THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

SCHOOL OF POPULATION HEALTH

THE SECOND INTERNATIONAL ASIAN HEALTH AND WELLBEING CONFERENCE

"Prevention, Protection and Promotion"

CONFERENCE PROCEEDINGS

13 - 14 November 2006
Auckland, New Zealand

Suggested citation:
Tse, S., Hoque, M.E., Rasanathan, K., Chatterji, M., Wee, R., Garg, S., & Ratnasabapathy, Y. (Eds.) (2006). *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14*. Auckland, New Zealand: University of Auckland.

Conference Organiser:
Centre for Asian Health Research and Evaluation (CAHRE), The University of Auckland.

Published by:
Centre for Asian Health Research and Evaluation (CAHRE), The University of Auckland, November 2006.

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ISBN-13: 978-0-473-11758-4
ISBN-10: 0-473-11758-4

Centre for Asian Health Research and Evaluation (CAHRE)

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The Centre for Asian Health Research and Evaluation (CAHRE) was formed on the 19th of May 2004 at a time when reliable data to understand the extent and severity of Asian health problems are scant. The mission of CAHRE is to develop critical and inter-disciplinary approach to improve health and wellbeing amongst members of Asian New Zealand population. CAHRE also has a vision for international collaboration with individual researchers and organisations.

CAHRE offers independent, university-based professional research and evaluation services:

- *Collaborative research*
- *Educational and workforce training opportunities*
- *Intervention and evaluation*
- *Consultancy services*

Partnerships:

Although, CAHRE focuses on health and wellbeing of local Asian communities but is fully aware of research prospects in collaboration with national and international research institutes. The key advancements that CAHRE aspires through development and implementation of the partnerships are:

- Excellence in research
- Innovative and strengths-based approach to Asian health issues
- Exchanges of research expertise and academics
- Capacity building benefits both emerging and established researchers
- Building meaningful and strong links with community

Furthermore, the International Asian health conference that CAHRE organises biennially increases profile of the centre with further prospects of research collaboration and partnership. Such international research gathering also facilitates prospects for attending institutes and individuals for future cooperation and exchanges of ideas.

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FOREWORD

Kia ora. Members of the Conference Organising Committee and Editorial Committee are pleased to welcome you to the Second International Asian Health Conference and this Book of Proceedings.

Two years ago we took our first faltering steps and launched the first International Asian Health Conference. We have now matured into a confident being, and although still youthful, no longer experience the trepidation of the past. As such, we enthusiastically present to you the Proceedings of the Second International Asian Health Conference. New Zealand still has very limited research-based information and systematic study on Asian health and wellbeing. For this reason, the importance of such a conference cannot be over stressed.

As in the past, every presenter in the conference was invited to contribute to this Book of Proceedings. All manuscripts were double-blind peer-reviewed to ensure a high standard of publication. Research on the health and wellbeing of Asians in New Zealand is a new discipline and most of us are emerging researchers in the sector; consequently, researching and writing in this field is not always easy and straightforward. I would like to acknowledge the commitment of the authors to the cause of Asian mental and physical wellbeing, and thank them for their effort.

Together with our colleagues and friends from government ministries or crown agencies, district health boards, other universities and non-government organisations, progress has been made, since we last met, in improving health and social services and policy with respect to the Asian population; however, this still presents a *significant challenge* to us. Much of our research and the trauma of our human participants still fades into the background and becomes just a “statistic” or “research finding”, as suggested two years ago. Hopefully, our efforts in this second conference will help alleviate that and motivate the change we all need and seek.

I would also like to express my deep gratitude to Mr Vishal Rishi from the Centre for Asian Health and Evaluation for his help in formatting the manuscripts and putting this Book of Proceedings together within a very tight time frame. My very sincere thanks are also extended to *Zoom Digital Print and Design* for sponsoring the printing of the Proceedings. Also, my heartfelt appreciation goes to members of the Editorial Committee for reviewing the manuscripts in the midst of their already very busy schedule.

I sincerely hope that this publication will make for interesting and thought-provoking reading.

Dr Samson Tse
Chair of the Editorial Committee

PROUD SPONSORS

Proudly supported by:
We are grateful to the support received from Auckland Chinese Medical Association (ACMA), Auckland District Health Board (ADHB), School of Population Health, Tamaki Campus, Pro-Vice Chancellor Professor Ralph Cooney, the Medical and Health Sciences Faculty's External Relations and Communications Office and ***Smooth Stream*** band led by Dr Ronald Ma.

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Samson Tse and M Ekramul Hoque

ABSTRACT

Asians are the fastest growing population group in New Zealand. Between 1991 and 2001, the number of people who self-identified as Asian doubled. Asian peoples comprise almost ten percent of New Zealand's current estimated population and this proportion is projected to grow to almost fifteen percent by 2021. The term "Asian" covers a group of people who have migrated from at least 28 different countries, representing a wide range of cultural, linguistic, social, religious and political backgrounds. Asian New Zealanders are also comprised of long-time settlers, recent immigrants and people from refugee backgrounds. Asian health and wellbeing is beginning to emerge as an important topic for New Zealand. Existing literature often reinforces the notion of the 'healthy immigrant effect', whereby recent immigrants are generally healthier and enjoy a better self-perceived sense of wellbeing than native-born persons. However, this effect tends to diminish over time, as the health of immigrants converges to the host country's norm. This effect has been examined according to health problems, years of residency, age of immigration, place of birth, language, marital status, socio-economic status, language ability, and category of immigrant status.

This paper takes into account the current immigration and acculturation framework and draws upon emerging evidence on the health status of Asian New Zealanders. It examines the applicability of the healthy immigrant effect on this population and unfolds some of the complexities surrounding this topic. It also highlights major problems or challenges associated with interpreting the health and social needs of Asian New Zealanders as a homogenous group, particularly in relation to policy development and service delivery.

Tse, S., & Hoque, M. E. (2006). Healthy immigrant effect- triumphs, transience and threats. In S. Tse, E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp. 9-18). Auckland, New Zealand: University of Auckland.

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INTRODUCTION

Census figures from 2001 show that the Asian population is the fastest growing group in New Zealand. It jumped from 3% of the usual resident population in 1991 to 6.6% (or 272,000 people) in 2001. Auckland as one of the metropolitan cities attracted migrants from around the world, between 1991 and 2001 particularly from Asia. It is projected that the Asian

population in Auckland City will grow from the present level of 18.7% to 34% of the total population by 2016. Moreover, according to the 2001 Census, there were about 43,000 Asian residents in the Northshore, Waitemata district (or 9.4% of the total population in that area), with the largest group being Chinese, followed by Korean and Indian (which were very similar in population size) and then Filipinos.

Although Asian people are often viewed as a single population group, they by no means exhibit a homogenous culture. Many intra- and inter-group similarities and differences exist. The values, beliefs, and worldviews of group members vary according to their experience, social background, and geographical settings (e.g. rural vs urban). Therefore, it is important to take note of the diversities within the same ethnic community in order to attain a correct understanding of these people. The term 'Asian' in the context of New Zealand has been described in a number of publications recently (Rasanathan, Craig, & Perkins, 2004 & 2006; Aspinall 2003; Workshop Organising Team, 2005). In this paper, Asian New Zealanders refer to local-born- the second and third generations, long time settlers, people from refugee backgrounds, recent immigrants and international students.

As with other Western countries, increases in the Asian population are mainly due to migration. On the other hand, it is noticed that an increasing number of young Asian New Zealanders are local-born. In 2006, Statistics New Zealand estimates that 9.5% of New Zealand's current population is Asian. This Asian proportion is expected to grow to almost 15% of the national population by 2020, as illustrated in the National Ethnic Population Projections 2001-2021. Such projected increase will inevitably influence the delivery of the health system and services in New Zealand. In order to provide an effective service, it is essential that the New Zealand health and social support system be *responsive* to the increasing language and cultural diversities among clients presenting to services.

Over the last two years, there have been three major reports about the health of Asian New Zealanders: *Asian Health in Aotearoa: an Analysis of the 2002–2003 New Zealand Health Survey* (The Asian Network Inc.) (Scragg & Maitra, 2005); *A Health Profile of Young Asian New Zealanders who attend Secondary School: Findings from Youth2000* (The Youth2000 project at the University of Auckland) (Rasanthan, Ameratunga, Chen et al., 2006) and *Asian Health Chart Book 2006* (Ministry of Health, 2006). All three of these reports identify key issues that concern the health and wellbeing of Asian New Zealanders, including access to health services, particularly for Chinese people; cardiovascular disease and diabetes for Indian people; levels of physical activity; and mental health, particularly in relation to young people (Rasanathan, Ameratunga, & Tse, 2006). The reports also indicate that Asian peoples in New Zealand are relatively healthy overall; much of this effect is due to the good health status of recent migrants - the so-called 'healthy immigrant effect'. The healthy immigrant effect hypothesis suggests that recent immigrants are healthier than their comparable native-born people but that the health advantage of migrants erodes over time and that disease patterns tend to converge to those of the host population. In this context, there are three important, unanswered questions to deal with: How healthy is the migrant population (the triumphs)? How long does the healthy effect last (the transience)? And what would happen if we choose not to respond to the emerging health and wellbeing needs of Asian New Zealanders (the threats)?

THE TRIUMPHS

A press release prepared by the prominent Asian community leader, Ms Pansy Wong's office (Members of Parliament, National Party), stated that the findings in the Asian Health Chart Book are indeed worth celebrating; in particular she referred to the overall good health status among most Asian people. For example Chinese have a much longer life expectancy at birth

(men: 85 years old; women: 88 years old) than the total New Zealand population (men: 76 years old; women: 81 years old). Avoidable mortality is significantly lower for Chinese, Indian and other Asian people than for the total population, and Chinese and other Asian men have significantly lower suicide mortality rates than that of the New Zealand population. Contrary to the stereotyping of bad Asian drivers in the media, youth road traffic injury hospitalisation rates for all Asian groups are significantly lower than the New Zealand average. In addition, Asian women are significantly less likely to be current smokers than European women.

Consistent with the New Zealand findings, Canadian research on immigrant health has found that a significant proportion of the immigrant population are less likely to be diagnosed with a chronic condition (e.g. allergies, asthma, back pain or more serious conditions like heart disease or cancer) compared to native-born Canadians (McDonald & Kennedy, 2004). In this study, the majority of immigrants came from non-English speaking countries, particularly Asia. In another study, children of immigrant mothers had significantly fewer injuries than children of US-born mothers, especially for immigrant mothers who reported their ethnicity as being non-white (Schwebel, Brezausek, Ramey, & Ramey, 2005). Similarly, it has been observed that children who were Asian or born overseas experienced more favourable health and wellbeing indicators such as school absence, learning disability, use of prescription medications and chronic diseases (Yu, Huang, & Singh, 2006).

There are many reasons to explain the relatively good health status among first generation Asian migrants:

- *Immigration selection factor*: Immigrants tend to be those who are young, reasonably educated, and have a successful business and professional background; this is particularly true for those who come to New Zealand under the business and general skill category but less so for family reunification migrants and people from refugee backgrounds (Ministry of Health, 2006; Schwebel et al., 2005).
- *Artificial inflation*: Some researchers have suggested that the 'self-reported' good health status among the first generation immigrants in the last decade might be confounded by the fact that the migrants tend to be younger, employed or maintain a source of good income prior to immigration (although unemployment and underemployment rates are much higher among Asian immigrants compared to average New Zealanders), married (or have a stable relationship) and non-smoking. Individuals with such backgrounds are less likely to rank their health as 'unhealthy' relative to the local-born counterparts in the host population (Newbold, 2005).
- *Health screening*: Individuals can only migrate to New Zealand if they have passed the immigration health check; those with serious health conditions do not qualify (Ministry of Health, 2006). Therefore, it is more likely that the healthiest and successful members of a population will migrate. One illustration of this is the longer life expectancy of Asian immigrants in comparison to their compatriots at home.
- *Unhealthy emigrant effect*: A tendency for chronically ill migrants to return to their country of origin to die, or seek medical treatment and long term rehabilitation services, further increases the apparent good health status of the migrant population (even though this might be of a lesser scale) (Harding, 2003; Ministry of Health, 2006).
- *Values, life-style and cultural practice*: Asian people still abide by practices of parental discipline where children are expected to achieve and excel, and lead a modest and balanced life-style. There is a collective orientation on Asian culture and the importance of family (including extended family - local or overseas). Family/whanau is considered the fundamental unit of society, and a source of strength and support for the individual in times of adversity (Centre for Asian Health Research and Evaluation, 2006; Tse, Sobrun-Maharaj, & Hoque, 2006). Asian people also tend to adopt controlled food habits with low-fat or special diets (the so-called healthy diet). On the other hand, the Health Chart Book documented that Chinese and other Asian women were less likely to participate in at least

150 minutes of physical activity per week than the total New Zealand population; Indians and other Asian people were also less likely than Europeans to consume the recommended intake of fruit and vegetables.

- *Health practice*: Asian health practices tend to emphasise a holistic and naturalistic orientation which involves the notions of harmony: an integration of mind and body, individual and universe. Confidence in and use of traditional and alternative treatment methods may sustain Asian people's good health in some cases. Traditional treatments and practices, for example, herbal medicine, ayurvedic medicine, acupuncture and therapeutic massage, yoga, Tai Chi have been popular among, and long been used by Asian people in general, for healing sickness - physical and mental.
- *Low health services utilisation*: Alongside the 'healthy immigrant effect', it is often found that recent immigrants do not use healthcare services as much as their counterparts in the host society (e.g. McDonald & Kennedy, 2004; Yu et al., 2006). In New Zealand, Asian people were found to be less likely than their European counterparts to have seen a doctor or dentist in the last 12 months (after controlling for age, sex and deprivation). Therefore, one possible explanation for the apparent good health among young first generation immigrants might be that they are under-diagnosed or that their health conditions remain undetected (Newbold, 2005).

However, two caveats apply to the above statements. Firstly, the healthy immigrant effect *does not apply* to everyone and *does not include* all health conditions within the immigrant population. Moreover, the time cohort of the migrant population and the circumstances under which immigration takes place (family reunification versus professional immigration) need to be considered. For example, recent immigrants at the age of 65 and above had poorer health compared to long-time residents and the Canadian born (Gee, Kobayashi, & Prus, 2004). It is also known that in New Zealand, newborns of South Asian parents are at higher risk of low birth weight than the total population; and ischemic heart disease hospitalisation and self-reported diabetes is significantly higher for Indian people than for the total population (Ministry of Health, 2006). Many young Asian people are significantly depressed and report symptoms of anxiety, particularly females and young Indians (Rasanathan, Ameratunga, Chen, et al., 2006). Secondly, the health advantage of immigrants does not last long. The avoidable mortality rates worsen for Chinese New Zealanders who have lived for longer periods in New Zealand. It has been observed that the likelihood of self-reporting high blood cholesterol and high blood pressure among Asian people is significantly related to longer duration of residence (after controlling for age, sex, deprivation and ethnicity). Some studies suggest the good health disappears in as little as four years, whereas some suggest ten or twenty years (due to a variety of reasons) (Gee, Kobayashi & Prus, 2004; Goel, McCarthy, Philips & Wee, 2004; McDonald & Kennedy, 2004; Newbold, 2005).

THE TRANSIENCE

Why does immigrant health status "deteriorate" with increased duration of residence? One popular explanation is related to acculturation theory. Acculturation is defined as a socialisation process of two different ethnic groups exchanging cultural elements, such as different attitudes and thought processes, beliefs, emotions, behaviours, and life style. It refers to the process of adapting to a new culture, the adoption of the behaviour patterns of the surrounding culture. For details on four acculturation strategies- "integration", "separation", "assimilation" and "marginalisation" refer to Berry (2001). However, how acculturation is related to changes of immigrants' health status are not entirely clear. Table 1 summarises the key arguments.

Table 1. Acculturation and health status.

	Worsens health status	**Improves or fosters good health status**
Less acculturation	Individuals or families feel isolated and nostalgic (initially), experience high level of stress, and under use the local healthcare and social services. This usually results in delayed or late help-seeking behaviours and detection of problems (Jaber, Brown, Hammad, Zhu, & Herman, 2003). .	Individuals or families practise a traditional way of life, including a healthier diet, extensive intra-communal social networks, and traditional values (e.g. primacy of extended family as a source of support and inspirations) (Schwebel et al., 2005; Yu et al., 2004).
Greater acculturation	Two possible explanations: 1) Greater acculturation improves access and use of health services leading to increased recognition and reporting of conditions, and skewing the health outcomes towards the mainstream population. 2) Some of the recent migrants may be more eager to 'integrate' and take up certain life styles of the host population (e.g. gambling, poor dietary habits, smoking and drinking) in an attempt to do so (Frisbie, Youngtae, & Hummer, 2001; Gee et al., 2004; Raylu & Oei, 2004). It is, however, agued that these adaptations will manifest themselves over a period of time and assume that immigrants will adopt less healthy behaviours in comparison to their local-born counterparts.	Immigrants will adopt the host populations healthy habits, such as eating low fat diets and regular physical activity; they will also access healthcare and social services more frequently or when necessary, and integrate into the host society and wider social networks.

The relationship between acculturation and health status is extremely complex. It is confounded by factors such as the individual's age, socioeconomic status, and immigration circumstances (Flores & Brotanek, 2005; Harding, 2003; Jaber et al., 2003; Newbold, 2005). It also depends on the particular health outcomes under investigation and in some cases the overall research design and how acculturation is defined and measured.

There are other factors to take into account when considering changes in migrants' health status. Firstly, there may be difficulties in accessing healthcare or social services due to language barriers, and lack of awareness, comfort or confidence in the medical and social welfare systems of the host country. Several overseas studies found that immigrants were less likely than loca-born counterparts to discuss dietary, exercise habit and use of herbal medicine with healthcare professionals (Goel et al., 2004; Kuo, Hawley, Weiss, Balkrishnan & Volk, 2004; Wang, 2006).These difficulties are compounded by the frequent restructuring of the healthcare system, of which the migrant population may be less equipped to cope with (Newbold, 2005; Yu et al., 2004). The issue of access might also be related to limitations in the availability of culturally and linguistically appropriate services for immigrants. In 2002, the New Zealand Mental Health Commission facilitated a literature review to identify specific mental health issues concerning Asian people. It concludes that "although it has been difficult to specify prevalence rates, the limited research findings have suggested that the mental health levels among Asians do not differ significantly from those of the general population" (Ho, Au, Bedford, & Cooper, 2003, p. xii). Highlighting the influence of cultural differences on

the assessment process in mental health services for Asian clients, the report wrote: "Cultural differences in Asian and Western styles of assessment and treatment create difficulties for both the health professionals and the Asian clients. Inefficient or incorrect assessment or treatment can impact greatly on the quality of service, and may cause prolonged stays in the service or hospital thus increasing the running costs of the health service" (p. 44). Other studies have mentioned a range of concerns expressed by immigrant Chinese mental health service users, some of which may have contributed to the worsening of the illness. For example, they identified financial problems, loneliness, separation from families and friends, employment issues, post-migration adjustment issues, boredom, altered socio-economic status, marital problems, language difficulties, low self-esteem, shame and stigma associated with mental illness and difficulties in accessing healthcare services (Lin, & Cheung, 1999; Tse, 2004). Recently Kydd and associates (2006) in their study on the needs of high users of mental health services in the Auckland Northern Region reported that "Asian peoples had higher levels of unmet needs in the area of basic education and community integration" (p.67). They reported that the rating of 'unknown' for cultural services/inputs by Asians (29%) was higher than expected. It was concluded that "more responsiveness in this area may make services more attractive to these consumers" (p. 67).

Secondly, declines in health status among recent immigrants over time could be explained by the determinants of health framework, which states that the "health is influenced by a broad range of factors and interrelationships between factors, with demonstrated associations between health status and social, demographic, economic, and environmental variables…loss of socioeconomic status, s*ocial networks, poor working conditions, and language barriers* may contribute to declines in health" (Newbold, 2005, p.1360, italic added).

Thirdly, as suggested in the Asian Health Chart Book 2006 the convergence of migrants' health status to the host population could be explained by, "…as the proportion of recent migrants/first generation settlers in the population reduces and selection effects decrease, the average health of the Asian ethnic category will deteriorate towards the all New Zealand average ('*regression to the mean'*)" (p.105, italic added). Such health convergence effects among the long time residence or local born Asians (e.g. Cardiovascular mortality among Chinese and other Asians) have already started to emerge.

THE THREATS

There are a number of issues threatening the health and wellbeing of Asian New Zealanders. A sense of initial complacence of the 'healthy immigrant effects' among Asians is masking the fact that the reported good health indicators are not applicable to every Asian. This also fails to recognise the diversity among the Asian communities in terms of language, social adaptability, attitudes, lifestyle, health concerns, and needs. Asians have recently earned recognition as a separate ethnic entity. Yet there is still ambiguity in the definition of 'Asian'. The 'other Asian' sub-classification is not represented explicitly and requires further attention.

Most of the available reports on Asian health in New Zealand are based on self-reported data or collected from existing medical records. Given the low utilisation rates of health and social services and the unsubstantiated nature of self-reported data, these reports may not represent the actual health burden for the Asian population in New Zealand. For example, it is reported that the Asian health burden for "self-reported doctor-diagnosed diabetes" is underrepresented by 30 percent (Ministry of Health, 2006 p. 47). Moreover, many Asians travel to their home country at the terminal stage of their illness to die, and others may travel overseas to seek medical care at their convenience (with regard to issues such as cost, waiting time and familiarity of the system). Therefore, a population based prevalence study which is culturally and linguistically appropriate is required to collect much needed baseline

data. This will enable the future health status of Asians in New Zealand to be monitored and fostered.

It is postulated from the existing reports on Asian health that a clear action plan with an achievable time frame and monitoring system, and an effective policy framework specifically for the Asian community is urgently required. At present, Asian health issues could be addressed on the basis of currently available reports and data, with the future incorporation of forthcoming research and information. The current reports could be used by the health sector to assist in identifying the health needs of Asian peoples in New Zealand (Ministry of Health, 2006, p.106). It is the responsibility of the appropriate ministries to utilise this information when formulating the advice conveyed to Ministers on how to address these needs in the future. Asian communities should be informed and actively engaged in debating and understanding their health needs and health service requirements. It would be helpful to ensure that acculturation processes impact in an adaptive rather than maladaptive manner on Asian health. As always, evidence based programmes and policies for positive health are advocated for. Similarly, the adoption of a strengths-based model for health promotion that builds on the cultural strengths and resilience of Asian communities could partially reverse the declining health trends with the level of acculturation and integration (Ministry of Health, 2006).

A number of specific health and social issues have already been identified in relation to addressing the future health needs of the Asian community, and are worth mentioning here (Abbott & Young, 2006; Ministry of Health, 2006, p.106-107). They are:

- Cultural barriers to health and social services access (Goel et al., 2004; Wang, 2006).
- Cultural safety of mainstream health and social services.
- Asian-specific health and social services and fostering of the Asian workforce.
- English competence of Asians and scope of integration into the workforce.
- Structural issues relating to social determinants of health e.g. employment, recognition of overseas qualifications and work experiences, racial discrimination (Harris, Tobias, Jeffreys, Waldegrave, Karlsen, & Nazroo, 2006).
- Health promotion activities to uphold healthy lifestyle habits, e.g. anti-smoking norms, dietary practices, identification and promotion of culturally acceptable forms of physical activity.
- Low utilisation of primary health services and clinical preventive services e.g. cervical screening.
- Actual disease burden of type 2 diabetes and cardiovascular risk in South Asian people to ensure early detection, and effective management and prevention strategies.
- Scope of culturally appropriate mental health services for recent migrants, refugees and asylum seekers (Ho, 2004; Marshall, Schell, Elliott, Berthold, & Chun, 2005).

It will be impossible to address the health issues of the Asian community unless all the concerned sectors and groups cooperate and work together, and support from the wider New Zealand community is obtained. In order to measure health trends and future directions, it will be vital to employ effective monitoring and assessment systems of Asian health progress over time. Asians have recently been recognised in the official health statistics as a separate ethnic group. Therefore, information gaps are easily detectable, e.g. dietary pattens for south Asians. Lack of appropriate information regarding health status and its relationship with ethnic specific habits and practices hampers appropriate health support needs. There are also negative impacts for preventive programmes and policies. Improvement in the collection and reporting of ethnicity data in health and other relevant information systems (e.g. New Zealand living standards monitored by the Ministry of Social Development) would prevent data loss and increase analytical power. While discussions tend to focus upon the dominant Asian subgroups (Chinese & Indian) the characteristics, diversities, health problems and

participation of other Asians subgroups should not be overlooked. A more pragmatic sub-grouping of Asian populations should be considered. For example, grouping on a regional basis (e.g. South Asians), thus matching cultural and ethnic similarities, is more beneficial than confining groups to country boundaries.

CONCLUSION

There are increasing numbers of Asian peoples in New Zealand and evidence of their health status in New Zealand is beginning to emerge. Their apparent good health status is due to the "healthy immigrant effect". However this abates with time in New Zealand. There are many threats to the health of Asian New Zealanders, some of which are unique to this population group. Many Asian New Zealanders do not have good health status and many of these risks are under-reported due to a variety of reasons. To ignore the health of Asian New Zealanders on the basis of this presumed good health status is a serious mistake. While the social integration of Asians with mainstream New Zealand is encouraged, there should also be encouragement to preserve the many positive values, inherent resilience (individually and collectively), healthy habits and behaviours associated with their Asian background. Therefore, proper recognition of Asian culture, practices and the expertise of the migrating workforce needs to be valued, fostered and allowed to contribute.

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IS MIGRATION NECESSARILY BAD FOR ASIANS MENTAL HEALTH

Edmond Chiu

ABSTRACT

The literature on mental health and migration generally refers to the doom and gloom of mental illness and psychological stress suffered by migrants. There is a scarcity of literature regarding the MENTAL HEALTH of migrants. But whilst not down playing the importance of diagnosing and treating mental disorders in Asian migrants and recognising the damaging effects on the patients and the families; this paper will address the more positive aspects of mental health of Asian migrants. By identifying and discussing the more positive contribution to Mental Health we can examine possible preventative strategies for enhancing Mental Health in Asian migrants. The domains of interest in this paper related to the concept of resilience and how this may be strengthened, enhanced and maintained in Asian migrants through accessibility for quality social support facilitated through the expression and acceptance and appreciation of their valued contribution by the host country. The role of the media, public institutions as well as citizens will be explored.

Chiu, E. (2006). Is migration necessarily bad for Asians mental health? In S. Tse, M.E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp. 19-25). Auckland, New Zealand: University of Auckland.

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THE QUESTION

Migration is an established behaviour of living organisms. Biologists have for years studied the migratory habits of birds, which fly from the end of the globe to the other and return. Land animals undergo seasonal migration to follow the availability of food. The biological advantage of migration of organisms in part contribute to the outcome of evolution and impact on survival or extinction of some species, during threatening changes in habitat and environment.

For the human species, migration is very much part of our history, leading to the strengthening of gene pools by the introduction of fresh genetic contribution to isolate in breeding communities; to the cross fertilisation of cultures and mores; sharing of successful agricultural and animal husbandry practices and, in our current times, cultural diversity in the context of globalisation.

People from Asia, as much as any other group of humans historically have travelled by land, by sea and now by air, to all parts of the world in search of a new life, new challenges, or to escape poverty, oppression, persecution and the threat of personal and family extinction.

If migration is a bad thing– why do Asians keep doing it? Like Lemmings into the sea to perish.

THE LITERATURE

In reading the psychiatric and social science literature in the English language of some three decades, one can be forgiven for coming to the conclusion that migration for all people, especially Asian, African, Caribbean and other non Anglo Saxon communities is indeed a "bad thing".

Mental Illness in Asian Migrants Dominates the Published Literature

In 1932, Odegaard in a much quoted paper entitled "Emigration and insanity: A study of mental disease among Norwegian born population in Minnesota" published in Acta Psychiatrica Neurologica, 4th supplement, wrote of the effects of strange language and customs of an alien culture on the development of "insanity". Since then, the transcultural psychiatry movement has encouraged the systematic study of the relationship between migration, culture and mental illness.

In a paper arguing the examination of cultural and social structures and their relationship to migrant mental illness Hitch (1997), derived a list of main ways in which culture has been held to influence the incidence of mental disorders.

- the culture as affecting the form that mental illness takes
- culture as a direct pathogenic influence
- culture as a direct pathological effect
- culture of approving of mental disorder
- culture differs in the criteria for the attribution of mental illness
- stress arising from cultures role prescription
- culture as preventing illness
- host society and attitudes and behaviour towards immigrant group culture
- culture as preparing its member for its input of social and cultural changes

In this list only 2 items (g & h) refer to issues of MENTAL HEALTH. The further analysis of Hitch's paper went to argue that social class with a migrant group (the rift between a city professional and a city peasant farmer) would be more pathogenic than cultural pluralism. Therefore, he posited that one should not make too much of cultural conflicts as much as social and cultural compatibility between the migrant themselves and with the whole society.

From 1977 to 2006 most papers target the prevalence of mental illness in migrant groups. These papers are generally of epidemiology emphasis, some with attempts in explanatory discussion on cultural conflict, unemployment, social exclusion and other social and cultural disadvantages as contributing to mental disorder. Cochrane Ananthanarayanan (1994) Shams R (1994) Pernice et al (1994). The Pernice paper particularly referred to the situation with Indo-Chinese refugees, pacific islanders in New Zealand, reporting that indo-chinese are high in clinical depression and emotional distress whereas Pacific Islanders demonstrated high level of clinical anxiety. This paper did not however support more emotional distress in refugees. Many papers compare the immigrant versus the local born of the same ethnicity (Kim et al 1997, Stuart et al 1998, Bhugra D 2004 and Bhugra D 2006). The Stuart et al paper from Melbourne came to the conclusion that migrants from West European countries had lower social economic status than Asian and UK born and that country of birth has a significant effect on development of mental disorder. It reported that people from Western Europe have more mental disorders than Greek and Italian born and much more than those born in SE Asia, United Kingdom and Ireland. Another interesting point was the Vietnamese seemed to have a higher unemployment rate but low mental disorder. Whereas the Greek born had low unemployment rate but high prevalence of mental disorders. No particular explanation has been profit for this reported phenomomen. Bhugra in 2004 raised the issue

of acculturation process and posit a hypothetical model relating to resilience, which will be discussed later in this paper. In another paper Bhugra described the level of acculturation, on cultural identity which are concordant or discordant; dissonance of expectations; social isolation; unemployment; poor housing and socio economic status as factors relating to mental disorders. A paper by Marshall et al 2005 published in the Journal of American Association reported an interesting phenomena that Cambodian refugees who have been living in the United States for 20 years reported that 70% of them had been exposed to violence after settlement in the United States of America. This was reported to relate to the high rate of mental disorder of this group of Cambodian refugees. That a country such as the United States exposed refugees to such a high level of violence thus perpetrating the psychological damage to the Cambodian refugees prior to migration to the United States indicated an interesting possible factor in development of mental disorder in this group of Asian migrants.

Commentary on the Negative Perspectives of Migrants and Mental Health

Kuo (1996) quoted the view of Nann 1983 from the book "Uprooting and Surviving" the following interesting commentary, on the prevailing negativity regarding mental illness and migration, "Cautioned researchers on the drawbacks on migratory research conducted exclusively in this pessimistic fashion. One danger is that social change itself will automatically being assumed as "bad" for ones health and wellbeing; another is that significant variables and factors related to successful adaptation and resettlement may be ignored and missed"

Kuo further cautioned that "migration cannot be treated as a unitary concept: it is very important to differentiate conditions of emigration, characteristics of migrant groups and conditions in the receiving society and stress mediating factors that allow migrants to make successful adaptations."

The concept of "uprooting" and "transplanting' concentrate on a very passive "vegetable" analogy. (Back 1980) commented that immigrants were able to re-route their social networks in a new society and thereby experience success in transplanting their lives from the homeland to the host country, did not usually receive the appropriate consideration. Central to the network perspective is the postulate that relinquishing social networks in their homeland is a necessarily reality of immigration, and re-routing in the new society is difficult in nature. However, while these life changes can produce anxiety and psychological insecurity, they are not necessarily hurtful or catastrophic. The mental disorder rate of the migrants in the host country frequently seen as a failure of re-routing. Immigrants are more or less aware of the re-routing problem even before emigration and work assiduously upon arrival and afterwards to explore possibility of re-establishing or entering into a new social network to support themselves.

Such networking is central to the development of ethnic neighbourhoods in all migrant groups. Whilst public hostility towards immigrants, racial and ethnic prejudices continue to flourish, the public opinion consistently denounces the "enclaves" of certain ethnic groups asserting that exclusive co-ethnic relationship will have an adverse effect on immigrants. Further there is the belief that assimilating the structural and social constitution of the host society will increase their social and psychological wellbeing. This ignores the evidence that culture and community are vital for sheltering the immigrant from adaptation stresses either by serving as a social support system or as an escape hatch from psychiatric ill health. The balance of the co-ethnic networks with that of network related to a whole society will likely assist in positive adjustment. However, some evidence (Walker et al 1977) indicated that a "dense" network "may trap the individual within the limited set of normal expectations rather than fulfil his need to make transition to new social roles"; in other words a "low density"

heterogeneous network maybe more functional in reducing social stress and in maintenance and enhancement to mental health.

RESILIENCE

In the mental health and migration literature, the concept of RESILIENCE is strangely ignored by most researchers. The question "is the glass half empty or half full". If there is 25% of migrants who develop mental disorders there will be 75% of those who did not. The question is - why not?

There are 3 studies which address the concept of RESILIENCE in very enlightening and useful manner.

Kuo and Tsai in their 1986 paper introduced the idea of HARDINESS highlighting social network; personality factors including psychological resources of mastery and self-esteem; role satisfaction; and efficacies in handling of stress.

As a psychiatrist, it is of particular importance to consider mastery and self-esteem in this context. Mastery and self-esteem denotes "the belief that ones life changes are under ones own control instead of being fatalistically directed". Such a internalised set of personality characteristics goes someway in developing an understanding or resilience in the Asian migrant who do not develop mental disorder.

To further develop the theme Kuo and Tsai expanded their discussion to theories from existential psychology to expand on the concept of "HARDINESS" to measure the quality of these migrants. Purposeful actions, their ruggedness or assertiveness in attaining and manipulating external rewards, initiative, willingness to take risks, and ability to face uncertainty are the hallmarks of hardiness.

Kobasa & Maddi 1997, described three characteristics of 'HARDY PERSONS"

1. A belief that they can control or influence life events and that they are not totally controlled by them. Coping skills are developed out of the ability to interpret, appraise and incorporate various stressful life events into a positive ongoing life plan.
2. An ability to feel deeply involved or committed to their life activities thus minimising their feelings of alienation and mitigate against perceived threats from surrounding stressful environment. This is assimilated with a strong sense of self-commitment, recognition of ones own distinctive value and life purpose with internal balance (what Asians would call "harmony").
3. Anticipation of change as an exciting challenge thus promoting further self development, and the capacity to explore their environment, locate supportive resources, take calculated risks to advance their defined and determined goals in the face of uncertainty.

Thus the HARDY personality characteristics support successfully adaptations are:

- Ability to plan for the future
- To take risks
- To feel confident in personal ability
- To comfortably tolerate uncertainty

This parallels the theoretical existential framework of important elements for **ego maturity** – being "ruggedness, activism, and willingness to risk change" as suggested by Kobasa and Maddi.

Denish Bhugra, the current Dean of the Royal College of Psychiatrists, in his paper "Migration and Mental Health" (2004) addressed RESILIENCE AND COPING MECHANISMS which included – pre-migration preparedness; social cohesion and social support; the concept of self; central identity and degree of comfort in the recipient culture; religion and faith with religious rituals as defensive strategies. Low level of differences between the two cultures is seen as a probable protective factor, as with knowledge of the language, which contributed to acculturation. However, he noted the benefit of knowledge of the language in relation to mental health is currently contradictory. In the UK context, the relationship of resilience, social factors and social support seem to be essential in understanding mental health response to migration. He proposed a hypothetical model of migration and psychiatric disorders, taking into account both vulnerabilities and resilience (see Figure 1).

PROMOTING MENTAL HEALTH IN MIGRANTS

Identifying and enhancing the positive personal characteristics would be theoretically the basis for mental health promotion. However, access to each migrant to do so may not be practical. The alternative would be by setting s societal environment to foster, cultivate, encourage and value those positive characteristics, through the migrants own community with positive promotional activities.

The negative image frequently portrayed by the media, "the gloom and doom" merchants, well meaning "do-gooders advocates" with a particular or ideological agenda, have for too long held sway. The "show-casing" of cultural diversity usually through festival, dancing, food and parades – all glitz and no substance designed for the politicians who participate in celebrating cultural diversity with photo opportunities. The real substance of promoting mental health is to affirm for each individual migrant that his his/her contribution to family own ethnic groups and to the whole society, no matter how small, is valued. With the "high flyers" of each migrant group, highlighting the personal and professional successors (not just making lots of money) and their contribution to the whole society will reflect positively on all people of that group.

Targeted, accessible, cultural and individually appropriate social network will hold each migrant in the safety net to enable each to develop and flourish.

The general **positive regard** of citizens of the host country will contribute to the mental health of migrants. In this, the media, community organisations, schools, and the general public have a strong role to play. An accepting host society which values and fosters migrants for their past, current and future participation and contribution will strongly promote their mental heath.

CONCLUSION

More emphasis needs to be placed on the factors contributing to the mental health of migrants rather than just keep repeating the mantra of mental disorder.

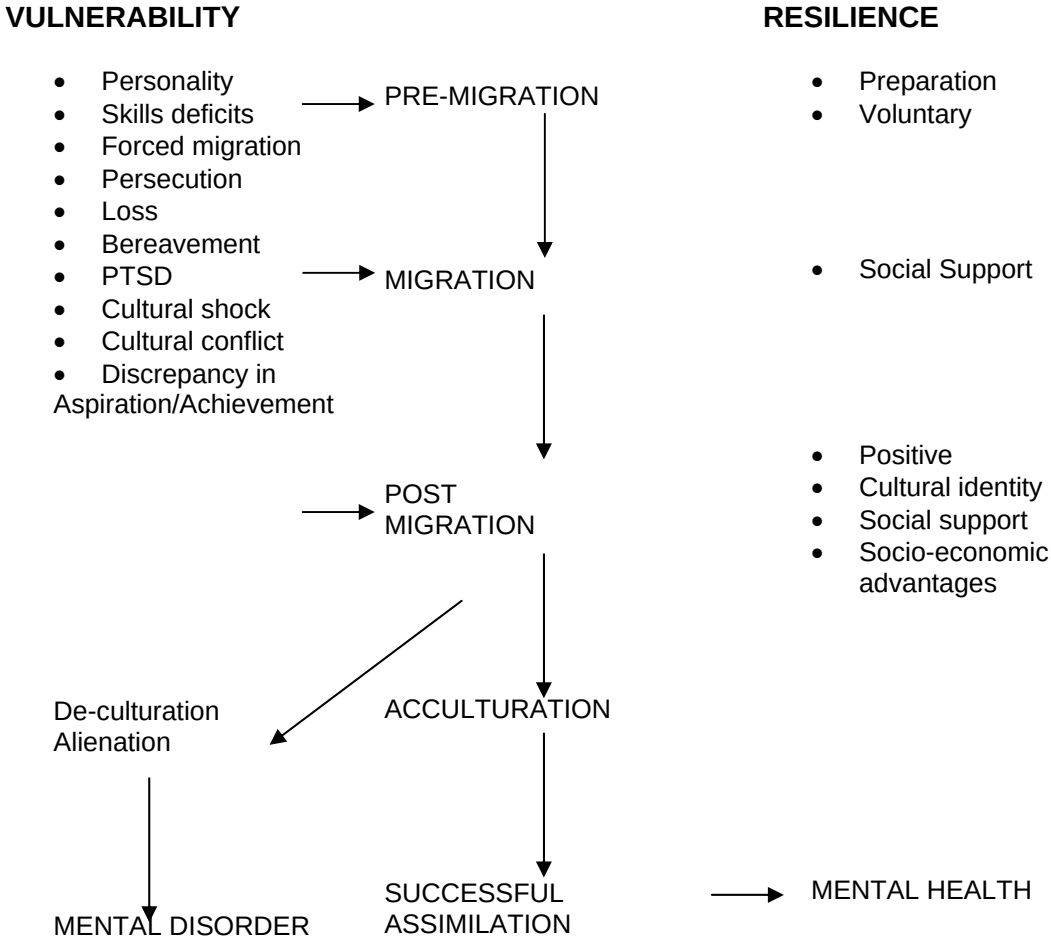
Their RESILIENCE should be celebrated and be encouraged towards mental health.

The resilience producing/enhancing factors of personality strength, social support systems, positive accepting host environments, valuing their skills and capacities are the major contributors to their mental health.

Migrants, generally speaking, are tough and resilient; otherwise they would not be surviving in another country whether they travel there voluntarily or by forced migration.

Let us celebrate their mental health and toast them for their successful contribution to all our countries.

Figure 1. Hypothetical model of migration and psychiatric disorders: Vulnerability and resilience.



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INCLUSIVE CULTURAL EMPATHY: REVISING THE RESEARCH TO MEET THE NEEDS OF ASIAN CLIENTS

Paul B. Pedersen

ABSTRACT

Good relationships emerge as a necessary but not sufficient condition in all research about effective mental health services. Good relationships are typically based on empathy. Empathy occurs when one person vicariously experiences the feelings, perceptions and thoughts of another. Most of the research on empathy predicates the shared understanding of emotions, thoughts and actions of one person by another. In Western cultures this is typically done by focusing exclusively on the individual while in traditional Asian cultures empathy more typically involves an inclusive perspective of the individuals and significant others in their societal context.

Pedersen, P. B. (2006). Inclusive cultural empathy: revising the research to meet the needs of Asian clients. In S. Tse, M.E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp. 26-39). Auckland, New Zealand: University of Auckland.

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INTRODUCTION

The intellectual construct “empathy” developed in a cultural context that favoured individualism and described the connection of one individual with another individual. However, globalization is changing that perspective. The individuated self which is rooted in individualism is being overtaken by a more familial self as best described by Clifford Geertz (1975). “The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgment and action organized into a distinctive whole and set contrastively both against other such wholes and against a social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world’s cultures. (p.48)” In the more collectivist non-Western cultures relationships are defined inclusively to address not only the individual but the many “culture-teachers” of that individual in a network of significant others. Being empathic in that indigenous cultural context requires a more inclusive perspective than in the typically more individualistic Western cultures.

The indigenization of psychology is not only an international issue but a domestic Western issue as well, where individualism is an indigenous pattern.. Lewis-Fernandez and Kleinman (1994) have identified three culture-bound assumptions about mental health and illness based on North American values. The first assumption is the egocentricity of the self where individuals are seen as self-contained and autonomous units whose behaviour is determined by a unique configuration of internal attributes. The second assumption is the mind-body dualism, which divides psychopathology into organic disorders and psychological problems.

The third assumption is the view of culture as an arbitrary superimposition on the otherwise knowable biological reality. This presentation suggests the need for a revision of the research about empathy to challenge the universality of these assumptions.

Inclusive Cultural Empathy (ICE) is a revision of the conventional empathy concept applied to a culture-centred perspective of counselling. Conventional empathy typically develops out of similarities between two people. ICE describes a dynamic perspective that balances both similarities and differences at the same time integrating skills developed to nurturing a deep comprehensive understanding of the counselling relationship in its cultural context. Inclusive Cultural Empathy has two defining features: (1) culture is defined broadly to include "culture teachers" from the client's ethnographic (ethnicity and nationality) demographic (age, gender, life-style, residence) status (social, educational, economic) and affiliation (formal or informal) backgrounds and (2) the empathic counselling relationship values the full range of differences and similarities or positive and negative features as contributing to the quality of that relationship in a dynamic balance. ICE goes beyond the exclusive interaction of a counsellor with a client to include the comprehensive network of inter-relationships with culture teachers in the client's cultural context.

The revision of research on empathy can be illustrated in two figures contrasting (1) conventional and convergent empathy with (2) inclusive and divergent cultural empathy.

Figure 1. Conventional and Western based "convergent" empathy.

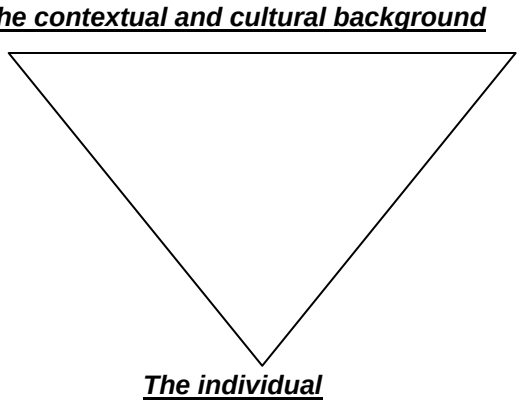
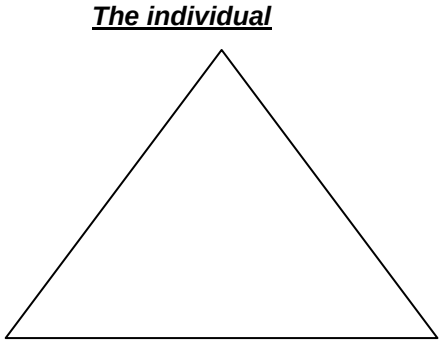


Figure 2. Inclusive and Asian based "divergent" cultural empathy.



The Contextual and Cultural Background Relationships

Empathy is constructed over a period of time during counselling as the foundation of a strong and positive working relationship in counselling. The conventional description of empathy moves from a broadly defined context to the individual person convergently, like a pyramid upside down. The revised version of empathy moves from the individual person toward inclusion of the broadly defined cultural context in which that individual lives, like a pyramid right side up.

ICE is a reframing and enlargement of the relationship-focus to include both similarities and differences in an increasingly comprehensive and culturally inclusive perspective. The conventional definition of empathy has emphasized similarities as the basis of co-membership in a one-directional focus that does not include differences (Ridley & Lingle, 1996; & Ridley & Udipi, 2002). "The new construct of cultural empathy presented in much of the literature appears to be indistinguishable from generic empathy except that it is used in multicultural contexts to achieve an understanding of the client's cultural experience" (Ridley & Lingle, 1996, p.30). Inclusive cultural empathy is therefore the learned ability of counsellors to accurately understand and respond appropriately to the client's comprehensive cultural context, both in its similarities and differences. Stewart (1981) suggests that the exclusive emphasis on similarities is likely to result in "sympathy" rather than empathy which provides an incomplete perspective.

Inclusive Cultural Empathy goes beyond accommodating cultural differences to achieve an empathic relationship toward a complex and dynamic balance of similarities and differences among the client's many different culture teachers that assume every counselling context is multicultural, if culture is broadly defined. ICE is a generic counselling perspective which requires the counsellor to manage both similarities and differences at the same time. This "inclusive" approach is in sharp contrast to the conventional "exclusive" perspective of dissonance reduction in conventional empathy. By reframing the counselling relationship into multicultural categories it becomes possible for the counsellor and the client to accept the counselling relationship as it is---ambiguous and complex--- without first having to change it toward the counsellor's self-reference and exclusionary cultural perspective.

ICE does not require the compromising exclusion of categories to find common ground but rather enriches the counselling relationship through inclusion of both the counsellor and the client's diverse perspectives as they contribute to the growing and ever-changing relationship. This complex and somewhat chaotic perspective is what distinguishes Inclusive Cultural Empathy (ICE) from the more conventional descriptions of empathy. We can best manage the complexity of ICE in a comprehensive and inclusive framework. This comprehensive and inclusive framework has been referred to as "multiculturalism." This presentation will match the three stage developmental framework of multicultural competence with the conference themes of prevention, protection and promotion revising the research to provide a more inclusive perspective.

The ultimate outcome of multicultural awareness, as Segal, Dasan, Berry and Poortinga (1990) suggest, is a contextual understanding. "There may well come a time when we will no longer speak of cross cultural psychology as such. The basic premise of this field--that to understand human behaviour, we must study it in its sociocultural context--may become so widely accepted that all psychology will be inherently cultural" (p.352). During the last twenty years, multiculturalism has usually become recognized as a powerful force, not just for understanding "specific" groups but for understanding ourselves and those with whom we work (Sue, Ivey & Pedersen, 1996).

An understanding of ICE moves from gaining increased **Awareness** (of culturally learned assumptions, context, and experiences) as a primary prevention strategy to gaining increased

Knowledge (information and essential facts about the cultural context) as a comprehension protection strategy to gaining increased **Skill** (making decisions and taking action based on accurate awareness and a meaningful understanding of the cultural context) as an accurate and interactive promotion strategy..

INCREASING THE "AWARENESS" OF CULTURALLY LEARNED ASSUMPTIONS AS A "PREVENTION" STRATEGY

One strategy of primary prevention is to examine and be aware of underlying assumptions ahead of the event. Cultural patterns of thinking and acting were being prepared for us even before we were born, to guide our lives, shape our decisions and to put our lives in order. We inherited these culturally learned assumptions from our parents and teachers who taught us the "rules" of life. As we learned more about ourselves and others, we learned that our own way of thinking was one of many different ways. By that time, however, we had come to believe that our way was the best of all possible ways, and even when we found new or better ways it was not always possible to change. We are more likely to see the world through our own eyes and to assume that others see the same world in the same way using a "self-reference" criterion.. As the world becomes more obviously multicultural this "one-size-fits-all" perspective has become a problem.

During the last twenty years multiculturalism has become a powerful force in mental health services, not just for understanding foreign-based nationality groups or ethnic minority groups but for constructing accurate and intentional counselling relationships generally. Multiculturalism has gained the status of a generic measure of competence, complementing other competencies to explain human behaviour by highlighting the importance of cultural empathy, building relationships and including the influence of context in psychological analysis in spite of culturally biased assumptions. Culture is more complex than these assumptions suggest. Imagine that there are a thousand culture teachers sitting in your lap and another thousand in your client's lap, collected over a lifetime from friends, enemies, relatives, strangers, heroes and heroines. That is the visual image of "culture" in the multicultural counselling interview.

Miller (1999) examined the self-interest motive and the self-confirming role of assuming self-interest in textbook psychology. "It is proposed that a norm exists in Western cultures that specify self-interest both is and ought to be a powerful determinant of behaviour. This norm influences people's actions and opinions as well as the accounts they give for their actions and opinions. In particular, it leads people to act and speak as though they care more about the material self-interest than they do" (p. 1053). The theory of self-interest has led to a psychological norm of self-interest fostering a powerful descriptive and prescriptive expectation in Western society.

The evidence supporting a bias toward self-interest may speak more to the power of social norms than of innate proclivities in a self-fulfilling prophecy. "The more powerful the norm of self-interest the more evidence there is for the theory of self-interest, which in turn, increases the power of the self interest norm" (p. 1053). However, there are other participants as well in the multicultural perspective who will also influence cultural bias

Psychology in the not so far away future promises to become an-inclusive science that routinely takes cultural variables into account. In contrast, much of today's mainstream psychology routinely neglects and underestimates the power of cultural variables. Soon, there will appear in connection with many psychological theories and methods a series of questions: "Under what circumstances and in which culturally circumscribed situations does a given psychological theory or methodology provide valid explanations for the origins and

maintenance of behaviour? What are the cultural boundary conditions potentially limiting the generalisability of psychological theories and methodologies? Which psychological phenomena are culturally robust in character, and which phenomena appear only under specified cultural conditions (Gielen, 1994).

The underlying principle of multicultural awareness is to emphasize both the culture specific characteristics which differentiate and the culture general characteristics which unite. The inclusive accommodation of both within-group differences as well as between-group differences is required for a comprehensive understanding of each complicated cultural context.

Wrightsman (1992) describes how the perspectives of behaviourism, psychoanalysis and humanism are supplemented by a more inclusive perspective based on George Kelly's personal construct theory. Wrightsman describes this new movement as more collectivistic, resembling non-Western indigenous psychologies. “We are living in a time when the conventional wisdom about human nature and the nature of society is under attack. Technology has run amok; many now question our ability to bring technology under manageable control. Bureaucracy---a social structure originally established to provide for personal growth---now stifles human development and generates a philosophy that human nature is lazy, irresponsible and extrinsically motivated. The communal movement has challenged a pessimistic drift in our society. Through study of the movement’s assumptions, aims, procedures and outcomes we may gain an understanding of the future of philosophies of human nature (Wrightsman, 1992 p.293).”

COMPREHENDING THE FACTS AND KNOWLEDGE ABOUT A CULTURAL CONTEXT AS A PROTECTION STRATEGY

Accurate information, comprehensive documentation and verifiable evidence are important to the protection of health sciences as a reliable and valid resource. Knowledge requires an inclusive understanding. By defining culture broadly to include ethnographic, demographic, status and affiliations the construct “multicultural becomes generic to all counselling relationships. The narrow definition of culture has limited multiculturalism to what might more appropriately be called multi-ethnic or multi-national relationships between groups with a shared socio-cultural heritage that includes similarities of religion, history and common ancestry. Ethnicity and nationality are important to individual and familial identity as aspects of culture but the construct culture---broadly defined---goes beyond national and/or ethnic boundaries. Persons from the same ethnic or nationality group may still experience cultural differences.

We have been misled by dichotomous thinking habits. Just as differentiation and integration are complementary processes, so are the emic (culture specific) and etic (culture general) perspectives necessarily interrelated. The terms emic and etic were borrowed from "phonemic" and “phonetic” analysis in linguistics describing the rules of language to imply a separation of general from specific aspects (Pike, 1966). Even Pike (1966) in his original conceptualization of this dichotomy, suggested that the two elements not be treated as a rigid dichotomy, but as a way of presenting the same data from two complementary viewpoints. Although research on the usefulness of emic and etic categories has been extensive the notion of a "culture free" (universal) etic has been just as elusive as the notion of a "culture pure" (totally isolated) emic.

Western cultures are described as more “idiocentric”, emphasizing competition, self-confidence and freedom whereas the contrasting cultures are more “allocentric”, emphasize communal

responsibility, social usefulness and acceptance of authority. Approximately one third of the people in the United States, half of those in Europe and about 80 percent of people worldwide regularly use some kind of complementary or alternative health treatment frequently originating in Non-Western cultures (Micozzi, 1996). The frequent themes of inclusion, relationships, balance, subjectivity, and harmony in non-Western therapies is in sharp contrast to the frequent themes of dissonance reduction, individuality, exclusion, empiricism, linear thinking and objective precision in Western therapies.

There are several assumptions which distinguish Non-Western therapies (Nakamura, 1964).
(1) Self, the substance of individuality, and the reality of belonging to an absolute cosmic self are intimately related. Illness is related to a lack of balance in the cosmos as much as to physical ailments.
(2) Asian theories of personality generally de-emphasize individualism and emphasize social relationships. Collectivism more than individualism describes the majority of world cultures.
(3) Interdependence or even dependency relationships in Hindu and Chinese cultures are valued as healthy. Independency is much more dysfunctional in a collectivist culture.
(4) Experience rather than logic can serve as the basis for interpreting psychological phenomena. Subjectivity as well as objectivity are perceived as psychologically valid approaches to data. In spite of these differences Western and Non-Western approaches are complementary to one another as psychology increasingly includes attention to Non-Western therapies Sheikh and Sheikh (1989) and Scotton, Chinen and Battista (1996) provide the best review of Non-Western therapies.

It will be useful to briefly describe examples of non-Western therapy in the global context before proceeding to show how the theme of inclusion fits with the non-Western perspectives.
(1) Ayurvedic therapies from India combine the word for life, vitality, healthy and longevity (dyus) with the word for science or knowledge (veda) focusing on promoting a comprehensive and spiritual notion of health and life rather than healing or curing any specific illness. Ayurvedic treatments are combined with conventional therapies more frequently in Europe than in the U.S.. Health is treated as more than the absence of disease and involves a spiritual reciprocity between mind and body. Western-based research has documented the efficacy of Ayurvedic therapies.
(2) Yoga has a history of thousands of years as a viable therapy based on the Sanskrit root yuj meaning to yoke or bind the body-mind-soul to God. Yoga has its main source in the Bhagavad Gita in understanding the connection of the individual to the Cosmos. Research on Yoga has demonstrated benefits in lowering blood pressure and stress levels through meditation, personality change and therapeutic self-discovery.
(3) Chinese therapies include an elegant array of approaches based on the concepts of the Tao or "the way", Ch'i or "the energy-force" and Yin/Yang or the "balance of opposites." The various systems of Chinese therapies are grounded in religion and philosophy by the mystical union with God or the Cosmos and nature. The Tao describes those patterns that lead toward harmony. The Ch'i describes a system of pathways called meridians in the body through which energy flows. The Yin/Yang describes the balance of paradoxes each essential to the other.
(4) Buddhist therapy is based on the absence of a separate self, impermanence of all things and the fact of sorrow. People suffer from striving to possess and desire things, which are impermanent. The cure is to reach a higher state of being to eliminate delusion, attachment and desire in the interrelationship of mind and body. Elements of cognitive restructuring, behavioural techniques and insight-oriented methods are involved in the healing process.
(5) Sufism is the mystical aspect of Islam inside the person. The outward dimension sharia is like the circumference of a circle with the inner truth haqiqa being the circle's center and the path tariqa to that centre going beyond rituals to ultimate peace and health. The Sufi's goal is to enable people to live simple, harmonious and happy lives. Jung's analytical psychology and Freud's interpretation of the fragmented person are similar but more objective in their emphasis

than the Sufi who seeks to go beyond the limited understanding of objective knowledge.
(6) Japanese therapies of Zen Buddhism, Naikan and Morita therapy focus on "constructive living" and their aim is for people to become more "natural." Morita was professor of psychiatry at Jikei University School of Medicine in Tokyo who developed principles of Zen Buddhist psychology. Yoshimoto was a successful businessman who became a lay priest at Nara and developed Naikan therapies in the Jodo Shinshu Buddhist psychology. Morita therapy is a way to accept and embrace our feelings rather than ignore them or attempt to escape from them. Naikan therapy emphasizes how many good things we have received from others and the inadequacy of our repayment.
(7) Shamanism is a family of therapies involving altered states of consciousness where a person experiences their spiritual being to heal themselves or others. Shamanism is found from Siberia and the Native American Indian cultures to Africa and Australia going back perhaps 25,000 years in South Africa. The focus of healing is through spirit travel, soul flights or soul journeys, which distinguishes shamans from priests, mediums, or medicine men. These altered states include psychological, social and physiological approaches to modify consciousness as perhaps the world's earliest technology.
(8) The Kabbalah of Jewish mysticism was developed by the Zohar schools of Spain and Provence in the 13th and 14th centuries and the Cordoverian and Lurianic schools in Safed in the 16th century to classical Hasidism of the late 18th century. The Kabbalah describes a four-world cosmology with the body in the world of Assiyyah associate with sensation action and behavior, Ru'aHh (the breath or spirit) involving feeling, images, values and myths aimed at purification of emotions and B'ruttah or creation in the world of thinking and philosophy. The Kabbalah brings individuals to inner states through levels of reality and by maintaining careful balance in a personal encounter.
(9) Native American Healers recognize four main causes of illness: offending the spirits or breaking taboos, intrusion of a spirit into the body, soul loss or witchcraft. Illness can be a divine retribution for breaking a taboo or offending divine powers requiring that the patient be purified with song, prayers and rituals. In the same way removing objects or spirits from the body by a healer restores health. When the soul is separated from the body or possessed by harmful powers it must be brought back to energize the patient and sometimes the Shaman must travel to the land of the dead to bring the soul back. Finally witchcraft causes illness by projecting toxic substances into the patient. Elements of dissociate reaction, depression, compulsive disorder and paranoia are present.
(10) African healing as described by Airhihenbuwa (1995) is based on cultural values, is available, acceptable and affordable and even today African divinities, diviners and healers continue to be popular in a religious or psychosocial dimension of health that goes beyond medical care. Beliefs include symbolic representations of tribal realities, illness resulting from hot/cold imbalance, dislocation of internal organs, impure blood, unclean air, moral transgression, interpersonal struggle and conflict with the spirit world. Health depends on a balance both within the individual and between the individual and the environment or cosmos. Similarities with allopathic medicine are evident.

A great variety of other Non-Western systems exist such as Christian mysticism, homeopathy, osteopathy, chiropractic, herabalism, healing touch, naturopathic medicine, Qigong, Curanderismo and Tibetan Medicine, among the many. Each of these systems are, in turn, divided into a great variety of different traditions. However, many of the same patterns of spiritual reality, mind-body relationships, balance and subjective reality run through many if not all the Non-Western therapies.

The basic issue facing counsellors is how to describe behaviour in terms that are true to a particular individual in a specific culture while at the same time comparing those behaviours with a similar pattern in a generalization to one or more other outside cultures (Pedersen, 2000b). Combining the specific and general viewpoints provides a multicultural perspective.

This larger, inclusive perspective is an essential starting point for mental health professionals seeking to be more accurate across cultures and to avoid cultural encapsulation by their own culture-specific assumptions.

The broad and inclusive definition of culture has been criticized for reducing culture to individual differences. The distinction between individual differences and cultural differences is real and important. We learn our individual identity in a cultural context. The cultural identities to which we belong are no more or less important than our individual identity. Although culture has traditionally been defined as a multi-generational geographic phenomenon the broad definition of culture suggests that cultural identities and culturally significant shared beliefs may develop in a contemporary time frame independent of geography and still be distinguished from individual differences. Your skin colour at birth is an individual difference. What that skin colour has come to mean is cultural. Culture is part of the environment and all behaviour is shaped by culture, so that it is rare---perhaps even impossible--- for any human being ever to behave without responding to culturally learned patterns.

Another application of the broad definition of culture is "cultural psychology," which presumes every sociocultural environment depends on the way human beings give each cultural context meaning and are in turn changed in response to that sociocultural environment. Cultural psychology studies the ways cultural traditions and social practices regulate, express, and transform people in patterned ways. "Cultural psychology is the study of the ways subject and object, self and other, psyche and culture, person and context, figure and ground, practitioner and practice live together, require each other, and dynamically, dialectically and jointly make each other up" (Shweder, 1990, p.1).

It becomes possible for a counsellor to identify "common ground" between two culturally different people whose positive expectations and ultimate goals are the same even though their behaviours may be very different without the counsellor having to disregard or minimalise those differences. Even the same individual may change his or her cultural referent group during the course of the interview---from emphasizing gender, to age, to socioeconomic status, to nationality or ethnicity, to one or another affiliation. Unless the counsellor is skilled enough to understand that each of these many changing and potentially salient identities will require a different understanding and interpretation of that person's behaviour the counsellor is not likely to be accurate in assessing the person's changing behaviour. The same culturally learned behavior may have very different meanings across people and even for the same person across times and situations (Pedersen, 2000a).

The multicultural perspective, broadly defined, complements rather than competes with traditional theories of behavioural, psychodynamic or humanist counselling. Counselling from whatever theoretical perspective is interpreted from the counsellor's own perspective of cultural self-awareness and is applied to the client's cultural context. Sue et al (1998) specify the importance of counsellor self-awareness and an awareness of the client's cultural context to the delivery of effective counselling services across theories.

The cultural context provides a force field of contrasting influences, which can be kept in balance through culturally inclusive empathy. There are several implications of considering culturally inclusive empathy to be necessary for competent counselling to occur. Each implication contributes toward a capability for understanding and facilitating a balanced perspective in multicultural counselling. Can a counsellor hope to know about all possible cultures to which the client belongs? Probably not, but the counsellor can still "aspire" to know about as many cultural identities as possible just as in "aspirational ethics," where the counsellor tries always to do good but never expects to achieve absolute goodness.

Westernized perspectives, which have dominated the field of mental health, must not become the exclusive criteria of "modernized" perspectives. While non-Western cultures have had a profound impact on the West in recent years, many less industrialized non-Western cultures seem more determined than ever to emulate the West as a social model. There is also evidence that the more modernized a society the more their problems and solutions resemble those of a Westernized society. While industrialized societies are fearful of technological domination that might deteriorate social values and destroy the meaning of traditional culture, less industrialized societies are frequently more concerned that the technology will not be available to them. The task is one of differentiating between finding modernized alternatives outside the Western model. Otherwise we end up teaching Westernization in the name of modernization. We need indigenous, non-Western models of modernity to escape from our own reductionistic assumptions.

We are at the starting point in developing culture-centred balance as the criteria for Inclusive Cultural Empathy in effective counselling. Only those who are able to escape being caught up in the web of their own assumptions and maintain a balanced perspective will be able to communicate effectively with other cultures. The dangers of cultural encapsulation and the dogma of increasingly technique-oriented definitions of social services have been frequently mentioned in the rhetoric of professional associations in the social services as criteria for competence.

DEFINING THE BALANCE OF INCLUSIVE CULTURAL EMPATHY SKILLS: **AS A "PROMOTION" STRATEGY**

Developing social action skills depends on accurate assumptions and meaningful knowledge to promote a balanced perspective. Balance, as a construct for Inclusive Cultural Empathy involves the identification of different or even conflicting culturally learned perspectives without necessarily resolving that difference or dissonance in favor of either viewpoint. Healthy functioning in a multicultural or pluralistic context may require a person to maintain multiple conflicting and culturally learned roles or viewpoints without the opportunity to resolve the resulting dissonance. Illness occurs when balance is missing.

Lin and Lin (1978) attribute mental illness to five harmful emanations affecting the "yin" and "yang" when they are disturbed or "out of balance" Health is more than the absence of illness but is a positive force with its own separate definition. The construct of balance is useful for understanding this unique characteristic of health as a goal orientation of counselling. Walsh (1989) describes the relationship between Asian and Western psychologies as complementary to one another. First Asian and Western psychologies both focus on development with the Asian systems focused on advanced stages of development in a more "transpersonal" focus and well being while Western systems focus on psychopathology and physical/mental development. "From a multiple-states-of-consciousness model, the traditional Western approach is recognized as a relativistically useful model provided that, because of the limitations imposed by state-specific relevancy, learning, and understanding, it is not applied inappropriately to perspectives and states of consciousness and identity outside its scope (p.549)." Pathologising mystical experiences would be an example of Western models going beyond their boundaries in some cultures.

Turtle (1987) describes the rapid movement of psychology from the "West" toward the "East." Given the theoretical dependence on principles of materialism, empiricism and determinism in Western psychology, this transition is difficult at best." To offer practical solutions to problems of social planning, to advise on maximal utilization of capacities of individuals, to claim the ability to counsel, to comfort and to cure those in trouble and distress, in the face of firmly established beliefs about the proper forms of social organization and the relation of the individual thereto, and of highly valued practices of guidance, consolation and spiritual

healing, gives evidence either of remarkable self-confidence and/or powers of salesmanship in modern psychologists, or of extraordinary social disruption in the East, or of both (p.1)." Social change in this context is perceived as a continuous and not an episodic process. Balance as a construct seeks to reflect the metaphors of organismic systems in holistic health. Problems, pain and otherwise negative aspects of our experience may also provide necessary resources for understanding the dark side of healthy functioning, an in ecological analysis of psychological process (Berry, 1980).

Chinese indigenous psychologists have worked to adapt Americanized individualism to make it applicable in both the Western individualistic and the Asian collectivist context. David Ho (1999) uses the term "relational counselling" to describe the uniquely Asian indigenous perspective based on a relational self in the Confucian tradition. "This relational conception takes full recognition of the individual's embededness in the social network. The social arena is alive with many actors interacting directly or indirectly with one another in a multiplicity of relationships. It is a dynamic field of forces and counter-forces in which the stature and significance of the individual actor appears to be diminished. Yet, selfhood is realized through harmonizing one's relationships with others "(p.2). Hwang (2000) has also written extensively on relationalism in his "face and favour" model as a manifestation of Confucianism as part of indigenous psychology. The process of indigenizing psychology has become a powerful force for psychological change in counselling (Kagitcibasi, 1996). Western counselling and psychology has promoted the separated self as the healthy prototype across cultures, making counselling and psychology part of the problem through an emphasis on selfishness and lack of commitment to the group, rather than part of the solution.

Sinha (1997) describes the indigenizing perspective as advocating (a) psychological knowledge is not to be externally imposed, (b) psychology needs to address every-day activities outside experimentally contrived laboratories, (c) behaviour is best understood from the local frame of reference and (d) psychology must reflect the socio-cultural reality of its social context. "The ultimate goal of indigenous psychology is the development of a universal psychology that incorporates all indigenous (including Western) psychologies...It only asserts that panhuman psychological principles and theories cannot be taken for granted or assumed merely because they are developed in the West" (p.160). Indignisation may be one step toward discovering true universals in psychology and counselling.

Inclusive Cultural Empathy recognizes that the same behaviours may have different meanings and different behaviours may have the same meaning. By establishing the shared positive expectations between and among people the accurate interpretation of behaviours becomes possible. The Interpersonal Cultural Grid is useful in understanding how cultural differences influence the interaction of two or more individuals. It is important to interpret behaviours accurately in terms of the intended expectations and values expressed by those behaviours. If two persons are accurate in their interpretation of one another's expectation they do not always need to display the same behaviour. The two people may agree to disagree about which behaviour is appropriate and continue to work together in harmony in spite of their different styles of behaviour.

THE INTERPERSONAL CULTURAL GRID

		BEHAVIOUR OR ACTION	
		SAME CONGRUENT	DIFFERENT INCONGRUENT
EXPECTATION OR INTENTION	SAME OR POSITIVE	I	II
	DIFFERENT OR NEGATIVE	III	IV

In the first quadrant two individuals have similar behaviours and similar positive expectations. There is a high level of accuracy in both individuals' interpretation of one another's behaviour and expectation. This aspect of the relationship would be congruent and probably harmonious. We are focusing exclusively on positive expectations here. If the two individuals share the same negative expectations ("I hate you") and behaviour ("I am beating you up!") the relationship may be congruent but certainly not harmonious.

In the second quadrant two individuals have different behaviours but share the same positive expectations. There is a high level of agreement that the two people both expect Trust and Friendliness, for example, but there is a low level of accuracy because each person perceives and interprets the other individual's behaviour incorrectly. This relationship is characteristic of multicultural conflict where each person is applying a self reference criterion to interpret the other individual's behaviour in terms of this person's own self-reference expectations and values. The conditions described in quadrant two are very unstable and, unless the shared positive expectations are quickly made explicit, the relationship is likely to change toward quadrant three.

In the third quadrant two people have the same behaviours but differ greatly in their expectations. There is actually a low level of agreement in positive expectations between the two people even though similar or congruent behaviours give the appearance of harmony and agreement. One person may continue to expect Trust and Friendliness while the other person is now negatively Distrustful and Unfriendly, for example. Both persons are, however, presenting the same smiling, glad-handing behaviours.

If these two persons discover that the reason for their conflict is their differences of expectation and if they are then able to return their relationship to an earlier stage where they did perhaps share the same positive expectations of Trust and Friendliness, for example, then their interaction may return to the second quadrant. This would require each person to adjust their interpretation of the other's different behaviour to fit their shared positive expectation of Friendship and Trust. If, however, their expectations remain different then, even though their behaviours are similar and congruent, the conflict is likely to increase until their interaction moves to the fourth quadrant.

In the fourth quadrant the two people have different behaviours and also different or negative expectations. Not only do they disagree in their behaviours toward one another but now they also disagree on their expectations of Friendship and Trust. This relationship is likely to

result in hostile disengagement. If the two persons can be coached to increase their accuracy in identifying one another's positive expectations, however, there may still be a chance for them to return to an earlier stage of their relationship where their positive expectations were similar even though their behaviours might have been very different, as in the second quadrant.

The perspectives of two persons may and usually is both similar (in expectation) and different (in behaviours). In this way the Interpersonal Cultural Grid provides a conceptual road map for Inclusive Cultural Empathy to interpret another person's behaviour accurately in the context of that person's culturally learned expectations. It is not necessary for the counsellor and client to share the same behaviours as long as they share the same positive expectations.

CONCLUSION

The notion of balance is familiar in other Asian cultures as well, as, for example, the harmonious tension between *Yin* and *Yang*, the female and male principles of Chinese philosophy. This emphasis on harmonious balance of forces once more underlines the basic theme of this chapter---human behaviour in Asian countries requires an understanding of *relational* units instead of the individualistic assumptions of Western psychological theories.

Defining Inclusive Cultural Empathy as described in this presentation involves increased awareness to prevent false assumptions, knowledge to protect against incomplete comprehension and skill to promote right actions. The first task is to become aware of culturally learned assumptions on which all the rest of our understanding is based. If counsellors are making wrong assumptions then they will fail regardless of their other abilities. The second task is to identify knowledge gaps, which need to be addressed to describe the cultural context of counselling. While we can not hope to accumulate all relevant knowledge we can still aspire to the complex task as best we can. The third task is to construct or respect a complex and dynamic balance of tendencies that a competent counsellor can manage. The skills required for Inclusive Cultural Empathy requires managing a comprehensive balance of essential similarities and differences at the same time.

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Prevention of problems: Prevention is better than cure

CARDIOVASCULAR DISEASE RISK FACTOR LEVELS OF ASIANS LIVING IN AUCKLAND: RESULTS FROM THE DIABETES, HEART AND HEALTH SURVEY

Patricia A. Metcalf, Robert K.R Scragg, and Rod T. Jackson.

ABSTRACT

Risks of cardiovascular diseases (CVD), including diabetes, appear to vary over the Asia-Pacific region, with South Asians reported as having higher risks. The objective of this study was to compare cardiovascular disease risk factor levels in Asian subgroups with Europeans. The Auckland Diabetes, Heart and Health Study was a cross-sectional community-based survey carried out in Auckland between 2002 and 2003 of 267 Asians and 1,741 Europeans aged 35-74 years. Asian participants were classified as: Eastern Asian (China, Taiwan, Singapore, and Hong Kong), South Asians (India and Fiji), and Southeast Asians (Thailand, Japan, Korea, Cambodia, Indonesia, Malaysia, and Philippines). CVD risk factor levels were measured using standard techniques and included a glucose tolerance test.

Compared to Europeans, all Asian ethnic groups had lower weights, heights, hips and income and higher 2 hour glucose levels; South and Southeast Asians had higher 5 year risk of CVD, and HbA_{1c} levels and higher prevalence of previously diagnosed diabetes and total diabetes; South Asians had higher prevalence of raised blood pressure, higher triglyceride levels and pulse rates, and lower HDL-cholesterol levels and time spent doing leisure physical exercise; South, Eastern and Southeast Asians had lower prevalence of obesity; Eastern Asians had lower cholesterol levels, and prevalence of current smoking and overweight; and Eastern and Southeast Asians had lower body mass indices and waist-to-hip ratios.

Levels of CVD risk factors varied significantly between Europeans and the Asian ethnic groups, and the most adverse patterns were observed in South Asians. In general, diabetes and related risk factors appear more prevalent in most Asian population groups compared to Europeans. These findings suggest that diabetes-related risk should be a key focus of CVD prevention and management strategies among Asian populations in New Zealand. The most easily modifiable risk factor would be to increase leisure time physical activity.

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INTRODUCTION

Cardiovascular diseases (CVD) are one of the leading causes of mortality in New Zealand (NZHIS, 2004). Furthermore, it has been reported that about half of the world's cardiovascular disease burden is predicted to occur in the Asia Pacific region (Asia Pacific Cohort Studies Collaboration, 2003a). As in other ethnic groups, blood pressure and serum

cholesterol are positively associated with the incidence of CVD in Asian populations (Asia Pacific Cohort Studies Collaboration, 2003a, 2003b). However, risk of CVD appears to vary between Asian populations, with a recent New Zealand report of significantly higher CVD hospitalization and mortality rates in Indian men and women compared to the total population (Ministry of Health, 2006), and a study in Singapore reported that Indian males were at greater risk of coronary heart disease than Chinese and Malays (Lee et al., 2001).

Studies have shown that Asians living in New Zealand may have an increased risk of CVD. A workforce survey in Auckland and Tokoroa during 1988-90 reported an increased risk of hypertension (Scragg, Baker, Metcalf, & Dryson, 1993a) and diabetes (Scragg, Baker, Metcalf, & Dryson, 1991) among Asians compared with Europeans. In contrast, serum cholesterol levels did not vary with ethnicity (Scragg, Baker, Metcalf, & Dryson, 1993b). The prevalence of known diabetes was highest among South Asians and lower among Chinese in South Auckland in 1999 (Simmons, Harry, & Gatland, 1999). The 2002/03 New Zealand Health Survey reported that the self-reported prevalence of diagnosed diabetes was higher among Asians compared with Europeans, but, in contrast, found that Asians had the lowest self-reported diagnosed hypertension prevalence of all ethnic groups (Ministry of Health, 2004). A further analysis of the latter survey by Asian ethnic subgroups found no significant differences between Chinese, South Asians, Koreans or Southeast Asians for self-reported hypertension, heart disease, or stroke, but a significantly higher prevalence of self-reported diabetes, particularly in South Asians, and treated hypercholesterolemia (Scragg & Maitra, 2005). Data from the latter survey also reported that Indians were more likely to have been tested for cholesterol and diabetes in the past 12 months than New Zealand Europeans and the total population, respectively (Ministry of Health, 2006).

Immigration has been reported to confer an increased risk of CVD. Duration of residence in Canada was associated with an increased risk of hypertension among Asian immigrants (Kaplan, Chang, Newsom, & McFarland, 2002). Longer duration of residence in New Zealand was significantly related to the likelihood of self-reporting high blood pressure and high cholesterol, and CVD mortality among Asian New Zealanders (Ministry of Health, 2006). Diabetes prevalence was higher among Asians who migrated than those who remained in their homelands (Fujimoto, 1992), and South Asian immigrants in the United Kingdom have been shown to have greater mortality and morbidity from CVD than the native population (McKeigue, Miller, & Marmot, 1989; Office of Population Censuses and Surveys, 1990).

The objective of this study was to compare cardiovascular disease risk factor levels in Asian subgroups with Europeans who took part in the Auckland Diabetes, Heart and Health Survey that was carried out between 2002 and 2003.

METHODS

The Auckland Diabetes, Heart and Health Survey was carried out between December 2001 and November 2003. Adults aged 35 to 74 were recruited from 2 sampling frames: one was a cluster sample where random starting point addresses were obtained from Statistics New Zealand and the probability of selection was proportional to the number of people living in that mesh block (response rate 61.3%); and the other was a random sample taken from the November 2000 Auckland electoral rolls stratified into 5 year age bands and included all people living in the Auckland area, but excluding Franklin and Rodney (response rate 60%). Out of the 2,024 non-Maori and non-Pacific participants interviewed, 942 were from the cluster sample, and 1082 were from the electoral roll. Four people were excluded as they were outside the age range leaving 2,020. Ethical Committee approval was obtained from the Auckland Ethics Committees.

Interviews were carried out in halls or clinics close to participant's homes. Personnel were trained in the administration of the questionnaires and in taking blood pressure and other measurements. Participants filled in a questionnaire which included questions on ethnicity, where born, time lived in New Zealand, smoking history, occupation, gross combined household income, alcohol intake, and past medical history. Questionnaires were translated into Cantonese and Mandarin, and an appropriate Translator was available when necessary. Ethnicity was defined according to the current NZ census (New Zealand Health Information Service, 2006). Those classified as Eastern Asians included people born in Taiwan, Hong Kong, Singapore and China. People classified as Southeast Asians included people born in Thailand, Japan, Korea, Cambodia, Philippines, Malaysia, and Indonesia. Southern Asians included people who were born in Fiji, and India. The small number of Western Asians (n=15) were excluded from analyses as their numbers were too small to draw any meaningful conclusions leaving 2005.

Participants fasted from 10pm the evening before the interview and collected a first morning urine sample which they brought along. A 75 gram oral glucose tolerance test was carried out in participants who had not been previously diagnosed with diabetes, and a fasting and 2 hour post Glucaid drink samples were collected for glucose measurement. Plasma glucose was measured using an enzymatic method (Roche Products (NZ)). Participants were classified as having newly diagnosed diabetes mellitus using 1998 WHO criteria using fasting glucose ≥ 7.0 mmol/L or 2-hour post glucose load of ≥ 11.1 mmol/L for diabetes; and fasting glucose < 7.0 mmol/L and 2-hour glucose between 7.8 and 11.0 mmol/L for Impaired Glucose Tolerance (Alberti, Zimmet, & for the WHO consultation, 1998).

Serum cholesterol was measured using an enzymatic method (Allain, Poon, Chan, Richmond, & Fu, 1974) and HDL-cholesterol was measured using a combination of a polyion and a divalent cation (Roche). Serum triglycerides were measured enzymatically. Urinary albumin was measured using an immunoturbidimetric method. Haemoglobin A_{1c} was measured by High Performance Liquid Chromatography on a Biorad Variant II instrument. The inter-batch percentage coefficients of variation for low control material were glucose 2.1, cholesterol 1.4, triglycerides 1.8, HDL 2.0, HbA_{1c} 1.7, and microalbumin 4.8; those of abnormal control were glucose 1.3, cholesterol 1.2, triglycerides 1.2, HDL 2.7, HbA_{1c} 2.1, and microalbumin 3.6.

An Omron-Hem-706 oscillometric blood pressure pulse monitor was used to measure blood pressure two times after the participant had been seated for at least 5 minutes. A person was classified as having raised blood pressure if the mean of the two measured blood pressures was > 140 mm Hg systolic or > 90 mm Hg diastolic, or if they reported taking medication for raised blood pressure.

Weight and height were measured to the nearest 0.1 kg and 0.5 cm, respectively. Body mass index (BMI) was calculated as weight (in kg) divided by the square of height (in m). Obesity was defined as a body mass index > 30 kg/m^2, and overweight as a body mass index between >25 and 30 kg/m^2. The 5 year cardiovascular risk was calculated using the Framingham equation (Anderson, Odell, Wilson, & Kannel, 1990). Occupational class was assigned as the highest of the participant or their spouse using the New Zealand Socioeconomic Index (NZSEI) (Davis, Jenkin, & Coope, 2003). Leisure exercise was assessed using a three-month physical activity recall questionnaire that has been validated (Arroll, Jackson, & Beaglehole, 1991).

Participant data were weighted according to the sampling frame that they were obtained from and means, standard errors, prevalences and odds ratios calculated using dual frame

sampling methodology (Lohr & Rao, 2000; Metcalf, Scott, & Hutchinson, 2005; Skinner & Rao, 1996) using SAS survey procedures (SAS Institute Inc, 2004).

RESULTS

Demographic characteristics are shown in Table 1. Of the Asians, 34.1% were Eastern Asians, 43.2% South Asians, and 22.7% Southeast Asians. There was a significantly lower proportion of males in the Southeast Asian group compared to Europeans. All Asian subgroups reported lower combined family incomes compared to Europeans; the New Zealand Socioeconomic Index (NZSEI) was lower in South Asians; and the mean age was lower in South and Southeast Asians. The median (range) lengths of time living in New Zealand were 7.0 (0-56) years for South Asians, 6.0 (0-65) years for Eastern Asians, and 7.0 (0-19) years for Southeast Asians. Only 2 South Asians and no Eastern or Southeast Asians were born in New Zealand. The proportions of Asian people living in New Zealand for ≤ 5 years were South Asians 44.7%, Eastern Asians 45.5%, and Southeast Asians 35.7% ($p = 0.6442$).

Table 1. Demographic characteristics of 2,020 participants. Asian groups are compared to Europeans.

	Europeans	South Asian	Eastern Asian	Southeast Asian
Number	1741	90	114	60
Age[1] (years)	51.9 (0.17)	48.6 (1.21)**	52.1 (1.89)	44.1 (1.35)***
Males (%)	49.8%	48.1%	47.7%	33.6%*
NZSEI[2]	41.2 (0.39)	36.5 (1.99)*	42.3 (2.54)	41.2 (2.24)
Income ($)[2]	63,317 (636)	48,457 (3447)***	48,621(4098)***	46,104 (3279)***
Tertiary education (%)	66.9%	66.1%	64.0%	69.5%

* 0.01 < p< 0.05; ** 0.001 < p < 0.01; *** p < 0.0001. NZSEI = New Zealand Socioeconomic Index.

1. Adjusted for gender.
2. Adjusted for age and gender.

Table 2 shows mean age and gender adjusted CVD risk factor levels by ethnicity. Compared to Europeans, all Asian ethnic groups had lower weights, heights, hips and alcohol intakes and higher 2 hour post Glucaid glucose concentrations; South Asians had higher triglycerides, systolic and diastolic blood pressure levels, pulse rates, fasting glucose concentrations and waist-to-hip ratios and lower HDL-cholesterol levels and leisure exercise times; South Asians and Southeast Asians had higher HbA_{1c} levels and 5 year risk of CVD; Eastern Asians had lower total cholesterol concentrations; and Eastern Asians and Southeast Asians had lower BMI's and waist measurements.

Table 2. Mean (se) age and gender adjusted levels of continuous cardiovascular risk factors by ethnicity. Asian groups are compared to Europeans.

	Europeans	South Asian	Eastern Asian	Southeast Asian
Number	1741	90	114	60
Systolic blood pressure (mmHg)	120.9 (0.43)	125.9 (1.68)**	123.0 (2.25)	123.8 (2.46)
Diastolic blood pressure (mmHg)	75.0 (0.25)	78.2 (1.09)**	77.5 (1.35)	76.1 (1.42)
Pulse (beats/min)	68.6 (0.26)	71.9 (1.12)**	71.0 (1.26)	70.3 (1.30)
Fasting glucose (mmol/L)	5.2 (0.03)	6.0 (0.24)***	5.5 (0.28)	5.5 (0.19)
2 hr glucose (mmol/L)	5.6 (0.05)	8.2 (0.55)***	7.1 (0.65)*	6.9 (0.58)*
HbA_{1c} (%)	5.5 (0.01)	6.1 (0.13)***	5.8 (0.17)	5.9 (0.16)*
Cholesterol (mmol/L)	5.56 (0.03)	5.57 (0.13)	5.07 (0.12)***	5.45(0.14)
HDL-cholesterol (mmol/L)	1.47 (0.01)	1.33 (0.04)***	1.41 (0.04)	1.43 (0.05)
Triglycerides (mmol/L)[1]	1.22 (1.028)	1.51 (1.171)**	1.13 (1.157)	1.33 (1.181)

Urinary albumin (mg/day)[1]	3.8 (1.043)	3.9 (1.280)	4.3 (1.221)	4.8 (1.339)
5 year risk of CVD (%)	6.0 (0.12)	8.5 (0.64)***	6.2 (0.87)	7.8 (0.65)**
Exercise time (mins/week)[1]	58.4 (1.117)	28.5 (1.712)*	54.6 (1.994)	33.4 (1.808)
Weight (kg)	79.4 (0.40)	70.3 (1.05)***	63.7 (1.30)***	65.4 (1.51)***
Height (mm)	170.0 (0.17)	162.2 (0.69)***	163.4 (0.61)***	163.0 (1.06)***
BMI (kg/m^2)	27.4 (0.13)	26.7 (0.37)	23.8 (0.46)***	24.5 (0.50)***
Waist (mm)	92.4 (0.31)	91.8 (0.95)	83.3 (0.97)***	84.7 (1.19)***
Hips (mm)	106.1 (0.26)	102.7 (0.78)***	96.5 (0.97)***	97.3 (1.01)***
Waist-to-hip ratio	0.87 (0.001)	0.89 (0.006)***	0.86 (0.007)	0.87(0.008)
Alcohol (g/day)[1]	0.7 (1.018)	0.3 (1.083)***	0.2 (1.067)***	0.3 (1.109)***

1. Geometric mean (tolerance factor).
BMI = Body mass index.
* 0.01 < p < 0.05; ** 0.001 < p < 0.01; *** p < 0.0001.

Table 3 shows age and gender adjusted odds ratios by ethnicity. South Asians had higher odds of raised blood pressure compared to Europeans. Southeast Asians had higher odds of being newly diagnosed with diabetes compared to Europeans and South and Southeast Asians had higher odds of having been previously diagnosed with diabetes and of both newly and previously diagnosed diabetes, and impaired glucose tolerance. Unadjusted prevalence of diabetes was 5.2% in Europeans, 20.0% in South Asians, 10.5% in Eastern Asians, and 16.7% in Southeast Asians. Eastern Asians had lower odds of being a current cigarette smoker, and South Asians, Eastern Asians and Southeast Asians were less likely to be ex-smokers. South Asians were more likely to be overweight compared to Europeans. However, all Asian ethnic groups were less likely than Europeans to be obese. South Asians were markedly less likely to report a past history of heart attack, angioplasty, angina or bypass; and Southeast Asians were markedly less likely to report a past history past history of stroke (individual data not shown). There were no significant differences between Europeans and the Asian subgroups for past history of previously diagnosed high blood pressure or impaired glucose tolerance (individual data not shown).

Table 3. Age and gender adjusted Odds Ratios (95% confidence interval) for categorical cardiovascular risk factors by ethnicity. Asian groups are compared to Europeans.

	Europeans	South Asian	Eastern Asian	Southeast Asian
Number	1741	90	114	60
Raised blood pressure[1]	1.00	2.44 (1.51-3.96)***	1.20 (0.68-2.12)	1.79 (0.86-3.73)
Newly diagnosed diabetes	1.00	2.78 (0.84-9.21)	2.96 (0.86-10.14)	4.90 (1.45-16.59)*
Previously diagnosed diabetes	1.00	3.22 (1.51-6.85)**	1.44 (0.45-4.63)	5.72 (1.05-14.78)***
Total diabetes	1.00	3.28 (1.67-6.48)***	2.01 (0.81-4.98)	6.12 (2.88-13.02)***
Current smoker	1.00	0.69 (0.33-1.46)	0.14 (0.03-0.47)**	0.97 (0.41-2.09)
Ex-smoker	1.00	0.41 (0.23-0.71)**	0.27 (0.14-0.69)***	0.27 (0.11-0.69)**
Overweight	1.00	1.94 (1.19-3.15)**	0.59 (0.33-1.07)	0.63 (0.33-1.20)
Obese	1.00	0.41 (0.21-0.81)**	0.06 (0.01-0.43)**	0.20 (0.06-0.69)*

* 0.01 < p < 0.05; ** 0.001 < p < 0.01; *** p < 0.0001.
1. Systolic blood pressure > 140 or diastolic > 90 or on blood pressure lowering medications.

DISCUSSION

South Asians had the most adverse cardiovascular disease risk profile and highest 5 year risk of a CVD event compared to Europeans, followed by Southeast Asians. Newly diagnosed cases of diabetes mellitus were higher in Southeast Asian and previously diagnosed diabetes

was higher in South and Southeast Asians compared with Europeans. Exercise times were lowest in South Asians. Combined family income was lower in all Asian subgroups.

In the current study only South Asians had higher systolic and diastolic blood pressure levels and higher odds of raised blood pressure compared to Europeans. However, past history of heart problems, stroke or diagnosed raised blood pressure were not significantly different between Europeans and South Asians. The 1988-90 Workforce survey reported higher odds of hypertension in Asians compared to Europeans, but systolic and diastolic blood pressure levels were not significantly different (Scragg et al., 1993a). In addition, the 2002/2003 New Zealand Health Survey reported a lower risk of self-reported diagnosed hypertension in Asians compared to the other New Zealand ethnic groups (Ministry of Health, 2004), though this was not significantly different between the Asian subgroups (Scragg & Maitra, 2005). However, the latter survey reported a significantly lower prevalence of self-reported heart disease in Asians than other New Zealanders (Scragg & Maitra, 2005), a finding only found in Eastern Asians in the current survey. The finding of higher pulse rates in South Asians does not appear to have been reported previously.

Eastern Asians had lower mean cholesterol levels compared to Europeans, whereas South Asians had higher triglyceride levels. The Workforce Diabetes Survey found no significant differences in serum cholesterol or triglyceride levels between Asians and Europeans (Scragg et al., 1993b). While Asian people had a similar prevalence of treated high cholesterol to other New Zealanders (Ministry of Health, 2004), South Asians had a higher prevalence of treated high cholesterol than other Asian people (Scragg & Maitra, 2005). However, we did not examine whether cholesterol levels were treated or not. The lower mean HDL-cholesterol observed in South Asians in the current study has been observed previously in a predominantly Punjabi Sikh group in Britain when compared with Caucasians (Gama, Elfatih, & Anderson, 2002).

South Asians had higher fasting glucose levels compared to Europeans and all Asian ethnic subgroups had higher 2 hour glucose levels. However, there were ethnic differences for newly diagnosed diabetes with Southeast Asian having higher odds, and for previously diagnosed diabetes with South and Southeast Asians having higher odds compared to Europeans. Both South and Southeast Asians also had higher Haemoglobin A_{1c} levels. The higher risk of both newly and previously diagnosed diabetes was consistent with the higher odds of diabetes among Asian people in the Workforce Diabetes Survey compared to Europeans (Scragg et al., 1991), and the higher self-reported prevalences of diabetes among Asians in the 2002/2003 New Zealand Health Survey (Ministry of Health, 2004), and the later Asian subgroup analysis where the highest prevalence was in South Asians (Scragg & Maitra, 2005) compared to the European and other Asian subgroups. The South Auckland Study also reported the highest prevalence of known diabetes in South Asian people and the lowest prevalence among Chinese (Simmons et al., 1999).

South Asians reported significantly less minutes of exercise time per week. The 2002/03 New Zealand Health Survey reported that Asian people were significantly less physically active than Europeans (Ministry of Health, 2004), and that South Asian women were less likely to be physically active than other Asian women (Scragg & Maitra, 2005). A review of British studies also reported that levels of physical activity (light, moderate or vigorous) were lower among South Asians than the general population (Fischbacher, Hunt, & Alexander, 2004). For example, the Newcastle study reported above found, for men, that 71% of Indians, 88% of Pakistanis and 87% of Bangladeshis did not meet current physical activity guidelines compared with 52% of Europeans (Hayes et al., 2002). Physical activity by Asians has been shown to be associated with reduced serum insulin, body mass index and triglycerides, and to have a favourable effect on systolic and diastolic blood pressure (Dhawan & Bray, 1997).

Eastern Asians were less likely to be current cigarette smokers than Europeans, and South, Eastern and Southeast Asians were less likely to be ex-smokers. The 2002/03 New Zealand Health Survey found that Asian women were less likely to smoke than women of other ethnicities, while the prevalence of smoking by Asian men was similar to European men (Ministry of Health, 2004), but there were no significant differences between the Asian subgroups (Scragg & Maitra, 2005).

Mean weights and heights were significantly lower in all of the Asian ethnic groups compared to Europeans. However, BMI was significantly lower in Eastern and Southeast Asians only. Mean waist-to-hip ratio was higher in South Asians compared to Europeans. The prevalence of overweight was higher among South Asians, and the prevalence of obesity was lower in all Asian ethnic groups. The 2002/03 New Zealand Health Survey also reported that Asian participants had a lower prevalence of obesity than all other ethnic groups (Ministry of Health, 2004). Comparisons with the Chinese group in the latter survey found higher BMI, waist measurements, obesity and overweight in South Asians and higher BMI in Southeast Asians (Scragg & Maitra, 2005). However, a recent review concluded that the BMI of Asians was 3-4 units lower than that of Caucasians at the same body fat percentage (Deurenberg, Deurenberg-Yap, & Guricci, 2002).

South Asians had a lower NZSEI score than Europeans. While there were no significant differences between ethnic groups for obtaining tertiary education, mean family household income was lower than Europeans for all Asian groups. It has previously been reported that Asian people have the lowest median personal income (Statistics New Zealand, 2002). The 2002/2003 New Zealand Health Survey also reported that Asian people were more likely to live in low income households compared to other New Zealander, but that South Asians had higher incomes than the other Asian ethnic groups (Scragg & Maitra, 2005). A British study has reported an inverse association between socioeconomic status and CVD among South Asians (Bhopal, Hayes, White et al., 2002).

All Asian ethnic groups drank less alcohol compared with Europeans. This findings was also observed in the 2002/2003 New Zealand Health Survey (Ministry of Health, 2004), but there were no differences between the Asian communities (Scragg & Maitra, 2005).

The major strength of the current study is that it was a community-based sample. Limitations to the current study include the collection of a single measure of cholesterol, HDL-cholesterol and triglycerides, the measurement of blood pressure on a single occasion, and that cigarette smoking information was based on self-report. A major limitation of the current survey was the relatively small numbers of Asian people so that analyses by gender would have had very low power. Therefore, genders have been combined.

Levels of CVD risk factors showed a wide variation between the Asian ethnic groups, and the most adverse pattern were in South Asians. Diabetes-related risk factors were generally more common among Asians than Europeans. Larger studies of CVD and diabetes-related risk among Asians living in New Zealand are required to substantiate these findings. The most easily modifiable risk factor would be to increase leisure time physical activity.

ACKNOWLEDGMENTS

We thank the technical and clerical staff who conducted the study so capably and efficiently; the people of Auckland for participating; and North Shore and Waitakere Hospitals, Te Pai Netball Centre, Takapuna District Cricket Club, Belmont Rose Centre, Glen Eden Ceramco Park Centre, Nga Tapuwhai Community Centre, Trust Health Care, Manuwera Nathan Homestead, Otara Leisure Centre (Te Puke O Tara Community Centre) and the Mangere

Town Centre for providing examination rooms. This survey was funded by the Health Research Council of New Zealand.

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SCOPING THE ISSUES OF ELDER ABUSE AMONG ASIAN MIGRANTS

Hong-Jae Park

ABSTRACT

Elder abuse has become an emerging social concern in New Zealand, as in other countries. As the Asian population is rapidly growing in New Zealand communities, the aim of this literature review is to identify what is known about the nature, prevalence and consequences of elder abuse and neglect among Asian older people crossing cultures. An electronic literature search was performed in computerized bibliographic databases such as ProQuest, Medline and Expanded Academic ASAP. The review also included published books as well as materials produced by governments and non-governmental organisations.

The majority of the studies with Asian ethnic groups support the notion that elder abuse is prevalent among Asian migrants and that their abuse cases are likely to be unreported in host societies. A few research articles, mainly conducted with Asian Americans, deal with ethnic differences related to the perception of elder abuse and attitudes toward the involvement of outsiders in abuse issues. However, there is a paucity of writing on elder abuse and neglect among Asian migrants. No research on the topic involving the Asian population in New Zealand has yet been found. Results of the literature review imply that elder abuse and neglect among Asian-New Zealanders could be a serious problem that remains hidden, in particular, due to the cultural characteristics and social situations of ethnic minority groups.

Park, H-J (2006). Scoping the issues of elder abuse among Asian migrants. In S. Tse, M.E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp.50-56). Auckland, New Zealand: University of Auckland.

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INTRODUCTION

Elder abuse and neglect has been an emerging social concern that “directly and indirectly impact on a significant proportion of people living in New Zealand today” (Schofield, 2004, p.93). Abuse of older people is a violation of human rights that undermines victims’ physical, psychological and social wellbeing. The phenomenon occurs indiscriminately across cultures, races and social-economic backgrounds and cases of elder abuse are likely to go unreported (WHO/INPEA, 2002; National Center on Elder Abuse, 1998). Although there are no population-based studies in New Zealand, it is generally assumed that elder abuse becomes prevalent as a population grows older (Fallon, 2006; Fanslow, 2005). The situation may be no less true among Asian ethnic groups in New Zealand. Coupled with the growing population, the prevalence and incidence of elder abuse among Asian older people are assumed to be increasing. Furthermore, they may be vulnerable to abuse and neglect in their new environment where they face multiple challenges, such as adaptation difficulties, ageism or racism.

This study aims to examine through exploring the literature currently available what is known about the nature, prevalence and consequences of elder abuse among Asian migrants living in foreign countries. The main concern of this review is to learn from elder abuse studies conducted with Asian older people in western countries, since no local research on the topic into the population has yet been found in New Zealand. The research questions include (1) Is abuse of older people among Asian migrants prevalent in host societies? (2) Do their traditional cultures impact on how they perceive elder maltreatment? And (3) are they likely to be reluctant to seek support outside the family?

Background on Elder Abuse in Asian Cultures

In traditional Asian cultures, respect for older adults is strongly advocated in society (Kramer, Kwong, Lee, & Chun, 2002). Older people, especially the male elderly, have power and status with their resources and experiences in the patriarchal traditions. Caring for aging parents, known as filial piety, has been enhanced and glorified as a strong value for family life (Wong, Yoo, & Stewart, 2006). A great emphasis has been placed on family harmony, along with mutual support and interdependence, maintained by adhering to the hierarchical family structure (Malley-Morrison & Hines, 2004). Conflict avoidance among family members has been valued over individual freedom or wellbeing while suffering and endurance are often recognised as a path to maturity (Rittman, Kuzmeskus & Flum, 1999). Problems are generally supposed to be solved within the family and seeking assistance outside the family tends to be restricted by the desire to avoid losing face in the community (Moon & Williams, 1993).

Traditional values are changing in many Asian cultures. For example, the practice of filial piety has fewer adherents than previously as there is an increasing number of westernised nuclear families in today's Eastern cultures (Hashimoto & Ikels, 2005). Practising appropriate caregiving may be difficult for many Asian immigrant families facing adaptation stress, language barriers and inaccessibility to health and social services (Yu, 2002). The traditional care for aged parents in families can become recognised as a possible source of burden in their host society. In these circumstances, it may not be surprising to assume that there are many risk factors related to elder abuse and neglect for Asian families due to resettlement difficulties along with impediments to the traditional filial values in their new country.

METHODS

This literature review involved a critical survey of what has been written on the elder abuse issue among Asian migrants over the last 15 years. The review mainly incorporated scholarly articles and books, but papers and reports produced by governmental and non-governmental organisations have also been explored to capture the practical issues of elder abuse. The research was limited to literature written in English so as to focus on studies with Asian migrants living in English-speaking western countries such as the United States, the United Kingdom, Canada and Australia. Web-based materials were largely used in order to gain comparable data as the Internet holds a wealth of information generated around the world.

Databases searched included ProQuest, Medline, PsycINFO, Scope and Expanded Academic ASAP from June 1991 to May 2006. For clarifying the scope of this research, the term 'Asian migrants' was defined as people living in some western countries with origins from Chinese, Korean and Japanese to Filipino, Vietnamese and Indian, following the Statistics New Zealand definition adopted in 1996. A variety of search terms were used, including 'elder abuse', 'adult abuse', 'elder mistreatment', 'Asian', 'Chinese', 'Indian', 'Korean', 'Filipino', 'Japanese', 'culture' and 'minority'. The literature search yielded 14 citations focusing specifically on elder abuse and neglect among Asian migrants living in foreign countries. In order to broaden the picture of elder abuse, the review also included

some mainstream literature that in general covers elder abuse among majority populations and partially contains information on the issue involving Asian immigrants.

FINDINGS

Nature of Elder Abuse among Asian Migrants

The majority of the studies searched accept the notion that behaviours perceived as elder abuse vary across ethnic groups since cultural factors play a large role in how people treat older people (Fallon, 2006; Kozak & Lukawiecki, 2001; Moon & Benton, 2000). This awareness partially stems from the recognition that existing definitions of elder abuse have been developed in western societies and, therefore, they might be inapplicable to Asian migrants who possess different cultural values and norms (Tatara, 1999). Cultural factors, such as emphasis on endurance in Asian families, can contribute to difficulties in perceiving and defining abusive behaviours as elder abuse or mistreatment (Moon & Williams, 1993; Tatara, 1999). In a study including Korean Americans, African Americans and white elderly women, the Korean elderly participants appeared as more tolerant of elder mistreatment than the other groups (Moon & Williams, 1993). Similarly, Japanese Americans were the most reluctant to perceive a situation as elder abuse among four groups including whites, African Americans, Japanese Americans and Puerto Ricans (Anetzberger, Korbin, & Tomita, 1996).

Elder abuse is a hidden problem in Asian immigrant communities, likewise in other cultures (Le, 1997; Moon & Benton, 2000; Moon & Williams, 1993; Moon & Evans-Campbell, 1999; Moon, Tomita & Jung-Kamei, 2001; Tomita, 1999). Cultural characteristics of a collectivism tradition and lower expectations of others may hinder Asian migrants who suffer elder abuse in reporting abusive situations to others. Such reluctance may also be caused by the 'shame culture' that often leads Asian families to hide shameful situations from the public. For example, Korean American migrants have negative attitudes towards seeking assistance or support from professionals (Moon, 2000). Tomita (1999) argued that Japanese Americans have a strong sense of 'we-self' which is deeply rooted in the Japanese culture. She believes such a collectivism tradition prevents Japanese elders from discussing with outsiders abusive behaviours that would dishonour their community in the host society. These findings are closely allied with reliable local studies showing that elder abuse is underrepresented in the Asian population in New Zealand (Age Concern New Zealand, 1999; 2002; 2004; 2005).

Extent of Elder Abuse among Asian Migrants

There is a dearth of population-based studies examining the incidence and prevalence of elder abuse among Asian immigrants whilst a general estimation shows between two per cent and ten per cent of the older population have been abused (Lachs & Pillemer, 2004). The majority of studies involving Asian migrants have concluded that there is no evidence that Asian migrants experience less elder abuse or maltreatment than other groups do in host societies (Malley-Morrison & Hines, 2004; Moon, 2000). Rather, studies indicated that a considerable portion of the research sample was aware of the problem of elder abuse and that psychological abuse and neglect are extensive in their community. For instance, Le (1997) confirmed the existence of elder mistreatment in the Vietnamese community in the United States. Chang and Moon's study (1997) showed that 36 out of 100 Korean American participants identified 46 incidents in the community as elder abuse. Proclivity to psychological abuse and financial exploitation, including free labour for housework, was more common in this group, while physical abuse was rarely reported (Moon, 1999).

No systematic research focusing on specific factors that may place Asian migrants at greater risk of elder abuse has been found. There is a general suspicion, however, that migrant older people are more vulnerable to elder abuse and neglect than non-migrant populations in society (Moon & Williams, 1993). Tomita (1999) suggested that the high level of alcohol use

among Japanese Americans, along with male dominance behaviours supported by their traditional culture, was significantly associated with elder abuse, in particular, sexual abuse in the community. An Israeli study (Lecovich, 2005), not involved with Asians but studying Russian elderly migrants, confirmed that being a new immigrant was found to be a significant predictor of physical abuse and neglect. The researcher pointed out specific risk factors for migrants, such as the difficulties of adaptation to a new and unfamiliar environment, dependency of the elderly person on other family members, and inaccessibility to services due to communication problems.

Consequences of Elder Abuse among Asian Migrants

The effects and consequences of elder abuse among Asians are seldom studied. A limited amount of information has been found in relation to the physical and psychological effects of elder abuse in the Asian populations. In a small sample of maltreated Vietnamese elders in California, Le (1997) argued that almost all of the abused respondents were isolated with a high level of anxiety and depression. Korean immigrant victims of abuse were found to be likely to blame themselves for the occurrence of elder maltreatment in an American study (Chang & Moon, 1997). They were inclined to believe that elderly parents who were abused by adult children contributed to the abusive situation and, then, partly deserved being abused. Moon (1999) cited a case of financial abuse that had resulted in the death of a Korean older person from malnutrition and depression.

DISCUSSION

Very little is known about the nature, prevalence and consequences of elder abuse in Asian immigrant populations around the world. Although the majority of the studies support the notion that differences exist among ethnic groups in the definitions and perceptions of elder abuse, it is not always clear how cultural characteristics play a role in these differences. The degree of acculturation to the host society may be more important in people's perceptions of elder abuse and help-seeking patterns than their ethnicity or cultural influences (Pablo & Braun, 1997). Added to this, a number of factors, such as income, living arrangements and educational levels, may also affect the risk of elder abuse among Asian migrants who experience a range of life stressors in their new circumstances (Moon, 2000).

Although there is virtually no research on how elder abuse affects the social meaning of Asian older people's lives, it is clear that a harsh atmosphere in the family can adversely affect Asian older people's social functioning. If ageism is a major cause of elder abuse and if elder abuse caused by ageism is exacerbated by racism (International Longevity Center, 2006), the effects of elder maltreatment will marginalise the abused elderly as the least advantaged members of society, and force them to become invisible in their unfamiliar environments. Within such a discriminative climate, older people's adaptation or acculturation can be severely hindered (Kim, 2001). Victims of abuse can be less able to adapt to a host society and its cultural patterns. They can be left socially isolated without support systems. Some of victims may return to their home countries while others remain in their abusive families.

Overall, findings of foreign studies may parallel the realities experienced by Asian older people in New Zealand. The lack of research in this area does not imply that elder abuse does not exist among them. In particular, elder abuse among Asian migrants is a sensitive, complex issue that requires a sound understanding of its nature, causes and consequences in the social, cultural and political contexts (Daichman, 2005). Further studies that lead to more dialogue within the society are sorely required since "a lack of New Zealand research severely limits the knowledge base about abuse and neglect that can be built up in this country" (Schofield, 2004, p.94).

CONCLUSION

Elder abuse is all about human beings; it has a long history, and it can happen anywhere, whether older people live in their home country or in a host country. Even in Asian cultures that value filial piety and respect for older people, elder maltreatment does occur. Asian elderly immigrants may experience a multiple jeopardy caused by their age, or ageism, and being a member of an ethnic minority, or racism, in their difficult host society. “Their eyes are blind because they can’t read English,” a social worker says, “Their ears are deaf because they do not understand English. Their mouths are mute because they do not speak English” (Manigbas, 2002, p.70). It could be said that Asian older people have been almost forgotten in their host society, while other older people are struggling against becoming invisible in their own society. Such conditions, along with the cultural characteristics, can become fertile ground for the seeds of elder abuse among Asian older people crossing cultures. Despite existing studies in this area being extremely limited, results of the literature review imply that elder abuse and neglect among Asian New Zealanders might be a serious, silent social problem remaining hidden in the mainstream community.

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THE ASIAN MENTAL HEALTH SERVICE OF ADHB, WHAT WE HAVE LEARNT FROM THIS INNOVATIVE MODEL

Sai Wong and Patrick Au

ABSTRACT

The Asian population is growing in the Greater Auckland area and is the second largest group in the Auckland District Health Board (ADHB) and Waitemata District Health Board areas (Census 2001). A review of the utilisation rate of Asian users of mental health services from both District Health Boards did not, however, reflect any growth in demand. A number of projects at the government level have recently been initiated to address the mental health needs of the Asians; these reports highlighted the importance of developing a workforce that can meet the clinical and cultural needs of this ethnic group. To date, resources both at the government level and the community level remained limited. Clinicians in Auckland have been requesting assistance to work with Asian users because of the language and cultural barrier.

In consideration of these needs, ADHB has recently set up an Asian Mental Health Service to provide liaison, consultation, clinical support and coordination services to the Mental Health Clinicians within ADHB. Although there is a wide cultural diversity within the Asian culture, Chinese feature as the biggest group, and therefore Chinese became the main group of clients that the Asian Mental Health Service have been involved in.

This presentation is to introduce to the participants: how this innovative model is different from the traditional working model, what make the model effective, how this Service addresses the clinical and cultural needs of the Chinese community and general feedback from the Clinicians. The presentation will also provide a summary of the challenges that the Clinicians and the Asian Mental Health Service are currently facing while working with Asian clients.

Wong, S., & Au, P. (2006). The Asian mental health service of ADHB, what we have learnt from this innovative model. In S. Tse, M.E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp. 57-65). Auckland, New Zealand: University of Auckland.

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INTRODUCTION

Engaging Asian migrants in Mental Health Services is considered challenging to the clinicians of the mainstream mental health services due to cultural stigma, the myths attached to mental disorder, a lack of understanding about mental health and traditional views on the cause and origin of mental health problems. Migrants are at risk of developing mental health problems due to language, cultural problems and other migration related psychosocial problems such as unemployment and change in social status (Ho et al., 2003).

The Asian Mental Health Service was developed based on the population needs analysis and the feedback from Asian clinicians working in the “mainstream” Mental Health Services. This

Service is possibly the first of its kind in New Zealand and the model of delivering this Service is also innovative.

This paper aims to provide the background information leading to the development of this innovative Service. Detailed discussion of the service delivery model is provided. Owing to the tight timeframe in submitting the paper for the Book of Proceedings, this paper is considered *"work in progress"*. Feedback evaluation of the Service is being undertaken. Users' feedback will be reported at a later stage.

The Healthcare System in New Zealand And Population Distribution

Over the past 10 years, New Zealand has become more global and "multi-ethnic". The Country has recently completed its Census in 2006; the finding is yet to be announced. The population distribution statistics used in this paper are based on the 2001 Census as the 2006 results are not yet available. Census 2001 reported that Asian, being the most culturally diverse group is the third largest population in New Zealand after Caucasian and Maori.

There are 21 District Health Boards (DHB) in New Zealand. Each DHB receives separate funding from the Government to offer health services to meet the needs of their local communities.

The Auckland Region has the highest and most diversified population amongst all the major cities in New Zealand. Within the migrant populations, about 65 percent of all Asian people in New Zealand reside in the Auckland Region (Statistics New Zealand, 2001). Due to its population distribution, three DHB's are established in the Auckland Region, they are the Auckland District Health Board, which covers the Central City Auckland area, the Waitemata District Health Board which covers the Northern and Western side of Auckland and the Counties Manukau District Health Board which provides health services to the Southern part of Auckland.

Asian is the second largest ethnic group (after Caucasians) in Auckland. Within this culturally diverse group, Chinese is the biggest subgroup and they accounted for over 40 percent of the Asian population among each of the three DHB. There are four types of Asians in Auckland, those who were born in New Zealand, the migrant populations, the International students who stay temporarily in New Zealand to complete their education and those who do not hold a New Zealand residency of any kind. The figures that were shown above do not cover the last two groups of Asians.

Utilisation of Mental Health Services

Among the three DHB in the Auckland Region, the Auckland District Health Board has the highest Asian population, more than one quarter (about 27.9 percent) of the ADHB overall population is of Asian ethnicity (Statistics New Zealand, 2001).

Utilisation figures for Auckland Mental Health in-patient and community services over the past decade have indicated a trend of increasing utilisation among most of the ethnic groups. However, despite the increase, some sectors of the population (e.g., Chinese) have shown a utilisation rate that is substantially below that of others, for example, despite Asian being the second largest ethnic group in the Auckland District Health Board area, the utilisation rate was 8.7 percent comparing to 64.1 percent for Europeans and 12.4 percent for Maori people. These trends have raised the concern that there are an increasing number of our clients from other ethnicities not being catered for. More importantly, there are still barriers to access from a significant sector of our population mix (i.e., Chinese). These latter barriers were delineated in the Waitemata survey of 2001 (Ngai et al., 2002) which concluded that language barrier

and cultural sensitivity of the service remain barriers to both patients and staff.

The New Zealand Health Information Service (2006) which provides a national survey of number of clients having been seen by the Mental Health Services in 2003 reviewed that Asian people constitute only two percent of the overall utilisation rate.

Ho et al (2003) in their literature review of the mental health needs and utilisation of mental health services by Asians suggested that their low utilisation rate does not reflect that they have good mental health. This argument is supported by Rasanathan et al (2006) in their latest survey on the health profile of young Asian New Zealanders. In their research, Rasanathan et al discovered that more than 15 percent of the participating young Asians expressed significant depressive and anxiety symptoms. More than 20 percent of this group of young people who reported depressive and anxiety symptoms also reported associating suicidal thoughts.

Ho et al (2003) identified a number of barriers that could have contributed to the low utilisation rate. These factors included language barrier, lack of cultural appreciation by the mainstream services and the negative cultural stigma adopted by the Asian clients.

McDonald & Steel (1997) when they conducted the epidemiological studies on migrants and refugees in New South Wales, Australia, commented that "t*he lowest rates of hospitalisation for mental disorders were for people from NE Asia, followed by SE Asian, Southern Asia.*"**.** The same literature also remarked that "*those countries which have relatively low rates of hospitalisation also have relatively low rates of utilisation of community MH Services*" (pxiii).

Staff Workforce Mix

An informal survey conducted in 2001 in Counties Manukau District Health Board indicated that 38 percent of psychiatrists and 33 percent of the registrars are from overseas. The study did not extend to other clinicians. Although this survey was not repeated in the other DHB in Auckland, it is envisaged that the figures would be similar, if the workforce mix is not even more diverse. It is also not unusual for clinicians being used to work with clients who come from the same ethnic group as themselves. Whilst on the positive side, it might indicate that the Mental Health Services have an inbuilt resource to provide a cross-cultural perspective to the clinical management of patients, the above practice is considered temporary. The more urgent need is the training of all staff from various ethnic backgrounds to be proficient in other cultures to deliver an integrated culture appropriate Service.

It is the authors' understanding that, to date in New Zealand, no formal study has been undertaken to survey the ethnicities of clinicians. The result of this type of study can help in workforce development, service planning and training of mainstream and minority clinicians.

Implication for Service Development for Asian People

From the above evidence, it is concluded that:

1. There is no doubt that there are increasing demands on the Mental Health services in the Auckland region to serve a population of mixed ethnicities.

2. The Mental Health service is not perceived as culturally appropriate for consumption by a significant sector of the minority population.

3. There is an increasing need from both clients and staff perspective for the development of a multiethnic appropriate service, targeting the migrant population including Asians.

4. There is, in existence, a strong multiethnic psychiatric work force which could serve as a basis for the updating and future development of integrated cross culture care. From a wider perspective, the existing staff could also form a nexus for further development of expertise and training in cross cultural psychiatry in New Zealand.

THE ASIAN MENTAL HEALTH SERVICE OF AUCKLAND DISTRICT HEALTH BOARD

After about eighteen months of project work undertaken by Asian clinicians and one non-Asian Manager, some funding was achieved and the Asian Mental Health Service was established in January 2006. Part of the ethos of the service is that is remains mainstreamed with current service delivery.

The Service Model

A care service is conceived as comprising of three key components: *the therapeutic strategies, the staff and systems to deliver*. The authors believe that each of these three components could be modified to make it become culturally appropriate for Asian people.

Modification to the three components to render the existing Mental Health Services culturally appropriate includes:

a. *Therapeutic Strategies* Research and experience would help to modify therapeutic strategies to render them culturally acceptable and effective; viz.
b. *Staffing* Training of staff to increase their cultural sensitivity, awareness, skill and knowledge would make them more effective in practising psychiatry across the ethnic divide.
c. *Delivering systems* The delivery system could also be modified so that it would be both appropriate and, more importantly, cost-effective to provide a culturally integrated service.

Background Data Significant to Modification of The Above Three Components

A. *Literature survey relating to modules of Service delivery*

In a survey of the literature, there are four different models stretching along a continuum illustrated (Figure 1).

Figure 1. Four models of services delivery.

On the extreme left is a unitary service that is developed with the predominant culture in mind. In between are the services with multiethnic staff and the more dedicated one with specialist team that could be called upon when needed to render an appropriate service. Lastly to the extreme right are dedicated units catering only to the needs of special populations.

There are advantages and disadvantages of each. The unitary service is economical but exclusive and unable to provide an acceptable and easily accessible service to the other ethnic groups. On the other hand, dedicated units might provide highly specific and cultural appropriate services. But the drawback is that they would still be exclusive and at the same time not encourage integration. Also from a practical point of view, the development of special units for each and every one of the ethnic groups would

overwhelm the resources of the system.

The two intermediate models represent culturally integrated services versus those with multiethnic staff or specialist teams working alongside the main stream staff. Those types of services would have a bridging function to help to integrate ethnic minorities into society and at the same time provide cross fertilisation, helping the main steam services to advance the embellishment of their skills and treatment strategies. The end result is that the mainstream service would also learn from these ethnic teams, broadening their range of treatment strategies.

B. *Local data*

Whilst the choice of models depends on local needs, three sources of information support the development of a cross cultural team (i.e., the intermediate two types of integrated service)

Searches into the literature have revealed that most of the culturally appropriate services have multiethnic staff on their teams. They are found to be most effective. The majority of these papers favour an integrated approach. There is also a consensus from the mental health professionals of both the Auckland District Health Board and Counties Manukau District Health Board that favoured a cross cultural practice i.e., an integrated Service and that in order to do this, the training of staff, the provision of an appropriate interpreting service, and a culturally appropriate MOPs programme to maintain quality; and access to specialists and resources from other cultures for liaison consultation, would be necessary.

The above sources of information have thus shown that the most practical and expedient model for a cross cultural service would be to form a team that could provide training, co-ordination and liaison.

Functions of the Asian Mental Health Service

The Asian Mental Health Service serves the following three functions:

a. Modifying the existing delivering system by rendering the Service culturally appropriate. To do this, the clinicians of the Asian Mental Health Service provide consultation/ liaison to mainstream clinicians and the service can be extended to a direct service delivery if needed. Other services include the exploration and networking of resources to assist the mainstream services for management and treatment planning.
b. Staff training. The aim is to increase cultural awareness, knowledge, skills and provide quality maintenance programmes.
c. Research. To stimulate and co-ordinate research into the effectiveness of various treatment modalities (including traditional practices), and to adapt these to transcultural practice.

The following is a detail discussion of the various functions of the Asian Mental Health Service:

A. *Delivering appropriate service*

a. The development of a resource database, which would provide information on
    - A list of staff from various units within and outside the Auckland District Health Board mental health services who can function as advisors and resource person in the day-to-day management of patients
    - Access to information on appropriate treatment for both traditional and occidental treatment

- A list of organisations which would provide a culturally appropriate service which the staff could draw upon.

b. Liaison consultation (indirect) This comprises of two functions :

- Indirect consultation by advice through telephone or other media.
- Recruitment and co-ordination of a network which could provide direct culture / specialty appropriate service for the patient. In this, the team functions as a co-ordinator, working along with the existing key workers and community facilities for patients and external networks e.g., GPs, main stream Service, community centres.

  In this co-ordination role, the Team seeks to build up working relationships both internally and externally in the fashion depicted in Figures 2 and 3.

Figure 2. Internal net-working.

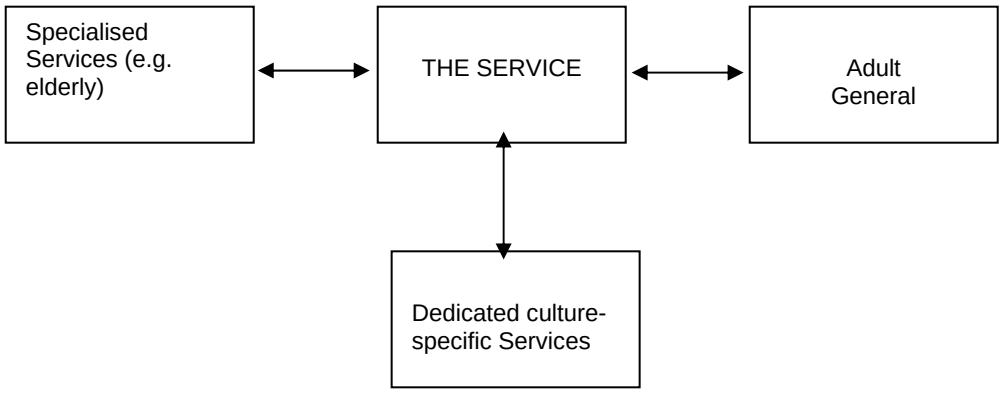
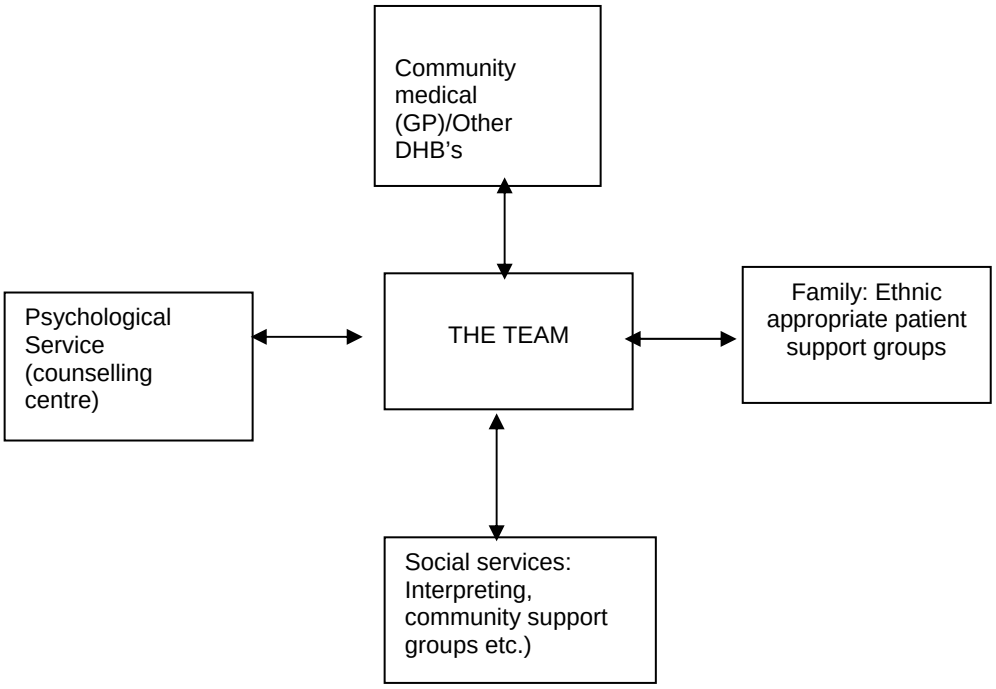


Figure 3. External net-working.



c. Direct Service: When resources allow, the Service performs the following functions:

- Direct single assessment, consultation and advice on management and Care Plans
- Monitoring for progress through indirect consultation
- Progress follow-up through direct reassessment with recommendations for further management.

B. *Staff training*

This aims to promulgate interest, knowledge and skills in cross cultural practice of psychiatry amongst trainee registrars, nurses and other staff. This is an area that is increasingly significant but not sufficiently emphasised at present.

A training programme has recently been developed and has been delivered across the three DHB. Content of this Programme includes Culture awareness, Cross culture knowledge, Issues in assessment/rapport and Issues in management as well as how to work with interpreters.

C. Research

It is the long term plan of the team to facilitate research and cooperate together with various organisations such as the Department of Psychological Medicine, the Cross Cultural Interest group and the Chinese research group of the Auckland University of Technology.

THE STRUCTURE OF THE SERVICE

There are two components:

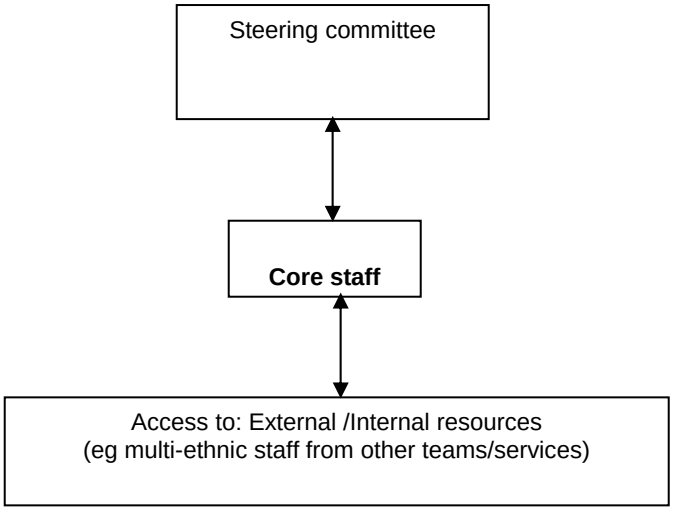
Core Developmental Staff

The team currently serviced by one Co-ordinator (Nurse Specialist) and 0.5 FTE Consultant Psychiatrist

Steering Committee

The core team is currently under the guidance and support from the Asian Users of Mental Health Service steering committee of the Auckland District Health Board. The Committee meets once every month. The core staff seek advice from and report back to the steering committee (Figure 4).

Figure 4. Steering committee and the core team relationship.



Service to date

As of the end of August 2006, the Asian Mental Health Service has been involved in working with more than 30 clients. Clients were referred from different mental health settings including the Adult Inpatient Service (Te Whetu Tawera), the four Community Mental Health Services, Child, Adolescent Inpatient and Community Services (Kari Centre), and Mental Health Services for Older People. Services required included direct and indirect consultation, liaison and co-therapy with the mainstream clinicians.

Training is a major part of the Service. This Service has recently been involved in training the Interpreters and Mental Health Practitioners from the three District Health Boards in Auckland. Other than training the mental health professionals, the Service has also conducted a series of training to a group of General Practitioners. The Service also identified a number of service gaps and has taken steps to rectify them with success.

The Service is in the process of developing a database of Asian professionals. The Service is endeavouring to work closely with the other non government organisations and DHB's in Auckland to compile an updated resource.

Service Evaluation

Due to time constraints, users' feedback was not obtained. A summary of the feedback evaluation will be presented at the conference day.

CONCLUSION

To mainstream clinicians, working with Asian is challenging because of the perceived cultural barriers and their lack of understanding of Asian cultures. It is not unusual for mainstream workers to be doubly cautious while working with Asians, making the treatment process more time consuming and possibly unnecessarily delayed. To the Asian Service Users, seeking help from mental health services is challenging due to cultural taboos, their perception that the mainstream services do not meet their needs, a lack of understanding of the health and legal systems and language difficulties. The clinicians working in the Asian Mental Health Service serve to bridge between the clinical and cultural gap.

The Asian Mental Health Team functions differently from other culturally specific services in

Auckland in that the Team's emphasis is on building up the skills of the existing workforce by providing a "consultation/liaison service" and training. Mainstream clinicians can then continue to work with their clients and be their primary clinicians. In this new model, the cultural and clinical advisory supports have the advantage of minimising the cultural barriers between the providers and the users without compromising the clinical expertise of the providers and the strengths of the users.

This Service would like to thank the Management Team of the Mental Health Services of Auckland District Health Board for their foresight and courage to set up this innovative model.

Although the demand to the Service remains high, the service is still in its infancy stage. There are rooms for improvement. Our Team would welcome the input and advice from any agency.

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OBESITY IN NEW ZEALAND ASIAN CHILDREN

Scott Duncan, Elizabeth Duncan, Grant Schofield and Elaine Rush

ABSTRACT

The prevalence of childhood obesity is increasing rapidly in many countries. In New Zealand, approximately one in three children are classified as overweight or obese according to international body mass index (BMI) standards. Despite these alarming statistics, our understanding of obesity in New Zealand Asian children is limited. The objective of this study was to compare the body composition of East Asian and South Asian children with those from other ethnic groups.

A total of 1247 East Asian, South Asian, European, Maori, and Pacific Island children (616 male, 631 female) aged 5-11 years participated in the study. BMI was determined from height and weight, and percentage body fat (%BF) was measured using hand-to-foot bioelectrical impedance analysis.

Using international age- and sex-specific BMI cut-off points, the prevalence of overweight and obesity was 14.3% and 4.1% (respectively) in East Asian children, and 11.1% and 5.1% in South Asian children. These estimates were significantly lower than those observed in Maori and Pacific Island groups, but similar to those observed in Europeans. However, South Asian children averaged 3.8% (boys) and 4.2% (girls) more body fat than European children at a fixed BMI and age. After adjusting for ethnic differences in %BF, a 4.2-fold increase in the prevalence of obesity (5.1% to 21.4%) in South Asian children was observed.

We conclude that estimates of overweight and obesity using current BMI standards may be misleading in South Asian children. Ethnic-specific BMI cut-off points provide a more appropriate criteria for assessing obesity in multiethnic populations.

Duncan, S., Duncan, E., Schofield, G., & Rush, E. (2006). Obesity in New Zealand Asian children. In S. Tse, E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp. 66-72). Auckland, New Zealand: University of Auckland.

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INTRODUCTION

The prevalence of childhood obesity has reached epidemic proportions in many countries (Janssen et al., 2005). Given the numerous negative health outcomes associated with excess body fat (Dwyer & Blizzard, 1996; Williams et al., 1992), accurate estimation of obesity in young people is becoming increasingly important. Body mass index (BMI), a simple anthropometric measure of weight (kg) divided by squared height (m^2), is the most common screening tool for obesity. However, the significant variation in BMI among boys and girls of different ages necessitates the use of age- and sex-specific definitions of overweight and obesity in children. The International Obesity Task Force (IOTF) combined data from six countries to develop a series of internationally relevant BMI cut-off points representing the mean BMI-age curves that pass through the adult standards for overweight and obesity at

age 18 years (Cole, Bellizzi, Flegal & Dietz, 2000). This classification system is currently the preferred definition of childhood obesity in New Zealand research.

Despite the practicality and cost-effectiveness of BMI as an estimate of childhood obesity, there is evidence that it is not a consistent predictor of body fat for Asian and non-Asian ethnicities. Mehta, Mahajan, Steinbeck, and Bermingham (2002) reported that South Asian adolescent boys aged 15-16 years averaged significantly more body fat at the same BMI than those from an East Asian or European background. Similar differences were observed between Singapore Chinese and European children aged 7-12 years (Deurenberg, Deurenberg-Yap, Foo, Schmidt, & Wang, 2003). This suggests that a given BMI cut-off point may correspond to a body fat level that is higher in Asian children than in European children. As a consequence, Asian children with excess adiposity may not be correctly identified by current BMI classifications of overweight and obesity. In their study of 623 Singaporean Chinese children aged 6-11 years, Fu et al. (2003) noted that the IOTF BMI cut-off points had relatively low sensitivity (75%) for predicting excess body fatness. In other words, the IOTF system failed to identify 1 in 4 of their obese participants. The diagnostic accuracy of existing BMI standards has yet to be investigated in Asian children from other regions.

The objectives of the present study were to: 1) compare body fatness at a given BMI in East Asian, South Asian, European, Maori, and Pacific Island children, 2) investigate the sensitivity and specificity of the IOTF reference values for detecting excess body fat in Asian children, and 3) examine the effect of ethnic-specific BMI cut-off points on prevalence estimates of overweight and obesity in Asian children.

METHODS

A total of 1,247 participants (631 girls and 616 boys) aged 5-12 y were randomly selected from 28 primary schools in Auckland, New Zealand. The age and ethnicity of each participant was determined from school records. The ethnic composition of this sample was 576 European children (46.2%), 237 Pacific Island children (19.0%), 170 Maori children (13.6%), 147 East Asian children (11.8%), and 117 South Asian children (9.4%). The East Asian ethnic group was comprised of Chinese (52.4%), Korean (18.4%), Filipino (12.9%), and Other Asian (16.3%) children, while the South Asian ethnic group included Indian (93.2%) and Sri Lankan (6.8%) children. Ethical approval for this study was obtained from the Auckland University of Technology Ethics Committee. Written informed consent was provided by each participant and his/her legal guardian.

The height and weight of each participant were measured with a portable stadiometer and a digital scale. BMI was then calculated as weight (kg) divided by squared height (m^2). Resistance (R) measurements were obtained using hand-to-foot bioelectrical impedance analysis. A prediction equation previously validated in New Zealand children (Duncan, Rush, Duncan, Schofield, & Freitas Jr, 2005; Rush, Puniani, Valencia, Davies, & Plank, 2003) was used to obtain estimates of fat-free mass and fat mass from height, weight, and R values. Percentage body fat (%BF) was then calculated as the ratio of fat mass to weight multiplied by 100. The BMI status of each participant was determined using the reference values provided by the IOTF (Cole et al., 2000). However, the ideal criterion for identifying excess %BF in children has yet to be established. For the purposes of this study, the 85^{th} and 95^{th} age- and sex-specific percentiles of %BF were used to define overweight and obesity, respectively.

RESULTS

Differences in physical characteristics (age, height, weight, BMI, %BF) between sexes and among ethnicities were examined using analyses of covariance with Bonferroni *post hoc* tests where applicable. Within each gender group, there were no significant differences in age or height among the five ethnicities. Pacific Island and Maori boys and girls were heavier and had a significantly higher BMI than European, East Asian, and South Asian boys and girls. European boys had less body fat than their Maori, Pacific Island, and South Asian counterparts ($p < 0.05$), whereas European and East Asian girls had less body fat than South Asian girls ($p < 0.05$).

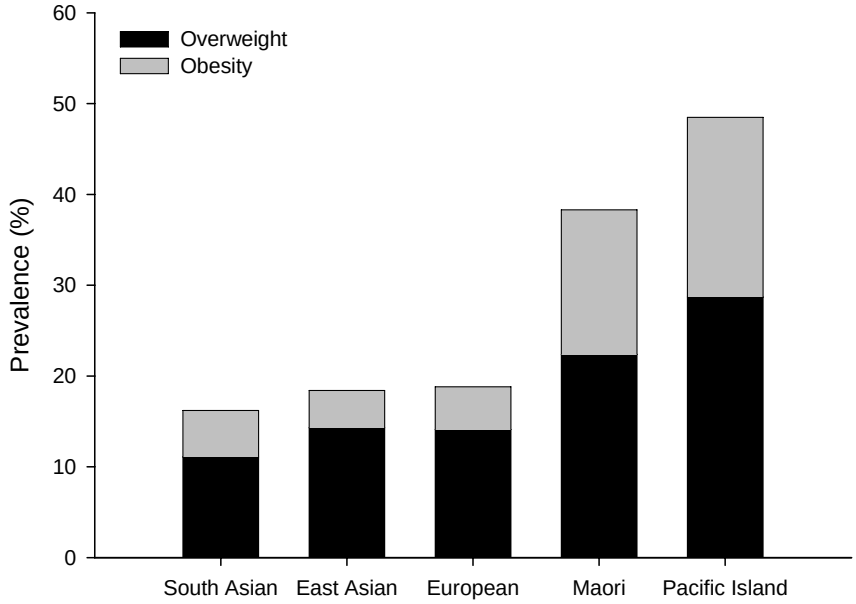

Figure 1. Prevalence of overweight and obesity in South Asian, East Asian, European, Maori, and Pacific Island children according to the IOTF BMI standards.

The prevalence of overweight and obesity in the five ethnic groups is presented in Figure 1. It is evident that Maori and Pacific Island children have the highest proportion of children positively identified by the IOTF BMI cut-off points. Prevalence estimates for overweight and obesity in South Asian (11.1% and 5.1%, respectively), East Asian (14.3% and 4.1%), and European (14.1% and 4.7%) children were of a similar level. These statistics indicate that Maori and Pacific children are heavier for their height than the other three ethnicities. However, the level of body fat at a given height and weight is more relevant with regard to overall health risk. Figure 2 shows mean (± 95% CI) %BF for boys and girls in each ethnic group when adjusted for age and BMI (ANCOVA). Although the level of body fat at a given BMI appears similar among European, Maori, and East Asian boys and girls, Pacific Island and South Asian children show contrasting %BF characteristics. South Asian children, in particular, averaged 3.0-5.1% (boys) and 4.2-6.1% (girls) more body fat than the remaining four ethnic groups.

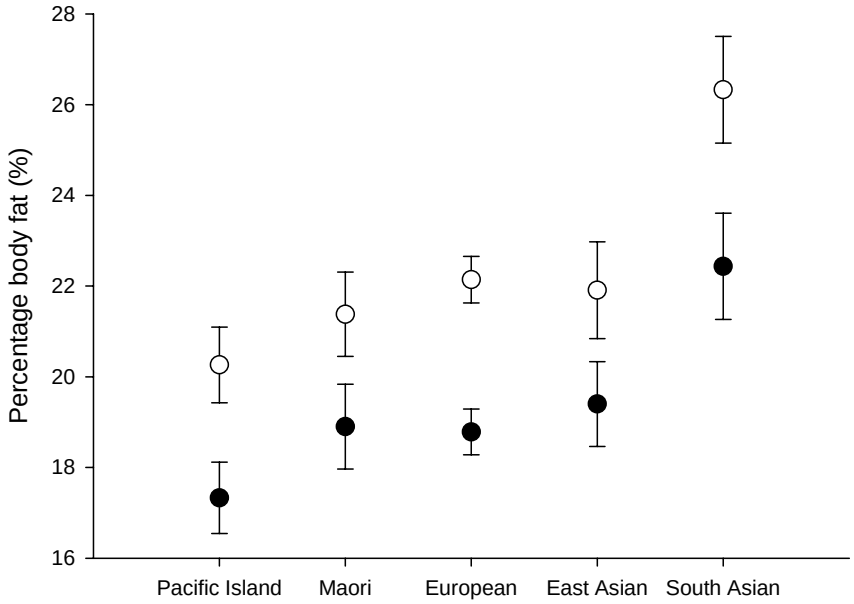

Figure 2. Percentage body fat ($\bar{x}$ ± 95% CI) in European, Maori, Pacific Island, East Asian, and South Asian boys (●) and girls (○) when corrected for differences in age and BMI (ANCOVA).

Our results confirm that Asian children can have markedly different BMI/%BF profiles when compared with other ethnic groups. A logical progression is to investigate the appropriateness of current BMI classifications for identifying excess adiposity in East and South Asian children. The number of children correctly defined by the IOTF standards as overweight and obese was determined by using the 85th and 95th percentiles of %BF as the criterion references. Sensitivity of the IOTF reference values was defined as the percentage of overweight (or obese) children correctly classified, and specificity was defined as the percentage of non-overweight (or non-obese) children correctly classified. Thus, it follows that an accurate classification system will have both high sensitivity and high specificity.

First, receiver operating characteristic (ROC) curves were used to evaluate the overall ability of BMI to accurately predict excess fatness (Figure 3). The age-dependency of the BMI distribution was negated by using BMI z-scores adjusted for age. The ROC curves for each ethnic group were constructed by calculating the sensitivity and specificity of a series of ethnic-specific BMI z-score percentiles (2-100) for predicting overweight and obesity. The area under the curve (AUC) was then calculated as an indicator of the predictive ability of BMI in each ethnic group. Low AUC values would imply that BMI is not a suitable tool for predicting excess body fat, regardless of the specific cut-off selected. For East Asian children, the AUC (± SE) was 0.905 ± 0.050 for overweight and 0.971 ± 0.048 for obesity. Similar results were observed for South Asian children, with AUC values of 0.919 ± 0.038 and 0.949 ± 0.043 for overweight and obesity, respectively. This indicates that, overall, BMI provides an acceptable proxy measure of body fat status in Asian children.

Figure 3 also shows the location of the IOTF cut-off points for overweight and obesity on the BMI percentile distribution for East Asian and South Asian children. Ideally, the cut-off point would be at the upper left position of the ROC curve, indicating an optimal trade-off between

sensitivity and specificity. It is clear from these results that the IOTF standards have relatively low sensitivity, especially for South Asian children.

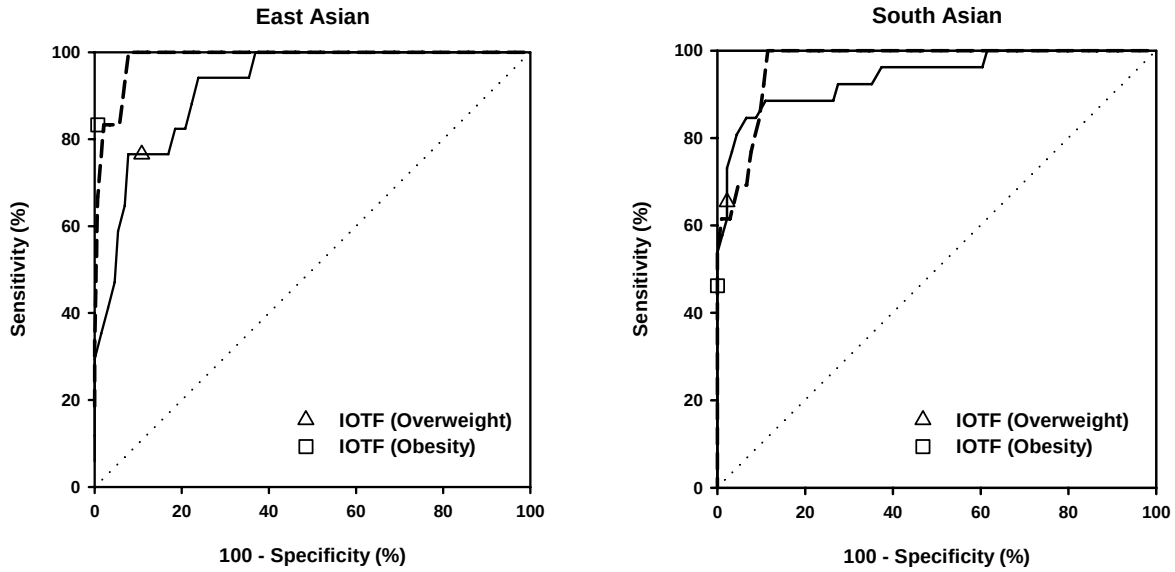

Figure 3. Receiver operating characteristic curves of body mass index z-score percentiles 100-2 (left to right) for the prediction of overweight (———; %BF > 85th percentile) and obesity (---------; %BF > 95th percentile) in East Asian and South Asian children. The sensitivity and specificity of the International Obesity Task Force (IOTF) BMI reference standards for overweight and obesity are given for each ethnic group.

Improvements in sensitivity between the IOTF and ethnic-adjusted BMI standards (i.e.,, the BMI percentiles nearest to the upper left position on the ROC curves) were assessed using chi-squared tests. In the South Asian group, overweight sensitivity increased from 65.4% to 88.5% (p = 0.048), while specificity decreased from 97.8% to 89.0% (p = 0.017). Similarly, obesity sensitivity and specificity changed from 46.2% to 100% (p= 0.002) and 100% to 88.5% (p < 0.001), respectively. Ethnic-adjusted BMI cut-offs did not produce significant increases sensitivity for East Asian children (overweight, p= 0.671; obesity, p = 0.296).

Finally, we calculated the theoretical changes to prevalence values that result from the use of our ethnic-specific BMI cut-off points rather than the IOTF standards. Of the 117 South Asian children tested in this study, 33 (28.2%) were classified as either overweight or obese. This represents a significant increase from the original IOTF estimate of 16.2%. Even more concerning was the 4.2-fold increase in the frequency of obesity (5.1% to 21.4%), suggesting that the majority of South Asian children in this sample who were overweight had progressed to the obese end of the body fat distribution.

DISCUSSION AND RECOMMENDATIONS

BMI is commonly employed as a screening tool for detecting overweight and obesity in children. At present, standard IOTF age- and sex-specific BMI cut-offs are used for classifying the degree of body fatness in all ethnic groups. This study represents the first investigation of BMI as an indicator of overweight and obesity in both East Asian and South Asian children. Our results showed considerable variation in the %BF/BMI relationship among

the ethnic groups tested. At a fixed BMI and age, South Asian children averaged significantly higher %BF than other ethnicities. These findings are similar to previous observations in adolescent boys (Mehta et al., 2002), and imply that a typical South Asian child will have a higher level of body fat than a child from a different ethnic group but with a similar height and weight.

The relatively high level of body fat at a given BMI corresponded to low sensitivity when using the IOTF BMI cut-off points to predict excess fatness in South Asian children. In other words, a large proportion of South Asian children with excessive body fatness will not be classified as overweight (or obese) using the current IOTF scale. This has serious implications for public health, as many of the children most in need of treatment will not be identified using traditional BMI standards. Our data show that developing ethnic-specific BMI cut-off values drastically reduces the number of South Asian children with excess adiposity that are misclassified as 'normal weight'. While these adjustments were accompanied by minor decreases in specificity, we would argue that sensitivity is a higher priority when screening for obesity in children.

Given that ethnic-adjusted prevalence estimates are more relevant than those based on a universal BMI system, it is clear that obesity in South Asian children is a problem more serious than previously imagined. Indeed, greater than one in five of the South Asian children in this sample were classified as obese, suggesting that interventions targeting obesity and its determinants this ethnic group are urgently required. Qualitative research examining the cultural issues associated with obesity in South Asian children is also recommended.

In summary, this study provides evidence that the relationship between body fat and BMI varies significantly between South Asian and European ethnic groups, and that existing BMI standards should be lowered for South Asian children to reduce the number of children with excess body fat that are not identified as overweight or obese. We conclude that estimates of overweight and obesity using current BMI standards may be misleading in South Asian children. Ethnic-specific BMI cut-off points provide a more appropriate criteria for assessing obesity in multiethnic populations. However, an understanding of the age-specific body fat levels related to increased health risk in children from different ethnic backgrounds is needed. From this information, appropriate BMI cut-off values can be formulated for diagnosing overweight and obesity in all New Zealand children.

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STIGMA AND DISCRIMINATION: THE OTHER FACE OF HIV/AIDS IN SOUTH ASIA

Sigma Huda

ABSTRACT

The paper aims at focusing on the impact and consequences that entail from the HIV/AIDS pandemic in the South Asian countries with specific attention on the issue of discrimination, deprivation and stigma directed towards people living with HIV/AIDS and their immediate family members.

Development of the paper has been based on a rapid desk-study of existing literature on descriptive information and statistical data available in scholarly texts, journals, thematic study reports, research findings and website pages of numerous national and international organisations concerned with the HIV/AIDS pandemic and its impact on broad human and social development. In addition to analysis of findings and observations made from the desk-study, relevant experience and insights of the author from her over three decade's active involvement in the area of human rights as well as a researcher and activist of social equity and access to justice has guided the directions adopted for the paper.

The paper begins with a brief regional context of South Asia and the extent to which the region has been exposed to the spread of HIV/AIDS; highlights key vulnerability issues caused by the pandemic including the most pertinent aspects of stigma, discrimination and violation of human rights; gender susceptibility to HIV and its consequences; migration, trafficking and HIV/AIDS; existing legal and policy frameworks in the region; and a general conclusion on how to face the constraints and challenges posed by these complex phenomenon.

Huda, S. (2006). Stigma and discrimination: The other face of HIV/AIDS in South Asia. In S. Tse, M.E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp.73-79). Auckland, New Zealand: University of Auckland.

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THE CONTEXT: SOUTH ASIA AND HIV/AIDS

Housing nearly half of the world's total illiterate population, over 600 million or 40% of the people in South Asia live on an income less than US$1 per day. There are more children out of schools in South Asia than in the rest of the world. This is also a region marred by ethnic tensions, religious fundamentalism, subversive activities, intra and inter state conflicts and border disputes, cross border trafficking and blatant human rights violations. The systems of Governance remain unresponsive and irrelevant to the needs and concerns of the common people. In fact, in a region where soldiers outnumber doctors by twenty times, the distorted resource allocation and priorities threaten the security and well-being of its population rendering the sub-continent as one of the most vulnerable spaces on the globe today.

South Asia is a collage of mini HIV-epidemics displaying considerable variations in scope and intensity. The earliest detection of HIV infection in the region was in 1986 in India. The following year, Iran, Nepal, Pakistan and Sri Lanka also reported the presence of HIV in their

countries, followed by Bangladesh in 1989. Although the latter mentioned countries are characterized by a low HIV prevalence among the general population, they have significantly higher HIV rates among high-risk groups, such as injecting drug users and those engaged in the selling and buying of sex. Similarly, the relatively new entrants to the HIV periphery including Bhutan, Maldives and Afghanistan also have nascent epidemics, but the threat of spread is significant in these countries due to high prevalence of risk behaviors and high vulnerability.

Today, of the world's 36.1 million people living with HIV/AIDS, South Asia has over 5 million HIV-infected people representing 0.4 percent of the region's total population, 90 percent of who are living in India alone.[1] Although the overall prevalence rates are relatively low, with a very large population in the region a minor increase in the figures has a huge impact. For instance, a rise of a mere 0.1 percent in the prevalence rate in India would increase the national total of adults living with HIV by half a million people.[2] Many recent studies suggest that South Asian countries run the risk of experiencing the devastating social and economic impacts of the kind of full-blown AIDS epidemics seen elsewhere in the world.[3]

HIV/AIDS: STIGMA, DISCRIMINATION AND HUMAN RIGHTS

People Living with HIV/AIDS (PLHA) in the South Asian countries, like in many other parts of the world, face manifold socio-economic, legal and cultural challenges. In the absence of a friendly environment, PLHAs, members of high risk population and their immediate families confront endemic discrimination, prejudice, stigma and violation of fundamental rights. In Bangladesh, for instance, there are examples of HIV positive people being brutally tortured, thrown into jail or isolated lockups.[4]

The prejudice and discrimination directed towards PLHAs, and their direct or indirect impact on their family members, bear negative consequences on their health and psychological well-being in addition to the social, economic and legal consequences that inevitably follow. These attitudes and practices increase the number of PLHAs, resulting in their non-accessibility to care, counselling and support. PLHAs naturally opt to live without disclosing their health conditions because of fear and shame, thus further aggravating the risks and consequences that the pandemic entails. As Andrew Baket stated in the film 'Philadelphia', AIDS imposes on its victims "*a social death which precedes their actual physical death*".

A recent UNDP study has found numerous incidents across the region of rejection of PLHA by doctors and paramedics as well as refusal to requests for treatment.[5] This is attributed to the fear of contacting the infection from PLHA, especially in places that do not have the facilities to enable the doctors to practice universal precautions. There is also the dimension of rejections by doctors in certain social situations, which are indicative of discrimination not based on fear for oneself, but seemingly on prejudices towards the PLHA. This illustrates the fact that just getting rid of irrational fears of infection by the dissemination of information or availability of treatment facilities is not by itself adequate to reduce discrimination and stigma directed towards PLHAs and their families, unless the judgmental basis of the discriminatory attitudes that persist in the entire region is also effectively addressed.

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1 Source: The Rationale for Mainstreaming HIV/AIDS in Social Development, South Asia Multi Sector Briefs on HIV/AIDS, The World Bank (January 2006); also, UNAIDS, 2005.

2 In fact, globally, India's HIV positive population of nearly 4 million ranks second only to that of South Africa.

3 HIV/AIDS in South Asia: A Threat to Development, The World Bank, June 2004.

4See, Ravaging the Vulnerable, Human Rights Watch, Vol. 15, No. 6©, (August 2003); also, Interim Report, "Snapshots of GIPA: the Greater Involvement of People Living with HIV/AIDS in South Asia Project", UNDP (2002).

5 GIPA/UNDP Report (2002), op. cit.

Theoretically at least, no national government in the region has denied that people living with HIV/AIDS deserve appropriate healthcare as well as socio-legal support and protection like any other citizen- and even that their need for this is often more acute than that of others. But the reality is that PLHAs, and often their family members too, are frequently denied access to such services, support and protection all over the region. On the other hand, as many research findings indicate, there is also an acute dearth of healthcare services for PLHAs in the South Asian countries, while many of the available services are unfriendly, some are even openly hostile to the PLHAs who come for treatment, thus rendering these people invisible and inaccessible.

Again, as the PLHAs become increasingly invisible, the reality of their human rights situation also becomes critical. In several countries of the region, including Pakistan, Nepal, India and Bangladesh, reports are found on flagrant violation of human rights of PLHAs, high risk groups and their immediate family members. The employment situation is invariably a complex phenomenon for PLHAs and the non-disclosure of HIV status is often based on fear of discrimination in finding a job or dismissal on the ground of HIV status. Inadequate or absence of any social benefits, life insurance or other welfare support for PLHAs may also be seen as a major area of concern in the countries of this region. There is a report of an HIV positive woman who died under suspicious circumstances in Bangladesh. No doctor was willing to perform an autopsy and the body of the woman was buried without any post-mortem examination. Even if the cause of her death was murder, there was no official interest in pursuing the case or the perpetrator. These incidents provide proof of the widespread discrimination that the PLHAs are subjected to, and the stigma of being HIV positive, even after their death.

On the other hand, however, a good practice instance is found in Sri Lanka where confidentiality is practiced by the Ministry of Health, which keeps the records of all known HIV positive people in the country. This exemplary principle has been made mandatory for all counsellors and other service providers in that country to protect PLHAs from the psychological impact of discrimination and possible loss of employment. In fact, this practice has been found to work so well that since the beginning of the pandemic in Sri Lanka, only one person has so far been reported to lose a job because of HIV positive status.[6]

THE GENDER PERSPECTIVES OF HIV IN SOUTH ASIA

Globally today, over 20 million women and 3 million children are living with HIV/AIDS. In South Asia, women account for 36% of all new infections.[7] Over 90% of HIV infections among children occur through mother to child transmission during pregnancy, at delivery or tragically through breastfeeding. AIDS is an increasing cause of death among women resulting in increasing numbers of orphans estimated to be over 15 million worldwide.

The changing patterns of HIV mirror gender inequalities and inequities present in the South Asian society. In the developing countries of the region, women and girls are more vulnerable to HIV infection because they are economically, culturally and socially disadvantaged and lack equal access to health-care, education, employment, resources, and decision-making powers on their own. Many recent studies show that women, especially young girls, are physiologically more susceptible to infection than males.[8] Girls are also susceptible to sexual violence and abuse, as well as coercion from relatives, teachers and friends.

6 UNDP Report (2002), op. cit.

7 HIV/AIDS and Development in South Asia, Regional Human Development Report (2003).

8 See, for instance, “Stigma and Discrimination and HIV/AIDS: The Plight of Women and Children”, World AIDS Day 2003, Elizabeth Lule (The World Bank), George Washington University School of Public Health and Health Services.

Cultural beliefs and social attitudes about sexual relations also fuel stigma and discrimination against women and children. In many societies around the region, women are socialized to be submissive on matters related to sex and therefore lack the power to negotiate safe sex and withstand sexual abuse, coercion and violence. Also, in many cultures, it is an acceptable phenomenon, or traditionally expected for men to have multiple wives/partners and even engage in commercial sex. This places wives and female partners at greater risk of HIV infection and other STIs. On the other hand, women themselves are often perceived as the transmitters of sexually transmitted infections. While men are excused for their sexual behaviours, women take the blame and shame for infecting their male partners and their children. Similarly, because of the somewhat accepted practice of violence against women, women run the risk of being assaulted if they ask their husbands to use HIV preventive measures.

Women's dependency on men stems from their lack of access to productive resources such as land property, other household assets, credits and livelihood skills. Lack of equal rights to inheritance of property may also leave many AIDS-widows and orphans destitute and homeless, particularly in the polygamous segments of the South Asian societies. When women are found to be infected, families and friends ostracize them as promiscuous and spoiled women and may even be thrown out of their homes and disinherited from their property. In some of the North Indian states, for instance, there have been numerous incidents of monogamous women getting blamed for the infection 'coming into the house'. The women in these situations are blamed for bringing 'bad luck' and disease into the families, when they have, in fact, got the infection from their respective husbands who had multiple partners. On the death of the husband, such women are often turned out of the house of their in-laws. The taboo on a woman who has 'failed in her marriage' is so prevalent that they cannot even return to the homes of their own parents. This is not an isolated incidence in the South Asian countries and similar instances are found in many other parts of the region.

Throughout the South Asian region, large numbers of children with HIV/AIDS and HIV-orphans are left out to grow up and fend themselves without education, leaving them open to exploitation and sexual abuse, a life of hard labour, and recruitment as child soldiers – all of which put them in situations of extreme vulnerability to HIV infection themselves. In India, for instance, infected children have been turned away from school. Health providers discriminate women with HIV/AIDS by refusing to touch them, withholding treatment, performing HIV tests without consent, and deny confidentiality, hospital facilities and appropriate medicines.

Recurring wars and conflicts in the South Asian countries have also contributed to women and children's vulnerability and risks to HIV infection. Displaced people and refugees, in general, have been populations exposed and vulnerable to HIV/AIDS, affecting both genders particularly young soldiers as well as men and women of all ages. Generally, conflict fuels the spread of HIV due to the increased interaction among military/combatants and civilians, poverty and commercial sex for survival, decreased availability of STI/HIV and other health services information, the breakdown of law and order, and the disintegration of social and family structure in conflict and post conflict situations.

MIGRATION, TRAFFICKING AND HIV/AIDS

For a large number of people in the region, migration (both rural-urban as well as cross-border) has become a key survival strategy. Many migrants are known to buy sex but do not have access to information, protective kits or supportive services that would enable them to have safe sex. However, the lack of safe, secure and legal channels for migration drive

unsuspecting and uninformed men, women and girls into the hands of unscrupulous agents and traffickers who promise them good jobs and safe travel into lucrative destinations.[9]

Trafficking in men, women and children has direct cause and effect linkages to the global dispersion and mutation of HIV subtypes. As stated earlier, the complex web of socio-cultural and macro-economic factors that affect women's vulnerability to HIV also heighten their susceptibility to being caught in the growing net of sex trafficking in the region, taking them into situations which remove the last vestiges of choice, violate their human dignity and security, and further increase the risk of exposure to HIV/AIDS.[10] Again, while violence is a common phenomenon for victims of sex trafficking, 'injuries and abrasions sustained during sexual contact also heighten physical vulnerability to AIDS transmission'.[11] Such vulnerability is further compounded by their inability to receive medical services, to speak or understand the language in a foreign land, poverty and indebtedness, and lack of freedom of movement.

Countries in the South Asia region are also witnessing an alarming trend of increasingly younger girls being trafficked into the sex trade. The majority of trafficking in India, both trans-border and in-country, happens for the purpose of sex work, and over 60 percent of those trafficked into sex work are adolescent girls in the age-group of 12-16 years.[12] In many Indian cities, girl children as young as eight or nine are sold at auctions. There are an estimated 2,000,000 prostitutes in India and 60 percent of these women in prostitution in Mumbai are HIV positive. One common myth fuelling the demand for young girls in South Asia is that sex with a virgin can cure Sexually Transmitted Infections (STIs) and HIV/AIDS. Girls who are orphaned by or from AIDS affected families are lured into commercial sex and trade sex for survival for themselves and their orphaned siblings or to take care of ailing parents. Also, stigma against prostitutes and the illegal nature of the trade in the region makes it difficult for prostitutes to seek treatment, report abuses or negotiate safer sex.

The growing menace of sex tourism and pedophilia has also been a matter of serious concern for the region. As a number of countries in the East (such as Indonesia) have begun to close their doors on Western sex tourists, they are increasingly turning to South Asia, e.g., the popular tourist destinations in Sri Lanka.

THE LEGAL FRAMEWORK

None of the South Asian countries has any specific statutory laws governing HIV/AIDS or ensuring protections to PLHAs. Consequently, fundamental rights guaranteed by national constitutions remain the prime sources of law in South Asia in this regard. Apart from these general constitutional guarantees, policies and guidelines on HIV/AIDS drawn up by national governments also become the basis on which the rights of PLHAs are defined. However, it should be noted that in most jurisdictions in the region, governmental policies and guidelines cannot be enforced by the courts of law. In addition, there are also customary and personal laws in several countries of the region that determine the rights of individuals, especially women.

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9 Because both trafficking and void migration are illegal and concealed activities, it is difficult to be precise about the exact numbers of victims involved in these processes. However, while estimates are based on the reports of law enforcement agencies, researchers and groups working with survivors and communities indicating that such numbers count in hundreds of thousands every year in the South Asian countries, what is of greater importance here is the consequential aspect of these heinous activities entailed on victims and survivors as well as their families and the community at large.

10 Shah, V, Brar, B. and Rana S. Layers of Silence: Links between Women's Vulnerability, Trafficking and HIV/AIDS in Bangladesh, India and Nepal, UNRISD, 2005.

11 Sex Trafficking and the HIV/AIDS Pandemic, Physicians for Human Rights, 2003.

12 UNDP, 2005.

Again, although nations who are signatories to different international treaties and other documents (such as the Universal Declaration of Human Rights) are bound by the standards laid down therein, this depends on the binding nature of such documents and the manner in which each country codifies it within its national laws.

International human rights instruments play an important role in respect of HIV/AIDS and human rights, since their norms may guide the establishment of procedural, institutional and social mechanisms to counter the HIV/AIDS epidemic. In addition to the legally binding treaties and conventions (e.g., the ICCPR, ICESCR, CEDAW, CAT, CRC, etc.), two prominent HIV/AIDS-specific international documents are the *Declaration of Commitment* passed at the UN General Assembly Special Session on HIV/AIDS (UNGASS), 2001 and the *International Guidelines on HIV/AIDS and Human Rights* adopted by the UN Commission (now the Council) on Human Rights in 1996. The Guidelines address multi-sectoral responsibilities and accountability including improving the roles of the government and the private sector. In addition, they stress upon the duty of the States to engage in law reform and identify legal obstacles to an effective HIV/AIDS strategy on prevention and care. The UN Declaration of Commitment,[13] on the other hand, addresses issues of prevention, care, support and treatment; leadership at the national, regional and sub-regional level; reducing vulnerability; alleviating social and economic impact, among others. It should, however, be noted in this context that none of these documents adequately address the need for a human rights-based approach to deal with HIV/AIDS.

Regionally, the SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution (2002) mark an important step towards addressing the concerns of gender, prostitution and human rights. The Convention requires all States Parties to enact legislation that provides punishment for the offence of trafficking. However, a major drawback of the Convention is that it considers trafficking solely for the purpose of 'prostitution' and thereby limits the scope and application of the treaty.

In the recent years, many rights of PLHAs have been defined through court judgments, particularly in India.[14] In 1997, the Lawyers' Collective, an NGO in India challenged the termination of the services of a worker on the ground of being HIV-positive though the person was otherwise functionally healthy. In the landmark judgment of the Mumbai High Court in this Public Interest Litigation (PIL), the worker was reinstated and paid back the wages. Similarly, when a PLHA was refused surgical treatment in a government hospital in Delhi, PIL was filed by an NGO in the Supreme Court of India. The hospital admitted the patient and performed the surgery before hearings commenced in the court. Similarly, the practice of identifying PLHAs at government hospitals in Delhi with a label that proclaimed "AIDS Case" was challenged, this practice was discontinued. However, the label was later replaced by one proclaiming "Bio-Hazard"! The body bags containing casualties of AIDS are often labelled, ensuring total neglect of these bodies or treatment like trash.

RECAPITULATION AND CONCLUSIONS:

As highlighted in the preceding discussion, people living with HIV/AIDS in the countries of South Asia cannot come out and live positive lives without fear of having their future shattered in the light of the pervasive climate of denial, stigma and discrimination that often render them as *modern-day untouchables* without any legal protection or social safety net. PLHAs are frequently ostracised, isolated and deprived of their fundamental human rights and freedoms including the right to mobility and residence, right to confidentiality, right to free

13 All the countries of the South Asia region, except Afghanistan, are signatories to this Declaration.

14 Apart from the United States and Australia, the highest number of HIV/AIDS-related litigation has perhaps taken place in India.

association, sexual and reproductive rights, and the right to essential services, support and protection, despite the fact that the UN Commission on Human Rights has confirmed that "Discrimination against people living with HIV/AIDS, or those thought to be infected, is [therefore] a clear violation of their human rights." This declaration has been signed and ratified by all member countries of the region.

Many countries elsewhere have enacted legislation to protect the rights and freedoms of people living with HIV/AIDS to safeguard them from discrimination. Much of these legislations have sought to ensure their right to employment, education, privacy and confidentiality as well as the right to access information, treatment and support. The countries of South Asia need to learn and adopt from these instances of legislation and policy reforms. Moreover, clarification, understanding and sensitisation of the particularities of the HIV/AIDS response are also needed within law enforcement agencies as well as in the judicial administration. A particular emphasis is needed to ensure that appropriate and accessible legal remedies are available to PLHAs, high-risk vulnerable groups and their immediate family members. This can be done by inserting relevant provisions in the national constitutions and the civil and criminal laws of the respective legal systems.

The countries of the region has several best practices instances from other countries to draw adoptable lessons, including those in Thailand that has achieved notable successes in mitigating the impact of HIV by expanding their responses beyond the confines of a health approach to one that embraces a broad spectrum of human rights and development. The South Asian Association for Regional Cooperation (SAARC) can also be used a useful vehicle in this regard. Thus, although HIV/AIDS is yet to be accorded a priority status by the Association, the member countries can still benefit through technical exchange, joint collaboration and coordinated initiatives. With concerns that India might emerge as the global epicentre of the second wave of HIV infections, HIV/AIDS stands as a matter of serious concern for the South Asia region.

In conclusion, the central argument of this paper is that HIV/AIDS in South Asia is no longer a mere medical or health problem. It’s a social and human development issue that demands consistent political commitment, a conducive and supportive legal and policy framework, and a multi-sectoral rights-based approach. The distinct South Asian phenomenon of religious, cultural and societal outlook towards PLHAs and their immediate families, public distaste of open discussion on AIDS, political understatement of the epidemic, and the position of women at the bottom of the family hierarchy as well as the community and social set up within which they live- are all part and parcel of such an integrated, coherent approach.

EPIDEMIOLOGY OF UNINTENTIONAL INJURY AMONG ASIANS IN NEW ZEALAND

M Ekramul Hoque, Mildred Lee and Shanthi Ameratunga

ABSTRACT

Injury is recognised as the leading cause of premature death in NZ, costing $6-7 billion a year. The profile of serious injury among Asian New Zealanders has, however, been poorly documented. This ACC funded study aimed to review the current literature on this topic and identify the socio-demographic patterns of fatal and serious non-fatal unintentional injury among Asian New Zealanders.

A systematic search of articles in the peer-reviewed and grey literature published between January 1990 and July 2005 was conducted. Injury-related deaths (1993-2002) and hospital admissions with a principal discharge diagnosis of injury (1993-2004) recorded by the New Zealand Health Information Service (NZHIS) were analysed to estimate the population-based rates of unintentional injury.

The published literature – primarily ad hoc reports identified in the grey literature – have drawn attention to burns, scalds and falls in Asian children, drowning, and road traffic crashes in rural highways in other age groups. The analysis of the NZHIS data revealed that Asian New Zealanders have an annual injury mortality rate of 27 per 100,000 population, with a preponderance of males among the victims. Asians aged 25-39 years accounted for the highest proportion of those injured while Asian people aged ≥75 years accounted for the highest age-specific rates of injury. Over two-thirds of the injury deaths were due to unintentional injuries, where motor vehicle crashes were the leading cause of unintentional injury deaths while falls (37%) were the main cause of injury-related hospitalisations. These findings are broadly consistent with the patterns of injury seen among NZ European/Pakeha.

The findings of this work identify important areas of concern and opportunities for injury prevention among Asian New Zealanders. While the common causes of serious injury are consistent with the identified priorities for action in the New Zealand Injury Prevention Strategy, the approaches to intervention in this population requires attention. The changes in the ethnicity definitions used in the NZ census surveys and the difficulties in accessing detailed denominator data relevant to Asian New Zealanders in the inter-censal periods limit the ability to examine temporal trends in injury rates among Asian New Zealanders.

Hoque, M. E., Lee, M., & Ameratunga, S. (2006). Epidemiology of unintentional injury among Asians in New Zealand. In S. Tse, E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp. 80-90). Auckland, New Zealand: University of Auckland.

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BACKGROUND

The New Zealand Injury Prevention Strategy (NZIPS) 2003 is a framework for injury prevention activity in New Zealand and a basis for action to make New Zealand an injury free society, in which members can live an active and challenging life (Dyson, 2003). With a broader vision of achieving a positive safety culture and creating safe environments in New Zealand, this strategic document encouraged participation from various ethnic communities in injury prevention research and intervention.

In New Zealand, references in popular discourse and concerns in the media about risks relating to injury among people of Asian ethnicity are not uncommon. Yet, a current and comprehensive profile of the characteristics and patterns of injury-related presentations in this group is unavailable. This limits the ability to recognise the extent of the issues involved and consider the most appropriate avenues of responding to these.

Injury is a leading cause of premature death and disability in New Zealand. The Accident Compensation Corporation (ACC) deals with 1.4 million injury claims each year and the annual economic costs of injury are estimated to be $6-7 billion (Dyson, 2003). Injuries vary significantly by age, gender and ethnicity (Anonymous, 2003). In New Zealand four people die every day from injury, over 100 people are hospitalised, and nearly 4,000 people seek medical help (Dyson, 2003). Overall injury death rate in New Zealand is 42.4 per 100,000 person-years. It is reported that 49,584 years of healthy life were lost due to injury in New Zealand in 1996. Motor vehicle crash injuries are reported to be the leading cause of death from external causes in New Zealand and are also the leading cause of loss of healthy life due to injury (Dyson, 2003). Males are more vulnerable (68%) where most of the deaths occurred in the age group of 75 years and over (Anonymous, 2004).

Asians are the fastest growing ethnic community in New Zealand. Between 1991 and 2001, the Asian population has doubled from 3.0% to 7.0% respectively and is projected to be 14.5% by 2021. Overall Asian ethnic groups in New Zealand have a youthful age structure with a median age of 30.1 years (Pink, 2002).

The Asian Public Health Project Report 2003 reported that injuries were the leading cause of death for 15–24 year old Asians, including motor vehicle injuries (50%), suicides (19%) and other injuries (12%). Between 1996 and 1998, the overall proportion of potentially avoidable injury mortality for Asians in Auckland was 12.5%, which was second to ischemic heart disease (25%). The overall proportion of potentially avoidable hospitalisations for injuries among Asians was 8.2% (motor vehicle 6.8% and recreational injuries 1.4%) as opposed to 9.9% for non-Asians. The Asian Public Health Project Report 2003 did not discuss the potential health risks for Asians. However, the report acknowledged the necessity for a comprehensive injury prevention initiative for Asians in New Zealand.

Injury reports between 2000 and 2002 in New Zealand suggest that approximately 2% and 4% of hospitalised children under 15 years of age with burn from fire and scald injuries were Asians (Safekids). Drowning is the third leading cause of unintentional injury death in New Zealand. Between 1995 and 2004, nearly 8% of drowning victims were Asians, an upward trends observed in recent years (Anonymous, 2005; Stanley, 2005; Watersafe). Most of the drowned deaths occurred in Auckland rocky foreshores and surf beaches, and during fishing (Foot, 2005; Stanley, 2005; Watersafe).

In 2001, 5% of falls related admissions in Starship Hospital were Asians, reportedly the lowest ethnic-specific rate (among the major ethnic groupings) in the pre-school age group in the Auckland region. During 2003-2004, Asians were more frequently involved with motor

vehicle crash injuries in rural areas than urban areas, with the majority of the drivers involved in these crashes were holding overseas drivers licences(LTSA, 2003a, 2003b, 2004a, 2004b, 2004c, 2004d, 2004e, 2004f, 2004g, 2004h, 2004i, 2004j, 2004k). A report by SafeKids noted that of the 125 child motor vehicle passengers killed between 1995 and 1999, 4% were of Asian descent (Gunn, 2004). The authors concluded that the correct use of child car seat restraints and safety seatbelt could reduce the overall risk of a fatal motor vehicle crash injury by 71% and serious injury by 67 percent.

We undertook an epidemiological analysis of the injury-related death and hospital admission data for Asian peoples in New Zealand with the aim to identify the major causes and mechanisms of fatal and serious non-fatal unintentional injuries. The expected outcome of this study was to inform priorities for intervention and identify gaps in knowledge requiring focused research.

METHODOLOGY

This study involved descriptive epidemiologic analyses of mortality and hospital discharge data relating to Asian people living in New Zealand between 1993 and 2004. The relevant information was extracted from the National Minimum Dataset held at the New Zealand Health Information Service (NZHIS). The mortality data for 2002 provided for this analysis was provisional.

The 'Asian' categorised in this report is in line with the definition used by the Statistics New Zealand (StatNZ) in 1996. This definition is employed for the analysis of most health sector data which includes people claiming ancestral connection with Asian continent stretching from Afghanistan in the west to Japan in the east, from China in the north to Indonesia in the south. This definition of 'Asian' is unique to New Zealand(Rasanathan, Craig, & Perkins, 2004) and does not correspond to definitions used in other Western countries such as the United Kingdom or Australia.

The International Classification of Diseases (ICD) system employed by the NZHIS to code causes of hospitalisation and deaths during the 1990s (ICD-9CM) was revised and the new version (ICD-10) implemented from July 1999. Consequently, we analysed the 1993-1999 and 2000-2002 data separately, but employed a mapping procedure recommended by the Centers for Disease Control (USA) to ensure the compatibility of the coded categories. Deaths due to medical misadventure and adverse effects were excluded from this analysis. Detailed analysis of intentional injury and deaths are not presented in this article.

Injury hospitalisation data were analysed for the period 1993-2004. All the injury hospitalisation data were available in the ICD-9 coding system except for the place of occurrence, which was available only in ICD-10 version-2 from July 2001 onwards, and version-3 from July 2004 onwards. Therefore the hospitalisation data by the place of occurrence of injury were presented in two parts: 1993-June 2001 and July 2001-December 2004. However, to standardise the rate with the denominator population, the injury hospitalisation rates were presented for the period of 1998-2004.

The selection criteria for the hospitalised injury cases in this study include: first injury admissions, primary diagnosis of cases of injury with a valid E-code, cases that included at least an overnight stay in hospital. The category 'Motor Vehicle Crashes' (MVC) included motor vehicle traffic and non-traffic crashes.

To calculate the crude injury rates and age-specific injury rates, the New Zealand 2001 Census population for Asian and European were used as the denominator. The findings were presented in tubular and graphic forms.

The SAS statistical package for Windows Version 9.1 was used in this study for data analysis and the MS Excel programme was used to calculate rates and create graphs.

FINDINGS OF ASIAN INJURY ANALYSIS

Asian Injury Deaths (all ages)

During 1993-2002, the total injury deaths for Asians in New Zealand were 446, with an average of 45 deaths per year. Nearly two-thirds (n=289; 64.8%) of the victims were males. Asians aged 25–39 years accounted for 32% and 29% of total injury deaths among males and females, respectively.(Figure 1) Among the Asians, children under 15 years of age had the lowest proportion of injury deaths. The annual numbers of injury deaths among Asians increased over the 1990s with a plateauing of the figures in recent years.(Figure 2)

During 1993 and 2002, over 67% (n=300) of injury deaths were due to unintentional injuries.(Figure 3) Over one-quarter (n=117; 26.2%) were attributed to suicide and the remainder (n=23, 5.2%) to homicide. The cause of 1.3% (n=6) of injury deaths was undetermined.

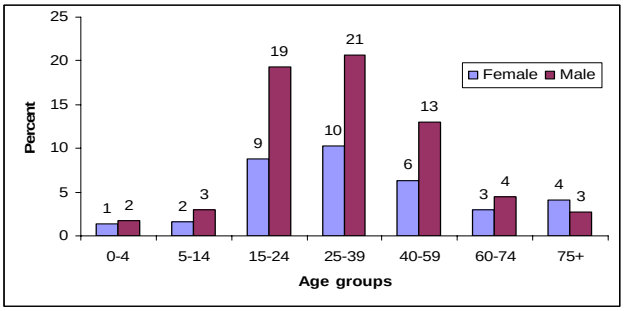

Figure 1: Injury deaths by age & gender for all Asians, 1993-2002

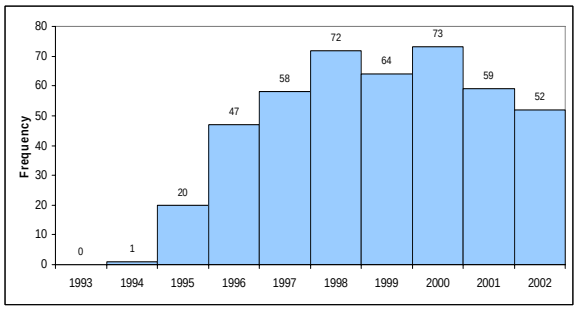

Figure 2: Injury deaths by year for all Asians, 1993-2002

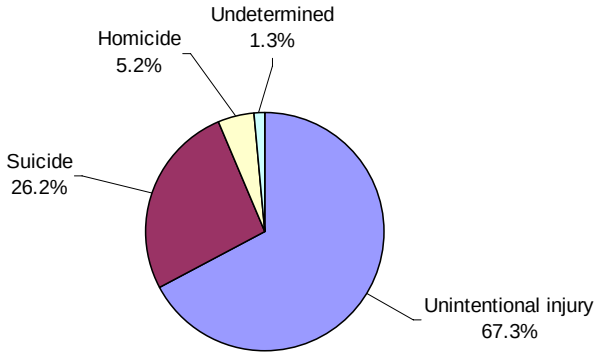

Figure 3: Manner/intent of injury deaths for all Asians, 1993-2002

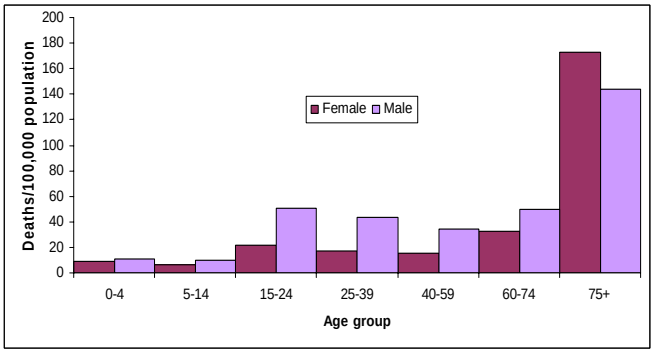

Figure 4: Annual injury rate of deaths by age and gender for Asians, 1998-2002

The leading causes of unintentional injury deaths for Asians were similar during the periods 1993-1999 and 2000-2002 where motor vehicle crashes (MVC) accounted for 62.3% of all the unintentional injuries, followed by drowning (14.7%).(Table 1) The proportion of MVCs was slightly higher during 1993-1999 than during 2000-2002, while more falls related deaths among Asians occurred during 2000-2002. During the same period, the crude injury death rate for Asians was 27 per 100,000 population where males (36 deaths per 100,000 population) had twice the rate that of females (18 deaths per 100,000 population).

Table 1. Unintentional (causes) deaths for all Asians , 1993-2002.

	1993-1999		2000-2002		Total (1993-2002)	
	Frequency	**%**	**Frequency**	**%**	**Frequency**	**%**
Unintentional Injuries by causes						
Motor vehicle crashes	117	65.4	70	57.9	187	62.3
Drowning	24	13.4	20	16.5	44	14.7
Falls	12	6.7	15	12.4	27	9.0
Transport, other	11	6.1	7	5.8	18	6.0
All others	15	8.4	9	7.4	24	8.0
Total	**179**	**100**	**121**	**100.0**	300	100.0

Age specific injury death rates during 1998-2002 were highest for Asians older than 75 years of age, where females had a slightly higher injury death rate (173 deaths per 100,000 population) than their male counterparts (144 deaths per 100,000 population).(Figure 4) Children under 15 years age group had the lowest injury death rate where male children had a slightly higher death rate than the female children of the same age group.

Asian injury Hospitalisation (all ages)

Between 1993 and 2004 there were 11,833 injury hospitalisations for Asians, accounting for an average rate hospitalisations of 986 per year. There were more males (58.2%) than females (41.8%) hospitalised during this period. The Average duration of hospital stay was 3.8 (SD±9.14) days.

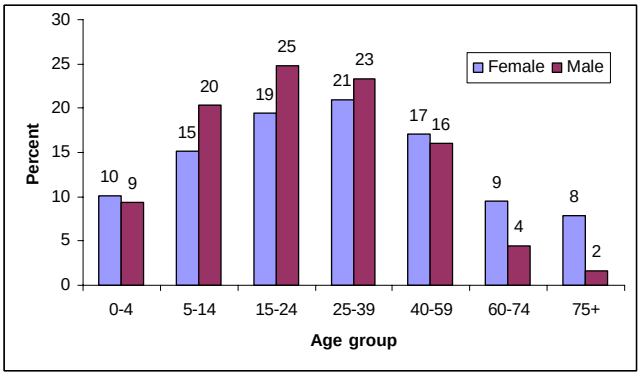

Figure 5: Injury hospitalisations by age and gender for all Asians, 1993-2004

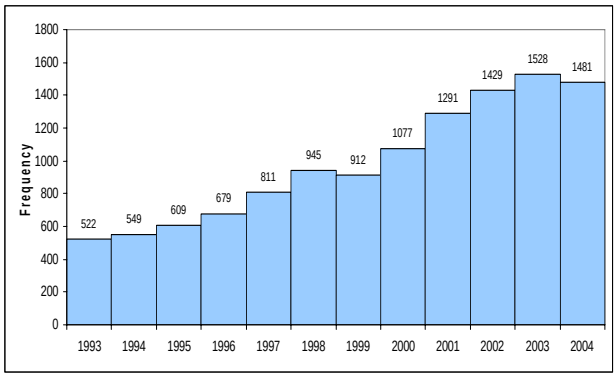

Figure 6: Injury hospitalisations by year for all Asians, 1993-2004

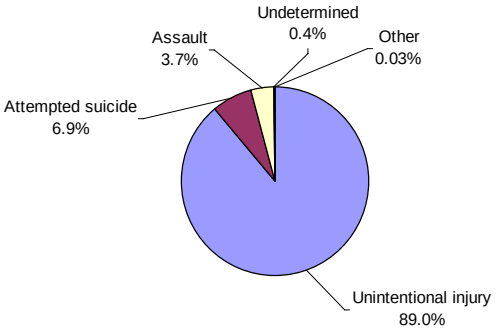

Figure 7: Manner/intent of injury hospitalisations for all Asians, 1993-2004

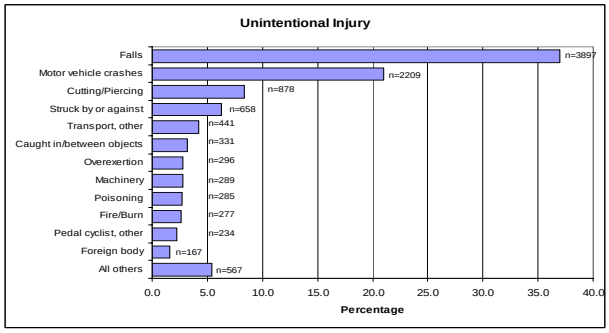

Figure 8: Causes of unintentional injuries requiring hospitalisation for all Asians, 1993-2004

The highest proportion of injury hospitalisations for Asian females and males was in 25-39 year (21%) and 15–24 year (25%) age group respectively; and the lowest proportion of injury related hospitalisations was in age group of 75 years and over (males 2% and females 8%).(Figure 5) In general, the numbers of Asians admitted to hospital following injury increased

steadily during the study period with some plateauing off in 2003-2004.(Figure 6) Most of the injury hospitalisations (89%, n=10,530) were due to unintentional injuries;(Figure 7) followed by attempted suicide (7%, n=816) and assault (4%, n=439). The causes of injury for 45 hospitalised patients (0.4%) could not be determined.

During the study period (1993-2004), falls (37.0%) were the leading cause of unintentional injury hospitalisations for all Asians.(Figure 8) Other leading causes of hospitalisations were motor vehicle crashes (21.0%), cutting and piercing (8.3%), struck by or against (6.2%), other transport crashes (4.2%), and caught in or between objects (3.1%).

Place of Occurrence of Injury Hospitalisations

For the period between 1993 and the middle of 2001, the place of occurrence of injuries for 37% of the total 6732 injury hospitalisations for Asians was not specified.(Figure 9) One-fifth (20.9%) of the hospitalised injuries occurred at home, followed by 16% on streets or highways, and 12% at recreational or sports facilities.

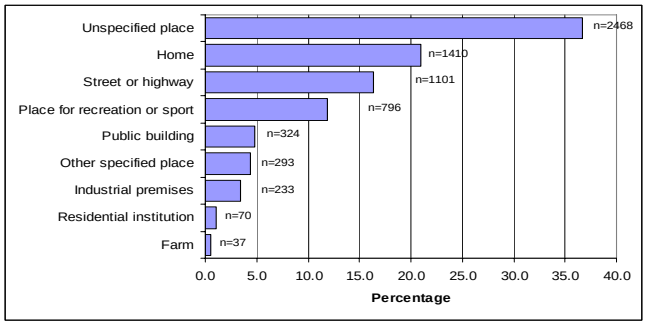

Figure 9: Place of occurrence of injury hospitalisations for all Asians, 1993-Jun 2001

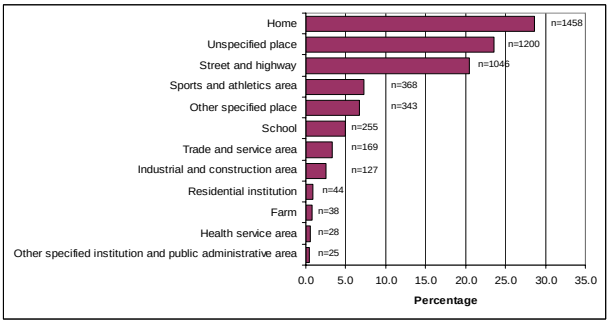

Figure 10: Place of occurrence of injury hospitalisations for all Asians, Jul 2001-Dec 2004

Similarly, between July 2001 and December 2004, over one-quarter (28.6%) of the 5101 injury hospitalisations for Asians occurred at home.(Figure 10) Nearly a quarter (23.5%) occurred in unspecified places, and one-fifth (20.5%) occurred on streets or highways.

Asian Injury Hospitalisation Rate (1998-2004)

During 1998-2004, the average injury hospitalisation rate for Asians was 520 per 100,000 population, where Asian males had a higher injury hospitalisation rate (626 per 100,000 population) than females (424 per 100,000 population).

Age specific injury hospitalisation rates for Asian females during 1998-2004 showed that adults older than 74 years of age had the highest hospitalisation rates (3075 per 100,000 population), where females ($3895/10^5$) had twice the rate that of males ($1813/10^5$).(Figure 11) Asians aged 25-39 years had the lowest hospitalisation rate (569 per 100,000 population) where males had higher rates ($740/10^5$) and females ($427/10^5$).

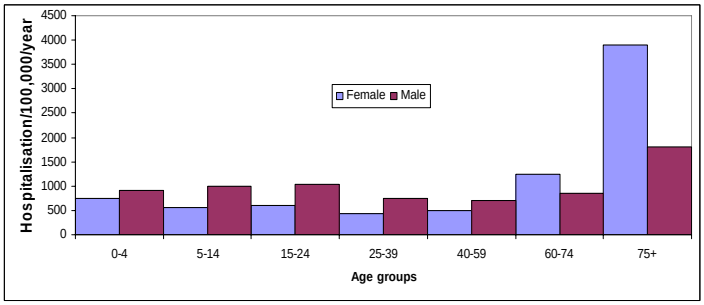

Figure 11: Injury rate of hospitalisations by age and gender for Asians, 1998-2004

Comparison between Asian and European/ Pakeha injury deaths

During 2000-2002, 184 Asians died from injuries, where 2,955 Europeans/Pakeha died from the same causes. The age-standardised injury death rate for Asians was slightly lower (30

deaths per 100,000 population) in all age group compared to Europeans (33 deaths per 100,000 population) except for children aged 5-14 years and adults aged 60 years and over.(Figure 12)

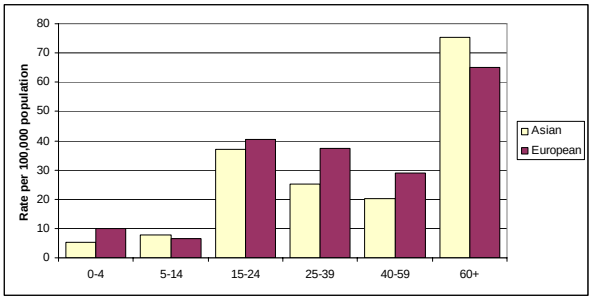

Figure 12: Average injury death rates by age group for Asians and Europeans/Pakeha, 2000-2002

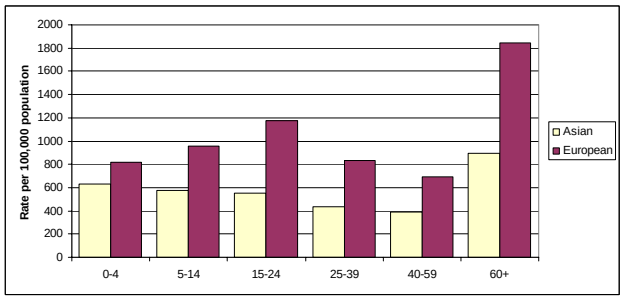

Figure 13: Average injury hospitalisation rates by age group for Asians and Europeans in NZ, 1998-2004

When comparing the age-standardised death rates by intent of injury, Asians and Europeans (21 deaths per 100,000 population) had the same death rate in the unintentional injury deaths category.

When percentage, crude rate, and age-standardised rate of the leading causes of unintentional injury deaths for Asians and Europeans during the period of 2000-2002 were compared, motor vehicle crashes were the leading cause of unintentional injury deaths for both ethnic groups with similar death rates ($10/10^5$ vs $9/10^5$).(Table 2) Asians had a slightly lower age-standardised falls death rate ($4/10^5$) than Europeans ($6/10^5$). However, Asians had a higher age-standardised death rate for drowning compared to Europeans ($3/10^5$ vs $1/10^5$).

Table 2. Ethnic comparison of leading causes of unintentional injury deaths, 2000-2002.

Causes	**Asian (n=121)**			**European (n=1909)**		
	%	Crude rate/100,000	Age-standardised rate/100,000	%	Crude rate/100,000	Age-standardised rate/100,000
Motor vehicle crashes	58	10	10	40	9	9
Falls	12	2	4	31	7	6
Drowning	17	3	3	4	1	1
Transport, other	3	1	0	5	1	1

Comparison between Asian and European/ Pakeha injury hospitalisations

For the period 1998-2004, there were a total of 209,080 injury hospitalisations for Europeans, where Asian had 8663 injury hospitalisations. Europeans had a higher age-standardised injury hospitalisation rate (1,024 per 100,000 population) compared to Asians (551 per 100,000 population). Hospitalisation was required for an average of 3.7(SD±10.05) days for Asians, where Europeans stayed an average of 4.6(SD±9.01) days in hospital. Compared with those of Asian ethnicity, NZ Europeans had higher age-specific injury hospitalisation rates in all age groups examined.(Figure 13)

Age-standardised hospitalisation rate for Asians was lower ($501/10^5$) than the Europeans ($926/10^5$) when causes of injury hospitalisation were considered. Falls were the leading cause of unintentional injuries among Asians and Europeans during the period 1998 - 2004.(Table 3) The average age-standardised rate of unintentional falls for Europeans (422 hospitalisations per 100,000 population) was much higher than the rate for Asians (218 hospitalisations per 100,000 population).

Table 3: Ethnic comparison of leading causes of unintentional injury hospitalisations, 1998-2004

Causes	Asian (n=7691)			European/Pakeha (n=189732)		
	%	Crude rate/100,000	Age-standardised rate/100,000	%	Crude rate/100,000	Age-standardised rate/100,000
Falls	38	173	219	47	445	422
Motor vehicle crashes	21	94	95	13	128	127
Cutting/Piercing	8	36	39	7	71	70
Struck by or against	6	27	25	6	56	57
Transport, other	5	22	20	4	37	39
Overexertion	3	13	14	4	40	39
Near drowning	0.5	2	2	0.2	2	2

DISCUSSION

The principal aims of this descriptive study were to review the existing literature on injuries among Asians in New Zealand and provide a profile of fatal and serious non-fatal injury in this population using data derived from the mortality and hospital discharge databases of the New Zealand Health Information Service.

The average rate of injury deaths among Asian population over the period 1993 to 2002 was 27 per 100,000 population, with males being twice as likely to die from an injury as females. The age standardised injury death rates among Asians ($30/10^5$) and Europeans ($33/10^5$) were relatively similar, but were lower than the national injury death rate ($42.4/10^5$) (Dyson, 2003). Asian New Zealanders aged 75 years and older appeared to be more vulnerable to both injury death and hospitalisation compared to other age group. Over two-thirds of all Asian injury deaths and nearly 90% of all injury hospitalisations among Asian were due to unintentional injuries. Motor vehicle crash (MVC) injuries (62%) were the leading cause of unintentional injury deaths followed by falls and drowning. On the other hand falls (37%) were the leading cause of unintentional injury hospitalisations among Asians. However, for 25-59 year age group MVC injuries appeared to be most common cause of deaths and hospitalisations for Asians. The main victims of falls injuries were adults aged 75 years and older where drowning victims were mostly young adults.

Asian population in New Zealand has increased three-fold between the 1991 and 2001 censuses (Anonymous, 2001). The Asian injury deaths found to be highest in proportion among 25-39 years age group which is much higher among males than females. However, the highest annual injury death rates in this analysis were found among people aged 75 years and older with a preponderance of females, consistent with a national injury study on all New Zealanders (Spicer, Miller, Langley, & Stephenson, 2005).

Although injury is recognised as a leading contributor to avoidable mortality and potential years of life lost below 75 years of age in New Zealand (Tobias & Jackson, 2001) the equivalent estimates for Asians were not examined in this report. While data on the place of occurrence of an injury can provide useful insights for focusing injury prevention efforts, the place of injury was not specified for more than a third of hospitalised Asians, suggesting an important information gap.

Motor Vehicle Crashes

Motor vehicle crashes (MVC) were the leading cause of injury deaths among Asians with males accounting for 62% of deaths, close to the national average of 68% (Anonymous, 2004). As a proportion of unintentional injuries, Asians (58%) had a higher proportion of

MVCs compared to Europeans (40%). The crude rates of MVC injury death rates among Asians ($10/10^5$) were similar to that among NZ Europeans ($9/10^5$), but lower than the national MVC injury rate ($13.8/10^5$) (Anonymous, 2004). Age standardised rates of MVC deaths were also similar among Asians and NZ Europeans. Equivalent proportions of drivers and passengers of motor vehicles were represented among road user injuries. A high proportion of MVC deaths and hospitalisations among Asians were in the 25-39 year age group, indicating an important target group for road traffic injury prevention efforts. Other recently published reports suggest that Asians were mostly involved with MVCs on the rural highways (LTSA, 2003a, 2003b, 2004a, 2004b, 2004c, 2004d, 2004e, 2004f, 2004g, 2004h, 2004i, 2004j, 2004k) although the context for the injuries in routinely collected statistics was not identifiable. This requires further investigation to identify appropriate interventions.

Falls

Falls were the second leading cause of injury death and the commonest cause of injury-related hospital admissions among Asians. Most falls that were classifiable by context, were attributed to slipping, tripping or stumbling on the surface. Falls were particularly common among people aged 40 years or older. Falls in the playground most commonly occurred among children who were school beginners (5-9 years). There are well-recognised limitations in the coding of falls using current classification systems including that employed by the WHO International classification of Diseases. The main limitation includes difficulties in understanding the context of falls which adds to the problems posed by missing information relating to the data field on the place of injury. This requires further investigation.

Drowning

Drowning is the third leading cause of injury deaths in New Zealand with Asians accounting for approximately 8% of these deaths.(Anonymous, 2005; Stanley, 2005) The circumstances of drowning among Asians require further review, particularly including knowledge of water safety, awareness of hazards, relationships to recreational pursuits and particular groups within the Asian community who may be at higher risk. Previous reports have highlighted the topic of Asians being drowned on the rocky foreshore, in surf beaches or during fishing (Watersafe). Some reports have also indicated that the rates of drowning among Asians have increased in recent years (Anonymous, 2005; Stanley, 2005; Watersafe). Our analysis also found that the age-standardised rates of drowning among Asians are higher compared to that among NZ Europeans. Most Asians who drowned were in the 25-59 years age group while hospital admissions relating to a near drowning were most commonly reported in those aged less than 10 years.

CONCLUSION

Asians comprise an increasing proportion of the New Zealand population. The analyses present the commonest causes and mechanisms of unintentional injury resulting in death and in-patient admissions in this group. These causes are consistent with the identified priorities for action in the New Zealand Injury Prevention Strategy. The findings indicate there are important reasons to identify the contexts and contributing factors for these injuries in the Asian population – potentially including the impact of migration and other areas of risk (e.g., un-identified issues relating to mental health or access to services) that may constitute particular hazards among Asian New Zealanders. The profile presented also indicates the need for appropriate health services for Asians who are injured, require rehabilitation, and/or need other support due to injury.

ACKNOWLEDGEMENTS

We are thankful to the Accident Compensation Corporation (ACC) for funding the project, the New Zealand Health Information Services (NZHIS) for providing the data for analysis, and the Injury Prevention Research Centre (IPRC) and UniServices for administrative support.

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WATER SAFETY KNOWLEDGE, ATTITUDES AND BEHAVIOURS OF ASIAN YOUTH IN NEW ZEALAND

Kevin Moran

ABSTRACT

Recent drowning statistics suggest that Asian peoples are now over-represented in drowning statistics, constituting 12% of the national drowning toll yet comprising only 6.6% of the population in 2002. In spite of this, little is known about the nature and extent of aquatic recreation among Asian peoples or what they bring to that participation in terms of their understanding of water safety. This paper reports on the participation in aquatic recreation and the water safety knowledge, attitudes and behaviours of Asian youth in New Zealand.

Two hundred and six students (9.4%) who self-identified as of Asian ethnicity were among a total of 2,202 students aged between 15-19 years who took part in a nationwide survey on water safety in 2003. A written questionnaire, completed under the direction of survey administrators during school hours, was used to gather data on student participation in aquatic activities, their water safety knowledge, attitudes and behaviours.

Asian youth did not participate in as much aquatic activity (with the exception of land-based fishing) as non-Asian youth. They held more positive attitudes towards water safety than their non-Asian counterparts, as well as reporting a lower incidence of self-reported at-risk behaviours during swimming and other aquatic activities.

Water safety knowledge and skills were generally poor however, with one third of students unable to swim 25 m (n = 66; 32%), more than one half unable to perform a rescue (n = 121; 59%) and almost two thirds unable to perform CPR (n = 130; 63%). In addition, knowledge of small boat safety and surf safety were limited. Ways of addressing these shortcomings through education are discussed, including swimming and water safety instruction at school and in the wider community, and especially for new settlers and students of short-term residency.

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INTRODUCTION

In an island nation with easy access to water, evidence of the propensity of young New Zealanders to recreationally engage in aquatic activity abounds. Preliminary findings on youth sport and recreational activities show that swimming was the most popular out-of-school active leisure activity for both boys and girls. (Sport and Recreation New Zealand [SPARC], 2002). While participation in recreational aquatic activity is generally perceived as a positive

indicator of a healthy New Zealand lifestyle, it does have attendant negative consequences, consequences that are frequently iterated in high profile media coverage of drowning and rescue incidences. A recent newspaper report (New Zealand Herald, October 31, 2005) for example, highlighted possible language difficulties as a reason for a 14 year-old Thai female getting into difficulty at a notorious west coast surf beach (Binning, 2005). Moreover, recent evidence suggest that Asian peoples are now over-represented in drowning statistics, constituting 12% of the national drowning toll yet comprising only 6.6% of the population in 2002 (WSNZ Drownbase, 2003).

To address the persistently high incidence of drowning among many sectors of New Zealand society, the recently released Drowning Prevention Strategy (Accident Compensation Corporation [ACC], 2005) has called for greater research on what New Zealanders know, think and do about their water safety during aquatic recreation. Currently, little is known about the nature and extent of aquatic recreation among Asian peoples or what they bring to that participation in terms of their understanding of water safety. What is known is that more than three-quarters (78%) of the New Zealand resident Asian population were born in Asia and, compared with the rest of a fast-ageing population, a greater proportion is youthful, with 21% of the Asian population aged between 15-24 years compared with 14% of the non-Asian population (Statistics New Zealand, 2002). How such demographics impact on the water safety of Asian youth in New Zealand society has not been investigated. Overseas studies have suggested that young immigrant populations are at greater risk of drowning than long-term residents (for example, Smith & Brenner, 1995 in the United States; Nixon & Pearn, 1978 in Australia; Verweij & Bierens, 2002 in Holland; Lindholm & Steensberg, 2000 in Denmark). It was the purpose of this paper therefore, to examine the drowning risk of Asian youth resident in New Zealand in terms of their participation in aquatic recreation and their associated water safety knowledge, attitudes and behaviours.

METHOD

The subjects of this study were part of a nationwide sample of 2,202 youth, 4% of a target population of approximately 50,000 Year 11 (5^{th} Form) students. Within this population base, 4,942 (9.7%) were identified as of Asian ethnicity (Source: Ministry of Education, Data Management Unit, July 2002 school rolls). A written questionnaire, completed under the direction of survey administrators during school hours, was used to gather data in a nationwide survey in the second school term (Autumn), 2003. The questionnaire included a range of forced-response questions on student participation in aquatic activities, their water safety knowledge, attitudes and behaviours. A draft questionnaire was subjected to cognitive testing in two pilot studies, peer reviewed by a panel of water safety experts and modified. Reliability of the questionnaire was established in two further pilot studies carried out one month immediately prior to the commencement of the main survey. A stratified random sampling frame based on school type and geographical region was used to select 41 schools in which to conduct the survey.

Data on aquatic recreation and associated water safety were analysed using a number of socio-demographic variables including gender, socio-economic status via the decile rating of the school attended, length of residency and ethnicity. While recognizing the limitations of agglomerating several peoples into one category (Rasanathan, Craig & Perkins, 2004), ethnic groupings were broadly based on Statistics New Zealand classification and included European/Pakeha, Maori, Pasifika, Asian and a category for those who self-identified as of other ethnicities than those specified. Comparisons between ethnic groups are available in the final report entitled *New Zealand Youth Water Safety Survey 2003* (Moran, 2003). For the purpose of this study, responses from students who did not self-identify as Asian have been

aggregated as non-Asian so as to provide a basis of comparison between the aquatic activity and water safety of New Zealand youth of Asian descent and their contemporaries.

Data from the completed questionnaires were entered into Microsoft Excel X for statistical analysis using SPSS Version 12.0 in Windows. Frequency tables were generated for all questions and, unless otherwise stated, numbers and percentages are expressed in terms of response frequency within groups of Asian and non-Asian students. Chi-square tests with levels of significance adjusted with Yates' Continuity Correction and Mann-Whitney *U* tests with Bonferroni Correction applied in multiple comparisons, were used to ascertain significant differences between groups.

RESULTS

Two hundred and six students (9.4% of the sample population), aged between 15-19 years and enrolled in full-time study in New Zealand state or private schools, who self-identified as of Asian ethnicity, were among a total of 2,202 students that took part in the survey. Youth who were non-permanent residents studying in New Zealand schools were included in the survey since they were exposed to the same drowning risk as others while residing in New Zealand. When compared with the non-Asian students respondents, the Asian student cohort contained slightly a greater proportion of males than females (60% vs. 53%), more students attending decile 8-10 schools indicating higher socio-economic status (52% vs. 42%), and more students with less than two years of residency (45% vs. 4%).

Participation in Swimming and Other Forms of Aquatic Recreation

Table 1 shows that most Asian students had, like other Year 11 students, used public pools for swimming in the previous year, although they were less likely than non-Asian students to have swum at other locations. Significant differences were found between Asian and non-Asian students in the frequency of swimming at all sites. Less than half of Asian students had used patrolled surf beaches (48%) and less than one third had used home pools (27%), non-patrolled surf beaches (31%), lakes (29%) or rivers (28%), for swimming.

Table 1. Aquatic recreation of Asian and non-Asian students in the previous year.

Aquatic Activity	Asian Students		Non-Asian students		χ^2	*df*
	n	%	*n*	%		
Swim - Public pool	167	81.1	1783	89.4	11.750*	1
Swim - Patrolled surf beach	98	47.6	1580	79.2	100.892*	1
Swim - Non-patrolled surf beach	63	30.6	1432	71.8	143.107*	1
Swim - Lake, pond	60	29.1	1343	67.3	115.830*	1
Swim - Home pool	55	26.7	1092	54.7	57.448*	1
Land-based fishing	103	50.0	1086	54.4	1.275	1
Paddling activity	80	38.8	1384	69.4	76.513*	1
Small-craft boating	77	37.4	1231	61.7	44.619*	1
Surfing activity	65	31.6	1374	68.9	112.868*	1
Underwater activity	53	25.7	950	47.6	35.040*	1

*Significant at the 0.05 level, adjusted with Yates' Correction for Continuity

Table 1 shows that, with the exception of public pools, approximately twice as many non-Asian students had swum at any of the other swimming locations. Further comparisons

between ethnic groups showed that Asian students were six times less likely than European/Pakeha and Maori students to have used patrolled surf beaches more than 20 times in the previous year (3% compared with 17% and 18% respectively).

Table 1 also shows the other aquatic recreational activities engaged in during the previous year. One half of Asian students (50%) had participated in land-based fishing, making it their most popular form of aquatic recreation. Approximately one third had participated in paddling activities (39%), small-craft boating activities (37%) and surfing activities (32%), and one quarter had participated in underwater activities (26%). As was the case with swimming, Asian students participated less frequently in other forms of aquatic activity than non-Asian students, with the exception of land-based fishing. Significant differences were found between Asian and non-Asian students in surfing, paddling, boating and underwater recreation, with approximately twice as many non-Asian students participating in these forms of aquatic activity.

Water Safety Knowledge and Skills

Students were asked to estimate their proficiency in swimming, rescue and resuscitation skills. Table 2 shows that Asian students estimated lower levels of swimming proficiency than other students, with one third (32%) unable to swim more than 25 m and more than three quarters (77%) unable to swim more than 100 m. By comparison, fewer non-Asian than Asian students thought they could swim less than 25 m (11% vs. 32%) and more thought they could swim more than 100 m (48% vs. 23%).

Table 2. Self-estimated swimming ability of Asian and non-Asian students.

Swimming ability	Asian students			Non-Asian students		
	n	*%*	*Cum%*	*n*	*%*	*Cum%*
Non-swimmer <25 m	66	32.0	32.0	221	11.1	11.1
Can swim 25-100 m	93	45.1	77.1	810	40.6	51.7
Can swim 101-400 m	23	11.2	88.3	572	28.6	80.3
Can swim >400 m	24	11.7	100.0	393	19.7	100.0

Similar disparities between Asian and non-Asian youth also were evident in the practical water safety skills of performing a deep-water rescue and cardio-pulmonary resuscitation (CPR). More than half (59%) of Asian students reported no rescue ability whereas a fifth (19%) thought that they had good/excellent rescue skills. By comparison, only a third (32%) of non-Asian students thought they had no rescue ability and almost half (46%) reported good/excellent rescue ability. In addition, almost two thirds (63%) of Asian students had no CPR skills and only a fifth (19%) reported having good/excellent skills. By comparison, four in ten (41%) of non-Asian students thought they had no CPR ability and more than a third (36%) reported good/excellent CPR ability.

Cognitive understanding of small boat and surf safety were analysed in two questions that required water safety responses to hypothetical activities that included a day out on a small boat and a visit to a surf beach. In the small boat safety question, students were asked to list safety items required for a boat which was illustrated in the question, and to suggest what safety preparation and on-board rules they would instigate for their safety and the safety of others. More than a quarter (27%) of Asian students failed to identify any boat safety items, and slightly less than half failed to suggest any safety preparation (43%) or on-board safety rules (44%). By comparison, fewer non-Asian students than Asian students failed to identify

any safety items (7% vs. 27%), suggest either safety preparation prior to setting out (15% vs. 43%) or establish any on-board safety rules (22% vs. 44%).

A question on surf safety asked students to identify hazards in a picture of a surf beach, to suggest what safety decisions they would take during a visit to that beach, and to identify where they would position themselves on the beach and where they would enter the water for a swim. Many Asian students (41%) failed to identify any surf hazards from the picture of the surf beach and one half (50%) failed to suggest any safety decisions they would make if visiting that beach. In addition, half (50%) of the Asian students took the worst of the four possible risk options with regards to where they would locate on the beach and enter the water. By comparison, fewer non-Asian than Asian students failed to identify surf hazards (33% vs. 41%), failed to suggest any safety decisions (27% vs. 50%) or took the worst risk option on where to locate and enter the water (25% vs. 50%).

Water Safety Attitudes

Students were asked their attitude towards a range of water safety issues that included surf safety, boat safety and alcohol consumption during aquatic activity. Table 3 shows significant differences in water safety attitudes between Asian and non-Asian students, with the exception of responses about lifeguard authority. In terms of surf safety, significantly more Asian students than non-Asian students disagreed that swimming outside surf-patrolled areas was acceptable if it looked safe (68% vs. 56%) or that it was safe to swim after surf patrols had finished if there were other people in the water (56% vs. 37%). Slightly more Asian students disagreed that lifeguards should not be able to tell you where to swim (78% vs. 75%), although the difference was not statistically significant. In terms of boat safety, significantly more Asian students disagreed that wearing a lifejacket was unnecessary close to shore (71% vs. 64%), that drinking alcohol was acceptable while fishing from a small boat on a calm day (72% vs. 54%) or that it was okay provided the skipper stayed sober (70% vs. 51%).

Table 3. Water safety knowledge of Asian and non-Asian students.

Water safety knowledge	Asian students		Non-Asian students	
	n	*%*	*n*	*%/(range)*[‡]
No water safety items identified for small boat day trip	55	26.7	130	6.5 (5.2-10.3)
No safety preparation suggested prior to departure on boat trip	89	43.2	295	14.8 (11.9-22.0)
No on-board safety rules suggested to ensure safety of self/others	91	44.2	429	21.5 (18.4-29.1)
Could not identify any surf or beach hazards from illustration of surf beach	85	41.3	331	16.6 (11.7-27.5)
Suggested no safety decisions for self/others on imagined arrival at the surf beach	102	49.5	546	27.4 (20.7-42.6)
Took worst of risk options with regards to where to locate on beach and enter water	103	50.0	506	25.4 (20.1-39.2)

[‡] Range of percentages among other ethnic groups

Water Safety Behaviour

Those students who had participated in aquatic recreation in the previous year were asked to report on their behaviour during swimming and other aquatic recreation. Table 4 shows that more than half (53%) of Asian students had swum unsupervised, a third had swum when cold or tired (33%) or outside patrol areas (30%), and a quarter had ignored water safety advice (26%) or swum in prohibited places (26%). Using alcohol/drugs in conjunction with swimming activity was the least reported at-risk behaviour (11%) among Asian youth. Table 4 also shows that, with the exception of never wearing a lifejacket, telling adults of their intentions and checking conditions beforehand, significantly fewer Asian students engaged in at-risk behaviours during aquatic recreation compared with non-Asian students. By comparison, twice as many non-Asian than Asian youth had swum when cold or tired, swum in prohibited areas, swum outside patrolled areas on a surf beach, or swum after using alcohol/drugs.

Table 4. Water safety attitudes of Asian and non-Asian students.

Appropriate water safety response to the following statements -	Asian students		Non-Asian students		χ^2	*df*
	n	%	*n*	%		
Swimming outside surf patrol flags is okay if it looks safe	140	68.0	1110	55.8	10.857*	1
Swimming after patrols have ended is okay if other people are in surf	116	55.8	738	37.0	26.873*	1
Lifeguards shouldn't be able to tell you where to swim in the surf	155	77.9	1484	74.5	0.190	1
Wearing a lifejacket in a small boat unnecessary if <100 m from shore	147	71.4	1266	63.5	4.582*	1
Drinking alcohol on a small boat is okay provided skipper stays sober	144	70.0	1014	50.8	26.206*	1
Drinking beer while fishing from a small boat is okay on a calm day	148	71.8	1081	54.2	22.623*	1

*** Significant at the 0.05 level, adjusted with Yates' Correction for Continuity**

Further analysis of differences in at-risk behaviours between ethnic groups showed that more Asian students never swam unsupervised compared with European/Pakeha, Maori and Pasifika students (48% compared with 25%, 19% and 25% respectively), never swam when cold or tired (67% compared with 40%, 45% and 45% respectively), and never swam outside patrolled areas at a surf beach (70% compared with 35%, 31% and 48% respectively).

Students were asked whether they had observed any of their peers performing at-risk behaviours in the aquatic environment. Where participants had never been with their peers to observe at-risk behaviours, nil responses were recorded and screened out of the data to leave only the observed behaviours. The most frequently observed at-risk behaviour among Asian youth was swimming without adult supervision, reported by more than half (58%) of students. Less than half (44%) had observed their friends swimming outside a patrol area, and slightly more than a third had seen their friends not wear lifejackets (39%) or swim in a prohibited place (35%). Approximately one quarter of Asian students had observed their friends encourage others to take risks around water (29%) or ignore water safety advice (29%). Less than one fifth (17%) had seen their friends use alcohol or drugs during aquatic recreational activity. As was the case with the self-reported risky behaviours shown in Table 4, significantly more non-Asian students had observed their friends engaging in at-risk

behaviours in the aquatic environment. For example, twice as many non-Asian students reported that they had observed their friends swimming outside surf patrol flags (64% vs. 30%), swimming in prohibited areas (26% vs. 52%) or swimming after alcohol/drugs (11% vs. 25%).

DISCUSSION

The comparatively low levels of participation in aquatic recreation among Asian youth that took part in this study suggest that they were less likely than others to drown because of reduced exposure to risk. In addition to swimming less frequently, they also swam in safer locations than their non-Asian counterparts. Most Asian students had swum in public pools that are generally supervised and thus a relatively safe environment. Less than half had used the supervised, though less safe, open-water environment of a patrolled surf beach, and less than a third had used non-patrolled surf beaches, lakes and rivers that are high risk, unsupervised, open-water locations. In contrast, non-Asian students were twice as likely to have swum at high-risk, open-water venues such as non-patrolled surf beaches (72% vs. 31%), lakes (67% vs. 29%), and rivers (49% vs. 28%).

With the exception of land-based fishing, Asian students were least likely of all ethnic groups to be exposed to risk from other forms of aquatic recreation. By comparison, risk exposure for non-Asian students was almost twice that of Asian students for small-craft boating (59% vs. 37%), surfing (69% vs. 32%) and underwater activity (48% vs. 26%). Half of the Asian students had participated in land-based fishing making it their most popular aquatic recreational activity. The popularity of land-based fishing among Asian youth is of particular concern because of the high incidence of drowning as a consequence of rock fishing among Asian peoples in New Zealand (Surf Lifesaving New Zealand / Water Safety New Zealand, 1996) and nearest neighbour, Australia (Jones, 2003; Mitchell & Haddrill, 2003). A combination of high exposure to danger and an inability to cope with that danger are likely contributors to the over-representation of Asian peoples in rock fishing fatalities. The lack of practical aquatic competencies among Asian youth in this study suggests that they may be at greater risk than other New Zealand youth in the event of an unintentional immersion (as is usually the case in rock fishing drowning incidents).

The lack of swimming ability among Asian youth is especially problematic because one third (32%) could not swim 25 m, giving them little protection in the event of either intentional or unintentional immersion in open-water. By comparison, twice as many non-Asian as Asian students thought they could swim more than 100 m (48% vs. 23%). Poor levels of swimming ability, attributable to a lack of opportunity to learn to swim, have also been reported as a major contributor to the high incidence of drowning among ethnic minorities in overseas studies (Mael, 1995; Smith & Brenner, 1995; O'Flaherty & Pirie, 1997). The ability to assist others in an aquatic emergency also varied markedly between Asian and non-Asian youth with twice as many Asian having no rescue ability (59% vs. 32%), whereas twice as many non-Asian students were confident of their rescue abilities (46% vs. 20%). In addition, almost two thirds of Asian students reported having no CPR skills compared with four in every ten non-Asian students (63% vs. 41%). Whether the limited swimming, rescue or CPR ability of more than one in every two Asian students is offset by the lesser exposure to drowning risk previously reported is difficult to ascertain. However, on the assumption that as New Zealand Asian youth, two thirds (67%) of whom are of recent residency, become more familiar with New Zealand lifestyle and its aquatic orientation, it may be prudent to increase the practical ability base of Asian students in order to offset any subsequent increased exposure to drowning risk.

Perhaps not surprisingly, given their reported lack of boating participation, young New Zealanders of Asian ethnicity demonstrated less understanding of small boat safety than non-Asian students, with almost four times as many Asian students failing to identify two essential boat safety items (27% vs. 7%). A similar lack of experience of surf beaches and surf activity also might account for more than twice as many Asian students failing to identify any surf hazards (41% vs. 17%). This lack of understanding of water safety principles coupled with the lack of practical competencies and experience previously reported, is likely to exacerbate the risk of drowning for many Asian youth in New Zealand. Similar concerns about a poor understanding of water safety among individuals from culturally and linguistically diverse (CALD) backgrounds have been expressed in Australia (Australia Water Safety Council, 1998). More recently, in a series of focus group interviews among the Chinese community in New South Wales, Mitchell and Haddrill (2003) found a lack of safety awareness during rock fishing and boating activities and recommended further water safety promotion within that community.

Even though the practical skills and knowledge of Asian youth in New Zealand were limited, their attitudes towards water safety were much more positive than those of other students. For example, even though many Asian youth were not able to identify surf hazards in the question relating to surf safety knowledge, they responded more positively than others to the necessity of swimming between the flags (68% vs. 56%) and not swimming after surf patrols have finished duty (56% vs. 37%). In addition, even though boat safety knowledge was lacking, Asian students were more likely to respond favourably towards lifejacket use (71% vs. 64%) and not drinking alcohol when fishing on a calm day (72% vs. 54%) or if the skipper remained sober (70% vs. 51%). Interestingly though, similar proportions of Asian and non-Asian youth students (22% and 25% respectively) disagreed that lifeguards should be able to tell you where to swim. It would appear that the antipathy towards authority during a developmental phase characterized by increasing independence from adult control (DiClemente, Hansen & Ponton, 1996) persists among some adolescent youth, irrespective of their culturally diverse backgrounds.

In addition to generally espousing more positive attitudes towards water safety than their contemporaries, Asian students also reported less at-risk behaviour during swimming and other aquatic recreational activities. This was especially apparent with regards to behaviours that required compliance with safety advice and rules. For example, non -Asian students were almost twice as likely as Asian students to have swum outside the patrol flags at a surf beach (64% vs. 30%) or to have seen a friend transgress this fundamental surf safety advice (71% vs. 44%). Compliance with water safety rules was more evident among Asian students with fewer students ignoring water safety directions (26% vs. 40%) or swimming in prohibited places (26% vs. 52%). In addition, they were far less likely than non-Asian students to have observed their friends ignoring directions (29% vs. 41%) or swimming in prohibited places (35% vs. 57%), a reflection of healthy social group norms among Asian students with regards to their water safety.

Asian students differed little from their contemporaries in the lack of adult supervision or companions during aquatic activity. When swimming, more than half of Asian students (53%) and three quarters of non-Asian students (76%) had swum unsupervised and slightly less than half (47%) of both groups had swum alone. In addition, a quarter (28%) of Asian students had participated in other aquatic activities without supervision, and a third had never told an adult beforehand of their intentions (33%) or had gone on their own (32%). While the lack of adult supervision is perhaps understandable among an age group that are typically moving towards independence of thought and action as they approach adulthood, the potential risk of not informing parents or doing the activity without companions may be more problematic for Asian youth. Their risk of drowning may be exacerbated because they may

not have immediate recourse to adult family members capable of responding in an aquatic emergency, they may not have adults who understand the importance of adult monitoring of youth aquatic activity and they may not have the pre-requisite skills and knowledge to act independently with safety as previously discussed.

Asian students were more averse than non-Asian youth to mixing alcohol/drugs with aquatic activity. Less than one in ten Asian students reported using alcohol/drugs during swimming (10%) and other aquatic activity (9%), a frequency half that of non-Asian students. In addition, fewer reported seeing their friends using alcohol/drugs than other students (17% vs. 30%), which again suggests a healthy group norm towards such practice. The strong aversion towards alcohol consumption during aquatic recreation, obvious in youth attitudes and behaviours, may be explained by their newness to New Zealand culture and hence an unfamiliarity with the traditional, but potentially life-threatening, association of alcohol with aquatic recreational activity that pervades other sectors of New Zealand society. Whether in the process of acculturation, such positive attitudes among Asian youth will persist into adulthood, is difficult to ascertain. To counter any possible negative attitude shift, reinforcement of the protective value of abstention from alcohol during aquatic recreation in any water safety campaign aimed at the Asian community would appear propitious.

CONCLUSION

The nature and extent of risk of drowning associated with participation in aquatic recreation among Asian youth resident in New Zealand differs from that of non-Asian youth. In terms of exposure to risk of drowning, lower levels of participation in aquatic recreation meant that Asian youth were less likely to drown than other youth. Rock fishing, an activity engaged in by half of all Asian and non-Asian youth alike, was the exception and, given the high incidence of drowning among Asian peoples, rock fishing safety requires particular attention in future water safety promotion. In addition, their likelihood of drowning was less because Asian youth held more positive attitudes towards water safety and reported less at-risk behaviour in and around water. This disposition towards safety in the aquatic environment was reflected also in less observed at-risk behaviour among friends. However, a lack of practical survival skills and a poor understanding of water safety principles heightened drowning risk since Asian students had the least capacity of all ethnic groups to manage risk in the event of unintentional or intentional immersion.

Because self-reporting in assessing safety skills, abilities and behaviours, as used in this baseline study, has limitations (Robertson, 1992), further research is required to corroborate the findings. Observational studies of behaviour in and around water, and qualitative analysis of attitudes and beliefs via focus group interviews are two possible ways of providing further understanding of what New Zealand Asian youth know, think and do about their water safety. In addition, further study of the suitability of current educational interventions for this group is also needed in order to determine whether alternative strategies and programmes are required. Further monitoring of Asian youth participation in aquatic recreation is also recommended since it is likely that, as they move into adulthood they are likely to engage in more aquatic recreation without the benefit of the water safety education that many of their contemporaries may have enjoyed.

These limitations notwithstanding, the study has provided robust evidence of a lack of water safety skills and knowledge among young Asian New Zealanders. To address this lack of water safety background, three water safety education initiatives are recommended. They include: school-based induction programmes for new migrants with an emphasis on water safety and aquatic recreation in New Zealand; subsidised commercial swimming and water

safety lessons targeted at new arrivals with poor swimming ability, and water safety information in a range of languages disseminated through new migrant community groups. Firstly, school-based induction programmes would provide a valuable first step in familiarising young Asian students with New Zealand's aquatic lifestyle and, at the same time, provide opportunity to identify and remedy specific weaknesses in their understanding of water safety principles and practice. Secondly, the government could fund water safety organisations and commercial providers to provide subsidised swimming and water safety lessons to those new migrant students, of primary or secondary school age, who are in need of such lessons. Such subsidies could be implemented using a voucher system for all recent arrivals on their enrolment in a state or private school. Thirdly, community-based water safety programmes could provide, not only the opportunity to reinforce water safety learning taking place at schools, but also learning opportunities for other family members and parents. Presenting water safety programmes in the language spoken in the home environment may be particularly valuable in helping overcome barriers that may face people from culturally and linguistically diverse (CALD) backgrounds.

Investment in Asian youth education has the potential to address many of the shortcomings identified in this study and thus positively influence the safety practice of a young and emerging sector of New Zealand society. Leaving the understanding and practice of water safety of Asian youth to chance in an aquatically oriented society such as New Zealand is simply not an option.

NOTE

Full details of the *New Zealand Youth Water Safety Survey 2003* are available in PDF format online at: http://www.watersafety.org.nz/news/index.asp

ACKNOWLEDGEMENTS

The author acknowledges the support of Water Safety New Zealand and Massey University in conducting the *New Zealand Youth Water Safety Survey 2003.*

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SAFETY ISSUES WITH HERBAL MEDICINES

Joanne Barnes

ABSTRACT

The use of herbal medicines is a popular healthcare approach in the UK among patients and the general public, and there is evidence that the use of such preparations is increasing. Although herbal medicines are widely perceived by the public to be safe, there is evidence that adverse effects (or adverse drug reactions, ADRs), including important interactions with conventional medicines, do occur. ADRs can occur, for example, due to problems with the pharmaceutical quality of unlicensed herbal medicines, intrinsically toxic constituents, as a side effect related to the desired pharmacological effect, as a result of excessive ingestion, or use by specific patient groups, such as pregnant women. Many herbal medicines have a long history of traditional use, but lack formal investigation of their efficacy, toxicity and safety profiles. Against this background, there have been several recent high-profile safety concerns which have had an impact on the public health. For these reasons, there is an increasing awareness at several levels of the need to develop pharmacovigilance (safety monitoring) practices for herbal medicinal products (HMPs). Pharmacovigilance for herbal medicines is in the early stages of its development. Challenges in pharmacovigilance of herbal medicines and future strategies will be discussed.

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INTRODUCTION

Herbal medicinal products (also known as phytomedicines or phytotherapeutic preparations) contain as intended active ingredients only crude and/or processed plants and/or plant parts; an isolated chemical constituent which originates from plant material is not a herbal medicine. The term ‘herbal medicines’ is used generally to describe both relatively crude preparations, such as herbal tinctures, usually supplied by herbal-medicine practitioners (medical herbalists), and manufactured or finished herbal medicinal products, usually formulated as tablets or capsules and available for purchase without a prescription.

The unique characteristics of herbal medicines, and the ways in which herbal medicines are named, perceived, sourced, utilised and regulated raise important issues and challenges for their safety and safety monitoring. Some issues arise because most herbal medicines can be obtained without a prescription from various outlets, not only pharmacies. Thus, the problems that apply to pharmacovigilance of conventional non-prescription medicines, for example, that generally their use does not involve a prescriber and is not recorded or monitored through the UK National Health Service (NHS), also apply to herbal medicines. Other problems are

specific to herbal medicines and present difficulties over and above those described for conventional prescription and non-prescription medicines.

Pharmacovigilance has been defined as "*the study of the safety of marketed drugs under the practical conditions of clinical usage in large communities*" (Mann & Andrews, 2002). It involves monitoring drug safety and identifying adverse drug reactions (ADRs) in humans, assessing risks and benefits, and responding to and communicating drug safety concerns. The definition makes no distinction between pharmacovigilance of conventional and herbal medicines; pharmacovigilance should embrace all preparations used medicinally regardless of their regulatory status, pharmaceutical composition, cultural use and philosophical framework. However, pharmacovigilance activities largely have been focused on conventional medicines, and the current model of pharmacovigilance and its science and processes have developed in relation to synthetic drugs. Applying the existing model and its tools to monitoring the safety of herbal medicines presents unique challenges in addition to those described for conventional medicines and it is important that these are understood by all stakeholders.

There is an increasing awareness at several levels of the need to develop pharmacovigilance practices for herbal medicines; the WHO, for example, has produced guidelines on this (WHO, 2004a). Awareness has arisen not only because of the extensive use of herbal medicines, but also because in recent years there have been several high-profile herbal safety concerns which have had an impact on the public health. Against this background, this paper aims to provide a critical overview of the current state of pharmacovigilance of herbal medicines, using the UK and New Zealand as examples, although the issues discussed have wider international relevance.

Characteristics of Herbal Medicines

In contrast with conventional medicines, herbal medicines are chemically rich complex mixtures comprising several hundreds of constituents, often more. For many herbal medicines, the chemical constituents are unknown, and even for those with well-documented phytochemistry, there are few for which the specific constituents responsible for pharmacological activity are fully understood. The profile of constituents is not uniform throughout a plant, and for many plants, only a specific plant part, or parts, such as roots or leaves, is (or should be) used medicinally. Moreover, the precise profile of constituents is likely to vary both qualitatively and quantitatively between different batches of herbal starting materials because of one or more of the following factors: inter- or intraspecies variation in constituents; environmental factors, such as climate, and growing conditions; time of harvesting – the profile of constituents can vary even over the course of a day; post-harvesting factors, such as storage conditions and drying (Barnes et al., 2002).

The method of processing crude herbal material, for example, the type of extraction, can also influence the precise chemical composition of a herbal preparation or product. Many herbal medicinal products contain several herbal ingredients, and medical herbalists usually prescribe combinations of herbal tinctures often supplied as a mixture, in both cases, further adding to the chemical complexity of the herbal medicine taken by the patient. The chemical complexity of herbal medicines creates difficulties in determining their clinical pharmacokinetics, pharmacodynamics and toxicology and, equally, where a safety concern has been identified in association with a particular herbal medicine, establishing which constituent(s), even which herbal ingredient(s) with combination herbal medicines, are implicated is problematic.

For the reasons given above, it is likely that there will be variations in the chemical composition of herbal medicines containing the same herbal ingredient but produced by different manufacturers; this will apply to both licensed herbal medicinal products and unlicensed herbal medicines. Several studies have found important differences in the pharmaceutical quality of different products on the USA market, for example, variations in the content of major constituents (de los Reyes & Koda, 2002; Kressman et al., 2002). Standardisation on content of certain constituents is an approach used by some manufacturers to achieve more consistent pharmaceutical composition, but its usefulness is limited at present since the specific active constituents are known only for a few herbal medicines.

Because of the variations that can exist between different manufacturers' products and preparations of the same herbal ingredient, evidence of safety (and efficacy) should be considered in this light; strictly speaking, evidence is product- or extract-specific, and should be extrapolated only to those products or extracts which have been shown to be pharmaceutically equivalent and bioequivalent (Loew & Kaszkin, 2002). This is largely impractical at present, given the limited data available for herbal medicines; nevertheless, the differences between different preparations of a herbal ingredient should not be ignored. In many cases, because of the nature of herbal medicines, a group of related constituents, rather than a single constituent, is likely to be responsible for an observed adverse effect. In this case, it may be appropriate to group together different preparations and products containing the same herbal ingredient or group of constituents in order to detect signals. In some ways, this is similar to investigating 'class effects' with conventional medicines.

The names that are used for herbal medicines present a further problem. Often, common or vernacular names are used to describe herbal medicines, but these vary widely, and may be used to describe more than one species, and cannot be precise.

Contrary to popular belief, herbal medicines are not 'safe' because they originate from natural sources; some plants are highly poisonous, and many others have inherently toxic constituents. For example, metabolites of 'unsaturated' pyrrolizidine alkaloids, such as senecionine, are hepatotoxic in humans, and carcinogenic and mutagenic in animals (Barnes et al., 2002). Senecionine is found in liferoot (*Senecio aureus*) and in other *Senecio* species, such as *Senecio scandens*, which has been reported as an ingredient in a traditional Chinese medicine product Qianbai Biyan Pian found in the UK. Other known intrinsically toxic groups of constituents, their effects and examples of plant sources include aristolochic acids (nephrotoxic and carcinogenic), found in *Aristolochia* species throughout the plant, sesquiterpene lactones (allergenic), found in feverfew (*Tanacetum parthenium*) and other species in the Asteraceae family, and furanocoumarins (phototoxic), found in angelica (*Angelica archangelica*) and other species belonging to the Apiaceae family.

Utilisation of Herbal Medicines and Related Issues

The use of herbal medicines is a popular healthcare approach among patients and consumers. Estimates of herbal-medicine use among adults in England come from a cross-sectional survey (n = 5010; response rate: 59%) carried out in 1998 which found that 19.8% (95% CI 18.3–21.3) had purchased an over-the-counter herbal medicinal product and that 0.9% (95% CI 0.6–1.3) had consulted a medical herbalist in the previous year (Thomas et al., 2001). There are no longitudinal data for prevalence of use of herbal medicines for the UK at present. Studies carried out in other developed countries, such as Australia and the USA, also suggest increasing prevalence of use of herbal medicines among the general adult population (MacLennan et al., 2002; Eisenberg et al., 1998). Extrapolating estimates of herbal medicine use from such studies suggests that large numbers of people are being exposed to herbal medicines; this in itself is of concern for the public health. Large-scale studies of the

prevalence of use of non-prescription herbal medicines are not available for New Zealand; the New Zealand Health Survey 2002/2003 included data on consultations with herbal and other traditional medicine practitioners (Ministerial Advisory Committee on Complementary and Alternative Health, 2004).

Herbal medicines are used by a wide range of individuals for both acute and chronic conditions. Many herbal medicinal products are purchased for maintenance of general health and well-being, and for use in the prevention and treatment of minor, common ailments. Use is not necessarily based on evidence, nor limited to symptoms and conditions suitable for self-treatment. Herbal medicinal products are also used by individuals with serious chronic diseases, including cancer, AIDS, multiple sclerosis, and asthma, and many other conditions, by older patients, and pregnant or breast-feeding women, and are administered by parents/guardians to children. Similarly, medical herbalists use herbal medicines to treat a variety of conditions (Barnes & Ernst, 1999). Some patient groups, such as children and older people, are at increased risk of adverse drug effects, and there is no reason why this should not also apply where they use herbal medicines. Other groups, for example, pregnant women, may use herbal medicines in preference to conventional medicines because they are perceived to be safer, without realising that little is known about the effects of herbal medicines taken during pregnancy.

Typically, users of herbal medicinal products do not seek professional advice in selecting herbal medicines, but rather rely on friends' or relatives' recommendations, and information in the popular media (Barnes et al., 1998). Herbal medicines are widely available for purchase over the internet and from retail outlets in which there is no trained healthcare professional available (Vickers et al., 1998). Even where herbal medicinal products are purchased from pharmacies, a consumer or patient may not have any interaction with a pharmacist or trained pharmacy counter assistant, or if a consultation does occur, pharmacy staff may not have sufficient knowledge to feel confident about providing information and advice on herbal medicines (Quinn & Waterman, 1997). A small proportion of users of herbal medicines seeks treatment from a herbal-medicine practitioner, but at present, there is no legal requirement for such practitioners to have undertaken training in herbal medicine or to belong to a professional organisation for herbal-medicine practitioners, and while many herbal-medicine practitioners will have taken these steps, some will not.

A related issue is that some users of herbal medicines may not disclose this use to a healthcare professional; equally, healthcare professionals do not ask their patients routinely whether they are using herbal medicines, even when receiving reports from patients of suspected ADRs associated with conventional medicines, and rarely record information on herbal-medicine use on patient records (Barnes, 2001). It is possible, therefore, that undisclosed herbal-medicine use could be an alternative explanation for reports of suspected ADRs associated with conventional medicines.

Disclosure of herbal-medicine use to healthcare professionals is particularly important where patients start, stop, or are already receiving treatment with conventional medicines and, equally, individuals consulting medical herbalists should disclose their current use of conventional medicines, because there may be a potential for drug-herb interactions. Information on the extent to which concurrent use of herbal and conventional medicines occurs is limited, although preliminary data suggest that it may be extensive. In a cross-sectional survey of complementary-therapy use among adults in the US (n = 2055 respondents; 60% weighted overall response rate), 44% were regular users of prescription medicines and, of these, 18.4% were using concurrently a herbal or high-dose vitamin preparation (Eisenberg et al., 1998). In a small study conducted in the UK, 59% of herbal-medicine users identified in pharmacies and health-food stores claimed that they had used

herbal medicines concurrently with conventional medicines, mostly prescription medicines, in the previous year (Gulian et al., 2002).

In summary, the ways in which herbal medicines are described (named), perceived and obtained, together with users' behaviour towards herbal medicines and issues relating to healthcare professionals' and herbal practitioners' practice present opportunities for herbal medicines to be used inappropriately, even unsafely, and for suspected ADRs to go undetected and unreported.

Regulation of Herbal Medicines

At present, there is no statutory regulation of herbalists in the UK and NZ. In the UK, a Herbal Medicine Regulatory Working Group was established to consider appropriate legislation and a report of its recommendations was published in 2005 (Department of Health, 2005).

Under existing regulatory frameworks there is little incentive for manufacturers to carry out pre-clinical tests and clinical trials and this has contributed to a general lack of objective information on the safety of many herbal medicines. Post-marketing surveillance studies involving certain herbal medicinal products have been conducted by some manufacturers (usually those based in Germany), but this is the exception. Generally speaking, there is a lack of information on the types and frequency of adverse effects, including interactions with other medicines, foods, alcohol, disease and so forth, and other aspects relevant to safety for herbal medicines, such as their active constituents, pharmacokinetics, pharmacology, use in special patient groups (e.g., children, older people, individuals with renal or hepatic disease, pregnant or breast-feeding women), effects of long-term use, and so on. It is often argued that herbal medicines have a long history of traditional use and that this provides evidence for their safety (and efficacy). However, while the 'test of time' may have identified inherently toxic plants, it cannot, for example, identify delayed adverse effects, effects that may arise from use in patients with 'modern' illnesses, such as HIV/AIDS, and safety issues arising from how herbal medicines are utilised today, for example, concurrently with conventional medicines (Ernst et al., 1998). Certainly, there are examples of type A reactions (those that typically are dose dependent and related to the pharmacological effects of the medicine) and type B reactions (typically unrelated to dose, idiosyncratic) and other types of ADRs (e.g., delayed effects in the user or offspring remote from medicine use in the user) associated with the use of certain herbal medicines (de Smet, 1995).

In the UK, the regulatory framework until 2004 allowed unlicensed herbal medicines, which may be of inadequate pharmaceutical quality and for which there is a lack of information on safety aspects, to be placed on the market and obtained by consumers and patients from a range of retail outlets without a prescription or other involvement of a healthcare professional. Manufacturers were under no obligation to carry out pharmacovigilance of such products.

The need for a new regulatory framework for herbal medicinal products in the UK was first discussed in the late 1980s: it was recognised widely that the existing regulatory framework did not adequately protect the public health. In particular, the system did not give consumers and patients adequate protection against poor-quality and unsafe unlicensed herbal medicinal products, and discriminated against manufacturers of licensed herbal medicinal products as their costs are likely to be higher because of the need to comply with the principles of good manufacturing practice and other regulatory provisions.

Against this background, a new European Union (EU) directive (2004/24/EC, which amends 2001/83/EC) has been introduced which establishes a harmonised legislative framework for authorising the marketing of traditional herbal medicinal products (Commission of the

European Communities, 2001; Commission of the European Communities, 2004). The directive required EU member states to set up a simplified national registration scheme for traditional herbal medicinal products meeting defined criteria. In essence, it requires manufacturers wishing to obtain registrations for their traditional herbal medicinal products under a national scheme to demonstrate the quality and, to some extent, the safety of their products, whereas the usual efficacy and, to some extent, safety requirements will be replaced by evidence of traditional use. Manufacturers of products registered under the directive will be required to comply with information and labelling requirements (until 2004, there was no requirement in the UK for manufacturers of unlicensed herbal medicinal products to provide systematic information with their products).

The directive will have an important impact on pharmacovigilance of herbal medicines since manufacturers of traditional herbal medicinal products registered under the UK national scheme established under the directive will be required to comply with relevant existing pharmaceutical legislation, including the provisions on pharmacovigilance. Several of these may pose problems for manufacturers with little or no experience in this area, for example, the requirement to have constant access to an appropriately qualified and experienced person responsible for pharmacovigilance.

In NZ, consultation documents have been released of a proposal to establish a trans-Tasman regulatory agency (the Australia New Zealand Therapeutic Products Authority) for the regulation of therapeutic products, including complementary medicines (Therapeutic Goods Administration & Medsafe, 2006).

METHODS FOR PHARMACOVIGILANCE OF HERBAL MEDICINES

Some standard methods used in pharmacovigilance, particularly spontaneous reporting schemes, are used to monitor the safety of herbal medicines, although these methods are less well-established than for conventional medicines. This section discusses the available methods, with a focus on spontaneous reporting schemes, and the particular challenges that herbal medicines present for each.

Spontaneous Reporting Schemes

The future of spontaneous reporting schemes in pharmacovigilance has been questioned (Waller & Evans, 2003), although it is likely that this point was raised in relation to conventional medicines for which other well-established tools, such as computerised health-record databases, can be used for pharmacovigilance purposes. By contrast, spontaneous reporting for herbal medicines is in the early stages of its development and, at present, in the absence of other tools and/or resources, is the main method of generating and detecting signals of potential safety concerns associated with herbal medicines. Spontaneous reporting schemes appear to function reasonably effectively as a pharmacovigilance tool for herbal medicines in countries such as Germany where herbal medicinal products are regulated as medicines, frequently prescribed by physicians and well known to other healthcare professionals, particularly pharmacists (de Smet, 1997). However, spontaneous reporting is likely to be far less effective in countries such as the UK and NZ where herbal medicines are marketed mainly as unlicensed products with no obligation for manufacturers to report suspected ADRs to the competent authority, and where herbal medicines are used mostly in self-treatment without any supervision from a healthcare professional.

ADR Reporting Form

The minimum information required for a report of a suspected ADR is the same for both conventional and herbal medicines. Although it is not desirable to introduce different reporting

forms for different types of preparations, herbal medicines present a special case and a more specialised reporting form may be required. Alternatively, modifications to the existing reporting card could be made so that important details on herbal medicines can be requested. A template modified reporting form with specific data fields relating to herbal medicines has been produced (WHO, 2004a).

Signal Detection and Assessment

In the UK, reports can be submitted by healthcare professionals and, since 2005, patients themselves, to the Medicines and Healthcare products Regulatory Agency. In NZ, reports can be submitted by healthcare professionals to the Centre for Adverse Reactions Monitoring, which operates under contract to Medsafe, the regulatory body for medicines. Reports from patients and herbal practitioners are also accepted.

In both countries, at present, there is a relatively small number of reports of suspected ADRs associated with herbal medicines. The assumptions made in proportional analysis, and the importance of considering the effect of selected backgrounds, has been discussed in the context of conventional medicines (Gogolak, 2003). Since there are additional biases and other issues in pharmacovigilance of herbal medicines, what is an appropriate comparator requires consideration.

Following confirmation of a signal relating to a herbal safety concern, the next stages in its evaluation are also difficult with respect to herbal medicines. Quantifying the risk is probably impossible as there is no reliable way of determining the number of individuals exposed to the herbal medicine of interest. Benefit-risk analysis is problematic because of the limited clinical data on safety and efficacy of herbal medicines, and identifying at-risk groups is also difficult because the user profile for herbal medicines is poorly defined.

Strengths and Weaknesses

Spontaneous reporting schemes have recognised advantages and limitations, and several of these may be even more important with regard to herbal medicines. In particular, under-reporting is a well-recognised, important and inevitable limitation of any spontaneous reporting scheme and, for herbal medicines, under-reporting of suspected ADRs could occur at several levels. Because of the perception that herbal medicines are ‘safe’, users of these preparations may not associate an adverse event with their use of a herbal medicine, particularly if they are taking other (conventional) medicines. If the user does make an association between use of a herbal medicine and an adverse event, they may take steps to resolve the problem themselves (for example, stop taking the preparation) and/or may not inform a healthcare professional (Barnes et al.,, 1998). Under-reporting can also occur at the level of the healthcare professional, since doctors, pharmacists and other recognised reporters could filter out reports of suspected ADRs described by patients (van Grootheest et al.,, 2003).

Several studies involving community pharmacists indicate that many pharmacists are unaware that they should report suspected ADRs associated with herbal medicines (Barnes J, 2001; Wingfield at al., 2002; Green et al., 1999). There may also be biases favouring ADR reporting for herbal medicines (Biscoe et al., 2002). Pharmacists can make an important contribution to ADR reporting for herbal medicinal products, but greater vigilance on the part of the pharmacist and initiatives to encourage herbal ADR reporting by pharmacists are required (Barnes, 2002).

Herbal medicines are widely available from a range of outlets without the need for interaction with a healthcare professional and suspected ADRs associated with herbal medicines may be

identified by or reported to an individual (e.g., herbalist) who is outside the formal system for ADR reporting. Health-food stores are a major outlet for herbal medicinal products, but it is not known if their staff receive reports of suspected ADRs associated with such products, and if they do, what action, if any, they take.

WHO/UPPSALA MONITORING CENTRE TRADITIONAL MEDICINE PROJECT

ADR reports, including herbal ADR reports, from the CSM/MHRA yellow card scheme and (in 2003) those from 79 other countries with national ADR monitoring schemes are fed into the WHO/Uppsala Monitoring Centre (UMC). The UMC recognises the problems inherent in ADR reporting for herbal medicines and has established a Traditional Medicines project to stimulate reporting in this area and to standardise information on herbal medicines, particularly with regard to nomenclature (Farah et al., 2000). For example, a special set of herbal anatomical-therapeutic-chemical (ATC) codes has been developed which is fully compatible with the regular ATC classification system for conventional medicines (WHO, 2004b; WHO, 2004c).

The UMC database, established in 1968, holds over 3.5 million reports of suspected ADRs (data to 2006), of which around 0.5% involve herbal medicines. For the period 1968–1997, almost 9000 reports involving herbal medicines were received by the UMC (Farah et al., 2000).

Herbal-Sector-Initiated Spontaneous Reporting Schemes

At present, herbal medicine practitioners are not recognised as reporters by the CSM/MHRA yellow card scheme. Several herbal-medicine practitioner associations, e.g., the National Institute of Medical Herbalists (NIMH) (the major organisation for medical herbalists in the UK) (Broughton, 2001) and the Register of Chinese Herbal Medicine (RCHM) (Ward, personal communication, 2002), and other herbal-sector organisations have initiated their own ADR reporting schemes for herbal medicines based on the CSM/MHRA scheme, While this is a responsible and potentially useful step forward where these schemes have developed a link with the CSM/MHRA or WHO/UMC, ad hoc schemes are not encouraged because there is a risk that reports will be dispersed and signals may be not be detected as early as possible, or may be missed. As with any spontaneous reporting scheme, herbal-sector-initiated schemes are also likely to be prone to limitations such as under reporting.

Prescription Event Monitoring

The methodology of prescription event monitoring (PEM) in monitoring the safety of newly marketed prescription drugs is well-established (Shakir, 2002). However, the existing method is of no use at present for pharmacovigilance of herbal medicines because they are rarely prescribed. A protocol for modified PEM methodology has been developed by the Drug Safety Research Unit, Southampton, UK, in collaboration with the NIMH and others. This approach involves using herbalists to provide adverse event data on green forms for patients treated with a specific herbal medicine (Layton et al., 2006).

Another potential approach, based on PEM concepts, is to use community pharmacists to recruit a cohort of purchasers (where consent is given) of a specific herbal medicinal product who would then be followed up over time and adverse event data collected. The feasibility of this approach is being evaluated as a method for pharmacovigilance of herbal medicinal products (Aggarwal and Barnes, 2006).

OTHER PHARMACOEPIDEMIOLOGICAL STUDY DESIGNS

The methodology for case-control and cohort studies is well established and these study designs can be used to investigate safety concerns with herbal medicines, although few studies have been carried out to date. The strengths and limitations of case-control and cohort studies are well documented, but the problems are compounded when these study designs are applied to herbal medicines. For example, to establish and verify both cases' and controls' exposure to the herbal medicine(s) of interest is particularly problematic since herbal medicines are rarely prescribed are not recorded on computerised patient medication records. In addition, for reasons explained earlier, there are likely to be variations in different manufacturers' products and, therefore, defining exposure precisely will be difficult at best. Case-control and cohort studies involving conventional prescribed medicines can be carried out using UK computerised health-record databases such as the General Practice Research Database and the Medicines Monitoring Unit database, but such tools currently are of no use for studies involving herbal medicines since herbal medicines are rarely prescribed and information on non-prescription medicines, including herbal medicines, is not recorded on GPs' patient records.

Systematic reviews and meta-analyses of adverse event data from RCTs of specific herbal medicines have been carried out, but this introduces other problems. Many existing RCTs of herbal medicinal products are of poor or limited methodological quality, and/or published reports of studies do not follow Consolidated Standards of Reporting Trials (CONSORT) guidelines. In addition, clinical trials of a particular herbal ingredient usually will have been carried out using several different manufacturers' products, but systematic reviews and meta-analyses often ignore variations between products. An elaboration of item 4 in the original CONSORT guidelines, aimed at improving the quality of reporting descriptions of herbal medicine interventions tested in randomised clinical trials, has been published (Gagnier et al., 2006).

COMMUNICATION OF HERBAL SAFETY CONCERNS

The importance of the timing, content and method of delivery of messages regarding safety concerns has been discussed extensively, and the requirements for successful communication of safety concerns should apply equally to herbal medicines. However, communicating information on herbal safety concerns presents additional difficulties for several reasons. 'Dear Doctor/Pharmacist' letters can be sent, but healthcare professionals are unlikely to know which of their patients are using herbal medicines and, therefore, will be unable to pass on safety messages to specific individuals.

Moreover, most users of herbal medicines obtain these medicines from outlets where there is no healthcare professional present and without seeking professional advice. Methods aimed at reaching the public directly (e.g., the internet) and the popular media are often the only ways of communicating herbal safety information to such individuals. There is a lack of research on how herbal-medicine users interpret information on risks associated with herbal medicines. It should not be assumed that users' understanding of risk associated with herbal medicines is the same as that for prescription medicines or conventional non-prescription medicines. Individuals may overestimate the risks of adverse effects associated with prescription medicines and conventional non-prescription medicines (Berry et al., 2002; Berry et al., 2003), but given that herbal medicines are widely perceived to be safe, the hypothesis that users of herbal medicines may underestimate risks needs to be tested. Manufacturers of products registered under the new THMPD will be required to provide systematic information with their products, including information on adverse events and special warnings. It is likely

that there is scope for improving communication with the public on herbal safety issues. Recognising this, an area on the MHRA website has been set up which is dedicated to providing early information on herbal safety concerns.

THE FUTURE FOR PHARMACOVIGILANCE OF HERBAL MEDICINES

The potential for herbal medicines to have a significant negative impact on the public health needs to be kept in perspective. Nevertheless, a parallel can be drawn between the lack of a formal medicines regulatory system before the thalidomide disaster and the current lack of regulation of herbal medicinal products in many countries. Most herbal medicinal products, including herbs from China, South America and many other countries, which are new to the UK and NZ, are sold without any requirement to demonstrate to the licensing authority evidence of quality, safety and efficacy. Post-thalidomide, new initiatives in drug safety monitoring initially followed further high-profile drug safety problems (Edwards & Olsson, 2002). Likewise, several recent high-profile herbal safety concerns, such as renal failure and urothelial cancer associated with exposure to *Aristolochia* species (Cosyns, 2003), drug interactions with St John's wort (Henderson et al., 2002), and hepatotoxicity associated with kava-kava (Anon, 2002), have contributed to the increasing awareness of the need to monitor the safety of herbal medicines. Against a background of increasing use of herbal medicines, particularly by patients using conventional drugs concurrently and those with serious chronic illness, it is likely that new safety concerns will continue to emerge.

Improvements in the safety and pharmacovigilance of herbal medicines can be expected following the new EU directive for traditional herbal medicinal products. Manufacturers of traditional herbal medicinal products registered under national schemes established under the directive will be required to adhere to quality standards, to provide bibliographic evidence of the safety of their products, and to comply with regulatory provisions on pharmacovigilance. These improvements may not happen immediately across all manufacturers, since some may take advantage of the transition period (7 years to 2011). Another effect of the directive may be to shift the emphasis of research involving herbal medicines from clinical efficacy to safety. While research into the safety of herbal medicines is to be welcomed, research into efficacy is also needed in order to develop herbal medicinal products with favourable benefit-risk profiles.

Statutory regulation of herbal-medicine practitioners is expected to be implemented over the next few years, and it seems reasonable that yellow card schemes would be extended to include state-registered herbal-medicine practitioners as recognised reporters. In the longer term, modified, even novel tools for monitoring the safety of herbal medicines may be developed.

The future for ensuring the safety of herbal medicines may lie, at least in part, with pharmacogenetics and pharmacogenomics. The importance of genetic factors in determining an individual's susceptibility to ADRs is well documented (Pirmohamed, 2001), and this applies to herbal medicines as well as to conventional drugs. However, optimising treatment, including reducing the potential for ADRs, on the basis of a patient's genotype has barely been discussed in the context of herbal medicines.

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Protection of health:
Building up
Resilience and strengths

ACCULTURATION, SOCIAL INCLUSION AND PSYCHOLOGICAL WELL-BEING OF ASIAN MIGRANTS IN NEW ZEALAND

Colleen Ward

ABSTRACT

The research addresses three questions: 1) What are New Zealanders' perceptions of migrants and their acculturation expectations? 2) What acculturation strategies do migrants prefer? And 3) How are these strategies related to social inclusion and migrants' psychological well-being? The findings indicate that both Chinese migrants and native-born New Zealanders prefer integration to assimilation, separation and marginalization. Furthermore, integration is associated with better psychological well-being and social effectiveness in Chinese youth. Although New Zealanders maintain positive attitudes toward cultural diversity, they view migrants of European descent more favourably than those from Asian countries, and Chinese youth report a moderate amount of discrimination, which exerts negative influence on their psychological and social adaptation.

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INTRODUCTION

How important is it to maintain my cultural heritage? How important is it to be like other New Zealanders? These are fundamental issues that confront both new migrants and members of established ethno-cultural communities in New Zealand (Berry, 2001). If the answers to these two questions are considered, four acculturation strategies may be identified: Integration (both are important); 2) Separation (only cultural maintenance is important); Assimilation (only being like other New Zealanders is important) and 4) Marginalization (neither is important). This paper examines the acculturation preferences of young Chinese migrants and the relationship of these strategies to psychological well-being and social effectiveness.

The acculturation process, including adapting to life in New Zealand, depends not only on the preferences of new migrants, but is also affected by the attitudes, expectations and behaviours of members of the wider New Zealand society (Bourhis, Moïse, Perreault & Senécal, 1997). The extent to which New Zealanders interact with new migrants, treat them fairly and respect cultural diversity influences migrant acculturation and adaptation. Therefore, these factors are also examined in this paper.

Finally, how migrants perceive and experience New Zealanders' reactions to them also affect acculturation and adaptation (Ward & Lin, 2005). Therefore, social inclusion and migrants' perceptions of discrimination are also considered.

The paper draws on samples of Chinese migrants and members of the host society.
Selected findings are presented to address three questions:

1) What are New Zealanders' perceptions of migrants and their acculturation expectations for them?
2) What acculturation strategies do migrants prefer?
3) How are these strategies related to social inclusion and psychological well-being?

OVERVIEW OF STUDIES

Migrant Experiences

The research findings presented in this paper are based on a sample of 103 (58 females and 39 males) Chinese migrant youth aged 13 to 21 years (M = 16.23). Of the sample, 56% were first generation migrants and the majority (71%) were New Zealand citizens. All youth completed an anonymous and voluntary survey.

New Zealand Perspectives

New Zealand perspectives are drawn from 1) a comparative sample of 247 New Zealand European youth and 2) a sample of 2020 New Zealand households. The youth sample included 85 females and 162 males aged 12-18 years (M = 15.03). The adult sample (877 males and 1143 females), aged 18 and over, were drawn from a random national sample of households. The majority of the respondents (70.4%) described themselves as New Zealand European; 5% of the respondents classified themselves as Maori, 4% as Asian, 1% as Pacific, and 6% as multiethnic.

The youth sample completed an anonymous and voluntary paper and pencil survey. The adult sample participated in a Computer Assisted Telephone Interview. Only a portion of the results from the larger surveys is reported in this paper.

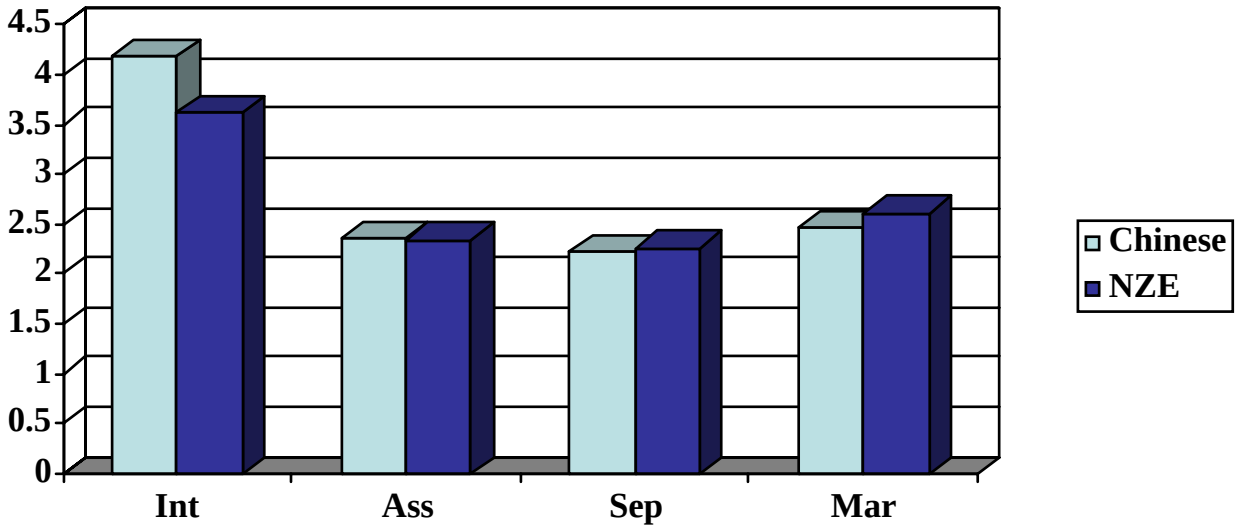
RESULTS

Acculturation Preferences

Figure 1 reports the acculturation preferences of Chinese youth. As can be seen in the figure, integration is endorsed significantly more strongly than any other options; F (3,341) = 108.04, p <.001. Indeed, separation, marginalization and assimilation all fall below the scalar midpoint (3 on a 5-point scale), indicating little support for those strategies.

Figure 1 also reports the acculturation expectations that Pakeha youth have for new migrants. As can be seen in the figure, integration is also most strongly endorsed. However, Chinese youth have a significantly stronger preference for integration than do New Zealand Europeans; t (341) = 4.12, p <.001.

Figure 1. Acculturation preferences.



The national survey data converge with these patterns (Table 1). There was strong endorsement of integration with 82% of the respondents agreeing that migrants should maintain their own culture while also adopting New Zealand culture. In contrast, assimilation (21%) and separation (28%) were only endorsed by a minority of respondents.

Table 1. Acculturation expectations.

	% of agreement
Immigrants should give up their original culture for the sake of adopting New Zealand culture.	21
Immigrants should maintain their original culture as long as they do not mix it with NZ culture.	28
Immigrants should maintain their original culture while also adopting NZ culture.	82

Social Inclusion

Social inclusion was examined in relation to perceived discrimination (Tables 2 and 3). Perceptions of discrimination against Chinese were relatively widespread with 40% agreeing that their group was subjected to unfair treatment. Over half of the Chinese youth (56%) reported that they had been teased or insulted on the basis of their ethnic background, and almost one in five (18.6%) said that they had been threatened or attacked. However, only a relatively small minority (12.3%) felt that they were not accepted by New Zealanders.

Unfair treatment on the basis of ethnicity was perceived as common with over half of the Chinese youth experiencing discrimination from their peers both inside and outside of school "sometimes" to "very often." Almost one in three (31%) experienced the same frequency of discrimination from adults outside of their school, and 16.5% reported this frequency of discrimination from teachers.

Table 2. Perceived discrimination.

	% agreement
Others have behaved in an unfair way towards my ethnic group.	40.4
I don't feel accepted by New Zealanders.	12.3
I feel New Zealanders have something against me.	16.5
I have been teased or insulted because of my ethnic background.	55.5
I have been threatened or attacked because of my ethnic background.	18.6

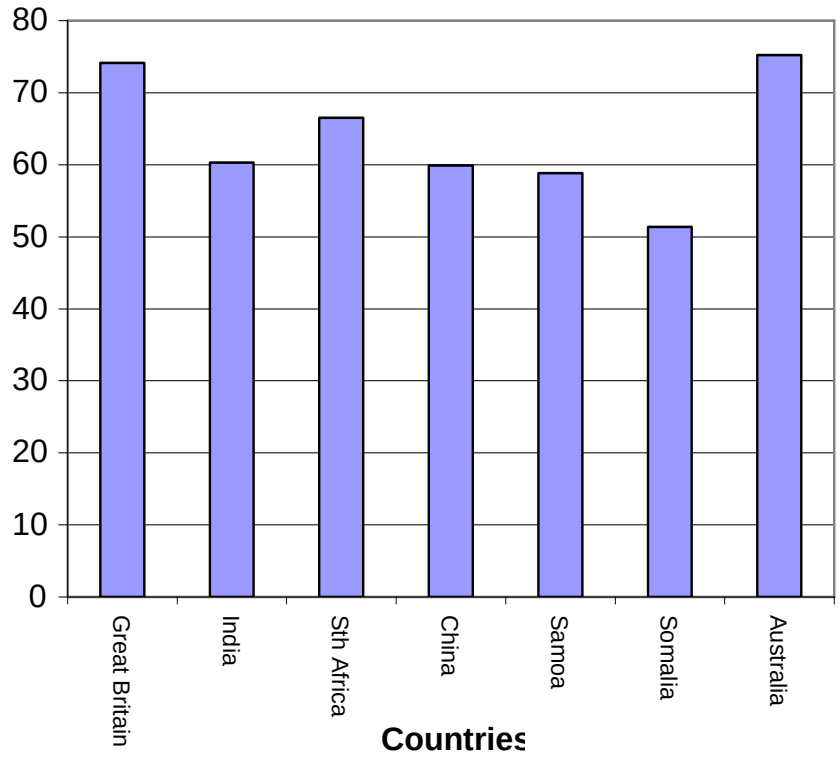
Analysis of these data found that there were significant differences across the sources of discrimination; $F(3,99) = 26.2$, $p<.001$. Students and youth outside of school were perceived as more frequent sources of unfair treatment than either group of adults, and adults outside of school were seen as a more frequent source of discrimination than teachers.

Table 3. Perceived frequency of unfair treatment on the basis of ethnicity.

Source	Never	Rarely	Sometimes	Often	Very Often
Teachers	46.1	36.9	12.6	2.9	1.0
Other adults outside of school	33.0	35.0	25.2	4.9	1.0
Other students	18.4	30.1	36.9	10.7	2.9
Other teens outside school	15.5	33.0	35.0	12.6	2.9

Discrimination was related to acculturation preferences in that those who perceived more discrimination had stronger preferences for separation ($r = .20$, $p<.05$).

Figure 2. Perceptions of migrants.



Although the national survey did not measure discrimination per se, it did examine various attitudes toward migrants in general and towards migrants from specific countries. On the whole attitudes toward immigrants were positive. For example, 81% agreed that immigrants have made a valuable contribution to New Zealand, and 82% agreed that immigrants have qualities that they admire. In addition, multiculturalism was strongly endorsed: 89% agreed that it is a good thing for a society to be made up of different races, religions and cultures.

That being said, perceptions of some immigrant groups were more favourable than others. Figure 2 presents the ratings of immigrants from seven countries. A repeated measures analysis of variance revealed that immigrants from Australia were perceived significantly more favourably than all other groups; F (6, 1547) = 181.2, p < .001). The preference for Australians was followed by British, South African and Indian migrants, with each of these groups differing significantly from the others. There were no significant differences in perceptions of Indians and Chinese or between Chinese and Samoans, but immigrants from Somalia were viewed less favourably than all other immigrant groups.

Psychological and Social Adaptation

Figure 3. Psychological and social adaptation.

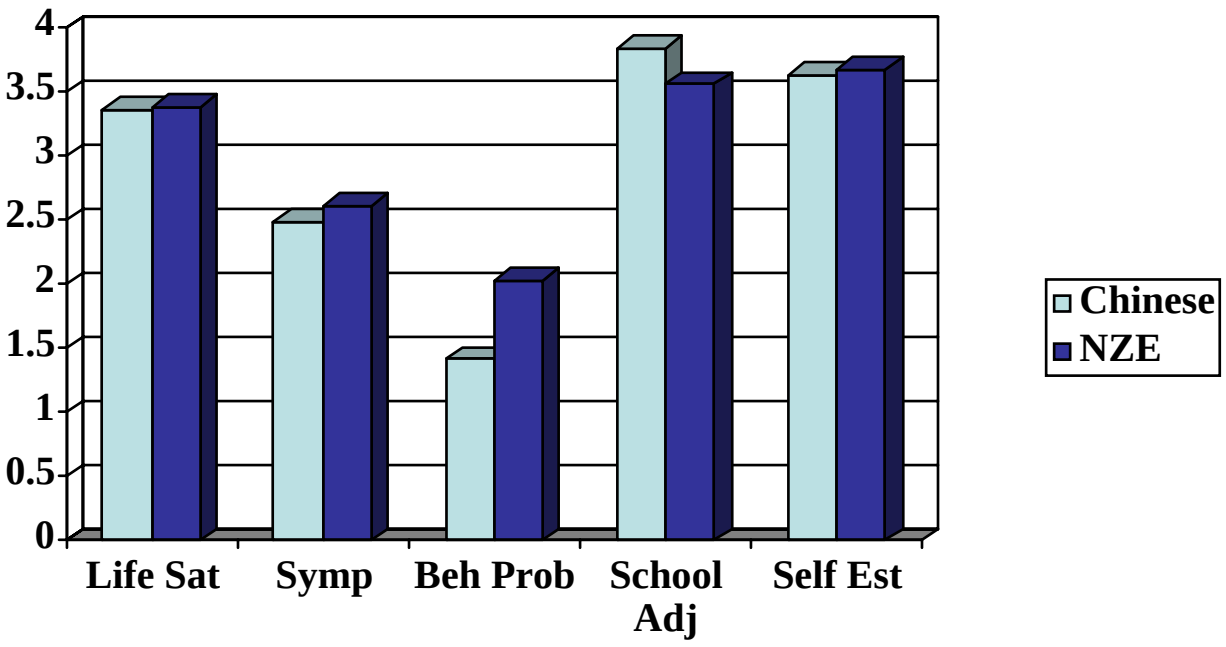


Figure 3 contains the mean adaptation scores for Chinese youth in comparison with New Zealand Europeans. Psychological symptoms, life satisfaction and self esteem are taken as indicators of psychological well-being while behavioural problems and school adjustment serve as indicators of social adaptation. Analyses indicated that Chinese youth were on the whole well adjusted. Furthermore, there was no significant differences in the psychological well-being of Chinese and New Zealand European youth (ts < 1.6); however, Chinese youth reported fewer behavioural problems (t (336) = 6.39, p <.001) and better school adjustment (t (347) = 3.33, p < .001).

The relationship between the acculturation strategies and adjustment outcomes is presented in Table 4. As can be seen in the Table, Integration is associated with more positive outcomes including greater life satisfaction, higher self esteem and fewer behavioural problems. In contrast, separation and marginalization are linked with poorer outcomes, particularly lower levels of self esteem. Chinese youth who endorse separation also have more behavioural problems and those who opt for marginalization have poorer school adjustment.

Table 4. Acculturation preferences, psychological well-being and social adaptation.

	Behavioural Problems	Psychological Symptoms	Life Satisfaction	Self-esteem	School Adjustment
Assimilation	-.14	-.02	-.12	-.04	-.17
Integration	-.30**	-.08	.23*	.24*	.13
Separation	.26	.02	-.18	-.34**	-.17
Marginalization	.13	.10	-.07	-.22*	-.32**

* p< .05, **p<.005

The Prediction of Psychological Well-being and Social Adaptation

Table 5 presents the regression analyses for the prediction of psychological and social adaptation[15]. The results indicate that both acculturation strategies and perceived discrimination influence migrant adaptation.

Table 5. The prediction of psychological and social adaptation (beta weights).

Variable	Social Adaptation	Psychological Well-being
Assimilation	-.01	-.12
Integration	.18	.23*
Separation	-.12	.01
Marginalization	-.21*	.03
Perceived Discrimination	-.41**	-.38**
R^2	.34**	.19**

* p< .05, **p<.001

Perceived discrimination is a robust predictor of adjustment outcomes, leading to impaired psychological well-being and poorer social adaptation. In addition, integration predicts better psychological well-being and marginalization is linked to poorer social adaptation.

DISCUSSION

The research addressed three questions: 1) What are New Zealanders' perceptions of migrants and their acculturation expectations for them? 2) What acculturation strategies do migrants prefer? And 3) How are these strategies related to social inclusion and psychological well-being?

The findings indicate New Zealanders have generally positive attitudes toward immigrants and strongly endorse integration as the preferred acculturation strategy for immigrants. In addition, there is an overwhelming appreciation of multiculturalism with nine out of ten agreeing that it is a good thing for a society to be made up of different races, religions and

15 In accordance with the ICSEY project, psychological outcomes combine life satisfaction and psychological symptoms; social adaptation combines school adjustment and behavioural problems.

cultures. These findings suggest that there is a highly receptive environment for new migrants, one that appreciates diversity and encourages retention of traditional cultures as migrants integrate into New Zealand society.

Unfortunately, there appears to be a gap between these positive, egalitarian principles and everyday practices. First, there is evidence that New Zealanders favour new settlers of European descent compared to Asian, Pacific and African migrants. Second, there is evidence of bias and discrimination against migrants from Asian countries, particularly in the labour market (Ward & Masgoret, 2004). Third, Asian migrants report that they have frequently been the victims of discrimination.

The extent of perceived discrimination is significant. In this study over half of the Chinese youth stated that they had been teased or insulted because of their ethnic background, and the majority reported unfair treatment on the basis of ethnicity, particularly from other students. Furthermore, related research suggests that New Zealanders are aware of these issues. In a survey reported by the Human Rights Commission in January 2004, 78 % of respondents believed that Asians in this country are subjected to some or a great deal of discrimination – more than any other identified group (Ministry of Social Development, 2004).

There is ample evidence that discrimination has negative consequences for health and well-being. In this study discrimination was a powerful predictor of impaired psychological and social adaptation. In international research on acculturation discrimination has been linked to a range of negative outcomes including poorer health, psychological distress, and antisocial behaviours (Ward, Bochner & Furnham, 2001). Indeed, Fernando (1993) cited racism the most serious risk factor for immigrants.

There is also evidence that discrimination influences identity and acculturation strategies. In this research greater perceived discrimination was associated with stronger endorsement of separation as an acculturation strategy. The link between perceived discrimination and separation has also been found by Barry and Grilo (2003) in East Asian migrants in the United States and by Ying, Lee and Tsai (2000) in Chinese Americans.

Chinese youth in New Zealand have a strong preference for integration- retaining their cultural heritage and also adopting aspects of New Zealand culture. Furthermore, integration is associated with greater life satisfaction, higher self esteem and fewer behavioural problems. In contrast, separation and marginalization are associated with lower self esteem, poor school adjustment and/or more behavioural problems. The predictive power of acculturation strategies on psychological and social adaptation is consistent with international findings, including those recently reported in the 13 nation International Comparative Study of Ethno-cultural Youth (ICSEY; Berry, Phinney, Sam & Vedder, 2006).

Overall, the results suggest that how migrants manage issues of identity, including cultural maintenance, and intergroup relations has implications for their health and well-being. They also suggest that how New Zealanders perceive and receive migrants affects the acculturation process. International research has concluded that multicultural societies that facilitate integration are most conducive to migrant health, well-being and social adaptation (Ward & Leong, 2006). This, however, requires commitment and change on personal, institutional and society-wide levels. Despite the challenge, this approach holds the promise for the future as cultural diversity continues to increase in New Zealand.

ACKNOWLEDGEMENT

The research was supported by the Foundation for Science, Research and Technology (UOWX0203, Strangers in Town), Victoria University of Wellington, and the Royal Society of New Zealand (James Cook Fellowship). The author would like to acknowledge the collaboration of Dr. Anne-Marie Masgoret on the national survey of attitudes toward immigrants. The youth data come from the New Zealand portion of the ICSEY Project. All collaborators of that project are gratefully acknowledged. Other members of the group are: Australia (W. Karnilowicz, C. Leung, R. Pe-Pua, R. Rooney & D. Sang); Canada (J. Berry & K. Kwak); Finland (K. Liebkind); France (C. Sabatier); Germany (P. Schmitz); Israel (G. Horenczyk); the Netherlands (F. van de Vijver & Paul Vedder); Norway (D. Sam); Portugal (F. Neto); Sweden (E. Virta & C. Westin); United Kingdom (L. Robinson) and United States (J. Phinney).

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HOW DOES SOCIAL CONTACT WITH LOCALS IMPACT ON MENTAL HEALTH: CHINESE BACKGROUND INTERNATIONAL STUDENTS IN AUSTRALIA

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ABSTRACT

China, Hong Kong, Taiwan, Singapore, and other countries with high concentrations of ethnic Chinese, such as Malaysia, represent Australian universities' most important sources of international students. Based on previous research on acculturative stress and intergroup contact, the quantity and especially the quality of social interactions with locals could be expected to impact on the mental health of international students from linguistically and culturally diverse backgrounds. This study aimed to examine Chinese-speaking-background (CSB) international students' amount of social contact with locals and the students' threat appraisals regarding such contact. As well, this study sought to investigate the relative contributions that these social contact variables, alongside the students' English language fluency, have on their depressive symptoms. We hypothesised that a high level of threat appraisal and low levels of English language fluency and intercultural social contact, would be predictive of CSB international students' depressive symptoms. We also hypothesised that threat appraisals of intercultural social contact would exert a stronger effect on depressive symptoms, than the amount of intercultural contact would.

Participants were 46 male and 47 female CSB international students recruited from Australian university student associations and using the snowball technique, who completed an anonymous survey on social and personal adjustment. Results obtained indicated, on average, slightly lower than medium levels of social contact with locals and threat appraisals regarding such contact. Regression analysis showed that threat appraisal exerted a large effect and English fluency a medium effect on depressive symptoms. Yet the amount of social contact with locals had no significant effect on symptoms. These findings are discussed in relation to theories on intergroup contact and services for promoting international students' mental health.

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INTRODUCTION

China is currently the biggest source country of Australia's onshore international student population, accounting for 66,348 of the 272,248 international students studying in Australian institutions in April, 2006 (Australian Education International [AEI], 2006). In the Australian higher education sector, nationals from China alone accounted for 38,666 of the 143,432

onshore international students. Four of the other top 10 sources of international students in the higher education sector – Malaysia, Hong Kong, Singapore, and Taiwan – further contributed to the large number of ethnic Chinese students studying in Australian universities.

While there are numerous social and economic benefits associated with international education (Kenyon & Koshy, 2003), the substantial cultural differences between Chinese-speaking-background (CSB) students and local Australians may pose barriers and issues for CSB international students' social and psychological adjustment. There is a need for a better understanding of the quantity and subjective appraisal of intercultural social contact between CSB students and the local people, and the impact that these may have on CSB students' mental health as they adjust to their sojourn in Australia.

Acculturative Stress

Berry's (1990) theory of acculturative stress provides a useful framework for explaining the changes and potential difficulties arising from acculturation. This theory suggests that the stress experienced during acculturation depends on the number of life changes that occur during the cross-cultural transition, the subjective perception of these changes as being stressful or benign, and the coping strategies and resources employed by the acculturating individual. Depending on the interplay of personal and social factors, some acculturating individuals adapt successfully to their new environment while others do not, resulting in acculturative stress and possibly heightened anxiety and depression (Ward, 1996; Zheng & Berry, 1991).

The current study draws upon this framework, focusing specifically on the relationship between (a) the amount and stress appraisal of social contact with locals, and (b) CSB international students' psychological adjustment as indicated by their self-reported depressive symptoms.

Social Contact with Locals

Previous investigations have shown that international students typically interact significantly more with overseas than local people (Furnham & Bochner, 1982; Nesdale & Todd, 1993). Recent Australian research has suggested that many Asian international students would desire a higher level of social interactions with local Australian students, but then there are various student- and context-related factors inhibiting such interactions and frustrating international students (Smart, Volet, & Ang, 2000; Takeda & St. John-Ives, 2005). Student-related inhibiting factors identified included mainly cultural differences, and also negative stereotypes, ethnocentric views and apathy. Context-related inhibiting factors pertained to the nature of orientation programmes and classroom practices. The lack of positive, equal status intergroup contact and the prevalence of negative stereotypes may make it difficult for international and local students to develop a common group identity and cultivate positive cross-ethnic attitudes, as intergroup contact is a necessary but not sufficient condition for reducing intergroup bias and racial prejudice (Allport, 1954; Pettigrew, 1998).

These findings on international students' social interactions suggest that the benefits of social contact with locals are often not being fully utilised, with many students missing out on the opportunity to learn vital sociocultural skills and practise their foreign language skills (Furnham & Bochner, 1982). This is an area of concern as recent New Zealand research has also identified a lack of social contact between international students and locals, while increased contact with locals was found to be linked with improved academic, social, and psychological outcomes for international students (Ward & Masgoret, 2004).

A number of socio-demographic variables have been explored in the acculturation literature as predictors of psychological adjustment amongst sojourning international students. In

particular, increased fluency in the host language has been found to be indicative of improved psychological adjustment among sojourners (Berry, Kim, Minde, & Mok, 1987; Ying & Liese, 1991). On the other hand, situational studies on stress have found higher levels of threat appraisals to be associated with adverse health outcomes, including more depressive symptoms, among people faced with potentially stressful situations (Folkman & Lazarus, 1985; Mak, Blewitt, & Heaven, 2004).

There is a lack of research on the extent to which international students from a culturally and linguistic different background may perceive social interactions with locals to be stressful. Previous theorists (e.g.,, Gudykunst & Hammer, 1988) have suggested that stranger-host intercultural communications can pose a high level of uncertainty and interpersonal anxiety for newcomers. This is an important reason why sojourning international students from a culturally and linguistically different background may become easily fatigued in interacting with host nationals and may prefer the comfort of interacting mainly with their co-nationals. Unfortunately, inadequate social contact with hosts may impede the development of social confidence and integration, perpetuating stress reactions in intercultural contact for newcomers to the culture.

It is conceivable that international students with a lower level of social contact with locals would experience more intercultural anxiety (Stephan & Stephan, 1992) and are more likely to appraise such contact to be stressful or threatening. More important, regardless of international students' fluency in the host language and the amount of their social contact with locals, students who perceive social interactions with locals to be threatening may experience a greater amount of mental health symptoms. In line with Lazarus and Folkman's (1984) cognitive-phenomenological theory of stress, we would expect that individual students' subjective threat appraisals will have a stronger effect on adverse health outcomes than the actual amount of social contact with locals.

Present Study

The purpose of the current study is to investigate CSB international students' quantity and subjective threat appraisals of social contact with locals, and the effects that they have on CSB international students' psychological adjustment. We also set out to assess the relative contributions of English fluency, amount of social contact with locals, and threat appraisal of social interactions with locals, to depressive symptoms using multiple regression analysis, while controlling for respondents' gender. Based on previous literature, we formulated and tested the following hypotheses.

Hypothesis1: Depressive symptoms among CSB international students would be associated with lower levels of English fluency and amount of social contact with locals, as well as a higher level of threat appraisal of recent social interactions with locals.

Hypothesis 2: CSB international students' threat appraisal of social interactions with locals will exert a stronger effect on depressive symptoms than students' amount of social contact with locals, after taking into account students' gender and English fluency.

METHODS

Participants

Ninety-three (46 male and 47 female) CSB international students participated in the current study, with participant age ranging from 18 to 35 years (M = 22.26, SD = 3.03). Participants' residence in Australia ranged from 1 month to 6 years, with a mean length of residence of 1.86 years (SD = 1.42). Participants reported being born in 6 countries in Asia, with 45.2% born in the People's Republic of China, Malaysia, or Hong Kong. Other countries of birth

included Singapore, Taiwan and Vietnam. Participants reported their home language to be Cantonese (34.4%), Mandarin (18.3%), or simply Chinese (47.3%). Just over 60% of participants reported their English fluency to be acceptable or limited.

Measures

The self-report questionnaire used included sections on participants' socio-demographic information and Likert-type scale measures of quantity of social contact with locals, threat appraisal of interactions with locals, and depressed mood. One of the socio-demographic items sought the respondent's self-rating of fluency in English on a single rating scale, with possible values ranging from 1 ("very limited") through 3 ("fluency acceptable for most purposes") and 4 ("quite well) to 6 ("extremely well").

We used a 3-item measure of quantity of social contact with local people, adapted from the work by Biernat and Crandall (1994) and Spencer-Rodgers (2001), to assess the frequency with which respondents would engage in social activities, study with, and talk to locals. Possible ratings ranged from 1 ("never"), through 4 ("if you do the activity sometimes") to 7 ("all the time").

A 3-item measure of threat appraisal of intercultural contact, adapted from Gallagher (1990) and Mak et al. (2004), assessed the extent to which individuals appraised interactions with local people over the past week as being threatening. For each item presented as a negative emotion characterising a threat appraisal, the anchors for the Likert-type scale ranged from 1 ("never felt this emotion"), through 3 ("occasionally felt this emotion") and 4 ("quite often felt this emotion") to 6 ("always felt this emotion").

Depressive symptoms during the past week were measured using an 11-item scale of depressive symptoms, adapted from the Center for Epidemiological Studies Depression Scale (Radloff, 1977) by Israel, House, Schurman, Heaney and Mero (1989).

Procedure

We recruited voluntary research participants through multiple channels, advertising the research through international student advisors, international student groups and societies, residence halls and specific international education courses, and using the snowball technique. Questionnaires were distributed amongst international students either directly by the researcher at pre-arranged international student meetings or by individual international student leaders and contacts. Participation was anonymous and the questionnaire took approximately 15 minutes to complete, with an overall response rate of 70.14%.

RESULTS

Descriptive Statistics and Intercorrelations

Table 1 presents the descriptive statistics and intercorrelations among depressive symptoms and their hypothesised predictors. The mean levels of English fluency, the amount of social contact with locals, and threat appraisals made of such interactions, fell just below the middle of their respective ranges. The distribution of depressive symptoms was somewhat positively skewed. All the summated scales had satisfactory internal consistency reliabilities.

Depressive symptoms were found to be moderately associated with lower levels of English fluency and higher levels of threat appraisal of contact with locals. However, the small inverse association between amount of social contact with locals and depressive symptoms did not attain statistical significance.

We noted a moderate positive correlation between English fluency and amount of social contact with locals, but not with threat appraisal. There was also a small inverse correlation between the amount of contact with locals and individuals' threat appraisal of contact with locals.

Table 1. Descriptive Statistics of and Intercorrelations Among Variables.

Variable	M	SD	Possible Range	1	2	3	4
1. English fluency	3.32	0.91	1 - 6	-			
2. Social contact with locals	3.68	1.25	1 - 7	.41**	.80		
3. Threat appraisal	9.39	3.23	3 - 18	-.07	-.18*	.81	
4. Depressive symptoms	18.61	3.88	11 - 33	-.32**	-.14	.54**	.79

Note. Internal consistency reliabilities are shown in the diagonals.
*p < .05. **p < .01.

Regression of Depressive Symptoms

We further conducted a hierarchical multiple regression analysis to assess the relative contributions of the hypothesised predictors of depressive symptoms. Table 2 presents a summary of the regression results. The demographic variables of gender and fluency in the English language were entered at the first step, with only English fluency having a dampening effect on depressive symptoms. At the second and final step, the amount of social contact with locals and threat appraisal of interactions with locals were added to the list of independent variables.

The final regression model explained a significant 38.2% of the variance in depressive symptoms. The significant predictors, in order of decreasing β values, were a large effect of threat appraisal of interactions with locals and a medium effect of English fluency. Neither gender nor the amount of social contact with locals contributed to the variation of depressive symptoms when the other predictors were simultaneously considered.

Table 2. Summary of Hierarchical Regression Analysis for Predicting Depressive Symptoms.

Variable	*B*	*SE B*	β	R^2	R^2 change
Step 1					
Gender	-0.92	.77	-.12		
English fluency	-1.37	.42	-.32**	.11	.11**
Step 2					
Gender	-0.07	.66	-.01		
English fluency	-1.37	.39	-.32**		
Social contact with locals	0.29	.29	.09		
Threat appraisal	0.65	.11	.54**	.38	.27**

**p < .01.

DISCUSSION

Levels of Social Contact with Locals and Inherent Stress

Present descriptive results obtained show considerable variation in CSB international students' levels of social contact with local Australians, and especially the threat appraisals that students made of such interactions. On average, the actual amount of contact with locals just fell short of the middle level of "doing the activity sometimes with local people". This finding is consistent with the existing body of literature that the amount of contact, especially informal contact, between international students and local people, tends to be low.

The mean level of threat appraisals that international students made of recent social interactions with locals fell just below the medium level. There is no comparative literature on this, but the implication is that the average Chinese background student would occasionally make a threat appraisal of interactions with local Australians. This suggests that interactions with Western host nationals could indeed be a common source of stress for acculturating Chinese background international students.

Support for Research Hypotheses

Based on correlational and multiple regression analyses, we found partial support for our first research hypothesis. As predicted, we found that lower levels of English fluency and higher levels of threat appraisals of social interactions with locals, were predictive of depressive symptoms among Chinese background international students. However, the inverse bi-variate association between amount of social contact with locals and depressive symptoms was small and did not attain significance.

Indeed, the latter association was further diminished when threat appraisals were simultaneously considered in the multiple regression analysis. The results lend support for our second research hypothesis, which posits that Chinese background international students' threat appraisal of social interactions with locals will exert a stronger effect on depressive symptoms than students' amount of social contact with locals, after taking into account students' gender and English fluency. Indeed, threat appraisal was found to have a strong effect on (and the most important predictor of) depressive symptoms in the regression analysis conducted, with English fluency also exerting a medium effect.

Other interesting observations can be made of the correlations obtained. Not surprisingly, a greater amount of social contact with locals was associated with greater English fluency, and, to a lesser extent, inversely associated with threat appraisals of such interactions. A notable result is the lack of an association between English fluency and subjective assessments of threat appraisal in intercultural interactions.

The overall pattern of present results generally corroborates the existing literature. One exception is that the amount of social contact with locals was only minimally related to the Chinese background students' mental health, contradicting Ward and Masgoret (2004). The main theme emerging from this study is that interactions with host nationals is a stressor for many international students, which is consistent with Gudykunst and Hammer's (1988) view about intercultural communication. In line with Berry's (1990) theory of acculturative stress, where individual acculturating students appraise these interactions to be threatening, they are also more likely to experience symptoms of depression, regardless of their actual amount of social contact with locals. This stress-depression link holds even among those relatively fluent in the host language.

Implications for Future Research and Student Services

Present findings show that there is considerable room for improvement for both the quantity and quality of social contact between international students and local people. The latter include domestic students, academic and general staff members, home stay families, other local service providers and people in the host community. The present findings have highlighted the perception of social interactions with hosts as being occasionally stressful for many international students from a culturally different background, which is further linked to their psychological adjustment, more so than the actual amount of social contact with hosts.

Future investigations on the incidence of such acculturative stress and how it may be reduced or prevented can be beneficial for promoting international students' mental health. Relevant

stress management strategies can include individual-level interventions such as exercise, relaxation, and cognitive restructuring, as well as training programmes facilitating cultural knowledge learning and cultivating social confidence and skills in intercultural situations.

Present findings also indicate the relevance of developing and implementing programmes that can foster a greater level of positive intergroup contact in multicultural educational environments, where the emphasis is on contact perceived to be inclusive, egalitarian, fun, and involving common goals. These are the conditions conducive to the development of a common student identity and the reduction in intergroup bias and ethnic prejudice (Pettigrew, 1998). This can in turn foster positive intergroup contact and greater social cohesion in multicultural campuses (Smart, Volet, & Ang, 2000).

Mak and Buckingham (in press) have recently reported an Australian intervention that incorporated a skills-based sociocultural competency training module – the EXCELL (Excellence in Cultural Experiential Learning and Leadership) Program (Mak, 2000; Mak, Westwood, Ishiyama, & Barker, 1999) – in a first year university communication course. The intervention has shown various benefits for both overseas- and Australian-born students, including significant improvements in social interaction skills and increase in time spent with friends from other ethnic backgrounds.

Future research utilising a larger sample size, a greater number of predictor variables, more refined measures, and a longitudinal design, can improve the present research design. Further investigations can also determine whether the present results obtained can be replicated with international students from other nationalities and generalised to other host countries. It will be particularly interesting to examine changes in subjective stress perceptions of intercultural interactions over time and evaluate the efficacy of health promotion interventions designed to alleviate those stress appraisals.

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SOCIAL ACCEPTANCE AND MENTAL WELL-BEING OF ASIANS IN AOTEAROA NEW ZEALAND

Amritha Sobrun-Maharaj

ABSTRACT

As part of a larger study measuring interethnic attitudes and interaction within Aotearoa New Zealand, this paper presents perceptions of Asian parents and students of their social acceptance within New Zealand's schools and communities. The data for this study was gathered from a survey of the perceptions and attitudes of 208 European, Maori, Pacific Island, Indian and Chinese students, and interviews with a sub-sample of 35 secondary school students (20 Indian and 15 Chinese) and 24 parents (12 Indian and 12 Chinese). Interviews were guided by a semi-structured interview schedule to produce in-depth data.
Data from Asian students and parents indicated that many felt unaccepted in New Zealand due to racism, prejudice, discrimination and ethnic intimidation in schools, the workplace and in the community, and that this may be impacting adversely on their mental and physical well-being.
The paper discusses the coping strategies Asians employ in dealing with feelings of non-acceptance, as well as the consequences of non-acceptance for this group of New Zealanders. It suggests prerequisites for positive attitudes and interaction in order to ensure social cohesion in Aotearoa New Zealand.

Sobrun-Maharaj, A. (2006). Social acceptance and mental well-being of Asians in Aotearoa New Zealand. In S. Tse, M.E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp. 133-146). Auckland, New Zealand: University of Auckland.

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INTRODUCTION

The 1990s saw an immigrant population with large numbers of visible ethnic minorities of Asian origin arrive in Aotearoa New Zealand, bringing unprecedented change to the New Zealand population, which changed from a bicultural to a multicultural one with a diverse range of cultures (Sobrun-Maharaj, 2002). As witnessed in the media during that time, this new phenomenon elicited negative reaction from the New Zealand community at large and from New Zealand students in schools where there has been an which is directed at Asians. It is clear amongst Asian communities that this condition persists today.

Behaviours such as bullying are indicators of non-acceptance. Such behaviours include physical and verbal abuse and exclusion, which are practices most encountered by peoples of Asian origin (Sobrun-Maharaj, 2002). Research evidence (Slee and Rigby, 1993; Rigby, 1996) confirms that non-acceptance can have a major effect on the health and social and emotional wellbeing of victims (Sobrun Maharaj, Ryba & Tie, 2000). This view is supported

by other writers who suggest that negative and dissatisfying contact with the host community can have adverse effects on the mental well-being of those experiencing such feelings (Ward and Searle, 1991; Ward and Kennedy, 1993). Their ability to cope with non-acceptance will determine the extent of the impact of adverse effects. This is of particular importance to Asian adolescents. Adolescents are on the threshold of adulthood and, as a result, the ways in which they cope with personal and social problems establish the patterns for the future and impact on the community at large (Frydenberg, 1997). Additionally, failure to cope can have grave consequences for individuals and the community.

Host groups are not passive observers of newcomers, but 'critical players' in the formation of interethnic relations and the adjustment process (Lambert & Taylor, 1990). Attitudes of host groups determine whether contact will be positive or negative, resulting in acceptance or non-acceptance of immigrants. Consequently, a larger study of the social acceptance of Asians within New Zealand society (Sobrun-Maharaj, 2002) surveyed inter-ethnic attitudes and behaviours amongst the major ethnic groups of European, Maori, Pacific Island, Indian and Chinese in New Zealand, including social distance, peer victimisation, self-esteem and mental and physical well-being. The study then focussed on the Indian and Chinese groups to determine perceived levels of acceptance, coping strategies employed by this subset and consequences of non-acceptance of these groups.

This paper presents Asian perceptions of their social acceptance within New Zealand, coping strategies employed in dealing with feelings of non-acceptance, and consequences of non-acceptance.

AIMS AND METHOD

The data for this study was gathered from a survey of the perceptions and attitudes of New Zealand students and interviews with a sub-sample of secondary school students and their parents of Indian and Chinese origin to ascertain their perceptions of their social acceptance and the perceived impact of social non-acceptance on their mental well-being.

Two hundred and eight European, Maori, Pacific Island, Indian and Chinese students were surveyed in the larger study, and a sub-sample of 35 students (20 Indian and 15 Chinese) and 24 parents (12 Indian and 12 Chinese) was interviewed. Interviews were guided by a semi-structured interview schedule to produce in-depth data.

RESULTS AND DISCUSSION

Data from Asian students and parents indicated that many felt unaccepted in New Zealand due to racism, prejudice, discrimination and ethnic intimidation in schools, the workplace and in the community, and that this may be impacting adversely on their mental and physical well-being. Acceptance issues, coping strategies and consequences are discussed below:

Acceptance

Interview data revealed that both parents and students had a strong need for acceptance in their new country. However, most felt unaccepted. Thirty-four students (97%) said they did not feel completely accepted here, and 28 (80%) did not feel accepted initially, however, as time passed they felt a little more accepted by their peers. More West Asian students (19-95%) appeared to feel accepted later than East Asian (9-60%). Twenty-two parents (92%) reported that they did not feel fully accepted here. Only one West Asian, year 13 student said that she felt totally accepted by her peers, had experienced no negative behaviour at any time, and felt no racism toward herself. However, she later said: "When I go out with my

friends I don't want to be Indian…. I don't really know [why]. I just know that it would be better sometimes if I weren't an Indian when I'm out".

Although refugees encountered acceptance problems from time to time, they said they regarded them as insignificant in relation to the aid given to them by this country, and were prepared to overlook them in gratitude.

An examination of intimidatory practices in schools, which are indicators of non-acceptance and determine the extent of acceptance of the different ethnic groups of students, found that Asians are more likely to experience ethnic intimidation than the other groups ($p<0.002$), and that they (particularly Chinese) are more likely to experience rejection and blame school problems on ethnic intimidation than other ethnic groups (for details see Sobrun-Maharaj, 2002). A survey of things that made students feel unaccepted found that 45 percent of the whole sample reported feeling unaccepted specifically because of ethnic intimidation. Eighty seven percent of these were visible ethnic minority pupils, and 13 percent were European. Of the Europeans who complained about ethnic intimidation, 45% were foreign immigrant Europeans. Ethnic intimidation included racist name-calling, taunts and comments, which were experienced by 43 percent of the sample, rejected/excluded because of ethnicity (37%), made fun of because of appearance and accent (14%). Forty six percent of the sample reported ethnicity as the reason for intimidation, and 90 percent of this group were visible ethnic minorities and ten percent were European. Of this, 44 percent were immigrants. Sixteen percent of the sample identified European students as perpetrators of intimidation, and 73 percent of this group were Asian. Twelve percent identified Pacific Islanders, of which 68 percent were Asian. Eleven percent said they were Maori, with 78 percent being Asian. Parents also reported being subjected to ethnic intimidation in the community.

This was corroborated by over half the teacher sample (53%) who acknowledged the existence of ethnic intimidation in their schools, and that this contributed to negative interethnic relations, tension and conflict within schools. One teacher described the situation as "tectonic plates rubbing against each other at the school". European teachers reported constantly hearing remarks of a racial nature and seeing ethnic minority pupils walking or standing around alone because they were not accepted. There was a "put-down culture" amongst students; consequently, there was a lot of "interethnic taunting and name-calling", and "racial slurs and putdowns". Those who were different in any way were soft targets, and were called names and mocked. This behaviour was confirmed during observations at schools.

Racism, prejudice and discrimination

Seven students (20%) (six East Asian and one West Asian) spoke of severe racism, prejudice and discrimination at school, while the other 28 students (80%) spoke of being subjected to moderate amounts of this. Many spoke of witnessing such experiences of other visible ethnic minority students at school. All 20 parents (83%) who worked within the 'Kiwi' community spoke about their experiences of racism and discrimination in the workplace, which they suggested was a consequence of European New Zealanders' prejudices against them. This data suggests significant amounts of racism, discrimination and ethnic intimidation in schools which makes a large proportion of Asian people feel unaccepted.

Several parents (21-88%) and a large number of students (74%) appeared to be convinced that racist attitudes in teachers influenced levels of pastoral and academic support given to visible ethnic minority students. They found such support to be lacking, which exacerbated feelings of non-acceptance. They felt that although their schools were offering some support, there was still much more that they could do. Students reported that many teachers have lower expectations of them due to assumptions guided by stereotypes; consequently, they

interact with them in intellectually limiting ways, a view supported by Bennet (1984). Eighteen (51%) children for whom English was a second language, including fee paying students, said that they were not receiving the kind of assistance from their schools and teachers that they expected. Eight (33%) parents stated that a lack of cooperation by staff due to negative attitudes toward ethnic minority parents contributed to poor relationships at school. They found the lack of respect for other cultures and ethnicities shocking and hurtful.

Social distance

Social distance between the groups was measured and occupational distance was found to be significant. Results show that the ethnic groups appear to be fragmented, and that there is significant distance for all groups, suggesting that students from the different ethnic groups do not mix with each other much, and that none of the groups is particularly close. The greatest division apparently lies between Europeans and the other ethnic groups suggesting that Europeans may not wish to mix with others.

The results indicate that Asians, particularly East Asians, experience the most non-acceptance, and feel the most rejected by other students, whom they identified as being mainly Europeans, followed by Pacific Islanders and then Maori. Bullying was considered to be a big problem and a large number of students reported feeling rejected because of ethnic intimidation.

Means for each ethnic group in the interethnic attitude scale indicate that European and Maori/Pacifika means tend to be relatively high suggesting high levels of social non-acceptance. Asian means tend to be relatively low suggesting lower levels of social non-acceptance.

Table 1. Average Occupational Distances from European, Maori, Pacific Islanders, West Asians and East Asians.

	Mean Average Distance (std. dev.) from:				
Ethnic Group	East Asians	Pacific Islanders	West Asians	Europeans	Maori
Europeans	4.375 (0.469)	4.513 (0.285)	4.366 (0.292)	2.770 (0.133)	4.489 (0.364)
Maori	5.433 (0.338)	3.764 (0.414)	5.636 (0.324)	3.155 (0.249)	3.327 (0.200)
Pacific Islanders	5.011 (0.276)	3.003 (0.223)	4.968 (0.358)	3.794 (0.357)	4.047 (0.356)
West Asians	4.189 (0.383)	4.283 (0.293)	3.133 (0.266)	4.057 (0.257)	4.926 (0.278)
East Asians	3.075 (0.299)	4.672 (0.338)	4.153 (0.294)	3.722 (0.312)	4.770 (0.344)
p-value(*)	0.000	0.000	0.000	0.001	0.000

(*) Kruskal-Wallis Test was used to compare independent ethnic samples. This nonparametric test makes no assumptions regarding the distribution of responses.

This is supported by qualitative data from interviews and observations which also indicate that there is little social interaction amongst the ethnic groups at school; the groups are fragmented, and none of the groups is particularly close.

Mental and Physical Well-being

Health and self-esteem levels for each ethnic group were analysed and correlations for peer victimisation, health and self-esteem were discussed. Although there were no significant

ethnic differences, there was a correlation between peer rejection, bad health and low self-esteem.

Effects of demographic factors on perceptions of social acceptance and their relation were analysed and discussed. Ethnicity and gender were found to have significant effects on perceptions of social acceptance. A structural equation model for perceptions of social acceptance (see Figure 1 below) confirmed these results and showed the influence of ethnicity and of peer victimisation on perceptions of social acceptance.

Correlations for peer victimisation, health and self esteem

Table 2 below shows that there were moderate but significant correlations for peer victimisation, bad health and low self-esteem ($p < 0.001$), suggesting that there may be an inter-relationship between these three variables and that intimidatory behaviour such as bullying may impact on health and self-esteem.

Table 2. Spearman Correlations for Peer Victimisation, Health and Self-Esteem.

Correlations

			PEERVIC	BADHEALT	SELFESTE
Spearman's rho	PEERVIC	Correlation Coefficient	1.000	.305**	-.317**
		Sig. (2-tailed)	.	.001	.000
		N	167	113	139
	BADHEALT	Correlation Coefficient	.305**	1.000	-.342**
		Sig. (2-tailed)	.001	.	.000
		N	113	138	123
	SELFESTE	Correlation Coefficient	-.317**	-.342**	1.000
		Sig. (2-tailed)	.000	.000	.
		N	139	123	174

**. Correlation is significant at the .01 level (2-tailed).

Table 3 below shows that there was a significant correlation between peer victimisation and perceived non-acceptance in Maori and Asians ($p < 0.005$). These are associations that show that there is a relationship between the variables, and do not necessarily imply causation.

Table 3. Spearman *Correlations for Peer Victimisation: Perceived non-acceptance for the three groups.*

Correlations

			PEERVIC	EUROPEAN	MAORIPI	ASIAN
Spearman's rho	PEERVIC	Correlation Coefficient	1.000	.127	.283**	.259**
		Sig. (2-tailed)	.	.167	.002	.002
		N	167	120	122	135
	EUROPEAN	Correlation Coefficient	.127	1.000	.293**	.233**
		Sig. (2-tailed)	.167	.	.001	.008
		N	120	147	119	129
	MAORIPI	Correlation Coefficient	.283**	.293**	1.000	.309**
		Sig. (2-tailed)	.002	.001	.	.000
		N	122	119	151	130
	ASIAN	Correlation Coefficient	.259**	.233**	.309**	1.000
		Sig. (2-tailed)	.002	.008	.000	.
		N	135	129	130	166

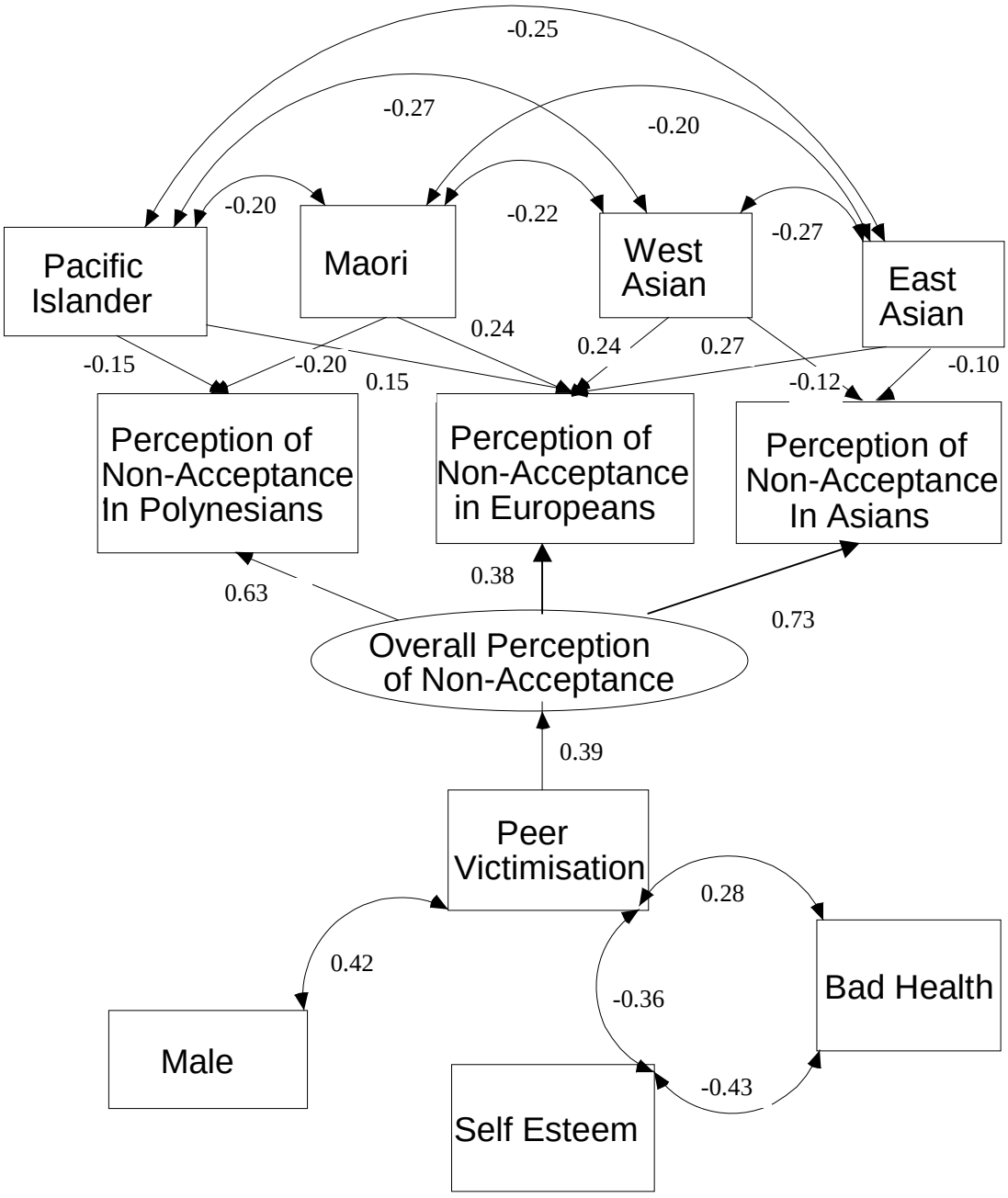
**. Correlation is significant at the .01 level (2-tailed).

Structural equation model for perceptions of social acceptance

This model, which was developed from the data, shows the influence of ethnicity and of peer victimisation on perceptions of social acceptance and confirms the results obtained from the scales. Amongst these are the following: ethnicity and feelings of peer rejection strongly influence perceptions of acceptance or non-acceptance, and all ethnic groups consider themselves to be more accepting than other ethnic groups perceive them to be. It suggests that ethnicity is more important than peer rejection as a source of perceptions of social acceptance. It also confirms that 55.8% of the variation in perceptions of Asian Social Acceptance, 44.8% of the variation in perceptions of Maori/PI Social Acceptance and 21.6% of the variation in perceptions of European Social Acceptance can be explained by ethnicity. The strongest correlation with Peer Rejection (not perceptions of social acceptance) occurs for gender (0.416) with males being much more likely to experience peer rejection than females. Peer Rejection also has a strong correlation with Self Esteem (-0.360), indicating that pupils with low self-esteem are more likely to experience peer rejection. This effect is bi-directional indicating that those who experience peer rejection are more likely to experience low self-esteem. The correlation between (Bad) Health and Peer Rejection is lower (0.278), but there is also an indirect effect because Self-Esteem and (Bad) Health are strongly correlated (-0.426), therefore all these effects are reciprocally interactive. In conclusion, it confirms the existence of interethnic social non-acceptance in Aotearoa New Zealand and the negative influence of non-acceptance on mental and physical well-being.

These results are seen in Figure 1 below:

Figure 1. Structural Equation Model for Perceptions of Social Acceptance: Showing standardised regression weights and correlations.



Coping with Non-acceptance and Intimidation

In this research, a coping scale was not used to measure students' levels of coping, however, questions asking them to identify stressful situations and to indicate the ways in which they deal with their stresses were asked in both the survey and interview, and these behaviours were also observed to some degree.

Many parents and students appeared to cope reasonably well with non-acceptance, apparently by employing functional coping strategies such as drawing strength from religious and spiritual philosophies. However, a large number did not appear to cope well. Some appeared to employ avoidance strategies such as silence, blocking out, pretending and ignoring in order to cope, while others resorted to other dysfunctional coping strategies such as self-blame and self-exclusion, anger, frustration and retaliation, as discussed below.

Those who did not cope reported experiencing feelings of anxiety, depression, helplessness, feelings of inferiority, and physical problems such as headache and stomach ache. This apparently impacts adversely on the self-confidence and self-esteem of a large number of students (74%) and many parents (42%) who complained of such psychological and physical problems.

Significant *dysfunctional coping strategies* are discussed below:

Self-blame and self-exclusion

There appeared to be a strong tendency amongst many respondents to blame themselves for the problems they experienced at school or elsewhere as they believed that they were not good enough for the locals. Consequently, they imposed self-exclusion on themselves which led to feelings of isolation.

Sprinthall and Collins (1995: 520) maintain that such self-blame can lead to apathy and depression. It is the view of the researcher that, due to their history of being inferiorised, ethnic minorities often succumb to the belief that they are unworthy to participate equally with their ethnic majority counterparts, therefore are to blame for negative interaction.

Silence

Some students chose silence as their coping mechanism and told nobody about their experiences. There were many reasons why this method was resorted to: Children were often afraid to tell their parents as they would reprimand them for being at fault and ask them to focus on their work instead, or they would ask them to ignore it. They also did not want to trouble their parents who had enough to worry about. Some thought their parents would dismiss it because they did not understand what was going on. They were also embarrassed to admit that they were subjected to such vile behaviour, and often blamed themselves for it.

Blocking out, pretending and ignoring

Another common coping strategy employed was blocking the nasty experience out of their minds and pretending it did not happen, or just ignoring it and the perpetrators. Most respondents apparently tried to block out these memories in order to be able to move on, and were reluctant to talk about them. They initially pretended that they had no problems at all, but slowly opened up after they became more comfortable with talking about themselves. This is a concern as it is suggested that this form of suppression would create more serious psychological problems, as students who report not being bothered by bullying may experience eventual consequences due to emotional repression or isolation of feelings (Sprinthall & Collins, 1995).

Frustration, anger and retaliation
Students appeared to be frustrated by being rejected which often led to feelings of anger. Interview evidence indicates that some students, especially Chinese boys, may possibly be resorting to some form of aggression in order to take control of their lives. They choose retaliation as a means of coping possibly because it makes them feel less vulnerable and stronger, and they also feel they are making some attempt to try to solve the problem themselves, as reflected in other studies (e.g., Sun & Gibson-Cline, 1996). Some of their apparent affiliations to gangs may also be a retaliatory response. Evidence from teachers suggests that such a response may be having an adverse effect on their academic performance.

Consequences of Non-acceptance and Intimidation
While most ethnic minority children appear to cope with non-acceptance without any visible consequences, it is possible that many could suffer serious psychological and even physical harm that is undetected and carried into adulthood, as suggested by Sprinthall and Collins (1995). This highlights the need for awareness amongst parents and teachers of the circumstances of these children so that symptoms may be recognised timeously and interventions appropriately implemented. The more significant psychological and physical consequences apparent amongst this sample are discussed below:

Poor mental and physical well-being
A large number of Asian immigrant students have reported experiencing poor mental well-being. Nine (45%) West Asian and seven (47%) East Asian pupils talked about physical problems such as headache and stomach ache suffered as a result of their experiences. Physical illness appeared to be an overt expression of an inability to cope. If the desired outcome is positive adaptation for immigrants, the apparent poor mental health of these pupils is cause for concern, as there is a relationship between mental health, acceptance and acculturation (Dona & Berry, 1994; Slee & Rigby, 1993).

Exclusion, isolation and alienation
A large number of parents and students reported feeling excluded, isolated and alienated because of racism, prejudice, discrimination, intimidation and non-acceptance. This was corroborated by teacher reports and observations, and supported by other studies that showed that ethnic minority students experience being socially isolated and excluded most intensely (Furnham & Bochner, 1986; Ward *et al*., 2001). These authors suggest that the blatant racism displayed by some students increases their sense of isolation from the rest of their peers. That most teachers (according to a European teacher) dismiss this kind of behaviour as adolescent jest thereby allowing it to burgeon, is of great concern.

Evidence from this study suggests that even when Asian students are informed about and prepared for the norms, values and expectations that predominate in the school community, they still experience alienation due to negative prejudice and discrimination on the part of teachers and classmates. Research has shown that students who are isolated may be more vulnerable to being bullied through a lack of supporters. The effect of bullying on victims is a deepening in isolation from others, and being vulnerable and unable to gain support may also lead to feelings of depression (Rigby, 1996: 51). It is for this very reason that Asian students choose to ‘stick’ with their own ethnic groups.

Lack of a sense of belonging
The qualitative data also suggests that, due to their feelings of alienation, students (15 - 43%) and all parents of both West Asian (Indian) and East Asian (Chinese) origin lack a sense of belonging here, which may be detrimental to ‘normal’ development as acknowledged by

developmental theorists (e.g., Bosma & Jackson, 1990; Frydenberg, 1997; Gibson-Cline, 1996; Lambert & Taylor, 1990; Sprinthall & Collins, 1995; Seiffge-Krenke, 1990; Sorensen, 1993). Having a supportive peer group has been found to be linked to a positive self-concept, appropriate classroom behaviour and scholastic competence, as well as other psychological, social and academic benefits (Ward *et al*., 2001).

Uncertainty and fear

Parents and students suggested that whilst there are many 'Kiwis' who are kind and hospitable to them, there are also those who do not want to mix with them. The perceived insularity and unwillingness of Europeans to mix, engendered feelings of uncertainty and fear of interaction amongst many immigrants, possibly contributing to the social distance between them. Forty percent (14) of students interviewed reported uncertainty about how people were going to react to them, and fear of being embarrassed. Twenty three percent (8) said they were afraid to talk to others because they felt that they were not liked by them.

Disappointment and disillusionment

Many parents (13-54%), particularly those who had suffered rejection at some level, showed signs of disappointment, disillusionment and unhappiness with their experiences here, and some said they regretted their move to this country. Even more students (26-74%) expressed disappointment, disillusionment and unhappiness with their education and the way they were treated by their peers. Perceptions of non-acceptance and feelings of disappointment, disillusionment and unhappiness have long-term negative consequences for successful adaptation, interethnic relations and national well-being (Ward *et al*., 2001); therefore steps need to be taken to eliminate circumstances that engender such feelings.

Lowered self-esteem and self-confidence

Many pupils and parents, especially those of Indian origin, appeared to have internalised notions of inferiority about themselves that have been projected by Europeans over centuries. Some reported adverse effects on their self-esteem and self-confidence as a consequence.

Anxiety and depression

A large number of students (26-74%) and many parents (10-42%) reported experiencing anxiety over rejection and intimidation. Some appeared to be visibly upset and perturbed by their negative experiences which were apparently having a detrimental effect on their mental health. Many appeared to be depressed due to their feelings of non-acceptance and intimidation. A year 11 boy who was intimidated and rejected from primary school first sank into a state of depression, and later at high school chose to rebel against anyone who attempted to oppress him in any way. This influenced his choice of friends and his behaviour, and according to his mother, had an adverse effect on his life.

Suicidal tendencies

Fortunately, none of the respondents displayed such a tendency. However, one student's concern about her friend who apparently displayed such tendencies and anecdotal evidence about an Asian immigrant adolescent who had committed suicide, which suggested an inability to cope with conflicting parental and peer pressures to conform for acceptance to be the cause, illustrate the need for awareness on the part of parents, teachers and counsellors of the immense conflict and trauma to which some ethnic minority adolescents may be subjected when in a foreign western environment. It also underlines the responsibility of these adults to provide sensitive and appropriate intervention.

Sense of crisis and conflict

It was clear that many of the visible ethnic minority people interviewed were experiencing conflict at some level due to their often hostile environment. Personal conflict included that of

culture and religion, erosion of values, peer pressure and, most importantly, identity. On the one hand, they wish to preserve their cultural identities as desired by their parents, a concern identified by other studies as well (Furnham & Bochner, 1986; Kashyap, 1996; Sun & Gibson-Cline, 1996; Ward *et al.*, 2001), and on the other, they wish to blend in with their peers as much as their difference allows. Because their cultural identities are often openly and directly devalued by practices such as name-calling and other forms of ethnic intimidation both in the wider community and in schools by their peers (e.g., Bagley, 1982; Verma, 1986; Bullivant, 1987; Smith & Sharp, 1994), they appear to want to conceal it from them, hence the dilemma of what they should be. Some students resorted to avoiding being seen with their own people or being heard talking in their own language. They were even ashamed of being themselves because they had been made to feel inferior about whom and what they were. They thought that being like 'Kiwis' would make them more acceptable and solve their problems, so they tried to be more 'Kiwi' by mixing with them more than with people from their own ethnic group.

This problem was also identified by other studies of Indian and Chinese youth (Kashyap, 1996; Sun & Gibson-Cline, 1996) and of other youth in other countries (Furnham & Bochner, 1986; Ward *et al*., 2001). It is suggested that such blatant racism places an extra burden on these adolescents during identity-formation phases. They have fewer resources and face greater psychological conflicts, which act as a barrier to identity achievement, even though they need more time and support to sift through two sets of cultural values and identity options (Sprinthall & Collins, 1995: 177). This may increase the sense of crisis and conflict which can in some cases lead to increased risk of joining cults, gangs, or other extremist groups, consequences which have been reported above.

One (5%) West Asian child and six (40%) East Asian children, one of whom was born in New Zealand, and most of who grew up here, appeared to be experiencing conflict with their identities. The West Asian student did not want to be Indian, yet did not want to change her culture. Chinese and Indian students born here appeared to be experiencing significant problems. Experiences with and observations of local New Zealanders show that many differentiate very little, if at all, between international and immigrant students. This poses a peculiar problem for visible ethnic minorities who were born and have lived their whole lives here. The 'old' (born here) Chinese respondents of this study reported experiencing conflict with their identities to a much larger extent than other students. One of these respondents appeared to be in crisis over her identity. These children have 'assimilated' into the New Zealand culture and consider themselves to be 'Kiwis', however, they are not accepted by the locals, and they are also not accepted by the 'new' Chinese (recent immigrants) because they are different from them due to their westernisation and inability to speak the vernacular. Because they experience problematic identification with both groups, they are marginalized and feel culturally alienated. This alienation – 'anomie' (Bourhis *et al*., 1997) – may be affecting their self-esteem negatively as these authors have warned. The realisation of Asian students that they could never be something else on account of their distinct physical appearance, which makes blending in with the host population impossible, may also be exacerbating this identity dilemma.

CONCLUSION

Immigrants of Asian origin generally feel unaccepted by New Zealanders and this impacts adversely on the mental and physical well-being of some. This conclusion is supported by results of the surveys in the larger study. Spearman correlations for peer victimisation, health and self-esteem show that there is a significant correlation between peer victimisation and perceived non-acceptance in Asians ($p < 0.005$), showing that there is a relationship between

the variables. A structural equation model confirms a relationship between peer victimisation, self-esteem and health.

Prerequisites for positive attitudes and interaction are as follows: equal status for minority members; a social climate that supports interethnic association; contacts that are sufficiently intimate to produce reciprocal knowledge and understanding between groups; and cooperative interaction aimed at achieving shared goals. All reports, both empirical and anecdotal, point to a lack of these elements and to the inherent negative nature of interethnic contact (e.g., Aronson, 1999; Larrain, 1994; Shorish et al., 1993; Tully, 1995; Ward et al., 2001; Ward & Brown, 2002).

The satisfactory adaptation of immigrants to their new country is crucial, not only to immigrants themselves, but also to the host population, because failure to do so would be costly to both parties in personal and financial terms. These costs, suggest Ward *et al.* (2001), include impaired self-esteem, delayed career progression and general unhappiness, and inter-group and international disharmony.

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SOCIAL INTEGRATION: STRATEGIES TO FOSTER MIGRANTS' EFFECTIVE PARTICIPATION IN A GROUP

Anita S. Mak and Michelle C. Barker

ABSTRACT

Asian migrants can sometimes find it difficult to demonstrate their knowledge and contribute to workplace meetings and class discussion in an individualistic host country, where locals often appear to be direct, outspoken, and eager to talk over other people. Migrant workers and students may become frustrated and discouraged when they cannot find the gap to break into a lively discussion. Developing the social competency of effective participation in a group discussion can enhance migrants' social integration and personal wellbeing.

This paper describes and explains how the cultural mapping approach, a schematic framework initially developed for the EXCELL™ (Excellence in Cultural Experiential Learning and Leadership) Program for fostering international students' sociocultural competencies (Mak, Westwood, Barker, & Ishiyama, 1998), can be adapted to facilitating Asian migrants' participation in a group meeting in Western settings. The paper provides practical examples of how cultural mapping can help break down complex social interactions into more manageable phases, to help migrants to join in a group discussion. The application and utility of cultural mapping as a stand alone tool or part of a more comprehensive sociocultural competency or host language training program are discussed.

Workshop Activity: Workshop participants will be invited to participate in a cultural mapping activity on effective participation in a group. Participants will be asked to reflect on their own observations in the challenges that Asian migrants face in participating in a group, and the potential use of the EXCELL™ cultural mapping method for enhancing migrants' social integration and promoting their health and wellbeing.

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INTRODUCTION

Asian migrant workers and students have become a visible presence in New Zealand and Australian workplace and educational settings. Owing to a change in emphasis in skilled migration policy since the mid-1980s, both countries have seen a dramatic increase of middle-class Asian migrants seeking entry into workplaces, attempting to advance careers, and striving to establish businesses (Fletcher, 1999; Ho, 2002; Mak, 2001).

Many skilled Asian migrants have returned to universities to study for local qualifications or to change to a field of studies with better perceived career prospects and lesser English language requirements, as an initial career development strategy (Mak, 2001). Large numbers of Asian-born children who migrated with their parents have also reached the age for attending university, many of whom are motivated by family values in academic achievement and are often encouraged by their middle-class parents to excel in their chosen field of professional training (Mak & Chan, 1995).

Yet research has shown that many Asian migrants have encountered language and especially cultural barriers in transferring their skills to mainstream workplaces. Ironically, their lack of local work experience further confers a substantial disadvantage in job search (e.g., Fletcher, 1999; Mak, 2001). Negative stereotypes and prejudicial attitudes towards Asian newcomers in the community also pose a cause for concern (Ip, Kawakami, & Duivenvoorden, & Tye, 1994).

CULTURAL DIFFERENCES IN PARTICIPATION IN GROUPS

Community observations have suggested that even among Asian migrants highly proficient in English, cultural differences could hinder migrants' effective participation in groups at work or educational settings, contributing to perceived and real issues in social integration. Migrant workers and students may be highly technically competent and have prepared well for meetings and classes, but still find it challenging to break into formal and informal group meetings because of their linguistic style and differences between communication rules in their culture of origin and the host culture. According to Tannen (1995), linguistic style is a set of culturally learned signals by which we not only communicate what we mean, but also how we evaluate others, their meaning, and their abilities. Turn taking in a conversation is one element of linguistic style.

In discussing the group dynamics of international project-based team activities in higher education, Paulus, Bichelmeyer, Malopinsky, and Rastogi (2005) have cited Hofstede's (1991, 2001) research on cultural dimensions impacting on work-related values and behaviours, highlighting that cultural differences in power distance and uncertainty avoidance are particularly problematic for effective group performance. Power distance, defined as "the extent to which the less powerful members of institutions and organizations within a country expect and accept that power is distributed unequally" (Hofstede, 2001, p. 98), is typically much higher in individualistic Western societies (such as Australia and New Zealand) than in Asian (e.g., Chinese and Japanese) societies. Asian cultures are relatively collectivistic, where people value group-centeredness and interdependence above individual rights and autonomy, personal identity, and independence, the latter being a constellation of individualistic values that are important to cultures with Anglo-European roots (Hofstede, 1991).

As Paulus et al (2005) put it, in a low power distance culture, individuals generally believe that the inequalities between levels of the hierarchy should be minimised, that supervisors should be more consultative of subordinates, and that the ideal leader believes power resides in the people. Participating effectively in project teams and other groups may be particularly challenging for students or workers with high power distance orientations, especially where decision-making and conflict resolutions within the groups are involved (Hofstede, 1991, 2001).

Uncertainty avoidance, defined as "the extent to which the members of a culture feel threatened by uncertain or unknown situations" (Hofstede, 1991, p. 113), is a value commonly held among some Asian cultures (e.g., Japan and South Korea), where people

prefer to follow precedents and rules that fit the norm. This contrasts with the relative comfort with which people from cultures characterised by low uncertainty avoidance (e.g., Australia, Great Britain, The Netherlands) tolerate uncertainty. According to Mead (1998), individuals from low uncertainty cultures are less likely to feel anxious and less emotionally resistant to change, and more able to take risks.

In group situations, Asian migrants from cultural backgrounds that emphasise high power distance and uncertainty avoidance may be surprised and irritated when other members appear to speak out of turn, express views different to established practices, boast about individual achievements, advocate changes that have apparently not been thought through, and generally not showing respect to people more senior in the organisational hierarchy.

Many Asian migrants who come from a cultural background that traditionally respects the positional power of the leader, falsely assume that in Western cultures the leader will indicate who can speak and when in a group meeting. There is anecdotal evidence that migrants may feel left out in groups and annoyed by locals who often appear to be direct, outspoken, and eager to talk over other people. Migrant workers and students may become frustrated and discouraged when they cannot find the gap to break into a lively discussion, and worry that their apparent reticence may jeopardise opportunities for academic success and career advancement.

Worse still, migrants' difficulty in joining in the group discussion may be misunderstood as lack of interest or competence by host group members. Such an interpretation may reinforce stereotypes of Asians as being passive and reserved, and are counter-productive to effective intergroup communication and intercultural relations (Gudykunst, 1994; Pettigrew, 1998). Recent research in the social psychology of language and cross-cultural psychology has found changes in identity and language behaviour occurring as a result of the contact between people from different ethnolinguistic groups (Noels, Giles, & LePoire, 2003; Noels, Pon, & Clément, 1996).

EXCELL™ CULTURAL MAPPING FOR EFFECTIVE PARTICIPATION IN A GROUP

An innovative approach for learning new cultural rules for effective participation in a group is using the EXCELL™ Cultural Mapping method, which was first described in Mak, Westwood, Barker, and Ishiyama (1998) as an integral part of the EXCELL™ (Excellence in Cultural Experiential Learning and Leadership) Program initially offered to international students in Canada, Australia, and the UK. Ideally co-facilitated by a leader from the host culture and another leader originally from a culturally different background, the group program has since been introduced to The Netherlands and New Zealand. It has also been used with migrant students and workers originally from various Asian countries or other non-English-speaking backgrounds, as well as mixed groups of locals and ethnic minority members.

Appendix A provides additional information on the EXCELL™ Program, including suitable participants, trainer requirements, the learning process, and group procedures incorporating the cultural mapping method.

This paper will outline the EXCELL™ cultural mapping method and process, and how it may be applied to facilitate migrants' effective participation in a group for employment and education purposes, to enhance their social integration and wellbeing. According to our recent experiences with an innovative implementation of the EXCELL™ Program with migrant jobseekers in a job placement program (offered by Bridgeworks Personnel in Brisbane), migrants may find themselves in a range of challenging scenarios involving participation in team and other workplace and community-based meetings. For example, some migrant

jobseekers were exasperated that they could not find a way to contribute to lunch room conversations between colleagues, or interject in a weekly cross-functional team meeting in headquarters, The migrants expressed their fears that colleagues would perceive them as people who had nothing to contribute, were overly shy or worse yet, snobs. While migrants were often clear about what they wanted to say, they simply did not know how to break into the conversations.

WHAT IS CULTURAL MAPPING?

Just as newcomers to a city need a road map to travel, conduct their business, and enjoy being part of the community, newcomers to a culture need a cultural map or schema with specific guidelines about how to navigate verbal and non-verbal communication in particular social contexts in the new cultural and social territory (Westwood, Mak, Barker, & Ishiyama, 2000b). This way, newcomers are more likely to experience success and social integration, and avoid costly mistakes that can impact on their confidence and wellbeing. People who grow up in a culture simply "know" how to "get around" (i.e., implicit social rules), but this knowledge is seldom written down and taught explicitly to new arrivals.

EXCELL™ cultural mapping makes explicit the unwritten social rules for commonly occurring sociocultural competencies. For Asian migrants in Western settings, a particularly challenging sociocultural competency pertains to participation in a group. A cultural map is a clear, succinct description of effective and appropriate ways of behaving (both nonverbal and verbal) in a specific social context (e.g., contributing to an interdisciplinary team meeting). Cultural maps can also include the social values and historical reasons underlying why these behaviours are preferred in the local culture.

The EXCELL™ Trainer's Manual (Westwood et al., 2000b) explains how facilitators can engage group members to develop a cultural map for participating effectively in a team meeting in the workplace. Facilitators ask group members what have they observed host nationals do when they participate actively in a group. Group members are encouraged to discuss their observations and comment on the extent to which these behaviours differ from what is considered to be appropriate behaviour in a similar situation in their home culture. Facilitators explain that there are many different ways of enacting the target behaviours, depending on the specific situation. Together with the facilitators, group members develop a cultural map comprising behavioural responses (presented as sequential steps) that people in the local culture would generally consider appropriate or acceptable in a workplace team meeting.

Behaviours in a cultural map are described as observable units that can be reproduced by the observer. These responses will include non-verbal behaviours such as tone of voice, eye contact, facial expressions, and hand and body gestures useful for indicating interest and engagement in the team meeting, readiness to speak up, agreeing or disagreeing with views expressed, being open to alternative views, or inviting others' responses. As well, the map will include suggested words and phrases that could be used to interject and then contribute to the discussion. An alternate approach used by EXCELL™ facilitators is to adapt a generic cultural map to the needs of individual group members.

The EXCELL™ ABCD Model provides a practical framework for appropriate behavioural and verbal responses for managing the **A**pproach/Attending, **B**ridging (or Breaking in), **C**ommenting/Communicating, or **D**eveloping/Departing phases of social interactions (Westwood et al., 2000b). The ABCD Model represents a schematic, user-friendly approach to breaking down apparently complex social interactions (e.g., turn taking in a group discussion). A template used when developing a cultural map for this scenario includes the

specification of the scenario (e.g., type of workplace meeting), any preparations required prior to the group meeting (e.g., background research on the topic for discussion), and each of the ABCD phases.

Values (such as directness, logical reasoning, respect for others' contributions, and relative informality) underlying critical behaviours in each of the ABCD phases can be incorporated into the cultural map. Participants are often pleasantly surprised to note that the same value, such as respect, may be expressed in rather different behaviours in their original (e.g., Asian) and adopted countries (e.g., immigrant nations such as New Zealand).

Below is a written example of what a cultural map based on the ABCD format and incorporating underlying values may look like. A video of this vignette featuring a migrant in Australia needing to participate in a group discussion at work will be shown in the workshop.

Example of an EXCELL™ Cultural Map for Participation in an Informal Staff Meeting

Scenario: Staff room discussion about planning a farewell function for a colleague (named Sandy in the vignette)

Goal: To interject and express a personal opinion about the party

Preparation: Think through options about type of party and type of present that could be appropriate before coming to the staff meeting.

Approach
Non-verbal behaviours: Make eye contact with the person who is speaking. This will indicate that you want to speak. Use a short sweeping open hand gesture as you start to speak to attract the attention of other group members

Breaking in
Say: "I have an idea about what we should do to farewell Sandy". Or "I've been thinking about what would be a great gift for Sandy".

Non-verbal behaviours: Smile, open hand gesture, lean forward in chair when starting to speak then move back into the chair; clear, strong voice that can be heard easily by all group members

(Value: Indicate that you appreciate Sandy as a member of your work group.)

Commenting
Say: "I think it's important that we find out exactly when Sandy plans to leave" Or
"Let's talk about the sort of gift that Sandy would really appreciate"

Non-verbal behaviours: Smile, use an animated/lively tone of voice.

(Value: You respect Sandy's plans and what she wants.)

Developing
Say: "What do you think of that idea? Or "I'm interested in other people's ideas"

Non-verbal behaviours: Smile, lean back in chair.

(Value: show respect and interest in other group members' opinions)

DISCUSSION

Asian migrant newcomers, along with other recent migrants, are often hard working and eager to contribute to their adopted countries' productivity and economic prosperity. However, coming from a culturally and linguistically different background (such as the case for migrants born and raised in different parts of Asia) may pose issues in fully participating in groups, which can impact on the migrants' successful settlement in mainstream workplace, education, and community settings.

In this paper, we offer the EXCELL™ cultural mapping method as a tool for increasing Asian and other migrants' cultural awareness of the different social rules governing effective participation in a group in their adopted countries. People coming from an Asian or other collectivistic cultural backgrounds can benefit from a better understanding that relative to their original cultures, generally speaking, Western cultures are characterised by lower power distance, and greater individualism and tolerance of uncertainty. A cultural map for participation in a group in the host culture represents one socially appropriate way to break into a group discussion that is likely to facilitate the newcomers' social integration, at least in a particular social context.

Cultural maps are not fail proof and are not prescriptions that must be followed rigidly. In the initial stages, however, facilitators must select specific identifiable behaviours in order to reduce confusion (Westwood, Mak, Barker, & Ishiyama, 2000a). Alternative support strategies (e.g., using different phrases to break into the conversation after an unsuccessful first attempt) written into the cultural map are often useful.

The emphasis on cultural observations in the mapping process encourages participants to practise observations of how host members behave in various group situations in everyday interactions. This can enhance participants' capacity to identify verbal and non-verbal triggers of participating in different types of groups (e.g., formal and informal, small and large, same gender and mixed gender, as a supervisor and as a subordinate). Being part of a training group confers additional benefits. Listening to other participants' experiences and observations is often affirming. The emotional and practical social support generated in a learning community can alleviate acculturative stress and enhance recent migrants' wellbeing.

The cultural mapping approach is fundamental to the EXCELL™ Program for intercultural skills training. The feedback we have obtained from having provided EXCELL™ Trainer Courses to hundreds of skilled group facilitators, suggests that cultural mapping can be an effective stand alone strategy in developing Asian-born and other non-English-speaking background people's cultural awareness of the social processes and micro skills in joining in a group discussion in English-speaking countries. Some international students and migrants have indeed found cultural mapping to be a particularly useful component of the EXCELL™ Program. Many other participants have indicated in their program evaluations that they have further consolidated their learning from cultural mapping through the subsequent behavioural practice stages of the EXCELL™ training, a process that we would recommend where time permits.

Increased settlement assistance and intervention to overcome barriers to employment and foster social integration are important for an optimal utilisation of imported talents among business and skilled migrants (Mak, 2001), and for attracting and retaining them amidst keen international competition for highly skilled labour (Fletcher, 1999; Ho, 2002). The cultural mapping approach for effective participation in mainstream groups represents a useful strategy for intercultural education and early intervention. It can be offered as a stand alone

training module, an integral part of a comprehensive intercultural social skills program such as EXCELL™™, or complement an advanced or professional English language program.

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Appendix A: Information on the EXCELL™ Program

EXCELL™ in a Nutshell

EXCELL™ is an experiential and practice-focussed social learning program aiming to develop people's intercultural social competence and facilitate intercultural relations without compromising minority members' original cultural identity (Mak & Barker, 2004). Key sociocultural competencies taught in the Program include culture access (e.g., participation in a group, seeking help) and culture negotiation competencies (e.g., refusing a request, giving feedback). The full program is offered over four to six weekly sessions of two to three hours duration. EXCELL™'s conceptual framework is described by its developers in Mak, Westwood, Ishiyama, and Barker (1999). Summaries of the program's application and efficacy of its use in multicultural educational environments are documented in Mak (2000), Ho, Holmes, and Cooper (2004), and Mak and Buckingham (in press).

Suitable Participants

EXCELL™ is designed to be offered, ideally by two trainers (co-facilitators), to groups of between 8 and 20 participants, all or many of them:

- being students, immigrants, refugees, or expatriates from diverse cultural backgrounds;
- who have been in the new country long enough to have dealt with their initial "survival" needs, and are now seeking ways of engaging with the new culture;
- who have enough fluency in the host language to participate in a group program, and
- who are motivated to improve their intercultural social competencies for attaining academic, professional, and personal goals.

Trainer Requirements

EXCELL™ trainers who deliver the program must have successfully completed a three-day EXCELL™ Trainer Course. The intensive course is suitable for counsellors, and academic and international office staff members who work with immigrants, expatriates, or international

students, or other “transition” or special needs students, or locals who want to increase their cross-cultural awareness and/or their social effectiveness. Candidates for the trainer course will have group facilitation skills and have experience in the field of cross-cultural service delivery. At the time of writing this article, delegates from over 60 educational institutions have completed the trainer course in Australia, New Zealand, Canada, the UK, and the Netherlands.

Theoretical Basis for the EXCELL™ Learning Process

EXCELL™ focuses on behavioural competence training derived from the following established learning paradigms (Mak, Westwood, et al., 1999).

1. Operant conditioning: Early attempts are shaped towards the desired behaviours by rewarding successful trials.
2. Classical conditioning: Social anxiety is reduced by pairing successful performance of the behaviours in a non-threatening environment.
3. Social cognitive learning: Participants watch credible models perform desired behaviours, and develop social-efficacy beliefs that they too can take specific actions to bring about a positive social environment;
4. Role-based group learning: Participants observe others’ behaviours and perfect skills in a supportive environment with like people.

Group Procedures Incorporating Cultural Mapping

Below is a summary of the group procedures in teaching each sociocultural competency (Westwood et al., 2000).

1. Alliance building and assessment: The trainers create an environment in which the unique cultural backgrounds of participants are acknowledged and validated, making it safe to share personal experiences with challenging intercultural social encounters (e.g., in having to interrupt to participate in a group discussion, or in putting a request to an authority figure).
2. Cultural mapping: Explanations of what behaviours will be appropriate in certain types of social encounters and why things tend to be done the way they are.
3. Modelling of a practice scenario to replicate the social situation by the trainer then follows, with the participants observing the interaction and commenting on it.
4. Participants are then invited to practise the same exchange in pairs with a third person as an observer, with the trainer coaching and giving feedback and mini-demonstrations of how to change the approach if required. This process is repeated if necessary until participants master specific micro-skills.
5. Goal-setting and contracting to apply learning in a real situation. Participants are helped to create realistic and specific action plans, and write them down as a homework activity in the relevant section in their individual copies of the EXCELL™ Participant’s Manual. Participants are encouraged to report back to the group the outcomes of their actions in the following session.

Further Information about EXCELL™

For further information and training opportunities about the full Trainer Course (3 days) or the Cultural Mapping Trainer Course (2 days), visit www.excellinterculturalskillsprogram.com or contact the authors. We have offered **EXCELL™** Trainer Courses in New Zealand at Christchurch College of Education in 2003, and Victoria University of Wellington in 2005 and 2006.

CYBERSEX AND LAVENDER ASIAN MIGRANTS TO NEW ZEALAND

Mark Henrickson

ABSTRACT

The Internet is changing the way we manage not only information but also human identity. Marginalized and stigmatized communities, and in particular same-sex attracted persons, are among the most affected by this change. Using data from the *Lavender Islands: Portrait of the Whole Family* study, the paper examines the use of the Internet by new immigrants for making contact with lesbian, gay and bisexual (LGB) communities and the extent to which the Internet is used to facilitate sexual contact by LGB and LGB Asians in New Zealand. The *Lavender Islands (LI)* study is the first national strengths-based study of LGBs in New Zealand (n=2,269). The 133-item *LI* quantitative survey instrument was made available both by website and paper copy from April-July 2004. 'Viral sampling' was used online, in addition to a high-profile publicity campaign was launched to recruit participants who might not have been online. LGB New Zealanders rely on pre-existing friendship networks to form communities, but such networks do not exist for new immigrants. Immigrants used the Internet more frequently than NZ-born. Overseas-born respondents, particularly Asian-born women, were significantly more likely to use the Internet to find a sexual partner than were NZ-born. The use of the Internet in this way has implications for health. The Internet allows people to experiment with their identities, which present both opportunities and dangers. The opportunity is that the Internet can move beyond oppressive social templates and boundaries, and allow individuals to discover and formulate their own individual identities and communities. The danger is the risk of Western hegemonies of identity, as well as risks to health. These models may challenge traditional and indigenous social and personal identities. The Internet challenges us to consider not only the technology as tool, but also the impact of that tool on the very nature of identity and health.

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INTRODUCTION

The technological revolution of the Internet has changed the way we manage information and even the way we manage identity. Marginalized communities are among the most affected by this change. Using data from the *Lavender Islands: Portrait of the Whole Family* study, the present paper examines the construction of identity in Asian migrants and the use of the Internet in New Zealand by that population for making contact with lesbian, gay and bisexual

persons (LGBs)[16] living in New Zealand. While Internet access is an important component of creating links among people who feel marginalized by their sexual identity, because of the dominance of English (and other European languages) on the Internet, Western models of personal and sexual identity can hegemonize indigenous models of personal and social identities. Further, because Asian-born migrants to New Zealand use electronic connections as a primary method of linking with other LGBs, they are at increased risk of a variety of health-related challenges such as STIs, including HIV. Health care, social service and resettlement providers must be mindful of these issues, and make no assumptions about the sexual behaviours or identities of Asian-born clients who present to them.

LITERATURE REVIEW

The Internet can be a medium for individuals to acculturate to LGB subcultures. Those who may have to conceal their sexual identities or interests, for fear of stigmatization or worse, can meet electronically and anonymously to talk about these issues openly. Ross (2005) has proposed that the Internet may in fact have become an additional stage in the 'coming out' process. He proposes that individuals exploring their identities can passively watch the interactions in chat rooms, use the experience to learn the language of the new identity, and thereby gain more of an understanding of what being 'gay' is about. In this way, notes Ross, the Internet may actually shape sexual communities, and, we may add, individual identities. McKenna, Green and Smith propose that the more that one locates the sexual self on the Internet, the more important the sexual identity becomes to one's sense of self, and that the result is a demarginalisation of one's sexual self (2001, p. 309). It may also result in an increased emphasis of that identity in the self-constructs. Brown, Maycock and Burns (2005) also note that for marginalized people the Internet has the capacity to remove barriers associated with geography, age, socioeconomic status, ethnicity and other constraints (Hillier, Kurdas & Horsely, cited in Brown et al., 2005). They find that gay men's experiences of the Internet include a stronger sense of anonymity, safety, control, and convenience than traditional gay venues. Pilwha (2003) proposes that the meaning and use of the Internet for Korean women differs from that of men. She proposes that (Korean) women who are sexually active are by definition stigmatized (and thus protect the traditional role of the asexual 'wife'), but that the Internet has responded to the social needs of women to expand their circle of friends and communities, and has also presented the challenges of commercialized sex and pornography to the traditional roles of Korean women.

Wang and Ross (2002) observe that in China, the concept of homosexuality as constructed in the West is relatively alien, and that there is a reluctance to take on discrete sexual identities. They found that the Internet has been appropriated by *tongzhi* (in this usage, 'same-sex comrades') to build up an unprecedented space of virtual communities (Wang and Ross, 2000). Chou (2000) has elaborated on this important issue, and argues for the need for an indigenous same-sex eroticism and politics that need not reproduce Anglo-American experiences and strategies (2000, p. 1). He writes that the Internet in China is a 'highly effective way to break through the oppressive boundaries created by the tight family-kin structure and the social control system of work units and residential arrangements' (2000, p. 134). The Internet is used, especially by overseas Chinese tongzhi, to disseminate positive information about tongzhi and to have regular exchanges of information with mainland (PRC) Chinese tongzhi (Chou, 2000, p. 135). The likelihood of these online communities increasing

16 The use of Westernised constructs "lesbian" "gay" and "bisexual" in this paper are not meant to imply the primacy or hegemony of Western identities, or even the appropriateness of applying these constructs to individual persons or to non-Westernised cultures. This contended language is used both for the sake of convenience, and because it is what our New Zealand LGB respondents told us they called themselves. Such language obviates the larger discussion which has been well-developed elsewhere. (see, for instance, Chou, 2000, or Murray, (Murray, 1992). In this paper, "gay" as a culturally constructed identity is used separately from "men who have sex with men" (MSM).

is great: while at the moment only 8.4 percent of China's population is linked to the Internet, young people under the age of 18 are 60 percent of the linked group (Hong, 2006). Of some relevance, however, is that a UNSECO sponsored study found that only an estimated 2 percent of Internet websites are in Chinese, while 72 percent are in English (Paolillo, Pimienta, Prado, & et al., 2005)

McKenna, Green and Smith (2001) found that individual's unsatisfactory offline social networks are more likely to turn to the Internet to explore important aspects of the self. Poon, Ho, Wong, et al., (2005) in their study of Internet use by Asian men in Toronto found also that the Internet overcomes isolation in socially stigmatised individuals. They found that gay Asian men tend to be socially isolated and highly marginalised, leading to strong needs for social connections. In this health-behaviours study they also found that many Asian men who had sex with men (MSM) who were attracted to men physically, psychologically and/or emotionally, did not identify themselves as gay, bisexual or even as MSM, yet still used gay male chat rooms. They found a reported lack of positive social space for gay Asian men to 'hang out' and meet other MSM and that there were Asian MSM who were not comfortable interacting in traditional gay male venues. Many of their participants were also dealing with coming out issues, contributing further to a sense of isolation; their respondents reported feeling confused about their sexuality, and stressed if people found out about their same-sex desires. Even those participants who were 'out' also reported that they did not feel connected either with a gay community or with their non-gay friends and families. Participants reported that the Internet was a useful means of meeting MSM, not only because it was accessible, but also because it gave them a sense of control, safety and anonymity. This experience of web-based communications is similar to that reported by Tsang (in Leong, 1996) in his personal account of the challenges facing gay male Asian-Americans.

The Internet is now used, of course, for linkages other than simply exploring or experimenting with one's identity. Cybersex—the use of the Internet for virtual sex, or for meeting someone for the purpose of a physical sexual encounter— has become more than the latest passing fad. Most international studies on this issue examine the phenomenon of unsafe or risky sexual activity, with a view to developing appropriate interventions; see, for example Benotsch, Kalichman & Cage, (2002). Brown, Maycock and Burns (2005) found that in studies in the US, Europe and China, 35 to 60 percent of MSM use the Internet to meet and have sex with other men. In a PRC Chinese sample of men recruited from Internet sites, Wang and Lin (2002) found that 70 percent reported sexual experiences with men known from the Internet. They propose that gay men who use Internet are at high risk for sexually transmitted diseases including HIV, and are an ideal target population for Internet outreach and harm reduction. Lau, Kim, Lau, and Tsui (2003) studied Hong Kong Chinese MSM and found that 17.7 percent of sexually active MSM had successfully found an Internet sex partner in previous six months, and that the percentage was more than double for anal-sex active men. They did not find any differences in marital status and education between those who networked online and those who did not.

METHODOLOGY

The present *Lavender Islands (LI)* study is the first national strengths-based study of LGBs in New Zealand. The authors of the study chose to focus on strengths and descriptors of the LGB communities in New Zealand, rather than on the more commonly studied issues of HIV, alcohol and drugs, mental health, suicidality, discrimination, and related challenges, because these problematic areas have been well-studied elsewhere (as for example, Rampton 1989, cited in Gearing, (1997); (Welch, Howden-Chapman, & Collings, 1998); (Fergusson, Horwood, & Beautrais, 1999); (Saxton, Dickson, Hughes, & Paul, 2002).

The 133-item *LI* survey instrument was made available both by website and paper copy from April-July 2004. The methodology, sampling strategy and general profile of respondents in the study have been presented and discussed elsewhere (Henrickson, Neville, Jordan and Donaghey, (in press). The survey was quantitative, although the final question invited participants to write whatever they liked. Viral sampling was used: that is, the website link was emailed to an initial group of eligible participants; each member of that group in turn emailed the website to eligible participants in their e-address book, and so forth. Web-based sampling is in its early years, and whether or not such a sampling method yields some kind of bias is still contended. A review of the current literature shows that there is yet no clear consensus on the implications of web sampling: see, for example, Bowen, (2005); Brown, Maycock and Burns, (2005); Reid, Weatherburn, Hickson and Stephens, (2002); Rhodes, DiClemente, Cecil, et al., (2002); Rhodes, Glorioso and Hergenrather, (2002); Ross, Tikkanen and Månsson, (2000); Whittier, Seeley and Lawrence (2004). Poon, Ho, Wong, et al., (2005) support the use of online methodologies, and propose that traditional venues may miss socially isolated persons, such as gay Asians. There is a growing consensus of the value of web-based sampling to reach LGB participants. While there may be some challenges inherent in the methodology, there is no clear consensus yet on whether those challenges result in an inherently or inevitably biased sample.

Over 83 percent of the total of 2,269 responses to the *LI* survey was through the website; 45 percent of all responses came from women, 54 percent from men, and the balance identified themselves as transgender or intersex. (Transgender and intersex responses are not included in any gendered analysis that follows, although they are included in all other analyses.). Unsurprisingly, the mean age of paper-based respondents (M=46.05 years, SD=11.920) was ten years older than that of web-based respondents (M=36.98 years, SD= 12.508); we would expect younger people to be more adept at computer use than an older population. There were no significant differences between web and paper-based responses by education (*p=.162) or income. (*p=.358), suggesting that the sample is not biased in these indicators.

The *LI* survey included multidisciplinary domains that were developed by a community reference group, and included questions related to education and income, identity and self-definition, families of origin, relationships and sex, families of choice, immigration and internal migration, politics, work and leisure, community connections, challenges, well-being and spirituality. Ethnic identification is a fraught issue in New Zealand, although respondents were asked for their country of birth and to write in their ethnicity in a space provided. Of these self-identified ethnicities, 30 described themselves as Chinese, 13 as Indian or South Asian, four as ‘Southeast Asian’, and 19 some other Asian country (including Japan, Taiwan, South Korea, and the Philippines); the balance described themselves simply as ‘Asian’. These responses have been grouped together as ‘Asian’ for the purposes of this paper in order to provide sufficient power for statistical testing Two questions asked about how respondents made both first and continuing contact with the LGB communities in New Zealand. Another set of questions asked whether participants had ever used the Internet to find a sexual partner or relationship. The responses to these questions were extracted and analyzed.

One of our questions asked respondents what they wanted to be called. Only five percent opted for ‘queer’, and the balance chose either ‘lesbian’, ‘gay’ or ‘bisexual’. For this reason the author has elected to use an abbreviated form of these terms (LGB) when describing results from the *LI* survey or talking about LGB communities in New Zealand.

RESULTS

Of the 2,269 respondents, 474 (20.9 percent) were overseas-born, and of this group 52 (10.2 percent) were born in an Asian country; the profile of countries in which overseas-born respondents were born parallels the 2001 New Zealand Census. Asian-born *LI* respondents were significantly younger (mean age=29.9 years) than other overseas-born respondents (mean age=39.62 years, p<.001). However there was no significant difference between the two groups at the mean age at which they arrived in New Zealand (mean age=22.7 years). Other differences between Asian-born respondents from other overseas-born respondents include that Asian-born respondents first 'felt different' from their peers at a younger age (mean age=11.13 years, compared with 12.16 years) and came out to themselves at a mean age of 19.07 years, compared with 20.33 years for other overseas-born. Interestingly, although the overall number is small, n=9), Asian-born women came out to themselves at a younger age (mean=17.98 years) than either other overseas-born women (mean=19.09 years, n=95) or New Zealand-born women (mean=23.27 years, n=406). A comparison between the mean ages of coming out and arrival in New Zealand suggests that most of the respondents understood themselves as LGB prior to their arrival in New Zealand.

Asian-born respondents also showed marked differences in disclosure of their LGB identities to other overseas-born respondents: 37.2 percent of other overseas-born had disclosed to 'everyone in [their] lives', compared with only 7.7 of Asian-born respondents. However, 55.7 percent of Asian-born respondents had disclosed their LGB identities only to 'a few trusted friends', compared with 13.6 percent of other overseas-born. Three times as many Asian-born migrants as other overseas-born say they have not disclosed their identity to anyone and do not plan to do so. Asian-born migrants clearly keep their identities more private than other overseas-born migrants, and disclose only when there is trust. Not surprisingly, then, other overseas-born respondents were significantly happier with an LGB identity (mean=6.11 on a 7-point scale, where 1 is 'very unhappy', 7 is 'very happy') than Asian-born respondents (mean=4.8, p<.001). If they had a choice, other overseas-born participants were more likely to choose an LGB identity (mean=5.09, on a 7-point scale where 1='would not choose', 7='would definitely choose') than Asian-born (mean=4.44, p<.001). However there were no differences between the two migrant groups on whether they believed that LGBs 'are born that way' (mean=5.79 on a 7-point scale, where 1='strongly agree' that LGBs are born that way, 7='strongly disagree'), or whether they 'choose to be that way (mean=2.38, on the same strongly agree-strongly disagree scale).

Slightly less than two-thirds (61.9 percent) of all immigrant respondents to the *LI* survey did not have information about New Zealand and its treatment of LGBs prior to immigrating, although 8.4 percent had information from a partner and 7.3 percent had information from the Internet. Pre-migration Internet use varied by region of birth: 16.7 percent of Asian-born and 6.2 percent of all other overseas-born (mostly Europe and Australia) had obtained information about New Zealand from the Internet before they immigrated.

Not surprisingly, all immigrant respondents felt less support from their families of origin than New Zealand-born. The survey instrument asked respondents to what extent they felt supported as an LGB person by their families of origin, to what extent families of origin include the respondent in their usual celebrations and rituals, and to what extent the family of origin includes (or would include) a same-sex partner of the respondent. On each indicator Asian-born respondents reported feeling significantly less supported by their families than other overseas-born respondents; interestingly, New Zealand-born ethnic Asian respondents (n=13) scored these three items significantly higher than Asian-born respondents.

Respondents were also asked to rate the importance of their ethnic culture in making decisions about their sexual identity (1= very low importance, 7=very high importance): the Asian-born mean on this indicator was 4.86, compared with 3.08 for other overseas-born respondents and 2.98 for New Zealand-born, indicating that Asian-born migrants rate their ethnic culture significantly higher than each of the other two groups when making decisions about sexual identity. The importance of ethnic identity was also born out in a related question, which asked respondents to rate on a 7-poin scale the balance between their ethnicity (=1) and their sexual identity (=7). The mean of other overseas-born respondents was 5.06 (mostly sexual identity); the mean of New Zealand-born respondents was 4.91 (more sexual identity) and of Asian-born respondents, 4.50, closer to a balance between the two. These two questions clearly indicate the importance of ethnicity and ethnic culture for Asian-born migrant respondents.

However, Asian-born respondents are also very keen to fit in to New Zealand culture and society. Two questions asked respondents to rate their agreement (1= strongly disagree, 7=strongly agree) with the statement 'Being a New Zealander is important to me' and 'It is important to share the values of New Zealanders'. On the first question the New Zealand-born mean was 5.79, and the Asian-born mean was 5.17; the other overseas-born mean was 4.98. On the values question the responses were even more striking: the New Zealand born mean was 4.23, compared with the Asian-born mean of 5.25, suggesting that it is more important to Asian-born respondents to share New Zealand values than it is to New-Zealand born respondents. The mean of other overseas-born was 4.59, which was also higher than the New-Zealand born mean.

Approximately 74 percent of all respondents reported that their health care providers 'usually' or 'always' assumed they were heterosexual (this was not different by ethnicity). The implications of this assumption have been addressed elsewhere (Neville & Henrickson, in press); to make assumptions about the identity of patients or clients at a minimum can close off conversation and lead to the loss of valuable information about health and risk behaviours.

Taking these findings together, we find that Asian-born respondents are younger, experience themselves as different earlier, and come out earlier than other respondent groups, although they keep this identity very private; they were LGB before they arrived in New Zealand. They believe they were born with an LGB identity, although they are not very happy about it, they remain highly connected to the ethnic cultures of their birth, although they very much want to share New Zealand values and culture.

The way overseas-born respondents in general constructed a relationship with New Zealand LGB communities is only slightly different, and in expectable ways, than New Zealand-born LGBs. New Zealanders rely heavily on pre-existing friendship networks, which usually do not exist for immigrants, at least at arrival. The primary way New Zealand-born LGBs (n=947 men, 817 women) made *first* contact with LGB communities was through friends (25.1 percent for men, 39.0 percent for women); 12.0 percent of men and 16.0 percent of women made their first contact through school or job. Of New Zealand-born LGBs, 12.4 percent of men and 4.9 percent of women made their first contact through the Internet. The profile of first contact for all overseas-born immigrants (n=262 men, 185 women) was similar: friends (28.2 percent for men, 33.5 percent for women), or school or job (7.3 percent for men, 9.7 percent for women). However immigrants used the Internet more frequently than New Zealand-born. The Internet was the first point of contact for 16.4 percent of immigrant men and 9.2 percent of immigrant women.

We also asked about *continuing* contact with LGB communities. For New Zealand-born respondents, the proportion responding 'friends' more than doubled for men (to 63.2 percent)

and almost doubled for women (to 76.4 percent). 'Internet', however, decreased only slightly (to 11.9 percent for men, and 4.7 percent for women). This suggests that reaching out through the Internet is stable relative to other contact venues. The profile of continuing contact for all overseas-born immigrants was similar. The proportion responding 'friends' almost doubled for both men (to 45.7 percent) and women (to 55.6 percent), and again, almost all other venues (except LGB social clubs) dropped. Again, the proportion responding "Internet" decreased slightly to 13.9 percent for men and 7.4 percent for women, suggesting that a substantial proportion of immigrant Internet usage is stable.

However, combining all overseas-born immigrants into one category masks an interesting subpopulation of Asian-born respondents, whose contact profiles are quite different. Of Asian-born respondents, only 18.2 percent of men and 18.8 percent of women made their first contact in New Zealand through friends. However, a remarkable 39.4 percent of men and 25.0 percent of women made their first contact with New Zealand's LGB communities through the Internet. When asked about continuing contact with LGB communities, there was an increase of 50 percent (to 27.3 percent) in Asian-born men reporting that 'friends' were their primary continuing contact, but no change in the proportion of Asian-born women linking to the community through friends. There was a decrease to 27.3 percent in the proportion of men whose primary continuing links were through the Internet, but the proportion of women reaching out through the Internet increased to 31.3 percent.

We asked whether participants had ever used the Internet to find a sexual partner or relationship (response choices were Yes, No, and Don't know/Can't remember). Of the 2,251 people who answered this question, 43.6 percent of the total had used the Internet in this way. However, this total masks important gender differences: 60.1 percent of males but only 23.4 percent of females had ever used the Internet to find a sexual partner or relationship ($p<.001$). New Zealand-born respondents were less likely than all overseas-born to have used the Internet to find a sexual partner (42.5 percent of New Zealand-born had used the Internet in this way compared with 47.8 percent of all overseas-born, $p=.021$). This difference was not present when data were analyzed by gender, suggesting the dominance of men in this analysis. However Asian-born respondents were significantly more likely to have used the Internet to find a sexual partner (59.6 percent said they had) than other overseas-born respondents (46.3 percent said they had, $p=.049$). Asian-born women were twice as likely to have used the Internet to find a sexual partner than other overseas-born women (50.0 percent of 16 Asian women had used the Internet this way, compared with 24.2 percent of 182 other overseas-born women, $p=.030$). There were no differences on this item between Asian-born and other overseas-born men.

Whilst the overall number of Asian-born participants in this sample is relatively small, these findings are suggestive. Asian-born respondents are somewhat socially isolated, and rely heavily on electronic connections for their first and continuing contact with LGB communities. Social isolation appears amplified for Asian-born lesbian immigrants, indicated by the relatively high use of the Internet for continuing connections. Asian-born respondents, and particularly Asian-born women, were significantly more likely to use the Internet to find a sexual partner or relationship than New Zealand-born or other overseas-born respondents. One possible reason for this high use of the Internet by Asian migrants may be unfamiliarity with New Zealand socialization venues, or a lack of facility or confidence in communicating in English. Equally, there may be an unwillingness to adopt Westernized socialization patterns, as found in men by Poon, Ho, Wong, *et al.* (2005). Another possible explanation may be that respondents are continuing patterns begun in their birth countries (as noted by Chou, 2000).

DISCUSSION

There are clearly limits to the methodology of the study and any conclusions that can be drawn from it. The literature remains conflicted about what sampling biases that may inhere to electronic sampling, although there were no significant differences between web and paper-based responses to the *LI* study by education or income. The most problematic issue may also be the feature that contributed to the success in attracting a large group of participants: that this was a quantitative study, written in English, aimed at and promoted to lesbian, gay and bisexual persons. Participants who choose to label themselves in this way and to affiliate with LGB communities in New Zealand were most likely to self-select and participate; this bias would be amplified in cultures for whom these labels do not have meaning, particularly Asian and other non-European cultures. People who, for whatever reasons, do not choose to identify themselves in this way are not included in this study and their voices are not heard. The overall sample is robust, but drawing conclusions from smaller subsample groups must be done with caution.

There are, nevertheless, some conclusions that can be drawn. We have seen that Asian-born respondents are younger, experience themselves as different earlier, and come out earlier than other respondent groups, although they keep this identity very private; they were LGB before they arrived in New Zealand. They believe they were born with an LGB identity, although they are not very happy about it, they remain highly connected to the cultures of their birth, although they very much want to share New Zealand values and culture. Asian-born respondents are somewhat socially isolated, and rely heavily on electronic connections for their first and continuing contact with LGB communities. Social isolation appears amplified for Asian-born lesbian immigrants. Asian-born respondents were significantly more likely to use the Internet to find a sexual partner or relationship than other overseas respondents. As with other respondents, most reported their health care provider usually or always assumes they are heterosexual.

It is quite possible that the group of Asian-born LGB immigrants is unwilling or unable to adopt Western models of identity for themselves and to participate more in in-person LGB-identified venues. However, in a national New Zealand general population study, an estimated 36 percent of all Asian/Indian peoples report being lonely some, most, or all of the time (Ministry of Social Development, 2005), the highest rate of reported loneliness of all population subgroups. Asian population groups in general appear to have a lower overall level of social connectedness than other groups in New Zealand. One can only imagine that this social isolation is amplified in Asian-born immigrants who identify themselves in some way as a sexual minority. This is an issue that should be considered by immigrant and refugee assistance, cultural, health and mental health care, and social service agencies. It is very important that these provider organisation and individuals make no assumptions as to the sexual identity, activity or relationship status of their clients or patients, even in the face of apparently confirmatory information (such as the presence of children or an opposite sex spouse.)

It is apparent from the literature review that the Internet allows at least some populations to experiment with and locate their identities, however those identities are conceptualized and constructed. This experimentation presents opportunities and dangers to indigenous cultures. The opportunity is that, as Chou (2000) has noted, with the Internet individuals can move beyond oppressive social templates and boundaries, and allow individuals to discover and formulate their own individual identities and communities. The danger is the risk of Western-European hegemony. English is the predominant language of the web; what curious Internet surfers may be most likely to encounter on line are websites and chat rooms that

present Western language and models as the dominant discourse of 'LGB' identities. Such models may challenge traditional and indigenous social and personal identities. Paradoxically, if non-Western governments and societies wish to resist the importation and adoption of external, Western models of identity, then it is to their advantage to support indigenous models and uncensored access to the Internet by their own populations. Meanwhile, it is incumbent upon helping and health care professionals not to perpetuate cultural stereotypes of the Asian populations with which they work. For instance, not all Asian-born migrants are 'heterosexual', or sexually active only with the opposite sex. Sexual identity and/or behaviour must be considered when assessing or working with all persons, and relevant risk-reduction messages delivered to all persons regardless of the perceived sexual identity or behaviour of the individual. Helping and risk reduction messages by Asian service organisations must be inclusive and available in as many languages as feasible, and available to all clients regardless of sexual identity or behaviour. It is particularly important to ensure that these messages are available on-line. In these way we can be assured that we are doing the best we can to support the migration transition, identities and healthy behaviours of Asian migrants to New Zealand.

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SELF-ESTEEM AND ITS ASSOCIATED FACTORS AMONG SECONDARY SCHOOL STUDENTS IN KLANG DISTRICT, SELANGOR, MALAYSIA

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ABSTRACT

Self-esteem is an important determinant of psychological well-being that is particularly problematic during adolescent life stage. There is a correlation between low self-esteem and other social problems among today's adolescents. This study was conducted to determine the mean self-esteem score, and to determine the association between self-esteem and age, sex, race, religion, number of siblings, ranking among siblings, family function, parental marital status and smoking among adolescents aged 12 to 20 years old.

A cross sectional study design using random cluster sampling method was done. Four out of a total of 35 secondary schools in Klang District, Selangor, Malaysia were selected. Respondents consisted of individual students in selected classes from the 4 selected schools. Data was collected using a self-administered, structured, pre-tested questionnaire and was analyzed using the SPSS version 12.0.

Out of 1089 respondents, 793 completed the questionnaire (response rate 73.82%). The overall mean self-esteem score was 27.65. The mean self-esteem score for males (27.99) was slightly higher than females (27.31). The differences in the mean scores by race were statistically significant. There was a statistically significant relationship between mean self-esteem scores and sex, age, race, religion, number of siblings, smoking and family function. There was a no statistically significant difference between mean self-esteem score with parental marital status and with ranking among siblings. The overall mean self-esteem score was 27.65. Self-esteem was associated with sex, age, race, religion, number of siblings, smoking and family function.

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INTRODUCTION

Self-esteem is defined as a person's feeling of self-worth (Rosenberg, 1965). Self-esteem is an important factor for helping persons deal with life stressors (Wilburn & Smith, 2005). It is an important determinant of psychological well-being that is particularly problematic during adolescent life stage (Rosenberg, 1965).

There is a correlation between low self-esteem and depression, and the resulting risk of suicide, increased unmarried sexual intercourse, teen pregnancy and alcoholism among

today's adolescents (Rosenberg, Schooler, & Schoenbach, 1989; Poikolainen, Tuulio-Henriksson, Aalto-Setala, Marttunen, & Lonnqvist, 2001; Demirbas, Celik, Ilhan, & Dogan, 2003; Young, Donelly, & Denny, 2004; Wilburn & Smith, 2005;). Self-esteem changes significantly during adolescence which provides important insights into the dynamics of adolescent self-esteem (Rhee, Chang, & Rhee, 2003).

As adolescents reach young adulthood, males and females often experience many adulthood stressors. Consequently, their reactions to these life stressors affect their self-esteem adversely (Baldwin & Hoffmann, 2002). Environmental issues such as socioeconomic status, family relations and language barriers may be factors that could contribute to the difference in the self-esteem level (Connor, Poyrazli, Ferrer-Wreder, & Grahame, 2004).

Ethnic differences were found to be predictors of self-esteem in a study conducted in Los Angeles where self-esteem was found to be significantly lower in Asians than Caucasians adolescents (Rhee, Chang, & Rhee, 2003). In the United States, Black adolescents have higher self-esteem than biracial adolescents followed by Asian adolescents. It was proposed that different levels of social support in communities resulting from varied racial backgrounds may partly explain racial differences in self-esteem (Bracey, Bamaca, & Umana-Taylor, 2004).

In the study conducted by Rhee et al in the United States, the number of siblings among Asian students was found to predict self-esteem. It was mentioned that the fewer siblings they have the more positively they thought of themselves (Rhee, Chang, & Rhee, 2003).

Quality of family relations has a strong influence on self-esteem (Hughes & Demo, 1989). Family environment is one of the most fundamental and central environments in adolescent life (James, Thames, Bhalla, & Cornwell, 2003). Family cohesion has significant effects on changes in adolescent self-esteem (Baldwin & Hoffmann, 2002). Self-esteem and family functioning are positively correlated with relatively greater effect in girls compared to boys (Mandara & Murray, 2000). Adolescents whose family challenged them to do their best, and encouraged autonomy and self-discipline have higher self-esteem (Schmidt & Padilla, 2003). Self-esteem and sense of mastery are enhanced by positive family environment. High parental support and parental monitoring were related to greater self-esteem and lower risky behaviors (Parker & Benson, 2004).

The aim of this study was to determine the mean self-esteem score for adolescents aged 12 to 20 years old and to determine the association between self-esteem and age, sex, race, religious practice, number of siblings, ranking among siblings, parental marital status, family function and smoking amongst adolescents aged 12 to 20 years old in Klang District, Selangor, Malaysia.

METHODS

This cross sectional study was carried out in Klang district, from March to May 2005. Klang is one of the nine districts in the state of Selangor in Malaysia. It covers an area of 571 km^2 and has a population of 828,202 people. In the year 2005, there were 35 secondary schools located in Klang district with a total secondary school student population of 52,409.

Random cluster sampling technique was used in this study. The sampling frame consisted of a list of all 35 secondary schools in Klang District. The sample population consisted of students from four selected schools. The sampling unit was the individual students in the selected classes in the four selected schools. The sample size was calculated with the Epi

Info statistical programme using 95% confidence interval. The sample size calculated was 446.

Data was collected using a self-administered, standardized, structured, pre-tested questionnaire prepared in English, Bahasa Malaysia and Mandarin versions. The questionnaire consisted of questions on social demographics, smoking history, self-esteem, family function and religious practice.

Self esteem was measured using Rosenberg Self-Esteem Scale (1965) which consisted of 10 statements related to overall feelings of self-worth or self-acceptance. The items were answered on four-point Likert scales ranging from strongly agree to strongly disagree. Highest score able to be attained was 40 and lowest was 10. A modified version of the Family Interaction Scale was used to measure the students' family function which consisted of 20 statements in 3 sub-scales; (i) Family awareness, (ii) Communication, and (iii) System maintenance and general functioning. The items were also answered on a four-point Likert scale ranging from strongly agree to strongly disagree. Highest score able to be attained was 80 and lowest was 20.

Data was analyzed using the Statistical Package for Social Sciences Programme (SPSS) version 12.0 and Epi Info version 6.0.4d. The statistical tests employed were student paired t-test, ANOVA test, regression and correlation test. Student paired t-test was used to test the difference between mean self-esteem scores for gender and smoking history. ANOVA test was used to test the difference between the mean self-esteem scores for race, religion, parental marital status, number of siblings and ranking of siblings. All significant levels were set at a standard p value of <0.05.

RESULTS

Out of the 1089 students, 793 students responded giving an overall response rate of 73.82%.

The overall mean age was 15.14 years old (SD = 1.64) and ranged from 12 to 20 years. Mean age for males (15.08) was slightly lower than females (15.20) but this difference was not statistically significant ($t = -.1.074$, $df = 791$, $p > 0.05$). Males and females were almost equally distributed with the slight difference of females exceeding males by 0.4% (Table 1a). The majority of respondents consisted of Malays, followed by Chinese, Indians and the minority were from the "Other Race" group. As for religion, only 2 respondents (0.3%) had no religion.

Table 1a. Distribution of respondents (n = 793) by sex.

Characteristics	Frequency	Percent
Male	395	49.8
Female	398	50.2
Total	793	100.0

Table 1b shows the distribution of respondents by parental marital status, number of siblings, ranking among siblings and smoking history. The results showed that majority of respondents had parents who were married and staying together (92.7%) and had less than five siblings (79.1%). Out of the 793 respondents, 163 (20.6%) were smokers.

Table 1b. Distribution of respondents (n = 793) by parental marital status, number of siblings, ranking among siblings and smoking.

Characteristics	Frequency	Percent
Parental marital status		
Married (Staying Together)	735	92.7
Married (Not Staying Together)	19	2.4
Married (Either parent pass away)	22	2.8
Divorced	17	2.1
Number of siblings		
Less than five	627	79.1
five or More	166	20.9
Ranking among siblings		
First Child	242	30.5
Second Child	215	27.1
Third Child	151	19.0
Forth Child	60	7.6
Fifth Child	43	5.4
Others	82	10.3
Smoking		
Yes	163	20.6
No	630	79.4

The overall mean self-esteem score was 27.65 (± SD = 3.485) and self-esteem scores ranged from 14 to 38. Table 2 shows the mean self-esteem scores for sex, race, age and religion. The mean self-esteem scores in the males (27.99) was slightly higher than the females (27.31), which was statistically significant ($t = 2.772$, $df = 791$, $p < 0.05$).

Respondents aged 13 years and less had the highest mean score of 28.35, and respondents aged 18 years and more had the lowest mean score of 26.78. A Pearson's correlation analysis showed that there was a statistically significant and direct but very weak relationship between self-esteem and age ($r = 0.122$, $p < 0.05$).

The mean self-esteem score was highest among the "Other races" group (31.60), followed by the Indians (29.28), Malays (27.47) and Chinese (26.55). This difference of mean self-esteem score among the races was statistically significant ($F(3, 789) = 23.789$, $p < 0.05$).

Table 2. Mean self-esteem score for sex, race, age and religion among respondents (n=793).

Characteristics	Mean	95% CI for Mean	SD	Range
Sex				

Male	27.99	27.65 – 28.33	3.470	14 – 37
Female	27.31	26.96 – 27.65	3.472	14 – 38
Race				
Malay	27.47	27.17 – 27.77	3.078	16 – 36
Chinese	26.55	26.04 – 27.06	3.753	14 – 36
Indian	29.28	28.77 – 29.79	3.402	19 – 37
Others	31.60	26.74 – 36.46	3.912	28 – 38
Age				
13 or less	28.35	27.86 – 28.85	3.268	18 – 37
14	27.82	27.29 – 28.36	3.162	19 – 35
15	27.77	27.23 – 28.30	3.447	17 – 38
16	26.82	26.21 – 27.43	3.529	14 – 35
17	27.50	26.94 – 28.07	3.555	18 – 36
18 or more	26.78	25.26 – 28.31	4.565	14 – 36

Characteristics	Mean	95% CI for Mean	SD	Range
Religion				
Islam	27.47	27.17 – 27.77	3.104	16 – 36
Buddhist	26.12	25.61 – 26.64	3.490	14 – 36
Hindu	29.55	29.04 – 30.05	3.167	22 – 37
Christian	28.85	27.55 – 30.16	4.145	19 – 38
Others	28.18	26.88 – 29.49	1.940	26 – 32
No Religion	25.00			

Maximum self-esteem score was 40; Minimum self-esteem score was 10.

Table 3 shows the results of the Post Hoc Test which indicate that there were statistically significant differences among two races in self-esteem scoring, where Indians scored significantly higher than Malays ($p < 0.05$) and Chinese ($p < 0.05$), and Malays scored significantly higher than Chinese ($p < 0.05$) and scored lower than “Other races” ($p < 0.05$).

The mean self-esteem score was highest among the Hindus (29.55), followed by the Christians (28.85), “Other religions” (28.18), Muslims (27.47) and Buddhists (26.12). There were only two respondents who had No religion and their mean score was 25.00. The difference of mean self-esteem score among the different religions was statistically significant ($F (5, 787) = 19.392$, $p < 0.05$).

The results of the Post Hoc Test indicated that there were statistically significant differences among two religions in self-esteem scoring, where Hindus scored significantly higher than Muslims ($p < 0.05$) and Buddhist ($p < 0.05$), and Christians ($p < 0.05$) and Muslims ($p < 0.05$) scored significantly higher than Buddhist.

Table 3. Results for Post Hoc test for mean self-esteem and race of respondents (n=793).

(I) Race	(J) Race	Mean Difference (I-J)	Std. Error	Sig.	95% CI	
					Lower	Upper
Malay	Chinese	0.918	0.285	.007	0.18	1.65
	Indian	-1.809	0.304	.000	-2.59	-1.03
	Others	-4.132	1.504	.031	-8.00	-0.26
Chinese	Malay	-0.918	0.285	.007	-1.65	-0.18
	Indian	-2.727	0.344	.000	-3.61	-1.84
	Others	-5.050	1.513	.005	-8.94	-1.15
Indian	Malay	1.809	0.304	.000	1.03	2.59
	Chinese	2.727	0.344	.000	1.84	3.61
	Others	-2.323	1.517	.419	-6.23	1.58
Others	Malay	4.132	1.504	.031	0.26	8.00
	Chinese	5.050	1.513	.005	1.15	8.94
	Indian	2.323	1.517	.419	-1.58	6.23

Table 4 shows the mean self-esteem scores for parental marital status, number of siblings, ranking among siblings and smoking history. For mean self-esteem scores associated with parental marital status, the highest mean self-esteem score was 27.68 and two groups of respondents had similar scores. These were respondents whose parents were still married and staying together, as well as respondents whose parent were married but one of them had passed away. However, the differences of mean self-esteem scores and different parental marital status was not statistically significant ($F(3,789) = 0.679$, $p > 0.05$).

Respondents with less than five siblings had a higher mean self-esteem score (27.87) compared to respondents with five siblings or more (26.81), and this difference was statistically significant ($t = 3.516$, $df = 791$ $p < 0.05$).

This study found that there was no significant association between mean self-esteem scores and the ranking of a respondent among his/her siblings, based on the one-way ANOVA test results ($F(5, 787) = 0.968$, $p > 0.05$).

Students who did not smoke had a significantly higher mean self-esteem score (27.79) compared to students who smoked (27.09) ($t = -2.286$, $df = 791$, $p < 0.05$).

Table 4. Mean self-esteem score for parental marital status, number of siblings, ranking among siblings and smoking among respondents (n=793).

Characteristics	Mean	95% CI for Mean	SD	Range
Parental marital status				
Married	27.68	27.43 – 27.94	3.480	14 – 38

(Staying together)				
Married (Not staying together)	27.05	25.22 - 28.89	3.808	21 – 37
Married (Either parents passed away)	27.68	26.22 - 29.14	3.286	21 – 34
Divorced	26.65	24.73 - 28.56	3.724	20 – 34

Characteristics	Mean	95% CI for Mean	SD	Range
Number of siblings				
Less than five	27.87	27.60 – 28.14	3.469	14 – 38
Five or More	26.81	26.28 – 27.33	3.429	14 – 36
Ranking among siblings				
First Child	27.87	27.44 – 28.31	3.436	18 – 37
Second Child	27.74	27.23 – 28.24	3.760	14 – 38
Third Child	27.50	26.96 – 28.03	3.344	14 – 36
Forth Child	27.55	26.66 – 28.44	3.432	20 – 37
Fifth Child	27.88	26.86 – 28.91	3.340	20 – 34
Others	26.96	26.25 – 27.68	3.241	18 – 34
Smoking				
Yes	27.09	26.57 – 27.61	3.375	16 – 35
No	27.79	27.52 – 28.06	3.502	14 – 38

Maximum self-esteem score was 40; Minimum self-esteem score was 10.

In Table 4, the Pearson's correlation test results show the linear relationship between self-esteem score and family function score. A statistically significant, direct, moderate relationship was found between self-esteem with family function ($r = 0.478$, $p < 0.05$). Linear Regression test was performed to evaluate the extent to which family function contributed to the changes in self-esteem. Result showed that family function explained 22.8% of the variation in self-esteem score ($r^2 = 0.228$, $p < 0.05$).

The Pearson's correlation test results showed that there was a statistically significant, direct but very weak correlation between self-esteem and religion ($r = 0.099$, $p < 0.05$) (Table 5). Linear Regression test showed that religion only accounted for 1.0% of the variation of self-esteem score ($r^2 = 0.010$, $p < 0.05$).

Table 5. Pearson correlation and linear regression of family function and religion with self-esteem among respondents (n=793).

	r	r^2	F	df	p
Family function	0.478	0.228	234.00	1	0.01
Religious practice	0.099	0.010	7.79	1	0.01

DISCUSSION

In this study, males (27.99) had a statistically significant higher mean self-esteem score than females (27.31). This finding corresponds with the other studies carried out by different researchers in other countries such as James R et al's study on adolescents in Lousiana, United States of America (James, Thames, Bhalla, & Cornwell, 2003), and Frost & McKelvie's study on self-esteem among students in Quebec, Canada (Frost & McKelvie, 2004).

The results of our study show that there was a statistically significant but very weak and positive direct relation between self-esteem and age of the respondents. This finding agreed with Baldwin and Hoffmann that self-esteem score increase significantly with age (Baldwin & Hoffmann, 2002). However, the results contradicted with another study done by Connor et al which found that age was not significantly correlated with self-esteem (Connor, Poyrazli, Ferrer-Wreder, & Grahame, 2004).

In our study, Indians (29.28) were found to have the highest mean self-esteem score compared to Malays (27.47), while Chinese (26.55) scored the lowest of the three major races in Malaysia. This finding was consistent with the research done by Rhee et al among Asian and American students (Rhee, Chang & Rhee, 2003), and Bracey et al's study among biracial and monoracial students in a south-western city in the United States of America that there are statistically significant differences on ethnicity in self-esteem (Bracey, Bamaca, & Umana-Taylor, 2004).

In this study, the respondents who had less than 5 siblings (27.87) had a higher mean self-esteem score compared to the those who had more than 5 siblings (26.81). This result was supported by Rhee et al in the case of having fewer siblings is positively correlated with higher self-esteem (Rhee, Chang, & Rhee, 2003).

This study found that students who did not smoke scored statistically significant higher mean self-esteem scores (27.79) compared to students who smoked (27.09). This outcome corresponded similarly with other studies carried out by other researchers such as Byrne & Mazanov's studies on self-esteem in cigarette smoking in Australia in 1999 (Byrne & Mazanov, 2001) and 2002 (Mazanov & Byrne, 2002), as well as another study by Kawabata et al among Japanese adolescents (Kawabata et al., 1999). Further studies should look into matters which could influence the self-esteem and smoking indicators such as neighborhood and school environment as well as family member influences.

In this study, the correlation between self-esteem and family function had a statistically significant, direct relation of moderate strength ($r = 0.478$, $p < 0.05$). In their study, Connor et al reported that adolescents who communicated more openly with parents were likely to have higher self-esteem score (Connor, Poyrazli, Ferrer-Wreder, & Grahame, 2004). In addition, the results of this study also lend support to the study conducted by Mandara and Murray among African American adolescents (Mandara & Murray, 2000). Consistently, these results are also supported by the study on parent-adolescent relations and adolescent functioning among 16,749 adolescents from the National Educational Longitudinal Study in the United States of America (Byrne & Mazanov, 2001).

Our results also show that there was a statistically significant, direct, very weak correlation between self-esteem and religion. This finding agrees with a study on Black Americans that religion is one of the contributing factors to self-esteem (Hughes & Demo, 1989). However, in their study James et al found that there was no significant correlation between self-esteem and religious practice (James, Thames, Bhalla, & Cornwell, 2003). Further studies should be

done in order to determine the correlation between self-esteem and religion especially in Malaysia.

CONCLUSION

The overall mean self-esteem score for the secondary schools students in the Klang district was 27.65. There were statistically significant associations between self-esteem and sex, age, race, religion, number of siblings, smoking and family function score. In this study the results showed no statistically significant relationship between self-esteem and parental marital status or self-esteem and ranking among the siblings. Larger-scale studies on self-esteem need to be carried out in Malaysia. Future studies should include factors such as parental education level, number of family members, family income and academic achievement of students. Religious practices need to be studied in more detail.

ACKNOWLEDGEMENTS

We would like to thank the Dean of the Faculty of Medicine and Heath Sciences, Universiti Putra Malaysia, and the Ministry of Education, Malaysia for permission to publish the paper. We are grateful to the Ministry of Education of Malaysia, Selangor State Education Department and Klang District Education Department for permission to carry out this study in the schools.

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GAMBLING AND PROBLEM GAMBLING AMONG CHINESE INTERNATIONAL STUDENTS IN NEW ZEALAND

Wendy Li, Darrin Hodgetts and Elsie Ho

ABSTRACT
The past decade has seen considerable growth in the number of Chinese international students attending New Zealand educational institutions. Research suggests that young Chinese international students have high levels of gambling and are at risk to problem gambling. However, little is known about gambling practices and the potential for problem gambling among this population. This paper presents initial findings from research into Chinese international student's gambling histories, self-regulatory practices, the implications of gambling, and strategies for change.

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INTRODUCTION

The past decade has witnessed considerable growth in the number of international students attending New Zealand educational institutions. The vast majority of these students are from China (Berno & Ward, 2003; Smith & Rae, 2004). Given the size and economic importance of this group, it is not surprising that they have attracted the attention of researchers. Studies have explored cultural identity issues (Lee, 1995), adjustment issues (Beaver & Tuck, 1998; McGrath, 1997), homestay experiences (Welsh, 2001), and the general welfare needs and cross-cultural experience of tertiary students (Bennett, 1998; Berno & Ward, 2003; Campbell & Cheah, 2000; Fam & Thomas, 2000; Ho, Holmes, & Cooper, 2004; Holmes, 2000; Searle & Ward, 1990; Ward, Masgoret, Berno, & Ong, 2004). Research conducted by Ward and Masgoret (2004) suggested that Chinese were less satisfied with their academic progress, homestay arrangement, and cultural inclusiveness, which would increase their stress. Chinese people seeking counselling services for their gambling problems often said they used gambling as a form of release from stress associated with such experiences of dissatisfaction (Wong & Tse, 2003).

Public discourse regarding the arrival of Chinese students has been less than supportive, often painting a hostile response from other groups in New Zealand. Media reports frequently refer to Chinese international students' gambling, engaging in associated criminal activities, and contributing to car crashes (Phoenix TV, 2003; The New Zealand Herald, 2004a, 2004b, 2006a, 2006b; Van, 2006; Young & Young, 2003). Whether justified or not, such attention has contributed to public perceptions of excessive gambling and crime within Chinese

international student population when compared to other ethnic international students. However, there is little research into such issues.

In the *1999 New Zealand Gaming Survey*, although a number of Asian problem gamblers were identified, none scored within the problem or pathological range (Abbott & Volberg, 2000). Nevertheless, services access data indicated that Chinese and other Asians did present with gambling problems (Abbott & Volberg, 1999). In the *Survey on Problem Gambling among Asian People in New Zealand* conducted by Asian Services, Problem Gambling Foundation of New Zealand, a number of groups were identified as at risk to problem gambling (Tse, Wong, Kwok, & Li, 2004). Those disproportionately affected by problem gambling included Chinese international students (Goodyear-Smith, Arroll, & Tse, 2004; Tan, 2006). However, our knowledge about gambling participation and attitudes among Chinese international students is limited.

It has been suggested that more research about Asian gambling is needed (Abbott, 2001; Abbott & Volberg, 2000; Goodyear-Smith et al., 2004). What remains unclear is when and why students gamble? Are service and community concerns warranted? The aim of this paper is to investigate gambling histories, self-regulatory practices, the implications of gambling, and strategies for change among Chinese international students in New Zealand.

METHOD

This research assessed accounts of gambling and social participation among 12 Chinese international students in Hamilton or Auckland, who gambled at least once during the period of their stay. The term 'Chinese international students' refers to people who reside in New Zealand with student visas at the time of their study, and who were from the People's Republic of China and over 18 years of age. Participants in this study included 9 males and 3 females aged between 20 and 41 years. With regard to their educational background, 5 attended universities, 5 attended institutes of technology, 1 attended private tertiary educational institution, and 1 was a visiting visa holder. The duration of the participants' stay in New Zealand ranged from 3 to 7 years. All had gambled when they were either in language schools or in first or second year of universities. To ensure anonymity participants agreed to the use of pseudonyms (see Table 1).

Table 1. Demographic information on participants.

Pseudonyms	Age (Years)	Gender	Education institutions
Eric	29	Male	Institute of technology
David	41	Male	University
Leo	24	Male	Institute of technology
Zhuang	26	Male	Visiting visa holder
Keith	24	Male	Private Tertiary Education
Jack	24	Male	Institute of technology
Scott	24	Male	University
John	29	Male	University
Lily	25	Female	University
Tony	20	Male	Institute of technology
Anita	23	Female	Institute of technology
Lucy	24	Female	University

Prior to commencing the research, extensive preparation work was undertaken. This included a literature review of previous research of gambling and international students conducted nationally and internationally. It also involved consultation with Chinese communities and educational institutions, internal and external peer review, pilot studies and obtaining ethical approval from the Research and Ethics Committee of the Psychology Department at the University of Waikato.

The research employed in-depth interviews, with participants recruited using a snowball sampling technique. The first author approached potential informants through Chinese communities, church groups, tertiary institutions and personal contacts who provided referrals. Subsequently, individual semi-structured interviews were held at times and locations that were mutually convenient for participants and the researcher. These interviews lasted approximately one and a half hours and were conducted in Chinese by the first author whose first language is Chinese. Using the interviewees' first language was a way to encourage interviewees to talk freely and deeply when answering questions so as to reach the goal that interview data needed to be captured in its natural form (Legard, Keegan, & Ward, 2003). The interviews started with general questions regarding experiences of studying and living in New Zealand and then moved to pastime activities before reaching the more sensitive areas of gambling. The structure was flexible to allow the topics to be covered in the order most suited to the interviewees, to permit responses to be explored in depth and to allow for responses to issues raised by interviewees. During the interviews a range of probes and other techniques were used to achieve depth of answers in terms of penetration, exploration and explanation (Legard, Keegan, & Ward, 2003). All interviews were audio-taped, transcribed and analyzed in Chinese. The resulting analysis was then translated into English.

At a more theoretical level, these interviews offered privacy and opportunities for documenting the subjective experiences of participants in a way that reflected the diversity of their lived experience (Silverstein, Auerbach, & Levant, 2006). Interviewees told their stories, explained their ideas, and presented accounts of their own situations. These accounts constitute attempts to guide the interviewer in understanding and making sense of the interviewee's lifeworld from the participant's perspective (Rubin & Rubin, 1995).

The analysis was ongoing during the data collection process. Data from interview notes were analyzed using a general inductive approach to identify key themes relevant to the research objectives, which comprised transcribing interviews, coding, generating a description of the participants as well as themes, presenting descriptions and themes in the qualitative narrative, and making an interpretation of the data (Creswell, 2003). Specifically, narrative analysis was utilised. This analysis adopted an interpretative approach which aimed to understand and report the views and culture of Chinese students. It identified the basic story which was being told in the interviews, focusing on the ways accounts were constructed, the intention of the teller and the construction of characters in stories of gambling (Spencer, Ritchie, & O'Connor, 2003). In the following section we present aspects of a composite story of drawing on extracts from various participants. Attention is given to reoccurring themes from across participant accounts.

FINDINGS

Initially, this analysis presents the findings from participants' personal and family histories of gambling in order to provide a context within which participants' later experiences of gambling involvement can be understood. Next, we present findings relating to why, when and with whom the participants gambled in New Zealand, and benefits and impacts of gambling. The

analysis is concluded with a consideration of self-regulatory practices and help-seeking patterns among participants.

Complexities Surrounding Histories of Chinese Game Play and Gambling

In considering the gambling activities of a group of students who have come to New Zealand from China, it is important to consider the relationship between their gambling related activities in the contexts of China and New Zealand. The majority of participants reported that they did not gamble before living in New Zealand. Many of these participants reported playing Mahjong or card games, which could be interpreted as a form of gambling. However, for these participants Mahjong was simply a popular form of Chinese gaming.

> *I did not gamble when I was in China. I played Mahjong with my friends, but I don't see it was gambling even though we bet. The amount we bet was very small, just for bringing more fun into the game. Playing Mahjong was a social activity rather than gambling. (David)*

Such participants believed that playing Mahjong was a form of leisure. The purpose of playing Mahjong was for communicating with friends and family members instead of winning money. Several participants reported that every household in the city they lived in was involved in playing Mahjong over the period of Chinese New Year. Such gaming was constructed by these participants as a core cultural process for building and maintaining social networks and community. Reflecting some diversity across accounts, a few participants did propose that playing Mahjong was a form of gambling.

> *Mahjong itself is not gambling. However, if you bet on it when you play Mahjong, it is a form of gambling then. Any form of games which involves money is gambling. (Leo)*

These participants base their interpretation on the presence of money in the game and the potential for financial gain.

It is important to note that, although the majority of participant's families engaged in games such as Mahjong, several participants' families did not. These participants reported that their families associated such Chinese games with gambling and presented negative views and encouraged them to avoid gambling.

> *My parents viewed gambling as a sin. They even wanted me not to make friends with gamblers. (Jack)*

These families are in the scope of good morality against gambling. Complexities surrounding Chinese game play and gambling reflect on the paradoxical practices in relation to gambling in China. Gambling was banned when the Communists seized power in 1949 (VOA News, 2005). Chinese government has launched anti-gambling campaigns in the past decade in battles against corruption (Cody, 2005). Such practices strongly delivery messages to the Chinese public that gambling is a crime. However, the complexities occur when the government reassured citizens that police would not disturb friendly games of poker or Mahjong on the eve of Chinese New Year celebrations (Cody, 2005).

All participants were aware of such anti-gambling arguments. However, several still gambled. In considering this, the following section explores why they gamble, when they gamble and with whom they gamble.

Why, When And With Whom Participants Gambled

As would be expected when employing a qualitative approach, a range of motivations for and experiences of gambling were put forward by the participants. In this section we consider some of the core reasons for participants gambling which were often contextualized by participants through a contrast between life in China and New Zealand.

Participants' relief from boredom was a critical factor in encouraging them to gamble.

> *Lacking of nightlife and entertainment that Chinese students loved was the main reason for me to go to Casino. Life was boring and being distant from family and friends raised adaptation issues among Chinese international students, which was the key trigger for them to go for gambling. I stood on the street, looking around, finding that Casino was the only place opened at nights. (Zhuang)*

Students stated that lifestyles and leisure activities in New Zealand were different from those in China. Participants generally reported that life in New Zealand was more boring than that in China where they had colorful nightlife and engaged in a lot of different peer groups. Some reported that boring life fed the desire of risk taking which was fueled by gambling involvement.

Curiosity was invoked by several participants as the primary reason for their first gambling experience in New Zealand. This reflected the fact that gambling was illegal in China where a casino was an alien place, associated with crime that was to be avoided. A few participants also described how they were regulated by strict parental monitoring in China. Now the physical distance between themselves and their parents freed them from parental monitoring, resulted in the temptation to gamble.

> *Everything was new to me in NZ. My parents were far away from me. Therefore I wanted to try everything new. Gambling was one of those new things. (Anita)*

The view that workloads were too low and that language education was unsatisfying in New Zealand language schools was associated with participants' increased gambling in New Zealand. Participants reported that they had large amounts of homework when they studied in China, particularly for those who prepared for the college entrance examinations. When reflecting on the New Zealand situation, participants reported that they left school at 3 o'clock in the afternoons without any homework. They did not know how to manage their time. Casinos were presented as a temptation in this context.

> *I was in a language school. I had nothing to do after school. I felt bored at nights, going to a casino with friends to kill time. I was not able to find a place with many people I was familiar with except Casino. (John)*

All participants reported that they gambled frequently in order to pass the time and when at a loss for something to do. Here we see the potential impact on differing educational systems across cultures on the uptake of gambling.

In close conjunction with the issue of boredom, the majority of the participants saw gambling as a supplement to their social lives. They were generally introduced to a casino by their friends or flatmates.

> *I went to a casino with my friends in the first week of my arrival in NZ. I asked my friends to go to somewhere else, but they concentrated on games rather than answering me. (Eric)*
>
> *It was the second day of my arrival in NZ. My friend took me to a casino. (John)*

Reflecting on with whom they gambled, a majority of the participants said they usually played in the company of their friends, except Lily and David. Lily said she gambled on her own because she did not want to be interrupted by someone else when she played in the casino. David started to indulge in gambling after he failed to meet the requirement of the IELTS (International English Language Testing System) exam a few times. He found playing pokie machines helped to balance his feeling of failure and gave him a sense of success. However he did not want to tell anyone about his indulgence because he was reluctant to be labeled as a gambler.

> *I started going to pub to play pokie machines after I failed my English examination for entering into tertiary study. I did not want people to know that I was a gambler because gambling was considered very bad in my culture. (David)*

A few participants who gambled with their peers also suggested that they gambled to release stress and to escape failure and other problems in their lives.

> *Living and studying overseas put high pressure on us who were very young when we first arrived in NZ. Feeling lonely requires us to have somewhere to give vent to our emotions. (Scott).*

On reflection, however, these participants admitted that using gambling to escape problems didn't work all the time because they often encountered more stress and tension when they kept returning to casinos.

Many participants who took part in this study suggested that their gambling experiences changed over time. Enjoyment of a fun activity, entertainment or socializing was the primary reason for most participants to gamble initially. When they continued to gamble, some participants said they were primarily motivated by a desire to make money. Some of them even considered gambling as a job.

> *I gambled to earn money. I viewed gambling as my job. I tried to improve my skills and knowledge in the areas of my interest. I developed strategies of how to bet and how to calculate risks. I had a full –time commitment to gambling. (Leo)*

Nonetheless in the long run none of the participants reported that they had been successful in making a profit by gambling. Many also no longer viewed gambling as a fun activity.

> I first went to casino for fun. It was enjoyable because I did not care winning or losing. However, when I expected to gamble for winning money I did not enjoy gambling any more. (Lily)

Benefits and Impacts of Gambling

In this section we consider the participants' accounts of the benefits and impacts of gambling. The most frequently cited benefits of gambling were entertainment and fun. Participants also gave a range of other benefits, including the hope of winning money, making friends, relief from stress and tension, feeling a sense of success, killing time, free parking, dinner vouchers and accommodation vouchers.

Zhuang lost about $50,000 in gambling and Jack lost $20,000 within a week. Both participants claimed that gambling was part of their growing up process even though it was extremely painful. They had learnt, through such painful experiences, that gambling was something they should have never touched. Zhuang, who had not returned to the casino for some months at the time of interview, further added he had learned to deal with stress and improve his judgment. One participant, Keith, who had stopped going to school for two years because of gambling, lamented that gambling offered him no benefits at all.

With regard to the impact of gambling, participants talked about issues over their study, finance and health.

Participants who reported that gambling severely impacted on them financially had net losses of between $5,000 and $50,000. They first used their savings, then accommodation fees and even tuition fees to pay off their debts When some of the participants got no more credit, they sold their cars, mobile phones and laptop computers.

> *I experienced losing $20,000 within one horrible week. I lost everything, ending up with no food and no place to stay. I had no choice but sold my car and my laptop. It was miserable. (Jack)*

Health problems, particularly emotional stress, were also predominant concerns for most participants. Some reported losing weight, developing stress-related health problems, losing self-esteem, depression and despair. Mood problems were frequent. Participants commonly reported feeling very depressed when they lost money. They used words such as “feeling worn out”, “tired”, “nervous” and “down in the dumps that nothing could cheer me up” to described their feelings. David, who played gaming machines to escape the frustration caused by his academic failure, said he felt numb and did not care about winning or losing.

> *I felt numb. I was very excited when I first won money. However, when I lost a lot and everything seemed not to be on a right track, particularly my study, winning or loss did not arouse me at all. I just felt numb. The most suffering I felt was that my head was floating in the air without feeling my body. I felt my soul getting out of my body when I lost severely. (David)*

Several male participants reported that their gambling was associated with increased consumption of smoking and drinking. They generally described that they increased the amount of tobacco and alcohol consumed when they gambled.

Participants also talked about the impact of gambling on their studies. Some reported they had taken time off during school hours to gamble, resulting in failures in their studies. A few participants lost their student visa because they failed to pay their tuition fees which was lost in gambling. Some ended up working illegally. Zhuang applied for a visitor visa after losing his student visa as a result of gambling. He wanted to enrol to get a student visa again but if that failed, he would be deported when his visitor visa expired.

Research has shown that gambling impacts on relationship with significant others (Abbott, 2002; Rankine & Haigh, 2003). In this study, however, participants rarely mentioned how gambling had impacted on their relationships. Generally, participants admitted that they rarely tell their parents or partners about their gambling.

> *Gambling did not impact on my relationship very much. I did not tell my wife and my parents about my gambling. I would never tell them about my gambling. It would increase my stress if I told them. (David)*

Self-Regulatory Practices and Help-Seeking Strategies

Self–regulatory practices varied among the participants. Participants who reported that they gambled recreationally had a tendency to set a limit on the amount spent on gambling. The limits they set ranged from $20 to $100 per visit to gambling venues. However, Leo, whose father worked in the UK and sent him American dollars, set his limit at US$20,000. This limit was inappropriate for recreational gambling and indeed, Leo finally prohibited himself from going to the casino by self-exclusion.

Other self-regulatory practices used by the participants included not carrying any bankcards, asking a friend to monitor one's gambling behaviour, and no borrowing money from others. A few simply admitted that "loss is loss".

> It might be my personality because I did not care that I won or lost. It was not a matter for me. I was never eager to chase loss. (Tony)

A majority of participants had not engaged in gambling in the past six months prior to the interviews. Some indicated that their gambling involvement had been a problem in the past, even though they would not want to admit it at that time.

> *It was a problem. But I did not think about if my gambling was a problem at that moment. Yah, I really did not think of it. I did not think about if I should change my gambling behaviours either. (John)*

With regard to help-seeking, most participants believed that they had solved the problem on their own, such as by self-exclusion which is a voluntary action taken by people who want to control their own gambling by excluding themselves from the casino. Most participants had hardly disclosed any gambling problems to their parents or their spouses. But there were a few who sought help after their gambling problem was made known to their significant others.

> *My landlord called my cousin and told her that I did not pay my rent for two months. My cousin then knew I had gambled and lost and she told my parents. My parents paid off my gambling debts and told me to stop gambling. (Keith)*

Counselling services were used by a number of participants. In addition, a few commented on prevention programmes provided by service providers. Because these programmes often used extreme cases to illustrate the harm caused by problem gambling, some participants said they were not convinced by the programmes until they experienced huge loss in casinos themselves. Besides, the timing of these programmes was often inappropriate because they were generally held on Friday afternoons.

DISCUSSION

Studying and living a new country is a huge challenge for young Chinese international students. Loneliness is often experienced when students leave their families and the familiar world of their home country to enter into a new environment where the educational system and culture are quite different (Santrock, 2002). They may feel anxious about meeting new people who generally speak different languages from theirs. Before new social networks are established, students may feel bored or alienated. Findings lend weight to the occurrence that cross-cultural differences of lifestyles, leisure activities and educational systems fuel the young students' loneliness, anxiety and boredom, which is consistent with previous research (Tse, Abbort, Clark, Townsend, Kingi, & Manaia, 2005). Findings also evince that the students' gambling experiences alter from time to time.

This research provides insights for understanding gambling experiences specific to Chinese international students in New Zealand. We offer a set of recommendations which educational providers and social institutions might consider in addressing gambling among this student group. The findings of this study offer self-regulatory practices as strategies for change. This involves setting appropriate limits of spending on gambling, not bringing bankcards into a casino, playing with a friend who could offer monitoring, not borrowing money from friend around when gambled, establishing cognitive acceptance of losing and so on.

In considering that the content of prevention programmes do not significantly raise students awareness of the consequences caused by problem gambling, and that the time arrangement

for such programmes are often inappropriate, we suggest that consideration may be given to providing professional development for teachers in language schools about the issues of problem gambling for international students, and encourage the teachers to discuss these issues with students in the classroom. As most Chinese students attend language schools when they first arrive in New Zealand, language schools, with support from service providers, could be seen as primary vehicles for delivering important messages to promote health and wellbeing among international students. In addition, given the educational differential between China and New Zealand, we also suggest educational providers to offer time management course to international students to enhance their abilities to better manage their studies in New Zealand.

ACKNOWLEDGEMENTS

This paper reports on the first stage of the first author's MSocSc thesis research into *Understanding Experiences of Chinese International Students' Gambling in New Zealand.* This research is sponsored by Trust Waikato Student Community Grants, a BRCSS Masters Thesis Award, a Faculty of Arts and Social Sciences Masters Award, and Asian Services of Problem Gambling Foundation of New Zealand.

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Promotion of wellbeing: Happier and fuller life

Physical Activity and Dietary Patterns in Asian Adolescent Girls and their Associations with Body Fatness

Elizabeth K. Duncan, Grant Schofield and J. Scott Duncan

Abstract

The objective of this research was to provide insight into the body composition, physical activity patterns, and dietary habits of Asian adolescent girls living in New Zealand.

A total of 292 Asian girls aged 10-15 years (60.3% East Asian and 39.7% South Asian) participated in the Girls Activity and Body Composition (ABC) Study. Data from a further 753 girls (51.5% European, 16.9% Maori, and 31.6% Pacific Island) involved in this study are presented to enable comparisons between ethnic groups. Participants wore sealed multi-day-memory pedometers for three weekdays and two weekend days to monitor their physical activity patterns. Percentage body fat (%BF) was determined from hand-to-foot bioelectrical impedance analysis, with the 90th percentile of %BF used to classify excess body fat. Background demographics and dietary patterns were assessed by questionnaire.

South Asian girls had significantly more body fat than East Asian girls (30.3 ± 6.5% and 27.3 ± 5.1%, respectively). Pedometer-determined physical activity for the two Asian groups was similar, but was significantly lower than all other ethnic groups. In addition, both Asian groupings showed a low prevalence of participation in sport and physical activity during school recess and outside of school compared with other ethnicities. Despite this, a relatively high proportion utilised active transport modes to travel to and from school. Missing breakfast and frequent takeaway consumption occurred less frequently among Asian ethnic groups, but were associated with an increased risk of excess body fat.

Results from this study indicate that South Asian girls living in New Zealand are a high risk group for overweight and obesity. There is a need for strategies promoting physical activity in Asian ethnic groups, particularly with regards to participation in sport and organised physical activity during leisure time. Interventions targeting specific dietary behaviours related to obesity are also warranted in Asian girls.

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INTRODUCTION

Over the last decade, rapid lifestyle changes in physical activity and dietary behaviours have brought about widespread increases in the prevalence of obesity and related co-morbidities among people of all ages. An understanding of the physical activity and dietary patterns associated with excessive body fatness in young people is essential for public health

organisations to facilitate the development of long-term preventative strategies. In 2002, the Children's Nutrition Survey (CNS) estimated that nearly one in three New Zealand children aged 5-14 years were overweight or obese (Ministry of Health, 2003). Furthermore, a study of Hawkes Bay children reported that the risk of obesity in 2000 was 3.8 times greater than the risk in 1989 (Turnbull, Barry, Wickens, & Crane, 2004).

Despite the identification of obesity, nutrition, and physical activity as priority population health objectives in the New Zealand Health Strategy (Ministry of Health, 2000), our knowledge of excessive body fatness and related health behaviours among young people is limited, especially with regards to Asian populations. The absence of literature on obesity and its determinants in Asian communities is not surprising given that these groups have been largely overlooked in New Zealand's health and research and policies to date (Duncan, Schofield, Duncan, Kolt, & Rush, 2004). In the CNS, for instance, Maori and Pacific Island children were over-sampled and analysed separately, whereas Asian groups were subsumed with the European group. This 'invisibility' of Asian migrants is also apparent in other national health research, such as in America's third National Health and Nutrition Examination Survey (NHANES III). Given that New Zealand's Asian ethnicities are projected to increase by 145% between 2001 and 2021 (resulting in a 15% share of the population) (Statistics New Zealand, 2006), it is vital that these ethnicities are prioritised in future health surveys and interventions.

The purpose of this study was to investigate selected physical activity and dietary behaviours and their relationships with excess body fat in East and South Asian adolescent girls living in New Zealand. We chose to focus on young adolescents as this stage of life represents a critical period in the development of obesity and life-long health behaviours (such as physical activity and diet) and is a time of major changes in body composition (Berkey et al., 2000; Xie, Gilliland, Li, & Rockett, 2003). This research provides an opportunity for insight into the modifiable risk factors underlying overweight and obesity in Asian ethnic groups, thereby forming a basis for tailoring preventative health strategies and interventions.

METHODS

Participants

In 2005, a total of 176 East Asian and 116 South Asian adolescent girls aged 10-15 years from 11 Auckland intermediate and secondary schools participated in the Girls Activity and Body Composition (ABC) Study. Data from a further 753 girls (51.5% European, 16.9% Maori, and 31.6% Pacific Island) involved in this study are also presented to enable comparisons between ethnic groups. Participants were classified as 'East Asian' if they were descended from China, Taiwan, Singapore, Mongolia, Korea, or Japan, and 'South Asian' if they were descended from India, Pakistan, Nepal, Bangladesh, or Sri Lanka. Ethical approval for this study was obtained from the Auckland University of Technology Ethics Committee, and all participants and their legal guardians provided written informed consent.

Measures

Height and weight were measured using standard anthropometric procedures, and body mass index (BMI) was calculated as weight (kg) divided by squared height (m^2). Body fat measurements were made using hand-to-foot bioelectrical impedance analysis (BIA; BIM4, Impedimed) according to methods described previously (Rush, Puniani, Valencia, Davies, & Plank, 2003). Fat-free mass (FFM) was calculated from BIA resistance measurements, height, and weight using prediction equations previously validated in New Zealand Chinese and Indian children (Duncan, Rush, Duncan, Schofield, & Freitas Jr, 2005). Fat mass (FM) was derived as the difference between FFM and body weight. Percentage body fat was

calculated as 100 × FM/weight. Unlike BMI, there are no generally accepted definitions of overweight or obesity in children and adolescents based on %BF. Given that approximately 10% of New Zealand children are classified as obese using international BMI thresholds (Ministry of Health, 2003), the 90th percentile of %BF was chosen as the cut-off point for identifying excessive body fatness in this sample.

Participants wore a sealed New Lifestyles NL-2000 pedometer to monitor daily physical activity for six consecutive days. Pedometers were the measurement tool of choice as they provide an accurate and reliable measure of physical activity in paediatric populations (Sirard & Pate, 2001). The NL-2000 pedometer has a multiday memory (MDM) function that enables steps counts to be automatically recorded for individual days. Pedometer compliance was determined from a questionnaire completed on the day the pedometers were collected. Step counts for participants that reported having the pedometer off for more than hour were not included in analyses. An additional questionnaire administered at the beginning of class provided information on background demographics, and selected physical activity and dietary behaviours.

Data Analysis

Data were analysed using SPSS version 12.0.1 for Windows (SPSS Inc., Chicago, IL). Differences in participant characteristics (age, height, weight, BMI, and %BF) between ethnic groups were assessed using independent samples *t*-tests. Where necessary, data from East and South Asian groups were combined to examine associations between body composition and physical activity/dietary patterns. A *p* value less than 0.05 was used to indicate statistical significance.

RESULTS

Participant Characteristics

The physical characteristics of the two Asian ethnic groupings in this study are presented in Table 1. There were no significant differences in height, weight, or BMI between East and South Asian girls. However, South Asian girls had more body fat than East Asian girls, and were approximately half a year younger. The elevated %BF of South Asian girls despite similar BMI values is in accordance with previous research that reported ethnic variation in the relationships between body fat and BMI (Deurenberg, Yap, & van Staveren, 1998). Given these differences, BMI may not be an appropriate proxy for comparing body composition in multiethnic populations.

Table 1. Participant characteristics (mean ± SD).

	East Asian	South Asian
	(*N* = 176)	(*N* = 116)
Age (y)	13.53 ± 1.12*	13.01 ± 1.16
Height (cm)	153.9 ± 0.07	154.6 ± 0.08
Weight (kg)	48.4 ± 10.0	48.3 ± 12.5
BMI (kg.m^{-2})	20.1 ± 3.2	20.2 ± 4.3
Body fat (%)	27.3 ± 5.1*	30.3 ± 6.5

BMI, body mass index.
* Significantly different from South Asian ($p < 0.005$).

Physical Activity

South and East Asian girls averaged 9,249 ± 2,248 and 9,012 ± 2047 steps per day, respectively. These step counts are well below the 13,000 steps/day target proposed by Duncan, Schofield, and Duncan (2006a) to minimise the risk of overweight and obesity in girls. However, the applicability of this guideline to the present sample is questionable given the younger age of the children (5-10 years) in which it was developed. Perhaps more importantly, the step counts of Asian girls were significantly lower than all other ethnic groups in this study. This finding is consistent with an earlier investigation of 1115 Auckland children aged 5-10 years (Duncan, Schofield, & Duncan, 2006b). In this study, we reported that Asian children accumulated substantially fewer steps than European, Maori, or Pacific Island children. Similarly, overseas research has also reported low activity levels in both Asian adolescents (Gordon-Larsen, McMurray, & Popkin, 1999) and Asian adults (Suminski, Petosa, Utter, & Zhang, 2002).

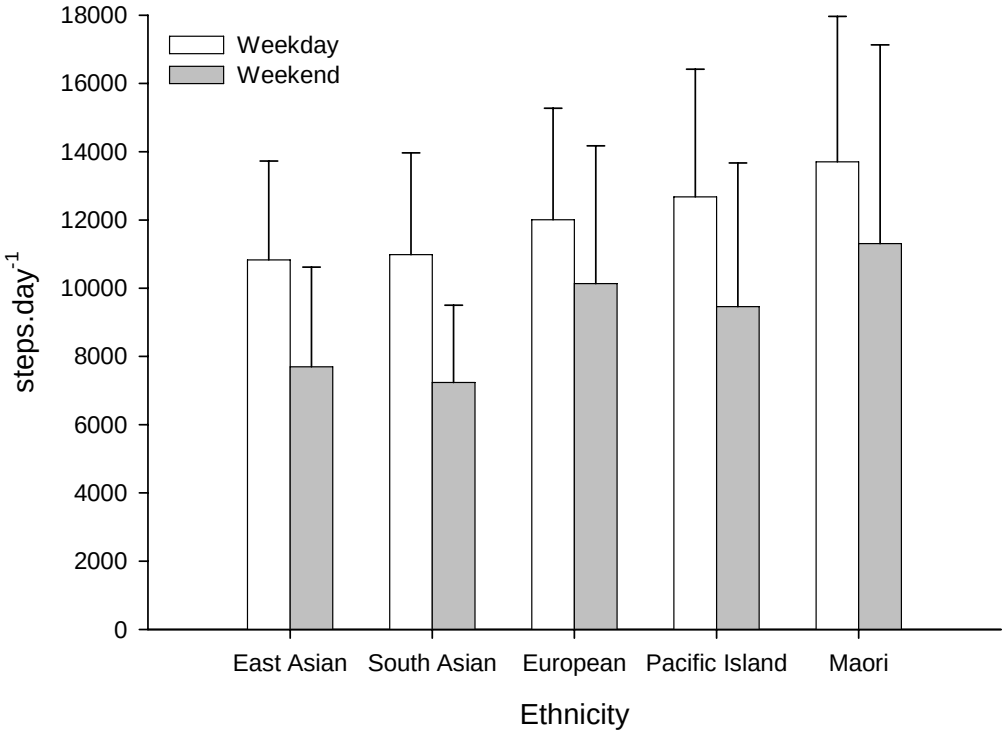
With the use of MDM pedometers, we were able to discern step counts for individual days, and thus compare step counts between weekdays and weekend days. Mean weekday step counts for Asian girls were significantly higher with smaller standard deviations than weekend days (Figure 1). Compared with all other ethnic groups, the decrease in steps from weekdays to weekend days was most pronounced in South Asian girls (3,752 steps), followed by East Asian girls (3,441 steps). It is likely that this trend underlies the low overall physical activity in Asian girls. Clearly, the low physical activity level of young Asians living in New Zealand is an issue that warrants attention.

In order to gain insight into the contexts in which Asian girls were engaging in physical activity, participants were asked about their involvement in organised sport and exercise. In accordance with the low daily levels of physical activity among Asian girls, 31% of South and East Asian girls reported doing no sport or other organised physical activities outside of school in the last full week, and only 7% of East Asians and 10% of South Asians reported engaging in sport or other physical activities on five or more days. Rates of physical activity participation during school lunchtimes were also low; 64% of East Asian and 41% of South Asian girls did not undertake physical activity during lunchtimes in the previous week, and only 9% and 11% (respectively) were physically active every lunch time.

Active transport (commuting by walking or cycling) patterns were also assessed by asking participants how they usually travelled to and from school. Despite being the least active group, Asian girls in our study were more likely to use active transport to/from school than other ethnicities. Forty five percent of South Asian girls used active transport modes to travel to school, and 50% to travel from school. Similarly, 39% of East Asian girls used active transport modes to travel to school, and 46% to travel from school. East and South Asian participants that actively transported to or from school averaged 674 and 1,289 more steps, respectively, on weekdays than those who did not. However, these differences were not statistically significant (p = 0.173 and 0.058).

In this study, there was no difference in weekday or weekend step counts between Asian girls with normal levels of body fat (< 90th percentile of %BF for each age) and those with high levels of body fat (> 90th percentile of %BF for each age). However, given that there were only 12 Asian girls in the high body fat group, it is possible that differences may be observed in a larger sample. Indeed, in earlier research we reported significant associations between the daily step counts of 5-11-year-old children and their %BF (Duncan, Schofield, & Duncan, 2006b). Children with high levels of body fat (> 90th percentile of %BF) averaged 1154 (boys) and 1893 (girls) fewer steps on weekdays, and 1480 (boys) and 844 (girls) fewer steps on weekend days than those with normal body fat levels (< 90th percentile of %BF).

Figure 1. Pedometer-determined physical activity during weekdays and weekends grouped according to ethnicity.



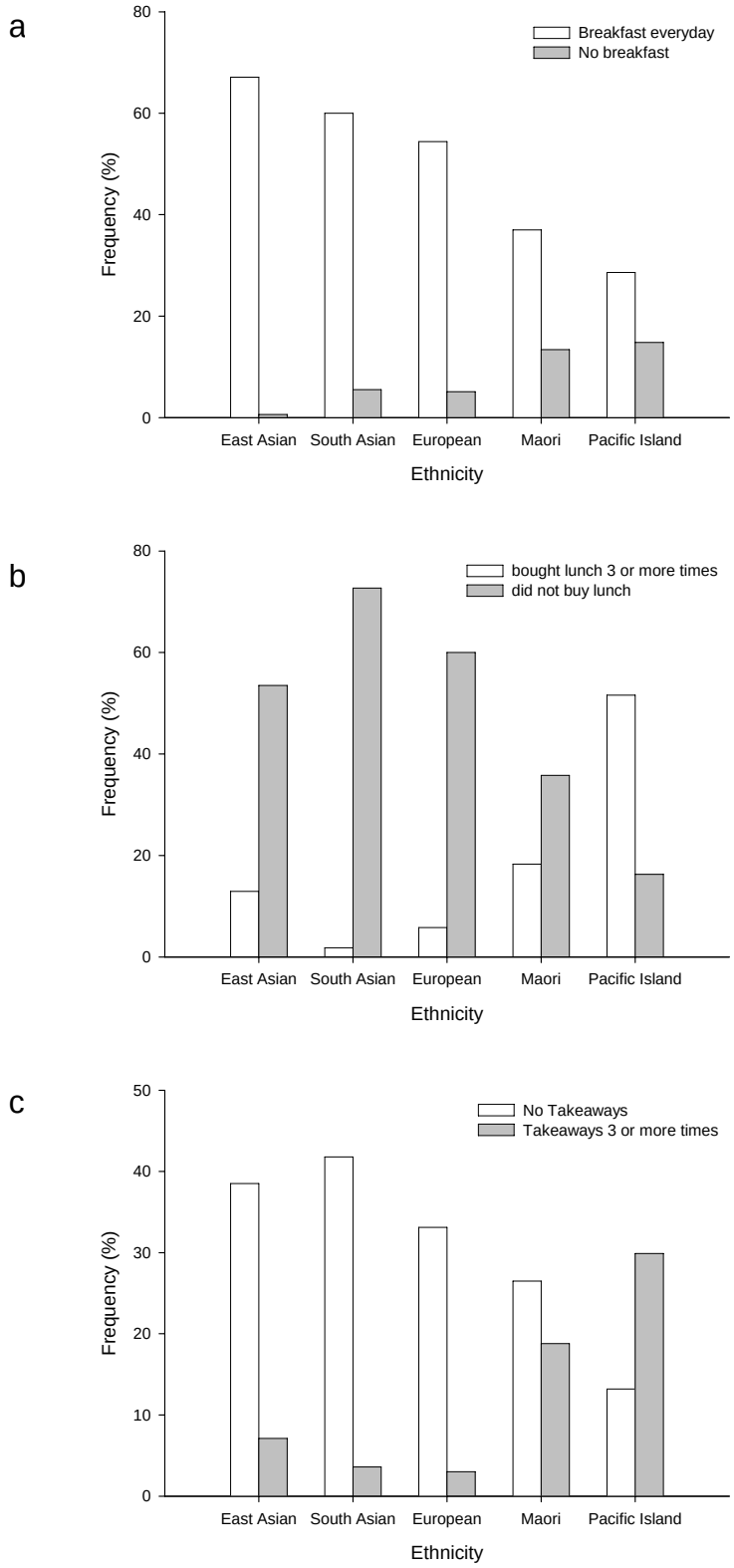
Dietary Patterns

In general, Asian participants in the Girls ABC study engaged in less unhealthy dietary behaviours than European, Maori, or Pacific Island girls. East Asian girls were the most likely to have breakfast everyday (67%), followed by South Asians (60%), and Europeans (54%) (Figure 2a). Similarly, East Asian girls were the least likely to have had no breakfast in the last week, followed by South Asians, and then Europeans. Asian girls who ate breakfast everyday had significantly lower %BF (27.4%) than girls who ate breakfast less than three days (29.8%) in the previous week (p = 0.027). The risk of having a high %BF was also 4.8 times greater in the group that had breakfast less than three days per week.

None of the South Asian girls bought lunch at school everyday, and only 2% bought lunch at school on three or more days in last week. In comparison, 13% of East Asian girls bought lunch on three or more days, 4% of which bought lunch at school everyday in the last week (Figure 2b). There were no significant differences in %BF between Asian girls who bought lunch on three or more days in the previous school week and those who did not buy lunch at school. Likewise, the risk of having high %BF was similar in the two bought lunch groups, suggesting that strategies targeting bought lunch may not a priority in Asian adolescent girls.

Seven percent of East Asian girls and 4% of South Asian girls consumed fast food on three or more days in the last week (Figure 2c). While these results do not appear excessive, they are slightly higher than for European girls (3%). The %BF of Asian girls who consumed fast food three or more times in the previous week was similar to those who did not consume any.

Figure 2. (a) Breakfast consumption, (b) bought lunch, and (c) takeaway/fast food consumption in adolescent girls aged 10-15 years grouped according to ethnicity.



DISCUSSION AND RECOMMENDATIONS

The purpose of this study was to examine the physical activity and dietary patterns of Asian adolescent girls living in New Zealand, and to determine which behaviours are priorities for obesity prevention interventions in these groups. Results from this study indicate that the physical activity levels of New Zealand Asian girls are of concern. Both East and South Asian girls did significantly less physical activity than other major ethnic groups, putting them at greater risk for lifestyle diseases related to inactivity. In particular, sport and organised physical activity during leisure time was identified as an important activity context to target. Based on the dietary behaviours assessed in this study, East and South Asian girls had relatively good eating patterns compared with non-Asian ethnicities. Although Asian girls were well represented among the healthy eating habits, a substantial proportion still engaged in behaviours such as missing breakfast that were significantly associated with excessive levels of body fat.

The research presented here is only a starting point; we recommend further investigation of the body composition, physical activity, and diet of young Asians living in New Zealand in relation to health risk. An understanding of this area will be imperative for counteracting the burgeoning epidemic of obesity and related health complications in New Zealand. It is important to note that knowledge on obesity and its key determinants is only one aspect of the health of Asians that is lacking. The paucity of ethnic-specific data on the health of Asians in New Zealand is most likely symptomatic of health policy that does not explicitly identify Asians as an at-risk group. While the New Zealand Health Strategy (Ministry of Health, 2000) makes it clear that reducing inequalities in health status is a priority, in practice this has failed to extend to the substantial Asian population currently in need.

ACKNOWLEDGEMENTS

Funding for this research was provided by grants from Sport and Recreation New Zealand and the Division of Sport and Recreation, Auckland University of Technology.

Students and staff at the following schools are gratefully acknowledged for their participation: Birkenhead College, Carmel College, Howick College, Kelston Girls College, Mt Roskill Grammar School, Mt Roskill Intermediate School, McAuley High School, Pakuranga College, The Manurewa High School, Wairau Intermediate, and Westlake Girls High School.

Elizabeth K Duncan acknowledges the support of the Tertiary Education Commission through the Bright Futures Top Achiever Doctoral Scholarship.

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BECOMING INFORMED HEALTH CARE CONSUMERS: ASIAN MIGRANT MOTHERS IN NEW ZEALAND

Ruth DeSouza

ABSTRACT

A central tenet of New Zealand's midwifery and maternity services is the emphasis on a partnership between two equals namely the midwife and the woman. However, such a partnership rests on the notion of an informed consumer who is independent. When the consumer is a migrant who has experienced social upheaval, lost their knowledge resources and is experiencing isolation and language barriers, they may take up a more dependent role rather than the autonomous and self-determining consumer that midwives are prepared for. This imbalance can mean that health professionals are challenged to take up less facilitative and more authoritative positions and in turn migrant mothers and their partners are challenged to develop more proactive roles. This paper presents partial and preliminary findings from a qualitative study of Asian mothers in New Zealand with regard to their information needs.

DeSouza, R. (2006). Becoming informed health care consumers: Asian migrant mothers in New Zealand. In S. Tse, M.E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp. 196-207). Auckland, New Zealand: University of Auckland.

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INTRODUCTION

The notion of a partnership between the midwife and the woman underpins New Zealand midwifery models, where both parties are equal and make equally valuable contributions (Pairman, 2001). Midwives bring their knowledge, skills and experience and the woman brings her knowledge of herself and her family and her needs and wishes for her pregnancy and birth. However, for women become equal partners, they need to make informed decisions about their health and this in turn depends on having access to relevant and timely information. For mothers, biological knowledge about the pregnancy, birth and labour is only one form of knowledge. In addition, social knowledge and institutional knowledge are important (Lazarus, 1994). While biological knowledge can be obtained from authoritative sources like experts and electronic resources, social and institutional knowledge are more difficult to access for migrant women. AS access to these forms of knowledge is dependent on context and social networks which migrant mothers often lose in the social upheaval of migration. For many women who migrate, the separation from family and peers leads to 'breaks in knowledge' (Fitzgerald et al., 1998) and the loss of these knowledge resources which help prepare the mother for the processes of pregnancy, childbirth and parenting, creates what Liem (1999, p.157) calls a "vacuum of knowledge". The vacuum of knowledge

needs to be filled and most often this role falls heavily on health professionals (DeSouza, 2005).

This paper begins with a description of the dramatic population changes in New Zealand with a particular focus on Asian women. A discussion about receiving accurate and timely information follows suggesting that the quality of communication between women and their carers is critical for feeling safe and satisfied with care. An outline of research conducted in Auckland New Zealand follows and the findings are presented through the transition to parenthood. Strategies for managing the transition to parenthood and becoming an informed consumer are discussed with the paper concluding with practice, policy and research recommendations.

LITERATURE REVIEW

The following section contextualises the study by reviewing the changing demographics in New Zealand society with a focus on Asian women. This is followed by a discussion about the link between information and communication and satisfaction with care for migrants.

An increasingly diverse New Zealand

Service providers need to develop skills and competence for working effectively with diverse members of New Zealand society. International trends show that people of diverse racial, ethno-cultural and language backgrounds are underserved by health and social services, experience unequal burdens of disease, experience cultural and language barriers to accessing appropriate health care, and receive a lower quality of care when they do access health care services in comparison with members of the population (Johnstone & Kanitsaki, 2005). The 2001 Census revealed growing numbers of Māori (14.5%), Pacific Island people (5.6%), Chinese (2.2%) and Indian (1.2%), in addition to European/Pākehā who make up 79.6% of the population. There has been a 20% increase in the number of multilingual people and an increase in people whose religion was non-Christian. People who practice Hinduism increased by 56%, there was a 48% increase in Buddhists and a 74% of people practising Islam.

Asians are the fastest growing ethnic group; increasing by around 140% over the last ten years and predicted to increase by 122% by 2021 due to net migration gains rather than high fertility rates (Statistics New Zealand, 2005). The Asian community has the highest proportion of women (54%), (Scragg & Maitra, 2005) who are most highly concentrated in the working age group of 15-64 years compared to other ethnic groups, a reflection of a skills focused migration policy. 23% of New Zealand women were born overseas, predominantly in the UK and Ireland, Asia and the Pacific Islands. Some of the most dramatic demographic changes are evident in the Asian community, for example in the period between 1991 and 2001, the number of women originating from the Republic of Korea increased 23 times from 408 to 9,354, numbers of women from China quadrupled from 4,620 to 20,457 and women from South Asia doubled in the same time period (Statistics New Zealand, 2005). Such diversity has been unprecedented and present both unique challenges and opportunities to health and social service providers and policy makers.

Communication, caring and safety

Migration often results in the loss of reference points in the form of family networks, peer support and familiarity with health services. Such a loss amplifies the necessity for receiving accurate and timely information. Davies and Bath (2001) suggest that information provision during pregnancy and childbirth is critical for both supporting choices that are made but also in preparing women to manage uncertain outcomes. Citing a study by Kirkham (1989), Davies and Bath argue that women's satisfaction with maternity services in secondary care is

primarily dependent on the quality of communication between the women and their carers. Little is known about the health care experiences of migrant women, however, they are thought to report more acute concerns about communication and sensitivity of care than the population in general (Davies & Bath, 2001). Furthermore, language barriers can exacerbate isolation and promote dependency on health workers rather than enhancing self-determination, a dominant midwifery discourse. Small, Rice, Yelland, & Lumley (1999) found that Vietnamese, Turkish and Filipino women in Melbourne who were not fluent English speakers experienced problems in communicating with their caregivers and this made experiences of care less positive. Of more importance than knowledge about cultural practices, was care experienced as unkind, rushed, and unsupportive. Another Australian study found that migrant patients (and their families) did not feel safe when in hospital. Safety was undermined when effective communication with caregivers was compromised through being unable to access qualified health interpreters or being unable to have family members around to advocate and participate in decision-making (Johnstone & Kanitsaki, 2005).

The study

Migrants tend to maintain better health than the local population initially so often have little to do with hospitals (McDonald & Kennedy, 2004), but motherhood is a common aspect of migration requiring contact with the health system. The study took place in Auckland, New Zealand among White migrants (from South Africa, United Kingdom and the United States of America), Muslim Arab migrants (from Iraq and Palestine) and Asian women from three ethnic communities (Korean, Chinese and Indian) as part of a larger Families Commission funded study. Ethics approval was obtained from the Auckland University of Technology Ethics Committee and the Plunket Ethics Committee. Participants for the migrant mothers' focus group were recruited though Plunket nurses who invited women to participate, selection criteria limited participation to migrant women who had become mothers within the last 12 months in New Zealand. Informed consent was obtained from all participants and consent forms were translated into Arabic, Korean and Chinese. Data collection involved focus groups using semi-structured interviews conducted in English, Chinese and Korean. The groups were facilitated by interviewers proficient in English and the language spoken by the women. These interviews were recorded and transcribed, translated into English if necessary and verified by an independent translator. The interview transcripts were then coded and analysed. The codes were clustered according to similarity and reduced. Similar phenomena were grouped into categories and named. The process was one of constant comparison, iteratively classifying and grouping the material to identify preliminary categories and sub-categories. This paper reports on a sub-theme about information needs and the findings focus on Asian women.

FINDINGS

Midwives caring for migrant Asian parents are challenged to reconfigure their model of partnership and in turn migrant Asian parents experience a shift from birth being a social event to more of an individual responsibility. This shift requires a more proactive and self-sufficient role for women and their husbands, who become more involved than they might have been in their country of origin. In addition, language and communication drive experiences of care. This separation from knowledge resources places greater responsibility onto midwives to assume a more central role in information provision and support. In particular migrant mothers require detailed, individualised, stage specific information in order to take up the role of informed consumer.

Antenatal period

Not only are migrant mothers confronted with changing bodies and roles when they become pregnant, they also have to deal with an unfamiliar health system in the absence of a support network and knowledge resources they might have had in their countries of origin. In this

study, Asian migrant women had to make decisions that required access to information in order to ascertain the choice of maternity carer and access to ante-natal classes. At this time women who were not fluent or confident English speakers had to contend with linguistic and cultural barriers to accessing services.

The loss of traditional sources of knowledge meant that pregnancy in a new country moved from being a social event and responsibility to being an individual one (DeSouza, 2005). This required the participants to become more involved and proactive in seeking out detailed, timely and specific information about the stages of their pregnancy. This allowed them to become more involved in the pregnancy than if they had been in their country of origin where this responsibility would have been shared. Husbands also became more involved in the processes of pregnancy, than they might have been in their countries of origin.
Knowing where to begin the process was difficult:

> *I had no idea at all about the system here. It was through the pregnancy test kit that I found out I was pregnant, but did not know what the next step was. I wondered whether I had to show my test result to my GP. I had no knowledge of how to get the necessary information [Korean participant].*

Obtaining language specific and precise information was important for many Korean women. Being given broad encouragement was not a substitute for specific information and was perceived as a *laissez-fare* attitude to their wellbeing.

> *I was given some information, but I didn't read it, as it was not in Korean. I always felt that I was one step behind. It was not only the midwife who did not give enough information or necessary support. Everyone kept saying, "It is okay, you are doing well" but gave few information or specific support [Korean participant].*

Pregnancy in a new country raised the need to develop active decision making strategies and to choose a health care provider. Many of the women were proactive about finding out about the New Zealand health system and turned to authoritative sources for information:

> *Luckily, I was attending school and the assignment from school was to complete a project. I chose 'New Zealand's maternity system' and that was how I got some ideas about my situation [Korean participant].*

For some women the absence of family members and the access to information meant that they could monitor themselves through the stages of pregnancy and this led to developing increased knowledge and greater self-sufficiency:

> *I have to take care of my own self. I found this good thing in New Zealand that you should take care of the baby and you should be aware of foods and what is going on each and every month, each and every week, what really is important [Indian participant].*

One Indian woman found that she was more engaged in her pregnancy because her previous pregnancy was a joint responsibility with other family members while this time round she had to take more personal responsibility:

> *Why didn't I get the feelings the first time? Time passed with families, mother in law, sisters, brothers and time passed like anything but here we are alone,*

thinking about the baby early and so every moment for me was a first time moment, even though I'm a second time mother [Indian participant].

Many husbands become more involved during the pregnancy and were more in tune with what was happening to their partner's bodies:

We used to wake up and the first thing we used to do was take a book and read 'Okay, so now our baby's doing that' and he will pat me on my tummy saying 'Oh my little one' you know? So I doubt whether the same feeling would have come if my pregnancy was in India [Indian participant].

In choosing a Lead maternity carer, the inability to communicate adequately in English meant that some women were prepared to have a Korean lead maternity carer (LMC) with a bad reputation rather than make themselves vulnerable with someone they could not communicate with:

I would still go for a Korean midwife. I was worried about my English too much to have a Kiwi midwife. This was why I chose a Korean midwife, who turned out to be infamous among Koreans. Even though there were more bad rumours about her than good ones, I had to choose her, as I had no other option [Indian participant].

Like the Korean participants, language dictated the choice of LMC for many Chinese women and they, more than any other cohort, relied on their networks to find a care provider with Chinese newspapers also being a useful knowledge resource.

She speaks English and can speak Chinese. After I met her, I had a good impression of her. So I decided to have her as my midwife. My midwife has a partner who is also a Chinese (Malaysian Chinese). When I gave birth to my child, her partner delivered my child. The whole process was quite smooth [Chinese participant].

Antenatal classes

Antenatal classes were a pivotal mechanism for acquiring knowledge:

When you know something it's better than just going without knowledge and you're worried. , Yeah and as a first time mother I didn't really know what was going to happen or what to expect and then yeah, I learnt a lot from that [Indian participant].

And for gaining confidence about what was to come by having some broad knowledge about what was to come:

I felt it was not so relevant to my delivery. But I felt more at ease and more confident during delivery. There are Chinese people in the class. The midwife was also careful when teaching us. We could understand her. My husband's English is very good. He escorted me to the class. It was about some basic ideas. I didn't find it useful for my delivery. During delivery, you follow the instructions of your midwife and have no time to reflect on what was taught in the class. But you feel relieved and less anxious. You roughly know what is going to happen and what is what [Chinese participant].

But language barriers made classes inaccessible for some:

I felt frustrated because I could not understand everything [Korean participant].

Both my husband and I have poor English so only attended once [Korean participant].

This section highlighted the importance of receiving detailed and specific information in one's own language and how this influences the choice of LMC or attendance at ante-natal classes. Knowing where to start can be difficult. For women and their husbands who want to take up an informed consumer role there are resources available which lead women and their husbands to be more self-sufficient, proactive and engaged in the process.

Labour and delivery

Labour and delivery was also a time when information, support and cultural needs were highlighted. Women wanted information that was specific to their stage of labour and that was individualised (some felt they had too much and others too little information to feel that they could make the best choice for themselves). The value of specific stage by stage information was supported by a Korean participant rather than broad encouragement:

In Korea mums are given lots of warning and feedback of what is happening during labour, and told by Dr's what to do regularly. This was missing in NZ. It would be good to be given feedback of our progress of labour and how many cm we are at each stage after the vaginal examinations. I was not told this. Not enough explanation and only told that "You are doing well" [Korean participant].

The need for not only specific information but also to be told the best option or given enough information to make the best choice was also voiced. The facilitative role of health providers was called into question with some participants wanting a more authoritative role. The partnership between the midwife and the woman underpins the midwifery model in New Zealand maternity services and is based on equity and the acknowledgement that both parties make equally valuable contributions (Pairman, 2001). Midwives bring their knowledge, skills and experience and the woman brings her knowledge of herself and her family and her needs and wishes for her pregnancy and birth. Midwives have moved from authoritative sources of knowledge to models of partnership and collaboration in a bid to empower women and distinguish themselves from the more hierarchical professional models of medical, nursing and obstetric practise (Tully, Daellenbach, & Guilliland, 1998). However, this is predicated on the notion of the informed consumer:

In NZ different delivery options are given to mums and we are asked to choose by ourselves but unable to choose the best options for ourselves due to lack of sufficient knowledge. Want more advice and guidance and even want to be told which better option for us is. So in the end we have limited options due to not enough knowledge of all the pros and cons of delivery methods [Korean participant].

Information does need to be individualised, one participant who felt that she was given too much information:

During the labour the ladies said that I need an epidural because I can't go through the pain anymore, the anaesthetist comes in the room and says out of 150 million there are 10% of cases with risk all that information beforehand [Indian Participant].

This section has highlighted the importance of detailed and specific information and the need for information to be individualised. The midwifery model of care which emphasises facilitative rather than authoritative relationships was challenged.

Post-partum

The postnatal period is a critical time for women but it is also a time when their needs are often not met (Baker, Choi, Henshaw, & Tree, 2005). In the postpartum, information needs were an issue, women needed to know how to handle an unpredictable and unknown baby, there were issues around feeding from a cultural point of view and what to feed and when, the amount and type of information became important too:

> *We need more information. Iron deficiency for example. We don't know what to feed our babies for this. And solid feeding too. We don't know how to begin solid feeding with Korean food. The information is only on Kiwi way of feeding [Korean participant].*

> *I didn't even know how to care for her after delivering baby. No knowledge. Had to cook and clean and do everything after delivering baby , had no one to help. Breastfeeding was hard, received no help. Got sore bones and joints. No Korean appropriate services available, so often missed out altogether on information and the right kind of help [Korean participant].*

However, not everyone wanted to be an informed consumer:

> *Yeah, you just want to get out of that place and these people are giving you like the advantages and disadvantages of various things, you don't want to hear all these things [Indian participant].*

The post-partum period highlights the need for the expansion of the information agenda from New Zealand models of infant feeding to incorporating other cultural models and the need for language specific information about breastfeeding. Some women contested the pressure to be informed consumers. The following section provides some discussion and recommendations.

DISCUSSION

This section focuses on five key areas where further exploration and consideration by both migrant mothers and health professionals would be beneficial, namely:

- Providing detailed and individualised information;
- Language support;
- Preparing women for new discourses of maternity;
- Developing fluency; and
- Developing health literacy.

Providing detailed and individualised information

Health-care providers have a responsibility to make available, accessible and up-to-date information. However this is not as easy as it sounds, when facilitating informed choice. Midwives and other health professionals are caught in a difficult position and have to strike other balances, such as between giving enough information for the woman to make a choice but not giving too much information and frightening her (Levy, 2006). They also have to delicately meet the needs of women and to appear neutral in their advice, when they might have strong feelings regarding certain issues. In this study, migrant mothers looked to health

professionals to fill the vacuum of knowledge by being authoritative rather than facilitative. Increasingly research shows that information is more effective when it is tailored to the individual and their needs (Rapport et al., 2006) and relevant to the women's current stage of pregnancy (Benn, Budge, & White, 1999). In addition detailed information rather than 'big picture' was valued. Therefore highlighting the need for individualised and detailed information when planning for the provision of maternity information (Soltani & Dickinson, 2005). Information that is available in ones own language or written information is important. While translated information is available about childbirth in New Zealand from the Maternity Services Consumer Council of New Zealand it is not clear how well this information is distributed or whether LMCs are aware of its existence.

Language support

Communication as a part of information support can be improved through implementing a two pronged strategy. First, health professionals and systems can become more skilful at information provision through linguistic competence and secondly through identifying and assisting in the extension of sources of information. Health providers can assist new migrants to identify information sources and encourage women to develop information seeking skills. Developing linguistic and cultural competence can be achieved by:

- Providing bilingual /bicultural staff;
- Providing foreign language interpreting services;
- Having link workers/advocates; and
- Having materials developed and tested for specific cultural, ethnic, and linguistic groups;

And having translation services including those of:

- Legally binding documents (for example, consent forms);
- Hospital signage;
- Health education materials; and
- Public awareness materials and campaigns, including ethnic media in languages other than English. Examples include television, radio, internet, newspapers and periodicals (Szczepura, 2005).

In the USA, health care organisations are required to both offer and provide language assistance services such as bilingual staff and interpreter services at no extra cost to clients who require it. It is recommended that information about services is provided both in writing and in a timely manner with credentialed interpreters and bilingual workers available (U.S. Dept. of Health and Human Services, 2003).

Lastly, research is needed to assess the level of unmet information needs among new migrant women in greater depth. To borrow from a recommendation from a recent study:

Research is needed on cross-cultural and intercultural communication in particular on the nature and impact on Culturally and Linguistically Diverse (CALD) people not being able to communicate with service providers; not being able to get information and explanations about 'what is going on'; not being able to get information in a timely manner; not being given information in a culturally appropriate manner; not being given any information at all; being given too much information; being given unwanted information (Johnstone & Kanitsaki, 2005, p.15).

Preparing women for new discourses of maternity

The study findings highlight the need for health providers to assist women socialise into new discourses in particular the discourse of partnership and the informed consumer. A useful mechanism for socialising women into an informed consumer discourse is to provide multi-lingual antenatal classes. Many women in this study felt the need for specific and detailed information in order to make the best choice but some women also wanted to be told the best option. The facilitative role of health providers was called into question with some participants wanting their LMC to have a more authoritative style. The partnership model underpinning midwifery in New Zealand maternity services assumes that midwives bring their knowledge, skills and experience and women brings their knowledge of themselves and their families to the relationship. This is intended to be a collaborative and empowering relationship but it requires that the woman wants the responsibility of being an informed consumer. It appears that the notion of partnership cannot contain women who don't want the equal responsibility that is required. In addition, one needs to be information literate in order to take this role on (Henwood, Wyatt, Hart, & Smith, 2003).

Developing fluency

Lack of English language proficiency impacts on access to health care, employment prospects, income levels and other factors which determine health status (Asian Public Health Project Team, 2003).The link between language and accessing health care is further strengthened by the findings of a New Zealand study where self-rated fair or poor health was found to be associated with Chinese-only reading knowledge, residency of more than five years and regretting having come to New Zealand (Abbott, Wong, Williams, Au, & Young, 2000). While a study of Chinese American women which found that lack of English language ability was a major barrier to access (Liang, Yuan, Mandelblatt, & Pasick, 2004). Ensuring that migrants are aware of Language line and encouraging them to take up their English for Migrants language courses, as proficiency is a key settlement enhancer. The migrant levy that migrants pay when coming to New Zealand entitles migrants to take up English language classes (English for Migrants). The Tertiary Education Commission pays for English language tuition on behalf of migrants to New Zealand who have pre-paid for their training, recent news reports indicate that few migrants take up these classes.

Developing health literacy

The development of health literacy among health care recipients is gaining prominence as a health promotion strategy. Health literacy is defined by the World Health Organisation as " the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health" (World Health Organization, 1998, p.10). Health literacy is a stronger predictor of health status than socio-economic status, age, or ethnic background (Speros, 2005). Speros claims that the lack of health literacy can act as a barrier to navigating the system and functioning successfully as a consumer, presumably then the combination of socio-economic status, ethnic background and low health literacy compound the issues of access. Speros cites a large study by Williams et al. (1995) which found that one-third of English -speaking patients at two public hospitals in the USA could not read and understand basic health-related materials. Sixty per cent could not understand a routine consent form, 26% could not understand information written on an appointment slip, and 42% failed to comprehend directions for taking medications. While little is known about health literacy is known in New Zealand, overseas research suggests that being culturally and linguistically different magnifies the problem.

CONCLUSION

This study highlights the importance of information provision for health care consumers, in particular migrant mothers. The study shows that migrant women frequently experience a vacuum of knowledge that needs to be filled. Factors such as poor English language proficiency, limited networks and unresponsive health providers can all increase the likelihood of migrant mothers experiencing a problematic birth experience and poor outcomes. This research suggests that improving the quality and range of information for migrant mothers and the inter-cultural resources for health providers could improve outcomes.

Further research is needed into how maternity information is provided and it is suggested that more attention is paid to the information needs of migrant mothers and migrants in general. Language proficiency is vital not only with regard to access to services but also for being empowered and prepared for the dual transition of parenthood in a new country. The study highlights the need for further exploration of changing demographics on dominant health care discourses in New Zealand such as partnership and whether there is space for new discourses. There are several aspects that contribute to a satisfying experience of health care for migrant mothers and these appear to be the ability to access a service, being able to obtain relevant information and having a supportive relationship between themselves and providers. These appear to be mutually dependent factors.

ACKNOWLEGDEMENTS

Funding for this research was provided by grants from The Families Commission and the Plunket Society volunteers in Central Auckland. The following people are gratefully acknowledged for their contributions: The mothers, Elaine Macfarlane, Sheryl Orton, Michele Hucker, Dr Wanzhen Gao, Rose Joudi, Paula Foreman, Rezwana Nazir, Lorna Wong, Jane Vernon, Zahra Maleki, Nagiba Mohamed, Hyeeun Kim, Catherine Hong and Stephanie Shennan.

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EXPERIENCE OF KOREAN ADOLESCENTS' ADJUSTMENT IN NEW ZEALAND: THINGS THAT HELP AND THINGS THAT IMPEDE

Grace Hyunjeong Kim

ABSTRACT

Korean ethnic group is one of the largest Asian ethnic groups in New Zealand with the highest growth rate. It is also a youthful and very recent immigrant group. This study attempts to explore the experience of Korean adolescents' adjustment in New Zealand and to illustrate things that help and things that impede their adjustment. In the study ten Korean adolescents were interviewed about their experience of living in New Zealand. They were asked to talk about the things that helped them and the things that were especially stressful for them. The data were analyzed using a thematic analysis. There were four themes on things that helped adjustment: 'Being Prepared', 'Being Open', 'Positive Interaction with Host-nationals', and 'Support from Koreans', and four themes on things that impeded adjustment: 'Being Distant', 'Rejection', 'Stress related to Other Koreans', and 'Future-oriented Worries'. Recommendations to improve the adjustment of Korean adolescents are provided.

Kim, G. H. (2006). Experience of Korean adolescents' adjustment in New Zealand: Things that help and things that impede. In S. Tse, M.E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp. 208-216). Auckland, New Zealand: University of Auckland.

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INTRODUCTION

When cross-cultural transitions are made acculturation occurs. Acculturation refers to changes that occur as a result of sustained cross-cultural contact between individuals of different cultural origins (Redfield, Linton & Herskovits, 1936). It has been suggested that acculturation can be further categorized into two adaptive outcomes: psychological adaptation and socio-cultural adaptation (Searle & Ward, 1990). The psychological adaptation is a set of internal psychological outcomes and socio-cultural adaptation refers to how individuals behaviourally adjust to the new context (Ward & Rana-Deuba, 1999).

Many researchers state that acculturation can lead to increased stress for the immigrants. As Ward's (1996) model of acculturation process suggests, the changes that accompany cross-cultural transition leave individuals with skills deficits and stress. More specifically, immigrants experience language difficulties, cultural difference, lack of social support, depression, anxiety, somatic complaints, identity confusion, and sense of marginality (Berry & Kim, 1988). Acculturating adolescents are especially vulnerable to acculturative stress, because they have to face acculturative challenges in addition to normative challenges adolescents face (e.g., formation of identity and independence (Berk, 2000). The most common difficulties among Asian adolescents can be found in the following areas: school (Zhou et al., 2003), family structure and interaction (Cho, 2002), other psychosocial and

cultural aspects (Lin & Yi, 1997; Park, Park, Choi & Cho, 2000; Ward, Bochner, & Furnham, 2001). Some New Zealand school counsellors and other mental health workers have shown concerns about the negative effects of stressors related to immigration on the psychological adjustment of immigrants (Jones, 1996; Aggett, 1996). Furthermore, the need for research in this field is high due to increasing number of immigrants in New Zealand (Statistics New Zealand, 2001).

While there appears to be an increase in most Asian ethnic groups, the 2001 census showed that the Korean ethnic group had the highest growth proportionately, increasing by more than 20 times in a decade (from 930 to 19,023) (Statistics New Zealand, 2001). It was also found that in the North Shore, Korean, in fact, was the most commonly spoken language after English (Ho, Au, Bedford, & Copper, 2002). Apart from the trend of rapid growth and its high density in Auckland urban area, 2001 Census (Statistics New Zealand, 2001) showed that Korean population is a youthful population with half of its population were under 24 years of age. It is also a very recent group of immigrants with 92% of the population being resident in New Zealand for less than 10 years.

Studying Korean adolescents in New Zealand is important for several reasons. Firstly, while there have been some studies with Chinese immigrants in New Zealand in the field of acculturative stress (e.g., Abbott et al., 1999; Florsheim, 1995; Eyou, Adair, & Dixon, 2000) there has been a lack of research on Korean group. Studies of Asian students in the U.S. showed that the Asian group is not homogeneous. For instance, Kuo and Tsai's (1986) study showed that compared to other Asian groups (Chinese, Japanese, and Filipino) Korean students scored higher in the overall index of adaptation difficulties (e.g., homesickness, English difficulties, and isolation from co-ethnic contacts). Another study showed that Chinese and Korean adolescents had higher perceived discrimination, and lower self-esteem than Filipino and other South Asian adolescents (Fang, 2001). Therefore, the investigation of Korean adolescents in New Zealand could reveal unique characteristics and factors associated with acculturation and psychological adjustment. Secondly, Korean adolescents in New Zealand have distinctive demographic characteristics, which could limit the generalizability of findings on other Asian adolescents in New Zealand (e.g., groups with a long history of immigration) and Korean adolescents in other countries. Thirdly, its recent migration history makes the Korean group a good example for studying acculturation (Lee, Sobal, & Frongiollo, 2003).

The main objectives of the study were:

1) To explore the experience of acculturation, and things that facilitate adjustment and things that impede adjustment of Korean adolescents in New Zealand.
2) To provide recommendations to individuals and organizations based on the findings

METHODOLOGY

The study consists of two parts: a qualitative exploratory study (Study One) and a quantitative survey study (Study Two). Study One consisted of semi-structure interview that aimed to explore experiences of Korean adolescents in New Zealand and things that helped and impeded their adjustment. Study Two consisted of a development and administration of a questionnaire based on the findings of the Study One to a larger sample. Questionnaires related to psychological adjustment and wellbeing were also administered to explore the aspects of the experience and demographic variables that were associated with psychological. This paper relates to Study One of the research.

In the current study 10 Korean adolescents (age 16 to 19) were recruited using a snowball technique (Table 1). The participants' years of residence ranged from 2.5 years to 15 years.

They were all living with family, but three participants (P4, P6, and P7) had earlier lived for a period away from the family in New Zealand. All participants had either permanent residency or citizenship, except one participant whose parents were on the work permit. The interviews were semi-structured and took around 1.5 hours. The participants were asked to talk about their experience of coming to New Zealand and living in New Zealand, satisfaction and stress levels at difference stages of settlement, and things that were stressful and things that were helpful in the process of adjustment. The interviews were mainly done in Korean and was transcribed and translated by the researcher. The interview data was analyzed using thematic analysis (Braun and Clarke, 2006).

Table 1. Demographic characteristics of participants.

Participant	Age	Gender	Years of residence in NZ	Residency status	Family in NZ
P 1	19	M	4	PR	Father & mother
P 2	18	M	6	Citizenship	Father, mother & sibling
P 3	17	F	6	Citizenship	Father, mother & sibling
P 4	18	F	4	PR	Father, mother & sibling
P 5	18	F	4	PR	Father, mother & sibling
P 6	16	F	2.5	Work Permit	Father, mother & sibling
P 7	17	M	2.5	PR	Father & mother
P 8	18	F	14	Citizenship	Father, mother & siblings
P 9	17	M	15	PR	Mother
P 10	17	F	9	Citizenship	Father, mother & sibling

NOTE: PR = permanent residency; NZ = New Zealand

RESULTS

Things that Help Korean Adolescents' Adjustment in New Zealand

Being prepared

There were some suggestions on what types of preparation for coming New Zealand could help Korean adolescents' adjustment in New Zealand. Firstly, there were practical aspects of preparation, such as studying English, finding out about the area they will settle, and having a sufficient time to prepare and move. Secondly, coming to New Zealand at an early age was thought to facilitate the adjustment. Coming to New Zealand in Year 3 or 4 was suggested to be an optimum time, since it allows them to speak both Korean and English and integrate both cultures relatively well.

> *"I came here when … I was 9 and my brother was 13. I adjusted better than my brother. I learned the language quicker... my brother was entering the adolescence at the time so he knew about being embarrassed, but at the time I didn't know anything like that so I would speak English to anyone... Year 4 and 5 is a good period (to move to New Zealand) because then they would know about both cultures."* [P10]

Thirdly, there were aspects related to mental preparation, such as having realistic expectations and willingness to change one's lifestyle. These prepared them for cultural shocks and difficulties, such as loneliness and racial discrimination.

Being open

All participants reported something that related to being open to new people, lifestyle, or environment in New Zealand. It was reported that taking initiative and being active and confident in social interactions with New Zealanders helped their adjustment. Being open

also meant having less prejudice against New Zealanders and less emphasis on how different they were from Koreans. Lastly, having a positive view on New Zealand's environment and lifestyle was reported to help their adjustment in New Zealand.

> *"Don't assume from the start that they (Kiwi) are different from us. Don't have prejudice. Don't assume that people will racially discriminate. Think of the good sides of people. Approach people as people, not as yellow, white, or black, and don't be scared."* [P4]

Social support from New Zealanders

Receiving emotional and practical support from teachers, peers, and neighbours in New Zealand were reported to facilitate Korean adolescents' adjustment. For instance, interaction with New Zealanders provided opportunities to learn English. Participating in group activities and sports at school with non-Koreans was also reported to have been helpful in adjusting to New Zealand. Moreover, some teachers provided additional attention and guidance to Korean adolescents for their learning. Emotional support was also provided by some teachers through encouragement and empathy.

> *"…when I was racially discriminated and bullied… I told one of my tutors about it and she was very understanding… she was tearful as she was listening to me and told me to work hard to prove to them that I can do well."* [P5]

Social support from Koreans

Participants received emotional and practical support from two groups of Koreans: family and friends. Family provided emotional support by making them feel secure and less lonely. Moreover, in the early stage of settlement family members provided opportunities to practice and learn English.

> *"A good thing about having the family in New Zealand is that you don't feel as lonely. When I was an international student I think I felt quite lonely… But now that I have my parents here I feel more secure and peaceful… because I have someone to lean on and to receive support from. As an international student I felt that I have to be responsible for everything."* [P1]

Talking to Korean friends provided emotional support, because they could speak their mother tongue language and could understand each other well given their similar situations and experiences. Korean peers also helped new Korean students by translating and interpreting things for them during the class.

Things that impede Korean adolescents' adjustment in New Zealand

Being distant

Cultural differences between Korean and New Zealand (i.e., cultural distance) were the main sources of acculturative stress for most participants. The language barrier and different culture and lifestyle impacted their level of stress as well as socio-cultural adjustment, such as making friends.

> *"I feel that kiwis are quite different from us… especially, in intermediate school… For example, if we (Korean) hang around with arms tied together they would call us lesbians and they would also tease some games we played. Also we eat lunch together, sharing our food, but Kiwis just eat their lunch… so they would say that we were disgusting… There were so many differences that I thought that even they accepted me (into their group) I didn't think would get along well with them."* [P10]

In addition to the cultural distance, the attitudes towards the differences were found to be important as well. For instance, having a strong preference towards Korea and Korean culture over New Zealand was related to low satisfaction and adjustment difficulties in New Zealand.

Rejection from New Zealanders

Experience of racial discrimination and bullying by New Zealand peers was a frequently emerged theme. In comparison to other themes, reports of racial discrimination were also described in a great detail and length. Most of the racial discrimination happened at school, by teachers and New Zealand peers. It was most reported when they were describing their initial stage of settlement. The inability to speak English fluently to defend oneself intensified their distress. Some also reported that some teachers ignored them in the class and treated them unfairly when there were conflicts between Koreans and New Zealanders at school.

> "*When I was around the lockers some Kiwis were playing with water balloons, which are forbidden in the school. They threw a water balloon at me and my friends and when I looked at them there was a teacher next to them, but the teacher told me to just go to the class and didn't even say a word to them... The teacher seemed to be discriminating other Asian students as well."* [P5]

While some participants learned to ignore racial discriminations and were less impacted by racial discrimination as time went, some continued to find them significantly stressful. Another form of 'rejection' from New Zealand peers was difficulty in getting into their cliques. It was perceived that they were not letting Korean adolescents regardless of how good their English was.

Stressful interactions with Koreans

Some types of interactions with other Koreans were reported to contribute to adjustment difficulties and stress. Firstly, having many Koreans at school was a barrier to interacting with New Zealand peers, because it led them to socialize with Korean students exclusively. This was because it was easier to get along with Koreans since they were more welcoming than others and there was no language barrier. Moreover, some felt guilty and 'weird' if they did not socialize with other Koreans in the same class. Secondly, some interactions with parents were found to be stressful. Those who have been living in New Zealand for a long period of time experienced intergenerational conflicts due to intergenerational differences in understanding of New Zealand culture.

> *"It's like I think my dad is quite strict… it's like if they don't do that I will lose Korean culture or heritage or sense of identity, Korean sense of identity. My dad is not familiar with the western culture so my dad gets really paranoid (of me hanging out with Kiwi friends)."* [P8]

Some also reported being pressured by their parents to socialize with New Zealand peers. For some participants, parents' dependence on them to assist them with English when making phone calls or sorting important things out was stressful, because they too felt unconfident in English.

Future-oriented worries

Worries related to studying, going to university and finding a career were frequently mentioned in the interview. Korean adolescents were stressed by their inadequate English proficiency and how it was affecting their studies. Stress related to studying and going to university increased as their grades went up and this was currently the most stressful factor for some participants.

> *"Stress increased as the grade went up. In college I am more stressed on studying than racism… I thought that because I've come to a foreign country I should study much harder. Since I don't know Korean culture that well I won't be able to get a job in Korea I should do well here, but since Kiwis speak English better than me I thought that I should study even harder."* [P10]

DISCUSSION

There appears to be five main domains that affect Korean adolescents' adjustment in New Zealand: 1) preparation, 2) attitudes toward changes, 3) interactions with New Zealanders, 4) interactions with other Koreans, and 5) attitudes toward future. Firstly, how they prepare practically and cognitively before coming to New Zealand influenced their adjustment. Having sufficient time to prepare, studying English, and having realistic expectations and ideas about New Zealand before coming to New Zealand facilitate Korean adolescents' adjustment, but having unrealistic expectations impede psychological adjustment. Secondly, being open to new people, culture, environment, and lifestyle helped. However, having a strong preference towards Korean culture over New Zealand and experiencing large cultural and environmental differences contributed to stress. Thirdly, positive interactions with New Zealanders facilitated adjustment. However, racial discrimination and bullying at schools by New Zealand peers or teachers and difficulties in making New Zealand friends were barriers to adjustment. Fourthly, emotional and practical support from Korean friends and family members helps their adjustments. However, having too many Korean peers at school, conflicts with parents and pressures from parents can impede adjustment. Furthermore, while intimate relationship with parents predict positive psychological adjustment, having only Korean friends, and not enjoying spending time with parents result in negative psychological outcomes. Lastly, being optimistic and confident about future and entering university predicted positive psychological adjustment. In contrast, worrying about studying, going to university and future contributed to stress.

There are potential limitations of the study, mainly in the characteristics of the sample of participants. Firstly, while three of the participants used live away from family as international students, currently none of the participants were international students. Therefore, the findings on the recent experience of adjustment in New Zealand might not be representative of international students. Secondly, the length of residence varied significantly among the participants. While two participants spent more years in New Zealand compared to years in Korea, most participants spent less time in New Zealand compared to the time in Korea. The experience and notion of adjustment appeared to be different between those who has grew up in New Zealand and those who came and tried to 'adjust' to New Zealand in later stage of their adolescence. Therefore, further study is needed to clarify any difference in the experience of living and adjusting in New Zealand among these groups. The representativeness of the findings of the current study, however, could be further explored in the subsequent study (Study Two); Study Two consisted of a larger sample (N = 153) with demographic characteristics that are likely to be more representative of the Korea adolescent population in New Zealand. Furthermore, relationships between demographic variables, experience of living in New Zealand, and psychological adjustment could be established in Study Two.

RECOMMENDATIONS

Apart from conceptualizing things that help and things that impede adjustment into five domains they can also be conceptualized into internal/ individual factors (e.g., cognitions, behaviours, and abilities) and external/ environmental factors (e.g., others, organizations, and

environment). Moreover, they also can be conceptualized in terms of time: things that occur before coming to New Zealand and those that occur after coming to New Zealand. Recommendations are outlined according to how the five domains can be implemented on these levels (Figure 1).

Figure 1. Recommendations on ways to facilitate Korean adolescents' adjustment in New Zealand.

	Internal factors	**External factors**
Before coming to New Zealand	- Realistic expectations about New Zealand - Studying English - Coming to New Zealand before intermediate school (around Year 3 - 4) - Sufficient time and practical preparation	- Orientation programmes - Cultural training programmes - Parents involving children in the decision making process
After coming to New Zealand	- Coping strategies to deal with racial discrimination - Open attitudes towards new culture and environment - Taking initiatives in interactions with new people - Willingness to adapt to New Zealand lifestyle	- 'Culturally safe' school - Counselling (career counseling and mentoring) - Korean staffs/ guidance counsellors at school - Programmes to support families and increase intimacy family members - Opportunities to explore recreational activities in New Zealand - Opportunities to interact with New Zealanders

Before Coming to New Zealand

After the decision to come to New Zealand individuals can start preparing by gathering information on life in New Zealand to form realistic expectations about living in New Zealand. Being informed of differences and difficulties they could encounter in New Zealand (e.g., culture shock) will be helpful. Individuals should also try to learn English as much as possible before coming to New Zealand, especially the conversational English. If possible, deciding to come to New Zealand in Year 3 – 4 will help to facilitate adjustment. Moreover, spending sufficient time to prepare is important, because it will give them time to say farewells to their friends and be mentally set for the transition. Providing orientation programmes and cultural training programmes by government agencies, education institutions or immigration agencies prior to their departure will help to make preparation easier and more practical.

After Coming to New Zealand

On the individual level being equipped with the coping strategies to deal with experiences of racial discrimination and other acculturative stresses will aid the adjustment. These could be taught through counselling, mentoring, or sharing of experiences with other peers. Moreover, having open and positive attitudes toward New Zealand culture and environment, taking initiatives in meeting new people, and willingness to adjust to New Zealand lifestyle should be

encouraged. Schools should be culturally safe, where teachers and students have awareness of other cultures and make active attempts to address racial discriminations and conflicts among students. This could be achieved by promoting positive interactions among different cultural groups through international days or cultural festivals, and raising awareness of racial discrimination and conflicts through education. Employing Korean staffs and Korean guidance counsellors could be helpful at schools with high number of Korean students. Schools and other organizations should also provide opportunities for Korean adolescents to explore recreational activities in New Zealand and to interact with New Zealanders. Lastly, since Korean adolescents' relationship with family is vital in their psychological wellbeing, programmes to promote intimacy, ways of spending quality time, and family's understanding of Korean adolescents should be implemented.

ACKNOWLEDGMENTS

I would like to thank my supervisors, Associate Professor Fred Seymour and Dr. Claire Cartwright for their continuous guidance and support in this research. I also thank all the participants for their contribution. I am also grateful to members of Korean Community Wellness Group for their feedback and support.

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THE OCCUPATIONAL LIVES OF IMMIGRANT INDIAN WOMEN: IMPLICATIONS FOR WELLBEING

Shoba Nayar

ABSTRACT

Increasingly New Zealand is becoming home to new immigrants from all parts of the world. This paper describes the findings of a small scale qualitative study into the things Indian women who have recently immigrated to New Zealand do in their everyday lives as they endeavour to settle into New Zealand society. The paper shows a pattern of engagement in self care, productive and leisure occupations that progresses over time and supports wellbeing, as the women learn about their new environment. Semi-structured interviews were carried out with eight women of Indian origin who had immigrated within the past five years. Using grounded theory methodology involving constant comparative analysis, a model explaining the occupational processes these immigrants experience was generated. Three interconnecting processes were identified. The first process women experience is 'Oh God, Where Did I Come?', which describes how being in an unfamiliar environment initially compels them to do familiar activities that boost their confidence and support wellbeing. The second process, 'Being In The Change', sees women getting to know their environment and engaging in new occupations, while continuing to do familiar activities. 'A New Zealander With An Indian Soul' finds women doing more occupations the 'Kiwi way' as they embrace a strengthening sense of self and wellbeing in a new land. Central to these processes is the core category Two Becoming One. This process is a commentary on the women's journey of integrating two cultures. The study highlights the importance of everyday activities in supporting wellbeing for Indian women recently migrated to New Zealand. Understanding this dynamic is essential for all those involved with working with immigrants, from health practitioners to policy makers.

Nayar, S. (2006). The occupational lives of immigrant Indian women: Implications for wellbeing. In S. Tse, M.E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp. 217-224). Auckland, New Zealand: University of Auckland.

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INTRODUCTION

For many people, establishing a home in a foreign country is not an easy transition and often more complex than anticipated. Certainly this complexity is identified within the occupational therapy literature, which acknowledges that immigration can be a stressful proposition that requires some form of adaptation and adjustment of valued occupations (Blair, 2000; Christiansen & Baum, 1997; Dyck, 1989; Hamilton, 2004). Occupation, in this instance, is taken to mean any task or activity that people undertake in their daily life that holds meaning and purpose for them. For those individuals struggling to meet the challenge of performing occupations in a new environment, overall wellbeing may decline. That is, occupations may

come to be characterized as uncomfortable, unfamiliar or energy intensive experiences that give rise to feelings of incompetence, frustration, foreignness and 'dis-ease'. Add to this the multiplicity of ways an individual's cultural values and beliefs may be confronted by the common-place practices and assumptions of the local people, and the potential for disruption to occupational performance and wellbeing is immense.

Between 1991 and 2001 the ethnic sector in New Zealand increased by 100%, mainly due to immigration, of which the largest ethnic communities are Chinese and Indian (Office of Ethnic Affairs, 2002). With the rising numbers of Asian immigrants entering the country, immigrants' welfare and success in settling in New Zealand is an emerging perspective in the current social and political climate. This paper explores the everyday occupations of recent Indian immigrant women to New Zealand engage in as they endeavour to settle in this society.

REVIEW OF LITERATURE

Within the disciplines of occupational therapy and occupational science, occupation, or one's daily activities are considered central to health and wellbeing (Kielhofner, 2002; Yerxa, 1998; Zemke & Clark, 1996). This perspective extends as far back as 1922, when Adolf Meyer expressed the belief that a person's everyday activities and experiences are primary resources for health (Meyer, 1977). Occupation is a means for utilising skills, engaging in personal interests and attaining satisfaction, all of which contribute to good health. Alternatively, a lack of occupation or disruption to occupation can be detrimental to wellbeing, in that not being able to engage in occupations that provide satisfaction may lead to ill health (Wilcock, 1996).

From an occupational perspective, people's health can be affected by any or all of the occupations they participate in, be that work, self care or leisure. However, the limited literature that addresses immigration from an occupational perspective tends to focus on work-related occupations. Similarly, New Zealand government policy over the past fifteen years has primarily focussed on work-related issues, particularly immigrants' education and skill levels. Nonetheless, many migrants find it difficult to enter the workforce and obtain employment appropriate to their qualifications and experience (Ethnic Affairs Service, 1996; Office of Ethnic Affairs, 2002). In a recent attempt to co-ordinate development of settlement support services which address the barriers some immigrants' experience, the government released the New Zealand Settlement Strategy (Department of Labour, 2005a). The Strategy outlines six goals for settlement, one of which is to support migrants in "obtaining employment", noting that "the speed with which they integrate into the labour market, finding work that fits with their skills and qualifications is a significant indicator of progress with settlement" (p. 5).

The social engagement and health needs of new migrants are also addressed, with three of the six Settlement Strategy goals pertaining to social aspects of settling in a new community. These goals relate to forming supportive social networks, participating in community and social activities, and supporting migrants to feel safe expressing their ethnic identity within the wider host community. In addition to these goals, the government's Ethnic Perspectives in Policy (Office of Ethnic Affairs, 2002) calls for an inclusive society, whereby people from different ethnic groups can be "seen, heard, included and accepted" (p. 1).

In addition to these general goals, government agencies and health professionals have been called on to address immigrants' mental health needs. For example, the Ministry of Health document Improving Mental Health: The Second National Mental Health and Addiction Plan 2005-2015 (2004) recognises that as immigrant numbers increase, so too does the number of immigrants accessing mental health services. Despite this knowledge, national strategies to

address the mental health issues of the full range of ethnic groups living in New Zealand have yet to be developed, although the Mental Health Commission has, called for more research into the needs of Asian immigrant women in particular (Ho et al., 2002).

METHODOLOGY AND METHODS

Grounded theory is a nonreductionist systematic approach to the simultaneous collection and processing of data to formulate theories that are "grounded" in the real world of the participant (Chenitz & Swanson, 1986; Glaser, 1998). Grounded theory assumes that social groups employ basic social processes to manage or ameliorate shared but unarticulated social problems, in this case, trying to do things in a new environment.

Ethical approval for the study was granted by the Auckland University of Technology Ethics Committee. Women who had immigrated to New Zealand from India within the past five years, and who were fluent in English were recruited. Data collection took place in Auckland during 2004-2005. The initial three participants were identified through intermediary contacts in the local Indian community and a snowballing was then used to recruit the remaining participants. The final sample contained eight women aged between 18 and 45 years, from throughout the Auckland region.

The interviews, each lasting about 90 minutes, were audio-taped and transcribed. Each participant received a transcribed copy of her interview as a means of ensuring accuracy. Three women responded to this. Data saturation was reached when no new information about the emerging theory was forthcoming from ongoing interviews.

Grounded theory as explicated by Strauss and Corbin (1998) served as the basis for analysis. Examination of the data and the categories generated led to formulation of hypotheses that were compared to the data, to the emerging categories, and to further, focused data collection and examination. This resulted in the emergence of a basic social process and theoretical model.

FINDINGS

Three processes emerged from data analysis and were named using the women's words, thus grounding them in the data. Each process captures the common experiences of the participants, while allowing for individual variations to be incorporated in the process. These processes do not stand in isolation from one another but at times overlap as the women move from one process into the next. In addition, the women's progression through the three processes is not always linear and at times they move back and forth between processes.

Oh God, Where Did I Come?

This process is the first stage in a process of settlement and a process in itself that encapsulates the experiences of those early days; arriving in a foreign country where everything appears new and unfamiliar. It identifies the feeling of 'not knowing' that occurs when entering a new environment, a feeling that has the potential to undermine wellbeing. The women respond to not knowing by performing familiar activities which engenders a sense of competence, thus facilitating wellbeing.

Familiarity is achieved through performing activities that relate to Keeping One's Culture and involve Sticking to the Known. Keeping One's Culture pertains to maintaining traditional practices, as part of sustaining wellbeing. Moreover, this strategy was pre-planned with many of the women bringing resources from home to ensure the continuation of cultural activities.

> *I do my Indian cooking… I brought all my vessels from India. So it's the vessels are the same. I've got my masalas, the ingredients, everything. The rice, whatever I cook in India, I still cook here. [Kate 5:12]*

The second strategy women use is Sticking to the Known. This is a technique for creating familiarity when performing daily occupations in a new environment. For some women this meant having a 'local' place, such as the supermarket, within which they could perform activities with minimal stress. Similarly, other participants reported deliberate repeat use of bus routes, petrol stations and shopping centres.

> *And I would just go to one supermarket. So that was easier for me you know, not going to a different one. I mean, if you go to a completely different one you kind of get lost. You don't know where's what. But if you're used to your own, you know where things are. [Megha 1:14]*

Engaging in activities that involve Keeping One's Culture and Sticking to the Known provides a sense of safety and support in an unfamiliar setting. *Oh God, Where Did I Come?* is the starting point for Indian women arriving in New Zealand. The need to change their ways of doing things and start integrating into their new community drives them towards *Being In The Change*.

Being in the Change

Although this process is a progression from *Oh God, Where Did I Come*, aspects of the two processes overlap. For instance, Keeping One's Culture is still important for many Indian women when *Being In The Change*, although not as crucial for feeling settled as when they first arrived. Thus the women still do occupations that are culturally based and familiar and in addition, actively explore their community, trying new activities or altering previous ways of performing activities.

In this process, the things that Indian women do are described as Gaining Skills and Expertise, Doing Things Differently, and Being Discriminating. Gaining Skills and Expertise involves initiating an unfamiliar activity and becoming increasingly competent at accomplishing the task. For the participants, Gaining Skills and Expertise often involved the assistance of friends or family and was acquired in a variety of occupations including household tasks, driving, employment, and leisure pursuits such as tramping.

Alongside Gaining Skills and Expertise they also start Doing Things Differently. Living in New Zealand is an opportunity to re-shape cultural expectations pertaining to the traditional roles women hold in Indian society. This includes, for example, being able to wear clothing commonly seen in New Zealand culture, which might not be so welcome in India.

> *The Kiwi culture gives me all the freedom to do things here. Especially in India, if you are single, if you are a widow of this age, 'What you're wearing shorts?' No, can't even imagine. But I love to. Here nobody bothers. It's New Zealand. Even my friend, when she came, her daughter is wearing shorts. She goes, 'Don't wear.' I said, 'Why did you come to New Zealand then? Why the hell you came to New Zealand?' [Girija 2:124]*

Feeling comfortable within their environment facilitates the increased doing that becomes evident in the women's process of now participating in activities shaped by the New Zealand culture. With a vast array of choices, these women can afford to Be Discriminating about which activities or aspects of their Indian culture they wish to retain, not only for themselves but for their family.

> *Ladies, ah women life is different over here but um, I like that. Like um, she [daughter] can live in house and she can look after the children, become a normal woman but she got a freedom. But like here, women got um, you know like here divorce and separation is very common. So all these things, like I want that freedom, I want that but in certain ways. Like she know her duties. She got the freedom but she know how to manage the house and husband, which ah, is hard to do. [Rajni 7:65]*

A New Zealander with An Indian Soul

This is a time for reflecting on the past, celebrating achievements and looking towards the future. As a process, it integrates the women's experiences thus far, drawing them further in to their new environment. Regarding daily activities, women are seen to hold on to traditional ways of doing things, while on some occasions adopting New Zealand practices. Sometimes the two cultures merge, as in the women taking Indian food to a pot luck dinner (a New Zealand custom).

Along their journey, women acquire knowledge and understanding about the New Zealand environment, so that in this process, they are familiar with their surroundings. This familiarity means the women now seek to do more, Pursuing Opportunities. Pursuing involves both creating and taking Opportunities in all facets of life, to assist with the settlement process.

> *I went to this ah, kindergarten. In fact I just went there to ask about my children. You know, wanting to put my children into the day care and ah, this Kiwi lady, the director happened to be there on that day. And ah, while I was talking to her, she was asking me a lot of questions about me, more than about my children and ah, she um, immediately, she sort of interviewed me on the spot and ah, told me that she quite liked me and would like to you know, um, hire me or whatever… And she told me that you know, ah if I need you, will you be able to come in and all. And I didn't expect, and the very next morning I got a call from this place telling me would you come to relieve and within a week of me working there, they offered me a part time job over there. [Kate 5:100-102]*

However, women can not always predict the challenges they may face in the future, and so have to Persevere with establishing the things they want or need to do. Persevering propels women to further themselves, recognising their full potential, thus promoting feelings of competence and optimism for the future.

> *Finding my job and working towards, I'm still working towards my career. I'm going to start working towards my registration as a psychologist, so that's quite a challenge for me still. I mean, I know I have to work hard, I mean I've been accepted for registration but I haven't gone with the plans yet. [Megha 1:62]*

During this process, women perform occupations they feel comfortable with. These occupations may be shaped by the New Zealand environment or stem from their Indian heritage. Choosing which occupations to engage in, and knowing they can do them with ease, is one way in which the women know they have settled as immigrants in a new society.

IMPLICATIONS OF STUDY TO NEW ZEALAND SOCIETY

The findings of this study hold important understandings for those involved with new immigrants such as, health professionals, policy makers and immigrant support services.

Health Professionals
As mentioned earlier, the mental health system is providing services to an increasing number of immigrants, who are facing difficulties with establishing life in a new culture (Ho et al., 2002). As my study highlights, a variety of occupations need to be adapted or learned anew, which can make establishing a new life more difficult. Health professionals can help ease some of the difficulties by working with immigrants not only to manage their mental health but to identify daily occupations in which they can engage which enhances their sense of competence and facilitates wellbeing. Placing more emphasis on the importance of maintaining daily activities and routines may prove an effective strategy by health professionals in reducing the numbers of immigrants needing to access health services over a sustained period of time.

Policy Makers
While the New Zealand government has policies in place to aid with the settlement of immigrants (Department of Labour, 2005a; Department of Labour, 2005b; New Zealand Immigration Service, 2004b) there is growing need for local government to provide hands on services to support immigrants with settlement issues. When considering the topic of occupation, currently the focus of support services is on occupation in the sense of finding 'paid employment' for new immigrants. This study considers occupation to be broader than work and would propose the need for services to consider the importance of everyday activities and the impact these have in determining how positive new immigrants feel about their journey towards settlement in New Zealand.

Immigrant Support Services
Arriving in a new country, with different environments for performing activities (e.g., supermarket) and differing values both individual and societal can make performing everyday occupations a difficult experience. Understanding some of these differences is vital for Immigrant Support Services to ease the transition of new migrants.

This study identified that for many of the women, having initial assistance from others helped with learning where and how to perform occupations. The primary form of support women identified was in the practical support of having someone to do the occupation alongside them. Therefore, services may need to consider the use of support workers to either go with immigrants or help them perform everyday activities or provide instructions to follow.

Services may also need to consider how to link new immigrants with people with sufficient local knowledge to be able to help them perform everyday activities, such as making use of public transport in order to access shops and other community settings. Ongoing educational services may prove beneficial to impart information on accessing health services and formal education, as well as community services such as getting appliances repaired. In considering the need for support around everyday activities or occupations, services need to consistently evaluate how best to implement support.

CONCLUSIONS

This study sought to answer the question "how do the things Indian women do in a new culture, support their sense of self and wellbeing?" It has generated answers that are founded on the understandings of Indian women who have immigrated to New Zealand within the last five years and who have had to make changes to their occupations to successfully live a healthy life in a new culture. The things immigrant Indian women do form three interactive and interdependent processes, *Oh God, Where Did I Come?*, *Being In The Change*, and *A New Zealander With An Indian Soul*.

Supporting immigrants to engage in everyday occupations in a new and unfamiliar place, is likely to increase their ability to master new ways of doing things and thus facilitate the development or nurturing of a positive sense of self and wellbeing. This in turn will ease the stress implicit in the process of integrating into a new culture. Any changes that are made by immigration support services will need to be researched to explore the effectiveness of such measures.

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AN INNOVATIVE GROUP APPROACH: Bo Ai She – A CHINESE MENTAL HEALTH CONSUMER PEER SUPPORT GROUP – CHALLENGES AND FUTURE DIRECTIONS

Wenli Zhang and Suet Yi Wong

ABSTRACT

Culture shame and disgrace from suffering mental health illness have often been cited as negative factors, further isolating individuals from available support services and undermining the acceptance and effectiveness of peer support groups. Thus, Chinese migrants with mental health illness who are already deprived of their own support network, would be further divorced from support networks at a time when they are highly in need of collective support.
This paper examines an innovative approach in the setting up of peer support groups that are receptive by, and effective for the Chinese Mental Health Consumers and their families. The authors walk a tight rope, balancing between the provision of support to empower, and assist in the development of collective esteem, on the one hand, and the risk of heightened rivalry mutual discrimination and fear of disclosure of the identity as mental health patients on the other. The authors both describe and discuss effective, and culturally acceptable techniques to engage individuals by the development of rapport via intermediaries, and the expression of compassion and personal empowerment. Group identity, cohesiveness and integrity are enhanced through the sharing of cultural values such as the encouragement of individuals to partake in collective honour established through achievements of the group and increasing social status and recognition by the community at large. At the same time, the authors have no hesitation in the application of authority vested in them by tradition as healers to overcome internal rivalry. The end result is the development of a new extended family amongst compatriots for clients in their home away from home.
In the paper, we also describe the advantages and benefits of such peer support groups; the challenges, the means of overcoming those challenges and the restoration of the sense of empowerment to mental health consumers. We have also discussed the direction of Chinese consumer-led support groups.

Zhang, W., & Wong, S. Y. (2006). An innovative group approach: Bo Ai She–a Chinese mental health consumer peer support group – challenges and future directions. In S. Tse, M.E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), *Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14,* (pp.225-230). Auckland, New Zealand: University of Auckland.

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INTRODUCTION

Chinese has long history of migration to New Zealand. According to New Zealand Government Statistic, Chinese Population has raised from 1.3 % from 1996 to 3 % in 2001 of the total New Zealand population. Migration often is a source of stress to migrants who have

to adapt to the new country. According to Abbott (1997), loss of support from old culture, difficulties in adjusting to new environment (language and cultural differences) and other practical issues such as work, finance, transportation, housing and health could affect the mental well being of new migrants.

For those who has already experienced trauma, social ridicule in the home country, the additional need to adjust to a new environment and being confronted by a perceived discriminatory environment could play havoc on their mental well being. As a double jeopardy in Chinese traditional mental health concept, people who suffer mental illness are treated as permanent outcasts of society (the term “life long patients”). Most of them felt banished from society as mental patients; to complicate matters, locked in hospital or in supervised residential environments. Cultural shame and stigmatisation and lack of understanding of mental health prevent them from seeking help. Health statistics has shown a low utilisation rate of mental health system as compared to other minority groups. These circumstances create significant challenges for the New Zealand government agencies and the Asian communities as well. The key point is ‘how’ these agencies could respond to the challenges in the way that could effectively integrate the values, morals and philosophies of ethnic communities (Yee, 2003).

The “Recovery Principle” has been widely adopted by the New Zealand mental health services to assist consumers to manage their psychiatric symptoms. As a consequence to that, a number of service delivery models and strategies have recently been developed. The use of community mental health services have proved to be effective in reducing the rate of hospitalisation and improving the quality of life for service users (Jacobson & Greenley, 2001; Mead & Copeland, 2001; Rapp, 1998 ; Tse, 2004).

Bo Ai She is a Chinese mental health consumer peer support group which was set up in Auckland in 2003. This arises from the Chinese concept of “people on the same boat could care for each other”. This aged old saying from the Sages is well accepted and has proven useful in combating the double / triple jeopardise quoted earlier, to provide mutual support, create unity, and more importantly, empower and give mental health consumers an enclave, a jumping board to launch their recovery. The group initially began as a spin-off from the Wellness Recovery Action Plan program (WRAP), but gradually evolved to include social advocacy and self-direction functions. The following is a description of WRAP program and the development of Bo Ai She. This would be followed by discussion on the advantage and benefits of such peer support groups, the drawbacks, the challenges and the future directions.

WELLNESS RECOVERY ACTION PLAN AND THE ESTABLISHMENT OF BO AI SHE

The Wellness Recovery Action Plan (WRAP) is developed by Mary Ellen Copeland (1997) and other survivors of mental illness. The consumers have ownership of the plan, which is a living document. The WRAP programme has helped mental health consumers developed plans to control symptoms and reclaim a more positive lifestyle (Mead & Copeland, 2001). In 2001 and 2002, Mary Ellen was sponsored by Te Korowai Aroha, a non-government community mental health organisation, to provide WRAP and WRAP facilitator training in New Zealand. One of the authors had the opportunity to attend these trainings and started facilitating the WRAP programme for Chinese clients. After running two successful WRAP groups, the facilitator and some of the participants felt a need to continue the companionship and enjoy the support they had from each other, they all opted to set up a formal peer support group.

Bo Ai She: The Past and The Present

In the earlier stage of the development, BAS has gone through a difficulty time and the group was in danger of disintegration. Two key conflicts between the group members were identified: (1) the notion of "who is in charge"; (2) conflicts around how the activities should be operated. At the end of 2003, after an intense and serious discussion, the group made a decision to invite representatives from the Chinese Mental Health Consultation Service, a local culture appropriate multi-disciplinary body, to join their committee. During committee meetings, members agreed that in peer support group should have:

- Equity and no hierarchy
- Collective decision making power
- Mutual respect and support from each other
- Equal opportunities for learning and sharing among the members
- An awareness on the individual's personal limitation and promote own self care
- Flexibility in group development
- Working in partnership with mental health professionals

Culturally, Chinese people respect authority; this is a challenge for us how to create an environment which empowers the group members to reclaim their life through professional knowledge by being positive role models. We have to be mindful that too dialectical and over involvement of the "authorities" would induce shame and a sense of being trivialised – a problem our members were very familiar with prior to their joining the group.

The year of 2004 was the transition stage for BAS. The group started having regular meeting fortnightly in a community hall for group members. They also started to launch a program to invite new members to join the group. During the year 2005, BAS has walked a big step toward a fully functional peer support group. The committee had a planning day and adopted Lao 'Tsu's word as their Philosophy - "The journey of a thousand miles starts with just one step". The BAS set up their Vision which is "to promote the mental health of the Chinese consumers and to ensure that they gain a healthy living". Their Missions are to create and promote an anti-discriminatory attitude against the stigma of mental illnesses; to maintain, preserve and foster the rights of the Chinese mental health consumers; to bring hopes to consumers and to assist them to instigate their utmost potentials. In another word, the group started to launch from a mutual support group into a functional group which promotes social advocacy and self-directness – an important mental health ingredient regardless of whether our members are of Oriental or Occidental origin.

Benefit of Consumer Peer Support Group

From our experience and observation that the benefits of setting up Bo Ai She are:

- Inducing a sense of hope by setting up positive role models - Hope is the most important factor in everyone's life particularly in a person's recovery (Adams & Partee, 1998; Deegan, 1996)
- Equity and safety – Through mutual respect and support, members feel that they are equal and safe to express their feelings and thoughts in Bo Ai She. There is no room for "power over" (Deegan, 1996).
- Reducing loneliness - Members shared same language and cultural background. Most of them find that developing friendships based on love and mutual respect is very important to their recovery. Relationship can heal (Deegan, 2005).
- Sense of belongings - Bo Ai She has become the member's extent family and created a strong sense of belongings that increased their confidence (a launch pad) to integrate into the wider society. Mental health patients require a sense of belonging and it only occurs in the context and in the transaction with others (Rapp, 1998).

- Mutual support and being valued - BAS has provided an opportunity for members to offer their support to each other, which has greatly increased their self-esteem and sense of being valued.
- Being a valued member of the society - BAS has become a place for members to learn the mental health system and the New Zealand society.
- Learning, practicing and growing - Members learned how to build relationships with other people in organizing the group activities; how to handle conflicts and stresses arising from running the group; and how to cope with member's crisis situations.

In summary, unlike their occidental counterparts, although Chinese have by-and-large an external locus of control, group mastery of lives vicissitudes has been the usual means of coping for thousand of years.

ADVANTAGES AND DISADVANTAGES OF THE CONSUMER PEER SUPPORT GROUP

Due to lack of access to the mainstream mental health service system and strong stigma for mental illness in Chinese communities, Chinese consumers are far behind in the consumer movement compare to their western counterparts. We have made a step ahead to shift our members' pessimistic attitude over the notion of mental disorder- from being dependent and passively waiting for treatment to becoming more actively and positively taking control over their own recovery journey. This shift has not only transformed the cultural belief that mental illness is incurable to a more realistic view that a full recovery is possible, it has also helped the members focus on their strength rather than their weaknesses. Of note is the change in the relationship between the professional and the consumers, that is, from having power over them to working with them in partnership. It is the authors' experience and our belief that mental health professionals should play a significant role in helping our clients, but the way they play their role should be of a power key nature which allows our consumers to take charge of their own recovery journey.

The authors have identified several advantages through the consumers' involvement in the operating of Bo Ai She. They are described as followings:

1. Balancing the power struggle – being fair, leadership and role model (mediators) eg. Demonstrating a win-win conflict solving skill while operating the committee
2. Providing training to the committees
3. Working closely togetherness – open communication between professionals / co-ordinator / committee members
4. Overseeing the mental states of members especially members in the committee who are subjugated too much pressures. The professional helped to dampen these pressures and taking over responsibility if necessary.
5. Providing a sense of security for group members with hope of recovery.
6. Providing support to build wide network with other agencies

There are also some disadvantages in such a consumer peer support group. The following points are identified by the authors:

- Rely on professional guidance – delay independence process
- Power struggle among specific group members, creating conflicts but more importantly, increasing an intra-group psycho-social pressure which may hinder the recovery of some consumers. (See above how this could be dealt with by professional involvement).
- The negative impact as a result of witnessing a relapse from other group members. The danger of a consumer driven group could be that without objective views, consumers would adopt increasing negative attitudes towards illness and society, becoming a marginalised group. Patient's relapse often has some form of impact on

members in a negative way. This could be rectified by early identification and positive reframing by the professionals.

- The issue of sub-group fragmentation - Chinese in New Zealand are a heterogeneous groups from various subculture e.g., local born, China, Taiwan etc. Intra group rivalry which based on countries of origin is not an uncommon occurrence. Encouraging members to be compassionate to each other could be a challenging task. .
- Danger of segregation as a Chinese group and not being able to integrate into New Zealand society

DIFFICULTIES ENCOUNTERED AND CHALLENGES IN THE FUTURE

Bo Ai She is overstretched in human resource. Because its financial constraints it is unable to provide a permanent position and we are under constant pressure to apply for funding for our survival. There is skepticism about the concept of consumer movement in Chinese community and Bo Ai She has been deprived in community provision. Other difficulties have already been highlighted under the section of disadvantages. All these factors have delayed the future development of this organisation and reduced the opportunity for more people to benefit from this innovative recovery approach.

The challenges for this organisation and professionals are:

- Empowerment - Balance to power: maintaining partnership relationship
- Dependency vs independency and interdependency
- Nurturing vs overprotection
- Culture sensitivity vs culture effectiveness
- Integrating of patients into the larger multi-ethnic New Zealand society.

CONCLUSION

It has often been said that the Chinese are highly family- orientated to the extent of being exclusive and insensitive to those outside the family circle. Hence, support groups are never easily accepted. Moreover, intra-ethnic rivalry between sub-cultures, shame and fear of breach of confidentiality have all but undermined the benefits of such groups and added a new dimension of difficulties to the effective operation of these groups.

But our experiences have demonstrated that contrary to common beliefs, the Chinese culture has great latitudes and flexibility not often known to others. There are cultural concepts that provide alternatives to counteract the resistance allegedly prescribed by culture to new ideas and to increase acceptances. However, one needs to have the patience, and the finesse of a high wire walker in order to bridge the divide between acceptance and rejection.

We have examined an innovative approach in the setting up of peer support groups that are receptive by, and effective for the Chinese Mental Health Consumers and their families. The authors walk a tight rope, balancing between the provision of support to empower, and assist in the development of collective esteem, on the one hand, and the risk of heightened rivalry mutual discrimination and fear of disclosure of the identity as mental health patients on the other. The authors both describe and discuss effective, and culturally acceptable techniques to engage individuals by the development of rapport via intermediaries, and the expression of compassion and personal empowerment. Group identity, cohesiveness and integrity are enhanced through the sharing of cultural values such as the encouragement of individuals to partake in collective honour established through achievements of the group and increasing social status and recognition by the community at large. At the same time, the authors have no hesitation in the application of authority vested in them by tradition as healers to overcome internal rivalry. The end result is the development of a new extended family amongst

compatriots for clients in their home away from home.

We will end this paper by quotes from two Chinese sayings which often help to increase group support:

> *"Whilse one depends on ones parents at home; one should rely on friends when venturing outside."*
>
> *"People on the same boat should help each other."*

We never cease to be amazed by the foresight of our ancestors who has sayings for all conceivable human interactions.

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WHY DO WE CHOOSE "MUSIC" IN PROMOTING MENTAL HEALTH?

Ronald Ma

ABSTRACT

Music, English playwright, William Congreve observed, "has charms to soothe a savage breast."

Meanwhile cellist, Yo-Yo Ma once commented, "Healing? I think that is what music is all about. Don't you?" (Source:The Power of Music) (Hanson 2004)

Participants in community activities have better health outcomes than non-participants. Participation in music, a creative activity, can develop supportive social networks and stronger communities, and better health and well-being. For young people, involvement in creative activity can improve academic achievement, school retention rates, self-esteem and reduced drug and alcohol consumption and juvenile offending (VicHealth, 2005a). Music is the leading arts therapy discipline (Hanson, 2004). Music can heal individuals and communities (Hanson, 2004). The power of music is its ability to bring diverse people together regardless of ethnicity, age, sex, religion and political beliefs around a common interest and sense of purpose. Music naturally reverberates, permeates, and goes through boundaries and walls. It calls to others, attracts, gathers, connects people together. It creates community. That is called, "ripple effect" (Pavlicevic & Ansdell, 2004). Musically-driven Mental Health Promotion (MMHP) is an innovative approach to promote positive mental health in Asian immigrants and refugees. MMHP can also be seen as a culturally-appropriate public health approach to promote mental health by combining the power of music and the power of health promotion.

This paper is to highlight the idea of arts participation in promoting positive mental health through music. Music can make the participants of the SmoothStream community band feel a sense of achievement, self-esteem, empowerment, and have lots of fun. The SmoothStream band is showing us real promising results everyday in terms of establishing informal social support network, which seems to be the most important resource for positive mental health.

Ma, R. (2006). Why do we choose "music" in promoting mental health? In S. Tse, M.E. Hoque, K. Rasanathan, M. Chatterji, R. Wee, S. Garg, & Y. Ratnasabapathy (Eds.), Prevention, protection and promotion. Proceedings of the Second International Asian Health and Wellbeing Conference, November 11, 13-14, (pp. 231-236). Auckland, New Zealand: University of Auckland.

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MENTAL HEALTH PROMOTION

The global health issues are now rapidly changing. At the start of the 21st century, the public health sector is facing new challenges such as globalisation, degenerative diseases,

evidence-based practice and cost-effectiveness. On top of those challenges, yet suddenly, community mental health seems to have become a major health issue around the world with the release of the recent WHO report in which depression is identified to be heading the list of ten leading causes of DALYs (the Disability Adjusted Life Year lost) (Mathers & Loncar, 2005). The report is essentially a powerful driving force behind the upsurge of interest in mental health promotion which is believed to be the greatest tool to tackle this global health problem. However, public health seems to remain preoccupied with limited number of physical diseases instead of setting its priorities in pursuit of mental healthiness, happiness and well-being. Community stress is everywhere. Discrimination, social isolation, depression, anxiety and suicidal thoughts are interrelated social problems, which eventually lead to mental health concerns in the community (Ministry of Health, 2002), especially in disadvantaged population groups such as ethnic minorities and migrants.

New Zealand has deteriorated dramatically from its 'one of the world's best' mental health and social health points over the past fifteen years (Raeburn, 2001). For example, youth suicide rate has gone from relatively low rates to reputedly the highest rate in the OECD countries and rates of violent offenses are now the highest in the world except South Africa (The United States exceeds New Zealand in homicides only). New Zealand went from the most equitable and egalitarian country in the world to the third most inequitable country in the OECD, which shows that there is a significant gap between rich and poor, which is in-turn highly associated with mental and social distress and lack of social cohesion.

All of those poor health and social indicators in New Zealand are alarming and mostly of community issues. The migrants and refugees are of no exception in this case. The longer migrants live in New Zealand, the poorer their health becomes (The New Zealand Herald, 2006). Mental health issues for Asian ethnic minority groups are the greatest concern in New Zealand, because they are more vulnerable to culture shock and higher degree of social isolation (Ho, Au, Bedford, & Cooper, 2003). The top three migration-related stresses in Asians are unemployment, language difficulties and culture shock, which can give rise to health and social consequences such as depression, anxiety, physical health deterioration, teenage pregnancies, divorce, domestic violence, alcohol-related and gambling-related crimes (Ma, 2004). Mental health promotion has significant potential to increase control over those migration-related stresses and mental health issues, and to promote mental well-being of immigrants and refugees

In the past, mental health promotion activities were dominated by prevention with promotion approaches targeted at 'at risk' groups or aimed at changing individuals' behaviours and risk factors. The challenge for health promoters is to move the focus from changing individuals to changing society as a whole to achieve our ultimate goal, that is the quality of life (Sainsbury, 2003). Now it is the time to focus the mental health promotion on all population groups or positive mental health promotion, not only for those with at risk or with mental illness.

However, mental health promotion in New Zealand is still in its infancy (Williams, McCreanor, & Barnes, 2003). There is no single way to promote mental health to include all population groups, because mental health is the result of many interacting factors and also communities are made up of a diverse range of people. So, efforts to promote mental health need to consider a variety of strategies and approaches that are relevant to the full range of population groups (Willinsky, 1999). A mental health promotion initiative should also be innovative and culturally-appropriate, especially in New Zealand in which its society is becoming more and more multi-cultural. So, how to promote mental well-being in multicultural societies?

WE CHOSE MUSIC TO PROMOTE MENTAL HEALTH

Music, English playwright, William Congreve observed, "has charms to soothe a savage breast."

Meanwhile cellist, Yo-Yo Ma once commented, "Healing? I think that is what music is all about. Don't you?"

The Power of Music (Hanson, 2004)

Music has two advantages. Firstly, music can create community. Secondly, music has therapeutic value. Let us look at it in more detail.

Music Can Create Community

Music has great opportunities to promote general health and mental well-being (USA for Africa, 2006; VicHealth, 2005b; Williams, McCreanor, & Barnes, 2003). We know that social connection is important for health. Music provides an opportunity for many voices to be heard, not just a few, so that it is good for everyone's mental health. Music can reach people by way of expression of the values and concerns that are communicated powerfully across the world. The result is the sense of meaning, which is a crucial element in positive mental health (VicHealth, 2004a). The Victorian Health Promotion Foundation (VicHealth) claims, "Have you ever listened to a song that rocked your world, read a book that changed you forever, seen a play or a film that made you walk out into a different world than the one you left behind just hours before? Most of us have. That's why VicHealth's investment in the arts is so powerful. Not only does it work for the participants, transforming lives in ways that can only be beneficial to health, but it can also, when done well, affect the audience: potentially altering perceptions; increasing understanding and respect for other views; and, in the process, improving a community's health" (VicHealth, 2004a).

Participants in community activities have better health outcomes than non-participants; especially those participants in creative activity who can develop supportive social networks, stronger communities, better health and increased well-being. For young people, involvement in creative activity can improve academic achievement, school retention rates, self-esteem and reduced drug and alcohol consumption and juvenile offending (VicHealth, 2005a). Community-based arts activity makes considerable contribution to community health (VicHealth, 2003). The results from the VicHealth's Community Arts Participation Scheme showed positive achievements in health outcomes such as enhanced social connectedness, valuing diversity and freedom from discrimination and violence, and economic participation and meaningful engagement (Williams, McCreanor, & Barnes, 2003). "Community Singing Across Victoria" in Australia and "Singing with Conviction" in New Zealand are committed to furthering and disseminating the evidence of the link between music and health (Arts Access Aotearoa, 2005; VicHealth, 2004b).

Music is a universal language across all cultural groups. The power of music is its ability to bring diverse people together regardless of disability, ethnicity, age, gender, religion and political beliefs around a common interest and sense of purpose. Music naturally reverberates, permeates, and goes through boundaries and walls. It calls to others, attracts, gathers, connects people together. It creates community. That is called, "ripple effect" (Pavlicevic & Ansdell, 2004). Music is also culturally-appropriate, because music is the heart of the culture (VicHealth, 2004a). Music has the power of community development and so is the power of mental health promotion. Therefore, music is an excellent tool to promote mental well-being of multicultural societies.

Music Has Therapeutic Value

Music has more than entertainment value. Melding of music and medicine that have been conjoined since the Greek god Zeus appointed his son Apollo as god of both. Apollo was a gifted musician and taught humans the art of healing and bestowed the gift of prophecy on those mortals he loved (Sammon, 1997). Music has therapeutic value on both individuals and communities, especially in its creative component (Hanson, 2004; Turry, 2005). That is why, physicians have approached music as therapy for generations.

Music is the leading arts therapy discipline, because music can heal individuals and communities (Hanson, 2004). Music, an aural stimulant, can evoke psycho-physiological response (Kneafsey, 1997). Music can reduce agitation and situational anxiety. Music can create significant mood changes. Music can facilitate communication and mobility. Music unlocks both body and soul. Music creates a healing environment that encourages meaningful emotional expression, free from confines of language and words. Music creates an atmosphere of beauty, peace, and reverence for all participants in the therapeutic settings (Young-Mason, 2002). Its goal as therapy is the reduction of stress, pain, anxiety and isolation. Music can improve the wellbeing of people. Music is sometimes better than any medicine for those purposes. Stige (1998), the prominent author from the music therapy world, summarised as music is a social thing, it is interaction, communication and community (Stige, 1998). The most recent progress in the music therapy is "community music therapy", which extends the practice of music therapists well beyond the confines of therapy rooms. The community music therapy seems to be very promising for mental health promotion.

Music is also used in workplaces to promote mental well-being and to improve productivity. Big corporations such as the oil giant BP and leading law firm Lovells pay for special singing workshops for their staff (Hanson, 2004). So, music has the power of healing and the power of community development.

Music Has The Power Of Healing And The Power Of Mental Health Promotion

"It makes sense. If you're part of a singing group you're connecting with other people, you feel a sense of achievement and most importantly, you're having fun. Every neighbourhood should have a singing group"

Rob Moodie, VicHealth Chief Executive Officer and singer (VicHealth, 2004b)

A United Kingdom study of members of a university college choral society found that participants had benefited socially and emotionally by being involved in the choir. A second study found six dimensions of benefit associated with singing such as better wellbeing and relaxation, improved breathing and posture, social, spiritual and emotional benefits and boosts to both the heart and the immune system (VicHealth, 2004b).

In summary, music has the power of healing, the power of community development and the power of mental health promotion. Therefore, we chose music to promote mental health.

Make Somebody Happy, Make Somebody Strong

The SmoothStream community band or Musically-driven Mental Health Promotion initiative is showing us real promising results everyday in terms of establishing informal social support networks, which seems to be the most important resource for positive mental health. The band participated in cultural events and community festivals. The harmony we created was mental healthiness, happiness and well-being. The melody we composed was all about 'community identity', 'community-esteem', 'community empowerment', 'community resilience' and 'strength'. This is what the mental health promotion is meant to be. A long-term

longitudinal study of the project outcomes is also underway. One of the success factors is 'back to the basics' in this world of high technology, market economy and globalisation where our social norms have been changed. The SmoothStream community has re-discovered and adopted a century-old close-knit rural community lifestyle in this modern society. We also use 'music', which is truly universal and time-tested in the art of creating community and in the science of promoting mental well-being. The SmoothStream keeps singing those harmonies and melodies in pursuit of happiness, which is a new domain of public health in the 21st century. And start, for once, to think about the power of music.

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