

Quilting Stories and Embracing Culture: An Arts-Informed Narrative Inquiry
Exploring the Experiences of an Older Chinese Canadian Immigrant with Depression

by

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EXPERIENCES OF OLDER CHINESE IMMIGRANT DEPRESSION

Abstract

Chinese immigrants tend to underutilize mental health services. Cultural and linguistic barriers may discourage Chinese immigrants from accessing these services. Yet, a paucity of qualitative research that explores the experiences of older Chinese Canadian immigrants with depression exists in the mental health literature. This study explored how older Chinese immigrants (age 55+) experience depression, and what their stories reveal about the sources of mental health support that they use. Using arts-informed narrative inquiry methods, I conducted a series of five research sessions with a co-participant from the Chinese Canadian community in the Greater Toronto Area. Narrative patterns regarding identity, voice, and communication, as well as a prominent narrative thread of relationship, emerged from my co-participant's story. This study illustrates the heterogeneity that exists within this group, and illuminates the value of a person-centered and culturally safe approach to providing mental healthcare to older Chinese immigrants with depression.

Key Words:

Chinese immigrant, depression, mental health, narrative inquiry, arts-informed methods

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“Trust in the Lord with all thine heart; and lean not unto thine own understanding; In all they ways acknowledge him, and he shall direct they paths.”
Proverbs 3:5-6 (KJV)

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In Academia

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In My Community

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* Neal is the pseudonym chosen by my co-participant in this narrative inquiry.

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Chapter One

Positioning Myself in This Narrative Inquiry

Divorce. Separation. These are words that cut the heart, leaving a scattering of questions and raw emotions in their wake. This is particularly true if these words are heard when a person is on their deathbed. These are words that my grandfather digested as his heart failed and he lay bedridden in my great aunt's apartment. When he died, any inheritance intended for his children and grandchildren had been lost in the turmoil of the marital conflict that punctuated his passing. And yet, he passed on to me a legacy of experience that has shaped my identity and forged my sense of resilience. It is from my grandfather that I inherited my depression.

In this chapter, I reflect upon how my experiences with my grandfather led me to explore how older Chinese Canadian immigrants experience depression through narrative inquiry (Clandinin & Connelly, 2000). I also share about how my narrative beginnings, specifically how my experiences as a member of my local Chinese Canadian community and a survivor of mental illness have contributed to my personal justifications of embarking on this narrative inquiry. I finish this chapter by outlining the purpose of my study and defining my research puzzle. The terms *research puzzle* or *inquiry puzzle* are used in Clandinin and Connelly's (2000) narrative inquiry to reflect the tentative nature of the knowledge and meaning that arise from the exploration of experience that occurs within a narrative inquiry. These terms draw upon Dewey's (1939) understanding that knowledge gained through personal experience is generative of further opportunities to continue learn and grow. The conventionally used term *research question* is imbued with connotations of finding a definitive answer, a notion originating from the positivistic paradigm that posits that an absolute truth that can be found (Clandinin & Connelly, 2000; Cresswell, 2013). Therefore, I use the term *research puzzle* in this narrative inquiry, instead of *research question*, to remain consistent with my chosen methodology of narrative inquiry.

My Turn to Qualitative Research

Prior to commencing my Master's studies at UOIT, my experiences of research within the fields of forensic psychology and health sciences exclusively utilized quantitative research methodologies. My initial interest in qualitative research stemmed from a desire to reconnect with my humanness as part of my process of healing from a resurgence of mental illness that had occurred during my undergraduate studies. *Humanness* is defined by Mayan (2009) as "living and learning with people to collectively make sense of our worlds" (p. 12). I was also intrigued by the possibility of learning how to combine my talents and skills as an artist with my scientific training in order to reconcile my identities as both an artist and a scientist.

Qualitative research is ideal to study phenomena that occur naturally (as opposed to phenomena that occur in closely controlled artificial environments, such as a laboratory), and focus on understanding the meanings that people may attach to their experiences in relation to a particular phenomenon (Mayan, 2009, p. 11). Qualitative researchers are also concerned with studying the contexts in which these experiences and phenomena may be found (Mayan, 2009). Generally speaking, qualitative researchers study the complexities of context by conducting in-depth studies with a small number of participants in order to attend to how a person's biography is influenced by, and influences, history and society (Chase, 2011; Mayan, 2009; Mills, 1959).

In qualitative research, researchers make their *ontological* and *epistemological* assumptions transparent. The term *ontology* refers to "the nature of reality" (Creswell, 2013, p. 20), and the term *epistemology* refers to how people's subjective experiences shape how "knowledge is known" (Creswell, 2013, p. 20) and reality is understood. Dewey (1939) highlights the importance of human experience in shaping how we learn, and how this "organic connection between education and personal experience" (p. 11) can be revealed by first probing our own stories (Clandinin & Connelly, 2000). In narrative research, the researcher begins by exploring how they are positioned autobiographically to a particular phenomenon (Chase, 2011, p. 421). In this narrative inquiry, I explore how older Chinese Canadian immigrants experience depression, and what these stories reveal about the sources of mental health support that are used. I will

now share my autobiographical positioning in relation to the focus of this narrative inquiry, and tell the story of how I came to choose Clandinin and Connelly's (2000) narrative inquiry as my research methodology.

Learning to Live, Living to Learn: Finding Narrative Inquiry

Narrative inquiry is reflexive in nature. Connelly and Clandinin (2006) describe narrative inquiry as involving a continual process of "living, telling, retelling, [and] reliving" (p. 478). I reflect upon these four words as I share my process of turning towards narrative research, and the appropriateness of drawing upon Clandinin and Connelly's (2000) *narrative inquiry* to explore how an older Chinese Canadian immigrant experiences depression and what these stories reveal about the sources of mental health support that are used. A researcher who is conducting a narrative inquiry may be referred to as a *narrative inquirer*. As a methodology, Clandinin and Connelly's (2000) narrative inquiry requires that narrative inquirers make transparent their relationships and personal interests in studying a particular phenomenon. How a narrative inquirer is personally situated in a narrative inquiry helps to illuminate how research interests arise from personal narratives of experience (Clandinin & Connelly, 2000). By writing about my experiences with my own depression and my grandfather's depression, I illustrate how I am personally invested in this study. Clandinin, Pushor, and Murray Orr (2007) refer to this as writing the *narrative beginnings* and it is a reflection of the autobiographical nature of this research methodology.

Living and Telling My Grandfather's Story

My initial experience with narrative inquiry occurred during the first year of my Master's studies. I was taking a graduate course on qualitative research methods in my institution's Faculty of Social Sciences and Humanities at the time. One of my first assignments was to summarize and present one of the many qualitative research methodologies using Denzin and Lincoln's handbook (2011). I was immediately drawn to the chapter on narrative research, as the term *narrative* implied the inclusion of people's stories. Reflecting upon this word, *narrative*, I recalled listening to stories as a young girl, told by my parents, grandparents, and other relatives, before bedtime. Often times these stories would be accounts of their own childhood experiences, or stories with imaginary

characters that nonetheless told of valuable life lessons. I was compelled to reflect upon how I have taken these stories for granted, and the ways in which qualitative research seeks to value stories of experience as legitimate sources of knowledge (Creswell, 2013). I learned about how narrative research, particularly narrative inquiry, can be empowering to individuals and communities, since “narrative inquiry revolves around an interest in life experiences as narrated by those who live them” (Chase, 2011, p. 421).

The stories that my grandfather told me, when I was a girl, centered on experiences that shaped his life. In turn, I have come to realize that many of his stories have influenced my understanding of my place and position in this world. Like me, my grandfather lived with one foot standing firmly within mainstream Canadian culture and the other foot planted proudly within the Chinese Canadian community. His stories reflected the pride he felt as both a Canadian-born citizen and a leader within the Chinese Canadian community. His stories inspired within me the value of hard, honest work, an appreciation of my Chinese Canadian identity, as well as the desire to help others. My grandfather lived these values.

He became one of the first Chinese Canadians to graduate from the chemical engineering program at the University of Toronto; He also strengthened bonds between Canada and China through his entrepreneurship in the early 1980's, and helped to strengthen his local community. By founding the Dragon Brands frozen Chinese food business with his father and siblings, he provided employment opportunities for women and immigrants (Suen, 2012). Through his stories, my grandfather taught me how to learn from past experiences to become a better person. I remember listening to my grandfather tell me a story about respect. “Respect is not given to you; it is something that is earned”, I remember him telling me as we sat in the living room of my parent's house. He then told me a story about how he learned this lesson through his first career as a chemical engineer at a paint-manufacturing factory.

My grandfather was grateful for the opportunity to work in his field. Most Chinese Canadians faced steep financial and social barriers in Canadian society, and obtaining a professional degree was rare within the community at the time. My grandfather knew that he would have to prove himself to his boss given the anti-Chinese

sentiment that was common in Canada back then. Despite his many years of dedication and hard work, however, my grandfather was not promoted once while he worked at the paint manufacturing factory. After some time, my grandfather and his siblings raised enough money to start their own business in processing and distributing frozen Chinese food. When the time came for my grandfather to leave his job as a chemical engineer to co-found Dragon Brand foods, his boss offered to promote him to the position of chief engineer in an attempt to retain his employment. While my grandfather chose to turn down the offer, he knew that he had finally earned the respect of his boss through his hard work. My grandfather told me that even a seemingly negative experience can be educational. He vowed to be different than his former boss at the paint manufacturing factory. My grandfather told me that everyone should have the opportunity to work, to prove themselves in the workplace, and be rewarded for their hard work and dedication accordingly. My mother and great aunt (my grandfather's sister) recall that my grandfather used to seek deliberately to hire individuals who traditionally had fewer opportunities to obtain stable employment at the time. Specifically, he hired many women, visible ethnic minorities, and formerly convicted persons while operating Dragon Brand foods in the City of Windsor, Ontario (E. Suen, personal communication, March, 13, 2016). My grandfather tried his best to live his values through his work as an entrepreneur.

When I reflect upon these stories, I gain a better understanding of my family's historical and current ties to the Chinese Canadian community. My identity as a Chinese Canadian places me in a unique position as I am able to empathize with the experiences of immigrants within our community while fully understanding and practising mainstream Canadian culture and values. I also am reminded of the humanity of older adults as my grandfather's stories engender within me a desire to listen to, and share, the stories of older Chinese immigrants with respect and dignity.

My grandfather also taught me about the virtue of stoicism, the importance of family, and the meaningfulness of caring for one another. As someone who witnessed the damaging implications of the Head Tax within our family and the Chinese Canadian community, my grandfather understood the hardships that early Chinese Canadian

immigrants faced as the *other* in a society ridden with racial tensions. Having grown up in a time before Canadian law prohibited racial and ethnic discrimination in schools and the workforce, my grandfather emphasized the importance of *being strong*. While this need to maintain harmony with mainstream Canadian society enabled my grandfather and the Chinese Canadian community to survive socially and economically, this desire for harmony in the face of adversity also stemmed from traditional Chinese culture (Hwang, 1987). Being strong, then, was not simply an adaptive measure, but also understood within the context of the Chinese concept of “impression management” (Hwang, 1987, p. 960) or *miànzi* (面子). While my grandfather and the Chinese Canadian community sought to live harmoniously amongst themselves, and with mainstream Canadian society, an unwavering pride in cultural identity imbued my grandfather’s stories.

I came to treasure the knowledge that was embedded in my grandfather’s stories as I learned that his sentiments towards his bicultural identity were shared across the Chinese Canadian community. According to Fernando (2006) and Stanley (2011), the term *Chinese Canadian* arose from the unique dual-cultural experiences of the children of Canada’s first Chinese immigrants, and was adopted as an act of political resistance during a time when Canada refused to grant citizenship to people of Chinese ethnicity, regardless of the country of their birth. Reflecting upon the resilience and tenacity that lay beneath the harmonious surface of our community, I reminisce upon a time when I asked my grandfather to help me with my math homework. I remember complaining to him about his refusal to allow me to use a calculator to assist me in my work. He explained to me the importance of being able to complete the calculations manually so that I could better appreciate the convenience that a calculator provided when more complex math problems arose. “But you’re not being fair!” I remember saying as I sighed in frustration. My grandfather then became quiet, and softly yet firmly told me that life was not fair. He emphasized the importance of working hard, and explained that as a Chinese Canadian, and young woman, I would have to work more than twice as hard compared to my fellow classmates in order to become successful in life. Looking back, I realize that his words were spoken from the standpoint of someone who understood the complexities and challenges of being a visible ethnic minority and part of a community of

immigrants. Taking my grandfather's advice to heart, I have learned to strive towards excellence by challenging myself in my work and studies, and gracefully enduring hardships. While heeding my grandfather's wisdom has served me well, I came to understand that upholding *miànzi* (面子) could be a double-edged sword when my grandfather's health started to decline.

My grandfather's physical and mental health started to visibly decline when I was around 10 years old. Before this time, I recall that he found much enjoyment in working and keeping busy with his various business endeavours--- always tinkering in his warehouse of Chinese antiques and housewares. Over time, his heart grew weaker and he suffered a number of heart attacks. He eventually had to sell his business and closedown his warehouse. I remember visiting my grandfather with my parents and overhearing discussions about heart medications and blood pressure, but I was told and understood that these matters were to be kept *private* and *within the family*. I also remember one day overhearing my parents and grandfather discuss my grandfather's behaviour, his feelings, and anti-depressant medication. It was then that I learned that my grandfather had depression. My parents later explained to me that, like my grandfather's heart condition, his depression was a *private* matter. Yet, it was even more important to keep his depression a *family secret* for the sake of protecting his good reputation within the community and protecting him from shame and embarrassment. Years after my grandfather's death, I have come to empathize with the suffering my grandfather may have endured while experiencing depression in silence. I have also realized my family's respect for his request to keep his condition a *family secret* was an expression of love and upheld in light of the stigma against depression, and any mental illness, that existed in our community, and Canadian society as a whole, at the time. Yet, I continue to look back in time and reflect upon his experiences with depression and wonder how my family's experiences with my grandfather's depression might have been different if he had been able to tell his story. I wonder how we might have been able to support him differently, perhaps better, if there was less of a stigma against depression in both mainstream Canadian and Chinese Canadian communities at the time. Perhaps, most

importantly, I reflect upon how my experiences with my grandfather have influenced my own silenced stories about living with depression.

Living and Telling My Story

Connelly and Clandinin's (2006) continuous process of living, telling, reliving, and retelling presents the opportunity to reflect upon our stories of experience and re-imagine new possibilities for the future. Through this process, I am invited to reflect upon my own experiences with depression, and make transparent my positionality towards this inquiry within the dimensions of person, place, and time (Clandinin & Connelly, 2000; Connelly & Clandinin, 2006).

Several years after my grandfather's death, I also was diagnosed with depression. This was a period of time marked with emotional turbulence, and I chose to withdraw from the Chinese Canadian community. My experiences as a pediatric psychiatry patient were also kept a *family secret*. I learned to hone my skills in the art of *mianzi* (面子) from a young age. My parents were concerned for my well-being, and worried that my elementary school peers might spread rumors and bully me if they learned that I had mental health issues. When I was in high school, my family and I worried that disclosure of my depression might reflect badly on our family, as people might wrongfully assume that my depression was the result of bad parenting. I learned to keep my feelings of sadness, hopelessness, and frustration to myself, and would cry privately in silence. Family relationships are very important to me. I strove to always project a friendly and cheerful demeanour while in public, in hopes of protecting the people I loved the most in life. When I started my undergraduate studies and started experimenting with dating, I believed that no one would want to date me if they found out that I had depression. I learned to ask careful questions and listen in order to determine a potential partner's opinions and attitudes towards mental illness. Experiencing my mental illness in silence began as a mechanism of survival, and eventually became a way of life for me.

My depression added yet another layer of difference to my already visible identity as one of the only Chinese Canadian students (besides my younger sister) amongst the primarily European Canadian student body at our elementary school.

Looking backwards in time, I recall words such as *insane*, *mental*, *crazy*, and *retarded* spoken as insults by both students and teachers. I came to understand that mental illness and neurological differences were viewed in a negative light, and I was thankful for my ability to hide my depression from others. I inherited a love for reading newspapers from my parents. Yet, while I was in high school I recall coming across numerous newspaper articles about violent crimes committed by the *mentally ill* and the dangers of patients escaping from mental health institutions. I took a mental note of these articles, and about gained a deeper understanding of my family's silence in light of these societal views of mental illness. Flynn, Gask, and Shaw (2015) explain that much of society's misconceptions and fears regarding mental illness and neurological differences result from the media's tendency to attribute the causes of violent crimes to mental illness. While I knew that I was not a dangerous person, my younger self was highly aware of these negative stereotypes against mental illness. Once again, I found myself keeping my experiences with depression a *private* matter.

My initial worries regarding the legitimacy of stories of depression as researchable data stemmed from my undergraduate training in quantitative research, and positivistic concerns about bias and validity of data (Creswell, 2013). This concern for legitimacy also was compounded by my self-stigma regarding my depression. Recent events in my undergraduate studies had exacerbated the symptoms of my depression, and I was experiencing difficulty in maintaining my previous levels of academic and extracurricular performance. I was, at the time, the leader of a student-based group representing the Faculty of Health Sciences--- a position in which I took pride, as it provided me with meaningful opportunities to collaborate with faculty and students. While this student group worked closely with the faculty and UOIT's Student Experience Centre, it was not affiliated with the Student Association (SA) (an independent organization from the university) due to a lack of SA policies regarding the formation of UOIT specific faculty clubs at the time of my group's formation. My group was in the process of joining the SA and a newly formed group of students also wished to form a club that represented the interests of the faculty, when my depression worsened. The SA's solution to this issue was to call an election, a process that I knew would require a significant amount of time, energy, and resources to successfully complete. Both my

family and psychiatrist were concerned for my mental and physical health, as I was concurrently working as an undergraduate research assistant in the Faculty of Social Sciences and Humanities and as an arts instructor at a local art gallery on weekends in addition to my academic and extracurricular pursuits. I felt devastated when my psychiatrist recommended that I withdraw my bid from the SA election and take a temporary break from school to care for my mental health. Since my depression was a closely guarded family secret, and some of my academic mentors suggested that I not mention to my peers that I was taking time off due to mental health issues, I once more remained silent about my depression. However, I knew that either way, I would leave a bad impression, or lose miànzi (面子). I withdrew from the election, resigned from my presidency with the student group, and reduced the amount of hours I worked as a research assistant, without providing an explanation for my actions. As a result, I did not graduate with the peers within my academic cohort, and felt a deep sense of shame and regret regarding the responsibilities that I left behind during my absence.

In light of my experiences with depression during my undergraduate studies, partaking in my Master's studies at UOIT has provided me with a form of social and academic redemption. Lindsay (2006) notes that sometimes a person's strong emotional responses to an event may prompt a deeper exploration of the meaningfulness of this experience in their lives. Perhaps my proclivity towards engaging in qualitative research concerning experiences of depression also has been influenced by an innate need to deconstruct and reconstruct my own experiences, and to transform the ways in which I understand myself as a person with depression (Lindsay, 2006). When reading Lindsay's (2006) account of her marital separation during her professional journey of becoming a nurse-teacher, or Schwind's (2003) disclosure of deep unhappiness during her experiences of illness, I admire the strength, wisdom, and beauty that permeated their writing. As a young woman, these stories inspire within me a desire to become stronger and wiser as I begin to navigate the complexities of adulthood. However, having grown up in a close knit Chinese Canadian community where individuals were expected to keep personal matters to themselves, I contended with the notion of vulnerability and the consequences of exposing my family's secret about my grandfather's, and my own,

depression. The act of telling our stories about experiencing depression allows me to relive these experiences and retell our stories in ways that may positively impact my life (Clandinin & Connelly, 2000; Lindsay, 2008b).

Reflecting upon my retellings of my experiences with mental illness, I see how stories are created in specific places and moments in time through interactions between people (Clandinin & Connelly, 2000). Narrative research helps to bridge the gap between the personal and social aspects of experience, and empowers individuals to become both social actors and life narrators (Maynes et al., 2008). The stories that we tell ourselves become stories that we live by--- ultimately shaping our personal knowledge and becoming our identities (Clandinin & Connelly, 2000; Lindsay, 2008a). I continue to reflect upon Clandinin and Connelly's (2000) explanation of how this process of living, telling, retelling, and reliving can transform people's lives. Clandinin and Connelly (2000) claim that, "we meet ourselves in the past, present, and the future. What we mean by this is that we tell remembered stories of ourselves from earlier times as well as current stories. All of these stories offer possible plotlines for our futures" (p. 9). Reflecting upon how I am positioned relative to this inquiry, I intend to tell about my experiences with depression (both my grandfather's and mine) while encouraging others to join in the telling. Through the process of telling our stories, I hope that we can relive our experiences with depression and come to understand them in a new light. This act of retelling of stories, and reliving experiences, is significant because it comprises what Dewey (1939) describes as the "active side [of experience] which changes in some degree the objective conditions under which experiences are had" (p. 22). With this understanding, personal experience births knowledge that is laden with transformative potential for an individual's future. Therein lies my personal justifications for embarking on this narrative inquiry.

Reliving and Retelling Our Stories of Depression

While there are generational differences between my grandfather and me, our stories and identities share some similarities. Importantly, we share an identity as Chinese-Canadians and our stories take place in both Chinese Canadian and mainstream Canadian communities. Many Canadians, particularly those with ties to ethnic and

immigrant communities, have a bi- or multi-cultural identity--- living within mainstream Canadian society while also identifying with their own ethnic community. This creates unique experiences within a healthcare system that has been traditionally oriented towards serving and treating mainstream Canadians. Previous empirical research has explored the disparities in healthcare that are influenced by this phenomenon. Compared to non-Chinese Canadians, Chinese Canadians are half as likely to contact a health professional regarding mental health concerns, even if they face a moderate to high risk of depression (Chen, Kazanjian, & Wong, 2009b). Older Chinese immigrants in particular are significantly less able to identify the symptoms of depression compared to their North American-born peers (Tieu, Konnert, & Wang, 2010). A number of studies have indicated that older Chinese immigrants also may be discouraged from accessing mental health supports and services due to increased stigma towards mental health issues, low levels of mental illness literacy, or a lack of perceived mental health need (Hsu, Wan, Chang, Summergrad, Tsang, & Chen, 2008; Nguyen, 2011; Tieu, Konnert, & Wang, 2010). Some research, however, suggest that older Chinese immigrants are better able to cope with the socioeconomic changes that occur with old age compared to their peers in mainland China, and therefore report less mental distress due to perceptions of better health (Wu, Chi, Plassman, & Guo, 2010). Even if a mental health need is perceived, older Chinese immigrants may prefer to utilize informal mental health supports and services, such as family members or close friends (Tieu & Konnert 2014). While the underutilization of mental health services by older Chinese immigrants has been well documented in North American literature, the cultural health beliefs and experiences of this population regarding the use of mental health services have not been extensively studied using a qualitative approach (Chen, Kazanjian, & Wong, 2008, 2010; Tieu & Konnert, 2014).

Qualitative research can help to enhance an understanding of phenomena by enabling scientists to explore the nuances of human experience that may be difficult, or impossible, to measure and quantify with numbers (Cresswell, 2013). Clandinin and Connelly's (2000) narrative inquiry aims to bring us as close to this human experience as possible by listening to people's stories and exploring how they are positioned across the dimensions of person, place, and time. In embarking on this narrative inquiry, my intent

is to listen to the stories of an older Chinese Canadian immigrant with depression and learn how these experiences might illuminate ways in which mental healthcare practices can better support such individuals.

Study Purpose

The purpose of this narrative inquiry is to better understand the experiences of an older Chinese immigrant (55 years of age and over) regarding depression, and the sources of mental health support that are used by an individual from this demographic group. The minimum age of my study's target population is 55 years of age, and is chosen because there may be a wide range of experiences related to being an 'older adult' between the younger Chinese seniors (i.e., 55-75 years), older Chinese seniors (i.e., 75-85 years), and oldest Chinese seniors (i.e., 85+ years) (Centre for Addiction and Mental Health, 2010). Specifically, the experiences of an older Chinese immigrant may vary concerning independence or dependence, marital status, the maintenance or decline of physical and mental health, immigration and acculturation (i.e., number of years since landing in Canada), and employment or retirement (Centre for Addiction and Mental Health, 2010). The specific aims of this narrative inquiry are as follows:

- (1) To co-construct stories and explore experiences of depression;
- (2) To explore how these stories of experience influence the conceptualization of depression, and the sources of mental health support that are used.

These specific aims lead to the following research puzzle:

Research Puzzle

How does an older Chinese Canadian immigrant (55 years of age and over) experience depression, and what do stories of experience reveal about the sources of mental health support that are used?

My focus on an individual's experience with depression is deliberate, and aligned with the theoretical and methodological purposes of this narrative inquiry. In Chapter Four, I draw upon Clandinin and Connelly's (2000) narrative inquiry methodology to further discuss the appropriate sample size, and the significance of storying individual

experiences in a narrative inquiry. In the next chapter, I use findings from the most recent peer-reviewed literature to illustrate the practical and social significance in conducting a narrative inquiry into the experiences of an older Chinese Canadian immigrant with depression.

Chapter Two

Literature Review and Synthesis

While narrative inquiry is autobiographical in nature, it is also important to outline the *practical justifications* of this narrative inquiry (Clandinin & Connelly, 2000; Clandinin et al., 2007) to demonstrate how this narrative inquiry may be useful in inspiring change or reflection upon current mental healthcare practices. The *social justifications* of a narrative inquiry are equally significant, and speak to the usefulness of a narrative inquiry in addressing larger social issues (Clandinin et al., 2007). Specifically, the social justifications of this narrative inquiry seek to explore how the experiences of older Chinese immigrants with depression may help to address larger social and cultural issues within the field of mental healthcare. Together the personal justifications, practical justifications, and social justifications illustrate the importance of a narrative inquiry. I elaborate upon how these three levels of justification also are used as a lens for critical analysis in Chapter 3. In the beginning of a narrative inquiry, the practical and social justifications for pursuing a particular direction of inquiry emerge from a critical review of the peer-reviewed literature.

In this chapter, I outline the peer-reviewed literature on depression and the utilization of mental healthcare services in North American Chinese immigrant populations. I also synthesize these findings to identify gaps in the literature that highlight the practical and social justifications for embarking on this narrative inquiry, and the need to explore the experiences of an older Chinese Canadian immigrant with depression.

Prevalence of Depression and Contributing Factors

Un/Healthy Immigrant Effect?

There is a paucity of research regarding the prevalence of depression in populations of older Chinese immigrants in North America. While challenges associated with immigration and a number of socioeconomic factors have been associated with higher levels of depressive symptoms in these populations (Casado & Leung, 2002; Lai, 2004, 2005; Mui & Kang, 2006; Stokes et al, 2002), this nascent body of literature suggests mixed results concerning the prevalence of depression amongst older Chinese

immigrants in North America. I acknowledge that Canada and the United States of America have distinct and different histories, sociopolitical climates, and healthcare systems, and chose to include studies from both countries in my review of the literature because previous studies have indicated that the epidemiological data on Canadians and Americans, particularly regarding depression, can be comparable despite these differences (Kuo et al., 2008; Joint Canada/United States Survey of Health, 2004; Vasiliadis et al., 2007).

Casado and Leung (2002) suggest that older Chinese American immigrants may experience feelings of migratory grief and depression after immigration. They note that, “immigration is a tremendous change in environment. When people face a change in environment, the experience of loss occurs” (p. 7). Using a survey that included components from the Chinese Depressive Symptom Scale, the Migratory Grief and Loss Questionnaire, the Immigration Factors Inventory, and the Acculturation Scale for Southeast Asians, Casado and Leung (2002) sought to explore the effects of migratory grief on depression by surveying 150 older Chinese American immigrants. Casado and Leung (2002) found that older Chinese immigrants who experienced higher levels of migratory grief also had high levels of depression. Experiences of migratory grief may be compounded by challenges associated with low levels of English proficiency. Casado and Leung (2002) also noted higher levels of depression in older Chinese immigrants with lower levels of English proficiency. Consistent with Casado and Leung’s (2002) findings, Nguyen (2011) found that lower levels of English proficiency were associated with an increased likelihood of perceiving a mental health need amongst a sample of older Asian American immigrants that included Chinese Americans. Nguyen (2011) suggested that, “the relationship between low English proficiency and higher levels of mental health need speak to the challenges associated with immigration” (p. 531). Noting the practical role of English language abilities, Casado and Leung (2002) suggested that fluency in English is key to the successful establishment of older Chinese immigrants into their new lives in America both personally and socially. Lacking fluency in English, therefore, might contribute to depression by impeding the development of a sense of identity and self-worth in a new country (Casado & Leung, 2002).

Having a lower level of English proficiency can make securing employment difficult, which may be a particular concern for older Chinese immigrants who wish to enter the workforce of their host country yet also have a low level of education (Casado & Leung, 2002; Lai, 2004, 2005; Stokes et al., 2002). Lai (2004; 2005) found that older Chinese Canadian immigrants who reported low levels of financial security also scored for higher levels of depressive symptoms on a translated version of the Geriatric Depression Scale (GDS) compared to those with higher levels of financial security. The GDS is a screening tool that is used to identify depression in older adults. In developing a Chinese translation (Mandarin) of the GDS and using it to detect symptoms of depression in a population of older Chinese American immigrants, Stokes et al. (2002) found similar results in their study of older Chinese American immigrants. Older Chinese American immigrants who reported lower levels of education and lower self-rated financial status were significantly more likely to be depressed (Stokes et al., 2002). Additional factors related to socioeconomic status that may be related to depression in older Chinese immigrants include low levels of life satisfaction, living alone, and higher levels of dependence on others (Lai, 2004, 2005; Mui & Kang, 2006).

Older Chinese immigrants who wish to enter the workforce of their North American host countries may also be younger in age (less than 70+ years), and the challenges associated with attempting to find paid work in a new country may contribute to symptoms of depression (Casado & Leung, 2002; Stokes et al., 2002). Casado and Leung (2002) found a weak inverse correlation between age and depression, and noted that this relationship may be caused by a heightened sense of loss for older Chinese immigrants who were in the workforce prior to immigration. This inverse association between age and levels of depression was also observed by Stokes et al. (2002), who observed that about 30% of the older Chinese immigrants in their sample (n=113) qualified as depressed when they used their modified and translated version of the GDS. Older Chinese immigrants who were in the age range of 60-69 years tended to have higher scores of depressive symptoms compared to those 70-79 years of age (Stokes et al., 2002). Older Chinese American immigrants aged 80 years and older tended to report the lowest amounts of depressive symptoms on the GDS. While it is possible that the findings of these studies may suggest older Chinese immigrants become more resilient to

depression with age, there remains a need to further explore other factors might influence this trend. For example, in a study that sought to determine the severity of stigma towards various forms of depression amongst Chinese American populations, Hsu et al. (2008) found a non-significant positive correlation between the age of the participants and scores for stigma when they were asked to respond to a series of clinically accurate vignettes that depicted depression. Therefore, there is a need to further explore whether additional factors, such as stigma, might influence the reporting of depressive symptoms by older Chinese immigrants in research studies.

The prevalence of depression also appears to be higher for older Chinese immigrants who have more recently immigrated compared to those who have resided in their North American host countries for longer periods of time. Lai (2004) found that approximately a quarter (23.2%) of the older Chinese Canadian immigrants in his study (n= 444) reported having symptoms of depression. Of these participants, 16.7% reported being mildly depressed and 6.5% described themselves as moderately or severely depressed. Lai (2004) found that older Chinese Canadian immigrants who had resided in Canada for a shorter length of time and who reported barriers to accessing health services reported having higher levels of depression in this study. These two factors were identified as being uniquely related to being an immigrant. Lai (2004) noted that the results of this study were aligned with previous research that “suggests that immigrant experience and disadvantaged socio-economic status often cause the elderly immigrants to be vulnerable to depression and other mental health problems” (p. 681). Similarly, Stokes et al. (2002) found that 100% of their sample’s older adults who had spent one year or less in the United States had Geriatric Depression Scale scores in the depressed range. They also found that 42% of their sample’s older adults who lived in the United States between two and five years had depressive symptoms. Only 22% of the older Chinese immigrants in this study who lived in the United States for over 15 years were depressed. While lower levels of English proficiency and lower levels of financial stability may create situations of vulnerability for more recent Chinese immigrants, researchers should be cautious in interpreting these factors as applying solely to depression in the newer segments of Chinese communities in North America (Casado & Leung, 2002; Lai, 2004, 2005; Stokes et al., 2002). Given that English language

proficiency may be used as a measure of acculturation in the study of older Chinese immigrants with depression (Casado & Leung, 2002), there remains a need to explore whether more established older Chinese immigrants also experience depression and what role English proficiency might play in these experiences. At the same, a continued research with more recent Chinese immigrants with depression might help to illuminate how multiple challenges associated with immigration and the process of acculturation may contribute to experiences of depression.

Elaborating upon the challenges of the immigration experience, Mui and Kang (2006) note that “depression may occur frequently in Asian immigrant elders because they have limited resources in dealing with multiple losses associated with the process of adaptation, acculturation, and family disruption” (p.244). In a study designed to explore the effects of various forms of stress and coping resources on self-reported symptoms of depression in a population of older Asian American immigrants (specifically from six ethnic groups: Chinese, Filipino, Indian, Japanese, Korean, and Vietnamese), Mui and Kang (2006) found that stressful life events, and acculturation stress (i.e., stress resulting from the challenges of adapting to the culture of the host country) were identified as significant associations with depressive symptoms in all six ethnic groups. Mui and Kang (2006) found that older Chinese, Japanese, Indian, and Vietnamese immigrants scored higher levels of depressive symptoms on the Geriatric Depression Scale compared to other populations of older Americans in the literature. These findings resonate with Lai’s (2005) study, where it was noted that the prevalence of depressive symptoms amongst the older Chinese Canadian immigrants in the study’s sample was 21.5%, and higher than the prevalence of depressive symptoms in the general population of older adults in Canada, which was reported to be 10-15%.

In contrast to the aforementioned studies, Wu et al. (2010) found that older Chinese American immigrants tended to report less mental health and physical health issues compared to older adults in Mainland China. Wu et al., (2010) used a short version of the Centre for Epidemiologic Studies Depression Scale (CES-D) to compare levels of depressive symptoms in a population of older Chinese immigrants in Boston, USA and Shanghai, China. The older American Chinese immigrants in their study also reported

higher levels of self-rated general health, higher levels of healthy behaviour, and less health problems compared to the older adults from Mainland China (Wu et al., 2010). Wu et al. (2010) suggested that their findings indicate that older Chinese immigrants may be more resilient compared to their counterparts in China. To investigate longitudinal trends in the mental health of various ethnic groups in Canada, Pahwa et al. (2012) analyzed data from Statistics Canada's Canadian National Population Health Survey (CNPHS) and found that Chinese Canadians reported the lowest levels of moderate to high mental distress compared to individuals from other ethnic groups. In congruence with the findings of Lai (2004, 2005), they found that Chinese Canadians who did report levels of mental distress on the CNPHS also reported also tended to report lower levels of education (Pahwa et al., 2012). Pahwa et al. (2012) and Wu et al.'s (2010) findings echo the notion of the *healthy immigrant effect*, a concept that describes the tendency for immigrants typically arrive to their host country in better health compared to individuals born in the host country. Indeed, Pahwa et al. (2012) noted that individuals who were born in Canada and identified as being of Eastern European ethnicity had the highest probability of reporting moderate to high levels of mental distress on the CNPHS. Within a Canadian context, Segall and Fries (2011) note that this may likely be the result of immigration policies that include health status as part of the screening criteria for prospective immigrants. Additionally, Segall and Fries (2011) suggest that the healthy immigrant effect may deteriorate over time explaining that "after ten years, as immigrants become more acculturated, their health appears to converge or even overshoot (i.e., become worse than) the patterns found among the general non-Aboriginal population [of Canada]" (p. 173). I note that both Lai (2005) and Wu et al. (2010) found that both older Chinese immigrants who had physical health issues, or poor self-reported levels of physical health, also reported experiencing high levels of depressive symptoms compared to older Chinese immigrants who were physically healthy. However, Wu et al. (2010) also found that older Chinese adults from China also reported high levels of depressive symptoms in the presence of physical health issues. This finding points to a possible intersection between physical health issues with depression for both immigrant and non-immigrant Chinese older adults which may be further examined through studies that include an in-depth exploration of individual experiences with depression.

The disparities in the prevalence of depression and mental health issues in populations of older Chinese immigrants that exist between the larger scale population-based studies by Pahwa et al. (2012) and Wu et al. (2010) and the smaller population-based studies previously mentioned (Casado & Leung, 2002; Lai, 2004, 2005; Stokes et al., 2002) may be due to methodological limitations and differences in each study's population focus and scope. For example, Pahwa et al. (2012) utilized data that was collected using a measurement tool (i.e., the Canadian National Population Health Survey and Centre for Epidemiologic Studies Depression Scale respectively) that was presumably not specifically designed for use with Chinese immigrant populations. Stokes et al. (2002), on the other hand, both translated the GDS and revised its questions to attend more closely to the cultural context of the older Chinese immigrants in their study. As a result, Stokes et al. (2002) noted that depressive symptoms were identified more easily in their study's population of older Chinese immigrants compared to when the original English version of the GDS was used in previous studies. Continued research that employs population-based quantitative methodologies is needed to further illustrate the prevalence of depression in populations of older Chinese immigrants. Furthermore, the use of qualitative methodologies, such as narrative inquiry, may be helpful in illuminating how the aforementioned socioeconomic factors identified in the literature may be meaningful to the specific experiences of individual older Chinese immigrants with depression.

Stigma and Perceptions of Depression

In addition to the mixed results in the literature pertaining to the prevalence of depression in populations of older Chinese immigrants, the stigmatization of mental health issues in North American Chinese communities may also negatively affect the perception of mental health needs by older Chinese immigrants (Hsu et al., 2008; Nguyen, 2011).

Both mental and physical illnesses appear to be highly stigmatized by Chinese immigrants in North America (Hsu et al., 2008). Hsu et al. (2008) used a series of clinically accurate vignettes to determine the severity of stigma towards various forms of depression amongst Chinese American populations, to examine how these levels of stigma may differ from stigma found in Caucasian American populations. Hu et al.

(2008) found that the overall stigma scores regarding depression were more severe in their Chinese American sample compared to the Caucasian American sample, even after gender, age, and level of education were taken into account. Chinese Americans tended to report feelings of fear and shame in response to all of the vignettes that pertained to depression (Hsu et al., 2008). Additionally, the Chinese American group had higher scores of stigma than the Caucasian group regarding the control vignettes that described physical disorders (Hsu et al., 2008). Given the stigmatization of both physical and mental illness in communities in the Chinese diaspora, one might wonder whether the lower levels of depressive symptoms in Wu et al.'s (2010) sample of Chinese American immigrants was the result of increased resilience in this population or due to higher level of stigma and accompanying potential barriers to perceiving and reporting mental health needs.

Chinese immigrants also may be unfamiliar with psychiatric terms used in the West to identify and describe depression (Yeung et al., 2011). Moreover, mental healthcare providers may often be initially unaware of a particular individual's indigenous illness beliefs (Yeung et al., 2011). Yeung et al. (2011) developed a culturally sensitive interview protocol to assist clinicians in engaging Chinese American immigrants in psychiatric treatment. In testing this interview protocol with a sample of Chinese American immigrants, Yeung et al. (2011) found that participants were unsure how to label their depression or identified their depression with somatic symptoms, such as insomnia and poor health, and emotional symptoms, such as worries. Participants also attributed their depression to financial issues, poor living conditions, relationship problems, and issues with adjusting to living in the United States (Yeung et al., 2011). Reflecting upon these identified causes of depression, I wonder how personal and social aspects of older Chinese immigrant's lives, such as relationship problems and experiences of adjusting to life in their host country, may matter to their conceptualization of depression.

In congruence with Yeung et al.'s (2011) findings, Tieu, Konnert, and Wang (2010) suggest that older Chinese Canadian immigrants may also have lower levels of depression literacy compared to their age-peers from other ethnic backgrounds. To define

depression literacy, Tieu et al. (2010) applied Jorm et al.'s (1997) definition of mental health literacy, which is defined as "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" (p. 182). Using a clinically accurate vignette depicting a case of depression, Tieu et al. (2010) found that only 11.3% of their Chinese Canadian sample (n= 54) identified the problem depicted in the vignette as depression. In comparison, 74% of the non-Chinese comparison group from a larger population-based study (n= 3047) correctly identified the problem in the vignette as depression (Tieu et al., 2010). Both older Chinese immigrants and non-Chinese older adults identified "day-to-day problems" (Tieu et al., 2010; p. 1322) as a primary cause of depression. Yet, older Chinese immigrants were less likely to attribute depression to chemical imbalances, trauma, abuse, or death of a loved one, and more likely to associate the cause of depression with "being a nervous person" or "having a weak character" (p.1322) compared to the non-Chinese older adults in this study. The attribution of depression to matters of personal character (Tieu et al., 2010) and adverse or challenging life experiences (Yeung et al., 2011), brings forth the question of how the use of narrative research methods might facilitate an in-depth exploration of the experiences of an older Chinese immigrant with depression. The disparities between how older Chinese immigrants and mental healthcare providers may conceptualize depression, as observed by Yeung et al. (2011) and Tieu et al. (2010) studies, illuminate the need to bridge understandings of depression between individuals from both groups. Yet, terms such as "depression literacy" bring to mind the possible privileging of clinical understandings of depression that are relevant to the contexts of Western medicine. Having a low level of depression literacy might allude to a lack of knowledge about depression, and overlook the value of alternative understandings of depression that may be meaningful within the personal, social, and cultural contexts of the lives of older Chinese immigrants with depression. This arts-informed narrative inquiry may help bring recognition to the value of alternative understandings of depression as told through the stories of an older Chinese immigrant with depression. Narrative inquirers seek to include the voices of their co-participants, and explore the ways in which stories of experience might be meaningful to addressing issues in professional practice (Clandinin & Connelly, 2000; Clandinin et al., 2007). This narrative inquiry resonates with Yeung et al.'s (2011) emphasis on the need

for culturally sensitive mental healthcare for Chinese immigrants and the importance of including patient's illness narratives in clinical encounters.

How older Chinese immigrants understand depression, and the causes that they attribute to depression, may have implications on whether mental health needs are perceived and help is sought. Nguyen (2011) notes that "an individual's perception of need for mental health services is an important concept for Asian Americans, as the conceptualization of need is an important step prior to help seeking" (p.527). In a study designed to determine the effects of acculturation on the perceived mental health needs of older Asian American immigrants, Nguyen (2011) analysed data from the California Health Interview Survey and found that only 5% of Filipino and Chinese Americans responded that they perceived a mental health need within the past year (n= 980). Asian Americans who were 65 years of age and older were less likely to perceive mental health needs compared to those who were 50 to 64 years in age (Nguyen, 2011). Nguyen (2011) noted that these findings suggest that older Asian American immigrants may either perceive having better mental health as they age, or they may either attribute mental health issues to other causes such as physical health needs and overlook mental health needs.

Conceptualizations of depression and perceived mental health need may also influence the attitudes of older Chinese immigrants towards seeking help for mental health issues (Nguyen, 2011; Tieu & Konnert, 2014; Tieu et al., 2010). Yet, inconsistencies in the peer-reviewed literature point to the need for further study in this area. In a study designed to determine factors that influence attitudes towards help-seeking and use of mental health services, Tieu and Konnert (2014) found that only 16% of the older Chinese Canadian immigrants in their study (n=149) responded that they sought help for a mental health issue within a year of their study's data collection period. They also found that older Chinese Canadian immigrants who identified as having lower affinity to Chinese cultural values and beliefs, perceived high levels of social support, and had high levels of physical health tended to report more positive mental health help seeking attitudes (Tieu & Konnert, 2014). Poorer levels of physical health, greater affinity to Chinese cultural values and beliefs, and increased age were factors that were

associated with more negative mental health help-seeking attitudes in this sample of older Chinese Canadian immigrants (Tieu & Konnert, 2014). Yet, these findings regarding age and levels of physical health conflict with Nguyen's (2011) findings that higher self-reported levels of physical health were associated with lower levels of perceived mental health need amongst older Asian American immigrants. How might older Chinese and Asian immigrants with higher self-reported levels of physical health be more receptive to seeking help for mental health concerns if simultaneously they perceive less mental health need compared to their less physically healthy counterparts? The inconsistencies between these two studies may stem from methodological limitations of population-based studies in contextualizing these correlations within the personal and social complexities that may be present in the lives of older Chinese immigrants. The use of qualitative research methodologies, such as narrative inquiry, may be particularly useful in helping to illuminate how conceptualizations of depression might be meaningful to both attitudes towards mental health help-seeking and perceived mental health needs as they are revealed in the experiences of an older Chinese immigrant with depression.

Understandings of depression might also influence which sources of mental health support are deemed "helpful" by older Chinese immigrants. Tieu and Konnert (2014) noted that, of the few older Chinese Canadian immigrants in their study who reported seeking help for a mental health issue, "approximately 5% of the participants had consulted a family physician, 8% spoke with a non-professional (e.g., spouse, friend, member of the clergy), and 3% of the participants consulted a family physician and a non-professional" (p. 143). When examining intentions to seek mental health support from various sources in this population, Tieu and Konnert (2014) found that older Chinese Canadian immigrants expressed a greater intent to rely on themselves, general practitioners, and close friends compared to psychologists. Tieu et al. (2010) also sought to determine which people and mental health interventions were deemed helpful or not helpful by older Chinese immigrants. They found that older Chinese immigrants ranked psychiatrists, close friends, and close family members as the top three most helpful people to consult for mental health issues (Tieu et al., 2010). This was followed by social workers, clinical psychologists, and general practitioners (Tieu et al., 2010). While both Tieu and Konnert (2014) and Tieu et al. (2010) found that older Chinese immigrants

identified close friends as a potentially helpful source of mental health support, findings were otherwise inconsistent regarding which sources of mental health support were considered to be the most helpful by older Chinese immigrants.

It should be noted that the majority of older Chinese immigrants in Tieu et al.'s (2010) study identified psychiatrists as helpful people to consult for mental health issues (86.8% of the sample), whereas less than half of the older Chinese immigrants identified general practitioners to be helpful (43.4 % of the sample). Given that most patients require a referral from a general practitioner before mental health services can be accessed, Tieu et al. (2010) noted that older Chinese Canadian adults may lack knowledge regarding how to navigate the Canadian mental healthcare system. This potential lack of familiarity with the Canadian mental healthcare system might be a relevant barrier to the underutilization of mental health services by Chinese immigrants that is documented in the peer-reviewed literature (Chen et al., 2008; Chen, Kazanjian, & Wong, 2009b; Chen et al., 2010; Sadavoy et al., 2004).

Utilization of Mental Health Services

Despite the presence of depressive symptoms in North American populations of older Chinese immigrants (Casado & Leung, 2001; Lai, 2004, 2005; Stokes et al., 2002), A number of studies have documented an underutilization of mental health services by East Asian and Chinese immigrants in North America, and explored the factors that may influence this trend (Chen et al., 2008; Chen, Kazanjian, & Wong, 2009a, 2009b; Chen et al., 2010; Sadavoy et al., 2004).

Chen et al. (2010) sought to determine the patterns of health service utilization of Chinese immigrants who have been diagnosed with persistent and severe mental illness. Chen et al. (2010) linked and analyzed data collected by the Landed Immigrant Data System (LIDS) and British Columbia Linked Health Data (BCLHD) databases. Chen et al. (2010) found that, compared to an unspecified comparison group, Chinese immigrants with mental illness were more than half as likely to underutilized mental health services provided by general practitioners and hospitals. Chen et al. (2010) also discovered that Chinese immigrants with the most severe mental illnesses visited a psychiatrist more frequently than the comparison group. The underutilization of these mental health

services by Chinese immigrants with mental disorders may be indicative of better overall mental health in this population (Chen et al., 2010). Yet, an alternative explanation for this trend may be that Chinese immigrants with mental disorders may tend to only seek mental health services when experiencing acute and severe symptoms of mental illness (Chen et al., 2010).

Using data from the College of Physicians and Surgeons of British Columbia, and an immigration database, Chen et al. (2008) sought to determine the factors related to the utilization of mental health services (i.e., services provided by general practitioners, and psychiatrists) by Chinese Canadian immigrants. Chen et al. (2008) found that for both younger immigrants (i.e., those who arrived to Canada while under 25 years of age) and older immigrants (i.e., those who arrived to Canada while over 25 years of age), the number of visits to general practitioners for non-mental health reasons was positively correlated with visits to the same health professionals for mental health reasons. For older Chinese immigrants, the overall number of consultations with general practitioners (for both mental health and non-mental health consultations) increased with the number of years spent in Canada (Chen et al., 2008). This finding supports Segall & Fries' (2011) suggestion that the healthy immigrant effect decreases as Canadian immigrants become more acculturated. Chen et al.'s (2008) study also indicates that it may be possible that the provision of mental healthcare in primary care settings may be beneficial to older Chinese immigrants, despite the mixed results concerning the perceived helpfulness of physicians and general practitioners for mental health needs in populations of older Chinese immigrants (Tieu & Konnert, 2014; Tieu et al., 2010).

Sadavoy et al. (2004) conducted a series of focus groups to identify the barriers to accessing mental health services experienced by Chinese and Tamil seniors in Toronto, Ontario. Clinically accurate vignettes depicting cases of mental illness were used to generate discussion (Sadavoy et al., 2004). Similar to the findings of Tieu et al. (2010), Sadavoy et al. (2004) observed that awareness of mental disorders seemed to be limited amongst both the Chinese and Tamil seniors. Mental health problems tended to be attributed to various social stressors such as low socioeconomic status, social isolation, and family conflicts (Sadavoy et al., 2004). Both Chinese and Tamil seniors also

displayed an insufficient amount of knowledge regarding how to access mental health services or social services within the healthcare system (Sadavoy et al., 2004). Significantly, the seniors expressed feelings of distrust towards health professionals outside of their respective ethnic groups and these feelings were compounded by the perception that mainstream health professionals were not culturally competent (Sadavoy et al., 2004). Language was also identified as a significant barrier to their use of mental health services by both the Chinese and Tamil seniors, (Sadavoy et al., 2004). The seniors relayed that they were reluctant to use family members as interpreters during visits with mental health professionals due to concerns about confidentiality (Sadavoy et al., 2004). Supporting Hsu et al.'s (2008) claim of the presence of high levels of stigma against depression and other mental health issues in Chinese immigrant communities, many of the seniors in Sadavoy et al.'s (2004) study also expressed feelings of shame and embarrassment at the thought of potentially disclosing mental health problems to close family members. Geographic barriers were also a cause of concern for many of the seniors, as most of the culturally competent healthcare services were located in Toronto's downtown core, while the majority of the seniors participating in the study lived in suburban areas (Sadavoy et al., 2004).

Chen, Kazanjian, and Wong (2009a) paired two administrative health databases in British Columbia to compare patterns of diagnosis associated with mental health visits by Chinese Canadian immigrants compared to non-Chinese Canadians. They found that Chinese immigrants were less likely to consult a physician regarding mental health issues compared to non-Chinese Canadians. This finding contrasts with Tieu and Konnert's (2014) and Tieu et al.'s (2010) observations that older Chinese immigrants viewed physicians as helpful people to consult regarding mental health issues. Compared to subjects in the comparison group, Chinese immigrants who did receive mental healthcare tended to seek help for serious mental health conditions, such as affective psychosis and schizophrenia (Chen et al., 2009a). This finding suggests that Chinese immigrants might tend to delay seeking mental health care when mental health conditions are perceived to be comparably mild. Chen et al. (2009a) also found that, for the Chinese immigrants who did consult with physicians, depression and anxiety were the two most common reasons for mental health consultations. In contrast, about a quarter of the study's comparison

group consulted physicians for mental health issues related to drug dependence, which was a relatively rare diagnosis among the Chinese immigrant group (Chen et al., 2009a). This finding is congruent with previous studies that demonstrate the presence of depressive symptoms amongst populations of older Chinese immigrants in North America (Lai, 2004, 2005; Mui & Kang, 2006; Stokes et al., 2002).

Chen et al. (2009b) suggested that cultural barriers also play an important role in addition to possible language barriers in the underutilization of mental health services by Chinese Canadians. Data from the Canadian Community Health Survey Cycle 1.1 was analyzed to determine the differences between the patterns of mental health service utilization of Chinese immigrants, Canadian-born Chinese, and non-Chinese populations in British Columbia (Chen et al., 2009b). The Canadian Community Health Survey Cycle 1.1 was a national survey conducted by Statistics Canada that collected information from a randomized cross-sectional sample of people aged 12 years and older. Chen et al. (2009b) found that both immigrant Chinese and Canadian-born Chinese were less likely to have visited a mental health professional within the past year, compared to people who did not identify as Chinese. Even when individuals from the Chinese populations were identified as being at risk for depression, they were about half as likely to have contacted a health professional regarding mental health concerns compared to non-Chinese persons, (Chen et al., 2009b). The ability to speak a Chinese language was associated with a significantly lower use of mental health services whereas a statistically weaker association between English language ability and increased use of mental health service use was found (Chen et al., 2009b). The authors of this study interpreted these findings as an indication that an orientation towards Chinese culture (i.e., use of Chinese language) had a greater influence on the utilization of mental health services, compared to the influence of potential language barriers faced by members of the Chinese populations (Chen et al., 2009b).

Interestingly, despite previous findings regarding the higher prevalence of depression amongst older Chinese immigrants with lower levels of education (Lai, 2004, 2005; Stokes et al., 2002), Chen et al. (2009b) found that having a higher level of education was a factor that was associated with an increased numbers of mental health

consultations in the Chinese immigrant populations. It is possible that the Chinese immigrants with higher levels of education are not necessarily immune to the challenges and stresses associated with immigration and the process of acculturation. It is also possible that Chinese immigrant with more education may have increased access to mental health services due to increased financial stability that might ameliorate the financial costs of mental healthcare in Canada (Segall & Fries, 2011; Chen et al., 2009a).

Summary and Critique of the Literature

Cultural tensions.

In my review of the literature, race and ethnicity were mentioned on occasion as contributing factors to the mental health status and patterns of mental health service use of older Chinese immigrants. Yet, the exploration of race and ethnicity were limited in studies that employed quantitative methods. Ethnicity refers to an individual's ethnic identity or self-identified belonging to a group that shares similar cultural beliefs, language, and ethnic origins (Clarke et al., 2008; Statistics Canada, 2011). Culture may include, or be influenced by, a multitude of socioeconomic factors including age, level of financial security, and social status (Segall & Fries, 2011). However, Statistics Canada (2011) routinely employs the term ethnic origin to identify the ethnicity of individuals and limits the notion of ethnicity to refer to the place or country from which a person's ancestors originated. The Statistic Canada (2011) definition of ethnicity was the most frequently used in the research articles that are included in my literature review. However, while a limited conception of ethnicity as ethnic origin lends itself well to large population based studies, the heterogeneity that exists within and between ethnic groups is unable to be captured and explored by a view of ethnicity as referring solely to the place or country from which a person's ancestors originated. Furthermore, quantitative measurements, such as those used in surveys that employ Likert scale measurements, generate sparse insights into the impacts of culture and ethnicity in experiences of living with mental health issues (Casado & Leung, 2002; Nguyen, 2011; Chen et al., 2008; Chen et al., 2009b; Chen et al., 2010).

Additionally, there is a paucity of qualitative research concerning older Chinese immigrant's experiences with depression and their use of mental health services. Of the

studies I examined in this literature review, only Yeung et al. (2012) and Sadavoy et al. (2004) employed qualitative methodologies. In quantitative research approaches, the researcher is assumed to hold an objective stance in which their personhood is irrelevant, and an interference, to research endeavors (Lincoln et al., 2011). Yet, I consider Foucault's claim that asserts that claims of objectivity or neutrality are often employed to give power and privilege to dominant groups (Mackey, 2007). In the literature I reviewed, the researchers' framing and approach to their studies hold hegemony over the ways in which knowledge about Chinese immigrants living with mental health issues is conceptualized, interpreted, and disseminated (Lincoln et al., 2011). This power is exercised by researchers towards their research participants and members of their support networks in a variety of ways, and is highly apparent in the ways that the voices of researchers are privileged over the voices of the research participants (Lincoln et al., 2011; Mackey, 2007). While the use of a priori measurements and definitions of depression are necessary aspects of conducting large-scale population-based studies (Lai, 2005; Stokes et al., 2002; Hsu et al., 2008), research approaches such as these do not effectively capture and represent the perspectives and meanings that an older Chinese immigrant may make of their experiences with depression and sources of mental health support. Conducting an arts-informed narrative inquiry into the experiences of older Chinese immigrants with depression may help to address these issues of voice by bringing the participant's stories of experience to the foreground, and enabling older Chinese immigrants to tell about these experiences on their own terms.

To date, research focused on the mental health of older Chinese immigrants in North America points to a need for the use of qualitative methodologies to help contextualize the contributions of various factors (e.g., socioeconomic factors, challenges with acculturation, physical health) to experiences of depression. There is also a gap in the literature regarding the portrayal of older Chinese immigrants' experiences with depression using a narrative approach. In my study, my intent is to provide older Chinese immigrants an opportunity to explore their experiences on their own terms and to add their knowledge to the mental health literature. The findings of my study that focus on the perspectives and experiences of older Chinese immigrants will contribute to the existing research on geriatric mental health by providing insight into the how members of this age

group experience depression, and why particular sources of mental health support are preferred by these individuals.

Like other forms of qualitative research, narrative inquiry engages the use of inductive reasoning. Therefore, while this chapter has helped to identify the gaps in the literature that support the direction of inquiry that is pursued in this study, I conducted subsequent reviews of the literature more fulsomely once the analysis of my co-participant's stories commenced. I return to the peer-reviewed literature in Chapter Six and Chapter Seven to unpack how my co-participant's experiences with depression may be meaningful to illuminating the thinking and practice of health care providers (i.e., practical justifications) and address larger social issues in the field of mental healthcare (i.e., social justifications) respectively.

Chapter Three

Research Methodology

In this chapter, I outline the theoretical underpinnings and key concepts of Clandinin and Connelly's (2000) narrative inquiry, and discuss the appropriateness of this methodology to explore my research puzzle about the experiences of an older Chinese immigrant with depression. I also illustrate how these concepts work together to form the guiding theoretical framework of my narrative inquiry. I then introduce Lindsay and Schwind's (2016) arts-informed narrative inquiry methods. I further reflect upon the meaningfulness of incorporating arts-informed methods into this inquiry by sharing my personal connection to the arts. This chapter helps to contextualize further discussions as I delve into the specificities of how these methods and methodology were applied during the unfolding of this narrative inquiry in Chapter Four.

Narrative Inquiry

Since the aim of this study is to explore the experiences of an older Chinese immigrant with depression and his use of mental health services, this study lends itself well to a narrative research approach. The philosopher Dewey (1939) theorizes that experience is a source of educative knowledge. However, Dewey notes that not all experiences are educative, acknowledging that some experiences may shut off a person's opportunities for further growth in certain directions. He claims that experience must be both continuous and interactive for it to be a source of educative knowledge. The criterion of continuity requires that a person's experience generate further opportunities for growth and learning (Dewey, 1939). The criterion that experience must be interactive to be educative acknowledges both the internal (i.e., personal) and external (i.e., social) factors that influence a person's experience. Using these two criteria, continuity and interaction, helps to determine whether an experience is educative (Dewey, 1939). According to Dewey (1939), "continuity and interaction in their active union with each other provide the measure of the educative significance and value of an experience" (p. 26). Drawing from Dewey's theory of experience, Clandinin and Rosiek (2007) concisely claim that experience "is characterized by continuous interaction of human thought with our personal, social, and material environment[s]" (p. 39). Following upon Dewey's

(1939) notion that experiences may be educative if they are continuous and interactive, Clandinin and Connelly (2000) conceptualize narrative as both the methodology and phenomenon within their research. Situating their approach within the broader field of narrative research, Clandinin and Connelly (2000) refer to their methodology as *narrative inquiry*.

Narrative inquiry entails an exploration of how a person lives, tells, retells, and relives their experiences, with the goal of understanding how these experiences are shaped by the individual's identities and social milieus (Clandinin & Rosiek, 2007; Connelly & Clandinin, 2006). Therefore, narrative inquiry is concerned with the construction and analysis of people's stories (i.e., narratives) of experience in the contexts in which they take place (Clandinin & Connelly, 2000; Creswell, 2013).

The Three Commonplaces of Narrative Inquiry

In narrative inquiry, experience is explicated by probing how people's stories are influenced by personal and social interactions, located in specific places, and situated over time (Clandinin & Connelly, 2000). Clandinin and Connelly (2000) created a metaphor of a three dimensional narrative inquiry space to suggest that an individual's narratives are simultaneously positioned within the dimensions of personal and social interactions, time, and place. The first dimension, comprising personal and social interactions, focuses on the narrator's personal interactions with others, society, and themselves (Clandinin & Connelly, 2000). The place dimension emphasizes that narratives are physically and contextually situated within one or multiple places (i.e., a hospital, a province, a municipality, a culture, a community) (Clandinin & Connelly, 2000). The temporal dimension acknowledges that narratives are situated in time--- past, present, future--- and reflect Dewey's notion that experiences can be generative and continuous (Clandinin & Connelly, 2000; Clandinin & Rosiek, 2007).

Connelly and Clandinin (2006) further built upon these three dimensions by identifying three commonplaces of a person's experience that must be simultaneously explored when conducting a narrative inquiry. Drawing upon aspects of Aristotelian philosophy, Schwab (1987) established four commonplaces of curriculum—learner, teacher, milieu, and subject matter—to address the complexities of curriculum, while

defining the requisite components of a curriculum argument in educational research. Borrowing from Schwab's (1978) notion of the commonplaces of curriculum, Connelly and Clandinin (2006) sought to identify the commonplaces of narrative inquiry in order to clarify how this methodology was distinct from similar qualitative methodologies. The three commonplaces are temporality, sociality and place.

The first commonplace, *temporality*, compels the narrative inquirer to seek to understand people, events, and places as having a past, present, and future (Clandinin et al., 2007; Connelly & Clandinin, 2006). This commonplace hails directly from Clandinin and Connelly's (2000) previous understanding of the dimension of time within their metaphorical three dimensional narrative inquiry space. By directing their focus to include the commonplace of *temporality*, narrative inquirers allow themselves to study phenomena as existing "in process, as always in transition" (Clandinin et al., 2007, p. 23).

The second commonplace of *sociality* attends to the personal conditions and social conditions of a narrative inquiry (Connelly & Clandinin, 2006). Connelly and Clandinin (2006) define personal conditions as "the feelings, hopes, desires, aesthetic reactions, and moral dispositions of the person, whether inquirer or participant" (p. 480). They define social conditions as matters pertaining to existential issues, the environment, external forces and factors, and people that are meaningful to an individual's social context (Connelly & Clandinin, 2006). Another aspect of the *sociality* commonplace is the relationship between the narrative inquirer and their participant. Connelly and Clandinin (2006) note that "[narrative] inquirers are always in an inquiry relationship with participants' lives. We cannot subtract ourselves from relationship" (p. 480). This emphasis on the relationship between the narrative inquirer and participants highlights the relational nature of this research methodology, and alludes to the continual negotiation of purposes, meanings, next steps, and outcomes that occur within research relationships (Connelly & Clandinin, 2006). The commonplace of *sociality* points to the requirement that narrative inquirers engage in reflexivity during a narrative inquiry. Connelly and Clandinin (2006) note that, "in contrast to the common qualitative strategy of bracketing inquirers out, narrative inquirers bracket themselves into an inquiry" (p. 480).

The third commonplace of *place* refers to “the specific concrete, physical and topological boundaries of place or a sequence of places where the inquiry and events take place” (Connelly & Clandinin, 2006, p. 480- 481). Place may change within the context of temporality, and narrative inquirers need to be attentive to the impact that each specific place may have on a person’s experiences (Clandinin et al., 2007; Connelly & Clandinin, 2006). In a narrative inquiry, these three commonplaces work together to create a conceptual framework through which narrative inquirers can identify the narrative threads that emerge from people’s stories as they are positioned to them temporally, personally, and spatially (Clandinin & Connelly, 2000; Connelly & Clandinin, 2006). The stories we tell of our experiences are often simultaneously situated in each of these three commonplaces, and in a narrative inquiry “we cannot focus on one to the exclusion of others” (Clandinin et al., 2007, p. 23).

The Four Directions of Inquiry

Clandinin and Connelly (2000) further conceptualize narrative inquiry as branching out into four directions: inwards, outwards, forward, and backward. Inquiries that are directed inwards are concerned with the narrator’s internal conditions, such as emotions, sense of morality, and expectations (Clandinin & Connelly, 2000). In this study, I follow this direction of inquiry to explore the health beliefs, emotional reactions, and expectations of older Chinese immigrants regarding mental health, formal mental health services, and informal mental health supports (Clandinin & Connelly, 2000; Segall & Fries, 2011). Inquiries that are directed outwards focus on the environments and external conditions in which narratives are formed (Clandinin & Connelly, 2000). I follow this direction of inquiry to probe about the physical and social environments that older Chinese immigrants inhabit, and how these might influence their conceptualization of mental health and attitudes towards help-seeking (Clandinin & Connelly, 2000; Segall & Fries, 2011). Inquiries that are directed forward and backward emphasize the temporality of experience, and examine how narratives may be situated in the past, present, and/or future (Clandinin & Connelly, 2000). By telling, and retelling, our stories, my co-participant and I allow ourselves to explore how past experiences may be influencing our present ways of being, and through this exploration, we can gain new understandings about ourselves and our possibilities for the future (Clandinin &

Connelly, 2000; Schwind, 2008). The four directions of inquiry described by Clandinin & Connelly (2000) focus attention to the multidirectionality of an individual's story, and together support an inquiry that more fully explicates the telling of a narrative.

Three Levels of Justification

Clandinin et al. (2007) identify three levels of justification for a narrative inquiry. These are *personal justifications*, *practical justifications*, and *social justifications* and they may be used to guide the design of a narrative inquiry (Clandinin et al., 2007). These three levels of justification present a series of questions that should be considered during each phase of a narrative inquiry, and responses to these questions are shaped by the three commonplaces of *temporality*, *sociality*, and *place* (Clandinin, et al., 2007). All three levels of justification follow the forward and backward direction of inquiry as the personal, practical, and social significance of a narrative inquiry is embedded in participants' stories that are situated in particular points in time (Clandinin & Connelly, 2000; Clandinin, et al., 2007). The inward and outward directions of inquiry are primarily pursued in the personal justifications of a narrative inquiry. In the beginning of this narrative inquiry, the three levels of justification help me to illustrate the personal, practical, and social significance of investigating a particular phenomenon. Once the field texts of a narrative inquiry are collected (i.e., interview transcripts, field notes, reflexive journaling), I revisit these three levels of justification as a lens of analysis in order to demonstrate the personal, practical, and social significance of my co-participant's story about his experiences with depression to the field of mental healthcare. I now further elaborate upon each level of justification.

Personal justifications.

The *personal justifications* of conducting a narrative inquiry take into consideration how the researcher is situated within their study (Clandinin et al., 2007). Through writing about interests in and relationships to an inquiry, the researcher is able to make transparent their autobiographical orientation towards a particular phenomenon (Clandinin, et al., 2007). The personal level of justification follows the inward and outward directions of inquiry as I write about my inward thoughts and feelings in response to outward events and interactions that occur in the stories that emerge in this

narrative inquiry (Clandinin & Connelly, 2000; Clandinin, et al., 2007). Through the writing about my own “*narrative beginnings*” (Clandinin, et al. 2007, p. 25) in Chapter One, I explore why I care, as a person, community member, and mental health advocate, about the experiences of older Chinese Canadian immigrants with depression. Why am I interested in listening to what their stories reveal about the sources of mental health support that they use? As part of my analysis of my co-participant’s stories, the personal level of justification reveals how meaning is co-created in my responses to my co-participant’s story. Conle (1996) defines *resonance* as “a way of seeing one experience in terms of another” (p. 299). During this first level of analysis, the personal level of justification, I also seek to unpack how my co-participant’s story resonates with my own experiences with depression and using mental health support sources.

Practical justifications.

The *practical justifications* of conducting a narrative inquiry ask the question: “How will [this inquiry] be insightful to changing or thinking about [our] own and other’s practices?” (Clandinin, et al., 2007, p. 25). In the beginning of this narrative inquiry, I first explore the practical justifications by identifying the gaps in the peer-reviewed literature on the mental health of older Chinese immigrants that this narrative inquiry intends to address (see Chapter Two). I revisit this justification as the second level of analysis in Chapter Six, as I reflect upon the experiences of an older Chinese immigrant with depression and explore how his experiences are related to previous studies in the peer-reviewed and grey literature on depression and the mental health of older immigrants. I also explore the research regarding the sources of mental health support used by older Chinese immigrants with depression. The practical level of justification enables me to discuss the significance of my co-participant’s stories in illuminating thinking and practices in immigrant mental healthcare.

Social justifications.

The *social justifications* of conducting a narrative inquiry prompt researchers to explore how a narrative inquiry may address social issues on a larger scale (Clandinin, et al., 2007). Similar to the practical justifications, the social justifications of this narrative inquiry were first examined in Chapter Two through an initial review of the peer-

reviewed literature on mental health that pertained to older Chinese immigrants. The social level of justification follows the inward and outward directions of inquiry as it enables me to demonstrate how my co-participant's experiences with depression resonate with social issues that exist within the larger field of immigrant health and mental healthcare. When working with my co-participant's stories in this narrative inquiry, I return to the literature in Chapter Seven to explore how research concerning the experiences of an older Chinese Canadian immigrant with depression may further professional understandings of providing mental healthcare to older immigrants.

Arts-Informed Narrative Inquiry

Arts-informed narrative inquiry is a qualitative research method that uses the arts (i.e., visual arts, performance, music, creative writing) to assist in the telling of stories of experience (Lindsay & Schwind, 2015; Schwind et al., 2014). Cole and Knowles (2008) describe arts-informed research as “a mode and form of qualitative research... that is influenced by, but not based on, the arts broadly perceived” (p. 60). Arts-informed research strives to contribute to our understanding of experiences through “representational forms of inquiry” (Cole & Knowles, 2008, p. 61), such as the visual arts, poetry, creative writing, and other artistic forms. Schwind et al.'s (2014) arts-informed narrative inquiry methods draw heavily upon Clandinin and Connelly's (2000) conceptualization of narrative inquiry, and seek to bridge the gap between the limitations of language and the expression of stories of experience. Arts-informed research methods can provide co-participants with an open-ended means of responding to research puzzles, and assist in the surfacing of ideas that may otherwise remain unarticulated (Butler-Kisber, 2010). This may be a particularly salient issue for older Chinese Canadian immigrants, as mental illness and depression are highly stigmatized in Chinese communities, and therefore discussions about these issues are often verbally silenced (Hsu et al., 2008). Cole and Knowles (2008) explain that,

“The central purposes of arts-informed research are to enhance understanding of the human condition through alternative (to conventional) processes and representational forms of inquiry, and to reach multiple audiences by making scholarship more accessible” (pp. 60-61).

Arts-informed research can be used as a standalone methodology, with special attention being paid to the conceptual, aesthetic, and theoretical aspects of an inquiry (Cole & Knowles, 2008). Lindsay and Schwind (2016) utilize Clandinin and Connelly's (2000) narrative inquiry as a methodological framework to guide their arts-informed research, and use the term *arts-informed narrative inquiry* to designate this particular way of doing narrative research.

While exploring the use of particular arts-informed methods in narrative inquiry, I felt particularly drawn to Schwind et al.'s (2014) recent narrative inquiry into the experiences of nursing students and nurses' engagement in person-centered care in mental health education and practice. Schwind et al.'s (2014) use of various multimedia and text based arts activities to inform their narrative inquiry appealed to my identity as an artist, and presented a multitude of possibilities for the collection of narrative data that is descriptive and rich. Lindsay and Schwind (2015) also emphasize the usefulness of arts-informed narrative inquiry in facilitating the construction of practitioner knowledge in mental healthcare settings by encouraging increased self-awareness and awareness of others.

Lindsay and Schwind worked with Professor Connelly at OISE/University of Toronto during their doctoral studies (Lindsay, 2001; Schwind, 2004). As experienced nurses, teachers and researchers, Lindsay and Schwind utilize Clandinin and Connelly's narrative inquiry to explore their respective programs of research in the field of nursing education and practice (Lindsay, 2008a, 2011; Lindsay et al., 2012; Schwind, 2008, 2014; Schwind et al., 2015), and collaborative arts-informed narrative inquiry (Lindsay & Schwind, 2015, 2014; Schwind & Lindsay, 2008; Schwind et al., 2014). Through their website *The Art of Experience*, they also facilitate an online community of researchers, scholars, and students who are interested in narrative inquiry (Lindsay & Schwind, 2016). It is through my initial joining of this online community, and later consulting with Lindsay and Schwind in person as part of their narrative inquiry works in progress group, that I gained a deeper understanding of their arts-informed narrative inquiry methods. Lindsay and Schwind (2016) use a variety of visual and text based artistic media as part of their arts-informed narrative inquiry methods. Adapting their arts-informed narrative

inquiry methods for this particular narrative inquiry, I used lifeline drawing, definition writing, short story writing, metaphor drawing, letter writing, poetry writing, and collage making to help my co-participant explore his experiences with depression. In the next chapter, I discuss these methods more fully, in terms of how they were constructed and utilized in my study.

My Personal Connections to the Arts

Elaborating upon my personal justifications for embarking on this narrative inquiry, I will now discuss the meaningfulness of using arts-informed methods by sharing my personal connection to the arts.

The arts contribute to the formation of knowledge by evoking “a kind of empathy that makes action possible” (Eisner, 2008, p. 14). While my fascination with the arts, and the creation of artwork, preceded my diagnosis with depression, the arts have also been significantly instrumental in the formation of my identity as a person and a mental health advocate. Eisner (2008) explains that, “becoming aware of our capacity to feel is a way of discovering our humanity. Arts help us to connect with personal, subjective emotions, and through such a process, it enables us to discover our own interior landscapes” (p. 15).

My mother is both a visual artist and a professor of graphic design. Because of this, I grew up in an environment that nurtured both my sense of creativity and interest in the arts. I fondly recall spending weekends and holidays with my parents visiting art galleries, attending the openings of exhibits for work made by my mother or her colleagues, and watching my mother mark the illustrations and product mock-ups that her students created for their assignments. Her creative practice operates within the world of the fine arts and academia. My father also was a creative influence in our household through his various hobbies. His fascinations were with origami, Chinese calligraphy, cooking, and recitations of Chinese poetry. His creative practice operated within the world of the vernacular, the ethnic, and the quotidian. For example, my father would create colourful banners bearing Chinese calligraphy during the Lunar New Year and Mid-Autumn Festivals. My parents also volunteered within the community as teachers, translators, and consultants. Often, I recall that my mother and father would work together as a team when she would exhibit her work in China, an exploration of her own

identity as a fourth generation Canadian of Chinese ethnicity (Suen, 2012). As a first generation Chinese Canadian who was born in Hong Kong, my father would provide insights into Chinese traditions and culture, as well as help with translation.

Our family's involvement with the Chinese Canadian community in the Greater Toronto Area can be attributed to the shared passion my parents have for both the arts and Chinese culture. Together, my parents' artistic practices have influenced my appreciation of my Chinese Canadian identity, and helped me to gain a tacit understanding of the power of the arts in facilitating self-reflection, including how I am situated in this world (Eisner, 2008). In addition to growing up in an environment that nurtured my creativity, having natural proclivity and talent in the visual arts also has enabled me to develop my own artistic practice. My experiences in participating in group showings of art work and teaching art classes at a local publically-funded art gallery, have helped me gain practical knowledge of both utilizing various artistic media and organizing art-making sessions with a diversity of audiences.

Approximately a decade of cognitive behavioural therapy and other psychiatric treatments have helped me to better understand my own limitations and strengths. Yet, it was through the act of creating works of visual art--- drawing, painting, collage, sculpture, poetry--- that I found psychological solace. Creating art helped me to express my thoughts and feelings about my experiences of illness without attracting the stigmatization that comes with words. When I created art, I was empowered to choose whether I revealed only parts or the whole story of my experience to my audience of therapists, relatives, friends, and strangers. Clandinin (2013) explains that the silences and white spaces that people choose to include in their stories of experience reveal the complexities of the living, telling, retelling, and reliving of experiences that occur during a narrative inquiry. While I have kept silent about my own experiences with mental illness in the past, the inclusion of an arts-informed approach in this narrative inquiry presents me with the opportunity to tell my story through methods of self-expression with which I am familiar. Reflecting upon the challenges of telling stories of difficult personal experiences (Lindsay, 2006; Schwind, 2009), my use of arts-informed narrative inquiry methods acts as an invitation for older Chinese Canadian immigrants to tell their stories

of depression, thus presenting them with a variety of types of creative self-expression while “author[ing] their own story” (Lindsay, 2011, p. 243). By including the arts in my narrative inquiry methodology, I invited my co-participant to become a constructor of knowledge through acts of creation, reflection, and discussion (Lindsay & Schwind, 2015; Schwind et al., 2014). Participating in an arts-informed narrative inquiry also allowed my co-participant to reflect upon aspects of his own experiences that extend beyond what he can express verbally (Schwind et al., 2014).

Significance of This Arts-Informed Narrative Inquiry

The personal stories of older Chinese Canadian immigrants with depression have the potential to uncover knowledge that may be extrapolated to further inform the ways in which mental health services are experienced by people needing care and are practiced by healthcare professionals. I have chosen to explore these stories using Clandinin and Connelly’s (2000) narrative inquiry because it compels me to acknowledge the complexities and multidimensionality of human experience. By reflecting upon how people live, tell, retell, and relive their experiences within the context of different social interactions, various places, and across time, I have come to realize the practical knowledge that may be gleaned from the personal experiences of older Chinese Canadian immigrants with depression (Clandinin & Connelly, 2000; Connelly & Clandinin, 2006). In the following chapter, I elaborate upon the specificities of the arts-informed narrative inquiry methods used in this narrative inquiry. I also reflect upon my experiences with my co-participant, while discussing the on-going negotiation of meaning that takes place between the researcher and co-participant (Clandinin & Connelly, 2000; Connelly & Clandinin, 1999).

Chapter Four

Study Design

In this chapter, I outline my recruitment strategies and briefly introduce my co-participant. I also describe the arts-informed narrative inquiry methods I used in each research session and reflect upon my observations in the field to demonstrate how I explored different dimensions of my co-participant's experiences with depression with him. Following this, I outline Connelly and Clandinin's (2006) evaluative criteria for a narrative inquiry and elaborate upon how I used each of these evaluative criteria to ensure rigour and quality were incorporated into the design of this study. I also draw upon these evaluative criteria to discuss how I addressed ethical concerns in this narrative inquiry, as well as the intricacies of negotiating relationships with co-participants and communities in the field. Finally, I conclude this chapter by discussing how the invitational quality of narrative inquiry enables the stories told by my co-participant to be transferrable to practice in the field of mental healthcare.

Co-participant Recruitment

During the recruitment phase of this narrative inquiry, my inclusion criteria required that potential participants were: at least 55 years of age; self-identified as Chinese or Chinese Canadian; immigrated to Canada from a country with a significantly large population of Chinese people (i.e., Mainland China, Hong Kong, Taiwan, Macau, Singapore, Malaysia); independently resided within a community (as opposed to being institutionalized in a hospital or a similar facility); self-identified as having an advanced or fluent level of English proficiency (or have either permanent resident or Canadian citizenship status, as English proficiency is a requirement to obtain these statuses); and self-identified as having experienced depression for prolonged periods of time (i.e., greater than two weeks) (Centre for Addiction and Mental Health, 2012).

I recruited potential co-participants via purposive sampling and snowball sampling. Community leaders from across the Greater Toronto Area were invited to share my recruitment information via posters and word-of-mouth (See Appendices A through D for recruitment materials). I anticipated that recruiting potential co-participants for this inquiry would be difficult, due to the language restrictions (the interviews were

conducted in English due to my inability to read and write Chinese) and stigma associated with mental illness in Chinese Canadian communities (Hsu et al., 2008). Therefore, the recruitment net for this inquiry was rather wide despite my goal of inviting 1-2 co-participants to join me (for a total of 2-3 co-participants in total, including myself). Initially four potential co-participants contacted me to express interest in this study. However, two of these individuals later withdrew their interest due to self-perceived social risks of being involved with a research project pertaining to depression and mental illness. The third individual withdrew their interest because of some discomfort in discussing personal experiences with depression in English. Ultimately, the fourth co-participant began and completed this narrative inquiry with me. He chose to use the pseudonym *Neal*.

The Significance of Storying Individual Experiences

The aim of a narrative inquiry is to explore deliberately and systematically how stories of personal experience may provide insights into larger practical and social issues (Clandinin & Connelly, 2000). This exploration of experience requires a large investment of time and trust to establish sufficient rapport to enable the deep sharing and examination of a co-participant's experiences (Clandinin & Connelly, 2000). Dewey (1939) also emphasizes the significance of personal experience as a foundational aspect of learning and education. The data collected through an arts-informed narrative inquiry is rich in thick description, and is valuable because it represents the nuances and complexities of the co-participant's experiences (Butler-Kisber, 2010; Clandinin and Connelly, 2000; Schwind et al., 2014). This focus on the particular, as opposed to the general, aspects of phenomena allows qualitative researchers to better identify possible changes that may improve the lives of their co-participants (Clandinin, 2013) as well as others. Because of the collection of extensive, in-depth stories of experiences often captured over multiple times using a variety of methods, one to five co-participants is deemed to be an appropriate sample size for a narrative inquiry (Cresswell, 2013; Lindsay, 2011; Schwind et al., 2012; Schwind et al., 2014, Walji, 2015).

Arts-Informed Narrative Inquiry Methods

Lindsay and Schwind (2015) note that “eliciting and exploring personal experiences can be augmented through creative self-expression” (p. 3). Lindsay (2011) notes that incorporating the arts in narrative research can “facilitate multidimensional awareness before there are words to explore experience” (p.243). Schwind et al. (2012) elaborates upon the role of the arts in promoting self-reflection, emphasizing that engaging in acts of creative self-expression can help to connect us with our own life experiences. Drawing upon Lindsay and Schwind’s (2016) use of writing (definitions, short stories, poetry, and letters), drawing (lifelines and metaphors), and collage, I designed this inquiry to span four to five sessions, with each session involving both an art-making and an interview component. Neal and I met for five research sessions at his home at his request due to concerns of privacy and the convenience of this location for him. Each session was 1.5 to 2 hours in length. Based on my previous experience as an arts instructor at a local art gallery, I have learned that a timeframe of 1.5 to 2 hours is appropriate for the completion of an arts activity, especially when followed by an audio-taped open-ended semi-structured interview. Throughout our research relationship, I emphasized the importance of respecting Neal’s comfort and energy levels during each session. I now briefly elaborate upon the purposefulness of each of the chosen art-making activities in this narrative inquiry, before describing more fully how these art-making activities were used during each research session.

Creating a lifeline entails drawing a line (can be straight, curved, loopy, etc) on a piece of paper, with one end signifying one’s birth and the other end representing the present day (Lindsay & Schwind, 2016). Significant life events and milestones in one’s personal life are marked along one side of this line (Lindsay & Schwind, 2016). Significant life events and milestones related to the phenomenon under study, in this case depression, are then identified and demarcated along the other side of this line. The creation of a lifeline enables a person to identify significant life events and illustrate how these experiences are positioned over time (Lindsay & Schwind, 2014; 2016). This activity also facilitates reflection upon how these experiences may influence an individual’s personal and social positioning in relation to a particular phenomenon (Lindsay & Schwind, 2016). Having Neal identify several key experiences with

depression on his lifeline, and inviting him to write a short story about each experience helped me to understand how these stories might be personally significant to his life (Lindsay & Schwind, 2016). In addition, I invited Neal to create a definition of depression during our first research session, and again during our final research session. This request was helpful to me in grasping how understandings of depression may have changed over time for Neal through the process of engaging in this narrative inquiry (Lindsay & Schwind, 2014; Schwind et al., 2014).

The creation of a metaphor drawing requires one to draw an (often familiar image) to help explain complex experiences and ideas (Lindsay & Schwind, 2016; Schwind, 2009; Schwind et al., 2014). In this narrative inquiry, I invited Neal to draw a metaphor for his depression. Drawing a metaphor for depression enabled Neal to unearth subconscious thoughts, feelings, and ideas about his experiences with depression. This activity encouraged him to reflect upon his identity and experiences with depression and on how these may be similar or different to his metaphor drawings (Lindsay & Schwind, 2014; Schwind et al., 2014). Writing letters to oneself from the perspective of a metaphor, and writing free-verse poetry, also provided additional opportunities for this kind of reflection (Lindsay & Schwind, 2014).

Collage is a term that “is derived from the French verb *coller*, which means ‘to stick,’ and refers to the process of cutting and sticking found materials onto a flat surface” (Butler-Kisber, 2010, p. 102). Butler-Kisber (2010) writes of the value of creating a collage, and expressing our responses to it, as a form of reflective practice. She explains that collage invites us to “[join] disparate fragments [to] produce associations and connections that bring unconscious thoughts to the surface.” (Butler-Kisber, 2010, p. 105). I invited Neal to create two collages during our sessions. The first collage was intended to represent a time and place where he experienced depression. The second collage was intended to explore a time and place where Neal sought help for his depression. Together, the creation of a lifeline; definitions of depression; metaphor drawing; collage and the writing of short stories, letters, and poetry form the collection of arts making activities that I incorporated into the arts-informed narrative inquiry methods for this study.

Research Sessions

Both Neal and I participated in the arts activities for each session to help facilitate our mutual sharing and exploration of our experiences with depression during the interview portion of our research sessions. In an arts-informed narrative inquiry, the purpose of art-making activities is to facilitate the telling of stories. The particular works of art that are produced during each session are not as important as the stories that are elicited through the art-making process. As a result, while I invited him to participate in my proposed order of activities (both art-making and interviews), Neal understood that I had built in a degree of flexibility into the agenda of each session and the types of activities offered.

First Research Session

The first research session involved the writing of a definition of depression and the drawing of a lifeline (Lindsay & Schwind, 2016). We each took a moment to write our own definitions of depression and later shared and discussed these definitions during the interview portion of our session. The purpose of this activity was to introduce ourselves to the creative process and to become mindful of the temporal aspect of our experiences of depression (Clandinin & Connelly, 2000; Lindsay & Schwind, 2016;). We then used drawing materials to draw a line (which could be straight, looped, curved, etc.), with one end signifying the beginning of each of our lives and the other end signifying the present time. We then marked down significant life events and achievements along this line.

Lastly, we identified significant places along the line where we experienced depression (Lindsay & Schwind, 2016). During this first session, Neal expressed an initial discomfort with participating in the art-making component of our session. He explained that this was due to his lack of familiarity with art-making. However, he seemed encouraged when I reminded him that the purpose of the creative activities in our sessions was to help facilitate his story telling, and that his artwork was his to use and keep as he saw fit. The art-making portion of our session was followed by a semi-structured open-ended interview where I asked Neal about how his definition of depression and lifeline reflected his experiences with depression. Staying with Clandinin

and Connelly's (2000) emphasis on focusing on experience, the interview question for this research session was, *How does your definition [for depression] and lifeline reflect your experiences with depression?*

Second Research Session

During our second research session, Neal and I wrote two short stories (three to four paragraphs maximum), while reflecting upon our respective experiences with depression. During the writing of the first short story, I invited Neal to recount a time when he experienced depression (Schwind et al., 2014). After a short break, I invited Neal to write a second short story about a time when he sought help for his depression from someone other than himself (Schwind et al., 2014). During the subsequent interview, we read aloud our respective stories and answered the question of what stood out to us in our stories about depression. The interview questions for this research session were, *What things stood out to you in your story about experiencing depression? What stood out to you in your story about seeking help for depression?*

Third Research Session

The third research session involved the drawing of metaphors for depression, and the writing of letters and poetry. The interview question for this session was, *Please describe your metaphor and how you are like, or unlike, your metaphor.* Berg (2008) and Butler-Kisber (2010) note that moments of self-reflection often take place during the experience of art-making that may help us to better understand how we produce knowledge. Given this, I initially intended that the interview and art-making activities would occur simultaneously, and the entire session be audio recorded, so that moments of self-reflection and discussion could occur and be captured. However, I respected Neal's request that we follow the more linear structure of our previous research sessions, with separate chunks of time allotted to the art-making and interview. This deviation from my initial plan for this session worked in our favour, as we ended up postponing our letter and poetry writing activities to our next session. This was Neal's first time drawing a metaphor, and he admitted that he was not very familiar with this type of activity. While he became more comfortable once we immersed ourselves in drawing, Neal was surprised at his ability to connect with the emotional side of his experiences with

depression, while discussing his drawing during our interview. The strength of his emotional response to his drawn metaphor for depression helped Neal to gain a tacit understanding of the cathartic nature of art-making. Yet this process also left him feeling tired and emotionally drained near the end of our session. Realizing the emotional impact of this session's activities, Neal requested that we stop our session after we finished discussing his metaphor drawing in order to allow him to rest and recharge for our next session.

Fourth Research Session

During the fourth research session, Neal and I made the joint decision to complete the letter writing and poetry activities from our previous session and begin the collage activity if sufficient time remained. Reflecting upon the metaphors for depression that we drew during the previous session, we wrote a letter to ourselves from the perspective of our respective metaphors. Afterwards, keeping our metaphors for depression in mind, we took words and phrases from our letters and wrote a short free verse poem about our experiences with depression. We then took a break from the art-making activities to share our artwork and conduct an interview. Later, we created the first of two collages. The first collage was to centre on a place where we experienced depression and the second collage was to centre on a time when we sought help for our depression. We finished the session with a second interview in which we shared how our collages reflected our experiences in seeking help for our depression. The interview questions for this session were, *Please read aloud your letter and poem. How do your letter and poem relate to your experiences with depression? Please tell me how your collage reflects a time when you sought help for your depression.*

Fifth Research Session

The purpose of the fifth session was to enable Neal and myself to complete any unfinished artworks or interviews. I intended that we use this time to create our final collages, centering on our experiences with depression. However, Neal requested to use this time to create a second metaphor drawing. He explained that he wanted to respond to the first metaphor drawing of depression, with a metaphor drawing of wellness. I respected this request, and we both created artworks that further explored our experiences

with mental health and wellness. He later explained that changing the art-making activity for this session helped him to better share his experiences of seeking help for his depression, as he was able to compare and contrast his previous metaphor drawing of depression with his metaphor drawing of wellness. Originally, my interview questions for this session were intended to ask Neal about this second collage, but I was able to adapt these questions to suit his preference to create a second metaphor drawing. As such, the interview question for this session was, *Please tell me what your second metaphor drawing reveals about the places in which you have sought help for your depression.* Neal also retrieved his first metaphor drawing of depression and wished to discuss the differences between the two drawings. We concluded our session with an interview that explored what our artworks revealed about the places where we had experienced mental health and wellness.

Member Checking

Since Neal ultimately negotiated the formation of the research texts, it was vital that I strive to ensure that his stories of experience were treated with care and fidelity (Clandinin & Connelly, 2000). Neal opted to participate in member checking after our research sessions were completed. Member checking helped ensure accurate representation of Neal's experiences in the qualitative data as confirmed by him (Creswell, 2013). Due to the large amount of time that Neal invested in this study over the five research sessions, I chose to provide him with summarized versions of our interviews to save him time during the member checking process. Given that I interviewed Neal five times, with each interview ranging from 20-35 minutes, asking him to review the raw transcripts of our interviews would have been very time-consuming, and likely an unreasonable request.

In narrative inquiry, member checking also presents co-participants with an opportunity to reflect upon the stories they have told (Clandinin & Connelly, 2000; Creswell, 2013). Inviting co-participants to engage in reflexive practices, such as member checking, aids in ensuring that their voices continue to be present in their narratives as we move from creating field texts to research texts (Clandinin & Connelly, 2000). Reflecting upon his experiences with depression, Neal had the opportunity to affirm his story and

deepen his understanding of how these experiences may be meaningful to his life. This process also allowed Neal to correct or elaborate on the interview summary.

The use of member checking, and prolonged engagement with Neal over the course of our research sessions also enabled me to ensure that I was accurately representing his experiences, while building trust and learning about his culture (Creswell, 2013). I now discuss Connelly and Clandinin's (2006) evaluative criteria for a narrative inquiry and demonstrate how I incorporated these criteria into the study design to ensure methodological rigour and address potential ethical concerns.

Evaluative Criteria for a Narrative Inquiry

Ensuring Rigour and Quality

Imagine a lifespace.

Connelly and Clandinin (2006) identify seven criteria to consider when designing a narrative inquiry. They note that narrative inquirers must first *imagine a lifespace*, consisting of specific places across time, in which the phenomenon under study and inquiry participants exist. Attending to this first design criterion, enabled me to imagine how older Chinese immigrants and their experiences with depression, are situated in specific places across time (Connelly & Clandinin, 2006). When I first started to focus the direction of this narrative inquiry, I reflected upon my experiences with my grandfather and his depression. Specifically, I acknowledged this a silenced chapter of my life that shaped my current understandings of my own experiences with depression. I began to look back in time and questioned the reasons why I felt the need to silence these stories for so long. I imagined myself inviting older Chinese Canadians, like my grandfather, to join me in the lifespace of this inquiry. Specifically, I imagined including older Chinese Canadian immigrants because my grandfather and I both grew up in households with at least one immigrant parent. I also considered the significance of family caregivers, the support of community members, and healthcare providers in influencing the experiences of older Chinese Canadian immigrants with depression. Reflecting upon this first criterion enabled me to tinker with the focus of this inquiry as I conducted my literature search, eventually narrowing down a specific research puzzle. Significantly, the various art-making activities that comprised the arts-informed aspect of

this narrative inquiry helped Neal and I to envision this lifespace, and deepened our understanding of the significance of time, place, and personal interactions in our experiences with depression.

Initiating the collection of field texts.

The second design criterion emphasizes the importance of initiating the collection of field texts by *first examining how our stories tell of our lives lived in the past while being lived in the present* (Connelly & Clandinin, 2006). Connelly and Clandinin (2006) specifically identify the sharing of past experiences as *telling* and the sharing of our present experiences as *living*. In a narrative inquiry, *field texts* refer to the interactions between the researcher and participant in which accounts of both *telling* and *living* may be shared and created (Clandinin & Connelly, 2000). The observations and notes I made both in the field (i.e., Chinese Canadian community) and in each research session also assisted me in identifying information that is salient to this inquiry by shedding light on the overarching institutional, social, linguistic, and familial narratives in which Neal's stories may be situated.

In this inquiry, Neal and I *tell* of our past experiences with depression, while collaboratively creating new understandings of ourselves as we relive and retell stories about our new experiences. Following our arts-making activities with a semi-structured open-ended interview created a space in which Neal and I could reflect upon our experiences and talk about how these experiences have shaped our past and present understanding of ourselves, and our depression. This second criterion highlights the transformative nature of narrative inquiry for both the researcher and co-participants. As Clandinin and Connelly (2000) note, "narrative inquiry in the field is a form of living, a way of life" (p. 78).

Commonplaces and contexts.

For the third design criterion, Connelly and Clandinin (2006) require narrative inquirers to define and find balance amongst the three commonplaces within the collected field texts. During my interactions with my Neal, I was attentive to how our interactions and stories were positioned with regard to temporality, sociality, and specific places (Clandinin & Connelly, 2000). Identifying these three commonplaces became especially

important during the analysis phase of this inquiry, as I utilized the personal, practical, and social levels of justification to move from field texts to research texts. Connelly and Clandinin (1990) elaborate upon the importance of balancing one's attention between each of the three commonplaces by calling narrative inquirers to observe how *scene* and *plot* unfold within field texts. Building upon elements from the field of creative writing, Connelly and Clandinin (1990) define *scene* as the characters, physical places, and contexts that exist within narratives. Subsequently, they explain that *plot* encompasses the notions of time and place that exist within specific narratives (Connelly & Clandinin, 1990). Reflecting upon the centrality of this third criterion to the design of a narrative inquiry, Clandinin and Connelly (2000) note that, "in narrative thinking, context is ever present. It includes such notions as temporal context, spatial context, and context of other people" (p. 32). It is important to note that the three commonplaces are often simultaneously present within our stories and present experiences (Connelly & Clandinin, 2006; Clandinin et al., 2007). Therefore, I attended to these three commonplaces simultaneously throughout all phases of this narrative inquiry.

Transparency.

The fourth design criterion hones in on the commonplace of sociality, and requires the *transparency of how the researcher is personally invested in the inquiry*. As such, narrative inquiry requires that researchers write autobiographically in relation to their experiences within the study's research encounters, and this writing is included as data alongside the information collected from other participants in the study (Clandinin, 2013; Clandinin & Connelly, 2000; Creswell, 2013). I embrace the autobiographical nature of narrative inquiry by beginning this narrative inquiry with an account of my experiences with my grandfather and continually reflecting upon my own experiences with depression.

Throughout my interactions in the field, I have also kept a qualitative journal of both my outward observations and internal thoughts and feelings (Clandinin & Connelly, 2000). By documenting my external observations of our environments and interactions, I engaged in the process defining how the three commonplaces influenced the interactions between Neal and me. By recording my personal thoughts, feelings, and emerging

questions, I identified how I am situated in relation to Neal's experiences and stories, and I marked my path as we delved deeper into our inquiry. Through my qualitative journaling, I allowed myself the space to reflect upon my own involvement in the narrative inquiry, while identifying the various contexts in which my experiences took place (Clandinin & Connelly, 2000; Cresswell, 2013). Journaling also enabled me to surface my assumptions, values, and beliefs so I could be aware of these as I made observations and interpretations in the field. The three aforementioned design criteria pertain to the multiplicity of experience and ensure the collection and rigorous analysis of the field texts (Clandinin & Connelly, 2000; Connelly and Clandinin, 2006). This results in the final research text flowing as a multifaceted and unified whole (Clandinin and Connelly, 2000).

Negotiating Relationships in the Field

The fifth design criterion concerns the *relationship between the researcher and participant* within the narrative inquiry (Connelly & Clandinin, 2006). This design criterion refers to the specific relationships and roles that were continuously negotiated between myself and Neal within this narrative inquiry (Clandinin & Connelly, 2000; Connelly & Clandinin, 2006). Within the context of this inquiry, our respective positions in the Chinese Canadian community played an important role in shaping our interactions and subsequent relationship as researcher and participant. Chinese culture emphasizes unity and collective identity within communities (De Mente, 1996). From my personal experiences, I can attest that remnants of this cultural tendency towards group identity remains imbued within the thoughts and actions of members of my own Chinese Canadian community. Therefore, I begin my discussion regarding my relationship with Neal by first reflecting upon the Chinese Canadian community in the Greater Toronto Area and exploring the complexities of our cultural realities.

Access to community.

My family members, family friends, and leaders from various faith and community groups have acted as key informants regarding the Chinese Canadian community in the Greater Toronto Area. These individuals have been invaluable in providing me with the proper introductions to additional community leaders, and offering

me opportunities to share my research in spaces where potential research co-participants may be found. These individuals have also provided me with opportunities to participate in the community through volunteer work. They have, in many ways, become what Clandinin and Connelly (2000) refer to as my response community, “ongoing places where [we] can give accounts of [our] developing work over time” (p. 73). Although I have grown up within the Chinese Canadian community in the Greater Toronto Area, negotiating access to the community as a researcher presented me with a number of challenges and rewards. Due to my positioning as both an insider (emic) and outsider (etic) in the Chinese Canadian community, there were times where I found it challenging to establish rapport with certain community leaders. This was particularly true during my interactions with older community leaders who led organizations that solely served segments of the community that had immigrated to Canada more recently.

Some of the challenges that I faced in establishing rapport with certain community leaders stemmed from the cultural and linguistic heterogeneity that exists within and between segments of the Chinese Canadian community in the Greater Toronto Area. These challenges were sometimes compounded by my limited Chinese language abilities as a fifth generation Chinese Canadian. The impending return of Hong Kong to China in 1997, after many decades of British colonial rule, triggered mass emigration of Hong Kong citizens to various countries in the West, including Canada (Waters, 2005). As a child growing up in the 1990’s, this meant that the community at that time was comprised mainly of Chinese Canadian immigrants who spoke Cantonese, with smaller segments of the community comprised of people who spoke Mandarin and other Chinese dialects. While my father’s first language is Cantonese, my mother’s is English, and English was the primary language used in our household. This reality, compounded by practices in our local education system that discouraged the use of additional languages at home (De Houwer, 1999), has contributed to my continued journey towards acquiring a functional level of Chinese language skills. Baez (2002) notes that language and cultural identity are intertwined, and yet, as children of immigrant families acculturate and seek to belong within mainstream culture their relationship with the languages of their parents is often changed or lost over time.

While my limited Chinese language abilities position me as an outsider within the Chinese Canadian community, my re-entry into the community as an adult also has heightened my awareness of how I had taken for granted the relationships my parents had with the Chinese Canadian community. During my initial interactions with community members, I often was introduced as the *daughter of my parents*. Community leaders would first ask about the well-being of my parents and other family members before delving into discussions regarding my research. These interactions have fostered within me a deeper appreciation for the work that my parents do with various organizations within our community, and their insistence that my sisters and I also participate in the community when we were growing up. Throughout this narrative inquiry, my parents have once again provided valuable mentorship, translation, and emotional support in helping me to nurture my relationships with our community.

Since I had disengaged from the Chinese Canadian community for a period of time after my grandfather's death, negotiating re-entry and access to the community also provided me with the opportunity to revisit my childhood experiences and retell them from an adult's perspective. My identity within the community also shifted over time, a metamorphosis from child to adult. I started to first notice this change during conversations with community leaders who had known me as *the daughter of my parents*. As we discussed opportunities for me to volunteer and use my time and talents to benefit the community, I was humbled and touched by the effort these leaders put forth to help me feel welcomed and included. Various leaders in the Chinese Canadian community kindly offered me English translation, opportunities to speak about my research, and spaces to be visible to the wider community. Despite the temporal gaps in our relationships, I am most grateful to these individuals for enabling me to be useful to the community and cultivate a sense of belonging, something that Clandinin and Connelly (2000) describe as "finding a place in the place" (p. 75).

Rapport and roles.

Respectful, engaging and open communication with the Chinese Canadian community has been essential to this narrative inquiry. As a result, the establishment of rapport with both community leaders and potential co-participants was emphasized

throughout the design of this study (Kirby & McKenna, 1989). Establishing a deeper level of familiarity with the community not only allowed me to elevate the degree of access I was granted within various community organizations, but also enhanced the bilateral understanding of the roles that were expected of me as a researcher and the members of the community as potential co-participants (Cresswell, 2013; Kirby & McKenna, 1989).

My relationship with the community also helped with the establishment of rapport between Neal and me. Belonging to the same ethnic community helped Neal to understand the significance of this narrative inquiry as a project that could potentially benefit the mental health and wellbeing of Chinese Canadians in the future. Despite our generational differences, our shared understanding of traditional Chinese etiquette and social norms enabled Neal to take on the role of the older mentor and teacher within our research relationship (Hwang, 1987). This empowered him in telling his story about his experiences with depression, and helped us to temper our moments of shared vulnerability with trust, during our research relationship.

Reciprocity and cultural etiquette.

Volunteering with various events and initiatives with the Chinese Canadian community also provided me with a means to express my gratitude and respect to community members that did not directly participate in this narrative inquiry. These expressions of gratitude and respect were important not only for my relationship with the community as a researcher, but also due to my positioning within the community as a young adult. In Chinese communities, social interactions are moderated by social hierarchies and rules of etiquette, which are heavily influenced by Confucian, Buddhist, and Taoist philosophies (Hwang, 1987). The term, *guānxi* (關係) refers to the relational hierarchy in which individuals are situated, with older family members and community members placed in positions of higher power and respect compared to others (Hwang, 1987). To strengthen relational ties within both families and communities, individuals are encouraged to follow certain guidelines regarding cultural etiquette. These guidelines are often unspoken, and understanding of cultural etiquette is often tacitly passed down

between generations of family and community members (De Mente, 1996; Hwang, 1987).

The term, *rénqíng* (人情), may refer to an emotional response (e.g. empathy) or resource (i.e., financial, material, social) that is exchanged to strengthen relationships (i.e. *guānxi*, 關係), and is governed by an unspoken rule or reciprocity (Hwang, 1987). When designing this inquiry, I invited potential co-participants to choose the location of our research sessions in order to respect their comfort levels and accommodate for any needs regarding privacy. Therefore, I anticipated that potential co-participants might choose their homes as places to hold our research sessions. Offering gifts of food is a sign of respect and goodwill in Chinese culture, especially if one is visiting another person's home (De Mente, 1996).

At the beginning of each session, I offered Neal a small bag of tangerines, grapes, or other fruit, a small box of cookies, or a couple of Chinese pastries as a gesture of goodwill. In turn, Neal would welcome me into his home and offer me tea during our session. Therefore, by offering food gifts and refreshments to Neal, I was also showing appreciation for his investment of time in my study while honouring his higher position in the Chinese community's age-based social hierarchy (De Mente, 1996; Hwang, 1987).

Study duration.

The sixth design consideration for a narrative inquiry is the *study's duration* (Connelly and Clandinin, 2006). Neal and I met for five research sessions, with each session lasting approximately one and a half to two hours. The frequency of our research sessions was necessary to enable the rich collection of field texts through various forms of creative expression. The duration of each research session was necessary to accommodate both the art-making component of the study and the following narrative interview.

Addressing Ethical Concerns

Co-participation and the creation of meaning.

The seventh criterion to consider when designing a narrative inquiry is *ethical concerns within the research relationship and throughout the narrative inquiry*. In narrative inquiry, the researcher participates alongside the study participants to co-create and negotiate meanings (Clandinin & Connelly, 2000; Clandinin, 2013). The co-creation and negotiation of meaning occurred during Neal and my interactions within the field, and during the creation of the research texts in the form of member checking (Clandinin & Connelly, 2000; Cresswell, 2013). This co-creation of meaning helps to address some of the ethical concerns regarding the research relationship, as it entails the ever changing, and constantly negotiated, dynamic of power between the researcher and participant throughout the narrative inquiry (Clandinin & Connelly, 2000). The specific interview methods of my study follow Clandinin and Connelly's (2000) focus on beginning with the participant's experience, and builds upon Holstein and Gubrium's (1995) concept of the "active interview" (p. 14). The concept of the active interview acknowledges the collaborative role of both the interviewer and interviewee in the creation of meaning through the dynamic interpretation of the substantive (i.e., what) and relational (i.e., how) aspects of experience that are expressed in the co-participant's narratives (Holstein & Gubrium, 1995).

Holstein and Gubrium's (1995) concept of the active interview is consistent with a narrative approach because both draw from similar key tenants of social constructivism, particularly that stories of experience are both generative and contextual (Clandinin & Connelly, 2000). Holstein and Gubrium (1995) emphasize that, "socially constructed meaning is unavoidably collaborative" (p. 18). The interview, according to Holstein and Gubrium (1995), becomes an environment in which narratives of experience are generated through interpersonal exchanges between the researcher and co-participant. In this context, the research participant transcends the role of a passive knowledge holder and may be empowered to actively converse, throughout the interview process (Holstein & Gubrium, 1995).

With Neal and my interview encounters, I understood my role was to guide the course of the interview by engaging Neal in conversations that were relevant to the research puzzle, actively listen to him, and to invite clarification and further explanation as required (Holstein & Gubrium, 1995). I encouraged Neal to frame the topics of discussion in ways that related to his experiences throughout our interview encounters (Holstein & Gubrium, 1995). The adoption of Holstein and Gubrium's (1995) concept of the active interview invited Neal to direct the process to bring a clearer focus to his personal experiences. By inviting Neal to guide the inquiry towards the stories and experiences that are most salient to him, I sought to fulfill Connelly and Clandinin's (2006) criterion for a more egalitarian interviewer-interviewee relationship within this narrative inquiry.

Confidentiality and anonymity.

An understanding of confidentiality and anonymity plays a significant role in enabling participants to share their stories (Clandinin & Connelly, 2000). This also helps to protect them from potential social risks (e.g., risks to reputation, stigma, shame, etc.) that might result from their participation in research studies (Cresswell, 2013). During our research sessions, it was important to ensure that the location in which they took place provided Neal with a place where his privacy would be respected and his confidentiality maintained. I invited Neal to choose the location of our research sessions, suggesting that the place be somewhere where he felt safe and comfortable. We ended up meeting in Neal's home as he requested. He told me that we could schedule our research sessions during times when his family was not home. For my personal safety, I carried a cell phone with me at all times and informed my family members about the dates and approximate times (but not specific location) of our research sessions. Neal explained that his family was aware of his depression and continued to love and care for him, but he preferred to hold our sessions during a time when we would be afforded more privacy and quietness. I agreed with Neal, reiterating the importance of me keeping his identity and identifying information confidential within our research relationship (Cresswell, 2013). After each of our research sessions, I would transcribe our interviews and change or omit any identifying information. I also encouraged Neal to create his pseudonym to protect his identity, although he initially was reluctant to do this.

During the creation the research texts of this thesis, I continued to attend to the importance of upholding the confidentiality and anonymity of my co-participant. During my process of reading and re-reading the transcripts of our interviews, my field notes, and reflexive journal entries, I ensured that I changed, masked, or omitted all potentially identifying information while staying close to the personal and social contexts of Neal's experiences. In Clandinin and Connelly's (2000) narrative inquiry, the particularities of personal experience are important to helping the stories to come alive and ensure that the research texts stay close to the co-participant's individual experiences. My rigor in staying aligned to the literary roots of this methodology's process of analysis becomes salient if readers of this thesis can visualize the complexity of Neal's story and imagine him to be a real, living, human being with particular life experiences and contexts. At the same time, the methodology of Clandinin and Connelly's (2000) narrative inquiry requires that I pay close attention to the relational responsibilities and my co-participant relationship with Neal. I invited Neal to participate not only in the creation of the field texts (i.e., interview transcripts, artworks), but also to participate in the co-creation of the research texts (i.e., chapters of this thesis) via member checking. Neal's engagement in this process of member checking, in addition to his understanding of the potential risks and benefits of participating as expressed through his voluntary informed consent to join me in this narrative inquiry, ensure that the rich meanings and contexts of his story were accurately represented while I maintained my ethical responsibilities as a researcher to protect his anonymity and confidentiality.

Measures also were put in place to ensure that confidentiality was kept during the handling and storage of our qualitative data. The audio recordings of our interview sessions were transferred onto an encrypted and password protected hard drive at the end of each session, and the audio files were erased. The transcriptions of our interviews also were stored on the encrypted hard drive, and hard copies of the transcripts were stored in a locked filing cabinet in a key holder restricted room (i.e., research supervisor's office). Since the purpose of creating artwork was to facilitate the telling of our stories during the research sessions, Neal was given a file folder to store his creations in, in between our research sessions. With Neal's permission, digital photographs of each of his artworks were taken and stored on the encrypted hard drive. Any identifying words or phrases

were removed from these images in order to protect Neal's identity. At the end of our research sessions, he also wished for me to keep his original artworks. The original artworks were then stored in the locked filing cabinet to ensure security. Both the hard copies and soft copies of our qualitative data will remain in secure storage for the next five years. After this period, the data will be destroyed.

Accessibility.

There were also instances when Neal and I had to pause our art-making activities and interview sessions to accommodate various physical and emotional needs. Washroom breaks occurred on an as needed basis, and a ten-minute break was implemented between the art-making and interview portions of our sessions. Refreshments were also provided to ensure that Neal did not become hungry or thirsty during our research sessions, which spanned up to two hours and were usually scheduled before noon. It also was important for me to respect Neal's emotional needs throughout our research relationship, as there was a risk of experiencing unpleasant emotions and memories as we shared our stories of depression (Edwards & Ribbens, 1998; Creswell, 2013). Therefore, I respected Neal's request that we conclude the session at the end of our first interview due to his feelings of emotional exhaustion after discussing his metaphor for depression. Neal was also free to decline to participate in any component of our research sessions, or change the type of arts activity to better facilitate the telling of his stories. The flexibility and freedom of choice that I built into the design of this narrative inquiry helped the art-making activities and interview sessions to be more accessible to Neal, ultimately enabling him to tell, relive, and retell about his experiences with depression in a safe environment (Connelly & Clandinin, 1999; Clandinin & Connelly, 2000; Creswell, 2013).

Integrating Connelly and Clandinin's (2006) evaluative criteria into my narrative inquiry have ensured that the design of this research has been rigorous. These criteria also helped to illuminate how the flexibility of the research sessions helped to address specific ethical concerns that can potentially arise when conducting a narrative inquiry. I now describe the process of moving from field texts to research texts in a narrative inquiry, and discuss how the three levels of justification become three levels of analysis as Neal and I relive and retell our stories of depression and using mental health supports.

Moving from Field Texts to Research Texts

Field texts, such as interview transcripts and field notes, are close to a co-participant's experience and tend to be descriptive in nature (Clandinin & Connelly, 2000). Research texts, such as thesis and research publications, are more removed from field texts and arise through a continuing process of asking "questions concerning meaning and significance" (Clandinin & Connelly, 2000; p. 132). The analysis and collection of data, in the form of stories, occur simultaneously in a narrative inquiry as meaning is co-created and negotiated during and between research sessions (Clandinin & Connelly, 2000). Tentative interpretations are made and noted in a reflexive journal as a narrative inquirer is in the midst of the field. My field notes included both observations about my interactions with Neal (e.g., body language, tone of voice, facial expressions) and external environment as well as internal thoughts, feelings, and responses (Clandinin & Connelly, 2000). I also made notes while transcribing our interviews between sessions, and was able to seek clarification with Neal during member checking. Member checking played a vital role in the negotiation and co-construction of meaning as I consulted Neal regarding the nascent narrative threads and patterns that emerged from his story. Clandinin and Connelly (2000) emphasize the importance of ensuring that the multiple voices of co-participants are represented in the research texts that are produced in a narrative inquiry. The multiplicity of the co-participant's voice should be influential in the final and interim research texts, as this reflects how their narratives are situated and re-situated personally, temporally, and spatially (i.e., socially and physically) as their life is in motion (Clandinin & Connelly, 2000; Connelly & Clandinin, 2006).

When writing the research texts of this thesis, I revisited the three levels of justification (i.e., personal level of justification, practical level of justification, and social level of justification) as three levels of analysis (Clandinin et al., 2007). Attending to the commonplaces of temporality, sociality, and place was also important as I repeatedly read and re-read the interview transcripts, summaries, field notes, and reflexive journal entries. Connelly and Clandinin (2006) note that "the text needs to reflect the temporal unfolding of people, places, and things within the narrative inquiry; the personal and social aspects of inquirer's and participants' lives; and the places in the inquiry" (p. 485). Writing and thinking narratively during the formation of research texts is also imperative. Since the

writing of research texts from field texts is part of the process of analysis in a narrative inquiry, it is also important to attend to the form of the text as it is being written.

Connelly and Clandinin (2006) suggest that narrative inquirers observe how particular literary forms may arise from their participant's lives. For example, during the first level of analysis, the personal level of justification, I observed how the telling of his story resonated with themes from classic poetry from both Eastern (i.e., Wang Wei's *Song of Wei City*, 渭城曲) and Western literature (i.e., John Donne's *No Man is an Island*). While unpacking the significance of Neal's story during the personal level of justification I explored how his story was personally meaningful to his life. Keeping aligned with narrative inquiry's emphasis on revealing how the researcher is autobiographically positioned to the phenomena under study, I also sought to unpack how Neal's story resonated with my own experiences with depression and mental health supports. The creation of research texts from field texts is a narrative act in which the contexts of stories and the positioning of both the co-participant and researcher are important. Connelly and Clandinin (2006) note that "in a different time, in a different social situation, and for different purposes, a different research text might be written" (p. 485). Accordingly, narrative inquirers acknowledge that the significance that arises from the living, telling, retelling, and reliving of experience is tentative, exploratory, and continuously unfolding to reveal new directions of inquiry.

In moving from field texts to research texts, I also turn my attention to the issue of addressing multiple audiences in my writing. Connelly and Clandinin (2006) identify co-participants, imagined readers, and the narrative inquirer themselves as three audiences that must be addressed in the writing of research texts. Attending to co-participants as an audience emphasizes the importance of ethically representing their stories and experiences during the writing of research texts. Attending to imagined readers helps narrative inquirers to respond to the questions "so what?" and "who cares?" Attending to one's self as an audience enables narrative inquirers to continue writing narratively while balancing their attention to the two other audiences reduces the risk of creating research texts imbued with a narcissistic tone. Indeed, Connelly and Clandinin (2006) caution that "research texts that emphasize any one [of these audiences] to the exclusion

of others lose impact” (p. 485). Attending to these three audiences became increasingly important as I moved to the second and third levels of analysis to explore the practical and social significance of Neal’s story to the field of mental health care.

Through the careful reading and re-reading, I began to *narratively code* my field texts while attending to the three commonplaces and three levels of justification of a narrative inquiry. Drawing upon aspects of literary form, Clandinin and Connelly (2000) explain that narrative codes may be “names of characters that appear in field texts, places where actions and events occurred, story lines that interweave and interconnect, gaps or silences that become apparent, tensions that emerge, and continuities and discontinuities that appear” (p. 131). During the second level of analysis (i.e., practical justifications), I unpacked how these aspects of Neal’s story might be meaningful to thinking and practices in the field of mental healthcare. During the third level of analysis (social justifications), I explored how Neal’s story might address larger social issues in the field of mental healthcare and provide insight into future directions of inquiry. Ultimately, responding to questions regarding meaning and social significance was key to shaping the research texts that emerged from the field texts in this narrative inquiry (Clandinin & Connelly, 2000; Connelly & Clandinin, 2006).

Readers can follow my process of moving from field texts to research texts through my writing on the first level of analysis and personal justifications of this narrative inquiry in Chapter Five, the second level of analysis and practical justifications in Chapter Six, and the third level of analysis and social justifications in Chapter Seven. I now discuss the invitational quality of narrative inquiry and its implications for the transferability of this study.

Invitation to Participate

M. Williams (2000) notes that interpretive research, such as narrative inquiries, often results in the creation of *moderatum* generalisations, where aspects of the topic of inquiry (e.g., how an older Chinese Canadian immigrant experiences depression) can be observed as “instances of a broader recognizable set of features” (p. 215). In qualitative research, we use the term *transferability* instead of generalizability, to convey this significance (Cresswell, 2013). Therefore, it is the theoretical inferences that arise from

this study's data, as opposed to the specific details of the Neal's stories, which present the potential for transferability to similar individuals or communities (Bryman & Teevan, 2005; M. Williams, 2000). The specific findings of this study will further our understanding of the experiences of older Chinese immigrants with depression and using mental health supports.

The symbolic meanings (i.e., the significance that is attributed to certain events, experiences, or characteristics) that Neal associates with his experiences of depression may provide insights into how culture influences the types of mental health supports that older Chinese immigrants with depression may use (M. Williams, 2000). The normative meanings (i.e., the socially constructed norms and behaviours) that Neal attributes to depression and the sources of mental health support that he uses may provide insights into how similar research might be done with individuals from different aging or immigrant populations (Bryman & Teevan, 2005; M. Williams, 2000). However, while the perceptions and meanings attributed to depression in this study may be transferable to individuals and groups of people who are demographically and contextually similar to Neal, this study's results are not representative of the views of all older Chinese Canadian immigrants or Chinese Canadians as a whole (M. Williams, 2000). If a reader begins to reflect on how this research applies to other populations, or settings or health challenges, that also is transferability.

When we respond to the experiences of an older Chinese immigrant with depression by reflecting upon our own experiences with mental health and mental healthcare, the invitational quality of narrative inquiry becomes salient (Connelly & Clandinin, 1999; Clandinin & Connelly, 2000; Lindsay & Schwind, 2015). Schwind (2008) elaborates upon this by explaining that "the paradox of human beings is that we are each unique individuals and yet at some level we are the same. It is at this latter level that our individual narratives are transferrable" (p.89). Narrative inquiry invites us to draw close to the experiences of others, and to explore how these stories resonate with the narrative threads of our own experiences (Clandinin & Connelly, 2000). In the following chapter, I return to the autobiographical nature of narrative inquiry as I begin the personal

level of analysis of Neal's narratives of experiencing depression and seeking help for his depression.

Chapter Five

First Level of Analysis: Personal Justifications

渭城曲

渭城朝雨浥轻尘，
客舍青青柳色新。
劝君更尽一杯酒，
西出阳关无故人。

王维 (701-761 AD)

A Song of Wei City

The morning rain bedews dust in Wei City down to rest:

The fresh green willows by the inn welcome the far-going guest.

I urge you to drink one more cup of wine, bottoms up:

Out of Yang-Pass no old friend you'll meet in the vast West.

Wang Wei (701-761 AD).

The *Song of Wei City* set to music and sung is a common strategy that is used in Hong Kong to help young students memorize verses from classic Chinese literature. As a child, I would listen with curiosity as my father read aloud Chinese poetry and told me stories about reciting verses during his own childhood. This particular poem is one of my father's favourites, and occasionally I would hear him sing the verses from poem while doing the dishes. I once asked him why he liked the *Song of Wei City* when it is such a

sad poem. My father told me that, when sung, one can really feel the emotion behind the author's words and in this way, the poem becomes very powerful.

The poem *A Song of Wei City*, written by the famous Chinese poet Wang Wei during the Tang dynasty, tells a story of mourning, loss, and solitude (Barnstone, Barnstone, & Haixin, 1991; 300 Tang Poems: wisdom of Chinese culture series, 2007). Wei's career as a scholar and a government official was punctuated by periods of imprisonment and exile due to the political turmoil that occurred during his lifetime (Barnstone et al., 1991; Encyclopaedia Britannica, 2016). In English, the title of this poem is sometimes translated to *Seeing Yuan Off on His Official Trip to Anxi*, to help provide more context to the narrative behind the poem (Barnstone et al., 1991). Written while Wei was in a remote area of the present-day Gansu province, this poem encapsulates his feelings of sadness, fear, and uncertainty when faced with the imminent departure and exile of his friend, Yuan, to the Gobi Desert (Barnstone et al., 1991). The original Chinese version of the poem is heavy with the sentiment of wishing to linger for a moment in the present and "drink one more cup of wine", seeing that the future is filled with loneliness and uncertainty (Barnstone et al, 1991; 300 Tang Poems: wisdom of Chinese culture series, 2007). Perhaps, this sense of mourning is made more apparent with the definitiveness of knowing that exile is permanent, and there will be no returning to this fleeting moment of friendship (Barnstone et al, 1991; 300 Tang Poems: wisdom of Chinese culture series, 2007). Reading Wei's poem, I reflect upon the isolating nature of depression. Depression is an exile from the person one used to be. One moves away from familiar landscapes and identities, towards landscapes that appear to be filled with darkness and isolation. During exile a person is changed, unable to go back to the way life used to be. In many ways, Neal's story tells of a similar journey of personal loss, mourning, and pausing to reflect before moving on into the future.

Wei is known for imbuing his poetry and paintings with themes that draw directly from his personal relationships and the isolated landscapes that he inhabited throughout his lifetime (Barnstone et al., 1991; Encyclopaedia Britannica, 2016). Relationships, particularly ties of friendship, are the unifying theme throughout Wei's poems (Barnstone et al., 1991). Part of narrative inquiry involves inviting individuals to re-examine the

relationships they have forged with themselves and others across time (Clandinin & Connelly, 2000; Connelly & Clandinin, 1999; Lindsay, 2008b). The process of telling, reliving, and retelling about certain experiences provides people with the opportunity to reconstruct and create new identities and knowledge about themselves and their relationships with others (Clandinin & Connelly, 2000; Lindsay 2001, 2006). This new knowledge, and understandings of one's self, informs a person's actions and enables them to envision new directions towards a brighter future (Lindsay 2006, 2008).

In this narrative inquiry, Neal chose to have his story represented using Adobe Heiti Std R, font size 12, to help visually express his voice in the telling of his experiences with depression and help-seeking. He explained that he likes this font because it is large, bold, and easier for him to read. I also note that this is a font that can be used to type both English words and Chinese characters. As a narrative inquirer, I reflect upon Neal's story and use Times New Roman, font size 12, to interject with my internal thoughts and feelings, external observations, and personal inquiries (Clandinin & Connelly, 2000). Neal's story, as it is represented in this text, is summarized from the discussions we had during the interview portions of our research sessions. This summarized version of Neal's story has been approved by him via member checking. I respond to Neal's story by exploring where there may be reverberations with the narrative threads of our respective experiences with depression. Through engaging in this process of reflection, I demonstrate the significance of the personal dimension of the three dimensional narrative inquiry space by revealing how the commonplace of sociality is interwoven throughout our interactions (Connelly & Clandinin, 1999; Clandinin & Connelly, 2000).

First Meeting: Who I Was and Who I Am

Duration: 10:10 am-12:15 pm, Location: Neal's home

Lifeline drawing.

I can feel a heaviness in the air as Neal and I sit at a table in his basement to draw our lifelines. We concentrate on our creations, our silence hanging over the scribbling of our pens and markers. I hear Neal sigh in contemplation, the faint wrinkle on his brow deepens with his frown. For a moment, I wonder if the art-making activity is causing

Neal to feel frustration, yet I notice that he continues to draw and write with determination. When we finish drawing our lifelines, we settle into our chairs over a pot of fresh tea and begin our interview by reading aloud our definitions of depression. Neal offers to share his definition first. With a weary sigh and slouched posture, Neal explains:

Depression is a time when a person has a lack of energy to do the things that he or she wants to do. The person... feels very sad, hopeless, and sometimes angry about his or her situation.

As I hear Neal read aloud his definition of depression, my attention is drawn towards the changes in his tone of voice and body language since we began the session's arts activities and interview. For a moment, Neal's voice sounds heavy with restrained emotion. I empathize with his desire to maintain composure despite the unsolicited emotional responses that sometimes surface when remembering difficult experiences. It can be hard to talk about depression. I sense Neal's vulnerability and I desire to protect him, to reassure him that our session is a safe place to be emotional. He closes his eyes and clasps his hands together once he has finished reading, pausing for a moment to reflect. We take a brief moment of silence. I flash him a reassuring smile, and he glances up to give a slight nod of appreciation. I am mindful to thank him for sharing before asking him to tell about how his definition relates to his experiences with depression.

I am feeling much better now since I have been seeing my psychologist, but I still have depression. I am currently staying at home due to physical health issues for which my doctors have advised that I take a leave of absence from work. Staying at home gives me time to see my doctors and my psychologist.

I listen to the inner strength that holds Neal's wavering voice together as he tells me about his depression. I feel Neal's vulnerability as he tempers his initial reflections upon depression with reassurance about his continued journey of healing. I admire his bravery in allowing himself to feel emotionally vulnerable in my presence. Is he trying to

reassure me about his determination to improve his mental health? I wonder if he is also reminding himself about the progress he has achieved with his psychologist since the advent of his depression. I have learned from my own mental health journey that sometimes reminders of past progress are helpful amidst the chaos of present struggles.

I sometimes feel very frustrated with my current situation. I enjoy doing well in my job as a school teacher and am a hard worker. I have been at my workplace as a teacher for the past 20 years. I try my best to do my job as a teacher, and some of the students I work with need intensive care due to their functional levels and health conditions. In order to teach these students and address their needs I work with a local school team. On this team, I work with a lot of consultants, such as speech language pathologists, school administrators, nurses, psychologists, social workers, and parents. We have to work very hard to become familiar with the learning profile of these students. We also have to write up report cards and individual educational plans (IEPs) for these particular students. Part of my job is to collect the input from all of these consultants, and work with them, to create the reports cards and IEPs for these students. In previous years I have worked very hard and it has been very fruitful work. I have been working in this field for 20 years. It was only this last September that I have experienced a lot of stress.

Neal identifies strongly as teacher. His eyes glimmer with pride when he mentions his work, his students, and his co-workers. His demeanour suggests a passion for teaching, an attention to detail, and a rigorous work ethic. Neal has been a teacher for more than half of my lifetime. I am reminded of my own identity as a student and the

pride I have felt as a contributing member to my school's student life. We share a common passion for our different identities within the landscape of education.

I feel that my teaching staff and I have received a lot of unfair treatment lately. Before the school year began I discovered that the classroom I was assigned did not have the appropriate layout or equipment for all our students' needs. The school administrators refused my request to change the room for my students during the preparatory summer months. I did not want to cause trouble and set up the classroom space. However, when the school year started, my colleagues noted that the classroom space was inappropriate and lacked the proper space to accommodate all of my student's needs. Together my colleagues and I requested that the school administrator change the classroom. Only then did the administrator listen to my request to change the classroom. Unfortunately, the school year had already started by this time. Fortunately, another teacher was willing to change classrooms with me, but having to move and setup both classrooms again was disruptive to us and the students.

Neal expresses a sense of injustice as he talks about identifying a problem but not having a voice that is listened to at his workplace. I empathize with Neal's tendency to desire the maintenance of social harmony, to not want to "cause trouble". This is something that stems from our shared understanding of traditional Chinese culture. Striving to work hard and continuously seek to make relationships and social relationships more harmonious are notions that originate in the teachings of the Chinese philosophers Confucius and Mencius (Chang, 1958; Fingarette, 1966). Neal's school administrator regarded his request to change the classroom *only* when he was accompanied by his colleagues. I wonder if Neal felt that his role and knowledge as a

teacher was also being disregarded during this interaction with the school administrator. I recognize this dismissal of identity and knowledge in my own experiences in high school. For a moment, I am brought back to the numerous times I challenged racism and misconceptions of mental illness in the classroom, only to be dismissed by my teachers and classmates. Neal and I are not without a voice in these situations, yet these voices are not heard during these particular social interactions.

There were also some new additions to my teaching team this year, and I had to work on establishing good working relationships amidst all this chaos. It was important for me to talk with my colleagues about my teaching philosophy and to work collaboratively with them for the sake of the students. There were also three new students this year, so my class size was bigger. I have to work hard to gather all the information when writing report cards and IEPs for each of these students. I had to ensure that I knew my students well to write the IEPs, having a bigger class and three new students whom I had not worked with before. I know from experience that it's not possible to quickly write a very good IEP at the first attempt because of a lack of information. Because of not knowing the student well enough within 30 days since class started. So I tried my best, but I had problems this year with the administrator because of the report card and IEP writing.

Neal demonstrates an attentiveness to the importance of time, collecting information, and getting to know his students in his teaching practice. Neal's desire to collaborate and share his teaching philosophy with his colleagues, and emphasis on learning about each student's individual needs, reveals that he values the creation and maintenance of personal relationships in his work.

Somehow, I found out that this school administrator did not really seriously look at my report cards and IEPs. Also, she was not transparent about her expectations for IEP writing... the way she wanted it. So there are a lot of very unhappy encounters at school on the process of writing the IEP for my students. I work closely with the consultants to write the IEPs for each student, particularly the speech-language pathologist, because part of the IEP writing requires input from them. When we had a meeting with these consultants, I found that the attitude of this school administrator was very poor. I felt so discouraged, so upset. I felt that the support system was not there and there was no way that I could work it out with these school administrators. They were not supportive and I did not know the reason why. They were not sincere, they might not like me, I don't know the reason. So I got very frustrated and was thinking about all these different things. I tried to reason with myself why this might happen and so on. So I got angry, so frustrated, and so on. I got a doctor's note that enabled me to stay at home. I have to stay at home because of my situation. So I started my depression at that time, January 9th.

This school administrator's lack of regard for Neal's work on the report cards and IEPs, and poor attitude towards his colleagues, are some of the "unhappy encounters at school" that Neal experienced. This breakdown of his professional relationship with the school administrators appears to have played a significant role in contributing to Neal's depression. I wonder if Neal's professional and cultural identities have shaped this emphasis on the significance of personal relationships at work. Neal recalls the exact date

that his depression began in a slow and gravelly voice, his eyes close and he sinks into his chair.

Before my depression, I worked very hard. I feel upset because I've realized that, no matter how hard I worked, my results were not deemed satisfactory to the school administrators. I feel sad and frustrated when I think about my recent experiences with work. I stay at home and have to see a psychologist. I talk to her about my situation and she is very helpful to me. She has taught me how to do some breathing exercises, to try and calm myself down. She also gave me some books to read about assertiveness and how to effectively communicate. So that was very helpful. When everything has calmed down, I examine myself and find that actually, this situation is not totally other people's fault. Not totally my fault either. Just a situation that happened.

Neal speaks about his depression as something that occurred, in part, as a consequence of his recent experiences with work at his school. I find it interesting that Neal identifies his depression as starting within the context of his home and psychologist's office, whereas school is a place where events occur that lead up to his depression. I listen to Neal talk calmly about his psychologist and wonder if his openness is a response to my own admission to being diagnosed with depression. Neal's repetition of his work with his psychologist, and mention of breathing exercises and reading material, suggests that he values his independence in improving his mental health.

Another thing that triggered my depression was an incident with one of the school administrators. She gave me a note informing me that she would no longer talk to me unless I notified the Teacher's Union. Like, she wouldn't talk to

me unless a representative from the Teacher's Union was present. I felt angry and offended that this administrator had closed the line of communication between us. I felt like there was no place for negotiation. This administrator also mentioned my physical condition in the note, how this might be affecting my performance as a teacher. I have heart conditions and sleep apnea, and have been seeing my doctors for these conditions. I currently have to look after my physical situation and mental situation. Although I am getting better, there is still a hurt. I worry that my sudden absence from work might have some sort of impact on my mental health.

Neal feels that involving the Teacher's Union would hinder negotiations between this school administrator and himself. This statement initially puzzles me, as I understand that unions exist to assist employees in negotiations with their employers. However, perhaps Neal is alluding to the shift in visibility that occurs in the workplace with the introduction of union involvement. By insisting that Neal involve the Teacher's Union, the school administrator has elevated her communication with Neal from a personal level to an institutional level. Stakes are raised when conflicts are elevated in such ways within the landscape of the workplace. Neal mentions that despite his progress in improving his physical and mental health, "there is still a hurt". Neal's worries about the consequences of his absence from work on his mental health indicates that he places a lot of importance on his work as a teacher. I also wonder if Neal worries about the potential social consequences that his absence may stir up amongst his colleagues.

I have been teaching for a long time. I spent a number of years as a part-time teacher, then had the opportunity to work full-time. I have also had the opportunity to teach both students with and without disabilities, so altogether I

have over 30 years of teaching experience. I am also in my mid-sixties, so in terms of my age I am fortunately eligible for retirement. Sometimes I think about other options in my life. If my health situation cannot improve, or remains the same, it might be better to let younger teachers take these kinds of teaching jobs. I will seriously consider retiring in two or three years, right now I am staying at home. Fortunately, there is still a bit of income coming in from my long-term disability benefits, which gives me the opportunity to see my psychologist and doctors so I feel more stable. The teacher's union sent me information regarding retirement recently, so this is an option that I have had in my mind. They also send me information about what I should be doing during this time while I stay at home. I don't feel nervous or worried about my future because my teacher's union keeps me well informed about my options and benefits if I do eventually retire.

Neal reflects upon his long teaching career and the wealth of teaching experience that accompanies it. He also mentions his age and takes a moment to contemplate the option of retirement. I sense a hint of reluctance in Neal's voice as he talks about leaving his career if his health conditions do not improve. Retirement does not yet seem to be an immediate concern for Neal, as he mentions beginning to only "seriously consider" retirement two or three years from now. Neal's future is uncertain, yet this uncertainty does not worry him. While he seems hesitant to make any definitive statements about retirement, I sense that Neal takes a bit of comfort knowing that his union will help him to make the transition when the times comes. A certain amount of foreseeable financial stability through the inclusion of benefits in Neal's retirement package may also

contribute to his attitude towards the future. He identifies retirement as an option, as if wishing to linger upon his role and identity as a teacher.

We pause the recorder and take a brief 10-minute break. Neal opens up the small mesh bag of tangerines that I have brought as a gift, and offers me one. The aroma of citrus peel fills the air as I resume the audio recording and invite Neal to share about his lifeline and how it relates to his experiences of depression.

I was born in the early 1950's in a very poor family. My parents were uneducated and my father was a self-taught business man. He came to Hong Kong while China was under the rule of the Kuomintang, not the Communist regime at the time. My father had a retail wholesale business, bringing merchandise from China to Hong Kong. I heard that he was doing very well at that time. However, by the time I was born, he was no longer in business. His business faced bankruptcy, and our family's members really suffered because of his failure in business. At that time, my parents were really poor. We lived in a squatter area, so it was really hard for my family. But at that time I did not know about wealth, you know?

Neal begins his lifeline by telling the story of the rise and fall of his father in his career as a businessman. His telling includes an account of immigration, from Mainland China to Hong Kong and from financial stability to poverty. The consequences of his father's "failure in business" resulted in hardship for Neal's family. Given the significance that Neal places on personal relationships, I wonder if he worries about the impacts of his situation and work and depression on his own family. Neal also refers to his parents as being uneducated. Education and socioeconomic status tend to be linked, with wealthier countries having more educated populations (Segall & Fries, 2011). Neal seems to have understood this association between education and financial stability from

a very young age. I wonder if, perhaps this understanding has helped influence the great importance that Neal places on education.

As a result, I wasn't able to attend kindergarten. I first attended school when I was seven years old, starting primary one without attending kindergarten. So I had difficulty adjusting to the classroom environment. I was a very naughty student, only interested in playing instead of actually learning. Because of my poor behaviour, I don't think my primary school teachers thought highly of me. In Hong Kong, at the time, teachers expected students to be very polite and quiet in the classroom. I was not a quiet student; I enjoyed talking.

It is interesting how a person's past experiences can generate and influence future experiences. The inability of Neal's family to afford to enroll him in kindergarten resulted in his lack of familiarity with classroom etiquette. His difficulty in adjusting to the classroom environment was identified as "bad behaviour" by his teachers. Personal interactions from the past can leave impressions on our identities that last into the future. Even Neal, who has since become a teacher, lightheartedly identifies himself as a "naughty student". I wonder how Neal's experiences as a "naughty student" might inform his relationships with his students.

There was an incident during primary school where I lost my bus money while playing in the school yard, 20 cents. The bus ride home from school was about a half hour journey, it was very challenging for me as I was in grade three. I asked one of my primary school teachers if I could borrow 20 cents to take the bus home. To my surprise, the teacher did not believe me and refused to lend me the money. Saddened, I eventually had to walk home. This was a significant

distance away from our house because my father insisted that I enroll in a special Buddhist primary school. I walked home by following the bus route, and tried to recognize the roads. I walked for a long time and it became dark, I was almost hit by a car at one point during my journey! When I returned home, my older brother was very worried about me and asked where I had been. In contrast, my father did not seem concerned about me at all. My brother, who is more than 10 years older than me, spoke to the teacher the next day and told her that I had to walk home alone at night. I think it was strange that neither my father nor my primary school teacher showed concern for my wellbeing. I almost lost my life on that walk home! I still remember this incident today. I wanted to mention this story here.

Once again, Neal tells a story about having a voice, but not being heard. In his account of the incident between one of his school's administrators and his request to change classrooms, Neal is a teacher whose concerns about the inappropriate classroom space are dismissed. In this story, Neal is a primary school student whose account of losing his bus money is dismissed by his teacher. I notice that in his telling of these stories, Neal weaves together his past experiences into a narrative tapestry that makes visible the connections between his experiences as a student and as a teacher (Lindsay, 2006). Just as the safety of Neal's students was compromised when the administrator did not heed his request for a classroom with proper equipment, Neal's safety was also compromised when his teacher did not listen to his request for bus money. I also note Neal's desire to tell this particular story, to have someone listen to it and record it. In both stories, Neal feels frustrated and confused when authority figures (i.e., his father, his elementary school teacher, school administrators at his work) do not seem to show a concern for his wellbeing or the wellbeing of his students. It appears that roles, and

meeting expectations, is important to Neal. By storying his experiences in the presence of a researcher, perhaps Neal wishes to document how his personal experiences as a student have influenced his concern as a teacher for the wellbeing of his students. As Lindsay (2008b) notes, personal experiences shape the development of both our personal and professional identities through the acquisition of experiential knowledge.

The reason why I wrote down my graduation from high school was that it was the first time I felt a sense of achievement. In Hong Kong, all the high school students have to take part in a provincial exam in order to graduate. This provincial exam is not the same as the high school exams. If they do not successfully pass the provincial exam, a student could have good grades and pass their high school exams, but they would still not be considered a successful high school graduate. Somehow I worked hard and passed the exam. This was the first time I experienced success. I knew that with this high school certificate I could find employment in Hong Kong. I could even work in the government too, without furthering my education from there.

In Hong Kong, as in many parts of the world, education provides individuals with a means of social mobility, increasing a person's opportunities to obtain more economic and cultural capital (Waters, 2006). Even as a teenager, Neal understood the value of a high school diploma in expanding his opportunities for employment and further education. Perhaps Neal's childhood experiences of economic hardship helped to deepen his understanding of the connection between education and employment opportunities, having previously mentioned that his parents were uneducated. Once again, Neal mentions, "working hard." I understand this repetition of the phrase through a cultural lens. Confucius teaches that a person improves upon their character through personal effort, continuously shaping their character through study and honest hard work

(Fingarette, 1966). Perhaps, besides telling about his personal work ethic, Neal is trying to tell me about his character. I am reminded of the ways in which I embody this notion, and reminisce upon the satisfaction I have felt in “working hard” in my studies, extracurricular activities, and paid work.

I drew my lifeline upwards, showing that my situation has improved since I was born. Coming from a poor family, then graduating from high school, I also had the opportunity to study one more year to prepare myself for further studies in education! Two years after I graduated from high school I received a letter from a relative in Canada. He told me that I could apply to university in Canada and further my studies, on the condition that I help him with his business. So I accepted his offer and this relative sponsored me, giving me the opportunity to study in Canada.

Education is important to Neal once again, providing him with opportunity to go to Canada despite growing up in poverty. Successfully graduating from high school also helped Neal to realize his dreams of furthering his education. Pursuing a post-secondary education is something that my parents and society expected of me as a young person in Canada, something that I have taken for granted as a normative process of training before entering the workforce. However, in Hong Kong and other places in East Asia, obtaining a “Western education” overseas is perceived to significantly enhance an individual’s employment opportunities and expand their global mobility (Waters, 2006). Often family members, such as Neal’s relative, will assist in sponsoring relatives in immigrating to countries such as Canada for the purposes of education (Waters, 2006).

After five years of studying, I graduated with a commerce degree. I had also initially sought to complete a bachelor of education afterwards. However, I

met a wonderful woman during this time--- my wife! After two years, I decided to move back to Hong Kong to find work. My wife was studying in China at the time. After a couple of years of working in Hong Kong, my wife and I married and returned to Canada. I worked in various jobs in business and real estate throughout the years, eventually going back into teaching. I worked as a part time teacher for more than five years, and finally found full time teaching work. Since then I have been working as a full-time teacher.

Neal continues to map his journey in becoming a teacher. This journey was delayed by other life events, highlighting the significance of relationships in Neal's life. He places value on his role as a husband. I also notice that Neal mentions the word "teacher" at least three times. His professional identity appears to be very important to him. Thinking about the more recent events at Neal's school, I ask him to elaborate about how his timeline is related to his experiences with depression.

Actually, I skipped the part about my depression. I actually experienced depression twice in my life. The first time was quite a while ago and involved a situation with my family. There were some family issues that threatened to break my family; it was a very hard time for me. I stayed home from work for several months due to depression related to this situation. However, my family and I were able to support each other during this time. I was able to return to work after those months, as my situation improved. I also decided to go back to work because I didn't want to stay at home during that time. I actually felt that my workplace was more pleasant at that time. When I concentrated on my work, I

thought less about my situation at home. This was my first time experiencing depression. I didn't experience depression again until January, because of my workplace situation. I actually feel better to be at home than to be a school now. So that is what happened to me, okay?

I understand Neal's initial reluctance to discuss his previous experience with depression. Family relationships, and the requisite bonds of love and obligation, are considered to be the foundation of human morality in Confucian philosophy (Liu, 2003). As such, it is generally understood in traditional Chinese culture that adverse matters concerning one's family are kept private out of respect. I also listen to Neal's desire to define himself, and his life, beyond the label of depression. In drawing and telling about his lifeline, Neal chooses to focus on his achievements to illustrate a holistic picture of his life. I also note Neal's awareness of how his relationships with specific places (i.e., a workplace, home) have changed as his relationships with other people (i.e., school administrators, family members) have changed over time. In his previous experiences with depression, Neal considered his work to be a refuge from the familial issues that occurred at his home. In his more recent experiences with depression, Neal's home has become his safe place from the stressors at his work. Clandinin and Connelly (2000) explain that, "we take for granted that locating things in time is the way to think about them" (p. 29).

My lifeline is about looking at the past from what I have now; I didn't just look at my depression. I've experienced two depressions so far, and besides depression I talk about my achievements. My improvement in my living standards, personal human value, and my education. My lifeline continues to improve up... even on this present day still you can see it is up. Besides seeing a consultant, seeing the psychologist and doctors, I think exercise is very

important. So far, I have found exercise to be better than taking medications. Actually, my doctor gave me some sleeping pills. That is somehow related to my depression, but the doctor gave me options. He told me that I can take the pills or not, if I didn't want to take them. So, instead of taking medication I choose to go to the gym every day. I find that I feel much better, I have more energy and my mind has become clearer. I can think better and concentrate. I don't know your situation, but I hope you can put away some of your time to do exercise every day.

Once again, Neal emphasizes his identity as independent from his experiences with depression. Neal's focus on the improvement of his quality of life, as illustrated through his lifeline, appears to compliment his focus on his efforts to improve his physical and mental health. Returning the Confucian notion of "hard work" and "self-improvement", Neal explains his preference to improve his health via exercise rather than rely on medications. Reflecting upon my own admissions to experiencing depression, Neal takes on the role of mentor and older community member in advising me also to engage in exercise to improve my health. Independence and choice appear to be important factors in Neal's mental healthcare.

I know you have the determination to do it. Look at me, I always reason and talk to myself about my own situation. This might help me out a little bit, because I am a very logical person. The most important thing for me is my Christian faith. Knowing that I am well looked after by the Creator, by God, helps me not to worry too much about my situation. For the unhappy things in my life,

there is always a scar. I will always go back and look at it, but I will not continue to get into that hole of depression.

Neal's words of encouragement remind me that healing from depression is a process. Neal's reference to metacognition, or reasoning with himself about his own situation, alludes to aspects of cognitive behavioural therapy and time spent with his psychologist (Burns, 1989). I also note that Neal identifies himself as a logical person. As a fellow Christian, I understand Neal's desire to mention the significance of his faith in helping him to heal from his depression. This shared understanding of the importance of personal faith practices, as well a membership in a faith community, helps Neal and I to establish trust within our research relationship. Reflecting upon Neal's closing words during our first session, I am reminded of the Bible verse from the book of Philippians 4:6-7, "Don't worry about anything; instead, pray about everything. Tell God what you need, and thank him for all he has done. Then you will experience God's peace, which exceeds anything we can understand" (New Living Translation).

Second Meeting: Confrontations and Exile

Date: January, 19, Duration: 10:10 am- 12:15 pm, Location: Neal's home

Short story writing.

Neal sent me an e-mail the night before our meeting. Knowing that we would be writing short stories during our next research session, Neal wanted to provide me with more information to help me better understand the context of his short stories. He described this piece of writing as a "free-write", and explained that exercising his writing skills (in both English and Chinese) was a valued past time. In his free-write, Neal elaborated upon the incident with one of the school's administrators--- this time with an emphasis on the interpersonal communication and interactions that took place. The title of this piece of writing was *Hard Work Without Fruitful Results*.

I said "are you sure that you want me to set up Room #526 and use it for my students? This room does not have enough space to enable them to move

around comfortably around the desks and other furniture. How can we accommodate the needs of students in this space?" The administrator said, "Yes, I want you to set up the room for your teaching in September". "Okay, I will set up the room, move all my stuff from my room to Room #526" I said. There were quite a lot of things that I needed to move to room 526. For the past years, I had been using Room #615 for teaching my students. Room 526 was the room that my colleague used to teach his class last year. This year, my colleague was taking a leave of absence so he had lots of his teaching materials stored in his room. To use his room for teaching, I needed to sort out his tools and tidy up the room before I could set it up for my students. I worked very hard to move my stuff into the room for teaching. I really decorated the classroom, but the most important thing was to set up the space to accommodate the needs of my students. I was very tired after spending four consecutive days setting the room up. It was Friday, and some members of my teaching staff came to visit the class before they started working. "How can we work in this room Neal!?", One of my colleagues shouted. The other colleagues said, "our students cannot move freely because the room is too small for them. The two assistants angrily said, "we need to talk to the administrator, asking her not to use this room for our students."

In his free-write, Neal's desires to advocate for the needs of his students, yet faces difficulty in advocating for himself and his students -- to have the administrator listen to

his voice and concerns as a front line professional. I feel tense as I read about Neal's compliance with the administrator's request. I am reminded of times when I too have succumbed to subjugating "the right thing to do" with "doing what I am told". For me, these memories are imbued with feelings of fear and powerlessness. Growing up in a Chinese Canadian family, I was taught to respect people in positions of authority. My grandfather would also remind me that, as a visible ethnic minority in the landscape of the Canadian workforce, I would have to continuously work harder than others to earn the respect of my supervisors and colleagues. As a result, there have been times when I have gritted my teeth and nodded politely when educators and healthcare providers have insisted on the correctness of their assumptions about how my cultural identity might influence my academic performance and experiences with depression. I wonder if Neal's story is also influenced by his cultural and professional positioning, within the landscape of his workplace.

Only with the support of my two colleagues, could I persuade the school administrator to drop her idea of using Room #526 for teaching my students. This incident brought a lot of attention to other teachers and teaching staff. They all felt sorry for me for taking such unfair treatment from the administrator.

Fortunately, I found a nice and kind colleague who was willing to change her classroom with me, although she had to move all her teaching tools from her room. I was not only tired but also very frustrated and angry because I could not figure out why this administrator was doing this to me and my colleagues. Yes, with the help of my assistants I was finally able to move all our teaching tools and equipment to a room with appropriate space for our students during the school year.

In contrast to the lack of support Neal experienced from the school administrator, Neal's colleagues appear to provide him with an outpouring of support. Neal is reluctant to make assumptions regarding the motives behind the administrator's actions, yet expressed frustration and anger at the way he and his colleagues are treated.

Honesty speaking, I was very dead tired after spending the whole day setting up the new room for my students. The first class commenced on September, 6. Since classes began, my colleagues and I encountered numerous challenges and unfair treatments for the next few months. I am convinced that all these challenges and lack of support were the result of the poor judgement and decision making by the administrators. I will continue to elaborate on all these unacceptable things from the administrators

Neal's colleagues are treated unfairly by the school administrators for supporting him in changing classrooms. He identifies the incompetence of the school's administrators as the source of the challenges that he and his colleagues faced during the following months. Neal's frustration and anger is emphasized in his repetition of telling about this incident. One of my psychotherapists once told me that depression occurs when anger is turned inwards. I wonder if Neal is using his writing to unpack some of his anger as he closely examines this significant incident.

Neal ended his email by requesting that I print two copies of his free-write, one for my reference and one for him to use the next day. Meeting for the second time in his basement, Neal seemed eager to begin the short story writing activity. He also seemed more comfortable and confident when he shared his first short story about a time when he experienced depression. Neal's story was written from a first person perspective, and he read aloud the following:

I feel more relaxed to be at home now. However, whenever my thoughts go back to my workplace--- the school where I have taught for 20 years--- I feel quite sad and disappointed. I feel sorry for the staff at my school too because the administrator was not really doing a good job. She doesn't show care for the teaching staff or the students' learning--- doesn't even greet people by saying "hello" or "good morning". The administrator also hasn't organized meaningful workshops for teacher development over the past two years. There is confusion amongst the teaching staff regarding how the administrator expects us to write our students' IEPs. I personally have the impression that the administrator doesn't really know how to write up an IEP herself. She has given absolutely no concrete or standardized way to write up IEPs and report cards.

Neal's frustration was evident as he frowned and paused to shuffle his papers. Neal explains that the free-write he sent to me earlier contained most of the story he wanted to tell. I notice that both his short story and this conversation focus on his thoughts and feelings regarding the actions of the school administrator. Neal expresses feelings of unfairness, sadness, and disappointment. I wonder if Neal's desire to tell, and retell, this story to me is helping him to understand himself and his situation better. Neal also mentions his disappointment in the lack of workshops available for teachers to build upon their teaching practice. I am prompted to think about the plethora of workshops available to me through my institution's school of graduate studies, and I am grateful for these opportunities to refine my skills. Neal seems to value a workplace that is supportive of his professional development. Relationships with his colleagues and supervisors at work appear to be very important to Neal, as he describes how the lack of support and communication between the school administrators and himself led to his depression.

I feel frustrated when I am working at school. These administrators do not care for the staff and teachers. There is especially a lack of support for teachers regarding report card and IEP writing. For example, there was a time when I submitted my report card and IEP writing ahead of the deadline in hopes of receiving constructive feedback. However, the administrators apparently did not look at my work until the last minute and rejected my writing without explanation. I found it unacceptable that there was absolutely no time to talk and discuss what I had written. I feel that the report card and IEP writing might not be the issue, perhaps these administrators simply do not want me to work at the school anymore--- for some unknown reason. I feel really sad, angry, upset, and emotionally distraught. Eventually, my doctor advised me to not return to work and seek help from a psychologist. My depression started when I could no longer report to work. Healing from my depression began when my doctor referred me to see a psychologist.

Neal's workplace has become a location in which he feels frustration due to his recent situation. Having been denied sufficient feedback regarding his work, Neal's frustration in this particular incident stems from a perceived lack of support from the school administrators. Neal also expresses distress in sensing that the administrators at his school may not want him to work at the school anymore.

I try not to talk about my work at the school because this makes me feel upset. My psychologist has given me quite a lot of reading material that I have found helpful. These books contain information about distorted thinking and

relaxation techniques. These are useful in helping me to understand my situation at work and lower my anxiety levels. I suddenly realize that not everything the administrator said about me was true. These readings also help me to improve the way I think about myself. I'm not a failure. Actually, I have been doing a really good job for my students. I understand that all the teaching staff, school consultants, parents, and even students like me. I got recognition from all these people except the administrators. I cannot say I am a failure; I did a good job. Because of this situation I got into depression and I have to deal with it, you know?

Once again, I recognize the techniques that Neal describes (e.g., distorted thinking, relaxation techniques), from my own experiences with cognitive behavioural therapy. I also empathize with Neal's appreciation for the reading materials provided to him by his psychologist. As a child, my pediatric mental health providers preferred to engage in talk therapy, walking me through the steps of cognitive behavioural therapy while encouraging me to write in a journal or create drawings to help express my thoughts and feelings about depression. As an adult, it was refreshing to have my psychiatrist recommend that I read *The Feeling Good Handbook Using the New Mood Therapy in Everyday Life* by Dr. David Burns (1989). This book was allegedly the "bible" of cognitive behavioural therapy, and I noted with interest the techniques that my childhood therapists had employed. Through my independent reading, I was empowered to adjust the pace and intensity of my self-directed therapy. Studying this book resonated with my proclivity towards lifelong learning, and now prompts me to wonder if Neal experiences a similar feeling when he studies his own reading materials. Focusing again on Neal's identity as a teacher, I note that he mentions that his depression began after he started his leave of absence from work. I ask him if he ever experienced depression while working at his school.

I admit that sometimes I had depressed feelings, but I am a strong person. I believe in forgiveness; this is because I am a Christian. I'm convinced that my Christian faith helps me quite a lot in my work. So even though sometimes I encounter very unhappy feelings, unhappy situations, I try to analyze it and forgive people. However, this particular incident at work was unusual. The administrator wrote me a note, telling me to contact my union. The message said that my wellbeing might be affecting my performance at school. I contacted my union representative, and he talked to the school administration team, but this only added to my stress. I felt that going through the negotiation process with this administrator through the union put me at a position of disadvantage. I eventually told my union representative that I could no longer bear the stress at school and had to stay at home. The union representative was really understanding of my situation and mentioned that it might not be a bad idea to stay at home and care for my own wellbeing.

I listen to Neal's assertion of his "strength as a person", and understand that he is aware of the stigma of personal weakness that is often associated with depression and other mental illnesses. As a fellow Christian, I empathize with Neal's account of drawing upon his faith to find the strength to forgive. Yet, I find it interesting that he points out the exceptionality of this particular incident. The negotiations between his union and the school administrators would have increased the visibility of Neal's conflict within the landscape of this school. Perhaps this is the "disadvantage" that Neal speaks of while recounting this experience? Neal finds support in his union representative, who reaffirms Neal's need to remove himself from the workplace to care for his wellbeing. Wanting to

take a moment to stay close to his admission to sometimes feeling depressed at his workplace, I ask Neal about the thoughts and feelings he might feel when he is depressed.

I experience a slight lack of concentration and confusion when I am depressed. I also do not sleep well. However, I'm not sure if my depression affects my sleep or if my sleep is more affected by my recent diagnosis of sleep apnea. I had heart surgery for a second degree heart block five years ago, you know? I feel sad and I don't sleep well right now. The doctors at the sleep clinic tell me that sleep apnea is a very serious condition, I might die in my sleep if I do not take care of it. Since my depression started, I now see my psychologist on a monthly basis. This is in addition to regular appointments with my family physician for both my physical and mental health needs.

I am all too familiar with the lack of concentration, problems with sleep, feelings of confusion, and thoughts about failure that Neal describes. These are some of the classic symptoms of depression (Centre for Addiction and Mental Health, 2012). The comorbidity of Neal's mental health issues with his physical health concerns is consistent with past observations within the field of psychiatry that suggest older adults who are diagnosed with depression also tend to simultaneously have chronic diseases and other health conditions (Harpole et al., 2005). While healthcare providers may focus on the challenges that these comorbidities may present in diagnosing and treating older adults with depression, Neal's story alludes to the experiential complexity that he faces in determining whether his difficulties with sleep are attributed to his mental or physical health issues (Harpole et al., 2005).

Reflecting on Neal's mention of issues with his cardiovascular health, I think about the significance of the heart in traditional Chinese culture. Lee, Kleinman, and Kleinman (2007) found that Chinese psychiatric patients tended to express emotional

distress in conjunction with bodily experiences, most commonly using words and phrases that refer to the heart (e.g., 心痛, *xīntòng*, heart ache; 心煩, *xīnfán*, upset/ heart vexed). In traditional Chinese medicine the mind and body are unified in an organic whole, where the heart is an organ that serves the function of pumping both blood and *qì* (氣), described as a life-force energy that regulates emotions, vitality, and wellness (Chengji & Yongqiang, 2008). The heart's role as "the seat or container of emotions" (Lee et al., 2007) is reflected in the prolific use of the word heart, *xīn* (心), in the construction of words used to describe emotions in the Chinese language (e.g., sadness, *bēi*, 悲; grief, *āisī*, 哀思; anger, *nù*, 怒). I reflect upon Neal's story about his previous heart surgery may have changed his heart's physical health. I think about Neal's current experiences with his mental healthcare providers and wonder how having depression might have changed the health of his emotional heart. Neal is aware of the seriousness of his physical health conditions, noting that he could die if his sleep apnea is untreated. The prospect of death can be frightening. My grandfather also had physical health conditions, concerning his heart and cholesterol levels, in addition to his depression. Looking back, I wonder how my grandfather felt as he experienced challenges to both his physical and mental health.

I maintain good relationships with my colleagues at work. I only noticed changes in the school administrator's attitudes towards me within the past year--- we had worked well together in the past. I found this to be very odd and wondered if this sudden change in her attitude was influenced by pressure from the upper administration to get rid of me. I asked one of my colleagues for feedback the second time I wrote my report cards and IEPs. This colleague told me that my writing was quite good. A very experienced colleague shared some

insight into my situation and said, “you will always lose, you will never be able to win.” I suspected that something fishy was going on in the workplace; this made me feel depressed. I was also upset that the administrator was not listening to my concerns, both with IEP writing and the issues with the classroom. At the school, a lot of colleagues rely on me, as a more experienced teacher, to obtain support from the administrators. Yet, the administrators were not supporting me, and therefore not supporting my colleagues either. This was very difficult for me, especially since I did not know why I was being treated unfairly by the administrators.

I am also frustrated with the school administrator because she only focuses on promoting the school through book publications, film, and media reports, rather than organizing workshops to help the staff build upon their teaching practice. I feel that it is the administrator’s job to facilitate the learning of teachers and staff members in current knowledge regarding the care and teaching of our school’s students. We need a lot of workshops, a lot of information on how to teach the students--- because information changes, right?

The administrator’s focus on promoting the school, instead of investing in the quality of education, frustrates me because I have dedicated my life to teaching my students. I really admire people who really help the staff at my school; the administrators are doing a superficial job.

Neal expresses frustration about his school administrator's emphasis on marketing a place rather than investing in teachers as curriculum makers. Reflecting upon Neal's frustration with the school's administrator, I think about my own experiences with the marketization of the university experience. As a young adult who has entered the Canadian post-secondary education system during neoliberal times, I notice that many of my undergraduate peers ascribed to the notion of valuing the *having* a degree over *being* a learner (Molesworth, Nixon, & Scullion, 2009). I sense a similar tension in Neal's story about how the school administrator tended to emphasize the students having a school to attend rather than investing in the quality of their learning. Despite the differences in the lengths of our teaching careers, Neal's passion for teaching resonates with my own.

Next, both Neal and I participated in the second short story writing activity. The topic of this second short story was to recall a time when we sought help for our depression. Neal's second short story highlighted the support he experienced when he sought help from his family physician regarding his depression.

I felt genuine support and help for the first time when I met with my family physician. I felt like I was being protected--- more relaxed. My family physician wrote me a support letter asking the school board to permit me to stay at home for rehabilitation purposes. He also referred me to see a psychologist whose office was nearby. The psychologist was able to conduct psychological testing on me to confirm that I was experiencing severe depression at the time. My family physician's letter of support was extremely helpful because it allowed me to stay at home and focus on recovering from depression. Since receiving treatment from both my family physician and psychologist, I have also been able to access more support from my work's rehabilitation consultants and financial support from the province's Teacher's Insurance Plan.

I felt that my family physician really understood my own situation. His letter of support was really important in enabling me to stay at home without worrying about my confrontation with the administrators at my school. Being able to stay at home really helped me to calm down and look at my own situation. My psychologist has also been a main source of support during my recovery from depression. She was the one who conducted the tests to confirm my depression. She also taught me breathing techniques to relieve stress, and assertive communication to help me manage unhelpful comments from people. I feel that my psychologist is very knowledgeable about my depression. The consultants from this province's Teacher's Federation have also been supportive of me during my recovery from depression. These consultants gave me permission for sick leave, and help me to access financial support while I stay at home. This has helped me to cope with my depression.

Reflecting upon his second short story, Neal admitted that he found it difficult to manage his depression by himself, so he first sought help from his family physician. Relationships with one's family physician is important, as they play a fundamental role in referring patients to more specialized forms of mental healthcare (Sadavoy et al., 2004). In my own journey with depression, I recall that my family physician's referral to a pediatric psychiatrist was one of my first experiences with mental healthcare. The note from Neal's doctor enabled him to access social and financial support from his teacher's union and the school board. Neal's story also reminds me of the wide range of supports that I have been able to access in my own work and studies, as a result of the power of a doctor's note. It is important that doctors believe us.

I take a moment to share my second short story with Neal. I told about a very recent check-up appointment with my psychiatrist, and how I felt discomfort and stress from the first couple of semesters of my Master's studies. I identified my source of stress to be the large number of responsibilities I had taken on pertaining to extracurricular activities, friends, and family. I was upset because I felt that these responsibilities were taking time away from my thesis research and graduate studies. I confessed to my psychiatrist that I had difficulty "saying no" when approached with requests from family members, friends, peers, and faculty members at school. My psychiatrist listened patiently and reasoned that I should try saying "sorry no, I hope you understand," especially since there would always be others who would be willing to take on these responsibilities. I felt encouraged by my psychiatrist's reassurance, and decided to implement this strategy at my school regarding the organization of an extracurricular event. I note that I felt better after declining to take on additional responsibilities at school and in the community. However, I also realize that I had tended to value the happiness of others over my own happiness. Neal responds to my story with words of advice, drawing upon his reflections on his own experiences at his school.

I think we are both careful not to offend others, we don't seek confrontation and strive to find peaceful solutions to our problems. Maybe our tendency to place the concerns of other people before our own might stem from our Christian faith. Yet, sometimes in certain situations, if something is really wrong, you should say "no, I cannot do this." Thinking back to my story about the inappropriate classroom space, I should have said "no" to the administrator's insistence that I work in the space I was assigned. Instead, I waited until I had set up the classroom and my colleagues and I could no longer tolerate working in this inappropriate classroom. The administrator finally granted our request to change classrooms, but only when I repeated this request alongside my

colleagues. In hindsight, I could have avoided a lot of problems in this situation if I had been more assertive in my communication with the administrator. It is important for both of us to learn to be more assertive in our communication with others. Sometimes, being concerned with feelings might not only hurt ourselves but also jeopardize other people's health and safety. The students might have been hurt if my colleagues and I did not move to a better equipped space. Sometimes professionals, particularly teachers, have to forget their own feelings in order to ensure the comfort and safety of others. This is what I have learned, God will help me to be firm.

Once again, Neal takes on the role of mentor and older community member, sharing with me wisdom and advice that he has gleaned from his own experiences. I think that Neal is correct in advising me to be more assertive in my communication with others. I reflect upon my past experiences with people who have taken advantage of my gentleness and generosity. I wonder if my experiences with mental healthcare might have been different if I had the courage to tell some of my counsellors how frustrated I felt about our client-patient relationship. I once again question whether the meek nature of both Neal and my own communication styles are shaped by the Confucian desire for harmony with others (Fingarette, 1966) or if this similarity is coincidental. This conversation also presents Neal with an opportunity to reflect upon the situation with the school administrators, as he admits that the use of more assertive communication may have helped him when requesting the room change.

Third Meeting: Walking Through Isolating Landscapes

Duration: 10:00 am- 12:00 pm, Location: Neal's home

I was like a newborn, I felt vulnerable, sad. Sometimes I felt vulnerable, sad, tired, angry, and hopeless. While I was drawing, I was thinking about all the events that happened at my school that led up to my depression. The note from this administrator said, “your wellbeing affects your performance at school. You were not like this several years ago”. I wonder if these words are true. I feel that this administrator doesn’t want me to be at school. I saw a sleep doctor shortly after I started to stay home from work. I was diagnosed with sleep apnea. This news made me feel worse about my physical condition. I know I also have a heart condition and experience challenges with my sleep. Even my doctors say that my sleep will affect my heart. I’m also getting old, my hair is getting whiter.

The poetic qualities of the words that Neal uses to describe his metaphor surprises me. I notice that his eyes are closed and his voice is breaking with emotion as he wonders about whether his age and health conditions have affected his performance at school. I wonder with Neal about the validity of the school administrator’s statement. Neal previously mentioned having heart surgery several years ago. Was there a gradual decline in Neal’s physical health starting several years ago? Neal’s recent diagnosis of sleep apnea indicates that his physical health conditions may have contributed to his situation at his work. I listen to Neal’s words “even my doctors say my sleep will affect my heart” and ponder the ways in which his sleep apnea might have also affected his emotional heart. I also wonder how the administrator’s comments to Neal about his wellbeing and performance might have impacted his emotional heart. Neal continues to reflect upon his metaphor.

I drew my metaphor with grey hair to represent aging or “getting old”.

Thinking about my age, perhaps what I should do is forget about returning to

work. Maybe I should just really take care about my health--- seriously think about my retirement from teaching. I think I will just wait and see that happens. It is hard to think about all these things, it makes me sad. Even though things seem to be getting better, I still feel bothered because I am still waiting to see what will happen to me in my current situation.

Thinking about his age and health conditions causes Neal to wonder about retirement. While Neal is concerned about the seriousness of his physical health conditions, he is reluctant to discuss his thoughts about retirement with certainty. I empathize with Neal's sadness as he alludes to potentially leaving the familiar landscape of his work and the effect this might have on his identity as a teacher. Additionally, there is a misconception in North American society that depression in older adults is part of the normal aging process (Tan, 2011). Older adults may be negatively stereotyped as incompetent, less able learners, and less productive compared to younger adults (Tan, 2011). Despite the falsehood of these negative stereotypes, I wonder if Neal's sadness is also a response to his own understanding of this perception of aging. For Neal, aging appears to be connected to the idea of retirement. Retirement would possibly involve leaving Neal's valued identity as a teacher and the relationships he has with his colleagues and students.

Sometimes, an awareness of negative stereotypes may lead to a fear of rejection by others and self-stigma. I reflect upon my own experiences with depression and am saddened by the numerous times I have been unkind to myself in response to my internalized stigma against mental illness. In persons with depression, self-stigma has been associated with lower self-esteem, increased experiences of psychiatric distress, and disengagement with others (Drapalski et al., 2013).

A short word or phrase to describe my metaphor would be "my very unhappy state." I chose to use red to colour in the eyes of my metaphor to show

a lack of sleep. The blue colour in the skin signifies a lack of sleep and feelings of tiredness. I also think I look at everything with a very blue colour, very depressed, very unhappy with a lack of energy. The chair that my metaphor is sitting on is made of wood and is coloured brown to show a dead object. The wood is not a living thing, everything seems pointless, it is wood. My metaphor is also wearing black pants to show that he is not in a celebrating mood. I am using black to symbolize that I am in a dark mood, a dark period, a very dark moment. The white and grey colours in my metaphor's eyebrows and hair show that I am getting older.

I note with interest Neal's astute use of colours to convey different meanings and emotions in his metaphor drawing. Thinking back to the emotional functioning of the heart in traditional Chinese culture, and the blueness of the figure's skin, I wonder if Neal is also conveying the interrelatedness of his physical and mental health conditions. Blue skin is also an indication of hypoxia in a person with a heart condition. Like how blue skin may indicate inefficiencies in the physical heart through a lack of oxygen in the blood, perhaps the blue skin in Neal's metaphor might also indicate issues with his emotional heart (i.e., depression) through a lack of flow in his *qi* (氣). I keep this personal metaphor of a heart in mind as I listen to Neal further elaborate upon his metaphor drawing.

I've drawn the eyebrows and mouth of my metaphor to show that I was not in a very happy mood, a very sad mood. My metaphor is also not wearing shoes, showing that I was initially disorganized at home. Not dressing properly with bare feet, this is how I am at home. Most of the time I am at home, so I have bare feet.

My metaphor is like a portrait of myself, I wrote words around my metaphor to show that he (the metaphor) is thinking. I have my hand on my chin, on my face, to say that I am pondering. I am thinking about things. The other hand is touching my belly, I am thinking about my health. I drew a big stomach on my metaphor, another sign of poor health. My stomach is so fat, so unhealthy looking. I was thinking, I cannot do anything now except taking care of my health at home.

Neal's image of a sad blue man, his "very unhappy state", helps me to understand the symbiotic relationship between a person's identity and experiences. Perhaps, Neal wishes to assert his ownership of his own experiences. I listen to Neal use the pronoun "he" and the phrase "my metaphor" to describe his image. At the same time, he also refers to his metaphor as himself. Neal's metaphor also resonates with the significance of time and place in the telling of experiences. I take note as Neal talks about staying at home from work and being in an initial state of disorganization. He uses various colours to help convey the various ways that the symptoms of depression manifested themselves in his body and mind during this time. My own experiences of depression resonate with Neal's story. I am reminded of the many times that the disorganization of my mind is often reflected in the disorganization of my desk, room, and state of dress. During these times of depression, I sometimes look at myself in the mirror and say "this is not who I am!" And yet, it is who I am in that particular moment in time. I wonder if Neal is also trying to convey this message by creating a metaphor drawing that is "like a portrait" of himself.

Writing a letter from our metaphors.

Next, both Neal and I participate in the metaphor letter writing activity. The purpose of this activity is to write a letter to ourselves from the perspective of our metaphor drawings. I invite Neal to reflect upon how he is like, and not like, his metaphor drawing. After writing our metaphor letters, Neal reads aloud his letter:

Dear Neal,

I'm like a newborn who has nothing, except finding myself very vulnerable, sad, tired, frustrated, and angry. In short, I'm in a state of sadness. In fact, I'm very unhappy with my situation. What is the cause of my sadness, frustration, and anger? It is the school administrators--- especially that one particular administrator who is full of imagination and has a lack of knowledge and experience when dealing with teachers and staff at school. Yes, I remember the day when she simply handed over a note to me without any discussion about my health issues. She wrote, "your wellbeing affects your performance at school." She wanted me to notify my union with the note. So the union was there with me and there were a few meetings with the school administrators. During the meeting we talked about the report card and IEP writing and the administrator rescheduled time for me to re-write them. It was quite a lot of work. I spent a lot of time and dug up a lot of resources to write up my report cards and IEPs. But after a few meetings, the administrator did not really look at my report cards and IEPs. Even after I explained how I wrote them. She simply did not accept my writing saying, "no this is not right." She did not really sit down and talk with me about what went wrong and so on. I'm very convinced that they are using the report cards and IEPs as an excuse to get rid of me. They simply don't want me to stay at school. Later on, in a private meeting with a union representative, he told me the same story. He said that for some unknown reason they don't want

me to be at school. But he also said that they did not mean to get rid of me. I am very sad, confused, and tired. Feeling hopeless. I talk to myself all the time. No matter how hard I work, I am not able to work well as a teacher at this school because this administrator simply does not want to work with me. They just want me to be out of the school. I felt even more hopeless when I found out that I have sleep apnea. This will affect my heart condition. Oh, perhaps this is the time when I should stay home and forget about returning to school. I should really take care of my wellbeing at home. Take care.

Sincerely.

Neal ended his letter without signing it. I asked Neal about this, and he explained, “because of my condition here, nothing can happen. I have to wait. I haven’t resigned yet.” He added that he was also unsure of how to sign the letter because “my metaphor is talking to me but it’s my story.” Neal considered signing the letter from his metaphor with his own name. To clarify, I explained that Neal *could* name his metaphor after himself, but it may cause confusion. Neal then decided to name his metaphor after his Chinese name. Perhaps, Neal also felt that naming his metaphor with his Chinese name allowed him to identify with the metaphor and maintain a sense of ownership of his story. He explained that “Neal” was only the name he used in Canada, and he chose to use his Chinese name in reference to his Chinese ethnicity. This was also the name he was born with. Neal recalled that his mother chose his name. Chinese names commonly tend to consist of three characters. The first character is the person’s surname. The two remaining characters usually convey the person’s given name. The precedence given to a person’s surname, or family name, in the Chinese language also reflects the value that is placed on familial relationships and identity in traditional Chinese culture (Chen & Davenport, 2005). Neal explained the meaning behind his Chinese given name. Neal described the first character of his given name as meaning “like a tree”. The second

character's meaning was "benevolence." "Benevolence means kindness", Neal explained. He added that the name does not simply mean "being like a tree", but that the first character was also a verb, "the tree is standing up... establish[ed]." Together, the meaning behind the characters of Neal's Chinese given name is "established benevolence."

According to Confucian philosophy, "benevolence [*ren*] is the most important moral quality a man can possess" (as cited in Liu, 2003, p.236). This is because benevolence is considered necessary to maintain interpersonal harmony within one's social circle, and society as a whole (Chen & Davenport, 2005; Park & Chelsea, 2007). Reflecting upon the name of Neal's metaphor, and his earlier comments about the chair in his drawing, I noted the contrast between the "established tree" in Neal's name and his comment about the "dead wood" of the chair on which his metaphor sat. Neal explained that since his story is very personal he decided to portray his metaphor as a person. He added that his metaphor was in a very sad mood, and that the letter detailed his story.

In my situation, I mention about my physical conditions... these are uncontrollable. It might be that the administrator might have observed something that was affecting my performance at school. She mentioned that I was not like this several years ago, you know? In other words, there might have been something that I was not aware of. This might have been due to my health, my heart, my sleep challenges, my age, my time of teaching, and so on... particularly my health conditions. So I think I need to stay at home, see how it goes.

A sad weariness crept across Neal's face as his voice softened to a whisper. Concerns about his physical health and age led Neal to ponder the possibility that his teaching ability may have been affected by his health conditions. I note that this is the first time Neal makes this connection during our research sessions. Neal's thoughts about

uncertainty of his future career and health seemed to bring him closer to “very unhappy state.” Earlier in this session, Neal had used these words to describe his metaphor. Yet, he chose to use his Chinese name to sign his metaphor letter. I am reminded of the significance of the personal dimension of the three dimensional narrative inquiry space. Neal’s relationships, inward thoughts, and feelings reveal the prominence of his position as a teacher, older adult, and person with both physical and mental health concerns, within the landscape of his narratives. At the same time, Neal’s concerns about his sleep apnea and heart condition add to his worries about an uncertain future. My past experiences as a psychiatric patient inform me that depression is a treatable mental illness, but might depression also be a natural and appropriate response to Neal’s situation at work?

Fourth Meeting: Walking the Lonely Road of Depression

Duration: 10:15 am- 12:10 pm, Location: Neal’s home

Poetry writing.

In this session, Neal and I started by writing a free verse poem about our experiences with depression. We did this by first re-reading the metaphor letters we created from our last session to refresh our memories and gather inspiration for our poems. Neal seemed more comfortable with this activity compared to the metaphor drawing and letter writing from our last session. During the previous activities, Neal initially expressed concerns about his self-perceived artistic abilities and was hesitant about sharing his thoughts and feelings through artmaking. However, he began writing with confidence and enthusiasm once we reviewed the activity for this session. We began the interview by reading aloud our free verse poems. Neal read his poem first, explaining that the topic of his poem was depression.

Feeling like a vulnerable newborn baby, feeling not able to defend myself.

Feeling sad, tired, and sometimes angry. What am I angry about? Who am I blaming? I am very angry about my report card and IEP writing. I wrote it many, many times based on all the resources about my students’ progress, conditions,

and learning styles and also input from the consultants but still it is not approved by the administrators. I'm very unhappy with the administrator. I have the impression that she has double standards when reading and approving a teacher's report card and IEP writing. I feel that she is deliberately picking on me for some unknown reasons. These unknown reasons have been bothering me a lot. Took many nights of my sleep until I started seeing a psychologist.

The End.

After listening to Neal read aloud his story, I invited him to elaborate upon how his poem related to his experiences with depression.

Basically, my depression is heavily influenced by the situation at my work, particularly the issues with the school administrators and report card and IEP writing. I began my poem by writing about my feelings about depression. I talk about my anger. I highlight this because I felt angry with the administrator who evaluated my report cards and IEPs during the time of my writing. I felt that the administrator had double standards and picked on me for some unknown reason. Not knowing why she treated me this way caused me to have problems sleeping at night due to worry and stress. My difficulties with sleeping continued until I had to see a psychologist.

I listen to Neal's words as he tells me about the impact of his situation at work on the development of his depression. I ponder about the emphasis that he places on the breakdown of his relationships with his school's administrators. Neal's situation at work

has often resurfaced throughout our research sessions. Having grown up with both Chinese and mainstream Canadian values, I wonder if this emphasis on Neal's situation at work is influenced by the traditional Chinese understanding of self. In Western psychology, the concept of "self" is largely based on an individual's personality traits and unique identity, both concepts that are understood to develop through a person's conscious and subconscious responses to life experiences (Hsu, 1971). However, the traditional Chinese notion of "self" can be described as interdependent, relational, and transactional; arising from a person's relationships with themselves and others (Hsu, 1971; Tung, 1991).

Thinking about these differences between Western and Eastern understandings of the self, I recognize the tensions that exist in my own understanding of myself as a person with depression. During therapy sessions with my mental healthcare providers, I tend to focus on my own emotions, actions, and thought processes. Having been born and raised in Canada, I notice that my concept of self is very Western. And yet, my familial relationships form some of the most significant markers of my identity--- I am a daughter, a sister, a family member. For example, I privilege my identity as a family member and member of my ethnic community more than my sexual orientation, preferring to live with the invisibility of my queerness rather than disrupting the harmony of my relationships. I view this as a measure of self-preservation, the maintenance of healthy relationships is inseparable from the maintenance of my mental health. In traditional Chinese medicine, emotional stress is understood to result from disharmony in the relationships that a person may have with their bodies as well as physical and social environments (Zhao, 2011). Neal and I appear to share this dual understanding of ourselves, and our experiences of depression, influenced by both Western and Eastern epistemologies.

My psychologist was able to give me a lot of advice regarding how to examine my thoughts about report card and IEP writing and the administrator. The situation at work was the main reason for my depression, but my physical

conditions also played a significant role. When I was experiencing depression, I also learned that I had sleep apnea. This caused me to become very tired during the daytime due to lack of sleep at night. This lack of sleep might have also affected my performance at school. I worry about my heart condition, one of the doctors mentioned that my lack of sleep could also affect my health. I am currently staying at home and aware of my various health conditions.

After seeing my psychologist, I know that after analyzing people's comments I need to think about whether this is true or if I need to correct my thinking. So I feel that I have a clearer picture of my situation at school. Due to my health conditions, I need to focus more on my physical health rather than depression. I find that it is actually a blessing to be able to stay at home so I can recuperate. As a result, I don't feel so bad about not being able to return to work. This might be good for me at the moment.

Chen and Davenport (2005) note that "among Chinese American people, a common and culturally accepted means of expressing psychological and emotional stress is through physical complaints" (p. 106). Yet, Neal understands his mental and physical health issues as existing as separate, yet related concerns. However, focusing on his physical health conditions also helps Neal to not "feel so bad about not being able to return to work." Disclosing physical health conditions and visible disability to colleagues and peers can be challenging. However, individuals may be discouraged from disclosing mental health conditions and invisible disability due to the intersection of stigma surrounding disability and mental illness in the workplace (Jans et al., 2012). I recall the discomfort I felt when I would submit my formal request for accommodations to my undergraduate professors at the beginning of each new semester. Each semester, a

number of curious classmates and peers would ask me why I submitted the coloured form to our professor and why I wrote my exams in a separate room. I would explain that I had an invisible disability that effected my ability to concentrate while writing tests. Often times this response would satisfy most of my classmates, but occasionally I would feel pressured to disclose my depression. This disclosure tended to evoke less sympathetic responses as my peers would exclaim, “that’s not a disability” or “you’re too intelligent to need accommodations.” These experiences helped me to better empathize with people who face ablest discrimination on a more regular basis. And yet, I recall wondering if my peers would be more understanding about my needs for accommodations if I had a visible physical disability instead of depression. Perhaps, Neal’s physical conditions also help him to better justify his absence from work to his peers and colleagues.

I feel that it is more important to focus on my physical health at the moment. I can feel the impact. I have sleep apnea and I’m now learning how to use the CPAP machine and adjust my lifestyle to fit these changes. The CPAP is really crucial to me; I need to learn how to use it properly. Learn how to be more comfortable using it... this is a struggle but I will hopefully be able to do it.

For my depression, I am seeing a psychologist. At this time, I am learning. She is teaching me how to do breathing exercises and gives me papers to read. This reading material is about assertiveness, how to deal with people’s negative and even positive comments. I find this to be very helpful. Sometimes I will talk to my doctor about my future plans to either return to work or retire from teaching.

The purpose of this letter writing activity is to help Neal explore his experiences of depression by reflecting upon how he is, and is not, like his metaphor. Neal is like his

metaphor, in that his recent experience with depression is heavily related to his situation at his work. Neal described his metaphor drawing as an expression of his experiences of depression that occurred when he first started to stay home from work. Neal tells me that he is unlike his metaphor through his efforts to improve his physical and mental health. These efforts mainly consist of consulting with this physician, sleep specialists, and psychologist.

Sensing that Neal has become more comfortable talking about his depression since our first session, I take a moment to invite Neal to reflect upon how his experiences with depression may have changed over time. I ask Neal about how his recent experiences with depression compare to his previous experiences of depression. I recall that when we created our lifelines during the first session, Neal indicated that he had experienced depression once before. Neal does not seem very comfortable talking about his previous experiences with depression, and hesitates at first saying:

Actually, I seldom touch on the things about my first experience of depression. This current experience is totally different from my previous experiences. The previous experience was home-related depression. This current depression is more related to work. At the time, I saw a consultant who advised me. My situation changed and the things I experienced at home gradually became much better and brighter. So I went back to school to work, you know? That was a completely different case.

I wonder if Neal's previous experiences with depression have helped him to better cope with his recent situation with depression. Noticing that Neal makes a differentiation between "home-related depression" and "work-related depression", I ponder how the distinct places of home and work might be significant to Neal's previous and recent experiences of depression.

With my situation at home, it was very bad in the beginning but gradually my family got back together and everybody was able to live together again. The issue of my depression disappeared, so I went back to work. With this current situation at work the issue is still there, the issue is not resolved in a proper way. I think it is very likely that the administrator made mistakes when evaluating report cards and IEPs. I also think that the way I responded to the administrator's criticisms might not have been right. So both sides share some sort of responsibility.

Relationships once again play a significant role in Neal's experience with depression. Neal and I share an understanding of the importance of family in Chinese culture, Confucian philosophy describes the family as "the cornerstone of the Chinese culture" (Chen & Davenport, p.103). Not wanting to risk Neal "losing face", and being aware of my positioning as a younger (and therefore lower status) member of the Chinese Canadian community, I do not pry into the details of Neal's previous issues with his family. Instead, I listen to him elaborate upon his more recent experience with depression.

This situation at work is a complicated issue. I am also becoming more mindful of my age and heart condition. I am close to retirement age, you know? I also wonder if it would be better for me to eventually leave teaching regardless of whether or not the situation at work is able to be resolved. This situation is complicated by my depression and physical illness.

Neal is aware of the complexity of his situation at work, and how his depression and physical health conditions contribute to his experience. I am reminded of my

grandfather, and how I used to overhear my parents expressing their concerns regarding his cardiovascular health and depression as he considered his own prospects of retirement. Neal's mindfulness of his heart condition, as well as his age, reflect a cultural tendency that is common for many Chinese older adults. Researchers have previously observed that,

Many Chinese [older adults] hold the belief that individuals should be content with their situation especially when they become old. Various ailments therefore are considered to be 'normal' and 'natural' when people reach old age... Cultural precepts, such as reserve, constraint, resignation to life, and modesty about one's ability have rendered Chinese seniors less demanding on meeting their health needs (Chow, 2011, p. 66).

Focusing on Neal's emphasis on the differences between his past and present experiences with depression, I ask if perhaps, his more recent depression is different because he is facing it alone. I deliberately phrase this question to focus on the temporal aspect of Neal's experiences with depression. Familial relationships are believed to form the basis of morality in traditional Chinese culture (Liu, 2003). As a result, family issues are generally kept private and the disclosure of family problems has the potential to be both personally uncomfortable and socially humiliating. Therefore, I am mindful to be sensitive and empathetic in regarding Neal's disclosure of past family issues. Keeping this in mind, I also ask if, in the past, his experiences with depression were different because his situation involved his family and therefore he was not the only one going through hard times.

During my previous experience with depression, my family and I were all working together as a family to approach the issue. We even sought a consultant's advice together. But I am by myself at this time. As a result, my current situation with depression is a bit harder.

I want to bring your attention to the final line in my poem. It reads, “these unknown reasons have been bothering me a lot. Took many nights of my sleep until I started seeing a psychologist”. During our next session, I want to write more about how my psychologist helped me pass through my deep depression.

Neal redirects the focus of our conversation towards his more recent experience with depression. He feels that these recent experiences of depression are harder than his previous experiences because he is journeying alone. I wonder if Neal discusses his depression with his family members. I notice that we schedule our sessions when his wife and children are at work or school. Neal also indicates to me that his letter ends with the beginning of his journey of recovery from depression. Neal’s words remind me of the generative nature of experience in narrative inquiry, often times the end of one journey unfolds into the beginning of another (Clandinin & Connelly, 2000; Lindsay, et al., 2010).

I suggest that Neal could tell this story in a collage if he wanted, as the focus of our second collage activity was supposed to be help-seeking. I suggested that we could change the order of the collage activities if he wanted, so he could tell his story about seeing his psychologist during this session. Neal liked this idea.

Collage making.

We then proceed to create our first collages. I invite Neal to tell more about how his collage reflects his experiences with depression and help-seeking.

I have put down three characters in my collage. The first one is a woman wearing a demon’s hat; she also has a big mouth. Actually, she has two mouths representing that she has double standards. I wrote a statement here, showing that she is saying in an angry voice, “your work makes no sense to me!” The second picture underneath is a woman walking slowly with both hands stretched

out, showing her frustration. The air around her is full of question marks, showing that she does not know what to do or how to respond, just getting angry. There are red dots showing her anger, anger towards the administrator. Also, there is also a blue dot, showing her sadness and frustration. The person here is walking along the road, which eventually leads to this picture of another person. This person is sitting down and holding his jaw, he has a very sad face. He is pondering, thinking. There's a speech bubble coming out of his head saying, "how do I deal with all these unhelpful comments?" So this is my collage.

I had initially assumed that we are going to switch the first and second collage and activities, and create collages about a time when we sought help for our depression. However, I am surprised when Neal instead creates a collage about a time when he experienced depression (which was the original plan!). Referring back to our earlier discussion, I seek clarification and ask Neal if this collage shows a time when he sought help from his psychologist.

Yes, I started seeking help from my psychologist at around this time. However, my collage isn't about the beginning of my healing. My collage shows a time when I experienced depression, when I started to show more frustration. At the time, I had to deal with all sorts of unhelpful comments that caused my depression. As a result, I started to see my psychologist.

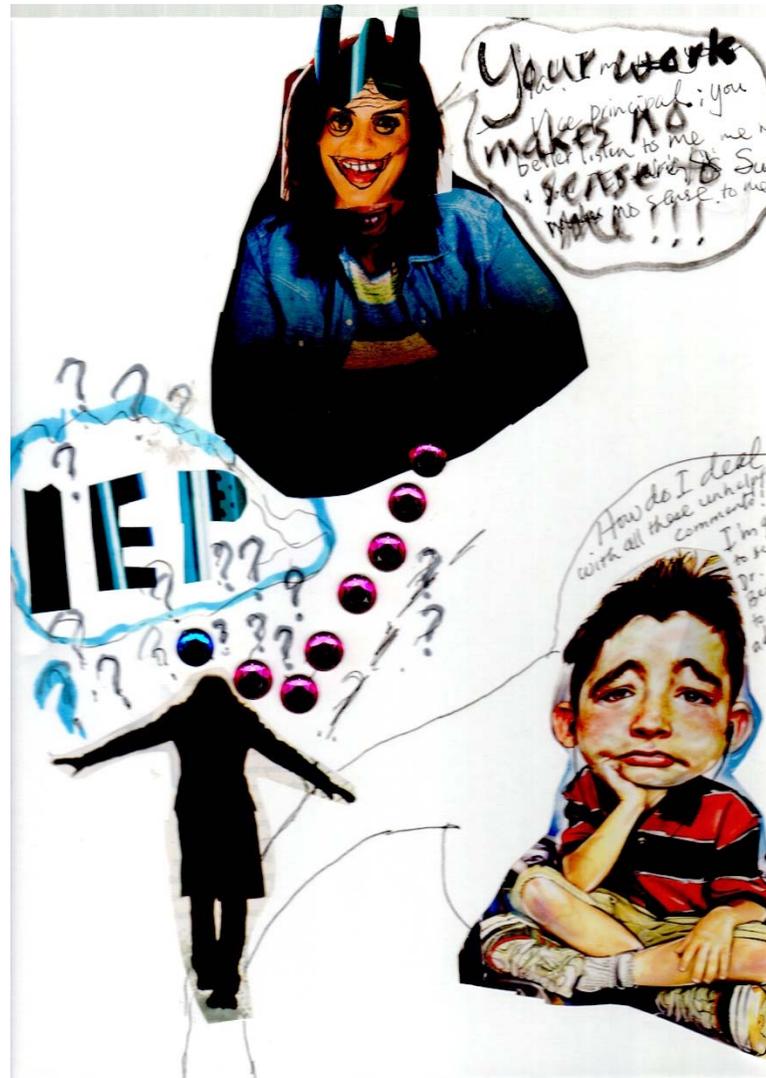


Figure 2. Neal's Collage

I saw my psychologist for advice because I was very frustrated and sad, not knowing how to deal with my feelings. She taught me breathing techniques and assertive questioning techniques. Through my work with my psychologist, I came to understand that there are a lot of people who give unhelpful criticisms

that are not right. I have to know how to analyze them, these unhelpful comments, and how to deal with them.

Once again, Neal invites me to explore his experience of depression related to the situation at his workplace. This time, I am drawn to Neal's use of the phrases "unhelpful comments" and "unhelpful criticisms." I reflect upon instances in my own life history when I have experienced depression as a result of interpersonal conflict. In one of these incidences related to my volunteer commitments within the Chinese Canadian community, there was a young woman who seemed to enjoy making snide comments about my body weight, Chinese language abilities, and sense of belonging with the group. When sharing about these experiences with my parents I use words such as "bullying" and "harassment." Neal's use of relatively neutral language to describe the interactions at his school interests me because his fluency in English does not prevent him from using different words. Perhaps Neal wishes to focus more on the "unhelpfulness" of the comments and criticisms that he experienced at his work because of the emphasis on pragmatism and problem solving in Confucian philosophy and traditional Chinese culture (Chen & Davenport, 2005; Hodges & Oei, 2007). I am also reminded of our shared Christian faith, and how these religious beliefs compliment traditional Chinese notions of harmony and peaceful interpersonal relationships. There is a passage in the Bible that says, "Do not repay anyone evil for evil. Be careful to do what is right in the eyes of everyone. If it is possible, as far as it depends on you, live at peace with everyone" (Romans 12: 17-21, New International Version).

I also notice that Neal asserts that his collage does not depict the beginning of his healing process, yet he also mentions his first encounters with his psychologist. I wonder about the ways in which Neal might differentiate between "being depressed", and "healing from depression". To further explore this experience, I invite Neal to tell me a bit more about what was happening in his life at the time when he first started seeking his psychologist's advice.

I was staying at home at the time, on sick leave due to my depression. I was quite frustrated with no intention of going back to work due to my situation. I just wanted to be by myself. I was quite unhappy about my own situation. I also could not concentrate much during the time; I was at the time in deep depression. I started seeing my psychologist after the first week of not returning to work.

Neal tells me that he was still in a state of depression during his initial steps in seeking help from his psychologist. He helps me to remember that help seeking is a process, and healing takes time to come to fruition.

Looking at my collage, I see myself in the image of the woman who is walking on the road with outstretched arms. Because of the stress I received from my workplace, I eventually got depression, which is represented by this road. I was eventually walking into depression. The image of the woman with the demon hat represents the administrator at my school. The image of the woman with the outstretched arms represents me before I sought help for my depression. You can also see the letters "IEP" near this image. The seated figure with the sad expression is also a representation of myself. This image represents me, when I was at home and thinking about seeking help for my depression.

The standing character with the outstretched arms is standing still but questioning, communicating my anger towards the administrator. I am still thinking that she might not know the right thing to do. She is not transparent

about her expectations of IEP and report card writing. She is also wearing a crown in my collage, like horns, and she has wrinkles. This is because I felt like she was an evil woman, so she is like a demon in my artwork.

Through his collage, Neal reconstructs his experience of depression to show me two different selves existing in two different points in time. Reflecting on the first image, of a woman walking on a road, Neal describes the decline of his mental health at work as “walking into depression.” I notice that Neal engages in metaphoric reflection when sharing about his collage, perhaps more so than during our metaphor drawing activity. I also notice that Neal represents himself with the image of a woman, although he identifies as a man. While Neal does not elaborate upon this, I also do not ask him about this gender choice. Perhaps, I take for granted the prolific use of the gender neutral pronoun *tā* (她 /他) in the spoken Chinese language. While there are separate Chinese words for “man” (e.g., *nánrén*, 男人) and “woman” (e.g., *nǚrén*, 女人), and separate written characters when *tā* (她 /他) is used to refer to females or males, *tā* (她 /他) is used to refer to both males and females in casual conversation and verbal discussions. Growing up in a Chinese Canadian family, I have become accustomed to hearing my father, uncles, aunts, and other community members often mix up the gendered English pronouns of “she” and “he” when speaking about others. Perhaps, this image of a woman with outstretched arms is also a *tā* (她 /他) in the visual conversation that Neal has created through his collage.

Neal tells me about how he is like the image of the seated boy with the sad expression, staying at home and in a state of depression. Neal’s reflections also help me to understand more about the temporal, spatial (work vs. home), and social (interactions with school administrators vs. personal thoughts in isolation) dimensions of each of these representations of self. Wondering if Neal’s collage also depicts the physical spaces that form the setting of his stories, I ask if the bubble surrounding the seated figure represents Neal’s home.

These lines are actually part of the road that the standing figure is walking on. The lines from the road that surround the seated figure create a place of doubt and questioning and frustration. I was thinking about how to deal with my own situation; it is a healing stage, a stage of no longer being able to work and staying at home.

I listen to Neal's account of wanting to isolate himself from others, his unhappiness, frustration, and the lack of concentration he experienced while staying at home. I empathize with Neal's experience of depression while staying at home, as I think about the depression I experienced this past summer. My mother was visiting her alma mater, the China Central Academy of Fine Arts (中央美術學院), in Beijing for a scholar's exchange. My father was experiencing health issues, and his usual forgetfulness seemed to intensify in my mother's absence. Being the eldest child in my family, I felt responsible for the care of both my father and teenaged sister. After a series of neurological tests and doctor's appointments, I was informed that my father might have health issues that reduced the quality of his sleep and therefore affect memory. The uncertainty of my father's prognosis, and the addition of extra familial responsibilities to my already busy schedule, contributed to a decline in my mental health as I struggled to balance my time. Once again, I found myself keeping silent about these experiences, in fear that my father's reputation in the community might be harmed if his health issues were disclosed. Like Neal, I preferred to stay at home during this time, isolating myself from both my colleagues at school and the Chinese Canadian community. Staying at home provided me with the privacy to experience my depression. This isolation also removed the pressure I felt to perform in a public environment, and gave me the space to seek ways to ameliorate my own mental health issues. Thinking back to Neal's collage, I wonder if the place of home also played a catalytic role in Neal's help seeking. He describes his experiences of staying at home as a place of doubt, questioning, and frustration. Yet, Neal also mentions the beginnings of healing. Neal continues to help me understand the story he is telling through his collage.

My collage focuses on a time when I experienced depression. If you look at the seated figure, you can see that this person is really sad. But I am a very practical person, you know? I always want to get help for myself. I analyze my own situation sometimes, not only thinking about the sad part. I'm a very practical person and I want to do something to help my own situation, even though I got so frustrated and angry. I know that there are some other people who will be able to help me. But this collage is mainly about my depression and how I got into this stage of my depression.

Neal's emphasis on the practicality of his personality, and his desire to improve his situation at work, resonates with my previous wonderings about Neal's adherence to the pragmatism and work ethic of Confucian philosophy (Chen & Davenport, 2005; Hodges & Oei, 2007). He reminds me that his collage tells the story of how he became depressed, yet Neal also reiterates that he is seeking help for his depression. I wonder if Neal is also trying to remind me to view him as a whole person; that his representations of his depressed selves only exist at certain points in time. The phrase "my illness is not my identity" comes to my mind.

During my next session, I might make a collage showing what will happen after seeing my doctors. I have been staying at home for almost a year and have experienced significant improvements with my mental health. However, my physical health has only been improving a little bit because my physical illnesses can be improved but not healed completely.

Neal indicates to me that he is telling about his experiences of depression with intent and purpose, paying deliberate attention to the plot of his story as it unfolds. His

decision to use this session to focus on the experiences of his depressed self, and his intentions of exploring the experiences of his help-seeking self during our next session, exemplify the multiple “I’s” that a person encounters within a narrative inquiry (Clandinin & Connelly, 2000, p. 182). I reflect upon Neal’s understanding of how he experiences “becoming depressed” and “being in depression”. I think about how Neal repeatedly tells about his situation at his workplace, and how each new telling reveals additional insights into his experiences with depression. Neal’s telling and retelling of this story reminds me of Dewey’s (1939) notion of the continuity of experience, and how “every experience lives on in further experiences” (p.13).

Neal’s use of the phrase “walking into depression” resonates with the theme of mourning and exile in Wei’s (701-761 AD) poem *A Song of Wei City* (渭城曲). Neal’s collage, like Wei’s (701-761 AD) poem, tells a story about “saying goodbye” in the face of an uncertain future. In Wei’s (701-761 AD) poem, the author is parting ways with a dear friend, who will be exiled the next day. In Neal’s story, he is parting ways with his previously working self and entering the exile of depression. And yet, I wonder how this metaphor of “depression as an exile from a previous self” may change as Neal and I explore his experiences of receiving mental health support, during our final session.

Fifth Meeting: From Exile to Exploration

Duration: 10:15 am- 12:00 pm, Location: Neal’s home

Final artworks.

Neal and I meet for our final art-making and interview session. The purpose of this session was originally to complete the second collage activity and to reflect upon how our understanding of ourselves and our depression has changed since our first session. The second collage was meant to focus on an experience when we sought help from our depression (from someone other than ourselves). During the art-making portion of this session, I am surprised when Neal decides not to use the collage materials for his artwork and instead chooses to create a metaphor drawing. However, Neal’s decision to create a drawing instead of a collage is purposeful for his story of experiencing mental health support.

I wanted to show myself doing exercise at the gym, specifically weightlifting, in this artwork. Weightlifting is only one of the kinds of exercising that I am currently doing. I also like to jog and walk to relieve my anxiety and stress. My psychologist also encouraged me to exercise. The coloured circles in my drawing represent the doctors who I have been seeing since I started experiencing depression. The first doctor here is my family physician. I have been actively seeking help from him, and he prescribed me some pills to help me calm myself. My family physician also provided me with a note that I could give to my school to inform them that that I was not yet ready to return to work. My family physician is also the main person who is overseeing and managing my health, especially since I started to experience depression. With my family physician's referral, I was able to see my psychologist. My psychologist helped me to better understand my situation and showed me a number of relaxation exercises. My psychologist also taught me how to breathe, and provided me with reading material regarding my depression. I also received some books on assertive communication. This helped me to deal with people who might give me unhelpful comments. I have to learn to communicate with people effectively. This will help me deal with comments that are sometimes not nice, not 100% true.

Once again, Neal emphasizes his individual efforts to improve his mental and physical health. Neal also tells about receiving support for his depression from a variety of healthcare providers, particularly his family physician. Neal's story is consistent with

Tieu and Konnert's (2014) observation that older Chinese Canadian immigrants tend to prefer relying on themselves and the advice of general practitioners for mental health support. However, Neal's experiences with seeking help for his depression is different from the findings in Tieu and Konnert's (2014) study in that he speaks comfortably about seeking help from a psychologist. In Canada, a patient's access to specialized healthcare providers, such as psychologists, is facilitated by a referral from a family physician (Tieu et al., 2010). I wonder if Neal's comfort in consulting a psychologist is influenced by his seemingly strong relationship with his family physician.

This next coloured circle represents my sleep doctor who is helping me with my sleep apnea. He gave me my CPAP machine, which enables me to sleep better at night. Next is my cardiologist. I have been seeing him over the course of several months to undergo testing for my heart. So far my heart is okay, but I need to take precautions and monitor my heart's health. There was also another doctor who helped me to obtain a special mouth guard for my sleep. I use both the mouth guard and CPAP to help me with my sleep apnea. This circle is a specialized nurse who conducted a memory test for me. So far everything is fine, you know? There seems to be progress.

Neal's concern with his physical health conditions is featured prominently in his second metaphor drawing. His recovery from depression appears to be intrinsically tied to the improvement of his physical health. Neal's overlapping concern for both his physical and mental health reflects Lai's (2004) finding that older Chinese immigrants who reported poor physical health also tended to report higher levels of depressive symptoms. Neal's mention of a specialized nurse in his account interests me, as this reveals both a respect for and understanding of the various types of healthcare providers in Canada's healthcare system.

work,” and tend to strongly identify with their roles as paid workers and income earners, perhaps Neal also values the social interaction that his work provides. In his previous metaphor drawing of depression, he mentions his frustration and discomfort in staying at home from work. I reflect upon my own experiences with taking time away from school to care for my mental health, and remember my own desires to return to my undergraduate studies. While I appreciated the space for recovery that I was afforded at home, I missed the sense of achievement and validation that I felt when I was at school and working part-time.

The colour of this figure’s face is bright pink. The eyes are getting brighter, and there is a smile on his face. Pink is a normal colour for skin, unlike the dark grey and blue colour I used for the skin in my first metaphor drawing. In the previous drawing, I used dark grey for the skin to reflect the time when I started my depression. So the colour of the skin in the second drawing shows that I am in a much better mood.

Neal shows me the differences between his depressed-self and recovering-self, as expressed in his previous and recent metaphor drawings. I notice Neal’s enthusiasm in sharing about his metaphor drawing, and realize that he has become more comfortable using artwork to help tell about his experiences of depression and help seeking. I compare this to Neal’s initial nervousness about engaging in creative self-expression during our first sessions. It is interesting how Neal has changed over time, not just in the telling of his stories, but also within our research relationship. I notice what looks like eyes within each of the circles in Neal’s drawing. I ask Neal to help me understand these images.

These eyes convey the message “I see.” I have drawn eyes where the coloured circles are, the doctors, to show that they are watching over me and helping me. They see. The different colours in the circles represent the different

healthcare professionals who are involved in my care. Since I was aware that I could not get myself out of my depression, I needed advice from the medical profession.

Neal defines his depression as a health condition as he refers to seeking help from the medical profession. In my own experiences with depression, I too sought advice from medical professionals when I first realized that my depressive mood was not a passing phase. I reflect upon my understanding of healthcare from the standpoint of someone who lives most of my life in mainstream Canadian society. While my father would occasionally prepare traditional Chinese herbal remedies for my sisters and I growing up, my parents would always schedule an appointment with our family physician or local clinic if one of us became ill. Traditional Chinese medicine was reserved for less serious injuries and ailments, such as bruises (my sisters and I trained in various martial arts) and minor sore throats. Curious, I ask Neal why he chose to seek help from medical professionals as opposed to other sources.

I'm not sure why, but I did seek help from my family physician first. He helped me to manage my health issues, and referred me to other healthcare providers in order to help me deal with my depression. My family physician has been caring for me for many years. He knows my family; he knows my physical health issues. He is also aware of all the different tests that the specialists were running on me, he helps to coordinate my care.

Neal tells about his long-term relationship with his family physician, and the trust and knowledge that they have built over time. I take note of his family physician's knowledge of Neal's family. Family relationships are very important in Chinese culture, and Neal tells about the deep level of trust and respect that his family physician extends not only to him, but also to his family members. A knowledge of Neal's family would

also be important in his mental healthcare, as his family physician would be better able to gauge whether Neal's family would be supportive of his recovery. In my own experiences with mental healthcare, I too have appreciated times when my psychologist and psychiatrist have trusted both me, and my family. As a pediatric psychiatry patient, it was important for me to have mental healthcare providers whom I could confide in without worrying whether they would think poorly of my family. I had heard stories from other children, while part of a mood disorders support group, about how healthcare providers would not believe their stories and had misunderstood their family situation. As a result, there were conflicts with their families due to these misunderstandings. While this did not happen to me, it was always something I feared and wished to avoid. Returning to Neal's experiences, I ask him if there were any barriers, which he might have encountered when seeking help from sources other than healthcare providers. Instead of responding to my question, Neal sighs and speaks about his self-care.

Reading books about my depression is helping me to better understand myself. This reading material really helps me when I come across people who are not really nice to me. This reading material, as well as reading material on assertive communication, has been given to me by my psychologist. Through my reading, I've learned how to communicate with people in a way that does not hurt my feelings, nor the feelings of others. This will help prevent me from getting into depression again.

Neal mentions the importance of effective communication at his work, and how his psychologist has been helping him to improve his communication skills. I reflect upon how communication and relationships are important to Neal's experiences with depression and seeking help for his depression. Interestingly, my own experiences with depression have been different. I have understood my depression as a health condition that seemingly flares up spontaneously at times. Other times, I have become depressed as a result of over-working myself, or lacking in physical or mental self-care. Relationships

are important to both Neal's and my experiences with depression, yet Neal is more concerned with his relationship with others, while I am more focused on my relationship with myself. Neal continues to elaborate upon the ways in which he is improving his mental and physical health.

Exercise is really helpful, instead of relying on medicine. My family physician prescribed me some medicine, but he gave me the option to take it or engage in exercise. I found exercise better than taking medicine. Healthy eating is also useful. At the bottom of my drawing, I wrote the words "gym", "exercise", "healthy eating." Going to the gym, seeing my doctors, following my doctor's advice, and reading books about depression have been very helpful to me.

I ask Neal to elaborate upon his preference to partake in exercise instead of taking medication for his depression. I too prefer to engage in cognitive behavioural therapy and exercise over taking antidepressants. However, my concerns were mostly related to the link between obesity and antidepressants, as well as my uncertainty of how I would afford the medications if my student insurance ever ran out.

The cost of the medication is not an issue for me. Rather, I have concerns about the side effects of the medicine. My family doctor prescribed me medicine to help me sleep. But once I started seeing my psychologist and found out about breathing techniques and exercise, I slept better. I prefer to use these resources to assist me with my sleep. I am not totally opposed to using medications because I use my CPAP.

Chen et al., (2010) found that Chinese Canadian immigrants with mental illness tended to use less psychiatric medication compared to other groups of people. While

Chen et al., (2010) suggested that there may be barriers in accessing mental healthcare services to Chinese immigrants, this does not seem to be the case for Neal. Given Neal's fluency in English, familiarity with Western culture (having been born in Hong Kong and educated in Canada), and relative socioeconomic security, his reluctance to use psychiatric medication is not related to his ability to access mental healthcare services. I note that the CPAP is a medical device and not medicine. Neal and I conclude that he prefers to engage in exercise and use medical devices rather than take medicine such as pills. Referring to Neal's concerns about the side effects of medications, I ask if he has had any adverse experiences in the past that informs this concern.

I did not have any adverse experiences with taking medications in the past. However, I am grateful that my doctors gave me a choice regarding whether to take medicine or not. You know, it's not like the doctor said I have to take medicine to sleep better, to get rid of my depression. My psychologist can't prescribe medication. I am fortunate that I did not go into really deep depression so I could gradually regain my strength and focus through exercise. I strongly recommend that people think about exercise as a means for dealing with depression rather than focusing on medication. However, I also strictly follow my doctor's advice. I feel that it is important to communicate with my family doctor to convey my feelings about the helpfulness of exercise, reading, and other activities. If I had no choice, then I would have to take the medication to help with my depression. But since I have a choice, then I choose the choice that best fits me.

Neal tells me that he values the ability to make choices and have his concerns about medications heard by his doctors. He respects his doctors and trusts their advice,

and yet he appreciates the opportunity to choose to treatments for his depression that work best for him. Neal's respect for his doctor reminds me of my own relationship with my mental healthcare providers. As a pediatric psychiatry patient, I used to believe that my doctor's advice was infallible and respected their authority with a mixture of reverence and fear. When I became an adult, I was transferred to the care of a different psychiatrist. As I gained more knowledge about the healthcare system through my undergraduate studies in the health sciences, my relationship with my psychiatrist and psychologist changed as I saw them more as peers with specialized knowledge. I learned to be unafraid to ask questions and, like Neal, communicate my thoughts and feelings about the various treatments I was prescribed. Similar to Neal, I am grateful for the opportunity to express my concerns and be heard by my mental healthcare providers. It is important to have a voice, and have that voice heard.

I think about getting out of the house more, you know? In my mind I think I want to go back to work. Even if I retire, I hope that I can retire with respect and dignity instead of... staying at home and just retiring.

I listen to Neal express his desire to return to work. I understand Neal's concerns about retiring with dignity and respect, as failing to return to work would not only result in a feeling of incompleteness but also a potential loss of face (*miànzi*, 面子). I wonder if Neal worries about what his colleagues might think if he were to retire without first returning to work--- even if only for a short period of time. I imagine that it would be uncomfortable for Neal to talk to his fellow community members about this kind of retirement, a retirement that would not follow the expected narrative of the hardworking employee who decides to retire on his own volition.

I reflect upon my own experiences of failing to live the expected narrative of graduating from my undergraduate program within a four-year time frame. I had been very involved with student life and leadership, and then seemingly disappeared for a year. I recall worrying about what my peers and professors might think if they learned that I had taken a medical leave of absence to care for my mental health. In hindsight, taking an

extra year to finish my studies appears to be more common than I previously believed. Yet, I feel my face still burns with remnants of this same shame as I recall these experiences.

I also started contacting my school again. I recently phoned and talked to one of the administrators. Apparently, the people at my school want me to come back to visit. I've been thinking about them.

As Neal anticipates returning to his work in the future, I take a moment to reflect upon how he has changed over the course of our research relationship. During our first several sessions, Neal expressed anger and frustration about his situation at work and his issues with the school's administrators. Neal now tells me about contacting his school and speaking to one of the school administrators. His voice is brimming with hope as he tells me about his progress.

I'm getting out, you know? So my mood has been changing since I got all this advice. I see my doctors and also focus on exercise and healthy eating. I see my family doctor once a month now because my situation has gotten better. I used to see him twice a month when I was experiencing depression. When I first started experiencing depression I had difficulty resting and felt very sad. I began seeing my psychologist two to three times a month, but now I see her once a month. I'm in much better shape than before.

I understand the importance of "getting out". There are some days when this is difficult for me. There have been times when I spend entire days, sometimes weeks, inside my house due to depression and anxiety. Neal tells me about how he is acting upon the advice of his healthcare providers, and is consulting them about his mental and

physical health less frequently. The recovery of his physical and mental health appears to be interrelated for Neal, as he inter-weaves these experiences together in his story.

In my drawing, there is a speech bubble that says “I’m getting stronger now.” Exercising at the gym makes me feel like I’ve accomplished something. When I accomplish something, mentally I feel stronger and also, physically I really feel stronger. I have more energy than before. I don’t want to be in depression, I want to get out of it. It is not good for me. That’s why I actively seek help, you know, from medical professionals.

Neal tells me that feelings of accomplishment are good for his mental health. I empathize with this, as I also engage in goal-oriented tasks, such as exercise and cleaning, to boost my sense of confidence on days when my mental health is poor. Neal also tells me that he views his mental healthcare providers as people who can help him get out of depression, people with specialized knowledge who can give sound advice.

However, Neal also expresses that he also plays an equally important role in his recovery from depression. Neal’s story of working hard and feeling a sense of accomplishment resonates with my own experiences and the stories of my grandfather. Perhaps our values are unified by the Confucian emphasis on individual hard work as a force that shapes a person’s character (Fingarette, 1966). Hoge and Oei (2007) note that, while Chinese and Asian immigrants readily acculturate behaviourally to the social norms of mainstream North American society, traditional Chinese values are still followed even after three generations of living in North America. Noticing that Neal’s story focuses on his experiences with mental healthcare providers, I ask him if he has also received support from people or places outside of the healthcare system.

I forgot to mention that my family really supported me. They particularly supported me when I started my depression. They said, “well, you should stay

home. Don't worry about work." I forgot to mention them because my depression is mainly related to my workplace. I seldom mention my family. One thing that I find relaxing that I did not mention was my Christian faith. I believe in God, so I know that my Creator is taking care of me no matter what happens. I know that everything is from Him, so I have comfort you know? Particularly during this time when I am at home, I have more time to study His Words, the Bible, so I get stronger. I think I get quite a lot of help from God and my Christian faith.

Neal tells me that he forgot to mention the importance of his Christian faith in his journey of recovery from depression. Yet, I recall that he had mentioned his faith during our previous research sessions. I find it interesting that Neal seems to be unaware of the repetitions and patterns that emerge within the telling of his story. However, I am also conscious of my heightened awareness of the narrative patterns and threads of Neal's story in my role as the researcher and narrative inquirer in this relationship. Neal's initial omission in mentioning his family as a source of mental health support reminds me of the importance of social context in traditional Chinese culture. The social webs of work, family, and faith community may be distinct for Neal. He previously mentioned that he does not talk about his family at his workplace. Confucian notions of social hierarchy and the intimacy of familial relationships require that individuals orient themselves to "the context of a specific social web" (Park & Chelsea, 2007, p. 302). I notice that I also tend to keep my work and home life separate, sharing about my family only with people whom I feel I can trust such close friends, mentors, and certain healthcare providers. I recall that my grandfather was a bit different, but only because he ran a family business. In addition to our shared cultural beliefs and practices, perhaps Neal and I also happen to have similar personality traits? I wonder whether this separation of private home life and public working life also applies to Neal's faith community. I ask Neal if his faith community played a role in supporting him for his depression, or if he was referring to his more personal faith beliefs and practices.

My independent beliefs and practices. Independent because I seldom disclose my problems, my depression, with anyone. Sometimes I talk about my stress at school and sometimes they pray for me. However, I don't think this is the main source of support that I rely on. What they [members of Neal's faith community] can do is pray for me because they do not have medical training in this area. So, instead of disclosing my depression to them, I just have them pray for me.

Neal and I are similar in regards to our preference to rely on individual faith practices for mental health support, rather than disclosing our depression to our faith communities. I am reminded of the verse in the Bible that states, "there is a time for everything, and a season for every activity under the heavens" (Ecclesiastes 3:1, New International Version). Once again, Neal reveals a heightened awareness of the importance of context in his own social interactions. Neal confirms that he understands depression to be a health condition, rather than a spiritual issue. He tells me that his spiritual practices, and the support of his faith community, play complimentary roles in his recovery of his mental health. Meanwhile, Neal receives the majority of his mental health support from healthcare providers, such as his family physician, psychiatrist, and other specialists.

Neal has a positive outlook on the recovery of his mental health, physical health, and position of employment. I see that his initial sadness and uncertainty for the future has been replaced with hope. Neal and I take a moment to reflect upon our shared journey in this narrative inquiry. To reflect upon how Neal's understanding of depression has changed through our living, telling, reliving, and retelling of his experiences, I invite him to create a new definition of depression. Neal writes:

Depression is when a person feels very sad and very angry about his own situation. When a person finds a way to know how to communicate better with

other people, knowing that there are always ways to resolve issues, when a person gets to know how to exercise, get enough energy, and sleep better, then that person will have more energy. Like myself, I have more energy. And as a result, I will be able to function better.

Neal's new definition of depression embodies his will to improve his mental health and interpersonal communication skills. He chooses to focus on the future outcomes of his efforts towards self-care and recovery, rather than dwell on his past situations. Once again, Neal emphasizes the importance of being able to care for one's own mental and physical health. I notice that, compared to Neal's previous definition of depression that focused on his situation at work, this new definition focuses on his abilities and functionality. In his new definition of depression, Neal tells me that he has accepted the presence of depression in his life, but is able to function better through the acquisition of knowledge, hard work, and self-care. I invite Neal to further share how he has, and has not, changed since the beginning of our research relationship.

I liked how there were a lot of different activities involved to help me to remember my experiences of depression. The art-making helped me to bring out my inner feelings about depression. The artwork was another way of helping me to remember what happened during the healing process, not just my experiences of depression.

I think that I still have depression, although I feel better since I have received treatment from my psychologist. I also have physical health issues, which also contributed to my need to stay at home from work. However, I feel better equipped to deal with the stress at my workplace after receiving advice

from my health professionals. However, I need to know how to better communicate with the school administrators. I should not blame myself all the time, knowing that this situation is not solely my fault. I have a better understanding of myself, I feel more forgiving than before. My physical health conditions have also improved. I think, if my health continues to make progress, I should continue to see ways in which I can return to work in September.

Neal acknowledges that he is still on the journey of recovery, yet it appears that he has reconciled with his depression. By exploring his experiences with depression and seeking mental health support, Neal has cultivated a deeper understanding of himself. Neal also notes that his mental and physical health will determine whether he will be able to return to work. However, he accepts that this hope of returning to work is contingent on his health. It appears that Neal's exile of depression has been transformed into an adventure towards wellness, as he re-constructs the unfolding of a new chapter in his life.

Learning from Neal's Experiences with Depression

As I conclude this personal level of analysis, I reflect upon the impact of Neal's story on my own understanding and experiences with depression. Neal's experiences with depression are intertwined with his experiences with physical health conditions. I feel compelled to examine the connection between mental and physical health in my own life. Throughout our research sessions, Neal tells about the significance of physical exercise in his journey towards mental wellness. He even advises that I partake in exercise in my own journey with depression. When I neglect to engage in regular exercise, I notice a decrease in my own energy levels, productivity, and mood. I appreciate Neal's reminder about the importance of exercise in improving both mental and physical health. I make a mental note to begin running again once the weather improves.

Reflecting upon the large belly of Neal's metaphor for depression, I think about my own struggles with weight gain and unhealthy eating habits. I was first prescribed anti-depressants when I was in Grade 10. Despite running up to three hours a day with

my school's cross-country team, I noticed that I was gaining weight. This extra weight manifested itself not in muscle mass, but in fat--- I later learned that this was a common side-effect of the anti-depressants I was taking. When I entered university, I developed unhealthy eating habits in response to late night classes. Like most Chinese Canadian families, my family has a tradition of eating dinner together. If a family member's schedule is running late, the entire family will wait before commencing the evening meal. Evening classes meant that my family and I would usually eat dinner between 8:00 pm and 10:00 pm. The consumption of large meals in the evening, particularly before bedtime, has been associated with an increased risk of obesity (Kinsey & Ormsbee, 2015). Similar to how Neal's mental and physical health issues are interwoven throughout this experiences with depression, my journey with depression is intertwined with my experiences with obesity.

Looking back to Neal's definitions of depression, I note that he conceptualizes his depression as a medical condition that results from his interactions with others and his environment. In contrast, I realize that I have tended to conceptualize my depression as a medical condition with a genetic cause, an internal brokenness that influences how I respond to others and my environments. Is Neal's understanding more holistic than mine? He mentions external factors, such as his interpersonal communication with his school's administrators, as well as internal factors like his physical health conditions, as contributing to his depression. However, he tends to initially focus on the significance of the external causes of his depression during our research sessions. Reflecting upon my own stories of depression, I realize that I emphasize the biological and genetic causes of depression when defining my mental illness. I wonder why it important for me to emphasize the internal and biological causes of my depression. Analyzing Neal's story on a personal level has pointed me towards an aspect of my own experiences with depression that may be further explored in the future. In the next chapter, I move onto the practical level of analysis and explore the significance of Neal's story on inspiring change in understandings and practices in mental healthcare.

Chapter Six

Second Level of Analysis: Practical Justifications

This chapter explores the practical justifications that comprise the second level of analysis in this narrative inquiry. In this chapter, I critically examine the prominent narrative thread of Neal's story, relationship, and the three narrative patterns of identity, voice, and communication. I use Kincheloe's (2001; 2005) concept of bricolage to draw upon aspects of patient-centered care, cultural safety (Ramsden, 2002), and the traditional Chinese values of *miànzi* (面子), *rénqíng* (人情), and *guānxi* (關係), to assemble a theoretical framework for my critical analysis of how the narrative threads and patterns of Neal's story might inform the practice of mental healthcare. I discuss how these narrative threads from Neal's story may facilitate reflection on a mental healthcare provider's own beliefs, attitudes, and actions towards relationships in their practice.

Sewing a Quilt from Narrative Patterns and Threads

Connelly and Clandinin (2006) define *narrative threads* as the story, or stories, which emerge in a narrative inquiry. Gaudite (2015) eloquently explains that "narrative threads that are related are grouped together to form narrative patterns" (p.96). The narrative threads and *narrative patterns* that emerge from Neal's story weave together to help me understand how his experiences of depression and receiving mental health support might inform practices in mental healthcare. Each narrative thread and narrative pattern is formed and shaped by the dimensions of temporality, sociality, and place--- the three commonplaces in a narrative inquiry (Connelly & Clandinin, 2006). I pay attention to these three commonplaces, as a narrative inquirer, to acknowledge that all human experiences exist within the context of an intertwining of particular points in time, personal understanding and interpersonal relationships, and physical location (Connelly & Clandinin, 2006). The analysis of the dimensions of temporality, sociality, and place helps me to identify, and unravel, the narrative threads and patterns in Neal's story.

French anthropologist Claude Levi-Strauss first applied the terms *bricoleur* and *bricolage* to the process of developing meaning in qualitative research in his book *La Pensée Sauvage* (The Savage Mind) in 1962. *Bricoleur* is a French word used to describe a

person who employs available tools and materials to finish a task or create an object (Levi-Strauss, 1962/1966). This process is referred to as *bricolage*, and has been used in qualitative research to describe the piecing together of elements from different disciplinary fields of study to create a functional methodological, theoretical, or interpretive whole (Denzin & Lincoln, 2011; Kincheloe, 2001, 2005; Levi-Strauss, 1962/1966). I become a theoretical bricoleur as I unpack the practical justifications in this narrative inquiry. Kincheloe (2005) defines theoretical bricolage as the use of “a wide knowledge of social theoretical positions... to situate and determine the purposes, meanings, and uses of the research act” (p. 335). Theoretical bricoleurs work within and between different disciplines, and sometimes paradigms, to better understand the phenomena being researched (Denzin & Lincoln, 2011; Kincheloe, 2005). Quilting is a craft that employs the use of bricolage in that it involves the physical act of sewing together different fabrics to create a unified piece that is both art and functional object (Denzin & Lincoln, 2011; Flannery, 2015). Flannery (2015) suggests that quilting is an appropriate metaphor for scientific inquiry since it is “a way to create order out of a multiplicity of pieces, just as science is discovering the order that underlies the multiplicity of phenomena that confronts us daily” (p. 633). As a narrative inquirer and bricoleur, I visualize a sewing kit as a metaphor for my theoretical framework, which is the lens of my critical analysis. Each piece of theory serves a purpose as I create my quilt of meaning, my bricolage, from the emerging narrative threads and patterns of Neal’s story. Before returning to Neal’s story, I present the contents of my sewing kit.

My Theoretical Sewing Kit

Spool of Thread: Narrative Inquiry

In my theoretical sewing kit, my analysis of the three commonplaces (i.e., temporality, sociality, and place), and three dimensions (i.e., time, person, place), of narrative inquiry is represented as a spool of thread. The analogy of a spool of thread helps to illustrate the omnipresence of temporality, sociality, and place in Neal’s story--- similar to how a bricoleur’s stitching runs throughout the entirety of a quilt. Narrative inquiry is both a process and phenomenon, and an attentiveness to how the three commonplaces of narrative inquiry create the context for each narrative thread and

patterns help to keep me close to Neal's experiences (Clandinin & Connelly, 2000). Similarly, a spool of thread is both a sewing tool and material as it holds the pieces of fabric together and ultimately becomes part of the finished quilt. I now elaborate upon this significance of the other theoretical tools used in my sewing kit, and their purpose in bringing forth the quilted piece--- the practical justifications of this narrative inquiry.

Scissors: Patient-Centered Mental Healthcare

The concept of patient-centered care originates from the field of nursing, where Florence Nightingale emphasized the value of focusing on the needs and care of the patient rather than solely the disease (Nightingale, 1860). Patient-centered care takes into account both the patient's personal needs and environment (Nightingale, 1860). Lauver et al. (2002) elaborates that patient-centered care does not exclusively pertain to an individual who is seeking healthcare, but also may be extended to social groups such as families and communities. Therefore, healthcare providers who practice patient-centered care may "deliver interventions mindful of and responsive to individual and family characteristics, such as affective states, beliefs, goals, and resources" (Lauver et al., 2002, p.247).

In my theoretical sewing kit, patient-centered mental healthcare is analogically represented by a pair of scissors. As narrative threads and patterns emerge from Neal's experiences with depression, I understand that Neal's story tells about successfully seeking, and receiving, mental health support from healthcare professionals. Like a pair of scissors that is used to cut patterns from a larger piece of fabric, the concept of patient-centered mental healthcare helps to differentiate the main narrative threads and patterns from the larger narrative of Neal's experiences with depression. A bricoleur uses a pair of scissors to bring forth the shapes of a pattern that will be used to create a quilt. Similarly, patient-centered mental healthcare helps to bring forth the usefulness of the practical justifications of this narrative inquiry to professional practice.

Needle: Cultural Safety

Kawa Whakaruruhau, known in English as cultural safety, is a concept that arose from nursing practices and education in New Zealand and emphasizes the recognition and respect of human differences (Papps & Ramsden, 1996; Ramsden, 2002).

Communication and access to health services are issues of concern in culturally safe healthcare (Papps & Ramsden, 1996). The work of Irihapeti Ramsden, a Maori person, nurse, and nurse educator, has been instrumental in defining the theoretical and practical basis of Cultural Safety (Nursing Council of New Zealand, 2011). The original focus of cultural safety was the professional development and practice of Maori nurses, as well as the experiences of Maori people with receiving healthcare (Ramsden, 2002). However, cultural safety draws upon the broadest definition of culture that can be used to help improve relationships between healthcare providers and patients who may differ based on ethnicity, socioeconomic status, age, religion, gender, and any number of human differences (Ramsden, 2002). The primary concern in cultural safety is the relationship between the healthcare provider and patient. Therefore, I envision cultural safety as the needle in my theoretical sewing kit as it pierces through the narrative threads and patterns to illuminate how Neal's experiences with depression might inform mental healthcare practices. I now briefly elaborate upon the concept of cultural safety and its purposefulness in this narrative inquiry.

Cultural safety requires that healthcare providers become mindful of the influences of colonial history and racism that exist in their own practices, attitudes, and policies in healthcare (Ramsden, 2002). A healthcare provider must engage in reflective practice pro-actively, instead of only retrospectively, in order to practice in a culturally safe manner. Building upon critical social theory, feminist theories, and Ramsden's (2002) autobiography and experiences as a nurse and Maori person, cultural safety questions relationships of power that may exist between healthcare providers and patients. Ramsden (2002) explains that, "cultural safety is a mechanism which allows the recipient of care to say whether or not the service is safe for them to approach and use. Safety is a subjective word deliberately chosen to give power to the consumer" (p.6). In this sense, cultural safety is a concept that is enacted by a healthcare provider while being defined by the patient.

The uniqueness of cultural safety lies in the impetus to provide healthcare that is "*respective* rather than *irrespective* of all the factors which maintain our integrity as member of the human race" (Ramsden, 2002, p. 98). Cultural safety rejects the

Eurocentric notion of categorizing a patient's culture based on generalized behaviours attributed to a particular ethnic or cultural group (Papps & Ramsden, 1996; Ramsden, 2002). Instead, cultural safety requires healthcare providers to communicate with patients and listen to how an individual may define, understand, and use culture in their life (Papps & Ramsden, 1996; Ramsden, 2002). Similarly, healthcare providers are encouraged to listen to their patients' stories in order to learn how culture may or may not affect a patient's health and access to healthcare. As part of this process of understanding, it is the primary responsibility of the healthcare provider to establish trust within the culturally safe patient-provider relationship (Ramsden, 2002). Ultimately, cultural safety aims to increase self-awareness in healthcare professionals while enabling them to provide quality care that is culturally safe, "as defined by the people they serve" (Ramsden, 2002, p. 94).

Neal's telling of his experiences with depression sheds light on how he is culturally and socially positioned within the landscapes of this narrative inquiry. The use of the concept of cultural safety in my theoretical sewing kit enables me to examine the practical significance of Neal's story, while addressing the cultural heterogeneity that exists within and between communities of Chinese immigrants across Canada. Returning to my metaphor of a sewing kit, the sewing needle is analogous to my use of cultural safety in stitching together the narrative threads and patterns of Neal's story. Working together with the analysis of the three commonplaces of narrative inquiry, the presence of the sewing needle of cultural safety is felt throughout the entire quilt. Similar to how needlework contributes to the overall quality and structural integrity of a finished quilt, I draw upon the concept of cultural safety to express how Neal's story may provide insights into how practitioners can contribute to the quality and accessibility of mental healthcare in Canada.

Quilting Pins: Elements of Traditional Chinese Culture

The values and mores of traditional Chinese culture are heavily influenced by the philosophy of Confucius, as well as Buddhist and Taoist influences (Schuman, 2015). By drawing upon Confucian philosophy in this level of analysis, I seek to acknowledge the potential value of re-appropriating the use of concepts that are indigenous to traditional

Chinese culture to further understandings within mental healthcare (Rosenlee, 2014). Rosenlee (2014) describes the act of feminist re-appropriation as “seeking to extract what is useful for feminist liberatory movements in traditional thought” (p. 317). In a similar manner, as a *bricoleur*, I seek to extract the usefulness of traditional Chinese concepts from Confucius for the purposes of unpacking the meaningfulness of Neal’s story to thinking and practices in mental healthcare. Relationships, particularly familial relationships, are highly valued in traditional Chinese culture and feature prominently in the teachings of Confucius (Hoges & Oei, 2007; Hwang, 1987). Relationships are governed by various values and rules regarding social hierarchy, respect, and duty (Hoges & Oei, 2007; Hwang, 1987; Park & Chesla, 2007).

Traditionally, Confucius describes society as being comprised of a hierarchy of five types of relationship: citizen and government, parent and child, husband and wife, older and younger siblings, and friends (Park & Chesla, 2007). And yet, liminal relationships exist between and within these categories of relationships. Hwang (1987) takes a sociological approach in understanding relationships in traditional Chinese society and describes three primary categories of relationships: expressive ties, instrumental ties, and mixed ties. Expressive ties are an individual’s closest and strongest relationships, usually within the family, and creates a space where an individual may freely express their inner thoughts and feelings (Hwang, 1987). Instrumental ties involve transactional relationships and serve the purpose of providing an individual with a means to exchange and obtain resources (Hwang, 1987). Such relationships are usually temporary in nature, for example, the relationship between a merchant and a client. Mixed ties are relationships that include aspects of both expressive ties and instrumental ties, and are governed by the values of *miànzi* (面子, face or impression management), *rénqíng* (人情, favor, reciprocity, or empathy) and *guānxì* (關係, relationship or personal connection). Relationships between healthcare providers and patients, and colleagues at work, are examples of mixed ties.

Each of these values interacts with the other to strengthen or weaken a person’s relationships with others in traditional Chinese culture. It is not my intent to unpack the

minutiae of how, and whether, each of these values may have influenced Neal's relationships in his story about depression. Rather, my intent in including these elements of traditional Chinese culture in my theoretical sewing kit is to invite mental healthcare practitioners to become more mindful of the more nuanced complexities that are embedded in their encounters and relationships with Chinese Canadian patients. I draw upon the values of *miànzi* (面子), *rénqíng* (人情), and *guānxì* (關係), as they are understood as impression management, empathy, and personal connection. Rosenlee (2014) states that the feminist re-appropriation of Confucian values can be used to conceptualize the caring of others as "a spontaneous act of moral heart that internalizes the needs of dependent and vulnerable others" (p. 327) that may enable mental healthcare providers to respond to the needs of older Chinese immigrants with utmost sincerity. I now briefly outline each of these values and their purposefulness in illuminating the thinking and practice in mental healthcare.

Miànzi (面子), face, and impression management.

The concept of *miànzi* (面子), or *face*, is a traditional Chinese value that refers to the management of impressions, or how a person is perceived by others (Hu, 1944; Qi, 2011). Similar to Goffman's notion of the performing self, or front stage behaviour, the Chinese notion of face is unique in that it is conceptualized as an exchange rather than solely a performance, with moral and social dimensions (Goffman, 1959; Hu, 1944; Qi, 2011). The word "face" is commonly expressed using the words *miànzi* (面子) or *liǎn* (臉). These two words may be used interchangeably, yet there are subtle differences in their specific meanings. *Miànzi* (面子) is the Chinese word for face that is more commonly used when Chinese culture and business practices are studied in the West, and refers to a person's individual social standing, reputation, and sense of self-respect (Hu, 1944; Qi, 2011). It refers to the social aspect of face (Qi, 2011). *Liǎn* (臉) is a Chinese word for face that refers to a person's moral reputation within a group, a sense of respect that a person may receive from a group (or themselves) for fulfilling certain obligations

as a “decent human being” (Hu, 1944, p. 45). It refers to the moral aspect of face (Qi, 2011). Both miànzi (面子) and liǎn (臉) can be translated as “respect” and “honour.” The interpersonal relationship between a patient and a mental healthcare provider usually involves two people (including a small number of family members). Therefore, I use to miànzi (面子) to refer to the traditional Chinese value of face for the purposes of this study.

A person’s miànzi (面子), or face, can either be gained, maintained, or lost during a social interaction and affects the closeness of a relationship (Hu, 1944; Qi, 2011). An individual may gain or maintain face if they are perceived to be respectful, knowledgeable, benevolent, and honest. This may be achieved by fulfilling a social or professional obligation, doing a person a favour (rénqíng, 人情), and conveying intentions of benevolence and respect to others (Hu, 1944; Qi, 2011). When an individual gains face they are improving their reputation with the other person, and both parties may experience a deepened sense of respect and trust for one another (Hu, 1944; Qi, 2011). An individual loses face if they are perceived to be disrespectful, unknowledgeable, malevolent, and untrustworthy. When a person loses face, their reputation is damaged, and that person may experience feelings of shame, embarrassment, and distrust (Hu, 1944; Qi, 2011). Having a great amount of face, or miànzi (面子), affords an individual a positive reputation and a high degree of respect within a relationship, which can be understood to be a form of social currency and power (Hu, 1944; Qi, 2011). An awareness of miànzi (面子), may help mental healthcare professionals to address issues of power within a patient-provider relationship, while fostering a greater sense of respect for their patients. Working in tandem with the concept of cultural safety, mental healthcare providers can help their patients to “gain face” by acknowledging their patients as “experts” in their own understanding and use of miànzi (面). Therefore, my intent in including the concept of miànzi (面子) in my theoretical

sewing kit is to encourage mental healthcare providers to reflect upon their own practice, rather than interpret and predict their patients' use of face.

Approaching the concept of face with a sense of mindfulness may help mental healthcare providers to become more aware about how they present themselves, and the impressions they may convey, when interacting with their patients. Ramsden (2002) notes that a healthcare provider's use of language, tone, and non-verbal actions can convey impressions to patients that may encourage or discourage the use of healthcare services. Reflecting upon her own practice as a nurse, she explains that cultural safety "is about protecting people from nurses, from our cultures as health professionals, our attitudes, our power and how we manage these things whether intentionally or unintentionally" (Ramsden, 2002, p. 161). In this sense, cultivating an awareness of *miànzi* (面子) may enable mental healthcare providers to develop more culturally safe practice.

With respect to Neal's experiences with depression, the concept of *miànzi* (面子) resonates with the way Neal orients himself to his multiple identities as teacher, patient, family member, and community member. Throughout Neal's story, he primarily discusses his depression and seeks support from his healthcare providers, but chooses not to discuss his depression with other people within his social network. Neal manages his multiple selves to fit the perceived appropriateness of his particular relationships and social interactions. Being a concept that is indigenous to traditional Chinese culture, the management of *miànzi* (面子) is an accepted social reality for many Chinese Canadians. The concept of *miànzi* (面子) also is a mechanism by which feelings of both shame and honour may be produced, and Confucian philosophy describes it as a reflection of a person's character and place in society (Hsu, 1971; Hwang, 1987; Lv, Wolf, & Wang, 2013). The concept of *miànzi* (面子) therefore is closely linked to traditional Chinese notions of identity (Hsu, 1971). Throughout this practical level of analysis, I share how

the concept of *miànzi* (面子) may be used to demonstrate how the narrative pattern of identity is present in Neal's story.

Rénqíng (人情), favour, reciprocity, and empathy.

The concept of *rénqíng* (人情), or *favour*, refers to a resource that may be given to, or exchanged with, other people to form, improve, or maintain good relationships (Hwang, 1987; Wang, 2008). *Rénqíng* (人情) also may refer to social norms of reciprocity that enable individuals to form and maintain positive and favourable relationships with others (Hwang, 1987; Wang, 2008). As a resource, *rénqíng* (人情) may be a physical gift or resource (such as money, food, medicine), a service (such as access to information or use of a specialized skill), or an emotional resource (such as trust) (Hwang, 1987). As a cultural value that embodies reciprocity within social relationships, *rénqíng* (人情) refers to the repayment of favors and the expression of empathy towards others (Wang, 2008). It should be noted that as a social norm of reciprocity, *rénqíng* (人情) exists as part of a complex and vast network of social and cultural values within the context of traditional Chinese culture.

In some ways and at times, *rénqíng* (人情) can be conceptualized as a form of power that may be held over another person due to the social obligation to repay (*bàodá*, 報答) the favor (Wang, 2008; Hwang, 1987). However, this understanding of *rénqíng* (人情) is arguably inappropriate within the context of a relationship between a patient and a mental healthcare provider, as this could create the opportunity for an abuse of power resulting in professional malpractice. My intent in including *rénqíng* (人情) in my theoretical swing kit is to encourage mental healthcare providers to develop a more nuanced understanding of empathy as an act of reciprocity. As a result, I emphasize the conceptualization of *rénqíng* (人情) as an exchange of emotions, such as trust, and

encourage mental healthcare providers to reflect upon how this specific conceptualization of *rénqíng* (人情) as empathy might be present in their relationships with patients. As Hwang (1987) notes, “a person who is versed in *rénqíng* is well equipped with empathy” (p. 953). In Neal’s story, the concept of *rénqíng* (人情) is reflected in the narrative patterns of voice and communication.

Guānxì (關係), relationships, and personal connections.

The concept of *guānxì* (關係) refers to relationships, or personal connections, between people (Hwang, 1987). *Guānxì* (關係) plays an important role in the development of trust between individuals, and the strength of a person’s *guānxì* (關係) with others is traditionally regulated by both *miànzi* (面子), *rénqíng* (人情) (Huang, et al., 2013; Hwang, 1987). If a person has favourable *miànzi* (面子) and a long and consistent history of *rénqíng* (人情) with another individual, they can expect to share a high level of trust in their relationship--- resulting in strong sense of *guānxì* (關係) (Huang et al., 2013; Hwang, 1987). Conversely, *guānxì* (關係) may also be damaged if a person fails to honour an ongoing *rénqíng* (人情) with another individual, or if they cause the other individual to lose *miànzi* (面子) (Hwang, 1987). This may result in other people being less willing to engage in future meaningful interactions with an individual (Huang et al., 2013). In this way, a hierarchy of *guānxì* (關係) is established, where a person is more willing to engage in *rénqíng* (人情) with individuals with whom they have strong *guānxì* (關係) (Huang, 2013; Hwang, 1987). In Neal’s story, *guānxì* (關係) resonates with the prominent narrative thread of relationship, and the narrative patterns of identity and communication.

Like the concepts of *miànzi* (面子) and *rénqíng* (人情), *guānxì* (關係) is a traditional Chinese value that is imbued with complex and multiple meanings. As previously noted, these values exist within larger social and cultural contexts that extend beyond the scope and purposes of this narrative inquiry. My intention in including *guānxì* (關係) in my theoretical sewing kit is to encourage mental healthcare providers to deeply reflect upon how the development of trust is a reciprocal act in their relationships with their patients. I also hope to encourage mental healthcare providers to reflect upon the significant value of building personal connections with their patients in the practice of person-centered mental healthcare. The concerns and wellbeing of the patient lie at the heart of person-centered mental healthcare (Nightingale, 1860; Lauver et al., 2002), yet it is also important to acknowledge the personhood of healthcare providers in patient-provider relationships (Lindsay, 2008b; Schwind et al., 2014). The concept of *guānxì* (關係) enables me to illustrate how trust might be deepened between a patient and healthcare provider in a culturally safe practice of mental healthcare, as exemplified by Neal's telling about his relationship with his family physician.

In my theoretical sewing kit, the traditional Chinese values of *miànzi* (面子), *rénqíng* (人情) and *guānxì* (關係), are represented as a box of quilting pins. Scattered across the entirety of the quilt, the quilting pins help to hold the pieces of fabric in place as the patterns of the quilt are stitched together. Similarly, *miànzi* (面子), *rénqíng* (人情), and *guānxì* (關係) help to illuminate the practical justifications of this narrative inquiry by helping to bring attention to how the narrative patterns in Neal's story are connected by the prominent narrative thread of "relationships."

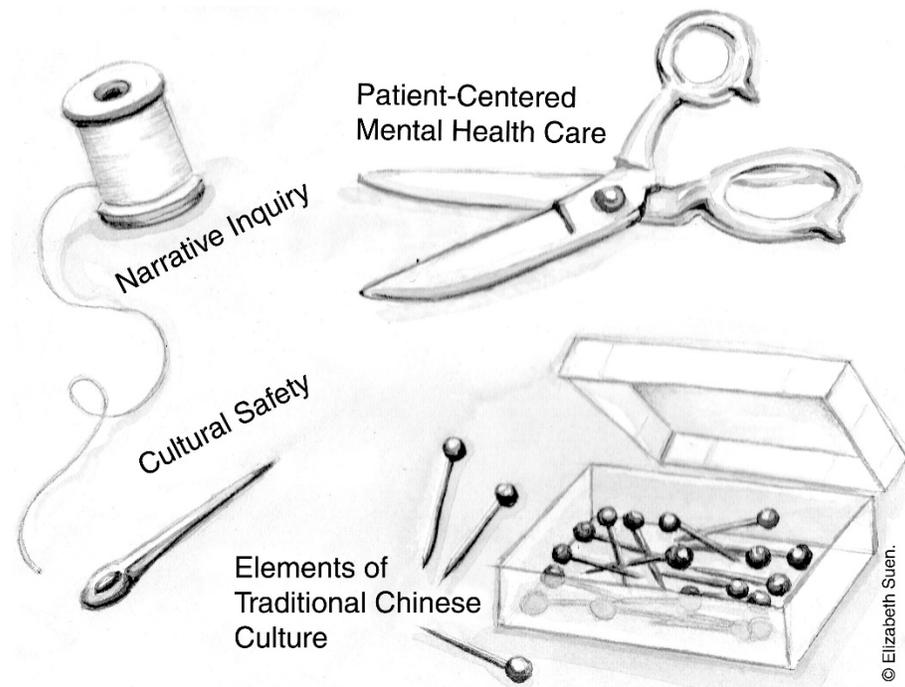


Figure 4. My Theoretical Sewing Kit.

Representations of Experience

Metaphors.

While I originally intended to use metaphor drawing as an activity for a single research session, Neal's desire to return to this activity during our final research session is telling of the significance of metaphoric reflection in the sharing of experiences with depression. Using metaphors as a tool of reflection provide insights into the subtleties of meaning that imbue a person's experiences (Schwind, 2009). Schwind (2009) posits that we are better able "to make choices in how to more intentionally and deliberately engage in life" (p. 17) when we become more aware of the metaphors that we unconsciously create throughout our personal experiences. Shank (2008) defined metaphor as extending "beyond the mere comparisons of simile and actually [equating] two objects that are on the surface not related" (p. 510). Expanding upon Clandinin and Connelly's (2000) work with experiential images and supported by the philosopher Mark Johnson's "work on experiential, embodied metaphors" (p. 3), I re-present each narrative pattern of Neal's experiences as a metaphor drawing.

Using metaphors as a tool of reflection provides insights into the subtleties of meaning that imbue our experiences (Schwind, 2009). Metaphors may also help to bridge our understanding between larger concepts, theoretical constructs, and our everyday experiences (Schwind, 2003; 2009), fulfilling what Eisner (2008) described as the proclivity of arts-informed research for “making the familiar strange and making the strange familiar” (p. 14). For example, Clandinin & Connelly (2000) used the metaphor of a pot of soup to help illustrate the complexities of narrative form may be present within and between the research texts of narrative inquiries (p.155). Reflecting upon metaphors can also enable people to explore their own emotions, learn from their experiences, and “make sense of an otherwise overwhelming situation” (Schwind, 2009, p. 17). In healthcare, metaphors can be used to assist both healthcare professionals and patients to gain enhanced understandings of their experiences (Lindsay & Schwind, 2015; Schwind, 2009). Metaphors can assist healthcare professionals in examining their own practices by providing moments of reflection on their attitudes, beliefs, and positioning towards their relationships with their patients, colleagues, and selves (Lindsay & Schwind, 2015).

Consistent with cultural safety’s concern that the reflective practice of healthcare providers should translate to real change in providers’ relationship with their patients, I encourage mental healthcare providers to reflect upon these metaphor drawings as they examine their own thinking, behaviours, and practices with older Chinese immigrants with depression (Ramsden, 2002). Integrating cultural safety into mental health practice involves a continuous process of critical self-reflection in which mental healthcare providers acknowledge the presence of their own cultures and identities, a seeking to minimize the marginalization of their patients that may result from their own thinking, behavior, and practices (Lu & Racine, 2015; Ramsden, 2002). Older Chinese immigrants are part of a population of patients who tend to be marginalized in both healthcare practices and research (Lu & Racine, 2015). A history of colonization in East Asian countries and exclusionary policies and practices in Western nations have contributed to the creation of a paternalistic dichotomy between the culturally “inferior” East and the culturally “superior” West (Rosenlee, 2014; Suen, 2012). Lu and Racine (2015) observe a similar dichotomy between “Chinese culture” and Western medicine” (p. 19) existing in

the literature pertaining to Chinese immigrants and the use of healthcare in Western countries. Rosenlee (2014) asserts that, “the colonial dichotomy between the progressive West and the oppressive non-Western world must be abandoned. Instead each culture must be granted a sense of dignity *a priori*, just [as] each person, as formulated by Kant, is owed a sense of respect” (p. 316). Much can be learned by listening to the stories of older Chinese immigrants with depression and the meaning that they reconstruct through the telling of their experiences. It is with this understanding that I invite healthcare providers and others to respond to Neal’s story by reflecting upon the metaphor drawings that I include alongside each narrative pattern and thread. These reflections may encourage the examination of a healthcare provider’s own attitudes, beliefs, positioning, and relations of power to culturally different patients. It is my hope that reflecting upon these questions will encourage healthcare providers to develop their own culturally safe practices in mental healthcare. In this next section, I proceed with the practical analysis of this narrative inquiry, and delineate the process of quilting together the narrative threads and patterns of Neal’s story.

The Process of Crafting the Quilt

The Narrative Thread of Relationship

Reflecting on my metaphor of quilt making, I envision the narrative thread of relationship as forming the border of my quilt as it unifies and frames all of the other narrative threads and patterns within this narrative inquiry. Gaudite (2015) notes that “sometimes one narrative thread is so prominent that it permeates all narrative patterns” (p. 96). Relationship is a narrative thread that resonates strongly throughout all of the narrative patterns of Neal’s story. In this narrative inquiry, relationship takes on a multiplicity of forms, with various definitions and significance depending on the context. Clandinin and Connelly (2000) note that an individual’s relationship with themselves is transformed as new understandings arise through the living, telling, reliving, and retelling of their experiences. The specific relationship between healthcare providers and patients is central to the concept of patient-centered care (Scholl et al., 2014). Relationships of power and mutual respect between mental healthcare providers, individuals, and communities are significant in the practice of culturally safe mental healthcare (Cox &

Simpson, 2015). The traditional Chinese values of *miànzi* (面子), *rénqíng* (人情), and *guānxì* (關係) emphasize the significance of impression management, the reciprocity of empathy, and the cultivation of personal connections in the development of trust in a relationship (Hwang, 1987).

The importance of relationship in Neal's experiences with depression is made apparent through his focus on telling his story through the context of his relationships with the administrators at his school and his various healthcare professionals. During the first several research sessions, Neal tells how the breakdown of his relationships with his school's administrators caused him stress and led to his depression. During the last two research sessions, Neal focuses on exploring his experiences of receiving mental health support from his family physician and psychologist. He also briefly mentions the support he has received for his physical health concerns from his cardiologist, sleep doctor, and a specialized nurse. Neal also briefly mentions the importance of his family relationships in helping him to cope with his depression. However, Neal's relationships with his school administrators, family physician, and psychologist are most prominently featured in his story, and provide the most insight into the practical justifications of this narrative inquiry. Like the border of a quilt, the narrative thread of relationship is present with each narrative pattern in Neal's story.

Narrative Patterns

Three significant narrative patterns emerge from Neal's story: identity, voice, and communication. I now examine each of these narrative patterns, and their respective narrative threads, to explore how the Neal's experiences with depression and mental health support may provide insights into the cultivation of culturally safe and person-centered mental healthcare practices. Throughout this chapter, I include significant lines from Neal's story, written in his chosen font of Adobe Heiti Std R, to help illustrate the connections between his experiences with depression and the narrative threads and patterns in this narrative inquiry.

Identity.

Throughout the beginning of Neal's story about his experiences with depression, he repeatedly refers to the significance of his identity as a teacher. He also occasionally mentions the significance of being a Christian and family member in his journey towards recovery. While Western notions of personality and individual identity tend to focus on the inner workings of a person's psyche, the concept of personhood and identity in traditional Chinese culture is dependent on a person's relationships with others (Hsu, 1971; Rosenlee, 2014; Schuman, 2015). Rosenlee (2014) explains that "the uniqueness of the individual is manifested not through her ability to shed all external attachments and relations down to the bare core self, but through her ability to respond productively to the existential demands of human relations" (p. 318). Through this understanding, a person's sense of self and identity are expressed through the fulfillment of various roles that may be expected of them within their various networks of relationships (Hsu, 1971; Rosenlee, 2014). Schuman (2015) notes that the central tenant of Confucian philosophy implies that "personal identity can only be understood in the context of a web of human relations that define who we are and how we should lead our lives" (p. 325). Lindsay and Schwind (2015) conceptualize person-centered care as a relationship that involves the personhood of patients, nurses, and nurse students. I draw upon this definition of person-centered care to unpack how Neal's multiple identities were significant to his experiences in seeking help for his depression and his relationships with his mental healthcare providers. I also discuss how this narrative pattern of identity may provide a useful point of reflection for mental healthcare providers who work with older Chinese immigrants with depression.

I am a teacher.

Throughout the telling of his story, Neal often reflects upon his professional identity as a teacher. His recent experiences with depression are related to a series of stressful situations that take place at his school. Neal's appreciation of education has been informed by his experiences of growing up in a poor family where his parents were uneducated. Earning his high school diploma in Hong Kong also gave Neal hope as new opportunities for future employment and further studies became accessible to him. Education and teaching are highly respected in traditional Chinese culture, and Confucian philosophy describes the continued self-cultivation and education of an individual to be a

moral obligation (Schuman, 2015). Neal's pride in his identity as a teacher can be understood to be informed by both personal experience and cultural understandings. Furthermore, Emslie and Hunt (2009) note that identities related to paid work tend to be particularly important to men. Neal's feelings about his involuntary absence from his work due to depression are understandable due to the significance of his profession to his identity. He notes:

I sometimes feel very frustrated with my current situation. I enjoy doing well in my job as a school teacher and am a hard worker. I have been at my workplace as a teacher for the past 20 years.

Lindsay and Schwind (2015), building on S. J. Williams' (2000) notion that chronic illness is a biographical disruption, understand mental illness as a disruption to an individual's life story. In this sense, Neal's depression causes him to experience feelings of frustration, sadness, and anger because it removes him from his school environment---a place where his identity as a teacher most strongly manifests. Neal's experiences with depression also are complicated by the presence of chronic physical health conditions, specifically heart problems and sleep apnea. The comorbidity of Neal's physical health issues with his depression is consistent with trends that have been previously observed in populations of older Chinese immigrants (Lin et al., 2014; Sun et al., 2016). Lin et al. (2014) note that older Chinese American immigrants with physical challenges, such as chronic illness and functional disability, tend to have a greater likelihood of having depression. Sun et al. (2016) also found that lower levels of self-rated physical functioning and health were associated with higher levels of depressive symptoms in older Chinese American immigrants. Neal's mention of cardiovascular issues prior to the onset of his recent experiences with depression resonate with Aziz & Steffens' (2013) suggestion that depression in older adults may be associated with vascular and cardiovascular conditions, as comorbidity of these kinds of physical health conditions are common. Neal's depression and health conditions affect his relationships with the administrators at his school. Neal tells me about the distress he feels as the situation at his

school and physical health conditions both contribute to his depression and interrupt his life story:

I am very sad, confused, and tired. Feeling hopeless. I talk to myself all the time. No matter how hard I work I am not able to work well as a teacher at this school because this administrator simply does not want me to work with me. They just want me to be out of the school. I felt even more hopeless when I found out that I have sleep apnea. This will affect my heart condition.

Neal takes pride in doing well in his role as a teacher, and tells me that he feels hopeless when he seems unable to do good work that is acknowledged by the administrator despite his efforts. Older adults who experience involuntary unemployment also tend to experience long-term depressive symptoms, especially if they lack financial stability (Gallo et al., 2006). While Neal mentions that he is experiencing a prolonged absence from work due to his depression and physical health conditions, his teacher's union has helped him secure a degree of financial stability during his time away from his school. Neal also notes that he is fortunate to be eligible to retire with a pension. Gallo et al. (2006) found that older adults with higher levels of financial security are less likely to experience long-term depressive symptoms compared to their less financially stable peers. Neal's professional identity as a teacher has helped him to gain a degree of financial stability, as he mentions in his lifeline drawing's upward trajectory that traces the improving quality of his life over time. His eligibility for retirement is something that he considers with both gratitude and hesitation. Lu and Hsieh (2012) note that retirement can be a major source of distress to many older adults due to a self-perceived sense of worthlessness and loss. In their study of healthcare provider's views on depression in a population of older adults in Taiwan, Lu and Hsieh (2012) noted that, "retirement was the most frequent cited distressing life circumstance. Although retirement is an expected even in old age, it was reported as a major factor that caused older adults to feel a sense

of loss and worthlessness in late life” (p. 1667). Feelings of failing to meet larger societal expectations of the role of the family breadwinner or primary financial provider, also have been identified as possible factors that contribute to the relationship between depression and suicidal thoughts in older men (Oliffe et al., 2011). Oliffe et al. (2011) found that older adult men with depression tend to perceive retirement as a loss of identity and purpose in life, as the masculine identities of men tend to be strongly associated with their paid work. While Neal tells me that he would consider retirement in the future if his mental and physical health did not improve, he also expressed a strong desire to return to work. He said:

Thinking about my age, perhaps what I should do is forget about returning to work. Maybe I should just really take care about my health--- seriously think about my retirement from teaching. I think I will just wait and see that happens. It is hard to think about all these things, it makes me sad.

In my mind, I think I want to go back to work. Even if I retire, I hope that I can retire with respect and dignity instead of... staying at home and just retiring.

Neal highlights the importance of allowing himself to retire with respect and dignity, enabling himself to conclude his career as a teacher on his own terms. Neal alludes to a potential loss of respect and dignity if he were to retire during his absence from work. Neal has also previously mentioned being well respected by his colleagues at school, and the identity of teacher is well respected in the Chinese Canadian community. Both physical health conditions and depression are stigmatized to a greater degree by Asian immigrants, compared to Caucasians within North American contexts (Hsu et al., 2008; Shamblaw, Botha, & Dozois, 2015). Having a certain degree of control over the choice to retire and the process of retirement may help Neal to save *miànzi* (面子) while providing him with the opportunity to reconcile with the potential change in his identity as a teacher. Additionally, retirement entails a period of transitioning in which

readjustments to an individual's use of time and skills, purpose, identity, and sense of self occur (Pettican & Prior, 2011). These occupational and social complexities are embedded in the landscape of Neal's story. Neal's story illustrates the value of inviting older Chinese immigrants to discuss how their identities, roles, and experiences in their work and retirement may be relevant to their experiences with depression. It is important for mental healthcare providers to acknowledge the significance of professional and occupational identities, as well as the emotional, social, and financial impacts that both employment and retirement may have on older Chinese immigrants with depression.

I am a Christian.

Neal mentions his identity as a Christian throughout his story, albeit to a lesser degree than his identity as a teacher. Neal's identity as a Christian is a recurring and significant narrative thread in his story. Religious involvement, including gatherings with fellow believers and private prayer, may help Chinese older adults cope better with depression (Huang et al., 2011). Participating in a religious community may help an individual to improve their quality of life by providing opportunities to rebuild a sense of well-being through social interaction and the affirmation of beliefs (Huang et al., 2011). Huang et al. (2011) note that drawing upon religion and spiritual practices as a mental health resource may be particularly appealing to Chinese older adults due to the holistic nature of traditional Chinese understandings of health and wellness, as well as the greater participation of older adults in religion compared to other age groups. Christianity has played a significant role in the history of Chinese Canadians, providing a sense of belonging to early Chinese immigrants and enabling them to mobilize against the racial discrimination that was rampant in Canadian society during the early 1900's (Stanley, 2011). Christianity and Confucian philosophy share many similarities, most notably a similar impetus to live a morally righteous life and enact the "Golden Rule", making Christianity a system of belief that is compatible with most traditional Chinese values (Shuman, 2015, p. 88). Within the wider North American context, Christian churches continue to act as community hubs for Chinese immigrant populations (Cao, 2005; Ni, 2000). Religious social identities also may significantly contribute to the mental and physical well-being of older adults because the adoption of a guiding belief systems may "help [older adults to] withstand the transitions and challenges of aging" (Ysseldyk,

Haslam, & Haslam, 2013, p. 869). Indeed, Neal alluded to the significance of his Christian identity in providing him with a sense of emotional security:

The most important thing for me is my Christian faith. Knowing that I am well looked after by the Creator, by God, helps me not to worry too much about my situation... I believe in God, so I know that my Creator is taking care of me no matter what happens. I know that everything is from Him, so I have comfort you know? Particularly during this time when I am at home, I have more time to study His Words, the Bible, so I get stronger. I think I get quite a lot of help from God and my Christian faith.

Throughout his story, Neal repeatedly mentions the importance of his identity as a Christian in aiding his thoughts about his depression and the process of improving his mental health. Neal discussed the significance of his independent religious practices (e.g., independent study of the Bible, private prayer) as a source of support during his experiences with depression. Ysseldyk et al. (2013) suggest that the positive effect of religious identity on mental health may be associated with the widened network of group memberships that older adults might access by being involved with a faith community. However, Neal was reluctant to disclose his depression to the members of his faith community.

I seldom disclose my problems, my depression, with anyone. Sometimes I talk about my stress at school and sometimes they pray for me. However, I don't think this is the main source of support that I rely on. What they [members of Neal's faith community] can do is pray for me because they do not have medical

training in this area. So, instead of disclosing my depression to them, I just have them pray for me.

Neal's choice not to disclose his depression appears to be related to his understanding of his depression as a mental health condition rather than a spiritual issue. The distinction that Neal makes between the types of support available to him through his faith community and mental healthcare providers resonates with a mindfulness of different social contexts that is embedded in traditional Chinese culture (Schuman, 2015). According to Confucian philosophy, how a person conducts themselves within particular relationships is based on whether a particular behaviour or level of intimacy is perceived to be appropriate within a given social context (Schuman, 2015). Hsu et al. (2008) note that stigma against depression tends to be higher amongst populations of Chinese people compared to Caucasian populations in North America. Neal does not explicitly mention concerns about stigma against depression in his faith community or other social networks. Yet, he also mentions that he seldom discloses his depression to anyone. Hsu (2014) noted that personal practices, such as prayer and the reading of religious scriptures, may reduce depressive symptoms in older Taiwanese adults by acting as a coping mechanism for stress. Hsu (2014) notes that these behaviours are not necessarily dependent on social interaction with others. This resonates with Neal's reliance on his personal religious practices, rather than group religious practices, such as communal prayer, for emotional and spiritual support regarding his depression. Neal's story reveals his use of *miànzi* (面子) in the presentation of his Christian self with spiritual needs to his faith community, and the presentation of his patient self with mental and physical health needs to his healthcare providers. Neal describes his affective ties with his faith community as strong, as he tells about sharing about his stress at school and requesting prayer support. Rather than conceptualizing his reluctance to disclose his depression to his faith community as a matter of hiding or shame, Neal understands his choice to be more of a pragmatic matter.

Mental healthcare providers should be mindful of the potential importance of familial and religious identities when working with older Chinese immigrants with depression.

While family and religious groups may present sources of mental health support, it is important to acknowledge that there may be differences in the degree to which older Chinese immigrants may rely on these supports for help with their depression. While Stanley et al. (2011) found that older adults who identify as Christian tend to express a desire to incorporate religion and spirituality into the counselling they receive for their depression and anxiety, Neal does not explicitly mention such a desire.

I am a family member.

Neal also mentions his relationship with his family throughout his story. While he does not explicitly reflect upon his roles as a father, husband, and family member, family ties are significant relationships to Neal. He first mentions family relationships as he begins to tell his story during our lifeline drawing activity. Neal's relationships with his immediate family growing up in Hong Kong provided the foundation from which his appreciation of education and his identity as a teacher were nurtured.

I drew my lifeline upwards, showing that my situation has improved since I was born. Coming from a poor family, then graduating from high school, I also had the opportunity to study one more year to prepare myself for further studies in education!

Familial relationships are significant in traditional Chinese culture, as Confucian philosophy identifies them as the closest affective ties in Chinese society and the primary setting where a person's sense of morality is first formed (Schuman, 2015). Neal's family relationships were instrumental in his immigration to Canada and the eventual establishment of his current immediate family. In his story, Neal briefly mentions that his previous experiences with depression were related to an incident involving the conflict with his family ten years ago. Yet, Neal seldom mentions his family when telling about his more recent experiences with depression.

I forgot to mention that my family really supported me, like my wife and children. They particularly supported me when I started my depression. They

said “well, you should stay home. Don’t worry about work.” I forgot to mention them because my depression is mainly related to my workplace. I seldom mention my family.

I understand Neal’s apparent reluctance to discuss his family relationships as they relate to his experiences of depression as a matter of protecting his family, and managing his *miànzi* (面子) within our research relationship. Leung, Cheung, and Tsui (2012) note that the potential to bring shame to their families is a concern to older Chinese immigrants when disclosing depression and help-seeking. The emphasis on family relationships in traditional Chinese culture means that familial conflicts can present a significant source of stress for older Asian immigrants with depression (Park, Unützer, & Grembowski, 2014). Sun et al. (2016) found that older Chinese immigrants in the United States tended to report higher levels of depressive symptoms in the presence of familial conflict and low levels of family support. Disclosure of familial conflict to others can also create a sense of shame, as this can be understood as an act that may lead to a loss of *miànzi* (面子) and harm a person’s reputation in the community (Hwang, 1987; Schuman, 2015). Mental healthcare providers should be mindful that, while family relationships are significant in traditional Chinese culture, older Chinese immigrants may need to be assured that discussions regarding their family in relation to their depression will be held in confidence.

Family relationships may also provide older Chinese immigrants with support during experiences of depression. Neal mentions that his family supported him during his recent experiences with depression by extending a sense of understanding regarding his need to take time off work. Leung et al. (2012) found that Chinese American immigrants in their study tended to prefer to seek help from family or friends who spoke the same language rather than seeking help from mental health professionals. In contrast, Neal tends to emphasize seeking help from mental health professionals for his depression in his story. I note that his high level of English proficiency and understanding of depression as a health issue may facilitate his tendency to utilize mental health services.

Interestingly, Neal's preference to rely on his family physician for support for his depression rather than seeking help from family and friends is consistent with previous trends in help-seeking behaviour in male Chinese immigrants with depression (Leung et al., 2012). Park et al. (2014) suggest that the support provided by family relationships may be particularly important to older Asian immigrants due to different levels of acculturation that may exist between multiple generations. While Neal is highly functional in mainstream Canadian society, older Chinese immigrants who are less established in Canada may be more reliant on their families due to differences in language and culture. Mental healthcare providers should be mindful that the significance of, and reliance on, family relationships may be different for individual older Chinese immigrants with depression.

A metaphor for Neal's multiple identities.

Reflecting upon Neal's multiple identities as teacher, Christian, and family member, I am reminded of the importance of acknowledging his personhood throughout the telling about his experiences with depression. It is interesting to note that, while Neal strongly identifies with these identities, he does not identify with his depression. Even in the creation of his metaphor drawings, Neal chose to create an image of a man to represent himself and his experiences with depression. Neal's definition and management of his multiple identities reveals an understanding of how these identities are relevant to his relationships at his workplace, within his faith community and home, and the offices of his mental healthcare providers. I re-present this narrative pattern in Neal's story as a pair of hands cutting out a chain of paper dolls.

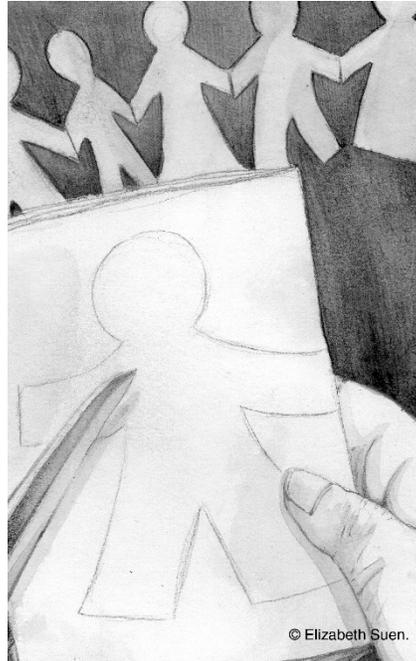


Figure 5. A Metaphor for Identity.

The chain of paper dolls represents the multiplicity of identities that Neal manages within the context of the different relationships in his life. Each of the paper dolls is slightly different and unique, yet they all are unified as a whole chain. Similarly, Neal's identities as teacher, Christian, and family member are different yet they are all parts of the same person. The pair of hands in this drawing represents Neal. The pair of hands hold a piece of paper and a pair of scissors to communicate that individuals are the ones who define their identities, and know the full extent of the different identities and roles that they assume in their lives. I also depicted the pair of hands in the act of creating another chain of paper dolls to represent how Neal's identities, his multiple selves, may change or be replaced over time. Returning to my metaphor of a quilt, the image of multiple paper doll chains is printed on the fabric from which the narrative pattern of identity is cut. The print on this fabric reminds me of the multiplicity of Neal's identities, and how each identity is uniquely situated within particular relationships, places, and points in time.

Voice.

Interwoven throughout Neal's story is the narrative pattern of voice. Neal tells about the frustration he experiences at his workplace when the school administrators do

not listen to his concerns. He also tells about his gratitude towards his mental healthcare providers for believing his story and enabling him to access mental health support. Neal also asserts his desire to accomplish a sense of mastery over his depression and physical health conditions--- a message that his healthcare providers listen to and respond to in their delivery of mental healthcare.

Listen to me, believe me.

In the beginning of Neal's story, he recounts a time during his childhood when he lost his bus money and his elementary school teacher refused to lend him money because she did not believe his story. The incident is significant to Neal, as it is the only point in his lifeline that he pauses to elaborate upon during our first research session. Neal also expresses a sense of injustice as he talks about identifying a problem (i.e., the assignment of an inappropriate classroom for his students) but not having a voice that is listened to at his workplace. Neal also shares about how these experiences of having his voice distrusted or ignored left a lasting emotional impact on him. In contrast, Neal expresses a deep sense of gratitude towards his family physician and psychologist for listening to his concerns about his mental health and believing his accounts about his experiences with depression.

I felt that my family physician really understood my own situation. His letter of support was really important in enabling me to stay at home without worrying about my confrontation with the administrators at my school. Being able to stay at home really helped me to calm down and look at my own situation.

The psychologist was able to conduct psychological testing on me to confirm that I was experiencing severe depression at the time. My family physician's letter of support was extremely helpful because it allowed me to stay at home and focus on recovering from depression.

Neal is grateful that his family physician and psychologist listen to his story and provide their support. Tummala-Narra, Sathasivam-Rueckert, and Sundaram (2013) report similar feelings of gratitude in their study of the mental health of older Asian Indian immigrants in the United States. The relationships between older Asian immigrants and mental healthcare providers may present the opportunity to create a safe space where patients may express their experiences with depression and mental health issues (Tummala-Narra et al., 2013). This safe space may be highly valuable to the support of the mental health of older Asian immigrants as the telling about life experiences may facilitate the “exploring meanings of life transitions and cultural shifts” (p. 8) that commonly occur in later life. Listening to Neal tell about his experiences with depression, and believing his stories, prompts his family physician to write a doctor’s note that recommended that he take a leave of absence from his school. This note enables Neal to access the necessary time away from work, financial support, and mental healthcare services that are crucial to supporting his recovery from depression. Shattel, Starr, and Thomas (2007) note that “genuine concern, care, sincerity, and understanding are requisites to knowing. Good listening skills are necessary to get to know the help-seeking person” (p. 280). Schroeder (2013) notes that older adults with serious mental illness tend to have stronger feelings of trust towards mental healthcare providers who listen to their concerns and express a sense of compassion towards them during the delivery of care. Neal’s family physician also refers him to a psychologist, who is able to help validate his experiences with depression by providing a formal diagnosis of depression. Neal tells about the importance of having his psychologist listen to his story. He also values the way his psychologist responds to his stories with advice and suggestions for coping strategies. Neal’s story resonates with the words of Barry et al. (2001) that “psychiatry is the area of medical specialty where talking and listening are most explicitly understood to be therapeutic” (p. 500). Neal also tells me that the strength of his relationship with his family physician has been instrumental to his experiences with depression, as well as his experiences of seeking to improve his mental and physical health. He explains:

My family physician has been caring for me for many years. He knows my family; he knows my physical health issues. He is also aware of all the different tests that the specialists were running on me, he helps to coordinate my care.

Neal values his relationship with his family physician, noting that his physician attends to both his physical and mental health needs by coordinating his care with other healthcare providers. Neal's family physician also acknowledges his personhood by becoming familiar with not only Neal's body and psychology but also his family. Given the significance of family and familial relationships in traditional Chinese culture, Neal's family physician expresses an interest in building a strong patient-provider relationship with him by getting to know him as a person (Shattel et al., 2007). Neal reciprocates the respect that his family physician shows him by listening to his family physician's advice, and believing that his family physician's advice and actions are intended to improve his well-being. In this sense, as trust is exchanged and reciprocated (*rénqíng*, 人情), the relationship between Neal and his mental healthcare providers becomes stronger as personal connections (*guānxì*, 關係) also are strengthened.

Help me to help myself.

Throughout his story, Neal expresses a desire to accomplish a sense of mastery over his depression and physical health conditions. He repeatedly emphasizes the importance of self-directed activities such as exercise, praying, and reading as giving him a sense of accomplishment in ameliorating his depression. Neal tells me:

When I accomplish something, mentally I feel stronger and also physically I really feel stronger. I have more energy than before. I don't want to be in depression, I want to get out of it. It is not good for me. That's why I actively seek help, you know, from medical professionals.

Lin et al. (2014) note that a sense of mastery is important to older Chinese immigrants, and high levels of mastery consistently have been observed to reduce the negative effects of stress that many older adults may encounter in life. Wuthrich and Frei (2015) found that older adults commonly express a preference for self-reliance regarding mental health concerns, and that this preference may act as a barrier to mental health help-seeking in this age group. Yet, Neal cites his preference for self-reliance as the driving factor in prompting him to seek mental healthcare. He explains:

Since I was aware that I could not get myself out of my depression, I needed advice from the medical profession.

Neal's preference for self-reliance also resonates with the Confucian emphasis on continuous self-cultivation, an underlying current in traditional Chinese culture that also is related to the importance that Chinese immigrant communities place on the value of education (Schuman, 2015). Neal's mental healthcare providers, particularly his psychologist, recognized Neal's desire to contribute to his own mental healthcare. Working with Neal, his psychologist gave him reading materials to enable Neal to educate himself about his depression and taught him various coping mechanisms that could be practiced in his daily life. Neal explains the impact this had on him:

My psychologist has given me quite a lot of reading material that I have found helpful. These books contain information about distorted thinking and relaxation techniques. These are useful in helping me to understand my situation at work and lower my anxiety levels. I suddenly realize that not everything the administrator said about me was true. These readings also help me to improve the way I think about myself. I'm not a failure.

My psychologist also taught me how to breathe, and provided me with reading material regarding my depression. I also received some books on

assertive communication. This helped me to deal with people who might give me unhelpful comments. I have to learn to communicate with people effectively. This will help me deal with comments that are sometimes not nice, not 100% true.

Neal tells about how his psychologist has equipped him with resources that empower him to change his thinking and understandings about his depression. Hoge and Oei (2007) note that the emphasis on assigning readings and other “homework” in counselling, as is the norm in cognitive behavioural therapy, is well aligned with the Confucian work ethic that exists in Chinese culture and therefore can be made suitable for use with older Chinese immigrants with depression. Educating older adults about depression and coping strategies through the provision of reading materials or courses is an effective way to help older adults manage their depression (Arean & Niu, 2014).

von Faber et al. (2016) note the importance of mental health practitioners discussing the usefulness of developing personal coping strategies with older adults with depression. von Faber et al. (2016) identify three types of personal coping strategies: cognitive strategies, social strategies, and practical strategies. Neal’s psychologist supports the development of Neal’s cognitive coping strategies by helping him to educate himself about his depression and teaching him breathing exercises to help him to combat depressed feelings and thoughts as they arise. Neal engages in social coping strategies through his continued engagement with his faith community and family members. His family physician, and other healthcare providers, encourage Neal to build upon his practical coping strategies by supporting him in continuing his regular use of his community gym.

Throughout his story, Neal expresses a love of learning, education, and self-cultivation. Having his psychologist listen to him, and acknowledge the value of his desire to help himself, facilitates his view of his psychologist as helpful and knowledgeable. Schroeder (2013) notes that being listened to and valued as a person is important in patient-provider relationships to older adults with depression. A strong relationship of care with mental healthcare providers, and “being seen and accepted as a

“normal” person” (Schroeder, 2013, p. 34) are both important to older adults who experience mental illness. Furthermore, it should be noted that feelings of individual responsibility towards managing symptoms of depression are common in older adults with depression (Lin et al., 2014; von Faber et al., 2016; Wuthrich & Frei, 2015). Having his mental healthcare providers listen to, believe, and respond to his voice has positively contributed to Neal’s experiences with receiving support from them for his depression. Neal’s story demonstrates the importance of providing older Chinese immigrants with depression the time and space to express their voices during consultations with mental healthcare providers.

A metaphor for voice.

I reflect upon the significance of voice in Neal’s story, and represent this narrative pattern as a metaphor drawing of a telephone. Throughout his story, Neal’s voice is a telephone conversation where each person involved participates in the acts of listening, believing, and responding to the voice. These three components, listening, believing, and responding, do not necessarily occur in a certain predetermined order within a particular telephone conversation, yet are all necessary for the conversation to continue. Trust is also exchanged and reciprocated in a telephone conversation, as oftentimes participants cannot see one another as they converse. The reciprocity of trust in Neal’s relationships with his mental healthcare providers resonates with the traditional Chinese concept of *rénqíng* (人情), as the continued exchange of trust over time strengthens their personal connections with each other. Ruddick (2010) suggests that within the practice of person-centered care, “spending time ‘being with’ a client reinforces the fact that they [the patients] are being valued” (p. 26). This investment of time, and listening, is fundamental to the establishment of rapport and empathy between patients and healthcare providers (Ruddick, 2010).

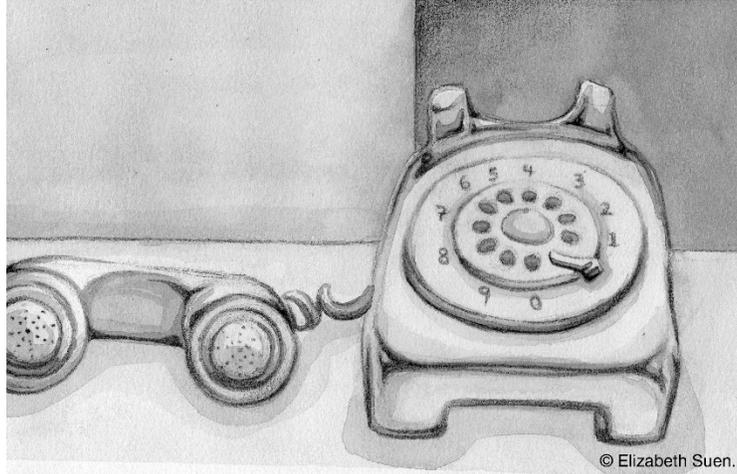


Figure 6. A Metaphor for Voice.

In this metaphor drawing, I deliberately depict the image of a telephone without including an image of a person using it. This is done with the intent to invite the viewer to imagine themselves responding to the voice on the telephone. Cultural safety emphasizes the privileging of patient voices in mental healthcare practices (Ramsden, 2002; Smye & Browne, 2002). The narrative pattern of voice in Neal’s story encourages mental healthcare providers to reflect upon their own thinking, behaviours, and practices and consider how they might listen to, believe, and respond to the voices older Chinese immigrants with depression, who are in their care.

Communication.

Throughout Neal’s story, the narrative pattern of communication is significant to his experiences with depression and mental health support. In the beginning of his story, Neal tells about how his situation at work leads up to his diagnosis of depression. He explains:

Another thing that triggered my depression was an incident with one of the school administrators. She gave me a note informing me that she would no longer talk to me unless I notified the Teacher’s Union. Like, she wouldn’t talk to me unless a representative from the Teacher’s Union was present. I felt angry

and offended that this administrator had closed the line of communication between us. I felt like there was no place for negotiation.

Neal mentions this specific incident with this school administrator multiple times throughout his story, highlighting the importance that he places on communication in his work. Neal's emphasis on the importance of communication in his experiences with depression continues as he discusses his experience in seeking support from his mental healthcare providers. Regarding the reading material about depression and potential coping strategies that his psychologist shared with him, Neal says:

Through my reading, I've learned how to communicate with people in a way that does not hurt my feelings, nor the feelings of others. This will help prevent me from getting into depression again.

Neal identifies effective communication as a skill that will prevent depression from recurring in the future. Neal views readings that his psychologist has shared with him as helpful, particularly the books on depression, distorted thinking, and assertive communication. In his story, Neal expresses a desire to improve upon his communication skills in order to improve his relationships with his school's administrators and to protect himself from experiencing depressive symptoms in the future. Neal's desire to draw upon his sense of self-reliance in his journey of recovering from depression is coupled with feelings of responsibility towards caring for his own mental health. Neal's story resonates with Holm and Severinsson's (2014) findings in their qualitative systematic review that suggests that older adults with depression tend to express similar feelings of responsibility towards their own mental illness. In his story, Neal also expresses a sense of responsibility towards how his communication in the past may have hurt his feelings and the feelings of others, contributing to the stress that led up to his depression. I also note with interest that traditional Chinese culture and Christianity, both important identities to Neal, also support similar notions of responsibility for one's self. Schuman (2015) explains that "at the very heart of Confucius's philosophy is a belief in the power

of the individual” (p. 30). Following this line of thought, Confucian philosophy encourages people to first seek to find fault within themselves in order to assess how they can solve a problem (Schuman, 2015). The New International Version of the Bible expresses a similar sentiment by stating, “why do you look at the speck of sawdust in your brother’s eye and pay no attention to the plank in your own eye?” (Matthew 7:3).

While the narrative pattern of communication is significant to Neal in his relationships at work and experiences with depression, it is also important to his experiences in seeking support from mental healthcare providers. Effective communication with his mental healthcare providers enables Neal to express his preferences regarding treatment options for his depression. Seebohm et al. (2010) note that good communication is necessary for the inclusion of real choice in the healthcare for older adults. Neal tells me that his mental healthcare providers communicate their respect for him by offering him choices in his mental healthcare:

Besides seeing a consultant, seeing the psychologist and doctors, I think exercise is very important. So far, I have found exercise to be better than taking medications. Actually, my doctor gave me some sleeping pills. That is somehow related to my depression, but the doctor gave me options. He told me that I can take the pills or not, if I didn’t want to take them. So, instead of taking medication I choose to go to the gym every day.

I feel that it is important to communicate with my family doctor to convey my feelings about the helpfulness of exercise, reading, and other activities. If I had no choice, then I would have to take the medication to help with my depression. But since I have a choice, then I choose the choice that best fits me.

The freedom to communicate mental health needs and concerns to mental healthcare providers, and knowing that these concerns are being listened to, is important in helping older adults to cope with depression (Lawrence et al., 2006). Neal explains that he engages in exercise not only for the sake of improving his mental health, but also to improve his physical health and for enjoyment. Areean and Niu (2014) note that regular physical exercise is an effective means of reducing depressive symptoms in older adults. During member checking Neal tells me that his preference to engage in exercise and counselling to manage his depression, instead of taking medications, is related to a tendency to view medications as a very powerful form of treatment with potential side effects. He adds that he, and many of his peers in the Chinese Canadian community, prefer to use medication only when all other less severe forms of treatment (such as exercise, change of diet, herbal medicine, etc) are not able to treat an illness

Neal's concerns about using medications to treat his depression resonate with the results of Lu et al.'s (2016) cross-sectional survey of Chinese older adults that revealed high levels of concern regarding potential side effects and the possibility of developing an addiction to depression medications. Like Neal, the older Chinese adults in Lu et al.'s (2016) study also acknowledged the importance of taking medications to treat depression if necessary. In Neal's story, his mental healthcare providers communicate with him regarding the treatment options that are available to him for his depression. Neal's concerns regarding the potential side effects of depression medication are not unfounded. Kaite et al. (2015) note that people who experience the side effects of pharmacotherapy for their depression may experience adverse effects in their social and personal lives. It is therefore important that mental healthcare providers communicate with patients who are older Chinese immigrants regarding concerns that may arise regarding the use of medications to treat their depression.

Both Neal and his mental healthcare providers exchange knowledge and information that is pertinent to his depression within their patient-provider relationships. Neal shares information with his mental healthcare providers about his depressive symptoms, relevant life experiences, and preferences for treatment. In turn, his mental healthcare providers share information about his depression and access to various

treatment options. Wen-Hsin and Davenport (2005) note that taking on the role of a teacher, which is a highly respected role in Chinese culture, can help mental healthcare providers to communicate their expertise and knowledge to Chinese immigrants with depression. Reflecting upon Dewey's (1939) notion that personal experiences can also provide a form of knowledge, and Ramsden's (2002) cultural safety, I envision patients also taking on the role of teacher as they hold the expertise and knowledge regarding their lives, bodies, culture, and experiences with depression. Given the longevity and strength of the relationship between Neal and his family physician, I understand their particular patient-provider relationship to be a form of *guānxì* (personal connection, 關係), albeit existing within the ethically appropriate confines of professionalism. Huang et al. (2013) explain that “*guānxì* also combines both instrumental and impressive components, hence the outcome of *guānxì* behaviour reflects not just in giving and receiving favors [and resources], but also an emotional impact” (p.337). In Neal's story the narrative thread of communication enables Neal's voice to be heard by his mental healthcare providers, and helps facilitate the development of trust within their patient-provider relationships. Neal's story resonates with the words of Schroeder (2013) regarding the relationships between older adults with mental illness and their healthcare providers. Schroeder (2013) says, “without these relationships, many [older adults] felt they would be lost. Instilling hope and promoting independence are critical factors for people who see their glass as half empty” (p. 33).

A metaphor for communication.

Reflecting upon the significance of the communication in Neal's story, I represent this narrative pattern as a metaphor drawing of a global positioning system (GPS) integrated into the inside of a motor vehicle. In this metaphor drawing, I am saying that communication within a patient-provider relationship is a car ride where information and responses are needed from both the driver and the GPS. In his story, Neal is analogous to the vehicle's driver who is seeking to reach the destination of recovery from depression. Neal's mental healthcare providers are analogous to the GPS, with their specialized knowledge regarding depression and its treatments. In order for a GPS to effectively help a driver to reach a certain destination, it requires input and adjustments from the driver.

In order for Neal's mental healthcare providers to effectively provide care for his depression, they require information from him regarding his symptoms, life circumstances, concerns, and preferences for treatment. Acknowledging the value of a patient's personal knowledge and experiences is a central idea in person-centered care (Morgan & Yoder, 2011; Schwind et al., 2014). Mental healthcare providers seeking to cultivate culturally safe mental health practices may consider reflecting upon this metaphor to explore how their thinking, behaviour, and practice with older Chinese immigrants with depression may be inspired by this understanding of patient-provider communication.

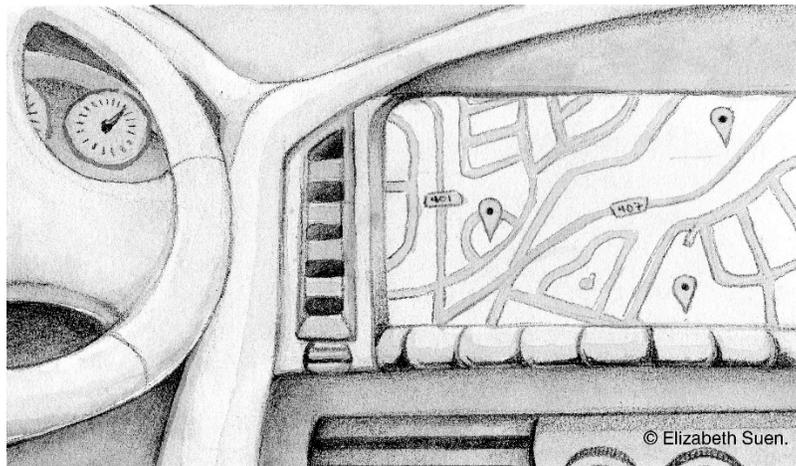


Figure 7. A Metaphor for Communication.

The Quilt of Neal's Story

I return to my metaphor of quilt making as *bricolage* within my narrative inquiry to re-present Neal's story as a whole. I create analogies to discuss how each of the main narrative patterns and threads of Neal's story are like patterns and pieces in a quilt. The prominent narrative thread of relationship is represented by the border of the quilt. During the telling of his story, Neal discusses each of these experiences within the context of a relationship. Neal's tells about his relationship with himself, members of his faith community, his family, his colleagues and the administrators at his work, and his various mental healthcare providers to unpack the nuances of his experiences with depression as they are situated within specific places and over time.



Figure 8. The Person Quilt, A Representation of Neal's Story.

In the centre and foreground of the quilt, the Chinese character for person, “*rén*” (人) divides the background fabric into three equal sections. The Chinese character for person (*rén*, 人) is homophonic with the Chinese character for benevolence (*rén*, 仁) and the interrelatedness of these concepts resonates with Schwind et al’s (2014) understanding that the personhood of both patients and healthcare providers informs relationships in person-centered care. Rosenlee (2014) explains that “*rén* [仁], the most prominent Confucian concept, etymologically is composed of the character person (*rén* 人) and numerical two (*èr* 二), denoting the ethical effort in sustaining and expanding complex human relations in achieving the perfect virtue of *rén* [仁]” (p. 325, pinyin accents added for emphasis). I also understand the inclusion of the character for the number two (*èr* 二), in the composition of the character *rén* (仁), as a testament to the collective nature of benevolence. Reflecting upon this concept, I am reminded of the poet and clergyman John Donne’s (1923/1572-1631) famous words “no man is an *Iland*, intire of it selfe; every man is a piece of the *Continent*, a part of the *maine*” (p. 98). Confucius

defined *rén* (仁) as an altruistic love for others, and a necessity for an individual to cultivate in order to function properly in society (Dubs, 1951; Shuman, 2015). *Rén* (仁, benevolence) is the ultimate goal concerning the expression of the traditional Chinese concepts of *miànzi* (面子, face or impression management), *rénqíng* (人情, favor, reciprocity, or empathy) and *guānxi* (關係, relationship or personal connection) (Dubs, 1951; Rosenlee, 2014; Shuman, 2015). In this sense, *rén* (仁) is necessary to the establishment and nurturing of relationships. Rosenlee (2014) notes that “to be *rén* (仁, benevolence), at the most basic level, is to have compassionate feelings towards others” (p. 325). Li (2012) noted that *rén* (仁) also is sometimes translated to mean “humanness”.

The Chinese character *rén* (人, person) connects and unifies each of the narrative patterns in Neal’s story. The narrative pattern of identity is represented in the upper left a section of the quilt. The word “identity” is emblazoned across this expanse of yellow fabric. The fabric for this section of the quilt is printed with images of paper dolls, all of which are connected as a unified chain, to represent the multiplicity of identities that Neal manages throughout his story. The narrative pattern of voice is represented in the upper right section of the quilt. The word “voice” is embroidered across the blue fabric that comprises this section of the quilt. The fabric for this section is printed with images of telephones, representing Neal’s understanding of the responsibility to listen, believe, and respond to the voices of patients and mental healthcare providers within the patient-provider relationship. The narrative pattern of communication is represented in the bottom section of the quilt. The word “communication” is inscribed upon the fabric that is incorporated into this section of the quilt. The fabric of this section of the quilt is printed with images of roads, building, and landmarks, as they would appear on the screen of a GPS within a vehicle. These images are meant to allude to my use of a metaphor of a GPS to represent exchange of knowledge and sense of trust that Neal experiences when communicating his mental and physical health concerns to his various healthcare providers.

Reflecting upon Flannery's (2015) metaphor of science as quilt making, I have concluded my process of using my theoretical sewing kit to quilt the narrative threads and patterns in Neal's story. Referring to the final product from the quilting process, Flannery (2015) notes that "a quilt can only be fully appreciated as a whole, yet in constructing a quilt, attention must also be paid to each square, each stitch, each step in the process" (p. 639). As a unified whole, the quilt of Neal's story represents the results of the second level of analysis, the practical justifications, of Neal's stories in this narrative inquiry. The quilt embodies the importance of acknowledging the complex and multiple identities of older Chinese immigrants with depression as they may be present within patient-provider relationships in mental healthcare. It also is imbued with the significance of listening to, believing, and responding to the voices of older Chinese immigrants with depression, and encouraging the expression of these voices, during patient-provider interactions that occur within relationships in mental healthcare. Also embedded within the quilt of Neal's story is the value of conceptualizing communication within patient-provider relationships as an exchange of knowledge, respect, and trust.

In the next chapter, I elaborate upon the significance of the quilt of Neal's story on illuminating larger issues that exist within the fields of immigrant and mental healthcare, concerning older Chinese immigrants with depression.

Chapter Seven

Third Level of Analysis: Social Justifications

In this chapter I use Ramsden's (2002) notions about cultural safety and Lindsay and Schwind's (2015) conception of person-centered care in the field of nursing to facilitate my contextualization of how Neal's story might be particularly relevant to the professional landscapes of nurses and similar frontline healthcare providers. Then I discuss the potential transferability of this narrative inquiry, and illustrate how Neal's story leads to further directions of inquiry and future directions of research in the context of how my inquiry may matter to broader society.

Significance to Nursing and Other Mental Healthcare Professions

The research puzzle that this narrative inquiry sought to explore was: how does an older Chinese Canadian immigrant (55 years of age and over) experience depression, and what do stories of experience reveal about the sources of mental health support that are used? In his story, Neal answers the first part of this question by describing his depression as a biographical disruption that is influenced by challenging life situations (i.e., issues at work, physical health issues), and is compounded by issues with his physical health (Lindsay & Schwind, 2015; S. J. Williams, 2000). Neal experiences depression through living and telling about his relationships with the administrators at his work; his colleagues and union representative; his family physician, psychologist, and other health providers; and his family. Neal's identities as a teacher, Christian, and family member are important to his life and contextualize his experiences as an older Chinese immigrant with depression. Neal understands his depression as a health condition that affects his energy levels. He also understands depression to be expressed as feelings of sadness, frustration, anger, and hopelessness that may arise in response to a person's life situations. Neal also understands depression to be a treatable condition that can be ameliorated through the improvement of communication and problem solving skills. He also notes the importance of physical exercise and sleep in improving the lack of energy that a person may experience from depression.

In answering the second part of this research puzzle, Neal's story reveals a preference to use resources and services that are provided by his family physician and

psychologist to treat his depression. Neal also notes the significance of his family physician and psychologist listening to his preference to avoid the use of antidepressant medication and focus instead on self-directed activities such as physical exercise, breathing exercises, and reviewing reading materials on depression. Neal also identifies his individual practices as a Christian, and his family, as sources of support that compliment and augment the mental health support he receives from his health professionals. Neal's story illuminates the complexities of culture and the significance of relationship in an older Chinese immigrant's experiences with depression. His story resonates with emerging models of care in nursing and mental health that embrace the complexity of culture and highlight the value of building relationships between patients and providers.

Shifting from Transcultural Nursing to Cultural Safety

The knowledge of nurses and other frontline mental healthcare providers is often subjugated in the evidence-based world of biomedicine, and experience-based ways of knowing often are taken for granted in healthcare settings (Browne et al., 2002; Schwind et al., 2014). This reality can complicate the translation of knowledge that is critically oriented, such as the concept of cultural safety, into mental health practice (Browne et al., 2002; Smye & Browne, 2002). Browne et al. (2002) suggest that introducing new or unfamiliar content first, and then inviting nurses and other mental healthcare providers to "supply context-specific applications" (p. 176) may be an effective way to both challenge dominant ways of thinking and practice while acknowledging the value of providers' knowledge that is gained through experiences of practice.

Neal's story provides a point of reflection that nurses and other frontline mental healthcare providers may wish to refer to when developing their own culturally safe practice. Neal's story demonstrates the potential value of giving older Chinese immigrants the time and space to define both culture and safety on their own terms when discussing experiences and treatment options for depression. Neal's experiences with depression also speak to the heterogeneity that exists within populations of older Chinese Canadian immigrants, and dispels notions that the culture and knowledge of a particular ethnic group can be generalized. This aspect of Neal's story is a testament to the need for

a shift from the use of transcultural nursing to cultural safety within the mental healthcare field.

Transcultural nursing is a term that was first coined by Leininger (1999), and is grounded in the notion that care is “the essence, the central, dominant, and distinctive domain of nursing” (p. 9). Leininger (1999) explains that transcultural nurses use aspects of cultural knowledge and tailor this knowledge to fit with knowledge from the nursing profession in order to provide care that is meaningful to the cultural beliefs of patients in a multi-cultural society (Leininger, 1999; Polaschek, 1998; Ramsden, 2002).

Transcultural nursing emphasizes the need for nurses to educate themselves regarding the practices and beliefs of other cultures, placing the responsibility of developing a culturally sensitive practice solely on the individual (Polaschek, 1998; Ramsden, 2002).

While the intent of transcultural nursing is to set a tone of respect for cultural and ethnic diversity in nursing practices, I suggest that it may be unrealistic and unreasonable to expect nurses and other frontline mental healthcare providers to educate themselves acontextually about the specific cultural practices and beliefs of each of their patients, especially given the numerous ways in which culture may be defined and lived out for each individual (Leininger, 1999; Polaschek, 1998). Transcultural nursing also assumes an understanding of culture that privileges the dominance of the culture of Western medicine within the field of mental healthcare. Moreover, it does not address social, cultural, and historical issues of power that may result when mental healthcare providers work with individuals from marginalized groups (Polaschek, 1998; Ramsden, 2002). In comparison, cultural safety requires that nurses and other frontline mental healthcare providers critically reflect on their own cultures, including the culture of their specific profession or place of work, and seek ways to understand how their personal and social positioning may create disparities of power and privilege in their relationships with patients from marginalized or minority groups (Gerlach, 2012; Ramsden, 2002). By encouraging nurses and other frontline mental healthcare providers to turn the cultural lens inward, cultural safety provides the opportunity to examine how “personal cultural heritage, colonial history, and the contemporary cultural nature of healthcare” (Gerlach, 2012, p. 153) may impact relationships and encounters with older Chinese immigrants

with depression. At the same time, older Chinese immigrants are acknowledged to be experts in their own understandings and uses of culture in their lives, and are valued as important contributors of personal and cultural knowledge in their relationships with their mental healthcare providers.

Incorporating cultural safety into nursing practice, professional development, and education also means an acknowledgement of the “social context which shapes human lives, within which individual attitudes are formed” (Polaschek, 1998, p. 454). In this sense, Neal’s story illuminates the value of inviting not only individual mental healthcare providers to develop culturally safe mental health practices, but also including mental healthcare institutions and Canadian society in dialogues that challenge marginalising assumptions regarding older Chinese immigrants with depression. Chen et al. (2009b) and Sadavoy et al. (2004) identified the potential importance of working with professionally trained interpreters to help make mental health services more accessible for older Chinese immigrants who speak different languages than their mental healthcare providers. Similarly, this narrative inquiry identifies the potential significance of incorporating the concept of cultural safety into mental healthcare practices, professional development, and education, in order to make mental health services more accessible for older Chinese immigrants who may identify as being culturally different from their mental healthcare providers.

Person-Centered Care as Relationship

Neal’s story also highlights the importance of establishing trusting relationships between older Chinese immigrants with depression and mental healthcare providers in the provision of culturally safe person-centered mental healthcare. Lindsay and Schwind (2015) conceptualize person-centered care to be a relationship between patients and nurses that values the personhood of both the patient and mental healthcare provider. Drawing upon the concept of cultural safety, I understand that the personhood of patients determines how culture and safety are defined within relationships with nurses and other frontline mental healthcare providers. In a similar manner, it is “the personhood of the nurse [or other frontline mental healthcare provider] that informs relationships with patients and the healthcare team” (Schwind et al., 2014, p. 1168). Both the personhood of

the patient and mental healthcare provider are important to the provision of person-centered mental healthcare. While this narrative inquiry did not explore how the personhood of Neal's mental healthcare providers was involved in constructing his care, this points to a future direction of inquiry that may be pursued through further research.

What this narrative inquiry does reveal is the significance of Neal's family physician and psychologist acknowledging and valuing his personhood during the provision of mental healthcare. By taking the time to know Neal as a person, both his family physician and psychologist were able to offer him resources and mental health services that met his needs and preferences. This acknowledgement of Neal's personhood is congruent with a turn towards attending to the significance of building relationships between patients and mental healthcare providers in the fields of mental healthcare and nursing; and particularly, the emergence of relationship-based models of care (Andvig & Biong, 2014; Lindsay & Schwind, 2015; Winsett & Hauck, 2011). A future direction of inquiry that arises from Neal's story might explore how relationships with mental healthcare providers, primary healthcare providers, family members, co-workers and others might be meaningful to the experiences of older Chinese Canadian immigrants with depression.

Neal's story illustrates how the nurturing of relationships between mental healthcare providers and older Chinese immigrants can facilitate the delivery of person-centered mental healthcare. For example, Neal's relationships with his family physician and psychologist were instrumental in enabling him to meet his mental and physical health needs. Neal's family physician acknowledged his personhood by providing Neal with options regarding the treatment of his depression, and respecting Neal's choice to rely on exercise and support from a psychologist over taking anti-depressant medications.

Neal's strong relationship with his family physician also allowed for the efficient and effective coordination of care with other healthcare professionals. His psychologist took the time to listen to Neal's concerns and work with him to recommend treatment options that best suited his individual orientation towards learning and self-improvement (i.e., the provision of reading materials on depression and depression management, breathing exercises, talk therapy). Neal's relationships with his family physician and

psychologist resonate with Andvig and Biong's (2014) suggestion that "getting to know [a] person and supporting the process of finding out what is important and valuable to his or her life" (p. 10) is significant to facilitating recovery from mental illness. Emphasizing the importance of building relationships between patients and mental healthcare providers also highlights the significance of including the patient's personal experiences and knowledge in mental healthcare (Taylor et al., 2014). Neal's story speaks to the need for patients, policy makers, and institutional leaders to advocate for policies and funding that enable nurses and other frontline healthcare providers sufficient time to nurture relationships with patients in their practice. Nurses and other frontline mental health providers should also be provided with access to opportunities for professional development that emphasize the significance of relationship in the delivery of person-centered mental healthcare. These recommendations may help nurses and other frontline mental health providers in delivering culturally safe person-centered mental healthcare to older Chinese immigrants with depression.

Providing Mental Health Support in Primary Care Settings

Neal's story also demonstrates the value of providing mental health support in primary care settings. Neal's family physician was the first healthcare professional he contacted regarding his depression, and remains a source of support throughout Neal's experiences with depression and receiving support from other mental healthcare providers. Neal's story resonates with Rybarczyk et al.'s (2013) suggestion that increasing the capacity of primary care settings to provide mental health supports may be especially beneficial in increasing the accessibility of mental healthcare for older adults since older adults tend to experience co-morbid physical health conditions that are usually treated by primary healthcare providers. Neal's family physician helped to coordinate both his physical and mental healthcare, and therefore was a significant source of support during his experiences of depression. Leung et al. (2012) note that Chinese American immigrants tend to seek help from physicians concerning mental health concerns, and this tendency illustrates the importance of encouraging collaboration between physicians and other types of mental healthcare providers. Rybarczyk et al. (2013) also suggest that physicians and other primary healthcare providers may play an important role in ameliorating stigma and reducing barriers to accessing more specialized

mental healthcare services. Neal's story highlights the important role that primary healthcare providers may play in providing mental health support to older Chinese immigrants with depression.

Future Directions

Revealing and Addressing Grand Narratives

Neal's story speaks to the need to identify and address the grand narratives about older Chinese immigrants that may exist in the mental health literature, and elucidates the heterogeneity that exists amongst older Chinese Canadian immigrants. Clandinin and Connelly (2000) use the term *grand narratives* to refer to dominant and conventionally accepted stories that prevail at social and institutional levels. For example, in their collaborative research in the field of education, Clandinin and Connelly (2000) identify "the reduction of the study of experience to consideration of issues of [the] measurement [of student and teacher performance]" (p. xxii) as one of the grand narratives prominent in the field of education research. Kirkpatrick (2008) notes that grand narratives are not necessarily oppressive, yet the storying of individual experiences can provide powerful narratives (i.e., counter narratives) that resist oppressive grand narratives and have the potential to facilitate changes in thinking in fields of professional practice, scholarship, and in other aspects of society. Neal's individual experiences as an older Chinese immigrant with depression highlights the need for future directions of inquiry to further explore and reveal the grand narratives about Chinese immigrants that may be present in the mental health literature.

One of the grand narratives concerning older Chinese immigrants prevalent in the mental healthcare literature is that a person's culture, and related health beliefs, can be distilled into generalizable behaviours and ways of describing symptoms. Smye and Browne (2002) note that culture is commonly conceptualized in the fields of nursing and healthcare as a set of practices, beliefs, and values that are associated with specific ethnic groups. While learning about cultural beliefs, values, and practices is a practical starting point of learning for healthcare providers, Smye and Browne (2002) suggest that this narrow definition of culture can "reinforce stereotypes and simplistic views of particular ethnocultural groups as outsiders, as different, and as 'other'" (p. 45).

The essentialism of culture within the field of mental health is a grand narrative that mental healthcare providers should be particularly mindful to avoid in light of the recent addition of cultural concepts in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013). The inclusion of the *Cultural Formulation Interview* (CFI) in the DSM-5 is intended to be used as a tool to assist clinicians and researchers to better understand how an individual patient's culture and health beliefs may influence the ways that they describe and express distress and various symptoms of mental illness (American Psychiatric Association, 2013). The CFI tends to conceptualize culture as being comprised of a person's background or identity, specifically mentioning community, languages, place of family origin, race, ethnicity, gender, sexual orientation, and faith or religion (American Psychiatric Association, 2013). While the CFI may help mental health providers to initiate conversations with patients regarding how these aspects of culture may influence their experiences of mental illness, there are risks to using predetermined parameters regarding how culture is defined when building patient-provider relationships with older Chinese immigrants.

Neal's story illustrates the complexities of culture, and how it is present in his experiences with depression. Neal's identities as a Chinese Canadian immigrant, Christian, teacher, and family member are all important to his experiences of depression. Aggarwal et al. (2013) found that a notable barrier to the implementation of the CFI was patient discomfort in disclosing personal information regarding sensitive subjects such as past experiences with mental illness and religious identity. Neal's story illustrates the importance of developing trust and respect within the patient-provider relationship in order to facilitate the comfortable disclosure of such information. Lewis-Fernández et al. (2014) note that there remains a need to develop standardized training for mental healthcare providers to provide the appropriate context and skills needed to effectively use the CFI. While contextualizing the use of the CFI may help nurses and other frontline mental healthcare providers to develop culturally safe mental healthcare practices, I contend that the implementation of standardized training may overlook the personhood of the provider in the delivery of person-centered care. The critical self-reflection that is inherent to the notion of cultural safety highlights the importance of including the personhood of nurses and other frontline healthcare providers in the relationships of care

(Ramsden, 2002). A future direction of inquiry might explore how including information about cultural safety in the professional development of nurses, and other frontline mental healthcare providers, might help contextualize the use of the CFI in the provision of person-centered mental healthcare.

Cultural safety emphasizes the importance of enabling patients to define what culture and safety mean to their experiences of health and illness (Ramsden, 2002). Neal's story suggests that incorporating information about cultural safety in such training may be beneficial in facilitating the building of trusting relationships between patients and mental healthcare providers. Enabling patients, particularly older Chinese immigrants, to define culture and safety within the context of their own lives and experiences with depression may help to emphasize the important role of relationship in person-centered care while reducing the risk of perpetuating essentialized notions of culture in the field of mental healthcare. A future direction of inquiry could explore how explicitly discussing and defining culture and safety might be meaningful to the building of relationships between older Chinese immigrants with depression and their mental healthcare providers.

Further directions of inquiry may also seek to reveal other grand narratives that may exist in the mental health literature, and explore how these grand narratives may be acted out in thinking and practice in the field of mental healthcare. Ramsden (2002) notes that the attitudes and practices of healthcare providers towards members of particular ethnocultural groups also may often be influenced by attitudes and thinking that prevail on a larger social scale. These attitudes are often shaped by historical events and popular stereotypes, and the understanding of how these influence grand narratives and their enactment is an important aspect of cultivating culturally safe mental healthcare (Ramsden, 2002; Smye & Browne, 2002). For example, a stereotype that Chinese and other East Asian immigrants are the *model minority* tends to persist in North American society. The model minority myth originated in North America during the 1960's, and attributes the relative financial and social success of Chinese and East Asian immigrants (compared to other ethnic minority groups) to individual efforts (Fernando, 2006; Ng, Lee, Pak, 2007). The grand narrative behind this stereotype is that in North America

“Chinese and East Asian Americans do not need government support... [and] individual effort [can be a] primary means to overcome racism, erasing the existence of structural barriers” (Ng et al., 2007, p. 97). Casado and Leung (2002) note that the model minority stereotype has likely influenced the assumption that Chinese immigrants generally do not have mental health issues. Indeed, the paucity of research involving the experiences of older Chinese immigrants with depression may be reflective of this belief (Kuo et al., 2008). A future direction of inquiry might explore how the model minority stereotype might be present in the mental health literature pertaining to older Chinese immigrants.

Individuals from Other Chinese and East Asian Immigrant Communities

Clandinin and Connelly (2000) note that the knowledge gained through a narrative inquiry is tentative, as new understandings lead to further directions of inquiry that prompt the cycle of living, telling, reliving, and retelling of experience to continue. Neal’s story demonstrates the heterogeneity that exists amongst older adults in Chinese immigrant communities. While this narrative inquiry took place in the Greater Toronto Area, a future direction of inquiry may explore the experiences of older Chinese immigrants with depression from other geographic locations. While the significance of Neal’s story is transferrable to mental healthcare practices that affect older Chinese immigrants from other communities, the experiences of other older Chinese immigrants with depression may help to illuminate the nuanced differences that may exist within communities and healthcare systems in other geographic locations.

Language barriers, lack of knowledge regarding Canadian mental health services, and unstable socio-economic status may pose legitimate concerns for many older Chinese immigrants with depression in seeking mental healthcare services (Sadavoy et al., 2004, Chen et al., 2009b). Yet, these tend to be issues that mostly affect older Chinese immigrants who are more recent immigrants, or less acculturated to their host countries (Nguyen, 2011; Sun et al., 2016). Neal is different from the older Chinese immigrants that the mental health literature focuses on because his story tells about the experiences of an older Chinese immigrant with depression who is well acculturated into Canadian society. Neal’s story reveals a preference for treatment options that enable him to actively improve his own mental and physical health as well as reflect his own personal and

professional positioning in his life. Yet, I also note that social factors such as Neal's level of education, relative financial stability, and access to insurance through his profession as a teacher, may have influenced his ability to access resources and mental health services provided by his family physician and psychologist. His story also reveals the meaningfulness of receiving mental health support from healthcare providers in his journey of recovering from depression. In many ways, his story provides an example of "what can go right" when larger structural barriers are removed and individuals are able to access mental healthcare that empowers them to communicate their needs and have their voices heard. Neal's experiences with seeking help for depression tell of the heterogeneity that exists within Chinese Canadian communities and between individual older Chinese immigrants. Neal's story points to a need for researchers to be mindful of this heterogeneity when pursuing future directions of inquiry.

Future directions of inquiry also may consider how Neal's story may be transferrable to older immigrants from other East Asian immigrant communities. Confucianism provides the epistemological basis of many aspects of traditional Chinese culture, and has had a profound influence on the dominant traditional cultures in Japan, Korea, and Vietnam (Reischauer, 1974; Schuman, 2015). As a result, concepts similar to *miànzi* (面子), *rénqíng* (人情) and *guānxi* (關係) may be practiced within other East Asian immigrant communities (Park & Chesla, 2007; Reischauer, 1974; Schuman, 2015). Reflecting upon this potential resonance with Neal's story, a future direction of inquiry might explore how older immigrants from other East Asian communities experience depression. Neal's story also touches upon the challenges of changing identities and aging, and points to a future direction of inquiry that might explore how experiences of aging might be meaningful to the mental and physical health of older Chinese immigrants or individuals with other ethnocultural identities.

My positioning in this narrative inquiry as a researcher, co-participant, and community member has enlightened my understanding of the importance of drawing upon multiple disciplines in order to address the contextual complexity that is inherent in the study of experience within a narrative inquiry. Both bricoleurs and narrative inquirers seek to explore how people's experiences may inform practice and transform

understanding (Clandinin & Connelly, 2000; Kincheloe, 2005). The findings from this narrative inquiry may encourage researchers to employ other qualitative methodologies, such as ethnography, to further inquire into how healthcare and community environments might matter to the experiences of older Chinese immigrants with depression.

Researchers may also consider using critical research methodologies to further examine and critique how larger social factors in mental healthcare and Canadian society might influence the experiences of older Chinese immigrants with depression. The findings from this narrative inquiry may also inspire future studies that employ quantitative methodologies to further explore how identity, voice, communication, and relationships might matter to older Chinese immigrants with depression on a large population-based level. Looking ahead towards the future, I seek to explore how further directions of inquiry may influence my understanding of myself as a narrative inquirer and bricoleur. Particularly, I am curious about how the concepts of a theoretical sewing kit and metaphorical quilt making may be useful in the co-creation of meaning in future narrative inquiries.

Epilogue: Two Letters

Returning to the autobiographical nature of narrative inquiry, I conclude this thesis by reflecting upon how this journey with Neal has been personally meaningful to me. At the start of this narrative inquiry, I recall feeling nervous about exploring my own experiences with depression—uncertain whether sharing about my depression would have detrimental consequences to my future employment prospects or reputation at school. Yet, through my journey with Neal, I have learned to recognize that the stories I told myself about my depression were imbued with fear and self-stigma. Living alongside Neal in this narrative inquiry has taught me to advocate for the respect and dignity of older Chinese immigrants with depression, and in turn learn to advocate for the respect and dignity of my-self. The self that I was in the beginning of this narrative inquiry is different from the self I have become through the process of living, telling, reliving, and retelling of my experiences with depression (Clandinin, 2013; Clandinin & Connelly, 2000).

When I first began exploring the resonances between my experiences with my grandfather and my experiences with my own depression, my initial reflections were imbued with an understanding of the genetic predispositions for my mental illness that I likely inherited (Levinson & Nichols, 2016). I realize now that my grandfather has gifted me richly with our shared experience, stories, Chinese Canadian identity, legacy of advocacy, and predisposition for depression. My experiences with depression are no longer a source of shame and embarrassment, but inspiration and empowerment. I now understand my depression to be not only a mental illness, but also a driving force that compels me towards greater mental wellness. When I neglect to allow myself sufficient rest, or spend too much time on work and neglect to tend to my personal relationships, or when I have denied myself the time and space to process my emotional responses to the complexities in life, my depression reminds me to care for myself. I am grateful for the opportunity to journey alongside Neal, and my grandfather, in living, telling, reliving, and retelling our experiences with depression. Like Neal, I have learned to embrace the importance of my multiple identities through this narrative inquiry. I am Chinese Canadian, a young adult, a student leader, a researcher, queer, depressed, and proud.

I have come to learn that there are people who will empathize with me, and care about me as a whole, complex person whose experiences of depression have shaped me into the person that I am. I have gained valuable knowledge about strength and vulnerability through my experiences in this narrative inquiry. The boyfriend who I feared would “drop me like a hot potato” if he learned about my depression is now my fiancée. I have found family members, academic mentors, and a diverse community of scholars who value the presence of both my personal and professional selves in my work. In reconstructing my experiences in this narrative inquiry, I write two letters, one to my grandfather and the other to myself.

Dear Grandpa,

It has been a while since you have passed away, and I continue to miss you dearly. Yet, I feel your lively presence once again every time I reminisce upon the stories we created together. Lighthearted stories of fond memories, sombre stories of darker times, and unspoken stories that we both experienced nonetheless, all of them are

important and cherished by me. I imagine the stern look of disapproval that you would have given me at the beginning of this narrative inquiry. “It is not your place to air out our family’s dirty laundry” you would say. To be honest, if you were alive today, I would not have included your story in this narrative inquiry out of respect for your choice to keep these stories secret in light of your position of leadership within our community and family. I understand that some stories can only be told beyond the grave. Over time forgotten objects become valuable artifacts, old garments become trendy vintage clothes, and the silences and white spaces in our narratives become signposts that point to the complexity and richness of our lives. I thank you for gifting me with the experiences we have shared and an interest in listening to people’s stories. Thank you for giving me the courage to stand with pride, knowing that I am gifted with the opportunity to continue your and your father’s legacy of advocating for our community, ourselves, and others. I am grateful for the valuable lessons you have taught me about being Chinese Canadian, embracing the heterogeneity within our community, and the struggle to make visible Chinese Canadian identities and knowledge within the landscapes of Canadian history and healthcare. Thank you for being an immense source of inspiration and a constant companion throughout this journey.

With love and gratitude,

Elizabeth

My experiences in this narrative inquiry have also set me on the path to the development of a professional identity that is inextricably and irreducibly intertwined with my personhood. Learning about cultural safety and person-centered care from the perspective of a Chinese Canadian with depression has cultivated within me a curiosity to learn first-hand how these concepts may be enacted in mental healthcare practice. Additionally, I am most grateful for the generous mentorship, support, and inspiration that I have received from nurse-scholars such as Dr. Gail Lindsay, Dr. Jasna Schwind, Dr. Hilde Zitzelsberger, Dr. Wendy Stanyon, and many others. I will soon begin my studies in a second-entry nursing program in Toronto, with the goal of eventually specializing in mental health nursing. As I continue my journey, I envision the numerous possibilities as I add yet another aspect to my identity and continue to learn about myself

through living, telling, reliving, and retelling my experiences. I imagine my future professional self and present the impact of Neal's story through the following letter:

Dear future nurse-self,

As you have come to experience being both a co-participant and a narrative inquirer in this arts-informed narrative inquiry, so you will soon experience being both a mental health patient and a mental healthcare provider as you begin to pursue this professional path. I write to you in hopes of reminding you about the learning that we have experienced through our narrative inquiry with Neal.

First of all, be mindful of your thinking, your attitudes and behaviours and assumptions. Be mindful of the messages that you convey through your words, actions, and inactions in your practice. These can either make your encounters with patients culturally safe or unsafe to them, and can have an impact on their experiences with mental healthcare.

Secondly, time will be a precious commodity, yet never underestimate the value of taking time for yourself and your patients. Identity, voice, and communication are important to the nurturing of relationships between patients and mental healthcare providers--- always remember to listen and critically reflect. Never forget that relationship is the heart of person-centered care. Advocate for your patients, advocate for yourself. Fight the good fight, even if it is a lonely one... the legacy of Irihapeti Merenia Ramsden can attest to this struggle. Yet, remember that you come from a family lineage of resilience, advocacy, and compassion. You are strong, courageous, and ever-growing. I believe in you, and know that you can face any challenges that come your way because you were born swimming upstream.

With love,

Elizabeth

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APPENDIX A: Recruitment Poster



2000 Simcoe Street North t 905.721.3166
 Oshawa, Ontario L1H 7K4 www.healthsciences.uoit.ca

FACULTY OF HEALTH SCIENCES

Participants Needed!

A research team from the University of Ontario Institute of Technology (UOIT) is conducting a series of creative writing, art making, and interview sessions with Chinese immigrants about mental health for a study titled: **A narrative inquiry into older Chinese Canadian immigrant's experiences of depression: conceptualization and sources of mental health support.** The stories that people have about mental health are important because they contain valuable information about how we can improve mental health care in our communities.

You are **eligible** if you:

- Identify as Chinese or Chinese Canadian;
- Are 55+ years of age;
- Are sufficiently fluent in English to participate in an interview;
- Are an immigrant from a country/area with a large Chinese population (e.g., Mainland China, Hong Kong, Macau, Taiwan, Singapore, Malaysia);
- Are a Canadian Citizen or Permanent Resident;
- Have experienced depression at least once since landing in Canada

There will be a series of 4-5 research sessions. Each session will be **1.5- 2 hours in length**, and will take place in a quiet location of your choice. You will be invited to participate in the creation of a life line, creative writing, metaphor, drawing, and collage during the first half of the session, and a narrative interview during the second half of the session. There is a minimal risk that you may experience upsetting or strong emotions if they recall certain memories or experiences about depression during the research sessions. There is also a minimal risk that you may experience mild physical discomfort if you have a physical disability that makes it difficult to participate in this study's arts activities (e.g., vision impairment, severe rheumatoid arthritis). In this case, accommodations (e.g., frequent breaks, alternative arts materials, option to decline participation in this activity) will be provided. However, this study presents you with the opportunity to be engaged in the creation of knowledge in the field of older immigrant mental health. You will be provided with light refreshments, and receive a thank you card for your participation.

With your voluntary consent (i.e., permission), notes will be written during the writing and art making portions of the research sessions. With your voluntary consent (i.e., permission) your interviews will be recorded using an audio recording device and transcribed. You will be free to ask questions, express concerns, or withdraw from the study at any time without consequence.

If you are interested in this study please contact us for more information:

Researcher: Elizabeth Suen (Masters of Health Sciences candidate, UOIT)
 Telephone: (905) 244-7909
 E-mail: Elizabeth.suen@uoit.ca

Supervisor: Dr. Hilde Zitzelsberger (RN, MSc, PhD, Faculty of Health Sciences, UOIT)
 Telephone: (905) 721-8669, extension 3811
 E-mail: Hilde.zitzelsberger@uoit.ca

This study has been approved by the UOIT Research Ethics Board (# 14-055), as of 12/05/14

APPENDIX B: E-mails to Community Organizations**Recruitment E-mail #1 (Initial Correspondence with Potential Community Partners):**

Dear [name of organization OR contact person from the organization],

My name is Elizabeth Suen and I am a Graduate Masters student from the University of Ontario Institute of Technology. Dr. Hilde Zitzelsberger is my supervisor. My research explores the ideas that older Chinese immigrants may have with depression, and who they might turn to if they were to need help for their depression. The stories that people have about depression are important to me because they contain valuable information about how we can improve mental healthcare in our communities.

To explore this issue, I will be conducting a series of creative writing, art-making, and interview sessions with Chinese immigrants about depression for a study titled: A narrative inquiry into older Chinese Canadian immigrant's experiences of depression: conceptualization and sources of mental health support. I am looking for people to participate in my study who:

Identify as Chinese or Chinese Canadian;

Are 55+ years of age;

Are sufficiently fluent in English to participate in an interview;

Are an immigrant from a country with a large Chinese population (e.g., Mainland China, Hong Kong, Macau, Taiwan, Singapore, Malaysia);

Are a Canadian Citizen or Permanent Resident;

Have experienced depression at least once since landing in Canada.

There will be a series of 4-5 research sessions. Each session will be 1.5- 2 hours in length, and will take place in a quiet location of the participant's choice. They will be invited to participate in creative writing (i.e., lifeline, letter writing, poetry), metaphor,

drawing, and collage making during the first half of the session, and a narrative interview during the second half of the session. There is a minimal risk that participants may experience upsetting or strong emotions if they recall certain memories or experiences about depression during the research sessions. There is also a minimal risk that you may experience mild physical discomfort if you have a physical disability that makes it difficult to participate in this study's arts activities (e.g., vision impairment, severe rheumatoid arthritis). In this case, accommodations (e.g., frequent breaks, alternative arts materials, option to decline participation in this activity) will be provided. However, this study presents participants with the opportunity to be engaged in the creation of knowledge in the field of older immigrant mental health. Participants will be provided with light refreshments, and receive a thank you card for your participation.

I am writing to invite you to assist in the recruitment of participants for this study. I will be pleased to answer any questions you may have.

I would also appreciate knowing if you would be interested in sharing more information about my research with [your members/followers/the community you serve]. If you would be willing to provide information about my research project, please let me know and I can send you more information and a message can be sent via e-mail to [your members/followers/the community you serve] and/or posted on your website.

Sincerely,

Elizabeth Suen (Master of Health Sciences, candidate),

Hilde Zitzelsberger, RN, MSc, PhD

Assistant Professor

Faculty of Health Sciences

University of Ontario Institute of Technology

2000 Simcoe Street North

Oshawa, ON L1H 7K4

905.721.8668, EXT. 3811 Email: hilde.zitzelsberger@uoit.ca

Recruitment E-mail #2 (To be Distributed Through Community Partners, with Permission):

Dear [members of organization/followers/community members],

A research team from the University of Ontario Institute of Technology (UOIT) is conducting a series of creative writing, art-making, and interview sessions with Chinese immigrants about depression for a study titled: A narrative inquiry into older Chinese Canadian immigrant's experiences of depression: conceptualization and sources of mental health support. The stories that people have about mental health are important because they contain valuable information about how we can improve mental healthcare in our communities. You are eligible if you:

Identify as Chinese or Chinese Canadian;

Are 55+ years of age;

Are sufficiently fluent in English to participate in an interview;

Are an immigrant from a country with a large Chinese population (e.g., Mainland China, Hong Kong, Macau, Taiwan, Singapore, Malaysia);

Are a Canadian Citizen or Permanent Resident;

Have experienced depression at least once since landing in Canada.

I am writing to invite you to participate in this study. I will be pleased to answer any questions you may have.

There will be a series of 4-5 research sessions. Each session will be 1.5- 2 hours in length, and will take place in a quiet location of your choice. You will be invited to participate in creative writing (i.e., life line, letter writing, poetry), drawing, metaphor, and collage during the first half of the session, and a narrative interview during the second half of the session. There is a minimal risk that you may experience upsetting or strong emotions if you recall certain memories or experiences about depression during

the research sessions. However, this study presents you with the opportunity to be engaged in the creation of knowledge in the field of older immigrant mental health. You will be provided with light refreshments, and receive a thank you card for your participation.

With your voluntary consent (i.e., permission), notes will be written during the writing and art-making portions of the research sessions. With your voluntary consent (i.e., permission) your interviews will be recorded using an audio recording device and transcribed. You will be free to ask questions, express concerns, or withdraw from the study at any time without consequence.

If you are interested in this study, please contact us for more information:

Researcher: Elizabeth Suen (Masters of Health Sciences candidate, UOIT)

Telephone: (905) 244-7909

E-mail: Elizabeth.suen@uoit.ca

Supervisor: Dr. Hilde Zitzelsberger (RN, MSc, PhD, Faculty of Health Sciences, UOIT)

Telephone: (905) 721-8669, extension 3811

E-mail: Hilde.zitzelsberger@uoit.ca

APPENDIX C: E-mails to Potential Co-participants**Recruitment E-mail #1 (For Potential Co-participants):**

Dear [name of potential co-participant],

Thank you for your interest in my study! The purpose of our study is to explore the experience of older Chinese immigrants who have experienced depression since their arrival in Canada. The stories of experience that people have about mental health are important to me because they contain valuable information about how we can improve the mental healthcare in our communities. Here is some more information about my study:

I (Elizabeth) am looking for people who might be interested in sharing their stories about depression in an interview setting. Interview candidates should identify as Chinese or Chinese Canadian; be an immigrant from a country with a large population of Chinese people; be 55 years of age or older; be comfortable being interviewed in English; and have had experienced depression at least once since landing in Canada. Participating in this study will provide you with an opportunity to share your ideas and concerns depression and other mental health issues. You will also be helping to build the body of knowledge that researchers have about immigrant mental health in Canada. However, if you participate in this study there is a risk that you may remember some unpleasant experiences you may have had with depression. There is also a minimal risk that you may experience mild physical discomfort if you have a physical disability that makes it difficult to participate in this study's arts activities (e.g., vision impairment, severe rheumatoid arthritis). In this case, accommodations (e.g., frequent breaks, alternative arts materials, option to decline participation in this activity) will be provided.

I would like to invite you to participate in an arts-informed narrative inquiry that will consist of 4-5 research sessions. Arts-informed narrative inquiry is a kind of research that uses creative writing, art-making, and narrative interviews to collect information about people's stories of experience. Each research session will be about 1.5- 2 hours long, and will take place in a location of your choice. The first half of the session will

involve either a creative writing or art-making activity. The second half of the research session will consist of a narrative interview. If you participate in this study, you will receive a thank you card when all of the research sessions are completed.

With your voluntary consent (i.e., permission) I will be using a pen and note pad to make notes during the creative writing and art-making portions of our research session. With your voluntary consent (i.e., permission), I also will be using an audio recorder to make a copy of our interview during the interview portion of our session. The notes and recordings of our interviews will be kept private and will not be shared with anyone except my Master's supervisor (Dr. Hilde Zitzelsberger) and me. The recordings of the interviews will be destroyed after we make a written copy of the interview (transcript). Your name will not be recorded in the transcript of the interview to keep your information private. The transcripts will be kept in a locked cabinet in a secure place that will only be accessed by me and my supervisor (Hilde). If you decide that you no longer want to participate in the study during the interview or throughout this project, you will be able to withdraw from the study without consequences. Also, you can let us know if you want to remove your data from the study at any time without consequences.

If you would still like to participate in this study, please let me know when you would like to meet for the first research session (e.g., dates and times when you are available). Also, please let me know where you would like the research session to take place (e.g., location). When choosing a location for our first session, please think of a location where your privacy will be respected. You should feel comfortable in this place, and your chosen location should ideally be relatively quiet.

Thank you for your interest in my study, I appreciate your willingness to help me with my research! Please let me know if you decide to cancel our research session or need to reschedule our session for a different time, date, or location. Also, may I have your phone number so that I may confirm your availability the day before our interview?

Once again, thank you for your interest in my study. I look forward to hearing from you!

Sincerely,

Elizabeth Suen (Masters of Health Sciences, candidate)

The University of Ontario Institute of Technology

Hilde Zitzelsberger (RN, MSc, PhD, supervisor)

Assistant Professor

Faculty of Health Sciences

University of Ontario Institute of Technology

2000 Simcoe Street North

Oshawa, ON L1H 7K4

905.721.8668, EXT. 3811

hilde.zitzelsberger@uoit.ca

Recruitment E-mail #2 (If Potential Co-participants Continue to Express Interest in Study):

Dear [name of potential co-participant],

Thank you for your continued interest in our study! Would you be able to meet on [day], [month], [year] at [time]? I can meet you at [location specified by co-participant] for our first research session. Please let me know if you decide to withdraw from the study before the research session takes place, or if you need to reschedule the interview date for any reason. Also, may you share your phone number so that I can confirm your availability the day before our interview?

Sincerely,

Elizabeth Suen (Masters of Health Sciences, candidate)

Hilde Zitzelsberger (RN, MSc, PhD, supervisor)

The University of Ontario Institute of Technology

Assistant Professor

Faculty of Health Sciences

University of Ontario Institute of Technology

2000 Simcoe Street North

Oshawa, ON L1H 7K4

905.721.8668, EXT. 3811

hilde.zitzelsberger@uoit.ca

Recruitment E-mail #3 (If Potential Co-participants Lose Interest in Study):

Dear [name of potential co-participant],

Thank you letting me know that you are no longer interested in our study. Even though you will not be participating in our research, we would appreciate it if you shared our contact information with people you know who might be interested in our study. However, you are not required to do this.

I wish you all the best!

Sincerely,

Elizabeth Suen (Masters of Health Sciences, candidate)

Hilde Zitzelsberger (RN, MSc, PhD, supervisor)

The University of Ontario Institute of Technology

Assistant Professor

Faculty of Health Sciences

University of Ontario Institute of Technology

2000 Simcoe Street North

Oshawa, ON L1H 7K4

905.721.8668, EXT. 3811

hilde.zitzelsberger@uoit.ca

APPENDIX D: Telephone Scripts**Telephone Scripts****Script for Initial Telephone Correspondence with Potential Co-participants (version 1):**

Hello,

This is Elizabeth Suen speaking, thank you for your interest in my study! I am a Masters of Health Sciences student at the University of Ontario Institute of Technology (UOIT), and I understand the ideas that Chinese immigrants might have about depression, and who they might turn to if they were to need help for their depression. The stories that people have about depression are important to me because they contain valuable information about how we can improve the mental healthcare in our communities.

[Ask the potential co-participant if they would like to hear more information about the study. If not, then thank them for their interest in the study and refer to version 2 of the telephone correspondence script]

I am looking for people who might be interested in sharing their stories about depression in an interview setting. Potential research co-participants should identify as Chinese or Chinese Canadian; be an immigrant from a country with a large population of Chinese people; be 55 years of age or older; be comfortable being interviewed in English; and have had experienced depression at least once since landing in Canada. Participating in this study will provide you with an opportunity to share your ideas and concerns about mental health. You will also be helping to build the body of knowledge that researchers have about immigrant mental health in Canada. However, if you participate in this study there is a risk that you may remember some unpleasant experiences you may have had with depression.

[Ask the potential co-participant if they think they qualifies for the study. Also ask if they have any questions or concerns about the study so far.]

I would like to invite you to participate in an arts-informed narrative inquiry that will consist of 4-5 research sessions. Arts-informed narrative inquiry is a kind of research that uses creative writing, art-making, and narrative interviews to collect information about people's stories of experience. Each research session will be about 1.5- 2 hours long, and will take place in a location of your choice. The first half of the session will involve either a creative writing or art-making activity. The second half of the research session will consist of a narrative interview. If you participate in this study, you will receive a thank you card when all of the research sessions are completed.

With your voluntary consent (i.e., permission), I will be using an audio recorder to make a copy of our interview during the interview portion of our session. The notes and recordings of our interviews will be kept private and will not be shared with anyone except my Master's supervisor (Dr. Hilde Zitzelsberger) and me. The recordings of the interviews will be destroyed after we make a written copy of the interview (transcript). Your name will not be recorded in the transcript of the interview to keep your information private. The transcripts will be kept in a locked cabinet in a secure place that will only be accessed by me and my supervisor (Hilde). If you decide that you no longer want to participate in the study during the interview or throughout this project, you will be able to withdraw from the study without consequences. Also, you can let us know if you want to remove your data from the study at any time without consequences.

It is possible that you may experience physical stress due to reasons of physical stress due to reasons of physical disability (e.g., cataracts or severe rheumatoid arthritis) participating in especially the art/manipulation aspects of the study. Accommodations (i.e., frequent breaks, use of alternative art-making materials, choice to decline to participate in a certain activity) can and will be made if you chooses. Also, activities will be immediately stopped if the you experience discomfort due to physical disability, and you will be invited to take a break or withdraw from the activity as needed.

[Ask the potential co-participant if they have any questions or concerns about the study]

If you would still like to participate in this study, please let me know when you would like to meet for the first research session (e.g., dates and times when you are available). Also, please let me know where you would like the research session to take

place (e.g., location). When choosing a location for our first session, please think of a location where your privacy will be respected. You should feel comfortable in this place, and your chosen location should ideally be relatively quiet.

[Arrange a time, date, and meeting place with potential co-participant].

Thank you for your interest in my study, I appreciate your willingness to help me with my research! Please let me know if you decide to cancel our research session or need to reschedule our session for a different time, date, or location. Also, may I have your phone number so that I may confirm your availability the day before our interview?

[Ask if the potential co-participant has any additional questions or concerns]

Excellent! Once again, thank you so much for your willingness to help me with my research. I look forward to seeing you [insert name of potential co-participant].
Goodbye!

Script for Initial Telephone Correspondence with Potential Co-participants (version 2):

Well, thank you for your interest in my study, I appreciate your phone call. If you know of anyone else who might be interested in my research, please feel free to share my contact information with them. However, you do not have to do this it will make you feel uncomfortable.

Once again, thank you for your call. Goodbye!

APPENDIX E: UOIT Ethics Approval



**RESEARCH ETHICS BOARD
OFFICE OF RESEARCH SERVICES**

Date: December 5th, 2014

To: Elizabeth Suen (Graduate Student), Toba Bryant (Co-I), Wendy Stanyon (Co-I), Gail Lindsay (Co-I) and Hilde Zitzelsberger (Supervisor)

From: Bill Goodman, REB Chair

Project Title: "A narrative inquiry into older Chinese Canadian immigrant's experiences of depression: Conceptualization and sources of mental health support."

From: Bill Goodman, REB Chair

REB File #: 14-055

DECISION: APPROVED

EXPIRY: December 1st, 2015

The University of Ontario, Institute of Technology Research Ethics Board (REB) has reviewed and approved the above research proposal. This application has been reviewed to ensure compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and the UOIT Research Ethics Policy and Procedures.

Please note that the (REB) requires that you adhere to the protocol as last reviewed and approved by the REB. Always quote your REB file number on all future correspondence.

Please familiarize yourself with the following forms as they may become of use to you:

- **Change Request Form:** any changes or modifications (i.e. adding a Co-PI or a change in methodology) must be approved by the REB through the completion of a change request form before implemented.
- **Adverse or unexpected Events Form:** events must be reported to the REB within 72 hours after the event occurred with an indication of how these events affect (in the view of the Principal Investigator) the safety of the participants and the continuation of the protocol. (I.e. un-anticipated or un-mitigated physical, social or psychological harm to a participant).
- **Research Project Completion Form:** must be completed when the research study has completed.
- **Renewal Request Form:** any project that exceeds the original approval period must receive approval by the REB through the completion of a Renewal Request Form before the expiry date has passed.

All Forms can be found at <http://research.uoit.ca/faculty/policies-procedures-forms.php>.

REB Chair Dr. Bill Goodman, FBIT bill.goodman@uoit.ca	Ethics and Compliance Officer compliance@uoit.ca
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University of Ontario, Institute of Technology
 2000 Simcoe Street North, Oshawa ON, L1H 7K4
 PHONE: (905) 721-8668, ext. 3693

APPENDIX F: Consent Form



**RESEARCH ETHICS BOARD
OFFICE OF RESEARCH SERVICES**

Title of Research Study: A narrative inquiry into older Chinese Canadian immigrants' experiences of depression: conceptualization and sources of mental health support.

You are invited to participate in a research study entitled “A narrative inquiry into older Chinese immigrant’s experiences of depression: conceptualization and sources of mental health support”. This study (# REB 14-055) has been reviewed by the University of Ontario Institute of Technology Research Ethics Board and was originally approved on (December, 1st, 2015). Please read this form carefully, and feel free to ask any questions you might have of the Researcher or the Ethics and Compliance Officer. If you have any questions about your rights as a participant in this study, please contact the Ethics and Compliance Officer at 905 721 8668 ext. 3693 or compliance.uoit.ca.

Researcher(s):

Principal Investigator, Faculty Supervisor, Students etc(s): Elizabeth Suen (MHSc, candidate), Dr. Hilde Zitzelsberger (RN, MSc, PhD).

Departmental and institutional affiliation(s): University of Ontario Institute of Technology

Contact number(s)/email: Elizabeth Suen (905) 244-2909,
Elizabeth.suen@uoit.ca; Dr. Hilde Zitzelsberger (905) 721-8668, ext. 3811,
hilde.zitzelsberger@uoit.ca

Purpose and Procedure:

*The purpose of this study is to explore the experiences of older Chinese immigrants with depression and how these experiences might influence whom they might turn to if they were to need help for their depression. In this study, you will be invited to participate in a series of 4-5 research sessions. Each session will include a creative writing or art-making activity (i.e., life line, writing, drawing, metaphor, collage) and participate in a narrative interview that will be audio recorded with your consent. Each research session is expected to be 1.5- 2 hours in length, and will take place in a quiet location of your choice. With your **voluntary** consent the interviews will be recorded using an audio recording device, and the audio recordings of the interview will then be transcribed (i.e., written down).*

*You will be verbally reminded of the voluntary nature of consenting before **each** distinct research session. You will also be clearly reminded each time of your right to withdraw at the beginning of, and at any point in time during, each research session without negative consequence. Additionally, you will also be clearly reminded of your right to withdraw your data that has been collected up until that point in time without any negative consequences.*

You will receive a thank you card for your participation in this study. The card will be awarded whether you complete the study or decide to withdraw. After all of the research sessions have been completed, you will have the opportunity to let the researcher know if you would like to receive a copy of the summary of your interviews at a later date so you can provide feedback. You will also be encouraged to invite other people to participate in this study, especially people whom you think might be interested in this study.

Potential Benefits:

Some people may experience feelings of emotional release (i.e., catharsis) when writing, creating art work, and participating narrative interview research, as they are given opportunities to express feelings, ideas, and thoughts about sensitive topics that they might otherwise be discouraged from talking about in public. Sometimes people feel an increased sense of validation (i.e., purpose, or self-esteem) as a result of sharing their stories with someone (i.e., the researcher) who actively listens to their point of view. People sometimes may also become more aware of themselves, and the value of their stories, through the act of reflecting upon their experiences as they tell their stories. However, not all people experience these benefits (or experience them in the same ways), and there is a chance that you will not benefit directly from participating in this study.

Please note that your participation in this study will have no bearing or influence on your overall physical or psychological health. Your participation in this study will also not infringe upon your privacy, nor will it benefit or harm your reputation or social status.

Regardless, the stories that you share in this study will help increase our knowledge about the experiences of older immigrants with depression. This knowledge may help us to develop new ideas about how we can improve mental healthcare in our communities.

Potential Risk or Discomforts:

During the research sessions, some of the discussion topics or questions may cause you to feel emotionally upset, angry, stressed, or uncomfortable. Please inform the researcher if you do not feel comfortable answering a question or discussing a particular topic, you can choose to skip over this question (or change the topic) if needed. If you do experience emotional discomfort during a research session, you may choose to stop the interview at any time and the research team can provide you with contact information for local counselling services.

It is also possible that you may experience physical stress if you have physical disability (e.g., cataracts or severe rheumatoid arthritis) that may affect your

participation in the art/manipulation aspects of the study. At the beginning of each research session, you will be informed that accommodations (i.e., frequent breaks, use of alternative art-making materials, choice to decline to participate in a certain activity) can and will be made if you would like. Also, activities will be immediately stopped if the co-participant experiences discomfort due to physical disability. You will also be reminded of the availability of alternative art materials (e.g., paint, ink, chalk, paintbrushes, sponges, stickers, etc.), and your choice to decline or withdraw from participating in any of the research activities throughout each research session.

You may also choose not to participate in any of the arts activities for a given session. In this case, you may opt to participate only in the interview portion of the session, reschedule the session for a different day, withdraw from the specific session, or withdraw from the study completely. You may also choose to start any research session with the interview instead of the arts activity. While the default structure of the study is to run the arts activity then interview, your comfort and energy levels will ultimately determine the structure of each research session.

*Your participation in this study is entirely voluntary. Please note that participating in the arts activities (including writing, drawing, metaphor, and collage) and audio recorded interviews during this study may cause mild alterations in your physical wellbeing, feelings, and/or mood. However, these alterations are not anticipated to be greater than that encountered during normal everyday life. If needed, please feel free to refer to the provided **mental health resource sheet** to contact a local mental health professional if you start feeling distressed at any point in time during, or after, your participation in this study. . If needed, please feel free to request additional copies of the mental health resource sheet at any point in time during your participation in this study.*

Storage of Data:

All notes that are written during the research sessions will be typed out and stored on an encrypted and password protected hard drive and jump drive. These notes will not be shared with anyone except my supervisor (Hilde), for research purposes. The original written notes will then be destroyed. Your name, and any other identifying

information, will not be recorded in the typed out version of the notes to keep your information private.

The audio recording of each interview will be immediately destroyed after I make a written copy of the interview (transcript). Your name, and any other identifying information, will not be recorded in the transcript of the interview to keep your information private. Digital copies of the transcripts will be kept on an encrypted and password protected hard drive and jump drive.

Hard copies of the notes, transcripts, and consent forms will be stored in separate folders and will be kept in a locked cabinet in an area that has key holder restricted access (i.e., Dr. Hilde Zitzelsberger's office), will only be viewed by members of the research team. All hard copies of materials related to this study will be kept for a maximum period of two years, after this time period the data (i.e., consent form, audio recording of interviews, transcripts of interviews, photographs of artwork, field notes), will be destroyed. All digital copies of materials related to this study will be kept for a maximum of five years, after this period the data will be deleted.

Confidentiality:

*All of the information collected in this study will be kept confidential. Your name will never be associated with any of the materials (i.e., audio recording of interviews, transcripts of interviews, photographs of artwork, field notes) in this study, except for the consent form, and your data will instead be assigned an alphanumeric participant number (e.g., A1). Your consent form will be kept separate from the rest of your data and stored in a locked filing cabinet in a room with restricted key holder access (i.e., Dr. Hilde Zitzelsberger's office). Your real name will not be used if your data is referred to in the study's findings, a pseudonym will be used instead (this also applies to any people, groups, or organizations you may mention during the interview). Your privacy shall be respected. No information about your identity will be shared or published without your **voluntary** consent (i.e., permission), unless required by law.*

*The researchers will respect your privacy, and information concerning your identity will never be published or shared without your **voluntary** consent. However,*

sometimes the law requires that we share participant information if the participant reveals that they are being abused, is abusing a child, or is planning to commit suicide. Confidentiality will be provided to the fullest extent possible by law, professional practice, and ethical codes of conduct. Please note that confidentiality cannot be guaranteed while data are in transit over the internet.

Right to Withdraw:

*Your participation is **voluntary**, and you choose can answer only those questions that you are comfortable with. The information that is shared will be held in strict confidence and discussed only with the research team. You can choose to withdraw from the study at any time without consequences. If you withdraw from the study, the researchers will **destroy** the information that was collected from you (i.e., consent form, audio recording of interviews, transcripts of interviews, photographs of artwork, field notes), and this information will **not** be used in the study. You will be invited to confirm your choice to withdraw from this study and destroy your data on a Withdrawal Form.*

However, if you voluntarily consent, you may choose the degree to which your data (i.e., consent form, audio recordings of each interview, transcripts, condensed stories, hardcopies of artwork, photographs of artwork, pieces of creative writing, field notes) are removed from the study. This entails choosing to either keep or destroy the data. You may choose to allow the researcher to keep and use your data, up until the point of withdrawal, for research purposes. Alternatively, you may choose to not allow the researcher to use your data, and instead keep this data for your own personal use. In all of these cases, these alternative options for data destruction are completely at your discretion and are neither required nor expected. You will also be provided with a copy of the Withdrawal Form for your records.

*Your name will **not** be recorded on the Withdrawal Form, instead an alphanumeric participant number will be written on the top left hand corner of the Withdrawal Form. This alphanumeric participant number will also be used if there is any*

data (i.e., transcripts, field notes, photographs of artwork) that the you voluntarily chooses to allow the research team to keep and use.

Please note, that withdrawal of your data once it has been anonymized and summarized with the data of this study's other participants may not be feasible. It is difficult, if not impossible, to withdraw results once they have been published or otherwise disseminated. You will be given, information that is relevant to your decision to continue or withdraw from participation.

Conflict of Interest:

The members of the research team declare no conflicts of interest with all aspects of this study. Neither the researcher (Elizabeth Suen) nor members of the research team (i.e., Dr. Hilde Zitzesberger) have any vested personal, clinical, or financial interest in the study.

Compensation:

You will receive a thank you note for your participation in this study. If you experience emotional discomfort at any point during the interview process, the researcher will stop the interview and provide you with information for local counselling services. If you experience emotional discomfort after the interview has finished, the researcher can provide you with information for local counselling services. You will be given a copy of this consent form to keep for your records in case you wish to contact the research team or UOIT's Research Ethics Board to report emotional discomfort that may be experienced after the interview session has ended.

Participant Concerns and Reporting:

This research project has been approved by the University of Ontario Institute of Technology Research Ethics Board on (December, 1st, 2015). “If you have any questions concerning the research study, or experience any discomfort related to the study please contact the researcher(s) at (905) 244-7909 (Elizabeth Suen), or (905) 721-8668, ext. 3811 (Dr. Hilde Zitzesberger) or via email Elizabeth.suen@uoit.ca, or Hilde.zitzelsgerber@uoit.ca . Any questions regarding

your rights as a participant, complaints or adverse events may be addressed to Research Ethics Board through the Compliance Office (905 721 8668 ext 3693)

By consenting, you do not waive any rights to legal recourse in the event of research-related harm.

Debriefing and Dissemination of Results:

If you would like to receive a summary of the findings once this study is completed, please let us know on the last page of this consent form. This summary can be sent to you via e-mail or mail.

*The summary of the results of this study will be used as part of Elizabeth's school project for her master's studies at UOIT. The findings of this study may also be used to help spread awareness of the special concerns of immigrants regarding depression. A summary of this study's results may also be distributed to community health organizations and other institutions that focus on mental health. The findings of this study will also be used to create presentations and write articles for journals that will be viewed by healthcare professionals, researchers, and members of the community. While the results of this study may be published, your identity will never be revealed in any journal article, presentation, or paper. If other researchers request to use the summary of this study's data for future studies, the research team must request your **voluntary** consent (i.e., permission) to before sharing this data.*

Consent to Participate:

(a) Written Consent

1. **“I have read the consent form and understand the study being described”;**
2. **“I have had an opportunity to ask questions and my questions have been answered. I am free to ask questions about the study in the future”;**
3. **“I freely consent to participate in the research study, understanding that I may discontinue participation at any time without penalty. A copy of this Consent Form has been made available to me to keep for my records.”**

(Name of Participant)

(Date)

(Signature of Participant)

(Signature of Researcher)

(b) Oral Consent (To be obtained if the participant lacks the ability to read and/or sign the consent form).

1. “I have read the consent form to the participant they have indicated that they understand the study being described”;

2. “The participant has had an opportunity to ask questions and these questions have been answered. They are free to ask questions about the study in the future”;

3. “The participant has freely consented to participate in the research study, understanding that they may discontinue participation at any time without penalty. A physical/digital consent form will be made available to the participant for their records.”

(Name or identifier of Participant)

(Date)

(Signature of Researcher)

Would you like the researcher to send you a copy of the initial summary of your combined interviews? The purpose of this would be to ensure the accuracy of the summary, and provide an opportunity for you to provide the research team with valuable feedback.

Yes _____

OR

No _____

Summary of Results

Would you like to receive a copy of the summary of results when this study is complete?

Yes _____

OR

No _____

If yes, how would you prefer to receive the summary of results?

Mailing address:

OR

E-mail address: _____

*** Please note:** You have the option to choose whether you provide or do not provide your contact information. This decision will not impact your ability to participate in this study.

APPENDIX G: Alternative Consent Form

Provided to Co-Participant If They Needed to Conceal Their Participation In A Study Regarding Mental Health



**RESEARCH ETHICS BOARD
OFFICE OF RESEARCH SERVICES**

Title of Research Study: A narrative inquiry into older Chinese Canadian immigrant's experiences of health: conceptualization and sources of health support.

You are invited to participate in a research study entitled “A narrative inquiry into older Chinese immigrant’s experiences of health: conceptualization and sources of health support”. This study (# REB 14-055) has been reviewed by the University of Ontario Institute of Technology Research Ethics Board and was originally approved on (December, 1st, 2015). Please read this form carefully, and feel free to ask any questions you might have of the Researcher or the Ethics and Compliance Officer. If you have any questions about your rights as a participant in this study, please contact the Ethics and Compliance Officer at 905 721 8668 ext. 3693 or compliance.uoit.ca.

Researcher(s):

Principal Investigator, Faculty Supervisor, Students etc(s): Elizabeth Suen (MHSc, candidate), Dr. Hilde Zitzelsberger (RN, MSc, PhD).

Departmental and institutional affiliation(s): University of Ontario Institute of Technology

Contact number(s)/email: Elizabeth Suen (905) 244-2909,
Elizabeth.suen@uoit.ca; Dr. Hilde Zitzelsberger (905) 721-8668, ext. 3811,
hilde.zitzelsberger@uoit.ca

Purpose and Procedure:

*The purpose of this study is to explore the experiences that older Chinese immigrants with health and how these experiences might influence who they might turn to if they were to need help for their health. In this study, you will be invited to participate in a series of 4-5 research sessions. Each session will include a creative writing or art-making activity (i.e., life line, writing, drawing, metaphor, collage) and participate in a narrative interview that will be audio recorded with your consent. Each research session is expected to be 1.5- 2 hours in length, and will take place in a quiet location of your choice. With your **voluntary** consent the interviews will be recorded using an audio recording device, and the audio recordings of the interview will then be transcribed (i.e., written down).*

*You will be verbally reminded of the voluntary nature of consenting before **each** distinct research session. You will also be clearly reminded each time of your right to withdraw at the beginning of, and at any point in time during, each research session without negative consequence. Additionally, you will also be clearly reminded of your right to withdraw your data that has been collected up until that point in time without any negative consequences.*

You will receive a thank you card for your participation in this study. The card will be awarded whether you complete the study or decide to withdraw. After all of the research sessions have been completed, you will have the opportunity to let the researcher know if you would like to receive a copy of the summary of your interviews at a later date so you can provide feedback. You will also be encouraged to invite other people to participate in this study, especially people who you think might be interested in this study.

Potential Benefits:

Some people may experience feelings of emotional release (i.e., catharsis) when writing, creating art work, and participating narrative interview research, as they are given opportunities to express feelings, ideas, and thoughts about sensitive topics that they might otherwise be discouraged from talking about in public. Sometimes people feel an increased sense of validation (i.e., purpose, or self-esteem) as a result of sharing their stories with someone (i.e., the researcher) who actively listens to their point of view. People sometimes may also become more aware of themselves, and the value of their stories, through the act of reflecting upon their experiences as they tell their stories. However, not all people experience these benefits (or experience them in the same ways), and there is a chance that you will not benefit directly from participating in this study.

Please note that your participation in this study will have no bearing or influence on your overall health. Your participation in this study will also not infringe upon your privacy, nor will it benefit or harm your reputation or social status.

Regardless, the stories that you share in this study will help increase our knowledge about the experiences of older immigrants with health. This knowledge may help us to develop new ideas about how we can improve healthcare in our communities.

Potential Risk or Discomforts:

During the research sessions, some of the discussion topics or questions may cause you to feel emotionally upset, angry, stressed, or uncomfortable. Please inform the researcher if you do not feel comfortable answering a question or discussing a particular topic, you can choose to skip over this question (or change the topic) if needed. If you do experience emotional discomfort during a research session, you may choose to stop the interview at any time and the research team can provide you with contact information for local health services.

It is also possible that you may experience physical stress if you have physical disability (e.g., cataracts or severe rheumatoid arthritis) that may affect your participation in the art/manipulation aspects of the study. At the beginning of each research session, you will be informed that accommodations (i.e., frequent breaks, use of

alternative art-making materials, choice to decline to participate in a certain activity) can and will be made if you would like. Also, activities will be immediately stopped if the co-participant experiences discomfort due to physical disability. You will also be reminded of the availability of alternative art materials (e.g., paint, ink, chalk, paintbrushes, sponges, stickers, etc), and your choice to decline or withdraw from participating in any of the research activities throughout each research session.

You may also choose not to participate in any of the arts activities for a given session. In this case, you may opt to participate only in the interview portion of the session, reschedule the session for a different day, withdraw from the specific session, or withdraw from the study completely. You may also choose to start any research session with the interview instead of the arts activity. While the default structure of the study is to run the arts activity then interview, your comfort and energy levels will ultimately determine the structure of each research session.

*Your participation in this study is entirely voluntary. Please note that participating in the arts activities (including writing, drawing, metaphor, and collage) and audio recorded interviews during this study may cause mild alterations in your physical wellbeing, feelings, and/or mood. However, these alterations are not anticipated to be greater than that encountered during normal everyday life. If needed, please feel free to refer to the provided **health resource sheet** to contact a local health professional if you start feeling distressed at any point in time during, or after, your participation in this study. If needed, please feel free to request additional copies of the health resource sheet at any point in time during your participation in this study.*

Storage of Data:

All notes that are written during the research sessions will be typed out and stored on an encrypted and password protected hard drive and jump drive. These notes will not be shared with anyone except my supervisor (Hilde), for research purposes. The original written notes will then be destroyed. Your name, and any other identifying information, will not be recorded in the typed out version of the notes to keep your information private.

The audio recording of each interview will be immediately destroyed after I make a written copy of the interview (transcript). Your name, and any other identifying information, will not be recorded in the transcript of the interview to keep your information private. Digital copies of the transcripts will be kept on an encrypted and password protected hard drive and jump drive.

Hard copies of the notes, transcripts, and consent forms will be stored in separate folders and will be kept in a locked cabinet in an area that has key holder restricted access (i.e., Dr. Hilde Zitzelsberger's office), will only be viewed by members of the research team. All hard copies of materials related to this study will be kept for a maximum period of two years, after this time period the data (i.e., consent form, audio recording of interviews, transcripts of interviews, photographs of artwork, field notes), will be destroyed. All digital copies of materials related to this study will be kept for a maximum of five years, after this period the data will be deleted.

Confidentiality:

*All of the information collected in this study will be kept confidential. Your name will never be associated with any of the materials (i.e., audio recording of interviews, transcripts of interviews, photographs of artwork, field notes) in this study, except for the consent form, and your data will instead be assigned an alphanumeric participant number (e.g., A1). Your consent form will be kept separate from the rest of your data and stored in a locked filing cabinet in a room with restricted key holder access (i.e., Dr. Hilde Zitzelsberger's office). Your real name will not be used if your data is referred to in the study's findings, a pseudonym will be used instead (this also applies to any people, groups, or organizations you may mention during the interview). Your privacy shall be respected. No information about your identity will be shared or published without your **voluntary** consent (i.e., permission), unless required by law.*

*The researchers will respect your privacy, and information concerning your identity will never be published or shared without your **voluntary** consent. However, sometimes the law requires that we share participant information if the participant reveals that they are being abused, is abusing a child. Confidentiality will be provided to the fullest extent possible by law, professional practice, and ethical codes of conduct.*

Please note that confidentiality cannot be guaranteed while data are in transit over the internet.

Right to Withdraw:

*Your participation is **voluntary**, and you choose can answer only those questions that you are comfortable with. The information that is shared will be held in strict confidence and discussed only with the research team. You can choose to withdraw from the study at any time without consequences. If you withdraw from the study, the researchers will **destroy** the information that was collected from you (i.e., consent form, audio recording of interviews, transcripts of interviews, photographs of artwork, field notes), and this information will **not** be used in the study. You will be invited to confirm your choice to withdraw from this study and destroy your data on a Withdrawal Form.*

However, if you voluntarily consent, you may choose the degree to which your data (i.e., consent form, audio recordings of each interview, transcripts, condensed stories, hardcopies of artwork, photographs of artwork, pieces of creative writing, field notes) are removed from the study. This entails choosing to either keep or destroy the data. You may choose to allow the researcher to keep and use your data, up until the point of withdrawal, for research purposes. Alternatively, you may choose to not allow the researcher to use your data, and instead keep this data for your own personal use. In all of these cases, these alternative options for data destruction are completely at your discretion and are neither required nor expected. You will also be provided with a copy of the Withdrawal Form for your records.

*Your name will **not** be recorded on the Withdrawal Form, instead an alphanumeric participant number will be written on the top left hand corner of the Withdrawal Form. This alphanumeric participant number will also be used if there is any data (i.e., transcripts, field notes, photographs of artwork) that the you voluntarily chooses to allow the research team to keep and use.*

Please note, that withdrawal of your data once it has been anonymized and summarized with the data of this study's other participants may not be feasible. It is difficult, if not impossible, to withdraw results once they have been published or

otherwise disseminated. You will be given, information that is relevant to your decision to continue or withdraw from participation.

Conflict of Interest:

The members of the research team declare no conflicts of interest with all aspects of this study. Neither the researcher (Elizabeth Suen) nor members of the research team (i.e., Dr. Hilde Zitzesberger) have any vested personal, clinical, or financial interest in the study.

Compensation:

You will receive a thank you note for your participation in this study. If you experience emotional discomfort at any point during the interview process, the researcher will stop the interview and provide you with information for local health services. If you experience emotional discomfort after the interview has finished, the researcher can provide you with information for local health services. You will be given a copy of this consent form to keep for your records in case you wish to contact the research team or UOIT's Research Ethics Board to report emotional discomfort that may be experienced after the interview session has ended.

Participant Concerns and Reporting:

This research project has been approved by the University of Ontario Institute of Technology Research Ethics Board on (December, 1st, 2015). “If you have any questions concerning the research study, or experience any discomfort related to the study please contact the researcher(s) at (905) 244-7909 (Elizabeth Suen), or (905) 721-8668, ext. 3811 (Dr. Hilde Zitzesberger) or via email Elizabeth.suen@uoit.ca, or Hilde.zitzelsgerber@uoit.ca . Any questions regarding your rights as a participant, complaints or adverse events may be addressed to Research Ethics Board through the Compliance Office (905 721 8668 ext 3693).

By consenting, you do not waive any rights to legal recourse in the event of research-related harm.

Debriefing and Dissemination of Results:

If you would like to receive a summary of the findings once this study is completed, please let us know on the last page of this consent form. This summary can be sent to you via e-mail or mail.

*The summary of the results of this study will be used as part of Elizabeth's school project for her master's studies at UOIT. The findings of this study may also be used to help spread awareness of the special concerns of immigrants regarding health. A summary of this study's results may also be distributed to community health organizations and other institutions that focus on health. The findings of this study will also be used to create presentations and write articles for journals that will be viewed by healthcare professionals, researchers, and members of the community. While the results of this study may be published, your identity will never be revealed in any journal article, presentation, or paper. If other researchers request to use the summary of this study's data for future studies, the research team must request your **voluntary** consent (i.e., permission) to before sharing this data.*

Consent to Participate:

(b) Written Consent

4. **“I have read the consent form and understand the study being described”;**
5. **“I have had an opportunity to ask questions and my questions have been answered. I am free to ask questions about the study in the future”;**
6. **“I freely consent to participate in the research study, understanding that I may discontinue participation at any time without penalty. A copy of this Consent Form has been made available to me to keep for my records.”**

(Name of Participant)

(Date)

(Signature of Participant)

(Signature of Researcher)

(b) Oral Consent (To be obtained if the participant lacks the ability to read and/or sign the consent form).

1. “I have read the consent form to the participant they have indicated that they understand the study being described”;

2. “The participant has had an opportunity to ask questions and these questions have been answered. They are free to ask questions about the study in the future”;

3. “The participant has freely consented to participate in the research study, understanding that they may discontinue participation at any time without penalty. A physical/digital consent form will be made available to the participant for their records.”

(Name or identifier of Participant)

(Date)

(Signature of Researcher)

Would you like the researcher to send you a copy of the initial summary of your combined interviews? The purpose of this would be to ensure the accuracy of the summary, and provide an opportunity for you to provide the research team with valuable feedback.

Yes _____

OR

No _____

Summary of Results

Would you like to receive a copy of the summary of results when this study is complete?

Yes _____

OR

No _____

If yes, how would you prefer to receive the summary of results?

Mailing address:

OR

E-mail address: _____

*** Please note:** You have the option to choose whether you provide or do not provide your contact information. This decision will not impact your ability to participate in this study.

APPENDIX H: Withdrawal Form

*As mentioned in the consent form, we will honor your choice to withdraw from the study at any time without consequences. Upon your withdrawal from this study, the researchers will **destroy** the information that was collected from you (i.e., consent form, audio recording of interviews, transcripts of interviews, photographs of artwork, field notes), and this information will **not** be used in the study.*

Please check off box below to confirm your withdrawal from this study and your permission to destroy your data:

YES, I am withdrawing from this study and would like the researchers to destroy my data (i.e., consent form, audio recordings of interviews, transcripts of interviews, photographs of artwork, field notes).

OPTIONAL:

*If you **voluntarily** consent, you may choose the degree to which your data (i.e., consent form, audio recordings of each interview, transcripts, condensed stories, hardcopies of artwork, photographs of artwork, pieces of creative writing, field notes) are removed from the study. This entails choosing to either keep or destroy the data. You may choose to allow the researchers to keep and use your data, up until the point of withdrawal, for research purposes. Alternatively, you may choose to not allow the researcher to use your data, and instead keep this data for your own personal use. In all of these cases, these alternative options for data destruction are completely at your discretion and are **neither required nor expected**.*

If you consent, and would like to keep your data in the study to some degree, please choose and check off the appropriate below:

YES, I choose to withdraw from this study, and I voluntarily choose to allow the researchers to keep and use my data up until the point of my withdrawal from their study.

OR

YES, I choose to withdraw from this study, and I voluntarily choose to not allow the researchers to use my data, and instead would like the researchers to give me all of my data to keep for my own personal use.

Please note, that withdrawal of your data once it has been anonymized and summarized with the data of this study's other participants may not be feasible. It is difficult, if not impossible, to withdraw results once they have been published or otherwise disseminated. You will be given, information that is relevant to your decision to continue or withdraw from participation.

If you would like to receive an update about the study entitled "A narrative inquiry into older Chinese Canadian immigrant's experiences of depression: Conceptualization and sources of mental health support" (#REB 14-055) once it study has concluded, or have any questions about your right to withdraw from this study, please feel free to contact the following people:

UOIT Ethics and Compliance Officer at 905 721 8668 ext. 3693

Elizabeth Suen (BHSc, MHSc candidate),

(905) 244-7909, Elizabeth.suen@uoit.ca

Dr. Hilde Zitzelsberger (RN, MSC, PhD),

(905) 721-8668, ext. 3811, hilde.zitzelsberger@uoit.ca

APPENDIX I: Mental Health Resource Sheet

Community Mental Health Resources:

Please feel free to contact the following organizations if you are in crisis, need to access counselling supports, or would like more information regarding mental health:

If you are in crisis, please call 9-1-1 or visit the emergency department of your local hospital. You can also receive immediate assistance via the following hotlines:

Distress Centre: 416-408-HELP (4357) This service offers confidential support for people who need help with mental and physical health issues, crisis, emotional disturbances, domestic violence, suicide, addictions, and social isolation. FREE.

ConnexOntario Mental Health Helpline: 1-866-531-2600 This service provides confidential support for basic mental health issues, helps people find information about mental health, and can help you find mental health services in Ontario. FREE.

Telehealth Ontario: 1-866-797-0000 Provides professional and confidential advice for mental and physical health issues from a Registered Nurse.

If you are interested in finding a mental health service provider, please make an appointment with your family doctor or general practitioner to obtain a referral to an appropriate. The following organizations provide counselling and other services:

Hong Fook Mental Health Association: (416) 493-4242 This organization specializes in providing counselling, mental health education, and other mental health services for people from East and South Asian communities in Ontario. Mental health services are available in a variety of languages.

Hong Fook Mental Health Association: (416) 493-4242 This organization specializes in providing counselling, mental health education, and other mental health services for people from East and South Asian communities in Ontario. Mental health services are available in a variety of languages.

Ontario Shores Centre for Mental Health Sciences Central Intake Department: (877) 767-9642 The Central Intake Department of the Ontario Shores Mental Health Sciences Central Intake Department can assist you in obtaining a referral from your physician for access to counselling services, psychiatric assessment, and other programs and services that may be appropriate for your needs.

Centre for Addiction and Mental Health: 1 (800) 463-6273 This organization is the largest hospital in Canada that specializes in mental health and addictions issues.
PHYSICIAN REFERRAL REQUIRED FOR ALL SERVICES.

***** If you are in crisis, please call 9-1-1, or visit the emergency department of your local hospital*****

APPENDIX J: Research Session Protocol

*Please Note: This protocol provides an outline of the default structure for each research session. However, as mentioned in the consent form, co-participants may choose to **not participate** or **withdraw from participating** in a certain art activity or interview portion of any given session. In this case, the structure of the research session will be changed to better meet the needs of the co-participants (with a maximum time of 2 hours allotted for each session).*

First Research Session

Action:	Approximate Time Allotted:	Details:
1) Greetings and food gift or sharing of refreshments (Chinese etiquette)	5-10 minutes	The researcher and co-participant will introduce themselves. Out of respect, the researcher will ask how the co-participant wishes to be addressed. If the co-participant chooses to meet in their place of residence, the researcher will offer them a small food gift as a gesture of goodwill and respect. If the co-participant chooses to meet in a non-residential location, the researcher will offer to purchase light refreshments (or bring these) to share with the co-participant.
2) Introduction to study and consent process	10-15 minutes	The researcher will explain the study's purpose, methods, benefits, and risks to the co-participant. The co-participant will be invited to read the consent form. The researcher will also discuss the main points of the

		consent form to ensure that the co-participant has a clear understanding of the consent information. If the co-participant is unable to provide their written consent due to physical disability (e.g., severe rheumatoid arthritis, cataracts, etc) oral consent will be obtained
3) Introduction to this session's activities	5-10 minutes	Once the co-participant's informed voluntary consent is obtained, the researcher will introduce the specific activities for this research session.
4) Writing a definition of depression	10-15 minutes	The researcher will provide the co-participant with writing utensils and paper. The co-participant will be invited to write their definition of depression (Schwind et al., 2014). This definition will be read aloud during the interview portion of the session.
5) Life line drawing	15-25 minutes	The researcher will provide the co-participant with paper, pens, markers, and colouring pencils. The co-participant will be invited to draw a line (can be straight, curved, looped, etc.) on a piece of paper that will represent their life from the beginning to the present time (Schwind et al., 2014; Lindsay, 2014a). The co-participant will then be invited to mark down significant life events and

		<p>achievements along one side of the line (Schwind et al., 2014; Lindsay, 2014a). After, the co-participant will be invited to mark down significant times in their lives when they experienced depression (Schwind et al., 2014; Lindsay, 2014a). The co-participant may choose to mark down these events using words, pictures, or symbols.</p>
6) Narrative interview	20-30 minutes	<p>The researcher will turn on the audio-recording device, and the co-participant will be invited to read aloud their definition of depression. The researcher will then ask the question: “please tell me how your definition and lifeline reflect your experiences with depression?”</p>
7) Conclusion of session, discussion of next sessions’ activities, and invitation to share study information	10-15 minutes	<p>The researcher will turn off the audio recording device to conclude the interview. The researcher will briefly discuss the next session’s activities with the co-participant. The co-participant will also be invited to share the researcher’s contact information with others who may be interested in participating in this study. However, this sharing of information is optional.</p>

Second Research Session

Action:	Approximate Time Allotted:	Details:
1) Greetings and food gift or sharing of refreshments (Chinese etiquette)	5-10 minutes	The researcher and co-participant will introduce themselves. Out of respect, the researcher will ask how the co-participant wishes to be addressed. If the co-participant chooses to meet in their place of residence, the researcher will offer them a small food gift as a gesture of goodwill and respect. If the co-participant chooses to meet in a non-residential location, the researcher will offer to purchase light refreshments (or bring these) to share with the co-participant.
2) Obtain verbal re-consent and reflect upon last session's activities.	5-10 minutes	Verbal re-consent will be obtained from the co-participant before the session begins. Both the researcher and co-participant will then reflect upon the last session's activities, and discuss any new questions, concerns, or insights.
3) Introduction to this session's activities	5-10 minutes	The researcher will introduce the specific activities for this research session.
4) Writing of short story #1	10-20 minutes	The researcher will provide the co-participant with writing utensils and lined paper. The co-participant will be invited to write a short story (3-4

		<p>paragraphs maximum) about a time they experienced depression (Schwind et al., 2014). Alternatively, co-participants may choose to type their story on the researcher’s laptop if accommodation is required.</p>
<p>5) Writing of short story #2</p>	<p>10-20 minutes</p>	<p>The researcher will provide the co-participant with writing utensils and lined paper. The co-participant will be invited to write a short story (3-4 paragraphs maximum) about a time they sought help for her/his depression from someone other than themselves (Schwind et al., 2014). Alternatively, co-participants may choose to type their story on the researcher’s laptop if accommodation is required.</p>
<p>6) Narrative interview</p>	<p>25-35 minutes</p>	<p>The researcher will turn on the audio-recording device, and the co-participant will be invited to read aloud their story about experiencing depression. The researcher will then ask the question: “please tell me about things that stood out to you in your story about experiencing with depression.” Next, the co-participant will be invited to read aloud their story about seeking help for their depression. The researcher will then ask the question “Please tell me about</p>

		the things that stood out to you in your story about seeking help for your depression”.
7) Conclusion of session, discussion of next sessions’ activities	10-15 minutes	The researcher will turn off the audio recording device to conclude the interview. The researcher will briefly discuss the next session’s activities with the co-participant.

Third Research Session

Action:	Approximate Time Allotted:	Details:
1) Greetings and food gift or sharing of refreshments (Chinese etiquette)	5-10 minutes	The researcher and co-participant will introduce themselves. Out of respect, the researcher will ask how the co-participant wishes to be addressed. If the co-participant chooses to meet in their place of residence, the researcher will offer them a small food gift as a gesture of goodwill and respect. If the co-participant chooses to meet in a non-residential location, the researcher will offer to purchase light refreshments (or bring these) to share with the co-participant.
2) Obtain verbal re-consent and reflect upon last session’s activities.	5-10 minutes	Verbal re-consent will be obtained from the co-participant before the session begins. Both the researcher and co-participant will then reflect upon the last session’s activities, and

		discuss any new questions, concerns, or insights.
3) Introduction to this session's activities	5-10 minutes	The researcher will introduce the specific activities for this research session.
4) Narrative interview	Continuous and concurrent with the other activities in this session (about 25-35 minutes in total)	For this session, the narrative interview and arts activities will occur simultaneously. The co-participant will be informed that the audio recording device will be turned on at the beginning of the session.
5) Metaphor drawing	10-15 minutes	The researcher will provide the co-participant with pens, pencils, markers, colouring pencils and paper. The co-participant will be invited to draw a metaphor that describes their depression (Schwind et al., 2014). The co-participant will also be encouraged to write 1-2 short sentences describing their metaphor. With permission, the researcher will take a photograph of the co-participant's metaphor for research purposes. The researcher will then ask the co-participant to describe their metaphor and explain how they are like (or unlike) the metaphors they have created (Schwind et al., 2014).
6) Letter and poetry writing	15-25 minutes	The co-participant will be invited to write a letter to themselves from the

		<p>perspective of the metaphor (1-2 pages maximum) (Schwind et al., 2014). The co-participant will also be invited to take the words, phrases, and images that they used to describe their metaphor and create a free verse poem (Schwind et al., 2014). Free verse poem is a suitable poetry form for this activity because the words do not necessarily have to rhyme, and there is no set meter (i.e., units of rhythm) and therefore can be written without any formal poetic knowledge. The researcher will then ask the co-participant to read aloud their letter and poem, describe how the letter and poem relate to their experiences with depression (Schwind et al., 2014).</p>
7) Conclusion of session, discussion of next sessions' activities	10-15 minutes	<p>The researcher will turn off the audio recording device to conclude the interview. The researcher will briefly discuss the next session's activities with the co-participant. Particularly, the co-participant will be encouraged to collect small objects, images, and other materials that can be used in the creation of collages.</p>

Fourth Research Session

Action:	Approximate Time Allotted:	Details:
1) Greetings and food gift or sharing of refreshments (Chinese etiquette)	5-10 minutes	The researcher and co-participant will introduce themselves. Out of respect, the researcher will ask how the co-participant wishes to be addressed. If the co-participant chooses to meet in their place of residence, the researcher will offer them a small food gift as a gesture of goodwill and respect. If the co-participant chooses to meet in a non-residential location, the researcher will offer to purchase light refreshments (or bring these) to share with the co-participant.
2) Obtain verbal re-consent and reflect upon last session's activities.	5-10 minutes	Verbal re-consent will be obtained from the co-participant before the session begins. Both the researcher and co-participant will then reflect upon the last session's activities, and discuss any new questions, concerns, or insights.
3) Introduction to this session's activities	5-10 minutes	The researcher will introduce the specific activities for this research session.
4) Creation of collage #1	15-20 minutes	The researcher will provide the co-participant with illustration board (letter sized, approximately 8.5 x 11 inches), white glue, paintbrushes,

		<p>acrylic paints, coloured paper, old magazines, scissors, and other miscellaneous mixed media items (e.g., stickers, glitter, feathers, dried leaves). The co-participant will be invited to create a collage representing what was happening in their life during the time when they experienced depression (Schwind et al., 2014; Lindsay, 2014b; Butler-Kisber, 2010). The researcher will also invite the co-participant to reflect upon how the objects and materials they have collected for the collage making activity are meaningful to them (Lindsay, 2014b). With permission, the researcher will take a photograph of the co-participant's collage for research purposes.</p>
<p>5) Creation of collage #2</p>	<p>15-20 minutes</p>	<p>The co-participant will be invited to create a collage representing the places in which they have experienced depression (Schwind et al., 2014; Lindsay, 2014b; Butler-Kisber, 2010). The researcher will also invite the co-participant to reflect upon how the objects and materials they have collected for the collage making activity are meaningful to them (Lindsay, 2014b). With permission, the researcher will take a photograph</p>

		of the co-participant's collage for research purposes.
6) Narrative interview	25-35 minutes	The researcher will turn on the audio-recording device. The researcher will ask the co-participant to describe their first collage and answer the question: "Please tell me how your collage reflects your experiences with depression?" The researcher will also ask the co-participant to describe their second collage and answer the question: "Please tell me what your collage reveals about the places in which you have experienced depression?" The researcher will ask the co-participant to reflect upon their experiences of creating artworks during our sessions, and ask about whether their definitions of depression and mental health support have changed since our initial session (Lindsay, 2014b; Butler-Kisber, 2014).
7) Conclusion of session, discussion of next sessions' activities	10-15 minutes	The researcher will turn off the audio recording device to conclude the interview. The researcher will give the co-participant a thank you note in acknowledgement of their participation in this study.

APPENDIX K: Alternative Interview Questions

Interview Only

*(Used in the event that the co-participant chooses **not** to participate in any of the arts activities for a given research session, **yet** chooses to participate in the interview portion of that session. Please note that question #2 does not apply to the first research session):*

- 1) Please tell me about your experiences with depression;
- 2) What are your thoughts and feelings about the last time we met for a research session? Did anything about our discussions stand out to you?

APPENDIX L: Notes in Preparation of Next Session**To Be Given to Co-Participant**

Session #2: The arts activity for the next research session will be asked to write two (2) short stories (3-4 paragraphs). In preparation for next research session please think of a time when you experienced depression and a time when you asked someone (other than yourself) to help you with your depression.

Session #3: In the next research session you will be invited to draw a metaphor, participate in letter writing, and writing, and poetry. In preparation for this session, please feel free to explore you own writing, thoughts, and feelings.

Session #4: In the next research session you will be invited to create two collages. In preparation of the next session, please feel free to collect small objects (e.g., leaves, small coins, newspaper words or images, stamps, train ticket stubs, etc.) that can be used in your collage making.

Session #5: If you require additional time to complete any of the arts activities or interviews in this study, please let me know. We can schedule a 5th research session and have discussion.

APPENDIX M: Thank You Notes

Thank you note (version 1)

Dear [name of co-participant],

Thank you for participating in my study! I really appreciated your help with my research, it was truly a privilege to hear your stories about depression. Please do let me know if you would like to hear about the results of the study when it is finished, I would love to share them with you.

Kind regards,

Elizabeth Suen

(905) 244-7909

Elizabeth.suen@uoit.ca

Hilde Zitzelsberger, RN, MSc, PhD

Assistant Professor

Faculty of Health Sciences

University of Ontario Institute of Technology

2000 Simcoe Street North

Oshawa, ON L1H 7K4

905.721.8668, EXT. 3811

hilde.zitzelsberger@uoit.ca

Thank you note (version 2)

Dear [name of co-participant],

Thank you for your interest in my study. Although you withdrew from the study, and we have agreed not to use your data, it was a privilege to meet with you. Please do let me know if you would like to hear about the results of the study when it is finished, I would love to share them with you.

Kind regards,

Elizabeth Suen

(905) 244-7909

Elizabeth.suen@uoit.ca

Hilde Zitzelsberger, RN, MSc, PhD

Assistant Professor

Faculty of Health Sciences

University of Ontario Institute of Technology

2000 Simcoe Street North

Oshawa, ON L1H 7K4

905.721.8668, EXT. 3811

hilde.zitzelsberger@uoit.ca

APPENDIX N: UOIT Consent Approval Letter



Date: December 5th, 2014
To: Elizabeth Suen (Graduate Student), Toba Bryant (Co-I), Wendy Stanyon (Co-I), Gail Lindsay (Co-I) and Hilde Zitzelsberger (Supervisor)
From: Bill Goodman, REB Chair
Project Title: “A narrative inquiry into older Chinese Canadian immigrant’s experiences of depression: Conceptualization and sources of mental health support.”
From: Bill Goodman, REB Chair
REB File #: 14-055
DECISION: APPROVED
EXPIRY: December 1st, 2015

The University of Ontario, Institute of Technology Research Ethics Board (REB) has reviewed and approved the above research proposal. This application has been reviewed to ensure compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and the UOIT Research Ethics Policy and Procedures.

Please note that the (REB) requires that you adhere to the protocol as last reviewed and approved by the REB. Always quote your REB file number on all future correspondence.

Please familiarize yourself with the following forms as they may become of use to you:

- **Change Request Form:** any changes or modifications (i.e. adding a Co-PI or a change in methodology) must be approved by the REB through the completion of a change request form before implemented.
- **Adverse or unexpected Events Form:** events must be reported to the REB within 72 hours after the event occurred with an indication of how these events affect (in the view of the Principal Investigator) the safety of the participants and the continuation of the protocol. (I.e. un-anticipated or un-mitigated physical, social or psychological harm to a participant).
- **Research Project Completion Form:** must be completed when the research study has completed.
- **Renewal Request Form:** any project that exceeds the original approval period must receive approval by the REB through the completion of a Renewal Request Form before the expiry date has passed.

All Forms can be found at <http://research.uoit.ca/faculty/policies-procedures-forms.php>.

REB Chair Dr. Bill Goodman, FBIT bill.goodman@uoit.ca	Ethics and Compliance Officer compliance@uoit.ca
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