any report or publications derived from this study. Any published quotes or information gathered in the interview will be processed in a fashion that does not identify participants. All information provided by the participants will be erased after six years of storage.

### Benefits and risks ?

Although participating in this research may have several benefits (e.g. a sense of empowerment via voicing yourself, an opportunity to reflect, and a better understanding of mental health resources), talking about experiences in life or at work can sometimes lead to people feeling down and upset. If you become upset during your participation, we encourage you to talk to a person you can trust, a counselor or Youthline (0800 376 633 or [www.youthline.co.nz](http://www.youthline.co.nz)) or Outline (0800 688 5463 or <http://www.outline.org.nz>). You can also choose to stop participating at any point and do not need to say why.

### Any conflict of interest?

No conflict of interest is present at the moment. If any potential conflicts of interest arise in the future, they will be made explicit in publications, and quality control processes, such as peer review from a researcher with no financial or conflicting interests, may be carried out.

**If you are interested in participating please contact us as soon as possible** via [www.csgmyp.webnode.com](http://www.csgmyp.webnode.com), [xs.chiang@auckland.ac.nz](mailto:xs.chiang@auckland.ac.nz) in New Zealand call (09) 923 1640.

Any questions or concerns?

**Researcher**

Mr. Szu-Ying (Xavier) Chiang  
Ph.D. Candidate  
The University of Auckland  
Department of Psychological  
Medicine  
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Phone: (09) 373 7999 ext. 48513/ ext. 48648

**Head of Department**

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Dr Theresa (Terry) Fleming  
Senior Lecturer  
The University of Auckland  
Department of Psychological Medicine  
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Phone: (09) 923 5494

**For ethical concerns contact:** The Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone: +64 9 373-7599 ext. 83711. Email: [ro-ethics@auckland.ac.nz](mailto:ro-ethics@auckland.ac.nz)

Approved by the University of Auckland Human Participants Ethics Committee, on 19/04/2016 for 3 years,  
Reference Number: 2016/016909

## Short Title: Rainbow Chinese Wellbeing Project

### “Mental Health Needs and Therapeutic Recommendations for Chinese Sexual/ Gender Minority Young People: The Views from Young People and Practitioners”

#### Information Sheet for Participants

To: Participants

My name is Szu-Ying (Xavier) Chiang. I am a Ph.D. Candidate in Psychological Medicine at the University of Auckland. Drs. John Fenaughty, Theresa (Terry) Fleming, and Associate Professor Christa Fouche are supervising the research and their details can be found on the next page of this sheet. Given your expertise in mental health needs of Chinese and/or rainbow young people, **we are writing to invite you to take part in this project.**

#### About this study

We would like your views to help us improve counseling and therapy for rainbow Chinese young people. We are running interviews in the department of Psychological Medicine at the University of Auckland. Alternative locations can be arranged to suit your convenience. The interviews will focus on your experiences working with Chinese and/or sexual/gender minority young people in New Zealand (and/or Australia) as well as how to meet their needs. As a follow-up, a brief survey will be emailed to you along with a draft of therapeutic recommendations for you to comment on at the ending stage of this study.

#### What would be involved?

Mental health practitioners/clinicians who are experienced in working with Chinese or sexual/gender minority young people.

- We hope to talk to a wide range of practitioners (e.g. nurses, social workers, therapists, counsellors, psychologists, psychiatrist, and etc...) in the mental health field.
- The interviews will take about one hour (less if needed to fit your timetable) to complete and will be held at a time that is convenient for you.
- You will have an opportunity to view a summary of therapeutic recommendations and provide feedback/ comments.
- You will be asked to comment on the pro's and con's of these recommendations as well as how we might be able to use these recommendations to improve the current therapy/ counseling services.
- You can request a summary of the final results once the study is completed.

#### How to register in the interview?

- You can register your interest in the research by contacting the researchers directly via email or telephone below. Details can also be found on the research website and poster, at <http://csgmyp.webnode.com/>
- We will confirm your participation within two weeks after receiving your details.
- We will contact you regarding when and where the interview will be held. The interview will usually take place within two weeks.
- As thanks, there will be snacks and drinks offered during the interview.

#### Confidentiality matters?

Information obtained in writing will be kept securely in a locked cabinet in the department of Psychological Medicine at the University of Auckland and all electronic files will be stored on password protected computers. Signed consent forms will be stored separately from the data. Participants can choose to use either English or Mandarin Chinese to conduct the interview. The discussion in the interview will be transcribed or translated (if not in English) for analysis and the transcripts will be treated confidentially (i.e. transcriber/ translator will sign a confidentiality agreement). No identifying information will appear in any report or publications derived from this study. Any published quotes or information gathered in the interview will be processed in a fashion that does not identify certain participants. All information provided by the participants will be erased after six years of storage.

#### Benefits and Risks?

Although participating in this research may have several benefits (e.g. an opportunity to make a contribution to the future psychological practice and self-reflective thinking on your own practice), talking about experiences in life or at work can sometimes lead to people feeling down and upset. We will encourage you to talk with your trusted colleague, clinical supervisor for consultation, or contact Employee Assistance Services (EPS) on 0800 327 699 for self-care if needed.

#### Any conflict of interest?

No conflict of interest is present at the moment. If any potential conflicts of interest arise in the future, they will be made explicit in publications, and quality control processes, such as peer review from a researcher with no financial or conflicting interests, may be carried out.

**If you are interested in participation, please sign the accompanying consent form and return it to us as soon as possible.**

Any questions or concerns?

**Researcher**

Mr. Szu-Ying (Xavier) Chiang  
Ph.D. Candidate  
The University of Auckland  
Department of Psychological Medicine  
Private Bag 92019, Auckland 1142  
Email: [xs.chiang@auckland.ac.nz](mailto:xs.chiang@auckland.ac.nz)  
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**Head of Department**

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Phone: (09) 923 5494

**For ethical concerns contact:** The Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone : +64 9 373-7599 ext. 83711. Email: [ro-ethics@auckland.ac.nz](mailto:ro-ethics@auckland.ac.nz)

Approved by the University of Auckland Human Participants Ethics Committee, on 19/04/2016 for 3 years, Reference Number: 2016/016909



## Appendix E: Participant consent form

Faculty of Medical and Health Sciences  
The University of Auckland  
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Auckland, New Zealand  
Tel (09) 923 5496



**MEDICAL AND  
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SCHOOL OF MEDICINE

### CONSENT FORM FOR PARTICIPATING IN RESEARCH

This form will be held for six years

#### Short Title: Rainbow Chinese Wellbeing Project

#### “Mental Health Needs and Therapeutic Recommendations of Chinese Sexual/Gender Minority Young People: The Views from Young People and Practitioners”

Researcher: **Szu-Ying (Xavier) Chiang**

Supervisor: **Drs. Johan Fenaughty, Theresa (Terry) Fleming, and Associate Professor Christa Fouche**

Prior to taking part in this research, I have been informed of the following and understand what this research is about. I have also had the opportunity to ask questions that were properly answered by the researcher.

I understand or agree that:

- Participation in this research is a voluntary choice I made.
- (For young people) I don't need to have prior experience with, or understanding of, mental health services.
- I can choose either English or Mandarin Chinese to communicate with the researcher.
- I can refuse to answer any questions and I don't need to give a reason.
- Similarly, I can decide not to continue participating at any time during the research.
- I cannot withdraw any information that I have already shared.
- I will not to disclose anything discussed in the interview.
- I have been informed of the possible benefits and risks for participation, and been provided supportive resources.
- The interview will be audio recorded and transcribed or translated (if not in English) for analyses.
- The transcriber or translator will sign a confidentiality agreement.
- There are limits to confidentiality that the researcher endeavors to comply with.
- No information that could identify me will be used in any reports or publications from this research in the future.
- The data will be kept for 6 years after which it will be destroyed. The audio recording will be destroyed right after the research is completed.

I **AGREE** to participate in this research

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**As we would like to ask your feedback when the research is about to complete, please provide your email address or any other details below:** (please be sure that the details you provide can reach you in at least a

year of time)

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**Contact:**

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Approved by the University of Auckland Human Participants Ethics Committee, on 19/04/2016 for 3 years,  
Reference Number: 2016/016909

## Appendix F: Interview Guides

### Guidelines for interview with rainbow Chinese young people

#### Researcher's introduction (5 mins):

I am a Ph.D. student at the University of Auckland and I will be asking you some questions today. We are currently working on a project to understand the wellbeing of rainbow Chinese young people in New Zealand. Because nobody has ever studied this area before, we are curious and open-minded about how you are doing living in New Zealand. We believe that you are the experts of your experiences and we are not being here to judge.

I will first do some housekeeping (explaining of procedure, process, and rules include consent form, limits of confidentiality, and audio-recording), and then you will have a few minutes to ask any questions about me and this project.

#### Questions (53 mins):

1. Introducing self: Where are you from? Where were you born? How long have you been in New Zealand? How old are you? What is your occupation? How would you like to be addressed or your preferred pronoun? How important is being Chinese to your identity? What does being Chinese mean to you? How important is being LGBTIQ to you? What does your LGBTI identity mean to you?
2. How are you doing? As you have already known that the focus of our project is about rainbow Chinese identity in New Zealand, which aspect of this identity you feel it is important to talk about first and why you feel this way: Chinese (reference to section A), rainbow (reference to section B), or the combination of both? (reference to section C; please start with this aspect if you feel these aspects are equally important.)
3. In each of these sections, please describe some major experiences in six difference areas of your life and tell me what's gotten your way and how'd you managed to go through in these experiences (point the following table to young people and say it's okay to leave some unanswered if you can't think of any). (young people don't need to write)

Area	Experience	What's got you down?	What's helped you up?
Personal			
Family			
Peer			
School			
Work			
Community			

4. If you do not choose to first report the combination of both, please tell me why it is secondary for you? (Why any particular identity is more important than being rainbow Chinese?)
5. Any other aspects of your identity you feel important to talk about even though they are not the focus of this project?
6. Regarding counselling & therapy (If young people do not have prior-experience, directly go to Question d) (Young people do not need to have knowledge about counselling & therapy):
  - a. Have you sought any form of counselling & therapy (explaining: talking to a counsellor one-on-one or in a group format to discuss what's upset you and how to deal with it) in the past?
  - b. If so, please tell us about this experience. How /when /in what situation you sought help?
  - c. How the counsellor had helped you or not? And what would you expect the counsellor could do it differently to be more helpful?
  - d. If you have never sought help from a counsellor, please tell us the reasons why (e.g. cost)?
7. Lastly, inform young people about the findings of the Youth2000 analysis on double minority youth's reported low rates of mental health concerns and high rates of mental well-being (relative to NZ European rainbow peers) and ask "what is your take on this?"
  - Barriers leading to under-reporting of mental health needs
  - Minority invisibility hypothesis
  - Resiliency and coping and micro-aggression
  - Tolerance of Chinese culture

Wrap up (2 mins):

A thank-you statement. Re-iteration of consent and limits of confidentiality. In rare occasion where the content of this interview upset participants, they will be referred to appropriate agencies as suggested in the Participants Information Sheet (Young People).

--Background framework (don't read/show it to young people)--

I use a six-domain risk and protective factors framework to explore your experiences that may be associated with shaping the mental health needs of rainbow Chinese young people. A risk factor (what's got you down?) is something such as an action, belief, situation, attitude, event, and etc...that may compromise mental well-being. On the other hand, a protective factor (what's helped you up?) builds up resilience in young people against any mental health threat. The six domains of your experiences include the person (you), family, peer or romantic relationships, school, work, and community---

Section A. Questions regarding culture of origin:

- a. What is your preferred ethnic identity?
  
- b. Please tell us your experiences living in New Zealand as a Chinese person.
  - (Personal) (follow up on question a) What are your thoughts and feelings about being Chinese/ or not prefer being Chinese?
  
  - (Family) Please describe your family (e.g. parent's occupations, living situations, communication style, family culture/ritual, and your extended family members that are close to you). What is the spoken language in your family? How do you relate to your parents and siblings (family connectedness)?
  
  - (Peer/romantic relationship) Please describe how/ who/ where/ when do you socialize and connect with (e.g. type of friends/ dates, friends/ dates' ethnic/cultural background). What is your experience making friends (and/or dating) outside of your Chinese ethnicity?
  
  - (School) Please describe your school life and academic progress. Do you sometimes feel being treated unfair or favourably due to your Chinese ethnicity? If so, please describe this experience.
  
  - (Work) Please describe your work experience. Do you sometimes feel being treated unfair or favourably due to your Chinese ethnicity? If so, please describe this experience.
  
  - (Community) Please describe your local community. Do you feel safe living in your community as a Chinese person? If not, please describe your reasons.

- c. What are the risk and protective factors associated with your mental wellbeing as a cultural being?
- (Personal) What are the thoughts/ feelings/ values you possess in relation to Chinese culture (you think) that may hinder or foster your mental wellbeing? (e.g. some people may self-identify as “banana.”, or competitiveness, over-emphasis on academic achieving)
  - (Family) Please identify something in your family that promotes or damages your mental well-being (e.g. family hierarchy, cohesiveness, or violence, or else).
  - (Peer/romantic relationship) Please identify how your social experience (peer/ dating relationship) foster or damage your mental wellbeing (e.g. racism within dating).
  - (School) Please identify anything in school you feel as a Chinese student in New Zealand, which may have hindered or fostered your mental wellbeing.
  - (Work) Please identify any characteristic of your work place that may be associated with your mental wellbeing (e.g. workplace doesn't allow people to communicate in Chinese).
  - (Community) Please identify anything (e.g. local Chinese newspaper) existing in your community that may be related to your mental wellbeing.

Section B. Questions regarding rainbow (sexuality/gender minority, LGBTQI):

- a. What is your preferred rainbow identity?
- b. Please tell us your experiences living in New Zealand as a sexual/gender minority person.
- (Personal) (follow up on question a) What are your thoughts and feelings about being a person of rainbow group (LGBTQI)/ or not prefer being identified as one?
  - (Family) Please describe your family experience in relation to your rainbow status. Have you ever tried to come out to any of your family members? If so, please describe that experience. If no, what are your considerations (e.g. parents' unsupportive attitudes, or communication)

- (Peer/romantic relationship) Please describe any rainbow friendship /or relationship experience you have. (e.g. who /how did you meet them as well as your thoughts about these relationships)
  
  - (School) Please describe your school experience related to your rainbow status. Have you ever come out to anyone (e.g. teachers or schoolmates) in school? If so, please describe this experience. Do you sometimes feel being treated unfairly or favourably after you came out? If so, please describe what makes you feel this way? If you have never come out in school, what are your considerations (e.g. unfriendly school staff)?
  
  - (Work) Please describe your work experience related to your rainbow status. Have you ever come out to anyone at work? Do you sometimes feel being treated unfair or favourably after you came out? If so, please describe this experience. If you have never come out at your workplace, what are your considerations?
  
  - (Community) Please describe your local community. Do you feel safe living in your community as a rainbow person? If not, please describe your reasons.
- c. What are the risk and protective factors associated with your mental wellbeing as a rainbow person?
- (Personal) What are your thoughts and feelings about being a rainbow person that may be related to your mental wellbeing? (e.g. joy, prideful, fear, or internalized homophobia)
  
  - (Family) Please identify anything your family does in relation to your rainbow status (e.g. support of the siblings) that is helping or damaging your mental wellbeing.
  
  - (Peer/romantic relationship) Please identify anything (e.g. gossip, sexual tensions, or else) in these rainbow friendships /or relationships that is related to your mental wellbeing.
  
  - (School) Please identify what is happening in school that may has something to do with your mental wellbeing (e.g. rainbow friendly policy).
  
  - (Work) Please identify anything at your workplace that may have something to do with your mental wellbeing (e.g. hostile work environment)?

- (Community) Please identify things in your local community that are related to your mental wellbeing as a rainbow person.

Section C. Questions regarding intersecting identities:

- a. Please tell us your experiences living in New Zealand as rainbow Chinese person.
  - (Personal) Is being a rainbow Chinese important for you? If so, what are your thoughts and feelings about being a rainbow Chinese person? If not important, what are your reasons?
  - (Family) Please describe your family experience unique to your rainbow Chinese status (e.g. people in China sometimes describe a ‘don’t ask don’t tell’ atmosphere while dealing with this issue in family).
  - (Peer/romantic relationship) Please describe any friendship /or relationship experience unique to being a rainbow Chinese person (e.g. fake marriage or pretended marriage).
  - (School) Please describe your school experience unique to your rainbow Chinese status, if any. (e.g. some people attend schools where most of the teachers or students are Asians/ Chinese, and their experience may be different from other schools)
  - (Work) Please describe your work experience unique to your rainbow Chinese status, if any. (e.g. similarly some people work in a Chinese company with certain cultural climate.)
  - (Community) Please describe your local community experience unique to your rainbow Chinese status, if any (e.g. anti-gay/ transgender movement in Chinese community).
- b. What are the unique risk and protective factors pertaining to your rainbow Chinese status that are associated with your mental wellbeing?
  - (Personal) Please identify what are the thoughts/ values pertaining to rainbow Chinese that may be related to your mental wellbeing. (e.g. I am gay so I am not proper Chinese)



- (Family) Please identify factors in your family unique to your rainbow Chinese status that are related to your mental wellbeing (e.g. mother's self-blaming for giving birth to a LGBT child).
  
- (Peer/romantic relationship) Please identify anything in your friendship /or relationship experience (e.g. fake marriage, racism within dating, racism in the rainbow community or else) unique to being a rainbow Chinese person and associated with your mental wellbeing.
  
- (School) If possible, please identify anything in your school unique to your rainbow Chinese status and associated with your mental wellbeing? (e.g. some schools may have a large concentration of students with certain backgrounds, or have a certain cultural climate.)
  
- (Work) If possible, please identify anything in your work experience unique to your rainbow Chinese status and associated with your mental wellbeing?
  
- (Community) If possible, please identify anything in your local community unique to your rainbow Chinese status and associated with your mental wellbeing (e.g. institutionalized homo-/trans- phobia)?

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## Guidelines for interview with mental health practitioners

### Researcher's Introduction (5 mins):

We are currently working on a project to understand the mental health needs of rainbow Chinese young people in New Zealand and how to service them better in counseling & therapy. (Explaining of procedure, process, and rules include consent form, limits of confidentiality, and audio-recording) You will have a few minutes to ask any questions about me and this project prior to the start.

### Questions (53 mins):

1. Introducing self:
  - a. Please tell me about yourself, such as your age, ethnicity, gender, primary occupation, professional background and training in the past.
  - b. Years of experience working with Chinese, and/or rainbow (i.e. sexual/gender minority or LGBTQI) young people.
  - c. What kind of experiences (e.g. individual or family counseling or support group or else) as well as in what settings (e.g. counseling centre, hospital, or else) have these experiences taking place?
2. (Follow upon Question 1) Please tell me which population (rainbow, Chinese, or rainbow Chinese) you have the most experience working with in counseling & therapy. You will answer Question 3, 4, 5, and 6 based on your chosen population. (If you also have experience working with the other population mentioned above, please start with rainbow Chinese if applicable and answer the optional Question 7 and/or intersecting Question 8.)
3. Based on your experience, how would you describe their mental health and well-being in general? Does it vary a lot? What are the overarching needs and concerns these young people may have?
4. Please describe some major issues your clients reported in six difference areas that are important for your work with your clients (e.g. Chinese, rainbow, or rainbow Chinese young people), as well as some risk factors and protective factors you have identified (point the following table to practitioners). (you don't need to write)

Area	Issue	Risk factor	Protective factor
Personal			
Family			
Peer			
School			
Work			
Community			

5. What are the services that have been provided from you and your agency? And what are the potential gaps/ barriers in the services?

6. Regarding the recommendations for therapy & counseling:
  - a. For young people (you have worked with) who have mental health and wellbeing needs, or significant needs, how many of them do you think proactively seek therapy & counseling? Why? How can we make therapy & counseling appealing to them (and to rainbow Chinese if you have worked with them)?
  - b. When these young people do come to see you, what are your therapeutic/ counseling orientations and preferred treatment modules when working with them? Why and how these modules are your preferred choices? (e.g. suits your personality styles? Or matches the characteristics of these young people? Difference in working with NZ vs Chinese born?)
  - c. Following the above, please elaborate on what has been working and not working in providing therapy/ counseling to these young people?
  - d. In particular, what are the therapeutic elements you feel significant for working with these young people (and with rainbow Chinese if you have worked with them)? And you would recommend these elements to other practitioners when they work with these young people.
  - e. Please describe what format of therapy & counseling (you think) can best encompass these therapeutic elements and work well with these young people (and with rainbow Chinese if you have worked with them)?
7. (Optional) In comparison, what are the differences and similarities in your work between these populations in terms of their presenting issues and your treatment modules? (If you have a lot of experiences working with either rainbow or Chinese **AND** rainbow Chinese, please also answer intersecting Question 8.)
8. (Intersecting) What are some additional (or unique) characteristics of your rainbow Chinese clients' strength, barriers, and drawbacks you have identified that may contribute to their dealing with sexuality and mental health as well as some therapeutic elements **unique** to rainbow Chinese clients?
9. Lastly, inform the practitioners about the findings of the Youth2000 analysis on double minority youth's reported low rates of mental health concerns and high rates of mental well-being (relative to NZ European rainbow peers) and ask, "What is your take on this?"
  - Barriers leading to under-reporting of mental health needs
  - Minority invisibility hypothesis
  - Resiliency and coping and micro-aggression
  - Tolerance of Chinese culture

Wrap up (2 mins):

A thank-you statement. Re-iteration of consent and limits of confidentiality.

--**Background framework (Can briefly explain it to the practitioners if being asked)**--

---We use a *six-domain risk and protective factors framework* to explore your experiences that may be associated with shaping the mental health needs of rainbow Chinese young people. A risk factor (what's got you down?) is something such as an action, belief, situation, attitude, event, and etc...that may compromise mental well-being. On the other hand, a protective factor (what's helped you up?) builds up resilience in young people against any mental health threat. The six domains of your experiences include the person (you), family, peer or romantic relationships, school, work, and community--- (Also, refer to the interview guide for young people)

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## Appendix G: Confidentiality agreement for transcription

Faculty of Medical and Health Sciences  
The University of Auckland  
Private Bag 92019  
Auckland  
New Zealand  
Tel (09) 373 7599

### Short Title: Rainbow Chinese Wellbeing Project

### “Mental Health Needs and Therapeutic Recommendations for Chinese Sexual/ Gender Minority Young People: The Views from Young People and Practitioners”

#### Confidentiality Agreement Form for the Transcribing/ Translating Typist

This form will be held for six years

I, \_\_\_\_\_

(print full name),

agree not to disclose any information that I may become aware of while transcribing/ translating audio-tapes/digital audio files for Mr. Szu-Ying Chiang and his co-researchers. I will erase any copies of the audio-tapes, transcripts or digital recordings in my possession as soon as my transcribing work is completed. I also agree to store the audio-tapes, transcripts and recordings securely while working on them.

Name of Transcriber \_\_\_\_\_

Transcriber's signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Witness \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Contact:** Mr. Szu-Ying Chiang: The University of Auckland, Health & Psychological Medicine. Private Bag 92019, Auckland 1142. Tel: +64 21 2249 373. Email: [sx.chiang@auckland.ac.nz](mailto:sx.chiang@auckland.ac.nz)