

## CONTEXTUAL ANALYSIS OF COPING: IMPLICATIONS FOR IMMIGRANTS' MENTAL HEALTH CARE

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*Providing high quality and effective health care services that are culturally acceptable and appropriate to clients has become an important issue for many health care providers. This paper explores problems associated with the traditional model that views coping according to hierarchical style and traits. While some scholars who have adopted this theoretical framework have made many contributions to the development of stress and coping theories, limitations are present. Using Vietnamese immigrants' experiences as examples, I argue that coping theories should emphasize the contextual nature of stress and coping, and that coping should be viewed as a dynamic process that varies under different social, cultural, political, economic, and historical conditions. Drawing from the work of others on coping, culture, imperialism, and colonialism, I explore the way that certain cultural conceptualizations determine how individuals cope. An understanding of the contextual nature of coping and of a Vietnamese immigrant's experience of coping with stressors and illness has implications for mental health care practice and research.*

Canada is a multicultural society, and immigration has always been central to Canadian history. An increase in the number of immigrants to Canada in the past two decades has changed Canadian social structure

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and approaches to health service delivery. Providing high quality and effective health care services that are culturally acceptable and appropriate has become an important issue to many health care providers.

As health care professionals, our interests and responsibilities are to provide effective health care for clients, while involving them in the process of acquiring a healthful lifestyle that promotes absence of diseases and illness (Anderson, 1987). Nevertheless, these goals are not always achieved. Problems may arise because health care professionals do not consider how clients' social, cultural, political, economic, and historical backgrounds shape the ways in which they cope with the experience of illness (Anderson, 1987; Mechanic, 1986).

The purpose of this paper is to: (1) explore problems associated with traditional coping models that view coping as a hierarchical style or trait, (2) emphasize the important role of social, cultural, economic, political, and historical factors in the coping process, and (3) discuss how certain cultural conceptualizations can determine how Vietnamese immigrants cope with illness. The first part of this paper provides an overview of coping theories and the meaning of illness. The works of Aldwin (1994) and Lazarus and Folkman (1984), and others are addressed. My intention is to emphasize the contextual nature of coping and provide evidence to illustrate that coping varies under different social, cultural, political, economic, and historical conditions. In the second part of the paper, I discuss issues related to culture and health care to illustrate factors that affect the ways in which Vietnamese immigrants cope with the experience of illness. I explore the work of Said (1993) and others on culture, imperialism, and colonialism, and the way that certain cultural conceptualizations influence how individuals cope by placing the individual in a certain position in a society. Finally, I show how an understanding of an immigrant's coping experience can affect mental health care practice and research.

## **COPING THEORIES: APPROACHES TO ASSESSING COPING**

The concept of coping has been of interest to the lay public and health care professionals for the past 40 years (Pollock, 1988). Developing successful coping skills has been the main aim of many psychotherapy, educational, and management programs (Newton, 1995; Pollock, 1988). Although coping has been examined extensively in the field of psychology, little consensus exists on theoretical approaches to coping research (Filipp & Klauer, 1990; Lazarus & Folkman, 1984). Initially, stress and coping research was divided into two distinct realms: physiological stimuli and psychological stimuli (Mason, 1975). More recent perspectives categorize coping into dispositional, contextual, or

integrative conceptual frameworks (Holahan, Moos, & Schaefer, 1996). Dispositional approaches emphasize relatively stable person-based characteristics, which determine coping behaviors. In contrast, the contextual approach stresses the important role of more transitory situation-based factors in determining coping choices. Finally, the integrative approach advocates a combination of both dispositional and contextual frameworks, and maintains that both approaches have complementary strengths in explaining the coping process (Holahan et al., 1996).

Lazarus (1993) distinguishes two main approaches to coping. The traditional approach to coping emphasizes coping as a style or trait. This approach assesses coping in terms of personality characteristics. In contrast, conceptualizing coping as a process emphasizes that coping is an "effort to manage stress that changes over time and is shaped by the adaptational context from which it is generated" (p. 234).

### **Coping as a Hierarchical Style or Trait**

A hierarchical style or trait approach to coping has roots in the psychoanalytic ego psychology model (Aldwin, 1994; Lazarus & Folkman, 1984). Scholars who view coping as a style or trait define coping as "realistic and flexible thoughts and acts that solve problems and thereby reduce stress" (Lazarus & Folkman, 1984, p. 118). As such, observations and evaluations of one's coping style often involve "what the person usually does, would do, or should do" (Lazarus & Folkman, 1984).

Coping as a style or trait is frequently categorized into higher order formulations which vary among authors. For example, Menninger divides coping strategies according to the level of disruption and disorganization that they reflect. With this model, any behaviors or thoughts that indicate a lack of control or imbalance are not seen as effective coping strategies. Effective coping strategies are evaluated according to their outcome and those strategies that reduce tension are viewed as most effective, and therefore placed at the top of the scale. In contrast, strategies that involve a disintegration of the ego are placed at the bottom of Menninger's original scale (Menninger, 1963, as cited in Lazarus & Folkman, 1984, p. 119). Similarly, Vaillant categorizes coping into four levels with "psychotic" mechanisms such as denial, distortion, and delusion at the lowest level and "mature" mechanisms including suppression, anticipation, and humor at the highest level (Vaillant, 1977, as cited in Lazarus & Folkman, 1984, p. 119).

The main value in measuring personality trait or style would be in its ability to predict or explain the product of certain responses. As such, coping as a style or trait has been widely used to identify risk factors that

can be altered to achieve favorable health or disease results, in particular, causal relationships between certain personality traits and poor health or illness related to work conditions (Parkes, 1994).

Researchers who are interested in coping styles and different abilities have identified five dimensions considered most relevant to the prediction of human behavior. These personality dimensions are locus of control, hardiness, type A behavior, dispositional optimism, and neuroticism. Many researchers have asserted that these personality traits are quite stable across individuals and are moderators of the stress outcome because they affect the extent to which an individual is likely to be affected by a stressful event. The traits are thus valuable in their ability to predict coping responses and outcomes (Bolger & Zuckerman, 1995; Carver & Scheier, 1994).

Other proposed advantages of viewing coping as a style or trait involve the predictive power of a standardized personality measure, which enables one to (a) generalize interventions across clients with similar personality characteristics, (b) have insight that helps to select a counseling approach that would lead to behavioral changes or adaptation, and (c) facilitate individual behavioral changes that are within the control of the client (Bolger & Zuckerman, 1995).

By viewing coping as a personal style or trait the focus is on personal "inner dynamics rather than on external environmental forces" (Lazarus, 1993, p. 241). Such an emphasis, as discussed by Lazarus (1993) and Parkes (1994), has not only caused the overgeneralization of personal styles and a tendency to group coping responses into a single continuum or dichotomy, but also ignores the influences of environmental conditions. Furthermore, "styles do not provide us with a description of the detailed, specific strategies of coping employed in particular stress contexts" (Lazarus, 1993, p. 241).

Lazarus and Folkman (1984) also contended that the main problem with viewing coping as a hierarchical style or trait is the way in which the concept of coping is operationalized. Coping as style is usually assessed with standardized measures. For example, Carver, Scheier, and Weintraub (1989) developed the COPE scale that measures both traits and specific coping strategies. On a scale of one to four, the COPE scale attempts to capture 14 modes of coping ranging from "active coping" to "alcohol-drug disengagement." Because these scales are based on a preconceived concept of the coping abilities of the subject, they run the risk of confounding the process and outcome of coping strategies (Lazarus & Folkman, 1984).

In summary, certain traits are fairly stable across individuals and may be valuable for predicting human behavior. Although evidence suggests

that traits are often associated with a particular pattern of coping response, the model of coping as a style or trait has often been criticized for having problems with (a) over-generalizations that lead to a lack of specific information on coping, (b) stereotyping and labeling of coping strategies and personal characteristics, and (c) ignoring the influence of environmental conditions (Aldwin, 1994; Lazarus & Folkman, 1984; Oakland & Ostell, 1996; Parkes, 1994; Schwarzer & Schwarzer, 1996).

### **Coping as Process**

In contrast to coping as a hierarchical style or trait, a theoretical perspective that views coping as a dynamic process emphasizes that coping is “not as an enduring personality trait, but rather a constellation of certain cognitions and behaviors that occurs in reaction to specific stressful situations” (Ridder, 1997, p. 418). Individual views of coping depend largely on the individual’s personal and social resources and on the context where the stressors occur. Because stressors encountered by an individual in everyday life and different situations are varied, coping is a continuous and dynamic process that changes according to an individual’s capacity, external environmental factors, and the inter-relationship between the individual and environment (Parkes, 1994). The individual’s coping is not static but constantly changing in response to external demands and subjective appraisals, and for this reason the contextual nature of coping is important (Aldwin, 1994; Lazarus, 1993; Ridder, 1997). Coping is defined as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141).

In this view, coping involves a cognitive appraisal process and coping responses. Cognitive appraisal is “the process of categorizing an encounter, and its various facets, with respect to its significance for well-being” (Lazarus & Folkman, 1984, p. 31). In other words, appraisal is the way an individual evaluates the degree and type of stressors as threat, challenge, or harmful loss in relation to his or her well being and then considers how to respond (Carver & Scheier, 1994).

As summarized by Lazarus (1993), coping as a process has the following principles and premises: (a) to avoid the risk of confounding the coping process and its outcomes, coping strategies which include thoughts and behaviors should be measured independently; (b) the judgment of the process as effective or noneffective should depend upon

the person, the type of stress, and the outcomes being studied; (c) an individuals' coping choices and options depend on the context at a particular time; and (d) people use two major ways to cope with stressful events: problem-focused and emotion-focused. Individuals who use problem-focused ways of coping aim to change the person-environment relationship by acting on the environment or their own behavior. In contrast, emotion-focused ways of coping are used to change "the relational meaning of what is happening, which mitigates the stress even though the actual conditions of the [stressful] relationship have not changed" (Lazarus, 1993, p. 238). In Western societies, a tendency exists to view problem-focused coping as a more effective strategy (Lazarus, 1993). For example, an immigrant who uses emotion-focused coping such as distancing to deal with the stress of culture shock may be deemed to be using a maladaptive coping strategy. However, depending on the type of stressor, distancing could be considered a more adaptive way of coping.

With the above principles and premises as a foundation, Lazarus and Folkman (1984) developed the Ways of Coping checklist, which has 67 items representing both behavioral and cognitive responses to stress. Review of the 67-item checklist shows that although effort was made to accentuate responses to stress as an inconsistent process in both time and situations, and to emphasize contextual influences, the measurement does not fully capture the contextual nature of coping.

Lazarus identified several general assumptions from studies that emphasized coping as a dynamic process:

1. In every stressful situation, the way in which individuals apply their coping options depends on appraisal of the event (Lazarus, 1993). For example, in migrating to a different country, if language deficiency is appraised as an immediate threat to security, individuals' coping strategies may be to stay at home, write letters to friends and relatives, or talk only to close friends in their own language. In later stages, if unemployment is appraised as a more serious threat to poverty, then going out to find a job may be a way of coping. Because individuals vary greatly in how they value and employ different coping strategies, it is essential to recognize that individual cognitive appraisal is a process that changes over time, across situations, and depends on context. Furthermore, an individual's evaluation of a stressful encounter is influenced by social, cultural, political, and historical conditions. For example, a Vietnamese immigrant with a mental health problem stemming from the experience of torture and the impact of migration might appraise his or her unemployment as

out of his or her control. Thus, the individual might use emotion-focused coping strategies such as denial or notion of fate to alter the relational meaning of the situation.

2. Coping pattern and strategies vary greatly in response to the given stressful encounter, situational demand, the individual capacity, and social resources (Aldwin, 1994; Lazarus, 1993; Lazarus & Folkman, 1984; Parkes, 1994).
3. When stressful encounters are appraised as out of one's control, "emotion-focused coping predominates," whereas if the situation is perceived as controllable, "problem-focused coping predominates" (Lazarus, 1993, p. 239).
4. "Coping is capable of mediating the emotional outcome . . . It changes the emotional state from the beginning to the end of the encounter" (Lazarus, 1993, p. 239).
5. Research on coping often focuses on identifying the variables that influence the choice of coping strategies and the effects of these strategies on outcomes (Lazarus, 1993).

A major limitation to the process approach, as identified by Lazarus, is that assessments, which are usually in the form of coping questionnaires, still do not assess the "whole" individual (Lazarus, 1993). Individuals' information—such as thoughts and actions, motivations, situational intentions, beliefs and value systems, life pattern, and social connections in specific contexts—would provide additional valuable insight for counseling practice (Lazarus, 1993).

## **Culture, Stress, and Coping**

Similar to Lazarus, Aldwin (1994) conceptualizes coping as "the use of strategies for dealing with actual or anticipated problems and their attendant negative emotions" (Aldwin, 1994, p. 107). She further elaborates that in the coping process, social and cultural factors can directly and indirectly influence individuals' appraisal of stress and shape the individual's response to stress by influencing the choices and options of their coping strategies (Aldwin, 1994). For example, social and cultural expectations of the children's future might influence the ways in which a Vietnamese woman appraises stress and directs her material resources toward helping her children to achieve certain educational levels, despite her own financial constraints.

Following these premises, Aldwin (1994) affirms that culture influences stress and coping in four different ways: (a) shaping the types of

stress, (b) affecting the individual's appraisal of the stressfulness of a given event, (c) determining the choice of coping strategies, and (d) providing mechanisms by which an individual can cope with stress. Aldwin further asserts that the way in which an individual copes is affected by four factors: the appraisal of stress, the individual's coping resources, the resources provided by the culture, and the reactions of others.

### **Vietnamese Cultural Perspectives and the Coping Process**

Culture may be defined in many ways. For example, Keesing (1981) defines culture as "a system of shared ideas, system of concepts and rules and meanings that underlie and are expressed in the ways that humans live" (p. 68). Latour and Woolgar (1979) refer to culture as "the set of arguments and beliefs that have a constant appeal in daily life and that are the object of all passions, fears, and respect" (p. 55). This paper proceeds from Helman's (1990) view, which suggests that culture is a set of guidelines that is passed on to individuals from generation to generation by ways of symbols, language, art, rituals, and social practices. These guidelines are the "cultural lens" through which individuals see the world and learn how to live within it. Not only do these guidelines provide a moral and ethical lens through which individuals understand the social world, but they are also aimed at maintaining social harmony and unification within the societies (Donnelly, 1998). Although many aspects of people's lives are influenced by their cultural beliefs and values, other factors such as an individual's past experiences, education, and socioeconomic factors influence the way that people view their world, make assumptions about life, and deal with life's circumstances (Lynam, 1992). As such, people's lives must be seen in their particular cultural, social, political, economical, and historical context (Dyck & Kearns, 1995). From a psychological perspective, not only do cultural beliefs, values, and practices influence an individual's perception of stress and their cognitive appraisal processes, but also their social positions within a particular society. These, in turn, will shape an individual's coping strategies and options.

Following these perspectives, an individual culture's conceptualization of health, illness, fate, and acceptable ways to deal with life events affect the appraisal processes, which in turn shape coping responses and outcomes (Aldwin, 1994; Kleinman, 1980; Lazarus & Folkman, 1984; Slavin, Rainer, McCreary, & Gowda, 1991). For example, for many Vietnamese, health is viewed as gold, whereas illness is viewed as an inevitable part of life—an event predetermined by destiny (Maltby,



1998; Nguyen, 1985). Thus, the acceptance of these beliefs has helped the Vietnamese to view changes in life, illness, and sometimes even death not as a source of stress, but as part of the Buddha's teaching: "to be born, grow old, fall ill and die" (Nguyen, 1985, p. 410). It is not uncommon to see an elderly person, living in a rural part of Vietnam, who spends his or her days polishing his or her own coffin in preparation for death. In this context, individuals' explanatory model of illness and disease, and their expectations toward treatments, both of which are rooted in their cultural background, help to determine how they make decisions regarding coping with illness (Good, 1994; Kleinman, 1980). For example, contrary to the Western biomedicine model that considers physical and psychological disturbances as causes of many illnesses, some Vietnamese believe that a weakening of the nerves, an imbalance of yin and yang, a loss of soul, bad wind, or an evil spirit may cause illness. For these Vietnamese, self-control, emotional restraint, consultations with a fortuneteller, the performance of ritual activities, or the restriction of certain "hot" and "cold" foods are considered appropriate coping strategies (Nguyen, 1985; Uba, 1992). Furthermore, the cultural belief that suffering from illness is often caused by immoral behaviors and desires has influenced many Vietnamese to adopt conformist coping strategies that are culturally and socially acceptable in the hope that these practices will reduce one's suffering in life (Nguyen, 1985).

In traditional Vietnamese culture, women have been taught and are expected not only to take care of their children and spouse, but also members of the extended family (Maltby, 1998; Waxler-Morrison, Anderson, & Richardson, 1990). These cultural values and expectations have led Vietnamese women to conform to their role as caregivers and to view additional responsibilities and hardship as "the way things are" (Maltby, 1998). These methods of coping are reinforced and supported within the Vietnamese community by the high regard that is given to these women as "good mothers," "good daughters," and "good women." This example illustrates that what appears to be "maladaptive" or "passive" coping may in fact be a form of "successful" coping, depending on the particular culture and situation. On the other hand, strategies considered to be "successful" may be judged "poor" when analyzed within the person's social environmental context (Filipp & Klauer, 1990).

With these perspectives, differences between traditional cultural values and Western values can become important sources of stress to immigrant families (Slavin, Rainer, McCreary, & Gowda, 1991). Because in North America, western values of individualism are often emphasized and encouraged, a counselor may see a Vietnamese woman who is devoting her life to raising her children and taking care of her parents as

a source of her stress. The Vietnamese family decision-making patterns reflect their respect for elders. Although the eldest male of the family or community is often consulted for advice when difficult life situations are encountered, consensual processes of the collective beliefs guide individual coping strategies (Nguyen, 1985; Waxler-Morrison et al., 1990). Thus, it is imperative for mental health care professionals to recognize that each individual's coping strategies should be viewed and assessed within their particular social, cultural, and situational context. Because the type of stressors, personal, and social resources influence the ways that individuals appraise and cope with illness (Aldwin, 1994; Lazarus & Folkman, 1984), social, cultural, historical, and economic background also affect an individual's coping process.

## **HEALTH CARE AND IMPERIALISM**

The Canadian health care system operates under the principle that all citizens ought to be given equal access to health care. Therefore, ensuring that immigrants have equal access to health and health care services is a primary concern of both the government and health care disciplines. The current notion that health is not only the absence of diseases and illness, and that health care is not only concerned with health care services, has directed health care professionals to examine issues related to health care from a broader perspective. Other determinants of health such as social, political, and economic factors have become important issues of scholarly analysis. Authors such as Anderson (1985, 1987, 1998), Dyck (1989), Kearns and Dyck (1996), Papps and Ramsden (1996), Stephenson (1995), and Stingl (1996) have examined barriers to health care confronting members of different ethno-cultural groups. These authors have identified that barriers are related not only to cultural beliefs and values, but also to ethnic inequality, in terms of political power and social economic status.

## **Culture, Colonization, and Post-Colonialism: Influences on Health and Illness**

Social, political, imperialist, and post-colonial perspectives can influence the individual's meaning of coping with illness. According to Williams (1981), cultural institutions are essential parts of the general social structure and basic components of selected traditions. The selected traditions usually reflect the dominant culture's social, political, and economic structures. These dominant ideologies and selected

traditions are taught in schools and expressed in the media such as the press, publishing and recording companies, television, and the film industry. These organizations represent and reflect a society's dominant relations and ideologies, which then become a norm against which other forms of social relations, behavior, and productions are interpreted and judged. Roseberry (1989) theorizes that because politics are often generated around particular social and cultural positions, culture represents the values of certain dominant societal political groups. Cultures also reflect images and involve movements in the society that are products of and responsive to particular forces, structures, and events within that society.

In the area of psychological science, the dominant ideology of stress and coping that is portrayed in the society shapes its attitudes and behaviors towards stress and the production of knowledge about stress and coping (Gergen, Gulerce, Lock, & Misra, 1996). According to criticisms by Gergen et al. (1996), the current production of knowledge in Western psychology has been geared toward generating universal knowledge. Not only does it reflect the dominant voices that emphasize individualism, mechanism, and objectivity, but any deviations from this norm are considered as errors or illegitimate knowledge, and subject to criticism.

Said (1993) examined culture in relation to imperialism and colonization. Imperialism and colonialism, Said theorizes, are acts of accumulation and acquisition of certain dominant ideologies within a society. The ideologies in which certain people are deemed "less advanced" or "subordinate" or even "inferior" have allowed the processes of domination to occur, creating tensions, inequalities, injustice, and racism in many societies. Said (1993) insists that a direct connection exists between imperial politics and culture and that the process of domination has been extended and embedded in all the affairs of cultures. Although a greater awareness of culture differences is now present and more effort is being put towards the elimination of racism, the consequences of these imperial ideologies include the discrimination of one culture by another, the tendency to dominate other cultures, and an inequality of power and wealth, which continues to exist in many societies.

Because Canada is a land of colonization, it cannot escape the effect of postcolonial processes. Li (1988), a Canadian professor of sociology, reveals that despite a commonly shared ideology of equality, ethnic inequality and racial discrimination exist in Canadian society. Li points out that ethnic inequality has become a systematic and institutionalized feature of Canadian society, and is maintained by differential power relations between dominant and subordinate groups. Similar to Li's findings, Elliott and Fleras (1992) find that structured ethnic inequality in terms

of unequal power relations, domination, and exploitation of the people of different ethno-cultural backgrounds exists within Canadian society.

Racial oppression and unequal power relations create barriers to labor job markets for subordinated groups, which indirectly leads to low income and poverty. A Vietnamese immigrant who works two, sometimes three, jobs to make enough money to live will experience low income and poverty as indirect barriers to health care access. Handy (1988) believes that many dimensions of social inequality such as an unequal power relations between a dominant and a subordinate group, class positions, and earning disparity will generate more stress for disadvantaged social groups. Furthermore, racial discrimination and oppression, which are the result of colonization processes, create low self-esteem and other psychological problems among subordinate groups (Bolaria & Li, 1985; Connell, 1989; Li, 1988; Papps & Ramsden, 1996; Ramsden, 1990; Said, 1993). Low self-esteem and psychological problems coupled with unequal distribution of power and wealth, which may lead to limited opportunities and access to social support and resources, have had a significant impact on the ways that immigrants cope with illness. Because Vietnamese immigrants come from a postcolonial country, colonization consequences often affect the cultural identity of the immigrants and shape their experiences within certain social networks and the health care system in disadvantageous ways. As evidence, from Stephenson (1995), the Vietnamese refugees' general fear of authority is perhaps due to a manifestation of other hidden problems. These problems may be related to (a) colonial patterns of inferiority and a history of torture by Vietnamese government officials, and (b) an unequal power relationship between health care providers and health care users as perceived by the Vietnamese.

As theorized by Said (1993), the process of domination, racial discrimination, and oppression, which are the direct results of imperialism and colonialism, have destroyed cultural identity and created unequal power relations, tensions, inequalities, and injustices within society. In the health care system, these consequences create unequal access to health care resources and create an unequal power relation between health care providers and health care users, which in turn affects how individuals receive health care and cope with illness. Anderson, Blue, Holbrook, and Ng (1993) found that non-English-speaking immigrant women were unable to obtain health care services they needed because of the position and condition in which these women worked and lived, and also because the existing health care system is set up to serve mainstream society. Therefore, to provide high quality health care and fully understand issues that are related to cultural health care, health care

professionals must be aware that (a) certain cultural conceptualizations determine how individuals cope with illness by placing them in certain socio-cultural positions, and (b) the clients' background influences their way of coping with the experience of illness.

In summary, according to Cassirer (as cited in Good, 1994), our perception and knowledge depends on symbolic forms that are a foundation of reality. Although these symbolic forms may not always accurately reflect reality, they constitute the world's diverse structures and human experiences. Conceptualizations of stress and coping are largely influenced by how stress and coping are portrayed symbolically within the culture. Stress and coping have been portrayed differently across cultures, between, and even within individuals. For some societies, such as the Vietnamese, the term "stress" is not common, but for other societies (i.e., Western), "stress" seems to connect to many aspects of the human experience. Not only that we are expected to cope with stress in an "effective" way, but the coping strategies must also be congruent with ideologies of the dominant culture. Thus, conceptualizations of stress and coping are not "something that naturally occurs in the world" (Pollock, 1988, p. 381), but are "man-made" concepts that are shaped by social, cultural, political, economical, and historical factors.

## **IMPLICATIONS FOR MENTAL HEALTH CARE AND RESEARCH**

### **Implications for Mental Health Care**

Health care professionals share common goals, which include the application of health care knowledge to reduce human suffering; assisting persons to achieve optimal health or a peaceful death; and promoting a lifestyle that prevents diseases and illnesses and promotes health. Health care professionals aim to promote a holistic approach to health care that includes warmth and caring for clients and quality and equality of client care. To achieve these goals, an understanding must be developed that social, cultural, political, economic, and historical factors affect clients' health and the way that they cope with illness. In clinical situations, such understanding can help health care professionals to identify appropriate coping strategies and choices to help clients manage the stress of illness.

Recognizing that cultural differences influence and shape the individual's coping strategies, mental health care professionals need to understand that coping strategies cannot be labeled as effective or noneffective without considering an individual's circumstances. What may appear to

be an irrational decision may, in fact, have been evaluated and appraised carefully according to the individuals' beliefs and values. Filipp and Klauer (1990) remind us that if we try to describe those who are "successful" at coping, we are dealing with the issue of values, which involves a need to define criteria for its evaluation. Not only is the selection of so-called "appropriate criteria" often reflective of the dominant culture's ideologies and values, but we are not justified in assigning labels of "good" or "bad" to certain coping behaviors (Aldwin, 1994; Filipp & Klauer, 1990). Mental health care professionals need to recognize that if we are committed to providing appropriate and high quality health care to clients, individuals' culture-specific beliefs, values, attitudes, and behaviors should be considered. We should avoid generalizations in explaining people's coping behaviors towards dealing with stress.

In addition, mental health care professionals need to recognize that "each health care relationship . . . is unique, power-laden and culturally dyadic. . . . Whenever two people meet in health care interactions, it inevitably involves the convergence of two cultures. This bicultural component involves not only unequal power and different statuses but often also two cultures with differing colonial histories, ethnicity or levels of material advantage" (Kearns & Dyck, 1996, p. 373). As health care providers, we need to recognize that our attitudes and behaviors affect helping relationships and can indirectly create barriers to health care access by causing clients to avoid seeking help (Anderson, 1998). This, in turn, can limit the clients' coping choices and options.

## **Implications for Research**

How stress and coping is conceptualized, its relationship with the environment, and the way mental health care professionals understand how people cope with health and illness will differ according to theoretical frameworks and philosophical perspectives. Although the dominant stress and coping paradigm has contributed valuable knowledge to the development of stress and coping theory, this knowledge does not provide specific information that can be "linked up with a whole person" (Lazarus, 1993, p. 242). The self-report questionnaire is often the main method used in quantitative research to measure coping. This method has limitations, which include: (1) participants are more likely to report what they are consciously aware of (Parkes, 1994), (2) coping items in the questionnaire may be over- or under-represented due to the lack of conceptual clarity (Oakland & Ostell, 1996; Ridder, 1997), and (3) questionnaires or surveys often assess only what people do and the choices that they make, but do not assess the meaning

of their coping actions (Stephenson, 1995). As such, stress and coping researchers should use research methods that would provide detailed information about the meaning that an individual attributes to their coping thoughts and actions, in a specific context. Qualitative research methodology such as phenomenology and ethnography, which uses in-depth interview and participant observation as the method of data gathering and analysis, should be encouraged. Future research on coping needs to pay more attention to identified ethnic and cultural strengths that enhance the development of an individual's coping. Different situational factors that influence an individual's coping strategies should be explored. In this context, researchers' initiatives to explore different coping strategies across stressful situations with different cultural groups should be encouraged, and institutional support should be available for such initiatives.

As pointed out by Banyard and Graham-Bermann (1993), the existing stress and coping theories do not place adequate emphasis on the analysis of power and power relations or how power may act as a mediator in the stress and coping process. Therefore, further research is needed to determine the effects of power and power relations in social support and the health care provider–health care user relationship. Researchers need to place more emphasis on issues that have the potential to influence health and social policy, and on the ways in which society constructs and shapes the position of different ethno-cultural groups within health care.

## **CONCLUSION**

An increase in the number of immigrants to Canada in the past two decades has dramatically changed Canada's social structure and health care system. Providing effective, quality health care services that are culturally acceptable and appropriate for clients has become an important issue for many health care professionals. This paper focused on ways to improve health and mental health care services given to Vietnamese immigrant clients and demonstrated that, to provide high quality and effective health care, mental health care professionals need to realize that social, cultural, political, economic, and historical backgrounds shape the ways that clients cope with the illness experience. Stress and coping theories should therefore emphasize the contextual nature of stress and coping, and coping should be viewed as a dynamic process that changes over time, shaped by the context out of which coping is generated. While scholars who adopt the theoretical framework that views coping as a personality trait have made many contributions, limitations are present. These limitations have been identified as over-generalizations

that lead to a lack of specific information on coping; stereotyping and labeling of coping strategies and of personal characteristics; and lack of consideration of environmental conditions that affect coping. Coping process measures need to focus on finding information that would not only identify individuals' coping strategies in a specific context, but also lead to the understanding of the meaning of their thoughts and actions. Finally, certain cultural conceptualizations can determine the ways that individuals cope with their illness experience by placing them in a certain position in the society. In light of our multicultural society, if the goals of health care professionals are to reduce human suffering, to provide holistic health care that is culturally acceptable and appropriate, and to improve the health of all clients, we must view the individual's life and ways of relating to the world within the larger framework of their society.

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