WHAT FACILITATES MENTAL HEALTH HELP-SEEKING?
A COMPARATIVE STUDY OF THE CHINESE AND NORDIC CONTEXT

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Acknowledgements

I still remember the time when I was working on the first assignment of NOSWEL program. I was constantly worried and doubtful about my ability to finish an academic essay in a second language, which I had never tried before. When I found it impossible to even start writing the first sentence, I began to record my random ideas about the topic, in my mother tongue – Chinese, sometimes switching between different dialects. After that, I would transcribe what was in the recordings, went through them and decided which parts to be kept. At this point, I already had some ideas about what worth exploring further. However, soon I got stuck during the process of transcribing the Chinese scripts into English. The problem, in fact, had little to do with my language ability; instead, it was due to my self-doubt and fear of failure before I even gave it a try. After some time, I finally managed to finish the first draft which in need of tons of improvements. But with the help of my supervisor back then, the final version turned out to be one of the best I've ever written during my study.

When it came to the time of the final project – master thesis, I went through similar struggle, except that this time it lasted longer and much worse, with the unexpected impediments of COVID-19, the struggle of confronting multiple dilemmas in my life, as well as my own mental health challenge. Nevertheless, it was also a period of time bringing out my growth on endurance, resilience, and most importantly, compassion for myself and others.

As a troublesome student compared to the others, I especially thank Lars and Kirsten for their patience and support during the process. Lastly, I would like to thank my family in China and my closest companion in Denmark. I would not be able to go this far without the generous love from them.

TABLE OF CONTENTS

ABSTRACT

During the construction of an effective mental health service system, one key issue to be addressed is the under-treatment of mental health problems. Help-seeking rate for psychological distress and mental disorders remains substantially low among those needing care. This study attempts to find out: What facilitates and hinders mental health help-seeking in Chinese and Nordic context? How mental health help-seeking is influenced by cultural and structural factors? A literature review on help-seeking is first conducted, followed by using the auth-ethnographic method to explore the research topic. Accounts from my auto-ethnography of seeking-help in both the Chinese and Nordic contexts are analyzed to understand how mental health help-seeking is hindered or facilitated throughout the help-seeking process. A comparative perspective is adopted to investigate cultural and structural influences on mental health help-seeking in Chinese and Nordic contexts.

INTRODUCTION

Ever since I became a social work student, mental health has been one of my main study interests. During my academic life, I was particularly interested in case work, not only because the work itself is meaningful and helpful, but also the gradual opening-up and revelation process of the inner-most world of another human being makes it intriguing. The kind of relationship formed and manifested throughout the journey might be one of the most fascinating human relations possible. That being said, the amount of efforts and difficulties lie in the collaboration process for both the professional and the person receiving help may be beyond description.

As a social work student and at one point a practitioner, it was natural that my focus had been mostly on the helping process in which the collaboration actually took place. Little did I think about what happens prior to the service from the perspective of a service user, or more precisely, a help seeker. What could be the experience of a help seeker before he or she becomes a service user? Particularly, for people met with mental health challenges, could their experience be more unique or could they face with extra challenges due to the very difficulty they already have in their lives? These are the questions rarely came into my mind till I myself had to go on the help seeking pathway because of my own mental health needs.

The formation of this study could be attributed to my academic background and my personal story. To put it in another way, my interest in the field of mental health, together with my personal experience of having undergone mental health challenges laid the foundation for the current inquiry. As it is briefly indicated, help seeking would be the focus of this research. My personal story as a help seeker and service user would play an important part in the current research, not only in motivating the initiation of this study but also in facilitating the inquiry through the utilization of auto-ethnography as a methodological tool. I had been a social work student and a help seeker in

both a Chinese context (as a Chinese citizen) and a Nordic context (as an international student), therefore, the current inquiry would involve help-seeking in both contexts.

THE PROBLEM AREA

Global Context: Definition and Global Burdens

World Health Organization (WHO) defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"(WHO, 2020). Mental health is also a state of balance, both within and with the environment. Physical, psychological, social, cultural, spiritual and other interrelated factors altogether contribute to this state of balance. Mental health enables people to think, learn, and understand their own emotions as well as those of others, thus lays the foundation for effective functioning of individuals. Not surprisingly, mental health and physical health are oftentimes interrelated (WHO, 2020). In a global context, the burden of mental health conditions is on the rise. Depression, being a common mental health condition, is one of the leading causes of disability. Suicide is the second leading cause of death among 15-29-year-olds. Approximately 800,000 people die due to suicide every year. It is indicated that people with severe mental health conditions die prematurely – as much as two decades early – due to preventable physical conditions (WHO, 2020).

Around 76% to 85% of people in low- and middle-income countries never receive any treatment for their mental health disorders (Wang et al., 2007). In 2013, a World Health Assembly resolution called for a comprehensive, coordinated response to mental health problems at the country level. WHO (2020) has proposed that increased investments are necessary to enhance mental health awareness to reduce stigma and to promote access to quality mental health care.

The Chinese Context: Mental Health Problems and Mental Health Care Development

WHO estimates that 173 million adults in China have mental health conditions, 24% of them are moderately or severely disabled by their illness (Wong & Li, 2014). By the end of 2018, the number of people registered as having severe mental disorders is close to 6 millions (Chinese Psychiatry Association, 2019); Among all the registered severely ill people, 73.8% have a diagnosis of schizophrenia, 60.4% live in poverty. An estimate of 54 million people in China suffer from depression, meanwhile about 41 million suffer from anxiety disorders, making depression and anxiety the two most prevalent mental health disorders in China. Other mental health disorders include bipolar affective disorder, schizophrenia and other psychoses, dementia, intellectual disabilities and developmental disorders including autism (WHO, 2020).

Epidemiological surveys conducted in China revealed similar outcomes. Based on a survey conducted in four provinces during 2001-2005 (N=63004), Phillips et al. (2009) found that the prevalence of mental disorders among adults in China was 17.5%, of which the prevalence of mood disorders and anxiety disorders were 6.1% and 5.6% respectively. A more recent cross-sectional epidemiological survey conducted in 31 provinces during 2013-2015 (N=32552) have indicated that the 12-month prevalence of any disorder (excluding dementia) is 9.3% and the lifetime prevalence was 16.6% (Huang et al., 2019). Although the prevalence rate from different surveys varies, it is evident that mental health problems pose serious challenges and high burdens on both the affected individuals and the country. Statistics from China's National Center for Mental Health further reveal that over 100 million Chinese people, meaning, one in every 13 people in China, suffer from some sort of mental health problem (Yuen, 2013). Mental disorders are accountable for 13% of all non-communicable diseases burden in China. It is therefore justifiable to say that mental health has been both a major public health problem as well as a social problem in China.

The first officially documented mental health care in China could be traced back to the Tang Dynasty (895 CE) when homeless orphans, widows and the mentally ill were taken care of in an institution established and administered under the influence of some charity facility set up by monks (Lan cited in Xu et al., 2017). In the late 19th century, the first western style psychiatric hospital was founded by American missionary John Kerr to care for the homeless mentally ill (Chen, 2015).

The foundation of the People's Republic of China in 1949 witnessed a rapid development of mental health services throughout the country. Psychiatric hospitals were gradually built in the 1950s. Psychotropic drugs such as chlorpromazine and lithium, insulin shock, and electroconvulsive therapy (ECT) were utilized in the treatment of mental illness. In addition, the idea of rehabilitation in the community was already welcomed and adopted back then. Still, forced restriction of patients in hospital setting was the main feature of mental health service model at the time. During the Cultural Revolution (1966–1976), the country was heavily struck in many aspects, causing the development of mental health service largely stagnated. That being said, in some parts of China, certain level of mental health care was still evolving, for instance in Shanghai, neighborhood committees administered rehabilitation centers for workers with mental illness as well as caring networks in the community (Zhang & Yan, 1990). Meanwhile, primary treatment model for people with mental illness was a hospital-based care.

From the 1980s, the country went through a massive scale of marketization followed by high-level of economic growth lasting for decades. The reduction of funding from the central government to the local governments and the reduction of government funding to hospitals contributed to the decentralization and privatization of healthcare system. As a consequence, mental health services were largely commercialized during the 1990s, with gradual elimination

of community-based mental health care (Chen, 2018). At the same time, new initiatives and treatment models were proposed and explored in order to tackle mental health problems, for example, a three-tier network (city, district/county and street/town levels) was set up to deal with psychosis; the use of medication, work rehabilitation and family-based intervention were extended in the field of mental health practice (Liu et al., 2011).

When it comes to mental health legislation, China had been lagging behind compared to the developed countries. Chen (2018) noted that mental health policy in China was not formulated until 1987. Over the last two decades, however, a series of policies and regulations, as well as reform measures were introduced to tackle mental health problems in China.

In 2002, the Ministries of Health, Public Security and Civil Affairs and the China Disabled Persons' Federation collectively signed the first National Mental Health Plan (2002−2010) in which targets and guidelines were specified. The following goals were included:

a) Develop a government-led mental health service system

b) Facilitate implementation of mental health legislation;

c) Raise awareness of mental health among general public;

d) Enhance mental health services to prevent disability and poverty caused by mental disorders

e) Expand mental health services and enhance the capacity of psychiatric hospitals (Liu et al., 2011; Ministries of Health, Public Security, Civil Affairs and CDPF, 2002).

Under the concept of the biological-psychological-sociological medicine pattern, health service in China has begun catering more to people's biological, psychological, and social needs. In 2004, in accordance with the determination of the Chinese government to enforce healthcare reform, the National Continuing Management and Intervention Programme for Psychoses, also called the 686 Program (named after the RMB 6.86 million of initial funding granted by the central government), was implemented in China (Liu et al., 2011). This program was in consistent with policy recommendations issued by the WHO on promoting community-based mental health services and service integration. The aim of the initiative of the 686 Program was to develop a system that includes monitoring, intervention, prevention, and rehabilitation management of individuals with a psychosis diagnosis. It represents one major ambition and endeavor to develop a patient-centered, recovery-oriented and hospital-community integrated mental health service mode (Chen, 2018). With the support of the 686 Program, patients with psychosis diagnoses, particularly those in a poor socio-economical position and those at risk for aggression, could get access to free medication, laboratory tests, subsidies for hospitalization, follow-up and crisis management. It is noted that the continuous implementation of the 686 Program contributes to the accessibility, equality of treatment as well as a continuum of care for people with mental health problems (Xu et al., 2017). By 2011, the program had extended to 680 districts/counties, reaching out to a population of 33 million people in

160 cities. A total of N280, 000 patients suffering from psychiatric disorders were registered in the program. What's more, close to 380,000 practitioners were trained as members of inter-professional teams during the period (Liu et al., 2011).

In 2013, the first national mental health law came in effect in China. One of the main goals of the law is to facilitate accessibility to mental health services, overcoming barriers that prevent people from accessing diagnosis and care. The introduction of mental health law represents a huge step forward in policy level to call for greater availability and higher quality of mental health services by "shifting the focus of services from specialized psychiatric hospitals in urban centers to general hospitals and community health clinics in both urban and rural communities" and by increasing facilities, mental health professionals, in addition to more awareness raising (Phillips, 2013). By 2014, 4.3 million people with severe mental illness had been registered in the system, among them 73.2% are followed up and under management (Chinese Psychiatry Association, 2019).

In 2015, China released its National Mental Health Working plan (2015–20). Compared to the first mental health plan (2002-2010), this plan includes more specific goals and expands to not only include severe mental disorders but also depression and other mental and psychological problems. Prevention and treatment of depression, autism, and dementia were put on the agenda. In accordance with the Mental Health Law, the plan aims to enhance greater availability and higher quality of mental health servicesby stating specific goals in a five-year timeframe.Goals such as, more than 80% of registered patients with severe mental disorders should be under proper management, at least 80% of patients suffering from schizophrenia are able to get treatment. Eligible, severely affected patients could receive financial support. Doubling the number of registered psychiatrists to 40,000 by 2020 and enhancing the capacity of health institutions to increase the treatment rate of depression by 50% were also main goals of the plan (The Lancet, 2015). Besides, the plan also touched on issues like anti-stigma, mental health education and promotion, with recommended strategies and measures such as "to use the media to disseminate core concepts about mental health". According to the plan, school settings should equip with psychological consultation centers or guidance office settings; furthermore, all provinces are supposed to set up at least one telephone helpline and crisis intervention teams. Despite the strong determination and ambition it demonstrated, scholars questioned whether the ambitious goals stated could be achievable "given that no explicit budget has been allocated for the plan" (Chen, 2018).

The Nordic Context: Welfare model and Mental Health Care

China’s interest in Nordic welfare states has been growing, both among scholars and policymakers, particularly since the late 1990s. Chinese researchers began writing on Nordic welfare states as early as the 1980s (Zhang, 2013; Lin, 2001). Sweden has been the main example of the universal welfare

state in Chinese literatures (Kongshøj, 2015). In recent years, Chinese policymakers have increasingly emphasized the need for more comprehensive welfare. An idea of building a 'moderate' or 'appropriate' universal welfare system has also been voiced frequently by policymakers and was first promoted by the Chinese Ministry of Civil Affairs (Lei & Walker, 2014). Kongshøj (2015) has argued that the problems China is facing in some regards are somewhat similar to historical problems in the Nordic universal welfare states during the 1950s and 1960s. Although Chinese perceptions of the 'Nordic model' are marked by ambivalence about the desirability and feasibility of encompassing welfare, both Chinese policymakers and particularly researchers are looking to the Nordic countries to some degree (Zhang, 2013; Lin, 2001).

The beginning of modern welfare state can be traced back to the 1880s when Bismarck's large-scale social insurance schemes was established and implemented in Germany (Sümer, 2009). The Nordic welfare model, however, emerged along with the Great depression during the 1930s (Sümer, 2009). The welfare state developments in the Nordic countries shared common roots and similar historical trajectories, which were associated with industrialization and related social, demographic, and political changes (Kautto, 2010). And by the time of mid-1980s, it was evident that a 'distinctive welfare state model' had developed among the Nordic countries. It is undeniable that the Nordic countries have a group of similar social policy designs, nevertheless the Nordic welfare model is the consequence of political evolution instead of intelligent design (Kautto, 2010). Key characteristics of the Nordic welfare model include: public sector is the main provider of welfare services and benefits; comprehensive, universal redistribution with a high degree of equality; and active labour market policies to promote full employment. To begin with, in the Nordic countries, the role of the state is central in welfare provision. In other words, public sector is the main provider of welfare services and benefits. Redistribution is financed through high level of taxes. In addition, as extremely decentralized unitary state, local civil authorities/municipalities are delegated a strong role in the management of welfare policies. As Esping-Andersen's welfare regime reveals, the Nordic welfare state belong to the social democratic regime which is characterized by institutionalism with an underlying notion that "the welfare of the individual is the responsibility of the social collective" (Sümer, 2009). Another distinguishing characteristic of the Nordic welfare model is the extent of the public provision of benefits and services, often referred to as "cradle-to grave", which indicates the comprehensiveness of the social benefits and services, including free or affordable education and health services, comprehensive family policies, old-age pensions and social insurance or social assistance for the unemployed and the invalid. The encompassing social security benefits and social insurance schemes constitute a much broader scope of public intervention than in most other countries. Universalism, which has been considered as a central aspect of the Nordic welfare model, represents the notion that welfare state aims to cater for the entire population rather

than just targets at particular means-tested groups of people. Social benefits are based on citizenship. It is believed that universal social policies are less stigmatizing and making it possible to gain support and consensus among citizens in general (Greve, 2007).

Through universal and comprehensive welfare services, Nordic countries become frontrunners in social equality and the welfare system is believed to be the safety net and to a large scale guarantee the well-being of its citizens. It is no coincident that Nordic countries consistently top the international rankings of subjective well-being and satisfaction with life. But even in the Nordic countries, it is reported that 12.3 percent of the total population are struggling or suffering mentally according to the World Happiness Report in 2016 (Helliwell et al., 2016). In Denmark, about 8 percent of the population reported that they were struggling mentally, which is the smallest proportion among the Nordic countries. According to the same report mentioned previously. That being said, when we take a closer at the figure, it is revealed that 18.3 percent of young people in Denmark between 16 and 24 years suffer from poor mental health (Nordic Council of Ministers, 2018). Statistics from the Danish National Institute of Public Health have shown that about 20 percent Danish population will experience mental health problems during the course of one year. Depression, anxiety disorders and drug addiction are the most common causes of mental health problems. Women and people with a non-Western background in Denmark report poorer mental health than men and people with a Danish background respectively (Sommar, 2016). Mental health issues account for the largest cause of the overall disability pensions in OECD countries, with young people being the most vulnerable. There is a great concern about the growing proportion of young people in the Nordic region who are excluded from societal arenas such as education and working life, as a result of mental health issues (Sommar, 2016).

Mental health has been a key area of concern in Nordic countries. To illustrate more clearly, here I am mainly using Denmark as an example. Mental health care in Nordic countries is provided almost entirely within the public sector. In the case of Denmark, public funding accounted for 84 % of all health spending (Olejaz et al., 2012). Mental health care for people with mental health problems may include health service and social service. The overall responsibility for services and support for people with mental health problems is shared between the Danish Ministry of Health and the Ministry of Children, Gender Equality, Integration and Social Affairs (Sommar, 2016).

Over the last decades, mental health care in Nordic countries has undergone considerable change, marked by an increase in outpatient treatment and a reduction in the number of hospital beds. In the words of Sommar (2016), key reforms in the mental health care have been “the dismantling of institutional psychiatry; the building up and strengthening of locally based mental health services, and the development of measures to serve the target group in the social sector”.

After the Danish municipality reform in 2007, the municipalities have taken on major responsibility for providing services for people with mental health problems. Whereas the regions are responsible for hospital care, including mental health care delivered by general practitioners, psychiatric specialists and psychologists. In order to ensure obligatory coordination and collaboration across sectors, "Health agreements", agreements between municipalities and regions, are implemented to guarantee comprehensive help and support for people with mental health difficulties from both the health and social services. Different sections are working towards the same goals which are, to provide services adapted to the individual's needs, to offer a range of sufficient and effective help and support, to make it possible for individuals to get help easier and sooner, and to fight against stigma. All of these focus points for action are in line with Danish Government's action plan: *Equality - new focus on treatment initiatives concerning people suffering from mental illness*. This action plan from 2014 underscored that people with mental health disorders will have "the same range of services and the same rights as people with somatic disorders" (Cited in Sommar, 2016), which marked another big step in the reformation of mental health service in the Nordic countries.

Substantially low rate of formal help-seeking among the psychologically distressed

While great efforts have been invested in the construction and reformation of mental health service, and notable development of mental health care could be identified in both China and the Nordic countries, one critical challenge lies here: the low help-seeking rate for mental health problems. As it is documented in numerous sources, the proportion of people who have some sort of mental helath problems is enormously huge, but what is even more striking is the substantially low help-seeking rate among them.

The largest psychiatric epidemiological study in China conducted during 2001-2005 found that 92% of individuals with a diagnosable mental illness had never sought any type of professional help. In other words, only 8% had sought some professional help, and what's more, only 5% had ever visited a mental health professional (Phillips, 2013; Chen, 2018). Wong and Li (2014) have noted that, of the 173 million adults in mainland China who have a mental disorder, 91.3% have never received any type of professional help. Those who did seek professional help often had experienced long delays between the onset of mental illness and professional treatment (Chen, 2018). Zhang et al. (2013) further report that about three-quarters of potential users consulted on average of 3.4 caregivers before actually seeing a mental health professional. In 2001-2002, World Mental Health Survey conducted by WHO estimated that the prevalence of mental disorders was 9.1% in Beijing and 4.3% in Shanghai (WHO World Mental Health Survey Consortium, 2004). Based on this survey, Shen et al. (2006) estimated that 96.6% of people with any form of mental illness and 80.2% of those suffering from moderate to severe mental disorders received no treatment during the past 12

months (Chen, 2018). Beijing and Shanghai are undoubtedly two largest and the most developed metropolitans in China, where both general healthcare resources and mental health services are highly concentrated, nevertheless, the help seeking rates are still much lower than that of the high-income countries. It is therefore arguably reasonable to assume that the situation in smaller cities and rural areas would be even worse. Liu and colleagues' research targeted at the less developed region in China could provide some evidence to this assumption. Liu et al. (2018) conducted a community-based survey among the general population in Xi'an, a capital city in northwestern China where it has long been underdeveloped. It is found that the lifetime prevalence estimate of mental disorders was 21%. Whereas, the lifetime use rate of mental health services among those who reported a mental disorder was less than 5%.

Outside of the Chinese context, situations in other low-and-middle-income countries show similar trend, that is, around 76.3% to 85.4% of those who have severe mental illness have never received any formal treatment. Low mental health help-seeking rate, however, did not just exist in low-and-middle-income countries, the fact is that even in developed countries, for the psychologically distressed, there are still around 35.5% to 50.3% of them have never sought any professional help (Xu et al., 2017). In the Nordic context in particular, a cross-sectional, population based study conducted in Norway in 2001 found that only 40% among the psychologically distressed had sought help from mental health professionals (Svensson et al., 2009). In Denmark, evidence has shown that under-treatment has especially affects young people outside education and employment who at the same time have mental health issues ((Sundhedsstyrelsen, 2010 as cited in Sommar, 2016). This is even more concerning when taking in account the fact that young people are the most vulnerable group, with around 20 percent of youth suffering from poor mental health (Nordic Council of Ministers, 2018). Moreover, men, especially young men, are found to be more at risk of under-treatment for their mental health problems. In other words, men in Denmark who have mental health concerns are less likely to seek help from the mental health services than women(Borg et al.,2010 as cited in Sommar, 2016).

All of the above figures have demonstrated the shocking problem of the underutilization of formal mental health services and the substantially low rate of formal help-seeking among the psychologically distressed.

RESEARCH QUESTION

Low mental health help-seeking rate among the psychologically distressed is an issue presented in both the Chinese and the Nordic context, although the issue is much more severe in China. People’s low help-seeking rate for psychological problems remains one of the major issues to be further understood and investigated. A deeper understanding is important to social work and welfare in that

this will not only social work knowledge but also social work practice in order to provide more effective services to people with mental health difficulties.

Phillips (2013) has maintained that "Studies of factors that influence mental health help-seeking that aim to increase service use are as important as the development of better treatments or expansion of services". In the field of social work and welfare, the current study deems it vital to further understand what influences mental health help-seeking so as to increase people's access to care among the psychologically distressed. As we know, both help-seeking in China and Nordic countries are included in this study, these two contexts distinguish from each other in terms of both culture and structure related to mental health service system. Therefore, a comparative perspective of the Chinese and the Nordic context would be adopted to further investigate cultural and structural influences on mental health help-seeking.

This study, therefore, aims to explore on the following research questions: ***What facilitates and hinders mental health help-seeking in Chinese and Nordic contexts? How mental health help-seeking is influenced by cultural and structural factors?***

In the next part of my thesis, a literature review on help-seeking in Chinese and Nordic/Western contexts would be conducted to shed light upon the current research subject.

METHOD

LITERATURE REVIEW

Most studies on help-seeking for mental disorders came from Western countries, while a few of them are on Chinese immigrants (Kung, 2004; Parker et al., 2005). However, study conducted in the Nordic context specifically focusing on mental health help-seeking is scarce or hard to identify. Therefore, in this literature review would not just be confined to Chinese and Nordic research, but would also include research from Europe and western research in general.

Western studies have indicated barriers to seeking professional help which include negative attitudes towards seeking help, as well as concerns about cost, transportation or inconvenience, confidentiality, a preference for self-reliance, and the belief that the treatment will not help (Mojtabai, 2001). For the rural population in the western society, perceived barriers to seeking help also include concerns about availability of services and not trusting being treated kindly (Fox et al., 2001).

European research on mental health help-seeking have a unique focus on unemployed people, with some focused on specific groups such as veterans (Levine et al., 2018). In Denmark, evidence has shown that under-treatment has especially affects young people outside education and employment who at the same time have mental health problems (Sundhedsstyrelsen, 2010 as cited in Sommar, 2016). Men, especially young men, are found to be more at risk of under-treatment for their

mental health problems than women in Denmark. Men often tend to seek help from mental health service because of drug-related problems rather than mood-related problems such as depression and anxiety (Borg et al.,2010 as cited in Sommar, 2016). A qualitative study conducted among unemployed persons with mental health issues in Germany has shown that there is a complex interplay of barriers and facilitators such as mental health literacy, stigma and structures of health care in the help-seeking process (Staiger et al., 2017). Another longitudinal quantitative study was conducted in Denmark to investigate mental health service use and to identify predictors for help-seeking behavior for mental problems among Danish veterans with self-reported mental problems (Møller, 2019).

Studies in China tended to focus on psychosis in specialist psychiatric settings (Zhang et al., 2013), but there is a relatively small number of help-seeking and mental health service studies in other settings, which were mainly conducted in major urban cities including Beijing (Chen, 2012) and Shanghai (Wong & Li, 2014). Only a few studies were conducted outside of urban China (Liu et al., 2018). In one recent systematic review, Shi et al. (2020) have identified a number of key barriers to help-seeking behavior among Chinese adults. Frequently reported barriers to mental health help seeking include a preference on self-reliance, seeking support from alternative sources, low perceived need, a lack of affordability, negative attitude towards seeking help, or poor experiences with help-seeking. Less frequently mentioned barriers included stigma, family's opposition, limited knowledge about mental disorders, a lack of accessibility, unwillingness to disclose mental illness, and fear of burdening family（Shi et al., 2020).

Although Chinese and Western findings show similar themes of barriers, Sun and collaborators (Sun et al., 2018) maintain that the Chinese have stronger barriers in most aspects, including under-recognition of the need for treatment, stigma on mental illness, somatization, worries about taking psychiatric drugs, and so forth. Cultural factors are often maintained to be accountable for the underuse of mental health services among Chinese, both living abroad (Kung, 2004) and in mainland China (Chen 2018; Shen et al. 2006; Wong and Li 2014). In the context of China, family is still the primary source of help and seeking professional help is uncommon. Specifically, stronger family functioning is associated with a lower probability of seeking help from general health professionals and alternative services, yet trust in professional mental health services does not diminish, even among the high psychological distress subgroup (Chen, Xu and Wu, 2019). Two major explanations are summerized to explain what deter people from seeking professional help. The first explanation is that informal networks, including family, friends, and so on, act as alternatives to formal mental health services for coping with psychological distress, which lead to people less likely to seek help from professional service providers (Villatoro et al. 2014). The second explanation is that cultural barriers concerning values and norms, and structural barriers relating to characteristics

of the mental health service system also deter people from seeking professional help (Villatoro et al. 2014).

Facilitators for formal mental health help-seeking are often comparatively under-researched in both Western and Chinese studies. Facilitators have been proposed by western findings include previous positive experience, higher education, the influence of intimate partners and general practitioner (Cusack et al., 2004). Previous studies in mainland China have found that living in an urban area; higher family income and health insurance are associated with higher use of services (Park et al. 2005). Variations in patterns of help-seeking may be partially explained by demographic and clinical characteristic (Yin et al., 2019). Yin and collaborators' study indicate that female gender, younger age, having higher education, a low income, a psychotic disorder and having more than one disorder are associated with increased help-seeking (Yin et al., 2019). Here, "a low income" instead of "high family income" as a facilitator seems to be inconsistent with previous studies, but it could also be explained by a stronger motivation to seek help when one is both economically disadvantaged and has mental ill-health at the same time. Furthermore, peer support programs, mental health referral services, promotion programs within the community, online information dissemination are proposed as solutions to enhance help-seeking intention and behaviors (Gong & Furnham, 2014; Chen & Zhu, 2015). Importance in improving mental health literacy has also been suggested as to facilitate mental health help seeking (Chen, 2018).

THE AUTO-ETHNOGRAPHIC METHOD

Qualitative studies are "essential for capturing the complexity and subtlety of help-seeking behaviors and service preferences that standardized survey instruments cannot disclose among potential user groups and in specific social and cultural context" (Phillips, 2013). In the current study, the method of auto-ethnography, a qualitative method, is going to be adopted in order to achieve a more detailed and nuanced understanding of the mental health help-seeking. As mental health help-seeking is in essence a very personal experience that could not be fully understood and captured without the voices of the one who is really experiencing or even struggling through it. Auto-ethnography suits my research topic as it offers a way of giving voice of personal experience to deepen sociological understanding of a certain subject, and possibly through this way making a contribution to social science.

Auto-ethnography is a qualitative research approach aiming to describe and systematically analyze personal experience so as to advance understanding of culture and society (Wall, 2008; Ellis, Adams and Bochner, 2010). According to Sparkes (2000), auto-ethnographies are "highly personalized accounts that draw upon the experience of the author/researcher for the purposes of extending sociological understanding". Inspired by postmodernism in the 1980s, auto-ethnography

challenges canonical forms of doing research (Spry, 2001). Auto-ethnography is ethnographic as it involves placing one's own cultural world in relation to some other world.

It is one of the approaches that acknowledge and take into account the researcher's subjectivity, emotionality, as well as his or her influence on the research. By recognizing the intersection of the personal and the societal, it makes it possible to "address several key theoretical debates in contemporary sociology: macro and micro linkages; structure, agency and their intersection; and social reproduction and social change" (Laslett, 1999).

Auto-ethnography is both a method and an alternative form of writing that can be situated in the middle ground between anthropology and literature. As a method, auto-ethnography is both process and product. As its name implies, auto-ethnography is part autobiography and part ethnography, in other words, it combines the features of autobiography and ethnography. Depending on how much emphasis is placed on *auto* (self), *ethno* (the socio-cultural aspect), and *graphy* (the application of research process), there are different approaches to auto-ethnography (Reed-Danahay,1997; Wall, 2008) For instance, forms of auto-ethnography may include *Personal narratives, Co-constructed narratives, Indigenous/native ethnographies, Narrative ethnographies, Reflexive ethnographies*, *layered accounts*, and so on. Among them, *personal narratives* is probably the most controversial form of auto-ethnography for traditional social scientists, in which authors mainly focus on the 'self' as they view themselves as the phenomenon. Authors of *personal narratives* write evocative narratives of selective stories of themselves with a purpose to further understand the self or certain aspect of life under a cultural context. Although some consider a personal narrative to be the same as an auto-ethnography, others demand for more traditional analysis and connections to scholarly literature (Ellis, Adams and Bochner, 2010). Precisely speaking, in this study, auto-ethnography would not be merely a personal narrative; instead, it is used 'as a means of explicitly linking concepts from the literature to the narrated personal experience', making it as justifiable as any other forms of qualitative inquiry.

Hence, in this sense, the approach to auto-ethnography I am adopting in this study is closer to the form of ***layered accounts*** in which author's personal experience is accompanied with data, abstract analysis, and relevant literature (Ellis, Adams and Bochner, 2010). Readers are invited to enter into not just the personal stories of the author but also the "emergent experience" of doing and writing research. Existing research is mostly framed as a source of "questions and comparisons" rather than absolute truth (Charmaz citied in Ellis, Adams and Bochner, 2010). Generally speaking, in this form of auto-ethnography, evocative and concrete texts are considered to be as important as abstract analyses.

Here are some of the key questions I am going to ask myself and probe into, to get close to the answers by doing critical analysis based on relevant literature and being reflexive throughout the whole narration process.

When did I realize I need some mental health support?

What did I do? Where did I seek help from?

What are the obstacles during the process of seeking help? What are some facilitators?

What could be drawn from my own experience and knowledge as a service user in both the Chinese and Nordic context?

MY AUTO-ETHNOGRAPHIC STORIES

Help Seeking In a Chinese Context

In the following section, I am going to write a personal narrative about my experience of having long-term psychological distress and help-seeking experience in a Chinese context and in a Nordic context. Although what I experienced may not be the same as other help seekers in both contexts, my intention is not to generalize my experience to everyone or to focus on the experience as a service user. Instead, I intend to draw from the experience and perspective as someone who had attempted to seek professional help in both contexts. Using this as a point of departure, combined with other empirical research data, this thesis is going to explore what hinders and facilitates mental health help-seeking in both contexts.

From what I remember, I have been suffering from mental distress for more than 10 years. Over the years, the severity of my mental health problem varies, but overall it has been a constant challenge for me to maintain a psychological wellbeing. Since I had been interested in psychology and later acquired more knowledge about mental disorders as a social work student in university, I was well aware of my own mental health state early on. The main problem I faced was anxiety, particularly social anxiety. I had also been in a depressed state for a very long time however without an official diagnosis. Although there was psychological counseling service in the university, it did not occur to me that I needed any professional help at the time. Undoubtedly, my self evaluation and interpersonal relationships were somewhat deteriorating, but I did not see the necessity to seek professional help because my daily life was not severely affected. Even though I had some knowledge about mental disorders and endorsed the idea of seeking professional help when necessary, I attributed my feelings of uneasiness and anxiety mainly as part of my disposition which I had to live with rather than something to be helped. Besides, I also did not explicitly seek support from family and friends. What I mostly did, was paying more attention to self-help information and books, trying to soothe myself through music and occasionally talking to close friends.

Frankly speaking, even as a Chinese, at the time I was not very clear about how the healthcare system worked in my country, not to mention the mental healthcare system. As far as I remember, occasionally there was some news about the ongoing healthcare reform, however, the fact that it was something relatively new and the complexity of the whole issue drew my attention away from it. The entire welfare system and the healthcare system have undergone great changes in recent decades, the mental health system, as a smaller part of it, has followed the same trend. For the general public, it is even more difficult to keep up with the policy changes, in the midst of tremendous societal changes which might have been greater than any other time in the history.

After I entered high school, the symptoms of depression and anxiety became more serious, but I never asked for help and never got a formal diagnosis. In the first year of study, the university organized an initiative to have every freshman to do a psychological measurement. Perhaps only those who were found to have serious mental illness have been intervened, and I was not among them. There were actually selective courses and occasionally lectures on mental health in the campus, but psychological counseling service was not well promoted as oftentimes counseling was depicted as a mysterious process where tricky problems got magically solved. It could be that lecturers were either trying to impress students with intriguing stories or overly emphasizing the professionalism of psychology. Even in the campus environment, most people still assume that their concerns need to be somewhat severe or “abnormal” in order to get “professional treatment” from counselors. But in many cases people just want to talk to someone reliable in a safe environment when they couldn’t or don’t want to share within their own social circle. And oftentimes this could have been especially beneficial for people with moderate psychological distress, in preventing them from developing into serious mental illness later in their lives. That being the case, it was still relatively easy to get in touch with the counseling service in the university when I was a student. Once I graduated, availability, accessibility and affordability of mental health service, all of them became problems. What's worse, usually it is after graduation that one has to be confronted with more challenging life situations: finding a job, making plans and working for future goals, getting used to work life, working towards an independent life while maintaining relationships with family, expecting a stable relationship and taking marriage into consideration and so forth. Each one of them could easily trigger psychological distress or make the existing problem even worse.

At some point I realized I really needed to get myself out of the restless and helpless situation, with some external support. Under this condition, internet became my main source of help seeking, either through reading self-help articles and guidance or through searching for potential helpers. I started to look for some information online but it was rather difficult to find professional and trustworthy resources. Despite that, the help-seeking process eventually began.

One day I came across an online intervention program for people with social anxiety. This program was an internet-based cognitive behavioral therapy （ICBT）, organized by psychologists from Peking University, one of the most prestigious universities in China. The fact that it was free because it was an experimental program made it even more appealing to me. This online treatment program benefited me to some degree, but it had to end after eight weeks when the program was over, even though I still felt the need to continue receiving support. Longitudinal follow-up studies have shown that ICBT has a significant effect on relieving social anxiety symptoms within the first year after the treatment, and the effect maintains even after five years (Berger, Hohl, Caspar, 2009; Hedman et al., 2011). What I found that program beneficial was not just the efficacy of ICBT itself as an evidence-based intervention. During the eight-week period, a so-called "little assistant" was assigned to each participant. A far as I know, little assistant was actually student assistants of the project, and part of their duty was to assist participants throughout the project, as project guidance, information provider, someone to give feedback to and someone to talk to, which made him/her a good companion. It is worth mentioning that "little assistant" had been anonymous, never shared his/her personal information and other contacts. They only communicated with participants via project email. Once the project ended, the relationship also came to an end. I could tell that they were strict about following ethics. Therefore, even though personally I did not wish to cut off the contact totally, I had to respect the project setting and simply appreciated their efforts.

That was my first attempt to seek for help through the Internet and actually got some effective help. Unfortunately, not every attempt would end up like that. When it comes to online help seeking, the availability of information is one issue, whether the information is valuable and whether the service is professional is another issue. The difficulty lies in the need to filter through a wide range of information. You may not be "lucky" enough to find suitable help, when taking into account of availability, accessibility and affordability of services. What's more, qualification and trustworthiness of the service providers is another important factor to be taken into consideration. One example of unsuccessful help seeking attempt would be as follows. Not long after the ICBT program, I contacted a private practiced psychologist whom I found online. But I only met her once, mainly because I was not satisfied with the service, and in part because I could not afford having counseling consistently, especially when I was unemployed. I had to be strict about whether I would pay for the next session depending on if the therapist was believed to be really capable to help me. Nevertheless, going to hospital had never been an option for me because I did not think I was seriously ill mentally, despite the fact that I had been having suicidal thoughts.

In retrospect, I would say there were other factors affecting my mental health help seeking behaviors. Why did I never tell my family and friends about my mental distress? Why going to hospital had not been my idea at the time? To begin with, like in many other cultures, mental illness

is rarely talked about among family members and friends in China. When it comes to physical illnesses, oftentimes people would talk about them, express concerns and share medical information among each other. Unlike physical illnesses, mental illnesses receive little attention, and when it does get some attention, often it comes with misunderstanding and stigma.

Growing up, I notice that it is typical for Chinese people to neglect the importance of mental health until the problem becomes extremely serious. Attitudes towards mental disorders often range between two extremes: on one side, mental health problem is not acknowledged when it is mild or moderate; on the other side, mental health problem is equalized to "madness" when it is thought to be severe. Not only the general public, but also the ones who suffer from psychological distress themselves have this type of attitude. On one hand it undermines people's awareness and help-seeking behaviors; on the other hand it contributes to the prejudice and stigma of mental illness in the society. Being afraid of negatively viewed by others, I gave up on seeking for understanding and support from people around me. The feeling that I was weak and inferior stopped me from disclosing my mental distress to others. Nevertheless, at this point, personally I had strong intention of seeking professional help, I just had difficulty getting access to the kind of mental healthcare service I needed, even as someone who have a social work background and was more familiar with social service than most people. What about the other people who are also suffering from mental health problems, especially those living in the rural regions and uneducated ones?

For the following years, I had two other encounters with mental healthcare in China. The first encounter was with 'Jiandanxinli' (In Chinese:简单心理, literarily translated as 'Simple Psychology') which has now become the largest online psychological service platform in the country. 'Jiandanxinli' was founded in 2014 by Jane Lee, a graduate from London College University, who has a background in Cognitive Neuroscience and had worked as a counselor at a Chinese university. 'Simple Psychology' is thought to be one of the first mobile apps dedicating to online mental health service provision. People in China generally find it difficult to get access to and discern information about mental health service in order to find a qualified therapist. What makes this platform stands out is that it screens and verifies the qualification and certificate of therapists first before they're entitled to conduct counseling service in the platform. The therapists come from all around the country or even around the world. Depending on the users' own preference and the distance, users can decide whether to meet their therapists face to face or have the counseling service online. In my case, at the time I chose to talk to a clinical social worker based in the US, which means the counseling would take place on the internet, via video call, to be more precisely. Online service was what suited my preference and comfort zone at that time, since transporting to somewhere to meet someone new would be too demanding and frightening for me. In digital age, online mental health service is an

alternative for people to seek for professional help when they cannot get access to the more traditional in-person service or when in-person service is too demanding due to certain reasons.

An investigation conducted by Simple Psychology and Peking University (2016) showed that 74% of the online service users are females while only 26% are males, which, is in accordance with results from other studies that women are more likely to seek help (Wigand et al., 2019). Among them, 41.8% lived in the capital Beijing, 14.7% lived in Shanghai, 8.4% and 6.6% lived in Shenzhen and Guangzhou respectively. That is to say, in total, over 70% of service users lived in the four largest cities in China where people have the highest income and probably also under the greatest stress. In economically developed areas, people's living standards are higher, they are exposed to more psychology knowledge, and their acceptance of psychological consultation is higher. Therefore, they are willing to invest more time and money to obtain psychological and spiritual growth. Another finding from the study is that 55.7% of the participants have a bachelor degree, 21.1% of them have a master degree, and 2.9% have a PHD degree. In other words, nearly 80% of service users have a bachelor degree or above. Since many well-educated people live and work in economically developed areas, partly it explains why citizens living in the largest cities are more likely to seek for professional mental health help. All of which are consistent with other findings that females, higher education, higher family income are associated with higher probability of seeking help and using mental health service (Yin et al., 2019). It is worth noting that there is a small portion of the service users (6.1%) were living abroad at the time when the survey took place. Overseas users often face problems such as environmental adaptation and cultural conflicts, and have a higher acceptance of psychological counseling; consequently they seek to facilitate their adaptation process with the help of professionals. Another possible reason for overseas Chinese to seek for psychological consultation on a Chinese online platform could be due to language and cultural barriers they encountered in where they migrated to. Talking with a therapist in their mother tongue, even if it is online service, may facilitate the communication and meet with more understanding from a therapist who has the same cultural background. In some case, it is even possible for overseas users to find qualified Chinese speaking therapists who are also located in the same country they currently live in, which, may end up with an in-person meeting otherwise unlikely to happen.

In China, before 2014, there was only one mobile application targeting at mental health service. Whereas in 2016, the number of mental health service related apps surged up to 64 in just two years. On one hand, the tremendous growth of mental health service apps indicates a massive concern and demand for mental healthcare among Chinese population; on the other hand, it reveals the potentiality of digital mental health service to become the future direction of mental healthcare. Particularly in countries where there is disproportionate allocation of mental healthcare resources between different regions, digital mental health service could largely increase the possibility for

people to equally access to high quality mental healthcare. But it is worth noting that even in digital platforms like “Simple Psychology”, still more than 70% of service users chose to have the more traditional, in-person counseling, suggesting that currently online apps are mainly used as a tool to look for and get in touch with professionals and treatments often take place in a traditional office setting.

The last experience of me seeking for mental healthcare in China was to get in contact with a psychologist in a hospital. Mental healthcare system within the context of hospital in China mainly consisted of two categories. The first category is mental healthcare in general hospitals, where psychological counseling and psychiatry either exist as individual department or are combined into one department. The second category is mental healthcare in specialized hospitals, in most cases referred to as psychiatry hospitals. But what distinguishes China from many other countries is that, in some cases people with mental health problems are one of the targeted groups of so-called chronic disease hospitals/centers.

Having experienced seeking mental health help from private practice therapists, there came to a time when I was considering whether mental healthcare service in the hospital would benefit me more, both for my finance and health. First of all, seeing a private practice therapist cost around 500kr each session in China a few years back. However, visiting a therapist in the hospital only cost about 20kr each time for registration fee, which made it much more affordable for people in need. Meanwhile, regardless of the capability of the individual doctor and the compatibility between patient and doctor, at least the qualification of the therapist is legitimate. In addition to that, therapists practicing in the context of an authorized hospital could be trusted to have certain level of competence and experience in terms of working with people who have mental distress. Therefore, one could say that it is more guaranteed to seek for professional mental healthcare in hospital. However, according to the previously mentioned study, in 2015, there were only around 120,000 psychological service practitioners in China; the ratio was 0.09/1000. Among them, there were 20500 psychiatrists; the ratio was 0.15/100,000 (Simple Psychology and Peking University, 2016). As we can see, mental health service supply in China has been insufficient. One challenge is that whether one is able to get the support he or she needs timely and sufficiently. Another bigger challenge is for people to accept the idea of seeking help for psychological problems the same way they seek help for physical illnesses in the context of a hospital.

Regarding to which category of hospital I chose, it was psychological counseling service in a general hospital. The whole process had not much difference from what I had experienced in private practice settings, except that the price was much cheaper, the duration was relatively shorter and the environment was less private as other patients who were not seeking for mental healthcare were also

waiting outside at the same area. The last part could make mental health service in general hospitals less appealing for some people, especially when the hospital is in their neighborhood.

Help Seeking In a Nordic Context

My experience as a mental health service user in Nordic countries began in Norway. According to the policy, as an international student, during the time of my study, I was entitled to have the same right as the locals to access to the same quality of health care. The same applies to international students in other Scandinavian countries. It is worth noting that I had spent one year in Norway and Denmark respectively, and had received some type of mental healthcare in both countries.

Before I went to Norway, I had already learned something about the welfare system in Nordic countries. At the same time, my mental health knowledge and understanding of my own situation accumulated. After learning about the psychological services in the university, I planned to seek more long-term help. Although I had a plan in mind, the real action was not carried out until I was given caring advice and more detailed information from the program administrator. After I contacted the service on my own, the whole process went smoothly. But unlike what I expected, I thought I would have long-term and stable psychological counseling in the university, but for some reason I had to agree to be referred to a private counselor and get a maximum of six counseling sessions. During this period, the cost was covered by the university, and after that if I wanted to continue, I could pay by myself. Overall, this psychological service did not satisfy my needs, mainly because the whole process tended to be too commercialized. And in general, my experience of getting privatized counseling service in both China and Norway had not much difference.

Even though I was under treatment in a private setting, it was still part of what the Norwegian healthcare system offered me. What is astonishing is that I successfully entered the "system" and got the service in such a short time, as a foreigner. Realistically speaking, in most cases, it is not easy to get helped smoothly in a foreign country. But in Norway I could get basically the same services as the local people, in terms of quality, cost and efficiency, except that being an immigrant might make the service expedience different. As discussed before, schools, as the place where most young people spend the most time, can function as a very important entry point to facilitate the process of treatment initiation. What is still to a large degree a proposal has been a reality in Nordic countries, which makes me realize that China's welfare system development still has a long way to go.

The following part is my help seeking experience in Denmark. I had a stronger need for help in Denmark due to the new environment and more challenging situations in my life. But this time I needed to explore what was out there by myself. I had some knowledge of the Danish healthcare system and I also deepened some understanding of mental health services as my study went on. However, knowledge itself was not enough to break through the fear of the unknown, when I was not

sure how to take the first step. In a country that was new to me, facing people who are "different" from me, as an "immigrant" in this country, I was afraid of making mistakes, afraid of shame, afraid of being evaluated. Therefore, even though the idea of help seeking was in my mind, it did not make any progress. What turned things around was a conversation with a Danish friend I met accidentally. He mentioned his experience of overcoming anxiety, even talked about taking medicine. So I asked him where and how to seek professional help, along with questions like making appointments, drug effects and price. At the same time, he encouraged me and made me feel that "seeing a doctor" and "taking medicine" are normal and common. It was under such an opportunity that I contacted a general practitioner (GP) in the community, thus I entered the Danish healthcare system as a service user and started my treatment journey. The detailed treatment experience was not the focus of this paper. But it is worth noting that during the encounter with the general practitioner, my opinion was heard and included regarding to whether to take medication and be referred to psychologist or not. Generally speaking, I am quite contented with the service and support I received. Only once in a while, because of language barriers, I had some difficulty having comprehensive understanding of the procedures of the system. During my help-seeking process in the Nordic context, the whole process was clear, open, and orderly, although it can be a bit cumbersome and complicated, especially for immigrants like me.

During my field study in Denmark, when I went to the care institution and contacted service users, it made me even more aware of the normality of “seeing a doctor” and “taking medicine”. It is generally regarded as “less heavy” or “not so heavy” topic. "Shame" was being discussed, and it was talked about naturally. At the same time, the whole society devotes a lot of attention and resources on mental health. I always thought it was hard to deal with the dilemma between paying attention to mental health and not "excessively negative attention". To some extent, my experience in Denmark solved my confusion, in that paying more attention; acknowledge mental health problem and normalizing it, and treating people equally as not contradictory to each other.

Going back to help-seeking itself, if there was no such coincidence, how long would I have to wait before I could really "enter" the system and really start to get some help? Sometimes even if a comprehensive care system is out there, potential users still need a little push and encouragement to initiate the treatment. Additionally, as a gatekeeper, general practitioner greatly facilitates service users' navigation in the system. As long as one enters this door, he/she can get a lot of information and services directly from the family doctor, or be referred timely and properly. This is especially helpful for people with mental health concerns who are not strong in their willingness to seek help or the ability to act. When people know what they should do, where to go, and whom to seek help from, they will have a greater chance of trying to seek help.

ANALYSIS

Social scientists have come to acknowledge that every individual exists within a complex set of environmental systems and that these systems affect his or her psychological well being at a fundamental level. Generally, the systems literature defines a system as an organized whole, made up of interrelated and interdependent components or parts, characterized by purposeful and goal-directed activities. Systems theories focused on the interaction or transactions between people and the environment and the way they influence each other, allowing for making an in-depth understanding of a situation at multiple system levels.

According to Bronfenbrenner's ecological systems theory, there are five environmental systems that influence an individual's development and functioning. When a change or conflict occurs in one of the systems, it can produce changes in the other systems as well. These multiple spheres of influence are defined by its proximity to the individual. The most proximal influence is the family, followed by contexts such as neighborhood, school, and community. At the most distal level is where culture and other contextual influences operate (Bronfenbrenner, 2009).

When it comes to youth facing mental health challenges, it is arguably true that developments and well-beings of these individuals are influenced by multiple environmental systems. Based on systems theory, attempt has been made to explore the relation between cultural and contextual factors and adolescents' pathways into mental health services. Through the lens of systems theory, Cauce et al. (2002) argue that help-seeking is "not simply a matter of personal or family decisions or choices…arise out of a dynamic interaction between individual and family choice, cultural values and beliefs regarding mental health and help seeking, and contextual and systemic factors such as the availability of services within the community and social networks that can provide referrals to them". Further, Cauce and collaborators drew from a mental help-seeking model identifying three stages of the help-seeking process that could be used as a framework for understanding cultural and contextual factors that affect pathways into mental health services. Those three identifiable stages along the help-seeking pathway are: problem recognition, the decision to seek help, and the selection of a help provider. It is worth noting that the three stages in the model are interrelated and that help-seeking process seldom follows the order strictly in reality. But in the following analysis, they would be discussed orderly.

In the following part of my thesis, accounts from my auto-ethnography would be analyzed to understand how mental health help-seeking is hindered or facilitated throughout the three stages help-seeking process. In the current study, as it involves help-seeking in China and the Nordic region, which means naturally it is going to be more related to the macro system including cultural and structural factors in these two contexts. That is to say, cultural and structural factors would be the focus of the following analysis. Cultural factor involves cultural values and beliefs regarding mental

health and help seeking. Structural factor here is related to the mental health service system in China and the Nordic countries.

Problem recognition

Problem recognition makes up the first step in the help-seeking pathway. Help seeking cannot begin in earnest until a problem or mental health need is recognized. According to Cause et al.(2002), this help-seeking need can be defined in one of two ways: as an epidemiologically defined need or as a subjective or perceived need. Epidemiologically defined need is typically assessed using the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), meaning it involves a formal diagnosis. Meanwhile, perceived need is an individual's subjective perception of his/her need to seek help.

With regards to my auto-ethnography accounts, when I was in China, I had not had a formal diagnosis of having a mental health problem across all my help-seeking attempts. That is to say, my problem recognition at that time was solely based on perceived need. Starting from online information search, reading self-help books, to visiting psychologists and even visiting hospital-based counselor, all of these help-seeking attempts were solely based on my own recognition of encountering mental health difficulties. The only exception may be the online-based intervention program which required participants to finish an assessment before taking part in the program. But still, it was dominantly perceived need that prompt my attempt to seek out the online service. In contract, during my help-seeking attempts in the Nordic context, especially in Denmark, the problem recognition of the help-seeking process was manifested by both perceived need and epidemiologically defined need. In other words, not only I myself subjectively perceived a need to seek help but I also received a formal assessment and diagnosis from a professional which formed a defined need to get mental health care

Although the correspondence between need and action is not always direct and reliable, generally speaking, help seeking is most likely to occur when a mental health problem is recognized as undesirable in the sense of a perceived need or/and a defined need (Cauce et al, 2002). In my case, the recognition of my mental health status and later a perceived need pushed me to initiate a help-seeking action afterwards. But in many other cases, a defined need or in other words, a diagnosis, plays a more crucial role in service initiation. A study found that youth with both a diagnosis and a functional impairment were about seven times more likely to receive treatment than those without a diagnosis or impairment (Leaf, Bruce, & Tischler, 1986 as cited in Cauce et al, 2002).

It is clear that help-seeking decision and eventually service utilization is closely linked to problem recognition. Then the question comes what hinders or facilitates problem recognition in the help-seeking process?

Cultural interpretation of mental illness has played a major part in affecting people's problem recognition of their own mental health status. Yu and colleagues' interviews conducted among psychiatrists and patients found that it is not uncommon there is low perceived need or even a reluctance to admit need among those psychologically distressed in the Chinese context (Yu et al., 2018). In China, there is a widely held belief that mental illness are the result of an individual's "bad thinking" and "dwelling on bad thoughts". In some cases, mental illness is even considered to be caused by "malevolent spiritual forces" or "a punishment for ancestors' misbehavior" (Phillips et al. 2002; Yu et al., 2018).

Previous research has shown that misconception of mental illness can cause individuals to minimize psychological concerns and prevent them from seeking formal care (Ip et al. 2015). People tend to minimize their psychological symptoms and focus more on somatic symptoms such as generalized pain and fatigue because these are deemed to be more acceptable and legitimate. Somatization has found to be more prevalent in Chinese culture than in other settings, psychological concerns may thus go unrecognized (Kleinman 1977 as cited in Yu et al. 2018). What's worse, due to lack of training and inter-professional coordination, doctors in general hospitals or clinics may fail to detect the psychological cause thus people's chance to get suitable mental health services got delayed.

In western societies, including the Nordic region, the bio—psycho—social medical model is more well-accepted and established. The idea is that mental illness is resulting from complex interactions between genetic, psychological, and social influences (Yu et al., 2018). Mental illness is less related to the failure of an individual, but is connected to social influences; mental illness is emphasized as much as somatic disease in a societal and political level. This way it has not only facilitated the problem recognition and identification but also helped to diminish stigmatization of mental health problems.

The universalistic welfare model, the Nordic region as a representative, has an active role in delivering strategies and methods for caring the people. This has facilitated the problem recognition of mental illness. Authorities and different welfare sectors have the obligation and task to reach out to and care for people "being outside of normative ways of living" (Julkunen & Rauhala, 2013). Youth risks of being unemployed and social marginalized due to mental health problem are no doubt one of the target groups. Meanwhile the welfare service system requires active participation of its citizens, meaning in order to get certain benefits, one needs to be active in certain activities (Sommar, 2016). Getting a formal diagnosis to confirm there is a defined need may be one of the first steps. A

focus on early detection and prevention of mental illness taking place in Denmark in recent years which involves reducing the taboo associated with mental illness would further facilitate the problem recognition and identification in help-seeking process.

Decision to seek help

While admitting one has a mental health concern or/and getting a formal diagnosis may be what leads to a decision to seek help, this is not always the case. The decision to seek help is hindered or facilitated depending on cultural and structural factors.

According to the mental health help-seeking model, decision to seek help could be involved in a coercive process or in a voluntary process (Cauce et al., 2002). Examples of coercive process may involve mental health treatment imposed on a person by the court and contacts with mental health professionals through mandated referrals (Cauce et al., 2002). Voluntary process as its name implies means a help-seeking decision made voluntarily. Here I will only discuss voluntary help seeking which is a more common one.

In both the Chinese and the Nordic context, my decisions to seek help were both voluntarily based. But before an action was actually taken to seek formal help, it took me a long time to make the help-seeking decision. It has been indicated that availability, accessibility and affordability are the main barriers to care-seeking, but in my case these practical concerns came much later until the service selection began. What hindered me from seeking help at the decision-making stage was none of the above (at least I did not realize at the time that they would become obstacles). Instead, it was the feeling of being ashamed, the embarrassment and guilty of not being able to act and live "like the others". That was also what caused me to deal with my psychological distress by myself without disclosing to others for a very long period. What may sound counterintuitive is that although I have family and more social connections in China, my mental health status was kept in secret from them. But in the Nordic context, where I had weaker social connections, I felt more comfortable talking about my need to seek help. In the Nordic context, I got advice and guidance from administrator in the university and local friend who had previous experience; I experienced "a push" from them that eventually led to service use. The difference could be partly explained by the fact that by the time I went to the Nordic countries, I had learned more out my mental health need and gotten more used to the idea of "seeking help". Nevertheless, cultural and structural differences in these two contexts may play a major part in influencing one's decision making process of help-seeking.

China is still greatly influenced by Confucian values that emphasize the caregiving role of family (Abe-Kim et al. 2002). Previous research found that family may contribute to one's decision to seek help since family are often among the first to notice the struggle one is facing (Chen et al., 2019). It is especially true for people with mental health challenges that encouragement, suggestion

and company from trusted ones are very much needed so as to make up one's mind to initiate help-seeking and become a service user. However, family may not always the facilitator during the process. For many young people suffering from mental health problems, family conflict is part of the cause of mental health difficulties they are facing. And this is especially true for people coming from a culture where strong kinship ties are still the cultural norm. It is reported that even for Chinese American living in the US community, family conflict is still more likely to be the key factor prompting professional mental health service seeking (Abe-Kim et al. 2002).

The decision to seek help is not just about getting support itself, it represents a determination to reveal one's own mental state to the outside world. It is closely linked with feeling shame and stigma. According to a systematic review conducted on mental health and stigma (Xu et al. 2018), stigma could come from different direction and sources, including structural stigma, Interpersonal stigma and Intrapersonal stigma/self-stigma. During the Decision making process, one may mainly go through interpersonal stigma and self-stigma, but stigma from different directions could sustain throughout the help-seeking process. Interpersonal stigma could come from the community, health professionals, family members and caregivers; while self-stigma is "an internalization of negative beliefs about the self, which are largely based on shame, the acceptance of mental illness stereotypes, a sense of alienation from others" (Henderson et al. 2014 cited in Yu et al., 2018).

Fear of being stigmatized with regards to having mental illness is present in cultures around the world. Mehta and Thornicroft (2013) put it this way: "There are few countries, societies, or cultures in which people with mental illness are considered to have the same value as people who do not have mental illness." (Mehta & Thornicroft, 2013 Cited in Yu et al. 2018). A study conducted in 14 European countries revealed severe self-stigma, with over 40% reporting moderate or high levels of self-stigma (Brohan et al., 2010 as Cited in Yu et al. 2018). However, kinship ties in Chinese culture have made it more complicated----Stigmatization related with mental illness extends beyond the individual to include family members. In Yu and collaborator's study, in which semi-structured qualitative interviews were conducted，the fear of being labeled as "not normal" have led participants with depression to hide their mental health status. Some even hide their psychological concerns from their family members being fear of burdening their family. One interviewee in the aforementioned study, had been struggling with depression for the past 20 years without disclosing her mental health status in social circle for fear of her son being stigmatized because of her (Yu et al. 2018).

Help-seeking decision is largely affected by how the structural system responds to mental health related issues. Facilitation of the help-seeking decision involves reducing the taboo associated with mental diseases. In this regard, in a societal level, China has not implemented sufficient measures to combat discrimination against people suffering from mental health problems. In the Nordic region, although taboo still exists, various campaigns and activities have been implemented to change the

perception and increase the understanding of mental conditions and their treatments. For instance, the ongoing campaign "One of Us" in Denmark was launched in 2011 with the purpose of reducing the stigma related to mental illness (Healthcare Denmark, 2020).

In the Nordic context, more intensive policy could be found for the marginalized youth group. Denmark, for example, is cited as an example of a country that has a coherent and intensive youth policy. There is now a greater focus on young people with mental health problems who find it difficult to remain in work or education. All young people under 30 without education are given an education supplement. The labour market activation policy also applies to young people with mental health problems in which some kind of activity obligation is required aiming for young people to find ways into the labour market or the educational system (Sommar, 2016). Legislation gives many players joint responsibility to ensure young people find their way into education or the labour market. (Sommar, 2016). These intensive supports offered by the system could facilitate the decision-making process by increasing one's perceived benefits of help-seeking.

Lastly, the notion of "otherness" could be turn to in response to the stigma, taboo and feeling of being ashamed among people with mental health concerns in the help-seeking process, as these concepts are highly related. Elias and Scotson (1965) first formulated the idea that people with "scarce everyday resources can be excluded from the normative or dominant lifestyle and living standards, and are at risk to be stigmatized as dangerous, the others, who do not belong to the 'us'" (Elias & Scotson,1965 cited in Julkunen & Rauhala, 2013). Otherness, according to Julkunen and Rauhala (2013), is often "the product of observations of strangeness and danger in 'them', in binary opposition to safety and familiarity associated with 'us'" (Julkunen & Rauhala, 2013). In the perspective of otherness, people with disabilities, in this case, people with mental illness, were recognized as a marginalized group. Social work as a professional practice has had as its mission to combat stigma and labeling. Social work, as a professional activity, traditionally has a task to manage social problems, poverty and deprivation – phenomena and issues highly connected to otherness. How can the other be seen as the cause of one's discomfort, but still be attended to, responded to, empathized with and emotionally connected with? The answer is for social work practitioners to understand the self as a social reality (Julkunen & Rauhala, 2013). The universalistic welfare model, which is considered to be one attempt at redefining otherness, or at least at "diminishing stigmatizing and labelling mechanisms", could be part of the answer.

Selection of service

In the following part, I will talk about how cultural and structural factors influence service selection in help-seeking in Chinese and the Nordic contexts. Service selection is defined as where or to whom a person turns after identifying a problem and deciding to seek help.

Culture has some influence over what type of support one chooses to turn to. When people decide to seek help, they could seek help from informal supports e.g. family and friends, or formal mental health services provided by psychiatrists, psychologists and social workers etc. Socio-cultural norms regarding help seeking facilitate or inhibit service selection, meaning "when norms are not congruent with those of formal service settings, the individual is discouraged or prevented from seeking that type of help." In collective cultures, China for example, where strong and interlocking community and familial networks are the norm, individuals may not seek out formal mental health services because their needs are met within the network. Loo and colleagues' study found that British participants tended to suggest professional help, while Hong Kong and Malaysian participants endorsed more self-help and social help (Loo et al. 2012). Another earlier study also reported that formal mental treatment is used only as a last resort among many Asian American families when dealing with children or adolescents' psychological problems (Lin et al., 1992 cited in Cauce et al., 2002).

Regarding structural factors, availability, accessibility and affordability of existing services in both contexts would affect what kind of service one chooses. When my experience of help-seeking in China was compared to that in the Nordic countries, I faced more difficulty and restriction in all of the three aspects mentioned above during the service selection process. Specially, there are less service available, harder to access to the existing resources and more unlikely to afford the expense of the service. All of these factors led to an insufficient support and the incontinuity of help one ended up receiving. This could be mostly explained by the fact that welfare development including mental health service system is still developing in the Chinese context. In other words, the main issue is that China's mental health service system is still in the stage of formation and initial development.

While in the Nordic context, first of all affordability is much less of a problem in the universalistic welfare model. In terms of availability and accessibility, there are a wide range of health services and social services universally available for people with mental health problems. The annual budget of mental health services could give people an idea of the extent of investment in the Nordic countries. In Denmark, more than 80% of health care expenditure is financed by the state through a combination of block grants and activity-based financing. In just the Capital Region of Denmark, mental Health Services have a budget of 2.7 billion kroner (362 million Euros) (Olejaz et al., 2012). By contract, in China less than 2.35% of the government's health budget is spent on mental health, which has resulted in a shortage of specialized services, a limited number of physicians trained in mental health care, and inadequate insurance coverage for treatment of psychiatric disorders' (Phillips et al. 2009). It is reported that in 2018, the total funding on mental health care in China was approximately 3.43 billion Yuan (433 million Euros) (Chinese Psychiatry Association, 2019)

Although I myself as a service user had only been in contact with health service in the Nordic countries, in many cases young people with mental health problems are likely to be users of both the health service and the social service. In Nordic countries, mental health services include both health care and social services (Sommar, 2016). Hospital care, including mental health care, is delivered by general practitioners, psychiatric specialists and psychologists. Social services administered by the municipalities provide guidance and support to young people with impaired capabilities or social problems so that an independent life would be possible for them. Citizens with mental health problems can get access to socio-educational and psychological support, housing support, outreach, accommodation, and day and activity services. Advice on housing, maintenance and education are as well provided by the municipalities (Sommar, 2016). In addition to that, as employment is deemed to be an integral part of having an independent life, helping young people to find their way into the labour market is another key service available in the Nordic region. Job centers in Denmark offer services to ensure the job opportunities of young people who are not in education or work, and who receive state benefits. Even though collaboration between the job centre and the social services department is not a legal obligation, some have entered into agreements which ensure cooperation between the relevant players (Cited in Sommar, 2016).

The availability of comprehensive and coordinated services relevant to young people with mental health difficulties in the Nordic context would no doubt facilitate the service selection process as one could have a wide range of options as well as a higher possibility to get the kind of services that benefit them the most. Even when someone has no idea what is available and where they can go for help, there is online platform where people can easily and simply search for what is available for help and support where they live. For instance, UNGEKOMPASSET (The Youth Compass) in Denmark acts as a digital GPS where young people who are mentally vulnerable, their friends and family can search for information on where they can go for help. Both private and public service providers are gathered in the database, including everything from the nearest psychiatric emergency room to support groups, cafés, leisure clubs, treatment facilities for counseling and telephone lines.

The involvement of service user

During my encounter with the mental health service in the Nordic context, in my story I mentioned that my opinion was heard and included regarding to whether or not to take medication and be refered to psychologist, this experience could be related to the notion of "service user involvement". Besides a wide range of services available for people with mental health difficulties, the fields of social work and social care in Nordic countries have increasingly emphasized the involvement of service users. The involvement of service users in social work used to be limited to accidental and incidental overlaps where social workers at some point in their life had been or

became service users themselves. But in recent years, “the fields of social work and social care have been notable for their efforts to involve service users, developing initiatives and exploring approaches in particular aspects of their activities ahead of many other policy areas” (Baresford & Croft, 2001). This notion of service user involvement would undoubtedly promote and facilitate help-seeking and service use among those facing mental health problems.

Social work as a professional top-down activity, the marginal position of the recipients of service in the knowledge production has been questioned recently in the Nordic context. Baresford & Croft (2001) points out the fundamental role for service users in the social construction of social work. According to Baresford & Croft (2001) the involvement of service users means to include the involvement of service users’ perspectives, knowledge and analyses. The importance of including the perspective of service users in all areas of public policy and social care is underscored. The idea is that service users should be active participants rather than passive recipients in policies and practice relevant to them. It is maintained that user’s own perspective and knowledge which based on first-hand experience would make better-informed provision possible.

DISCUSSION

Low mental health help-seeking rate among the psychologically distressed is an issue presented in both the Chinese and the Nordic context, although the issue is much more severe in China. The current study deems it vital to further understand what influences mental health help-seeking so as to increase people’s access to care among the psychologically distressed. Knowledge and Understanding of factors that influence mental health help-seeking that aim to increase service use are as important as the development of better treatments or expansion of services. People’s low probability of seeking formal help for psychological problems is one key issue to be further understood and investigated. A deeper understanding of it is important for the field of social work and welfare as this will not only contribute to social work knowledge but also to social work practice so that more effective services could deliver to people with mental health difficulties.

This study begins with an introduction of global mental health burden, followed by a broad summary of mental health care in the Chinese and Nordic context, and later the research questions: What facilitates and hinders mental health help-seeking in Chinese and Nordic contexts? How mental health help-seeking is influenced by cultural and structural factors? A literature review on help-seeking in Chinese and Nordic/Western contexts is conducted to shed light upon the research subject. The method of auto-ethnography is then introduced and explained, followed with my auto-ethnographic story of my help-seeking in both the Chinese and Nordic contexts. Analysis of the auto-ethnographic story is based on a model of mental health help-seeking in which seeking

professional help is conceptualized as a three-stage process consisting of problem recognition, decision to seek help and selection of service. An individual's mental health help-seeking is affected by multi-spheres of influences. This study particularly focuses on the investigation of cultural and structural influences on mental health help-seeking. Cultural factor involves social norms, cultural values and beliefs regarding mental health and help seeking. Structural factor is relating to charicteristics of mental health service system in China and the Nordic countries. Cultural and structural influences on mental health help-seeking are analyzed throughout the three-stage help-seeking process with a comparative perspective of the Chinese and the Nordic contexts.

Mental health care in both China and the Nordic countries have undergone considerable change, with some similarities and some different progress. Sommar (2016) has summarized that the key changes in the mental health care in the Nordic countries are these three aspects: "the dismantling of institutional psychiatry; the building up and strengthening of locally based mental health services, and the development of measures to serve the target group in the social sector". China at the same time is still in the process of developing a national mental health service system, with a focus on enhancing greater availability of mental health services. While mental health care in China has made progress in the dismantling of institutional psychiatry and building up community-based mental health services, as the Nordic countries. But in the aspect of "the development of measures to serve the target group in the social sector", mental health care in China has been very much lagging behind compared to the progress made by the Nordic countries. And this aspect is exactly where social work plays an important role to contribute to the well-being and benefits of those people who are mentally vulnerable. Many problems people facing are not purely psychological problems, but there are indeed other factors that affect: physical health, family conflicts, interpersonal relationships, financial difficulties, etc. This cannot be solved by relying solely on mental health service. In many cases, people may tend to think that "talk" therapy is not really helpful to their lives, so they have no motivation to invest time and energy to seek such help. On the other hand, the possibility of knowing they could get support in other practical areas in their lives would increase people's help-seeking intention. Therefore, measures in relation to work, education, and social, personal, practical and professional development, housing and financial considerations, and treatment are needed when targeting at supporting adults with mental health issues. Before comprehensive services are possible, two types of service initiatives that could facilitate young people's mental health help-seeking and service use would be suggested, they're online mental health service and easy-to-drop-in centers.

The potentiality of online mental health service. Nowadays young people have high rates of ownership and use of mobile phones and other digital devices. When someone has no idea what is

available and where they can go for help, online service like UNGEKOMPASSET (The Youth Compass) in Denmark which private and public service providers are gathered in the database could act as a digital GPS where young people who are mentally vulnerable, their friends and family can search for information on where they can go for help. Evidence-based online intervention program, e.g. ICBT, other interventions conducted under professional guidance based on the Internet are worthy of promotion, especially for those with psychological needs. The help can also be not limited to those with social anxiety, and can include other mild to moderate mental disorders. Malla et al. (2015) propose that e-health may be particularly attractive for young people as a growing resource for managing health problems, including mental health problems. The technology can be utilized in a variety ways, from simple appointment and medication reminders to delivering interventions, to mental health tracking and self-management strategies (Malla et al., 2015).

Easy-to-drop-in centers. Based on the experience form Nordic countries, meeting places could be described as daytime and sometimes evening spaces where people in psychosocial hardships can spend their days with peers and professional staff on an easy-access volunteer basis, participate in diverse activities. Meeting places and other easy-access drop-in centers have been described as valued and favored by people attending them (Larsen and Topor, 2017). Headspace in Denmark could be one of the good examples. Headspace is a civil society service where young people could drop in and met by competent youth counselors who can help the young people further, from offering counseling to building bridges to other service providers. Over 20 municipalities around Denmark now have Headspace centers.

CONCLUSION

Help-seeking rate for psychological distress and mental disorders remains substantially low among those needing care. This study attempts to find out: What facilitates and hinders mental health help-seeking in Chinese and Nordic context? How mental health help-seeking is influenced by cultural and structural factors? Accounts from my auto-ethnography of seeking-help in both the Chinese and Nordic contexts are analyzed to understand how mental health help-seeking is hindered or facilitated throughout the help-seeking process. A comparative perspective is adopted to investigate cultural and structural influences on mental health help-seeking in Chinese and Nordic contexts.

I will end my thesis with discussion of the limitation of my study and recommendation for future research. Qualitative research is by its nature a subjective process. Auto-ethnography has its own limitations, which may make the research seem not "scientific" or "objective" enough, but I

using it in a more traditional analysis way and connections to scholarly literature can avoid excessive limitations and subjectiveness to some extent. On the other hand, a certain degree of "subjectivity" is inevitable and may well be the pursuit of this research theme, because help seeking itself includes intention and behavior and interplay of various factors. Although this research is not "comprehensive" enough, it adds some nuances about the current topic. In addition, because of the need to dig deeper into the personal experience of seeking help, it is a greater challenge for me to turn the emotional and intuitive mindset into a more rational and evidenced-based narrative. In the future, if researchers want to make similar attempts, they should do so with sufficient time and supervision. Furthermore, due to limited time and energy, some topics have not been explored fully, such as mental health help-seeking as international students/immirants in a Nordic context. With the increase of immigrants and a more diverse society in Nordic region, such topics will have great practical significance.

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