Exploring Experiences of Mental Health in Second Generation South Asian Canadians

by

Nurul Hinaya Cader

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Abstract

Although many studies have focused on the conceptualization of mental health, the literature only sparsely describes this phenomenon within the South Asian Canadian immigrant population. Furthermore, despite experiencing differential acculturation, there is a paucity in the literature concerning second generation South Asian Canadians. Thus, this research explored their experiences of mental health using Interpretive Description to conduct seven individual in-depth interviews. Seven themes were identified during data analysis: mental health stigma; mental health literacy; the in-between space; primary care; stress; the positive mind; and community participatory approaches. This research highlights the complexity of the conceptualization of mental health, the prevalence of the stigma of mental health, as well as the need for increased mental health literacy in the South Asian community. Findings of this research have implications for the development of targeted anti-stigma campaigns and for advocating for increased cultural safety and humility in the Canadian healthcare system.

Keywords: mental health, stigma, culture, South Asian

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CHAPTER ONE: Introduction

1.1 Background

Mental health is an important aspect of an individual's well-being. Unfortunately, it is often not prioritized due to a number of factors that influence the conceptualization of mental health. Particularly, within the South Asian immigrant population, mental health often does not become a concern until after immigration (Ahmad et al., 2005). However, South Asian immigrants tend to present with physical symptoms, often ignoring the possibility of underlying mental health issues[1] (Ciftci, 2013; Kramer, Kwong, Lee, & Chung, 2002; Rastogi et al., 2014). This method of framing mental health can make it difficult to communicate issues (Bottorff et al., 2001) as strong ties to native culture and norms related to mental health create cultural distancing (Ekanayake, Ahmad, & McKenzie, 2012) that may prevent an understanding of mental health. Additionally, a lack of understanding of available resources after migration deters treatment seeking (Ekanayake et al., 2012). However, increased contact with the host culture tends to be aligned with more of a presentation of psychological symptoms rather than physical ones (Rao, Young, & Raguram, 2007). Furthermore, there is a significant paucity in the literature addressing the conceptualization of mental health in the South Asian Canadian population; this lack of knowledge is even more pronounced in terms of the second generation South Asian Canadians, who tend to experience differential acculturation levels in comparison to their immigrant parents. Therefore, this study seeks to fill this gap in literature by exploring the understandings and experiences of mental health within the

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[1] In this thesis, the term 'mental health issues' will be used to identify all terms associated with negative mental health i.e. mental health problems, mental illnesses, mental disorders etc.

second generation South Asian Canadian population. It is important to conduct such research to understand the conceptualization of mental health within this population so that appropriate help-seeking interventions can be developed for those who may need help for mental health issues.

Considering that this study uses a qualitative approach to address the research questions posed later in this chapter, this thesis is written in the first person, which is a writing strategy often used in qualitative research (Creswell, 2014). Conducting this type of research encompasses the fact that the manner in which the study is written is a reflection of the researcher's interpretation of the data. Thus, I use the first person as part of my efforts to engage in reflexivity as a qualitative researcher, acknowledging that qualitative writing cannot be separated from its author (Creswell, 2013). This includes the notion that I aimed to capture and understand the subjective experiences of my participants, which required me to exercise a more personal role as a researcher and work to construct knowledge alongside my participants. Further information about the use of a qualitative approach and addressing my positionality as a researcher in this study can be found in Chapter 3: Methodology and Methods.

In this study, I used the definition of mental health of the World Health Organization (WHO): a state of being in which an individual can reach their full potential, deal with stress, work productively and make positive contributions (WHO, 2014). According to the Canadian Mental Health Association (CMHA), mental illnesses can be defined as "health problems that affect the way we think about ourselves, relate to others, and interact with the world around us. They affect our thoughts, feelings, and behaviours." ("Mental Ilnesses," 2014). In this study, I will use the term 'mental health

issues' to encompass a number of terms used to describe negative mental health i.e. mental illnesses, mental disorders, mental health problems, etc.

Stigma associated with mental health issues is a major obstacle in terms of access to care (Corrigan, Druss, & Perlick, 2014; Corrigan & Wassel, 2008; Sartorius, 2007). Cultural beliefs held within cultural groups have been identified as an influential factor on the level of stigma and perceived discrimination faced by stigmatized groups (Abdullah & Brown, 2011); thus, to understand the stigma associated with mental health issues and how it develops, sociocultural context must be taken into consideration (Ng, 1997). This finding is further complicated in immigrant populations because they must reconcile their native cultural beliefs with those of the host country (Ataca & Berry, 2002). Considering that South Asians are the largest visible minority group in Canada (Chui, Tran, & Maheux, 2008) and that they have been noted to inadequately access mental healthcare services (Ahmad et al., 2005), it is important to understand the influences/shaping of a person's understandings of mental health and their willingness to access mental healthcare. I am particularly interested in the experience of second generation South Asian Canadians, i.e., those born in Canada to immigrant parents, because this population has received little attention in the literature, especially with regards to mental health.

1.2 Purpose of Study

The overall purpose of this study is to examine the experiences of mental health for second generation South Asian Canadians. I will explore the experiences of second generation South Asian Canadians in the context of them being the adult children of

immigrant parents who have been influenced uniquely by their South Asian and Canadian cultures, including having lived in distinct geographic locales.

The proposed central research question for this study is: "What are the experiences of second generation South Asian Canadians with regard to mental health?" Additional sub-questions include:

1. How do second generation South Asian Canadians define and experience mental health?

2. What are those factors that shape/influence understandings of mental health and the development of mental health issues?

3. How do they maintain mental health?

1.3 Overview of Thesis

In the following chapters, I describe the study I conducted to explore the answers to these questions. In Chapter Two, I present a literature review related to key terms that are relevant to my inquiry, namely mental health, stigma associated with mental health, culture, and the South Asian population in Canada. In Chapter Three, I describe the methods I used to conduct this inquiry, individual in-depth interviews using an Interpretive Description approach. I highlight the research design, ethical considerations, the research setting and participants, and data collection and analysis procedures I used. In Chapter Four, I present the findings from the interviews I conducted with my participants. Lastly, in Chapter Five, I discuss my findings in the context of the literature and discuss some limitations. I then conclude by providing a summary of my research and note some implications it may have in future initiatives.

CHAPTER TWO: Literature Review

In this chapter, I present a review of the literature related to the key terms included in my study. First, I discuss the search strategy and criteria I used to find articles relevant to my study, providing rationale for my choice of search words etc. Next, I describe what I found in the literature about mental health and illness; stigma; culture; and South Asians in Canada. Then, I elaborate on stigma in association with mental health and illness as well as culture. I conclude by stating the significance of the current study as well as my proposed research questions.

2.1 Search Strategy & Criteria

Through the UOIT Library, I was able to access multiple databases, including Scholar's Portal, ProQuest, Springer Link, Taylor & Francis Online, and PsychINFO. These search engines provided access to the online database of Ontario university libraries, allowing easier exploration of academic research on specific subjects. I was able to find academic books and journals that were peer-reviewed and available online.

Key words I used to conduct my research for the literature review were: mental health, stigma, culture, treatment, cultural competence, cultural humility, South Asian, immigrant, and Canada. I set out to examine the association of stigma with mental health and culture. I focused on the South Asian immigrant population in Canada because that is where I identified the particular need for this type of research to be done. Thus, I used these keywords to examine the relevant literature about my focus of interest and/or if this topic has been studied, in the specified group, in depth already.

Inclusion criteria used to narrow down my search were: research articles published within the last twenty years to ensure currency and relevance; stigma related to

mental health; help-seeking for mental health issues; articles that address the intersection of at least two of culture, mental health, and stigma; articles published in English; and journal articles and/or books only. Consequently, exclusion criteria included the following: stigma related to other social attributes like racism and homophobia; help-seeking for other issues like intellectual disabilities; articles that do not address at least two of culture, mental health, and stigma; and news articles. For the purposes of this study, I was interested in the manifestations of stigma associated with mental health/illness, not necessarily the stigma associated with other aspects of social identities, such as racism and homophobia. Although I recognize the existence of multiple intersecting stigmas such as race, geography and sexuality, to name a few, in this study I was particularly interested in the stigma associated with mental health/illness and its intersection with culture more broadly understood. Therefore, I felt it was important that the articles I examined made mention of these key words i.e., culture, mental health, stigma.

I only looked at works published in English because it is the only language I can read and understand. I felt that peer-reviewed and/or authoritative journal articles provided me with the most accurate and relevant information; thus, I refrained from using articles that have not been peer-reviewed and/or published in authoritative journals.

2.2 Mental Health and Illness: Differing Worldviews

According to the World Health Organization, mental health is "a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community" (WHO, 2014). Furthermore, mental health encompasses

human affect, perception and cognition, motivation and behaviour, and interpersonal functioning (Corrigan, 2014) and how these aspects of an individual impact how a person deals with daily stressors and contributes to society at large. Thus, good mental health acts as a buffer against stress; however, having good mental health does not mean the absence of mental health issues. It is possible to have mental health issues and still have good mental health (Canadian Electronic, 2012). The term 'mental health issues' is used here to represent a variety of problems and illnesses: any kind of behaviour, thought, or feeling that evokes distress, suffering, or impairment in life activities like school, work, family interactions, or independence (Canadian Electronic, 2012). There are many different types of mental health issues ranging from common ones, like anxiety and depression, to less common ones, like schizophrenia and bipolar disorder. Their manifestations vary for each person, and they can be acute or chronic. Some issues can even evoke negative feelings that can lead to suicide ideation (Canadian Electronic, 2012). No one is immune from mental health issues; they are thought to be affected by a combination of social, economic, psychological, biological, and genetic factors (Canadian Electronic, 2012).

Sickel, Seacat, and Nabors (2014) stated that one out of every two adults will experience a mental health issue in their lifetime, yet more than two thirds of those affected do not get the help they need (Ngui, Khasakhala, Ndetei, & Roberts, 2010) and, as of 2010, only 2% of global national health budgets have been allocated toward the preservation of mental health (Ngui et al., 2010). Mental health issues account for more of the global burden of disease than all cancers combined; in fact, depression is considered to be the leading cause of disability internationally (Cohen & Peachey, 2014).

Specifically, in Canada, the Centre for Addiction and Mental Health (CAMH) posits that

one in every five Canadians face a mental health challenge each year and at least 500,000

Canadian employees are unable to work because of a mental health problem each week

(Dewa, 2010). Yet, less than 5% of total health spending in Canada is on mental health

(Cohen & Peachey, 2014). This points to the significance of mental health issues in

Canada and the need for attention to this very important health issue. In order to do this,

the paradigms used to frame mental health and associated issues must be considered.

Both traditional and emerging paradigms of mental health are discussed below.

2.2.1 Traditional Paradigms of Mental Health

Traditional models of mental health emphasize the 'expert' role of mental health

professionals; they focus on segregated services rather than integration; they neglect

social conditions; they deliver services that stigmatize and disconnect people from the

community; and they provide little opportunity for liberation (Lord, Ochocka, & Nelson,

2001). The traditional model in which mental health has often been framed, and remains

in use today, is the biomedical model of mental health (Deacon, 2013), which equates

health to the absence of disease (Koslander, Barbosa da Silva, & Roxberg, 2009). It is a

positivist model that engenders the idea that mental health issues can be resolved using

the same tools we use to address physical health issues (Bracken et al., 2012; Lake,

Helgason, & Sarris, 2012). It emphasizes causal relationships and the treatment of acute

symptoms over prevention and wellness (Lake et al., 2012). Even the language used to

describe psychiatric medications reflect the prevalence of the biomedical model, making

them appear to target the biological cause of mental health issues e.g., selective serotonin

reuptake inhibitors (SSRIs), anti-psychotics, and antidepressants (Deacon, 2013).

The traditional view of mental illness is that it involves a chemical imbalance in the brain, involving a deficiency or excess of neurotransmitters, conveying that a person is essentially powerless to do anything about it; the biomedical model promotes pharmaceutical interventions as the main solution to mental illness (Thachuk, 2011; Wand, 2013). Consequently, it is assumed that psychological phenomena can be reduced to biological causes; this view tends to be endorsed on popular websites like WebMD and MayoClinic (Deacon, 2013). Traditional models frame recovery through the treatment of disease and improvement of psychiatric symptoms. They are pathogenic approaches that define recovery as solely the extent of remission from mental health issues (Provencher & Keyes, 2011), and they primarily focus on finding the biological cause of disorder (Deacon, 2013).

Criticism of the biomedical model is that a primary focus on issues associated with mental health promotes a culture of hopelessness and dependence on mental health services instead of promoting autonomy, resilience, and independence (Wand, 2013). The biomedical model also has been criticized for being ineffective, accused of corrupting academia regarding mental health, and entangling psychiatry with the pharmaceutical industry (Bracken et al., 2012; Thachuk, 2011). For example, despite billions of dollars going into new drug development, serious mental health issues are still the same or even increasing (Deacon, 2013; Lake et al., 2012). In fact, those in the neurosciences have been unable to identify a single biological marker that could reliably inform the diagnosis of a mental illness (Deacon, 2013).

Anti-stigma campaigns based on biomedical models also have been ineffective (Bracken et al., 2012; Deacon, 2013; Thachuk, 2011). In fact, they may actually increase

the desire to 'other' and reinforce beliefs that mental illnesses are chronic, untreatable, unpredictable, and dangerous (Deacon, 2013; Thachuk, 2011). For example, when brain imaging is used to visualize the 'schizophrenic brain' and the 'bipolar brain,' it draws a line between people, demarcating between those with and without mental illness and emphasizing violence and unpredictability; this is despite the fact that 80-90% of people with mental health issues are not violent (Thachuk, 2011). According to Stuart (2003), "the prevalence of violence among those with a major mental disorder who did not abuse substances was indistinguishable from their non-substance abusing neighbourhood controls (p.122)…mental disorders are neither necessary, nor sufficient causes of violence. The major determinants of violence continue to be socio-demographic and socio-economic factors such as being young, male, and of lower socio-economic status." (p. 121) In fact, it is more likely that the mentally ill are actually the victims of violence rather than the perpetrators.

Even though the chemical imbalance theory has long been disproved (Deacon, 2013), the biomedical model is so widespread in society that it is hard to change (Lake et al., 2012); however, there have been a number of initiatives that aim to phase out the biomedical model. Even though mental illnesses have a biological dimension, they also involve social, cultural, and psychological dimensions that should be addressed (Bracken et al., 2012; Deacon, 2013; Koslander et al., 2009). The inclusion of these dimensions is characteristic of many of the new models that have emerged to describe mental health and mental health issues.

2.2.2 Emerging Paradigms of Mental Health

Considering the failure of the biomedical model to address the many dimensions of mental health, there has long been a need for a more holistic approach that also considers a person's autonomy and dignity. According to Bracken et al. (2012), a new model needs to include a concern with the human aspect of mental health services—the importance of relationships and narrative understanding in general practice, which highlights the social dimension of mental health (Bracken et al., 2012). As Wand (2013) suggests, this new model should focus on wellness instead of illness, "working to water the flowers, not the weeds" (p. 120). As opposed to the pathogenic approach characteristic of traditional models of mental health, Aaron Antonovsky coined the term "salutogenic" approach to mental health, which encapsulates factors that support human health and well-being rather than only factors that cause disease (cited in Provencher & Keyes, 2011).

Furthermore, Koslander et al. (2009) shared that humans have spiritual needs, not necessarily tied to religion, that must also be met. These spiritual needs consist of finding the purpose of life, needing to feel useful, and needing hope and dignity. The right to health is a basic human right, and most humans link spirituality to their health—thus, spiritual rights should be met too. This also is in accordance with the finding that there is a positive correlation between religiosity and coping mechanisms of people with mental health issues (Koslander et al., 2009). Additionally, the use of spiritual tools in mental healthcare like meditation, prayer, and scriptural reading has shown to be effective, as cited in Koslander et al. (2009). Coinciding with the dominance of the biomedical model, spiritual needs of those with mental health issues often remain unmet.

One model that has emerged is the Empowerment-Community Integration approach, in which participation, empowerment, community support and integration, social justice, and access to resources are emphasized as important (Lord et al., 2001; Piat & Sabetti, 2012). This approach to mental health is underpinned by the idea that individuals with mental health issues need to have increased control over their lives, and participate valuably in their own recovery. The focus here is on empowerment, not just being in the community, but also being a valued part of it. Furthermore, underpinning this approach is the belief that fair and equitable allocation of resources such as affordable housing, adequate income, and meaningful employment/education are essential aspects of mental health treatment. Lord et al. (2001) reveal that the usage of this model increased participation among mental health service users, promoted access to valued resources, emphasized community support and integration, and gave individuals more choice/control over their issues.

Provencher and Keyes (2011) suggest positive mental health and mental illness are not two ends of a single continuum; thus, it is possible to experience positive mental health while living with mental health issues. Positive mental health can be defined as feeling good and being resilient despite life challenges, which has been shown to improve overall health and quality of life, as well as bring social and economic benefits to society (Canadian Electronic, 2012). This is the fundamental basis of the 'Recovery' model, underpinned by the notion that a person living with a mental illness can have a fulfilling life despite living with a mental illness. Furthermore, the Recovery model emphasizes strengths-based initiatives and client-centered treatment approaches, i.e., client choice is featured centrally on the team. There are three pillars of recovery: choice, community,

and integration (Piat & Sabetti, 2012). This model involves the personal transformation of individuals with mental health issues, focusing on a positive view of self, purpose in life, relationships, and managing mental illness; unlike traditional models, it focuses on optimizing positive mental health rather than simply reducing mental health issues (Provencher & Keyes, 2011; Thornton & Lucas, 2011; Wand, 2013). The Recovery model has been offered as the ideal alternative to the biomedical model, as it focuses attention on building a meaningful life regardless of living with a mental illness, moving toward wellness, advocating for greater individual control and self-management, shifting healthcare professionals from an 'expert' role to a 'coach' role, and breaking social exclusion (McKay, McDonald, Lie, & McGowan, 2012; Thornton & Lucas, 2011).

2.2.3 Access to Mental Health Services

Mental health services are often limited and underfunded. This is partly due to the fact that stigma of mental illness is widespread in Canada, inclusive of the healthcare system; sadly, some of the people most able to help also hold negative attitudes (Kirby, 2008). In 2013, Statistics Canada reported that 1.5 million Canadians have a perceived unmet need in terms of mental healthcare (Cohen & Peachey, 2014). Access to services is often limited by legislation and policies that place set limits. What stakeholders and policymakers fail to realize is that spending less on such services consequently means spending more elsewhere later e.g., in terms of the economy and/or workplace. People with untreated mental health issues continue to seek help from the healthcare system, which is both costly and wasteful of limited resources. In fact, the estimated lifetime cost for untreated childhood mental health issues is $200 billion (Cohen & Peachey, 2014). Initiatives to increase access to care should not work simply to increase the number of

users of mental health services—they should work to increase effectiveness and responsiveness of mental health services (Chen, 2010).

In 2004, it was reported that up to 70% of issues brought to family doctors are mental health issues; unfortunately, family doctors are often not educated adequately to deal with such issues (Cohen & Peachey, 2014; Vasiliadis, Gagné, Jozwiak, & Préville, 2013). Existing mental health services are often built around the biomedical model; many remain ignorant to the usefulness of psychosocial approaches (Chen, 2010). Psychological treatment can be as effective as medication and also less expensive; psychotherapy also contributes to better outcomes in patients (Cohen & Peachey, 2014). However, coverage for mental health services of this kind is limited—both private and public health systems provide very little funding for this kind of mental healthcare coverage (Cohen & Peachey, 2014). Unfortunately, Canada does not have enough mental health service providers. A resultant heavy reliance on family physicians to address mental health issues stems from the manner in which public funding is organized and puts an unnecessary burden on them (Kirby, 2008).

A number of studies indicate that immigrants often underuse mental health services, which signifies a concern for health equity (e.g. Thomson, Chaze, George, & Guruge, 2015; Chen, 2010). A number of barriers exist for immigrants in terms of: the uptake of information and services, stemming from a lack of awareness of mental health issues and existing services; settlement experience, associated with low income and social exclusion; and inadequate culturally and linguistically appropriate services (Chen, 2010; Thomson et al., 2015; Vasiliadis et al., 2013). This is one reason why the Mental

Health Commission of Canada includes the increasing of diverse communities' access to services as one of their strategies (Thomson et al., 2015).

Even if services are available, they are not necessarily accessible (Chen, 2010).The Canadian Psychological Association (CPA) has done a lot to raise awareness about the inequities of access to care, but simply describing the problem is insufficient. Therefore, the CPA released a report on recommendations for stakeholders to make psychological services better accessible to Canadians. Cohen and Peachey (2014) also made a number of recommendations to resolve the issue of limited access to mental health services, including the suggestion that all primary care teams should include a psychologist.

As late as 2008, Canada was the only G8 country without a mental health strategy; this sparked the need for the Mental Health Commission of Canada (MHCC) to be developed (Kirby, 2008). The MHCC seeks to integrate the physical and psychological domains of mental health, and it has three initiatives: develop a national mental health strategy, combat stigma, and promote knowledge exchange. The federal government committed $15 million a year to the MHCC, but it operates at arms-length from any level of government. Moreover, the MHCC advocates for the implementation of the Recovery model, aiming to work with patients to allow them to live full lives despite living with mental illness (Kirby, 2008). It is anticipated that with the help of the MHCC, access to mental healthcare will be significantly increased for all Canadians. However, even with access to healthcare, mental health surveys conducted by the World Health Organization indicated that people often cannot agree about when treatment should be sought for mental health issues (Andrade et al., 2014). This may be partly due to the

prevalence of stigma associated with mental illness (Corrigan et al., 2014), as will be

discussed in the next section.

2.3 Stigma

2.3.1 Defining Stigma

Erving Goffman is often credited with the development of the term 'stigma'

(Stuart, 2005), defining it as an "attribute that is deeply discrediting" (Goffman, 1963,

p.3). The term has been used to explain how people who "deviate from the norm" are

often marginalized (Benoit, Shumka, & Barlee, 2010). The word stigma comes from

ancient Greece, where people were physically burned/cut to identify their inferior status;

today, rather than being physically identified, they are societally labeled (Thachuk,

2011). Stigma has been applied across a number of areas where oppression operates;

mental health, race, religion, and sexual orientation, to name a few. Stigma also occurs as

a degree – people can be connected to few or many stereotypes and these connections

can be weak or strong; thus, the degree of 'othering' and the extent of discrimination can

vary, meaning some people can be more or less stigmatized than others (Link & Phelan,

2001). Additionally, each person in a stigmatized group suffers different outcomes based

on a multitude of factors—no two people experience stigma in the same way.

Link & Phelan (2001) outlined four components that converge in their

conceptualization of stigma: people with differences are identified and labeled; labeled

people are linked to negative stereotypes rooted in hegemonic beliefs; labeled people are

placed in categories, which essentially 'other' them; and labeled people face status loss

and discrimination that robs them of opportunities. The convergence of these components

depends on a number of different social, political, and economic factors that may occur

together in a power situation. Status loss is when the status of labeled people is diminished in the eyes of the 'stigmatizers,' those who actively stigmatize individuals based on their membership in a particular group (Link & Phelan, 2001). According to Link and Phelan (2001), discrimination involves the mistreatment of people based on their membership in a particular group.

The occurrence of stigma depends on power differences (Link & Phelan, 2001). Powerless groups may develop stereotypes for powerful groups and discriminate against them but the powerful groups do not consequently become stigmatized. Only powerful groups can stigmatize (Knaak, Mantler, & Szeto, 2017). Thus, how much stigma people experience depends on how power operates. Link & Phelan (2014) introduced the concept of stigma power to describe how 'stigmatizers' use power to push people down, in, and away. The stigmatized are pushed down in terms of social status, pushed in as they are pressured to conform to hegemonic beliefs, and pushed away when they deviate from social norms. They surrender to this pushing in fear of being rejected, and subsequently fall prey to such mechanisms as modified labelling theory and stereotype threat. Modified labeling theory describes how people are raised with negative attitudes towards certain groups of people that eventually become lay theories that guide them in determining whether to reject/devalue such groups; when they then find themselves as qualifying members of such groups, they apply these attitudes to themselves, which contributes to low self-esteem, provokes anxiety, and robs them of opportunities for successful life outcomes (Link & Phelan, 2014; Link & Phelan, 2001; Phelan, Lucas, Ridgeway, & Taylor, 2014). Stereotype threat is a phenomenon in which people are

aware of stereotypes that may apply to them and avoid certain opportunities/situations in fear of confirming such stereotypes (Corrigan & Fong, 2014; Link & Phelan, 2001).

2.3.2 Types of Stigma

In his work, Goffman described several types of stigma. Perceived stigma occurs when a person assumes they will be discriminated against, consequently making several modifications to their behaviour/thought to avoid it. Enacted stigma occurs when a person is actively discriminated against (Benoit et al., 2010). Courtesy stigma, also called stigma by association, is that which is felt by family/close friends of the stigmatized person (Stuart, 2005). Goffman highlighted two main consequences of stigma: status loss and social rejection (Phelan et al., 2014). Stigma robs people of opportunities (Corrigan & Gelb, 2006; Stuart, 2005; Wahl, 2012). The literature conveys that the stigma associated with a disorder can be more harmful to an individual than the disorder itself; in fact, people can die as a result of the stigma associated with their health condition, independent of the health condition itself (Benoit et al., 2010; Stuart, 2005; Szeto & Dobson, 2010).

Decades after Goffman's initial work on stigma, three main types of stigma have been identified in the literature: public, self, and structural (Corrigan & Fong, 2014; Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012). Public stigma manifests in the discrimination that stigmatized individuals face from the general population e.g., an employer who will not hire them, a landlord who refuses to rent to them, and/or a doctor who provides low-quality care. Self-stigma, which was also described by Goffman (cited in Stuart, 2005), occurs when the stigmatized individual internalizes the public's negative beliefs and prejudices about their condition and often contributes to a 'why try' attitude

that prevents them from seeking out opportunities. Structural stigma appears, for example, in laws that may limit the rights of parents who have children with mental health issues. Because of the many negative outcomes associated with being stigmatized, individuals with a stigmatizing condition often actively work to stay away from being identified; this is what is referred to in the literature as 'label avoidance' (Corrigan & Fong, 2014). Furthermore, Wahl (2012) identified indirect stigma, which is when individuals with a stigmatizing condition are not the direct objects of attention/rejection, but they are witnesses to things that convey negative attitudes about people with conditions similar to themselves; for example, movies that portray characters with mental health issues as villains and/or violent.

2.3.3 Fighting Stigma

Three main approaches have been identified to combat public stigma: protest, education, and contact (Corrigan & Gelb, 2006; Corrigan & Fong, 2014; Corrigan et al., 2012). Protest, in the form of social activism, has sparked concerns about possible rebound effects that might worsen stigma (Corrigan et al., 2012). Studies done on the education approach, namely the distribution of books, flyers, movies, websites, etc., have shown that it does not do enough to reduce stigma (Corrigan & Fong, 2014). However, Corrigan et al. (2012) found that, when working with adolescents, education seems a more effective approach than contact, perhaps because their attitudes have not yet firmly developed and are more easily influenced. Contact, involving the interaction with people who have lived experiences of the stigmatizing condition, appears to be the most influential in combatting stigma (Corrigan et al., 2012; Stuart, 2005). Two mechanisms exist within this approach: screening videos and face to face contact, the latter of which is

the most effective, although the former is better for reaching broader audiences. For example, in their evaluation of the screening of the play 'That's Just Crazy Talk', (Knaak, Hawke, 2013) found that it was effective in improving attitudes and reducing stigma among healthcare providers. In terms of combatting self-stigma, Corrigan & Fong (2014) suggest the implementation of interventions that promote disclosure.

However, it should be noted that stigma is persistent and difficult to eliminate (Link & Phelan, 2001). There are two points to be considered when developing approaches to change stigma. Firstly, the approach must be multifaceted, to address the multiple mechanisms that contribute to stigma, and it should be multileveled, to address both structural and individual stigma. Secondly, the approach must address the main cause of the stigma; for example, by changing the attitudes of powerful groups who endorse stigma or by limiting the power of such groups. Corrigan & Fong (2014) also suggest that anti-stigma campaigns should be careful to make appeals based on parity rather than pity. In her work on fighting stigma and discrimination, Stuart (2005) made several suggestions for stigma reduction, two of which are most relevant to the current study: programs should be targeted to specific audiences, and programs should be developed based on the needs of the specific group. Using the findings from my study, these suggestions can be implemented to more appropriately cater to the South Asian population in Canada, a specific group that my study identifies as requiring anti-stigma interventions.

2.3.4 Stigma & Mental Health

The greatest barrier to treating people with mental health issues is stigma; it delays mental health reform and perpetuates a negative cycle (Stuart, 2005). More than

100 articles have been published showing that stigma is indeed a barrier to seeking treatment for mental health issues across different populations (Corrigan, 2014). In a study done with 46 patients who use mental health services, 41 expressed feeling stigma and shared anxiety about how to share information about their mental health issues. Thirty of these participants reported experiencing overt discrimination (Dinos, Stevens, Serfaty, Weich, & King, 2004). Feelings of stigma can make people feel like they deserve prejudice and are incapable of independence; in fact, this can happen even in the absence of any discrimination, provoking feelings of stress, isolation, and shame. Consequently, people may refuse to be treated and/or hospitalized for fear of further stigmatization. Dinos et al. (2004) described two types of stigma with regard to mental health issues: acts of overt discrimination experienced by those with psychotic mental health issues, and subjective stigmatizing feelings experienced by those with non-psychotic mental health issues. This is exacerbated when education about or exposure to various aspects of mental health through the media tend to have negative connotations, encouraging many to automatically associate the word 'mental' with something adverse or unfavourable, such as violence.

It is apparent that stigma, especially with regards to mental health, is universally prevalent and requires a more holistic model to address it. This is because mental health stigma seems to be connected to many different aspects of a person's life and influences a number of human experiences (Sickel et al., 2014). Attempts to eradicate stigmatizing mechanisms such as label avoidance, by framing mental health issues as a treatable physical disease of the brain, have unfortunately worked to reduce the abilities of the mentally ill, which further strengthens stigma (Deacon, 2013). Simply erasing the

symptoms of a mental health issue cannot erase the stigma associated with it (Corrigan & Fong, 2014). Even within the healthcare system, people with mental health issues can experience considerable stigma: they are often excluded from decision-making; they are threatened about coercive treatment; they endure excessive wait times; they are insufficiently informed about their condition and treatment; they are looked down upon and treated as lesser beings; they receive poorer physical healthcare; and they are not taken seriously (Knaak et al., 2017). The literature has highlighted a serious need for awareness campaigns and interventions to reduce mental health stigma, especially considering that the economic burden of mental disorders in Canada is valued at $51 billion (Szeto & Dobson, 2010). This points to the fact that stigma is present here in Canada as well as elsewhere; it contributes to the underfunding and underutilization of services. Canada has participated in various anti-stigma campaigns with regard to mental health issues, going back to the 1950s, perhaps making it the first country to commence such campaigning (Stuart, 2005). Some of these programs include: Opening Minds (Knaak & Patten, 2013); That's Just Crazy Talk (Knaak et al., 2013); Understanding Stigma; Combating Stigma; and the Working Mind (Knaak et al., 2017). In terms of approaches for stigma reduction in healthcare, it has been suggested that appropriate skills need to be taught to avoid discrimination, and social contact must be made with individuals with mental health issues. Additionally, initiatives that debunk myths surrounding mental health issues and emphasize recovery would be useful (Knaak et al., 2017).

2.3.5 Stigma, Mental Health, and Culture

Measuring stigma is complex and multifaceted and its level depends on how mental health issues are conceptualized (Ng, 1997). Cultural beliefs may play a significant role in the conceptualization of mental health and illness (Ward, Clark, & Heidrich, 2009). How groups differ in relation to stigma is missed when people are indistinctly lumped together without considering their culture of origin (Abdullah & Brown, 2011). Corrigan (2014) indicated that culture actually determines the endorsement of stereotypes and discrimination that comprise stigma; it is developed out of the stereotypes and discrimination people learn based on the cultures in which they are reared (Corrigan & Wassel, 2008). Cultural norms determine which behaviours are considered normal, which are considered odd, and which denote mental health issues (Abdullah & Brown, 2011). Additionally, inadequate knowledge and awareness of mental health within some cultural groups could also lead to cultural mislabeling, resulting in unnecessary stigmatization of individuals who do not suffer from mental health issues and impeding help for those who actually need it (Ciftci, 2013). For instance, in collectivist cultures, Asians in particular, there is almost no distinction between mind and body, thus leading to the medicalization of mental health issues (Corrigan et al., 2014; Ng, 1997); this is in contrast to Western thinking which posits the duality between mind and body, treating them as separate entities (Corrigan et al., 2014). Thus, some ethnocultural groups may prefer presenting physical symptoms instead of mental symptoms because, as Rao and Valencia-Garcia note in Corrigan (2014), "people living with mental health issues who expressed psychological symptoms experienced more stigmatization than people who expressed somatic symptoms" (p.286). Few studies

have been completed with relation to ethnicity and mental health stigma (Abdullah & Brown, 2011; Clement et al., 2015), highlighting the need for research in this area.

2.4 Culture

People of different cultural backgrounds can have different values and beliefs that inform the way they think about health; they can experience and describe mental health issues differently, which could be challenging for healthcare providers (Canadian Electronic, 2012). Before studying the impact of culture on experiences of mental health, it is important to define 'culture,' which is not an easy task (Varcoe & Browne, 2006). Unfortunately, the dominant perspective on culture is through 'essentialist' and 'culturalist' viewpoints, which use it to identify groups of people solely based on a set of shared beliefs and practices (Browne et al., 2009; Gray & Thomas, 2006). Essentialism occurs when sweeping generalizations of individuals are made based on what Gregory, Harrowing, Lee, Doolittle, and O'Sullivan (2010) refer to as "generic cultural blueprints" (p.7). This effectively and narrowly paints culture as something that is static and disregards the fact that culture is a dynamic, multi-faceted process that involves the relationship of individuals with their environments, sociopolitical, and historical contexts (Browne et al., 2009; Gregory et al., 2010). This is in addition to the popular 'culturalist' understanding that, for example, draws attention to food preferences and religious practices while failing to acknowledge the social and structural inequities that manifest in the healthcare system as a result of such narrow perspectives (Browne et al., 2012). Thus, Gray and Thomas (2006) state, there has been a move towards a critical constructivist perspective on culture that conceptualizes it as "not a list of features and characteristics to be memorized, but rather a set of complex interactions to be examined and engaged"

(p.77). This perspective would make it possible for healthcare providers to know and

appreciate the cultural backgrounds of individuals and communities by understanding

that culture is complex and multi-dimensional (Varcoe & Browne, 2006) because, as

Gregory et al. (2010) indicate, culture is then viewed as a "filter that affects how people

understand the world" (p.12). With this in mind, critical cultural perspectives will be used

as a lens in this study with an understanding that individuals express their culture

differently, based on the given situation and context and their acculturation histories.

2.4.1 Culture, Cultural Safety, Cultural Competence/Humility

Adapting to a new culture involves both culture learning and culture shedding,

occurring to varying degrees and depending on a number of factors (Ataca & Berry,

2002). Children acculturate to a new culture more readily, but parents may prevent them

from doing so because of the fear that their native culture will be lost (Kramer et al.,

2002). Young adults have been observed to adopt a dual identity as a result of the

pressures of acculturation, which affect their mental health (Rastogi et al., 2014).

Focusing on the young adult proportion of the immigrant population is a worthy

objective, given that young people are more likely to experience mental health issues

more than any other age group (Dewa, 2010). This is an important area of study because,

as previously stated, mental health is an aspect of health that is often ignored;

understanding the experiences of mental health within the immigrant population would

effectively assist in developing targeted, culturally appropriate, and safe interventions and

services for a significant proportion of the Canadian population. Research on mental

health within the immigrant population, specifically in Canada, is an area that has

received little attention in the literature. Furthermore, mental health experiences within

the second generation immigrant population seem to be an area that has not yet been explored.

Awareness of and attention to culture is important in order to understand how culture affects the formation of a person's beliefs and values; it allows people to recognize how culture influences identity, in turn conducing appropriate cultural interactions (Parisa, Reza, Afsaneh, & Sarieh, 2016; Sarieh, 2016). Key terms have been developed to address this concern, particularly within healthcare, e.g., cultural safety, cultural competence, and cultural humility.

In the past, colonialism in the West resulted, as Parisa et al. (2016) point out, in research done "on" people instead of "with" people, which is a transgression of cultural safety. The concept of cultural safety was developed in the 1980s out of interactions between healthcare practitioners and the Maori people of New Zealand (Parisa et al., 2016). It emphasizes the influence that culture has on health promotion and treatment-seeking, and the structural inequities that tend to prevent holistic care for marginalized groups in multicultural societies (Parisa et al., 2016). Cultural safety reminds healthcare professionals to be open-minded and flexible, creating a safe atmosphere in which patients need not worry about insecurity and humiliation in the presence of dominant culture in the healthcare system, and refraining from the use of stereotype checklists (Giles, Hognestad, & Brooks, 2015; Parisa et al., 2016). Additionally, it allows for the recognition of power relations and the ability to address the imbalance of power, allowing both patients and providers to develop an effective standard of care (Gerlach, 2012). In terms of research on the application of cultural safety, Gerlach (2012) advises researchers to begin by hearing out the very people who have been marginalized and to shift focus

onto non-dominant culture to better cater to participant needs (Giles et al., 2015), which is a prime endeavor of the current study – to give voice to those whose voices are often silenced – in this case, second generation South Asian Canadians.

It has become paramount worldwide for healthcare professionals to be disciplined in both cultural competence and safety (Rowan et al., 2013), especially because cultural differences may affect patient clinical outcomes (Chang, Simon, & Dong, 2012; Prasad et al., 2016). Parisa et al. (2016) define cultural competence as "the process of the development of knowledge and skills associated with attitudes and cultural awareness" (p. 36), supporting healthcare professionals to work efficiently and respectfully with multicultural groups (McEldowney & Connor, 2011). However, the efficacy of cultural competency has been questioned; healthcare professionals cannot just assume expertise in a patient's cultural background (Hammell, 2013); it is something that is explored and interpreted together with the patient to determine the ideal course of treatment (Chang et al., 2012; Hook, Davis, Owen, Worthington, & Utsey, 2013; Isaacson, 2014; Prasad et al., 2016). Further to this idea, Foronda, Baptiste, Reinholdt, and Ousman (2016) and Hook et al. (2013) state that cultural humility, developed by Tervalon and Murray-García (1998), in which the patient's worldview takes precedence (Hook, 2014), is considered to be more effective than cultural competency. Cultural humility emphasizes humbleness, respect, and openness in every interaction (Hook & Watkins, 2015) and is a process that is developed over time, reflection, and effort, incorporating a complete change in perspective (Foronda et al., 2016; Isaacson, 2014; Prasad et al., 2016). Cleaver, Carvajal, and Sheppard (2016) indicate the particular value that cultural humility has in Canada, with its rich multiculturalism yet significant inequalities in terms of healthcare,

suggesting early incorporation of cultural humility in medical education is essential. In fact, Fisher-Borne, Cain, and Martin (2015) affirmed that training in cultural humility improved health outcomes and provider-patient relationships. Conclusively, Prasad et al. (2016) insist that cultural humility, in which the dynamic nature of culture is acknowledged, should actually be a prerequisite to cultural competency.

Thus, some of the aims of this study are to inform a critical constructivist view on culture, acknowledging that it is complex and multifaceted; to shift focus onto non-dominant culture to allow individuals to express themselves in a culturally safe setting that could inform healthcare practices; to explore experiences of mental health without assuming to be well-versed in the multiple different cultural beliefs that make up the South Asian diaspora; to allow the individual's worldview to take precedence; and of course, to acknowledge the dynamic nature of culture.

2.4.2 Individualism vs. Collectivism

Some cultures can be identified as predominantly individualistic while others may be considered to be mostly collectivistic in nature. Individualistic cultures tend to emphasize the importance of personal goals over group goals, autonomy, and independence (Lalonde, Hynie, Pannu, & Tatla, 2004; Tse & Ng, 2014). In contrast, those in collectivistic cultures view the family or community as an inextricable part of themselves, focus on the rights and goals of the group, and emphasize interdependence and closeness. Members of collectivistic groups internalize the cultural values of the group, and this affects the way they interact with others (Lalonde et al., 2004). Moreover, it is important to note that there are variations in the individualism-collectivism among

different groups within the South Asian population (Tse & Ng, 2014); thus, as mentioned earlier, they cannot be viewed as culturally homogenous even in this respect.

The adoption of individualistic vs. collectivistic beliefs leads to very different views of the self (Lalonde et al., 2004). Furthermore, the degree to which a person identifies with individualistic and/or collectivistic beliefs has been shown to influence the conceptualization of mental health and help-seeking attitudes. In fact, the individualism-collectivism paradigm has become an essential concept within the realm of culture and mental health (Tse & Ng, 2014). In terms of recovery from mental health issues, both views have their pros and cons, as outlined in (Tse & Ng, 2014). Individualistic views are beneficial because they allow people to control their recovery, give them a greater commitment to recover, and provide them with the freedom to try their own wellness strategies. However, individualistic views may also hinder recovery because they may reinforce the use of individualistic approaches such as biomedical approaches and elicit little support from the extended family. On the other hand, collectivistic beliefs may help recovery by providing assistance and support from the family; however, it may also hinder recovery by exacerbating the stigma of mental health if there are strongly held negative views related to mental illness in the family and/or community of origin.

However, the literature discourages the dichotomization of individualism and collectivism; rather, some cultures may possess both individualistic and collectivistic qualities (Tse & Ng, 2014). Different cultures can have different degrees of individualism and collectivism, and this is further complicated when considering the newcomer/immigrant population. For example, the second generation immigrants in this study must deal with both collectivistic beliefs stemming from their parents' countries of

origin and individualistic beliefs that tend to dominate here in the West. Thus, they may face internal conflict as a result of being caught between two cultures (Lalonde et al., 2004). This in turn will likely have an effect on their conceptualization of mental health.

2.5 South Asians in Canada

Before exploring the experiences of South Asian Canadians, it would be relevant to understand a bit about their history here in Canada. South Asians first started arriving in Canada in the early 1900s, though immigration was limited because of restrictive laws; these laws became more relaxed in the later 1900s, contributing to a large influx of South Asian immigration, especially in Toronto and Vancouver (Tran, Kaddatz, & Allard, 2005). Ninety-five percent of South Asians live in family households, indicating the importance of family; also, among the elderly, 8% of South Asians live alone as opposed to 29% in the overall Canadian population (Tran et al., 2005). South Asian Canadians are the least likely of the visible minority groups to marry outside their group and most South Asian children learn to speak their native language first, indicating strong cultural ties. However, South Asians are more likely than other Canadians to report a strong sense of belonging to the Canadian community (Tran et al., 2005).

South Asians are a diverse group (Ashutosh, 2014; Ekanayake et al., 2012), and they are the largest visible minority group in Canada, representing at least 4% of the population (Ashutosh, 2014; Chui et al., 2008). The term 'South Asian' first appeared in the 1986 Census, and it was first identified as a visible minority category in 1996 (Ashutosh, 2014). Groups identified as South Asian do not necessarily share a common culture; they are as unique and diverse as Canada's cultural mosaic (Ashutosh, 2014). Even mainstream Canadian institutions, like art galleries and museums, tend to lump

items from South Asia into one, disregarding the political boundaries that developed after colonialism (Ashutosh, 2014). The term 'South Asian' is then quite fluid, encompassing different languages, nationalities, religions, foods, experiences, and even immigration statuses; it can be considered an oversimplification (Ashutosh, 2014). Additionally, cultural variability depends on factors such as acculturation history, socioeconomic status, and immigration (Kramer et al., 2002). There has been recent debate on who exactly should be considered South Asian, as the term itself signifies a certain homogeneity that does not accurately capture the complexity of this particular diaspora (Ashutosh, 2014). Upon entering Canada, people of certain nationalities are automatically identified as South Asian, whereas in other countries, they would be identified by their specific nationality (Ashutosh, 2014). Labeling a region of over one billion people with this single term essentially blends them all together. Considering my awareness of the heterogeneity of the South Asian population, in my proposed study, individuals originating from India, Pakistan, Sri Lanka, Bangladesh, and/or Afghanistan will be noted as being of South Asian origin.

According to a number of studies done within the Asian immigrant population, mental health often does not become a concern until after immigration (Ahmad et al., 2005), i.e., the mental health of the immigrant population is impacted post immigration and many individuals are more likely to present with physical symptoms though they may be suffering mentally (Ciftci, 2013; Kramer et al., 2002; Rastogi et al., 2014). Framing mental health in this manner, as physical symptoms, makes it difficult to communicate what could actually be mental health issues, thus impeding treatment (Bottorff et al., 2001). Continually strong ties to native culture creates a sort of cultural

distancing (Ekanayake et al., 2012) that may prevent understanding of mental health. Additionally, stronger ties to native culture indicate less positive attitudes towards counselling (Miville & Constantine, 2007). However, increased contact with the host culture indicate more presentation of psychological symptoms rather than physical ones (Rao et al., 2007), highlighting an increased recognition of possibly underlying mental health issues post-migration. Additionally, Fogel and Ford (2005) indicated that lower levels of acculturation in the new country resulted in greater stigmas of mental health and this stigma was more pronounced in the presence of family members than friends or employers. Some treatment barriers that were identified, in a study on the perceptions of clinicians who work with South Asian patients, were stigma and denial; loss of confidentiality; sensitivity to medications; overly involved parents; and limited finances (Rastogi et al. 2014). Additionally, a lack of understanding of available resources after immigration deters treatment seeking (Ekanayake et al., 2012).

2.6 Research Questions

As indicated by the literature review above, there is an apparent lack of education about mental health that results in the development of stigmatizing beliefs surrounding mental health. It has been shown that culture also plays a role in producing these stigmas. The multiple identities that second generation immigrants develop as a result of conflicts between native and host cultures (Lalonde et al., 2004) provide an interesting avenue for research as it remains to be determined whether this particular group would seek help for mental health issues, the origins of stigma, and how they deal with their conflicting identities when it comes to their understandings of mental health. This study will be applied to South Asian Canadians, considering they are the largest visible minority group

in Canada, thereby focusing attention on a group that may often be overlooked when advocating for mental health literacy though they make up a significant proportion of the Canadian population.

Thus, my proposed research questions are:

i) How do second generation South Asian Canadians define and experience mental health?

ii) What are those factors that shape/influence understandings of mental health and the development of mental health issues?

iii) How do they maintain mental health?

CHAPTER THREE: Methodology and Methods

The goal of this research inquiry was to explore the experiences of mental health in second generation South Asian Canadians. The questions that were addressed in this study include: i) How do second generation South Asian Canadians define and experience mental health?; ii) What are those factors that shape/influence their understandings of mental health and the development of mental health issues?; and iii) How do they maintain positive mental health? In order to answer these questions, recruitment posters were distributed to South Asian Canadians in the Greater Toronto Area. Interested and eligible participants were then asked to participate in individual in-depth interviews, from which data were collected and analyzed using Dr. Sally Thorne's Interpretive Description approach as described below. In this chapter, I will describe the research design used to conduct this study; my position as the researcher; ethical considerations for this inquiry; the setting and participants of this study; data collection and analysis procedures; and scientific rigor of this study.

3.1 Research Design

A qualitative research approach was used to conduct this study, under the philosophical paradigm of interpretivism. Specifically, the methodology employed was Interpretive Description (Thorne, 2008). I used a method in keeping with this approach, i.e., individual in-depth interviews. Rationale for this approach is provided below.

3.1.1 Qualitative Research

A qualitative approach was an appropriate methodology to answer the research questions. Quantitative research is unable to address the subjectivity of human experience and capture the way in which it affects the understanding of mental health, failing to

provide useful interventions in this aspect (Rice, 2009), particularly in relation to the questions posed in this study. The use of qualitative research is also beneficial to the participants involved in the data collection because it provides individuals with the outlet needed to speak up and report on their experiences, in turn shedding light on how the experience under study is understood in different ways by different people (O'Day & Killeen, 2002). As Wolgemuth et al. (2015) point out, this type of research provides participants with the opportunity to discuss issues with someone; reflect on themselves; become educated about the experience or phenomenon of interest; connect with others based on shared experiences; advocate on behalf of a community or cause; and help someone who might be in their position in the future.

Qualitative researchers collect data from multiple sources including interviews, observations, and audiovisual information. The researcher focuses on how participants make meaning out of their experiences (Creswell, 2014) and it allows for a holistic account of the phenomenon being studied. Thus, I as the researcher was the main instrument of collecting data that was descriptive and focused on participant experiences and how they make sense of their lives. I have attempted to understand the multiple realities that exist concerning the phenomenon (Creswell, 2014); in this case, I examined the experiences of mental health with second generation South Asian Canadians.

3.1.2 Interpretivism

The philosophical paradigm that informs my work is interpretivism in which individuals seek to understand the world they live in and make meanings out of their experiences (Creswell, 2013). Specifically, in this study, I looked at how second generation South Asian Canadians develop their views on mental health through their

interaction with others who share some aspects of their culture. The manner in which they develop their understandings of mental health as a result of their experiences, how they define mental health, is essentially what an interpretivist viewpoint entails. Within this paradigm, I sought to make sense of the meaning that the participants have about the world and acknowledged that their interpretation is a result of their own experiences (Creswell, 2013).

3.1.3 Interpretive Description

An interpretive description was the methodology of choice for this study because it allowed for a better understanding of those complex factors surrounding the conceptualization of mental health within the second generation South Asian Canadian population. Critical cultural perspectives informed my approach to this topic. According to Varcoe and Browne (2006), this includes the notion that culture is complex and "a relational aspect of ourselves that shifts over time depending on our history, our past experiences, our social, professional and gendered location, and our perceptions of how we are viewed by others in society" (p.166). As discussed earlier, it has been argued that there is a need for us to shift our understanding of culture from the dominant essentialist perspective to a more critical one that highlights structural inequalities in healthcare dynamics (Harrowing, Mill, Spiers, Kulig, & Kipp, 2010). Additionally, this approach acknowledges the heterogeneity within groups as well as the similarities apparent across groups (Gustafson, 2005). Using this framework allows healthcare providers to identify opportunities for change that can better cater to unique patient needs (Gray & Thomas, 2006).

Interpretive description draws from the work of Dr. Sally Thorne and includes aspects of three popular qualitative methodologies: ethnography, grounded theory, and phenomenology (Brewer, Harwood, McCann, Crengle, & Worrall, 2014). Additionally, this iterative approach is ideal in circumstances in which themes can be discovered in subjective experiences (Gibson, Henderson, Jillings, & Kaan, 2013); in this case, subjective experiences of South Asian Canadians were captured through the use of interviews. This was an inductive approach in which I as the researcher identified codes from obtained data and developed these codes further into themes as the data collection and analysis proceeded (Brewer et al., 2014). In this methodology, there is an acknowledgement that knowledge is co-created between researcher and participant (Brewer et al., 2014). Most importantly, in this study, this information could be used to advocate for increased cultural safety/humility within our healthcare system; thus, an interpretive description was ideal for this study because it places importance on clinical applications (Brewer et al., 2014).

3.1.4 Individual In-Depth Interviews

Data was collected in the form of one-on-one, in-depth, individual interviews with seven participants. Considering this small sample size, it is important to note Thorne (2008) points out that interpretive description can be conducted on essentially any sample size, and that most studies that utilize this approach are relatively small, usually including between five to thirty participants. Furthermore, conducting a small-scale interpretive description study such as this one is justified as long as I as the researcher acknowledge that there is always something more to study, that there is no such thing as reaching saturation of data collection. Interviews lasted about thirty minutes to one hour in length,

with about six open-ended questions and associated probing questions. Interviews were digitally recorded and transcribed with the consent of the participant. Before the questions were asked, participants had the opportunity to tell me a little bit about themselves and what motivated them to participate in the interview. This activity was used as an ice breaker to help increase participant comfort level and enrich insights provided during the interview thereafter. Open-ended questions were used to elicit the views and opinions of participants (Creswell, 2014) without too much interference from myself as the researcher. Individual interviews were useful in allowing me to guide the line of questioning and ideal for when participants cannot be directly observed (Creswell, 2014). When participants were not articulate or perceptive, it was important for me to address assumptions, values, and beliefs in my field notes, following the lead of participants as they unraveled their experiences. I, as the qualitative researcher, also listened actively, occasionally clarifying and checking for understanding as interviews proceeded. This was done in addition to acknowledging my role as the researcher at the beginning of the study. Participants were recruited and interviewed over a period of approximately three months. How and where participants were recruited is discussed later in this chapter.

3.2 Researcher's Positionality

In qualitative research, it is important for the researcher to acknowledge their role in the study and how it shapes the direction in which the study proceeds (Creswell, 2014). The researcher acknowledges their background, including past experiences with the phenomenon of interest, being explicit about how these experiences shape interpretation of data (Creswell, 2014). This is important because the experience of my participants is

also shaped by their encounter with me as the researcher; I affect and am affected by the phenomenon I wish to understand (Anderson, 1991).

As the researcher, I firstly acknowledge that I am a South Asian Canadian, similar to the participants in my study. The phenomenon of interest became important to me and worth studying as a result of a number of personal experiences I had recently. I was approached by a person very close to me to discuss their mental health issues and to inform me they had started to seek counselling. This individual made me promise to keep this information from their family; it was so disheartening to see a respected and reputable adult in such a vulnerable and fearful position. It made me wonder whether this was because of his native cultural beliefs he had brought with him upon immigration to Canada. On another occasion, I met with a couple whose child clearly seems to have a developmental disability or mental health issue; this was apparent to me with the little education I received on these topics with a minor in psychology during my undergraduate studies. But these parents refused to discuss or even acknowledge this crucial revelation, preventing their child from receiving possibly life-changing intervention. This was particularly interesting because they were initially open to getting help; however, after a single conversation with their own parents, they seemed to have changed their minds. Also, over the summer during a coffee date with a friend, she mentioned how she tried to discuss the concept of depression with her father, who simply responded, "Our people don't have those problems" with a dismissive wave of his hand. My friend's desire to discuss mental health issues was not shared with her father, who is an immigrant to Canada. These incidents provoked my thoughts on what mental health means to people in my community. Through these personal experiences, it was clear to me that a piece of the

puzzle in understanding this phenomenon was missing and, through my thesis, I hoped to find it. My personal experiences indicate that quite often people defer to the beliefs imposed on them even though it may be detrimental to their well-being. I want to do something about this and help to change the understandings around mental health. It was alright to be unsure of what I was looking for as that was a part of my role as a co-participant, looking to construct knowledge with others. As indicated earlier, I came to this study with a particular definition of mental health. However, I was not sure this would be the same definition my participants were going to give me. It was important to continue to revisit my research questions throughout my study so not to lose sight of this original intent.

3.3 Ethical Considerations

In order to protect the rights and confidentiality of participants, certain safeguards were exercised. The objectives of the study were provided to participants both verbally and in written form. Explicit written consent was obtained from participants prior to the start of the data collection process. Participants were provided with a copy of the signed consent form. Ethics approval was sought from the Research Ethics Board at the University of Ontario Institute of Technology; approval was received on October 27, 2016 (REB# 14106, see Appendix A). Participants were informed of the use of all data collection devices such as digital recorders and access to the data. Transcripts of interviews were made available to participants. Additionally, when transcribing data, participant identifiers were masked with pseudonyms to preserve anonymity. Acquired data was stored in a password-protected personal laptop computer that was kept in a secure and locked location, accessible only by the researcher. Participant ethical rights

are paramount (Brewer et al., 2014) and as many precautions as possible were taken to guarantee participant confidentiality.

3.4 Setting

Individual in-depth interviews were conducted in private study rooms available at a public library. This was to ensure that participants were in a comfortable, safe, and relaxed environment and that noise level was at a minimum.

3.4.1 Recruitment Criteria & Sampling

Data was collected from individuals living in Canada with South Asian immigrant parents. To be considered second generation Canadian, participants must be born in Canada with at least one parent born outside Canada (Dobson, Chui, Maheux, 2013). Participants were 18-30 years of age. Purposeful sampling was used; that is second generation South Asian Canadians who could answer the research questions were engaged in this study. A total of seven in-depth interviews were conducted. Though sample sizes for qualitative interviews are often small, they tend to provide richer insights into social phenomena because of the complex data that is acquired (Bowling, 2014). Participants were recruited through the distribution of flyers and word-of-mouth at locations where South Asian Canadians frequently visit: South Asian grocery stores, religious institutions, universities, social media websites etc. Once participants were recruited, they were provided with a complete overview of the research process and asked to sign a consent form to collect data in confidentiality before including them in the study. Considering my congruent identification as a South Asian, I was easily able to establish trust and rapport with participants based on familiarity and relatability.

Participants included in this study were of South Asian descent; living in Canada to parents who immigrated from a South Asian country; were 18-30 years of age; and were able to speak English. Additionally, because mental health was the topic of discussion, individuals who were cognitively impaired were not included in this study as they would have been unable to provide informed consent. The term South Asian included individuals originating from Afghanistan, Pakistan, Bangladesh, India, and Sri Lanka. Those who contacted the researcher for recruitment were screened for eligibility based on these criteria.

3.5 Data Collection

Data collection and analysis procedures for an interpretive descriptive approach are relatively flexible (Brewer et al., 2014). At the outset of the study, eligible participants were informed of the aims of the study and the researcher, and they were guaranteed confidentiality of data provided. Each participant was asked a brief set of questions about demographics i.e., gender, ethnicity, education, religion, etc. Interviews were audio recorded with participant consent so it could be later analyzed; this allowed for me to attend to the participant more closely without being intrusive and is consistent with what Bowling (2014) states, encouraging them to talk freely about their feelings and experiences. Meanwhile, I recorded key phrases/words mentioned with pen and paper. Additionally, a field journal was used to record personal reflective thoughts and feelings throughout the research process, especially during and immediately after each interview was conducted. This also included notes about my opinions (as the researcher) and the participant's non-verbal cues. Examples of interview questions included: What does the notion of mental health mean to you? If someone close to you had a mental health issue,

how might you respond? How do you think other people in your community understand

mental health? What do you see as those factors that influence mental health? And what

do you feel are important factors for maintaining mental health? Probing questions were

used to obtain further information and expand on the answers provided to these questions.

In alignment with an interpretive descriptive approach, participant comfort levels were

consistently observed and ongoing informed consent was conducted (Brewer et al.,

2014), giving them the opportunity to reconsider their answers if needed. At the end of

each interview, a transcript was made available to the participant to allow for them to

validate the data that was collected and contribute to the trustworthiness of the data. Each

participant was identified with a unique pseudonym in place of their names to preserve

confidentiality.

3.6 Data Analysis

Data analysis occurred simultaneously with data collection, as is the norm with

interpretive description (Gibson et al., 2013), and qualitative research in general

(Creswell, 2014). Interview data was first transcribed verbatim and viewed holistically

before proceeding to code data by hand (as opposed to the usage of computer software).

A line by line analysis of each interview transcript was then conducted, after which a

summary sheet was developed consisting of an aggregation of main points identified

from all transcripts in combination. During this initial overview of data, broad narratives

and relevance to the phenomenon of interest were explored (Gibson et al., 2013). This

information was used comparatively with subsequent emergent themes and patterns.

Codes were created by piecing together similar data and making connections between

related ideas that emerged from the interview data. Before analysis, transcribed data was

matched with audio recorded data to ensure accuracy. Field journal notes were also added

to each interview transcript. Patterns and themes were then identified and described as

understood from participants' perspectives; these were developed out of clustering the

codes that were created upon analysis of the transcripts. Individual transcripts were

compared with each other to assist in developing coding templates and identifying similar

themes. Once I had a more defined set of themes, I extracted quotations from individual

transcripts that could be categorized under these themes, to assist me through the writing

of my findings. With interpretive description, in order to minimize unintended effects of

my preconceptions, the written reflection on my role as a researcher was compared to

analyzed data to ensure that findings were not preconceived (Brewer et al., 2014).

3.7 Scientific Rigor

In qualitative research, evaluative criteria include the concepts of transferability,

credibility, dependability, and confirmability (Creswell, 2013). These are the four main

criteria for trustworthiness outlined in Guba and Lincoln (1982). Credibility can be

defined as confidence that the findings are accurate, and in this study, it was established

through the use of audio recordings and verbatim transcripts, essentially establishing

integrity throughout the research process. Peer debriefing was conducted in which my

research supervisor examined the entire research process in consultation with the research

committee as appropriate. Transferability is ensured through the process of examining

how well the findings can be applied in other contexts and was upheld through the use of

purposive sampling and the engagement of rich descriptions during the data collection

process. Methods used have been described in detail, and evidence that is contradictory to

previous findings will also be presented in a later chapter. Dependability has been

achieved by maintaining an audit trail and indicates that the findings are consistent and can be replicated. Lastly, confirmability relies on the fact that the findings of the study are based on respondent data and not on researcher motivations or interests. This criterion was met through the continuous use of reflexivity on my part as the researcher by maintaining a field journal throughout the research process. With regards to researcher reflexivity, it was important to constantly and critically reflect on my own thoughts and feelings to address possible assumptions and biases in order to maintain honesty in my data. Thus, I acknowledged my role as a researcher and provided a self-reflection through journaling and note taking, as indicated earlier, to clarify my position in relation to the phenomenon.

Specifically for an interpretive descriptive approach, value is placed on the clinical application of the knowledge obtained from participant subjective experiences. Using this approach I attended to the context in which the research occurred, in this case South Asian culture; acknowledged that the researcher and participant influence one another; acknowledged that human experiences are socially constructed; and continued to be aware of participant comfort levels, conducting research in the setting most suitable to the participant (Brewer et al., 2014). I, as the interpretive descriptive researcher, focused on four main evaluation criteria: i) epistemological integrity, i.e., that the research question is consistent with the epistemological standpoint and the interpretive strategies used; ii) representative credibility, i.e., that the theoretical claims are consistent with the method used to study the phenomenon; iii) analytic logic, i.e., that I provided explicit reasoning for how the research proceeded and made the decision making process

accessible; and iv) interpretive authority, that I acknowledged reactivity that occurred

during the research process (Thorne, 2008).

CHAPTER FOUR: Results

In this chapter, I present the findings collected from my analysis of interviews conducted with second generation South Asian Canadians regarding their understandings of and experiences with mental health. Several themes emerged from the data analysis: mental health stigma; mental health literacy and its intersections; living in the in-between space; access to primary care; the role of stress in developing mental health issues; the importance of staying positive; and community participation in mental health awareness. I begin the chapter by providing an overview of the participant demographics and definitions of mental health provided by my participants.

4.1 Demographics

Seven participants were interviewed for this study (3 males and 4 females). Median age for participants was 22 years. The highest level of education completed by most participants was a university undergraduate degree (n=5); one participant had completed a Master's degree and another participant had completed a high school education. Most participants expressed their current occupation as students (n=5); one participant had a full-time job and another was unemployed. Most participants identified a religious affiliation to Islam (n=5); the two other participants were Agnostic and Hindu respectively. Nationality of participants were split among Sri Lanka (n=3), India (n=2), and Pakistan (n=2). All participants reside in the Greater Toronto Area; regions of residence were split among Toronto (n=3), Durham (n=2), York (n=1), and Peel (n=1). See Table 1 for a summary of demographics.

Gender	Male = 3
	Female = 4
Age	Median = 22 Mean = 22.4
Highest level of education	High School = 1
	Undergraduate = 5
	Master's = 1
Current occupation	Unemployed = 1
	Student = 5
	Working full-time = 1
Religious affiliation	Agnosticism = 1
	Hinduism = 1
	Islam = 5
Parents Country of Origin	India = 2
	Pakistan = 2
	Sri Lanka = 3
Region of Residence	Durham = 2
	Toronto = 3
	York = 1
	Peel = 1

Table 1: Demographics

4.2 Defining Mental Health

When asked to define mental health, a few participants associated mental health with something negative, assuming at the outset that 'mental health' is a reference to the presentation of issues that impede one's functioning. For some participants, there was some initial confusion and possible miscommunication on the usage of terms that had to be clarified. One participant had the following response when asked to define mental health: "To me it means like a variety of things. So like anxiety, stress, and disorders, like mental disorders, eating disorders and all that stuff" (Martha, L13). Another participant responded similarly: "Basically…like a chemical imbalance that causes you to not…be able to have control over your actions or maybe…not act in a way that a sane person would" (Noora, L24). Participants tended to define 'mental health' in terms of illness. When clarifying that I was thinking about 'mental health' more broadly as an individual's mental well-being, one participant responded with the following,

> Of course. Fair enough, fair enough, fair enough. And I would rather talk about it like that, but…I've been thinking of it in my mind as mental health issues. Because…like the word, issue, is negative in itself. Connotation, right? And that's the, me being South Asian, maybe that's why I say it like that… (Peter, L81)

The participant is explaining here that his South Asian heritage may be the reason for his framing of 'mental health' as an umbrella term for what he actually considers 'mental health issues.' This could be one of the many manifestations of the stigma associated with mental health to be discussed later in this chapter. Other definitions provided by participants for mental health frame it more positively, as a resource for managing stress, as one participant stated: "being able to control your emotions and deal with stress" (Noora, L30). Similarly, another participant discussed mental health as the ability to cope with stress,

> We live busier, busier lives, more and more stress…there's more and more pressures in the world. If there's so much more going on, how can you as an individual cope with what's going on in the world and keeping your mind and soul happy, I guess. (Peter, L156)

These definitions generally are in keeping with the World Health Organization (2014) definition of mental health, "as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." Another participant defined mental health differently as follows,

> It's making sure that your brain is operating at the best capacity that it can. Make sure that…you don't have different…things weighing on your mind constantly…It's making sure that you're in the right state of mind to be able to make decisions that ultimately impact you. (Ruben, L12)

Here the participant had defined mental health in keeping with the traditional biomedical approach, emphasizing the singular role of the brain when assessing mental health.

Another participant described mental health as: "I'm thinking of mental health is um, being able to live independently without anyone's, uh, assistance in like, you know, normal everyday cognitive function" (Kevin, L14). In a similar vein, another participant expressed mental health as: "Um, I feel like mental health really has to do with experiences, emotions, or has to do with, um, psychological stuff…things that impact the way you think" (Angelika, L38). Cognitive function and its association with emotions also was identified as an important factor when thinking about mental health.

In a slightly different vein, another participant framed mental health as a spectrum ranging from good to bad,

> So, good mental health, like I would say…you're just like at peace…Bad mental health, I would say that it's just--you're not--it's like to a point where you can't really cope with life. So--it's just, you're on one side of the spectrum…you don't have that balance… (Rebecca, L12)

In this study, mental health was defined in a number of ways, however, several of the participants did see mental health as the way in which an individual adapts in response to coping with life experiences and emotions to attain a sense of balance, a peace of mind. Participants also noted that an inability to sympathize with someone who has mental health issues further stems from stigmatizing beliefs held about mental health issues among the South Asian community, discussed in the following section.

4.3 Mental Health Stigma

Several participants pointed out that the discussion of mental health issues is something that tends to be avoided in the South Asian community because of an associated stigma. As one participants notes in the following,

> They would, uh, try to cover up as much as possible. Because it brings a bad reputation in the community and then, no one would give you job, you will lose

relatives. People will talk behind you and then, um, you'll have issues with like marriage, education, and other things (Kevin, L60).

Concealment of mental health issues often was attributed to shame and fear of reprisal within the community that can have serious consequences. Another participant speaks further to concealment processes in the following, "telling somebody that they're depressed…you didn't talk about that…it was just this silent agreement that, you know, nobody would speak about [it]" (Ruben, L100) and went on to say, "we haven't spoken about it since I gave them the diagnosis…nobody outside my family knows about this" (Ruben, L576). Another participant notes, "that happens a lot back home. Once a person is deemed to be suffering from any mental issues, they are just kept, you know, inside the house, isolated rather" (Kevin, L237). Here the participant speaks to the isolation of people with mental health issues by their own family in their country of origin; a practice that continues in many immigrant families here in Canada today. As another participant explains in relation to his brother, "my parents are very embarrassed to take him out…they'll [South Asian community members] ask…'is there something wrong with him?' And my parents are like 'no, no, no, it's nothing, it's nothing.' Like, they try to ignore it and hide it" (Peter, L213). Another participant notes,

> You don't want to seem weak in front of other people. You want to look like you have everything together all the time. So nobody wants to like be vulnerable and admit that they have issues that they're dealing with or they're going through a hard time in their life. Instead, they want to make sure, make people think everything's perfect. (Noora, L132)

Mental health stigma in this study was reflected in the strong sense of shame and fear of reprisal on the family (loss of face, jobs, relationships etc.) that led people to hide mental health issues/illness within the family; this leading to isolation of the family member. Showing vulnerability and admitting to having mental health issues/illness would,

according to participants, result in being labeled in the community; this fear of labeling and possible reprisal also was described as common in the South Asian community by participants in this study.

4.3.1 Fear of labeling

A participant in the study describes the fear of labeling in the following,

> if that particular member is suffering, then the other members of the family who are not suffering from the mental health issues, could be, in the future they could have problems as well. So we need to, you know, be careful with the whole family (Kevin, L245).

Here the participant points to labeling as something with consequences for the entire family. Another participant elaborates on this further in the following, sharing an analogy to describe this circumstance:

> So if I were to see someone…have a schizophrenic episode, okay? Um, and now everyone thinks that he's the village crazy, he's just crazy, you know, there's something wrong with him. Now if I notice that my own child…is having even mildly, like you know, schizophrenic episodes, I'm scared that other people are going to know. And then, like you know, label my child as an outcast or I might get angry, why are you behaving that way? Why are you acting like that guy, you know? Um, so I might punish my child or I might treat my child in a way that's going to cause him or her to implode even further because, instead of getting support, my child might be constricted more, you know. Just so they're not labeled as an outcast as well. (Angelika, L254)

This analogy points to 'the why' of the fear of labeling; however, it also points to the consequences of attempting to conceal a mental health issue/illness. In a similar vein, another participant explains,

> if I were in that situation, I'd probably hide it because I just don't think that their solutions would work for me. Like if they're labeling it as something else, then they're going to, like make me go through all these things that are not necessarily the solution... (Rebecca 112).

Participants viewed that stigmatizing beliefs about mental health issues are more

common among their parents' generation; a belief leaving this participant feeling that she

would not disclose a mental health issue to avoid negativity and ineffective solutions.

Another participant notes, "it would just put like a little asterisk next to my name if they

knew" (Ruben, L630), again underlining the possible negative impact of sharing this

information.

Participants also noted mental health issues often are associated with 'being crazy' in the

older generation. As one participant shares,

> When a person kind of acts this way, they're being weird. You know back home, I
> feel like people get, um, they're considered outcasts instead. It's just labeled
> differently, you know. Or people react to it differently, especially when there's
> severe cases of [mental health issues], they'll think it's like, um, you know, are you
> possessed or something? Oh, you know, you're just born weird, there's something
> wrong with your genes...They get like labeled as an outcast. (Angelika, L227)

and another participant explains,

> "[the older generation] doesn't see it as something like it's an actual mental illness.
> They'll just be like, oh we just see them acting not sane or acting not like a normal
> person so I guess they're crazy. (Martha, L140)

Many participants noted mental health is associated with 'being crazy' by many in the

older generation in the South Asian community; another factor that fuels mental health

stigma. Participants in this study explained the fear of labeling as associated with the fear

of possible consequences for the entire family and that this fear leads many to keep

mental health issues to themselves, rather than sharing with the family. A network of

unique elements contributed to the process in which the people in this study developed

their understandings of mental health and what it encompasses, as discussed in the next

section.

4.4 Mental Health Literacy and its Intersections

When discussing general views on mental health prevalent within their communities and amongst their parents, participants noted a general lack of understanding of mental health. One participant blatantly stated, "I don't think they [the South Asian community] understand it at all" (Angelika, L118). As another participant explained,

> I just feel like mental health itself is not something that's specifically discussed. You might learn a little bit about it in your curriculum [at school], but they don't actually discuss it. It's just not a topic. (Angelika, L18)

Participants indicated there is a general lack of discussion or attention to mental health in the South Asian community. One participant describes this further in the following,

> I think a lot of people just assume that mental health just means, oh you're feeling sad. Okay, well go do something and like make yourself happy. They just think there's such simple solutions to it. They don't understand that it goes so much…deeper…so that's what it is, just lack of knowledge, lack of understanding. Um, they just think that whatever they've seen, like the physical manifestation of illnesses is the only thing that can exist. (Angelika, L83)

Here, the participant speaks to an observed perception that mental health lacks legitimacy in the South Asian community—physical health takes primacy. Another participant goes on to speak about this in the following,

> I have seen first-hand that my parents have had no idea how to deal with it. Like absolutely, it is completely like foreign to them, not only is it taboo but all the things that you would, um, uhhm, just expect from like South Asian parents, they don't think it's a thing. Like it's just like completely foreign to them. (Peter, L8)

This participant spoke to his parents' perception of mental health as a "taboo" topic in the context of speaking of his brother's struggle with mental health issues. He went on to say, "[my parents] were like no, no, no, he'll fix himself in like a year. Just don't worry about it and they never took it seriously right" (Peter, L14). Similarly another participant

notes that parents tend to have a "pick up yourself from your bootstraps sort of mentality" (Ruben, L14), implying that mental health issues are challenges that must be overcome by one's individuals efforts. The same participant elaborated further on this idea in the following,

> It's very direct, it's very, you know, hey shape up, what's wrong with you, or they'll tell you, you know, go do this, go do that, they'll be very specific, very blunt about it… They would've just said, uh, do the regular old, uh, you know. Study harder or go to sleep earlier or stop watching TV, or you know, just the regular basic treatments. Like my dad couldn't believe it. He was just like what. And, uh, my mom threw holy water at me [laughs]. This was before the diagnosis. Because I was just miserable and staying home all day. (Ruben, L565)

Here the participant speaks to his parent's understandings of mental health issues as aligned with perceived incompetence or laziness. Generally, participants were clear that there was a limited understanding of mental health and that it was a "taboo" topic in the South Asian community.

Participants discussed a number of factors that played a role in the development of understandings of mental health: cultural preconceptions; age and generational differences between parents and children; and acculturation experience.

4.4.1 Cultural Preconceptions: Attitudes towards Mental Health in South Asia

Participants in this study associated attitudes towards mental health as shaped or influenced by 'cultural norms' in their country of origin. As one participant notes, "I think here, people are a little bit more aware of what mental health issues are, but back home, they probably maybe don't even have the resources to find the information because, you know, they have to worry about just paying the bills and surviving" (Noora L322). Here the participant identifies understandings of mental health as shaped by

economics and associated priorities in their country of origin. Another participant

elaborates on this in the following,

> …in a country where the doctors that are there are focused on, you know, things like tuberculosis and, uh, measles, you know. You want to prevent people from dying off. There's not much of a focus on preventing people from, you know, undergoing anxiety and depression. I'm sure it's there. I'm sure people are suffering from it, but it's hard to find help, and because it's not as, it's not a well-known issue. (Ruben, L181)

Participants noted that treatment of disease tends to take priority over mental health

issues in South Asia – perhaps related to the prevalence of the biomedical model.

Another participant goes on to say,

> I just feel like a lot of people don't know it. And it's not like it's a purposeful, it's not like it's intentionally shut out of the education system, right? …I just kind of feel like mental health wasn't one of the topics, they never called it mental health (Angelika, L220).

A lack of prioritization of mental health and resultant absence of education about it and

the lack of resources in their country of origin suggests a significant paucity of mental

health literacy in South Asia. This is reflected in another participant interview excerpt as

follows,

> A lot of the times, they don't consider, they don't even consider depression as, because I know my grandma, specifically, she said depression is not that big in Sri Lanka. But I think it's just not known. It's just not open. Like people just don't think about depression as existing. (Rebecca, L102)

The lack of existence of attention to mental health in their country of origin creates what

participants view as a conflict with, and inability to, discuss mental health with parents

[and grandparents] born in South Asia. Another participant speaks to this again in the

following,

> It was definitely a taboo topic back home right. So, they've carried that here. If you were having this interview with someone from my parents' generation or

someone from my parents' camp, they would have no idea what the purpose of this conversation is. (Peter, L298)

Again the prevalence of the biomedical model and associated marginalization of mental health issues and the lack of mental health literacy in their country of origin have contributed to views of mental health as a "taboo" topic that have been carried with many individuals who immigrate to Canada from South Asia, as another participant notes, "it's not something that they were exposed to back home. So that's carried, they carried that with them here" (Angelika, L127). Here the acculturation experiences of immigrants and age intersect to influence how mental health is understood.

4.4.2 Age and Generational Differences

Age and generational differences in relation to understandings of, and the approach to mental health, were raised by several participants. As one participant notes, "my siblings, they're around my age so I can relate to them. I can talk to them more easily than I could with a parent" (Martha, L103). Another participant noted similarly, "I guess because [family], they sometimes brush it off. And they'll be like, oh no, you're just going through a phase. So, with friends, I think they might take you a little more seriously" (Noora, L102). A few participants stated they would have difficulty discussing mental health with their parents, instead preferring to discuss mental health with individuals similar in age such as friends and siblings. Another participant further elaborates,

> If you're not exposed to something at a younger age, it's just hard to accept. Because, you know, you have 30-40 years of…very conservative-minded values and this whole notion of mental health   and you can get help for mental…that's a new concept that a lot of older, people in the older generation just haven't accepted. (Ruben, L89)

Here the participant speaks to the long-term acculturation experiences of a population regarding mental health. He goes on to discuss his grandparents and their approach to mental health in the following, "Honestly, they'd just be more confused than anything else. They'd just be like what. He looks fine. What's wrong with him?" (Ruben, L665). This inability to discuss mental health due to generational differences intersected with acculturation experiences to shape/influence understandings of mental health.

4.4.3 Acculturation Experience

Acculturation experience was noted by several participants as a central influence regarding understandings of and approaches to mental health. As one participant notes, "You can have people that are much older that were brought up here or spent more time in North America or the western world, who are more susceptible to the awareness and like internalizing it" (Peter, L291). Aside from age gaps, participants perceived that people who had been living in North America longer were more likely to have increased mental health literacy and awareness. Another participant went on further to note,

> With the current second generation, um, because we're the people that were most exposed to this sort of thing in school. So we know a lot more about this issue than a lot of our parents who frankly, if you tell them, they won't really believe it. (Ruben, L47)

Second generation South Asians, with Canadian education experiences, were perceived to have a different understanding than their parents. Similarly another participant notes, "my parents grew up there and got raised there so they have that mentality, where they grew up. Versus here, we kind of know more about it, like Canadians" (Martha, L120). In the same vein, another participant notes, "Well, my parents have been through the school system here…but if they hadn't, I probably wouldn't want to bring it up with them"

(Rebecca 135). Differences associated with acculturation experiences are further explored

in the following interview excerpt,

> I was raised more like individual kind of view, that an individual's life is more important, but my parents have like a group view, like a family view. So they think, you know, do whatever's best for the family. So if it's best for the family that you don't talk about your problems and you kind of hide them away or deal with them by yourself, then you do it. Just so that, you know, it doesn't look bad on the family or something. While I think it doesn't matter what people think. You want to take care of yourself before anyone else. (Noora, L155)

Acculturation differences also were described in terms of individualist vs. collectivist

understandings as associated with the philosophical underpinnings of North American vs.

South Asian societal norms. Several participants noted central differences in

understandings of mental health and mental health literacy as associated with differences

in acculturation experiences across the South Asian population.

4.4.4 Education and Exposure to Mental Health Issues

Education and level of exposure to mental health issues were perceived by

participants to be key factors in the development of mental health literacy and positive

responses to mental health. As one participant notes, "like if it was my son, like I'd be

proud, like he's my son, sure he has a mental health issue, but um, we're dealing with it"

(Peter, 231). This participant's response is in opposition to his parents' response who,

when confronted about his brother's mental health issues, were avoidant and dismissive.

Another participant elaborates on the Canadian experience in the following,

> So the second generation, my friends you know, people in university, high school, they understand this full well. Because this is, you know, it's in the curriculum, it's being taught, um, we see it daily, you know. Like, we all know somebody who's going through some sort of mental issue. (Ruben, L133)

Other participants shared this sentiment that, in comparison to their parents' generation,

they were more educated about mental health as a result of receiving more formal

education and exposure. Another participant speaks to this further in the following, "those who have achieved more high school education and above, would tend to have, uh, ideas that mental illness is something that happens and it's not a result of a person sinning or anything" (Kevin, L107). Here the participant points to the importance of education in the support of mental health literacy and a consequent shift in attitude regarding mental health and illness. In contrast, people born and raised in South Asia who did not receive formal education before immigrating to Canada were perceived subsequently as not being equipped to deal with the ability to identify mental health issues (e.g., Angelika, L137).

Without education regarding mental health, many people have limited understandings of and potentially negative responses to mental health and illness. A participant speaks to this in the following, "they just put that…blame on that individual and saying that they're not like doing the right things, they're not maybe praying enough" (Rebecca, L184). In a similar vein, another participant explains, "When [South Asians] see a person suffering from mental issues, they immediately blame his lifestyle. Something is wrong that he's doing. His lifestyle and habits are not good so that's why probably he's suffering. That's what they think" (Kevin, L80).

However, participants also noted another side of this narrative, as follows in a participant interview excerpt, "They are becoming more aware of it..it's more in your face because they're hearing more and more about situations, um, where kids are not totally of mind, I guess" (Peter, L273). He went on to say, "Now, my parents have an idea because of my youngest brother" (Peter, L304). Another participant also states, "people in my family, they've had, they've gone through it, mental health issues, so now

they like, now they're more aware, my family's more aware…" (Rebecca, L208). This is elaborated further in the following,

> I've seen and I've felt it myself. So that's why, when I see someone else struggling, I don't just dismiss it and say oh, it's okay, like you know, you'll get better tomorrow. Because these issues that have taken so long to accumulate, they're just not undone in a span of a couple of days. They can take forever sometimes, or sometimes it's never. They're never resolved. Um, so I think just from personal experience (Angelika, L93)… "…eventually, they'll feel it, whether within themselves, within their family, or within their friends circle. They're going to come across it. Um, and maybe that'll spark to them to like know about it. (Angelika, L468)

Despite the lack of education regarding mental health and illness for some, there have been changes in perception of mental health and illness based on a personal experience with mental health issues.

Participants in this study spoke about education as an important aspect of mental health literacy and a positive response to mental health issues; however, they also spoke about personal experience as shaping/influencing understandings of mental health and responses to mental health issues. One particular experience that second generation South Asian participants in this study described as influential to their views on mental health was that they live in the 'in-between space'; a place between experience, values and beliefs—South Asian and Canadian.

4.5 Living in the In-Between Space

A conflict between the generations of parent and child were identified, creating what will be termed as an in-between space which second generation South Asian Canadians find themselves inhabiting. This space arises as a divide between first generation immigrants who have transplanted their beliefs and values here from South Asia and the second generation who have been raised and educated with Canadian beliefs

and values in addition to the South Asian values inculcated via their parents. As one

participant notes, "it's very hard for people to seek help through their parents" (Ruben,

L46) because of this divide. Particularly when discussing mental health and associated

issues, participants felt like they were unable to connect and share information with their

parents. With regard to his own mental health issues, one participant noted that "it's not

something that we openly discuss about because there's this understanding that…if you

have any problems with yourself…make some prayers, you know…and then you'll be

okay" (Ruben, L107). Later, he indicated that when he was experiencing symptoms of

mental health issues, he did not go to his parents, instead informing them he "was just

going through a routine health checkup" (Ruben, L493) when he consulted with a doctor.

One participant provided the following example:

> especially in South Asian culture, if you're the eldest son in the family, you have a
> ton of expectations thrown on to you…the son is not really interested in upholding
> these expectations…and does some things that the parents completely disagree
> with…And it's constantly affecting the relationship the parents have with that child.
> And now this child kind of feels isolated, doesn't feel like he's getting a lot of
> support, but he has to live now in this household with these same parents all the
> time. And that kind of like, you know what I mean, it kind of like adds to the stress.
> (Angelika, L352)

Here, the participant indicated that children are forced to question themselves and worry

they are disappointing their parents because of expectations that parents hold as a result

of their immigration to Canada for a better life for their children. These expectations, as

another participant suggested, contribute to an inability to strike up a conversation with

parents about mental health issues. Another participant voiced a similar view when she

suggested, "they expect you to follow their own mind-frame of what religion is and also

about career. Maybe they think only certain careers that have a level of…respect

attributed to them are acceptable" (Noora, L53). One participant describes, "the younger

generation are very good at keeping things under wraps…there's a lot of cases of people breaking away…and becoming…more westernized…but it's…kept hidden. So I feel that even something like [mental health issues] would be kept hidden" (Ruben, L209). Here, the participant voices his perception that children of South Asian immigrants are perceived to conceal things from their parents, noting that mental health and associated issues are one of the topics that would be avoided in conversation with parents. According to their responses, several participants perceive that the issues with living in the in-between space are exacerbated by the pressure to succeed in academics and careers because of their parents' immigration context, which also affects their mental health.

4.5.1 Pressure to Succeed

Several participants shared that parents in the South Asian community often place pressure on their children to perform well in academics. One participant noted, "I find that in the community…the pressure that parents put on the children in academics and that has brought on like depression…kids are not going to class or yeah, just not themselves anymore" (Peter, L95). Here, the participant perceives that these pressures affect mental health as well as behaviour. Another participant elaborated on this point when he said,

> you don't push yourself to the limit that you know that you can go to because you're scared that if you fail, you're not good enough, and that leads to that whole…cycle of, I'm not good enough, I'm a failure to my parents…my parents brought me here so…I can get a good education. Am I going to disappoint them… (Ruben, L34) …There's this…expectation amongst our community. Especially with my age, you know, you have to be strong in your academics, you have to get into a good university, you know. You can't just end up doing some nonsense degree because then, what's the whole point of us coming to this country in the first place? …parents are constantly, you know, telling you about these success stories…thinking that they're motivating you…it comes with good intention, everyone wants to see their child succeed. But sometimes they just don't realize the

effect that's having on the kids…they're so focused on…making sure that we succeed, that they don't really pay attention to sometimes their own mental health and sometimes the effect that this pressure is putting on us. (Ruben, L254)

Here, the participant discussed the negative cycle of self-doubt that he believes children often find themselves in because of the pressures placed on them. He also suggested that this pressure to succeed stems from parents' immigration to Canada, their feeling the need to be successful, the need for their immigration to have been worthwhile, and that this success is sought through their children. Thus, he believes children are expected to perform well in academics and to work toward what are deemed to be respectful careers. Later, he mentioned,

It's like they're betting everything on their children…parents have sacrificed a lot in immigrating, uprooting themselves" (Ruben, L280)…You feel that feeling of worthlessness because it's like, I'm not doing something they want me to do…and your parents' lack of approval can impact you negatively. It may make you lose your confidence and your self-worth (Ruben, L370).

Here, this participant noted that parents feel they have the right to uphold these expectations of their children because parents left their country of origin to provide a better life for their children. He suggested that when a child's chosen academic and/or career path does not match with his/her parents' expectations, feelings of worthlessness and self-doubt can lead to mental health issues. Another participant expressed a similar position when he indicated that "you have competition in like education, job, career…if, at any time, a person seems that he's unable to…be ahead in the competition…issues that arise from, you know, a lack of self-confidence or self-esteem can lead to issues in…mental health" (Kevin, L155). Another participant noted, "they're all like, who has a better car, bigger house, more wealth…they have a very idolized view of my family because we've all done relatively well. So it's like where are, where can we get…the weaknesses, the faults" (Peter, L251). Here, these participants provide a possible

explanation for the reason parents may place pressure on their children to succeed and

consequently consider immigration to have been a success. They noted that individuals

who have immigrated to Canada tend to develop competition amongst themselves,

explaining that competition to be considered as successful immigrants places pressure on

their children to succeed, which then compels the second generation to live in an in-

between space, unable to connect with their parents. These participants believe that this

then leads to, not only symptoms of mental health issues as a result of the pressure, but

also an inability to discuss mental health issues with parents, as discussed earlier.

Because of this absence of conversation with parents about mental health issues, several

participants shared that the family doctor is often the first contact in discussing mental

health and getting help for mental health issues, which outlines the significance of access

to primary care as discussed below.

4.6 Access to Primary Care: relationship, trust, and credibility

In terms of seeking help for possible mental health issues, most participants

highlighted that their primary point of contact would be their family doctor, as one

participant stated,

> it takes that trained eye…it took an expert to get me to realize that, yeah, I was
> going through some issues" (Ruben, L471)… "it's never fun to receive…a
> random chat from…a person that you're not comfortable with, inquiring about
> your mental health. It feels, you know, it's pretty invasive" (Ruben, L197).

Here, the participant explained that it is important to have a positive, trusting relationship

with someone before sharing information about mental health. Similarly, another

participant indicated the importance of rapport with the family doctor: "it always helps to

go back to a doctor that's known you for a very long period of time…I feel like a doctor

is easily able to pick up that…this may be an mental health issue" (Angelika, L107). One

participant suggested, "we have to bring the conversation and the one to initiate that could be the family physician" (Kevin, L291). Here, this participant indicated the family doctor is the one most capable of initiating the conversation on mental health that seems to be so difficult to establish in the South Asian community. With regard to his family doctor, another participant noted,

> like in hindsight, the questions he was asking me, he was teasing me into it…from him I was able to go through some counselling from school…he gave me the legal documents and medical documents so I could go to a counsellor with…something legitimate…after the doctor told me, then I was able to, I told my parents…I knew for a fact that he wouldn't overstep doctor-patient confidentiality. (Ruben, L536)

Concerning his own diagnosis with depression, this participant shared that his family doctor's support was the most substantive in dealing with his mental health issues and even helped him share the diagnosis with his parents, with whom he was having difficulty connecting. As described here, the participant expressed confidence in his family doctor's ability to help him. Earlier, this same participant articulated that, "even though the parents are more traditional minded, the word and the value of a doctor is still important to them" (Ruben, L127). Here, this participant identifies that the family doctor is also a valuable resource to his parents. This is similar to when another participant shared that her father went through a period of depression and "the first person he went to was [their] family doctor" (Angelika, L208). In order for the family doctor to be viewed as the primary contact in the event of issues with mental health, several participants suggested that a trusting relationship and credibility had to be established first. One participant stated, "to be honest, like I'm not fully…confident in his abilities and what he's doing…I feel like…there's incentive for him to continue the services…we just don't feel like he is properly trying to get him out of this vicious loop" (Peter, L194). In the

absence of this rapport, this participant expressed doubt when sharing his experience of getting help for his brother's mental health issues. Here, the participant mentioned that it felt like the physician dealing with his brother's case was acting out of incentive, implying a sense of distrust and perceived incompetence. Thus, accessing primary care as the first point of contact for mental health issues was observed to be contingent upon the establishment of a positive, trusting relationship with the physician. Next, I will discuss participants' perceptions of the role that stress plays in the development of mental health issues.

4.7 Stress: Having Too Much on Your Plate

Participants expressed that a combination of personal, societal and environmental factors contribute to the development of mental health issues. One participant indicated that being overwhelmed and having "too much on your plate" (Peter, L337) with pressures stemming from a variety of contexts like "pressure from friends, pressure from significant other, pressure from parents, academic pressures" (Peter, L337) contributed to the development of mental health issues. Another participant explained, "you can give the person all the medicine in the world and…they'll never get better" (Rebecca, L230), if an individual is influenced by such social factors. Another participant indicated that, "having too much work and not being able to balance it with your real life" (Noora, L39) could contribute to mental health issues. Some examples provided by participants included: "maybe having a boss that's really hard on you or having co-workers that you don't get along with" (Noora, L39); "living in poverty...facing discrimination…bad family relations" (Rebecca, L27); and "a high intensity stressful job" (Rebecca, L280). These are examples of pressures that could be placed on an individual that could affect their mental

health. One participant pointed out, "you're constantly worried about paying off stuff" (Martha, L176)… "[they] want to escape from that stuff because [they] don't want to like deal with it" (Martha, L192). This participant explains here that unemployment could cause stress and prompt an individual to consider ways to escape the stress. Another participant expressed a similar sentiment when she shared that, "if you're living in poverty, you'll always be stressed out so you can't provide food for yourself and your family...it could have a physiological effect because you…can't afford food" (Rebecca, L38). This participant made a connection between physical health, explicitly having access to food, and mental health. She later explained how having an inadequate food supply could affect mental health in that the body becomes strained physically with improper nutrition, preventing the achievement of goals and resultantly causing discontentment. Another participant also identified poverty as a contributing factor to mental health issues when she described that, "if you're in a lower income family…you're more likely to live in an area where [there are] less opportunities for jobs" (Noora, L181). In a similar vein, one participant noted, "when you feel that you're not good enough" (Ruben, L250), indicating the possible feelings of incompetence that come with not being able to secure a meaningful job.

This participant also noted that "it causes stress when a relationship is strained" (Ruben, L315), suggesting that these feelings of incompetence could also arise within the home environment. One participant identified, "an environment where they've been constantly put down" (Angelika, L43). Here, this participant shared the example of living in a dysfunctional family, where there is enduring tension because of constant disagreement between family members. Another participant discussed siblings who are

"doing really well and you're struggling and you can't go to them because you think your parents are favouring them more than you" (Ruben, L321). Here, this participant identifies that sibling rivalry could also create this tension and dysfunctionality. Another participant shared the sentiment that family functionality is important when she pointed out that "family kind of teaches you how to deal with your first…exposure to people. So they teach you how to deal with social situations and stress. And if your family…isn't stable, then it's probably going to impact your mental health" (Noora, L188).

A participant mentioned that "being alone makes you think a lot" (Ruben, L438). Here, he identified loneliness as another contributing factor to mental health issues. Along a similar vein, another participant described how people "put away social life…family and friends…if they're staying in their room all the time…they're not socializing…that makes them…alone all the time" (Martha, L24). Here, this participant is referring to academic pressures producing feelings of loneliness because having a lot of homework, or a significant workload, could provoke people to isolate themselves and minimize socialization.

One participant indicated that "society accepts certain parts, like as normal, and certain things as not normal…if you fall into like the category of having certain characteristics that are not normal…you might face anxiety" (Angelika, L313). Here, this participant identifies societal contexts, pointing out that pressures to conform to society's expectations can trigger mental health issues. Another participant furthered this point with an example: "maybe if you committed an act and like people in your community frown upon it…wherever you go, people are always judging you" (Martha, L216). One participant provided the following analogy:

> Sometimes maybe if you live in an environment that's unclean…if I'm somewhere where I mentally associate as being a very dark, negative place…my mentality, if I were to stay in that place for a long period of time, it kind of grows dark itself" (Angelika, L287).

Here, this participant identified the role of the environment in the development of mental health issues, providing an example from her own experience living in an unkempt environment for a few months and believing it negatively affected her mood and outward personality.

Another participant suggested that his brother's mental health issues "might not have come out if he hadn't used {drugs} as much" (Peter, L351), perceiving drug use to be a contributing factor to mental health issues. Another participant elaborated on this, explaining that drugs cause an imbalance of chemicals in the body causing individuals to attribute happiness to their drug use and consequently becoming depressed or anxious in the absence of drug use (Noora, L62).

One participant explained that "seeing everyone near you die and stuff…it's just not normal to see that so it makes [people] feel like they're always in that moment, where they have to fear for their lives" (Martha, L203), suggesting that war-related circumstances can provoke the development of mental health issues.

Another participant shared that "they [the South Asian community] think depression is a sign of possession, like I've heard that a lot" (Rebecca, L99), identifying paranormal possession as a common perceived cause of mental health issues in the South Asian community.

One participant noted that an "accumulation of different experiences" (Angelika, L49) can lead to mental health issues, a sentiment that is shared with several other

participants who acknowledged that there are a number of different contributing factors to the development of mental health issues. Similarly, participants also identified a variety of perceived approaches to maintaining mental health, as discussed in the next section.

4.8 The Positive Mind as the Healthy Mind

Participants shared a number of approaches to maintain good mental health. One participant mentioned, "I try to do things that I like to do" (Peter, L361), similar to another participant who recommended doing "things that are rewarding to you" (Ruben, L353). Other participants also shared this sentiment: one shared the importance of doing "something that you do for yourself that you like to do (Rebecca, L299); and another spoke about "finding activities that you enjoy" (Noora, L204). Here, these participants suggest doing activities that are pleasurable and rewarding is a perceived approach to maintaining mental health. One participant provided the example of having a pet "so they kind of…relieve some tension or stress" (Martha, L244). This participant viewed having and caring for a pet as a rewarding activity.

Another participant mentioned, "keeping a positive mind and…feeling a sense of belonging" (Peter, L361)… "some of the basic…needs…for human beings…to feel like they're part of something" (Peter, L365). Here, this participant speaks to the importance of maintaining a positive mind and a sense of belonging. Comparably, one participant noted, "having good friends and family around you" (Noora, L204) and another participant suggested, "having a good relationship with family…contributes to happiness" (Rebecca, L286). These participants recommend socializing with others as a way to maintain mental health. Another participant provided an explanation for this

approach when he shared that socializing allows you to "share your feelings or express your…emotions" (Kevin, L144). Further to the approach of keeping a positive mind, one participant discussed, "having a positive view on life…not letting little things bring you down too much…like your bus is late, or you didn't get a promotion…just trying to have hope that things will get better and not just giving up" (Noora, L204).

One participant stated, "structure can be very good for a person's mental health, and religion is structure...a primary form of counselling. Through religion, seeking God, puts you at ease for all your issues" (Ruben, L419). Here, he identifies the role that religion can play in maintaining positivity. He suggested that the older generation in his community actually consider religion as a primary form of counselling. Another participant also mentioned, "having hope in God" (Noora, L218), so this may be a common sentiment in the second generation as well.

One participant suggested, "if you see someone struggling, and you kind of go help them even though you're going through issues on your own, it…makes you feel better inside, that you've done something for someone" (Angelika, L399). Here, this participant speaks to the value of helping others who are struggling, which she believes can positively affect mental health.

One participant stated:

> You have to be challenged…if you start to stagnate, that's when these issues start to bubble up…you start micro-analyzing every little thing…if you're not doing anything, If you're sitting at home every day and not going out, in your room…browsing the Internet all day…you're far more prone to experience[ing] some mental health issues. (Ruben, L341)… "working towards something" (Ruben, L358).

Here, this participant specified the importance of setting goals in order to maintain an active mind. Similarly, another participant suggested, "something to wake up to the next day, something to work toward" (Rebecca, L308)…"if I didn't have a goal in life, I'd just wonder…why am I living…just having these kind[s] of thoughts that just [make] you depressed" (Rebecca, L314). This participant also speaks to the significance of goal setting in maintaining an active mind.

One participant noted, "you should exercise your mind just as you exercise your body" (Noora, L235). Here, she drew a connection to physical health and its link to having an active mind, which in turn is perceived to prevent the development mental health issues. Another participant described, "if you're maintaining your body, if you're taking care of it, automatically, you'll feel stronger inside…like your immune system's better…if you maintain your…physical health, then it definitely makes an impact" (Angelika, L412). This is similar to the perspective of another participant who suggested that "if you have poor physical health…if you're always tired, then it's just going to stop you from doing things that you like…and then that could make you unhappy" (Rebecca, L326). Thus, a connection was made by several participants, linking physical health to mental health, with the maintenance of physical health perceived as an approach to maintaining a positive mind.

After discussing these various approaches to maintaining positivity, participants shared strategies for the community to come together to share this information and increase general mental health awareness among South Asians, which is discussed in the next section.

4.9 Community Participatory Approaches

Several participants were of the understanding that there is a general lack of mental health awareness in the South Asian community and they suggested a few strategies the community could implement to increase such awareness. One participant suggested, "conferences…teaching youths and seniors about like mental health and why [it is] important" (Martha, 276) and similarly, another participant suggested, "information session[s] about mental illnesses…what the symptoms are, and the reasons that people have [mental health issues]…educat[ing] them that…it's something that could happen to anyone" (Noora, L254). These participants provided strategies to promote awareness in the form of campaigns hosted by the South Asian community. One participant pointed out that South Asians are "always meeting up with each other…organizations that are frequently visited by the community…[should] host awareness campaigns or let other people do awareness campaigns in their spaces" (Angelika, L434). Here, she explains that these awareness campaigns should be hosted by South Asian community centres because community members often congregate at such locations.

One participant suggested that an awareness campaign should be held as a "cultural event, like a celebration" (Noora, L271); similarly, another participant suggested that people "dress up in like…cultural clothes and come out to a hall and have dinner and celebrate…the awareness of [mental health]" (Peter, L264). These participants noted that awareness campaigns in the form of social events would be more favourable to community members. As another participant pointed out, "it's a social event, right? So if people are coming, they'll be like, oh hey you want to come? And then their friends will come or their family will come…word of mouth…families and friends can talk about it

amongst each other" (Rebecca, L352). In a similar vein, one participant noted that it would be "easy to sneak [mental health awareness] in instead of if people find out it's only for mental illness, they're probably like, oh, let's not go to that" (Noora, L271). Here, this participant explains that hosting awareness campaigns as social events would make it easier to bring up the topic of mental health, instead of hosting an event focused solely on mental health, which she assumes community members would not be interested in attending, perhaps associated with the perceived paucity of mental health literacy apparent in the community.

One participant discussed the importance of getting

> "community leaders on board…talking more about mental health issues and incorporating it more into their lectures" (Angelika, L473)…"everyone kind of has like a favourite speaker or a favourite lecturer…if you get more high profile people on board, it really helps" (Angelika, L475).

Similarly, another participant pointed out the importance of

> "having the community come together [to provide these] resources" (Rebecca L377)…"if we have more people in our own communities providing these resources…we can come from our own place and provide those services, that are more understanding of what our community needs" (Rebecca, L391).

Both these participants spoke to the idea of getting community members, specifically leaders, to participate in raising mental health awareness in the community, presumably because community leaders have greater rapport with the community and are more understanding of what the community requires in terms of development.

One participant noted that "the most important thing is to bring the dialogue" (Kevin, L316). Another participant suggested that "people who have mental illnesses and they know it…should try to speak up even though it's hard. So that they can help other people who aren't able to do it" (Noora, L243). These participants believe the dialogue

on mental health awareness is a key strategy that must be initiated from within the South Asian community.

One participant stated that when South Asian community members are "able to see the facts, see the statistics and like the actual cases and hear about them…that has a huge impact. Because it creates acceptance, that these things are actually happening" (Angelika, L425). She perceived these campaigns as necessary for the community. Another participant explained,

> When it comes to talking about others, [South Asians] are very curious…If you give examples in the community, they would be interested…they would be curious as long as you're talking about somebody else. They would be interested in finding out" (Kevin, L308).

Here, this participant describes how he perceives that members of the South Asian community are often curious about others, suggesting that providing real examples from within the community would spark interest in increasing mental health awareness.

One participant mentioned that people "could have like a mental checkup that you should also go to, maybe once a year" (Noora, L292). Another participant suggested that doctors perform a type of "informal screening...to make an individual feel more open, and more safe, and more confident that he can share everything regarding his mental health issues" (Kevin, L284). These participants recommend additional strategies for increasing mental health awareness through the healthcare system, providing examples such as informal screening and annual mental health exams. One participant also advocated for "services offered in like the major South Asian languages would be amazing" (Peter, L137), suggesting the diversification of the healthcare system to cater better to the needs of South Asian Canadians. On a similar note, one participant provided

an example of a South Asian doctor who "understands their culture and therefore when people go to her, it's easier to talk about issues because she would understand what kind of upbringing they've had or where they're coming from" (Angelika, L491). Here, this participant alluded that the inclusion of healthcare providers of South Asian descent may help raise mental health awareness because they are able to connect better with patients. However, another participant shared that he preferred a doctor who "went to school in Canada" (Ruben, L521)…[doctors] from South Asia…brought their beliefs with them" (Ruben, L525). Here, this participant expressed a contrasting thought to those of other participants, implying that doctors of South Asian descent were more likely to have internalized the stigma associated with mental health that seems to be common in the South Asian community; this, he felt, would make them less suitable to deal with mental health issues in the South Asian community.

In summary, a total of seven participants were interviewed for this study, all of whom provided their own definitions of mental health, understandings of which have been developed through a network of unique elements. Several participants noted a general lack of understanding and discussion of mental health in the South Asian community, with physical health taking primacy over mental health as well as the discussion of mental health being viewed as a taboo topic. A number of factors were observed to contribute to these understandings of mental health in the South Asian community, including cultural preconceptions; age and generational differences between parents and children; and acculturation experiences, including education and exposure. Several participants noted a stigma associated with mental health is prevalent in the South Asian community, contributing to a perceived fear of labeling, and that this stigma

is more common among the parent generation. A few participants also discussed that second generation South Asian Canadians live in an in-between space, which contributes to an inability to discuss mental health with parents as well as a perceived pressure to succeed in areas such as education and employment. Some participants noted that the family doctor is often the first point of contact to discuss mental health issues, and all participants agreed that there may be several causes for mental health issues, including personal, societal, and environmental factors that contributed to pressure and feelings of stress. Participants shared a number of approaches for maintaining mental health including doing activities that are rewarding and keeping a positive, active mind. To increase mental health awareness in the South Asian community, several participants suggested that the community should host awareness campaigns, possibly framed as cultural or social events, not solely focused on mental health awareness, that would attract attendance and spark interest. Some participants agreed that mental health awareness should start from within the community. With regard to improvements that could be made in the healthcare system, a few participants suggested annual mental health checkups and a diversification of health services to better cater to South Asian mental health needs.

In the next chapter, I will discuss a number of concepts that were extricated from the results of this study, making connections with the available literature in order to elaborate on them and suggest future implications for research and clinical practice.

CHAPTER FIVE: Discussion and Conclusions

In this chapter, I discuss and interpret the significance of my results in addition to providing implications for clinical practice and education as well as future research. The purpose of this study was to explore answers to the following questions: How do second generation South Asian Canadians define and experience mental health?; What are those factors that shape/influence their understandings of mental health and the development of mental health issues?; and how do they maintain mental health? In this study, I used a qualitative methodology and methods to seek answers to these questions. Below, I discuss some of my major findings and enrich them further with the available literature: the stigma and discrimination associated with mental health and how they tend to arise from cultural norms; the scarcity of mental health literacy within the South Asian community; and the importance of positivity for maintaining mental health. Then I discuss some of the limitations of my study before providing a summary of my major findings. Finally, I conclude by highlighting a number of implications/recommendations in terms of education and clinical practice.

5.1 "An asterisk next to my name": the Stigma of Mental Health

Participants were in agreement that there is a considerable level of stigma stemming from cultural beliefs about mental health prevalent in the South Asian community that negatively impact help-seeking behaviours for many in this population; a finding that is corroborated in the literature concerning the South Asian population (Abdullah & Brown, 2011; Arora, Metz, & Carlson, 2016; Bignall, Jacquez, & Vaughn, 2015; Han & Pong, 2015; Patel & Shaw, 2009). In fact, one participant in my study recognized that he frames mental health solely in the context of issues, disregarding the

idea that there is such a thing as good mental health —that is, in his mind, the words 'mental health' have an automatic negative connotation. This stigma is perceived to elicit several negative attitudes and behaviours in community members such as avoidance, dismissal, isolation, fear of reprisal, and shame. For example, one participant spoke of how his brother, who was diagnosed with mental health issues, was being kept hidden from relatives by his parents who were in persistent denial that anything was wrong with him. His parents believed that the 'issues' would resolve themselves eventually on their own. Another participant spoke of the belief that individuals with mental health issues are perceived to simply be going through a phase of sorts; their issues are dismissed as trivial. Similarly, in their study of mental health help-seeking behaviours among Asian American community college students, Han and Pong (2015) explained that mental health is often overlooked in Asian communities despite the prevalence of mental health issues.

Participants in this study noted that this tendency to avoid/dismiss the existence of mental health issues is possibly related to a perception of personal failings e.g., the inability to obtain a decent job, get married, or even be a productive member of society; this is consistent with the findings of Abdullah and Brown's study on the relationship between mental illness stigma and cultural beliefs (2011), citing that "an inability to bring recognition to the family for achievements may also lead to stigmatization" (p.941). Similarly, none of the participants in a study on mental health stigma (Ciftci, 2013) would be willing to marry a person with mental health issues; only half were willing to socialize with them, and even less would consider a close relationship with a person with mental health issues. Concealment was preferred to avoid seeming vulnerable or weak in

front of others. This is consistent with several studies in the literature whereby the disclosure of mental health issues was reported to be attributed to shame and weakness to the family, thus resulting in the concealment of mental health issues and refraining from using mental health services (Arora, Metz, & Carlson, 2016; Karasz et al., 2016).

Another belief identified by a few participants is the understanding that the presence of mental health issues is an indication of supernatural possession. Findings in a study on mental health help-seeking behaviours among Asian Americans (Han & Pong, 2015) as well as another study on mental health stigma in ethnic minority communities (Knifton et al., 2010) correspond to this, stating that some Asians believe mental issues to arise from possession by demons, spirits, and other such entities. As one participant in my study explained, sharing the existence of mental health issues would consequently place an asterisk next to his name—he would be labeled for life. With this labeling comes a source of shame that is subsequently perceived by the community to affect the entire family of the individual with mental health issues. Similarly, Han and Pong (2015) discuss the notion of loss of face and status as a manifestation of the negative reflection of mental health issues. The notion that the stigma associated with mental health issues becomes attributed to the entire family of the individual in question is also described in Larson et al. (2010) and further identified as 'courtesy stigma' in Corrigan et al. (2014), where family members are victimized because of their association with an individual who has mental health issues. Thus, in an effort to avoid being shameful or associated with being crazy, concealment, and isolation in more extreme cases, has become the cultural norm. This finding was also reported in the extant literature as the tendency for problem avoidance and social withdrawal as primary coping mechanisms in Asian Americans, as

opposed to seeking professional help which is often considered to be an exacerbation of shame and disgrace (Han & Pong, 2015; Kovandžić et al., 2011; Roberts, Mann, & Montgomery, 2015). In fact, Ciftci (2013) pointed out that shame is so extreme in some cases that "fathers would blame mothers for giving birth to a child with mental illness" (p.22).

Some participants in my study perceived the community's solutions for mental health issues as ineffective, with one participant providing the example of his mother throwing holy water at him to presumably rid him of his mental health issues. These ineffective solutions and stigmatizing beliefs are contributing factors to the views of several participants in my study that, in addition to a preference to conceal mental health issues, they are conclusively unable to discuss mental health with their parents. Similarly, clinician participants in a study conducted by Rastogi et al. (2014) observed that young South Asian patients were uncomfortable discussing issues with parents because of concerns about being labeled as crazy. Moreover, witnessing others in the community being discriminated for mental health issues further discourages individuals from acknowledging and sharing the existence of their own mental health issues; thus they are unable to sympathize and relate with those similarly afflicted. This is comparable to Gilbert et al.'s (2007) concept of 'stigma consciousness,' described as the fear of being associated with a socially stigmatized group, and Ciftci's (2013) discussion on label avoidance.

Several participants in my study observed that such South Asian cultural norms surrounding mental health are more common among their parents, first generation South Asian immigrants who have carried these beliefs with them from their countries of origin.

The adherence to these cultural beliefs is thought to be associated with a general lack of education regarding mental health resulting from a lack of access to such education and related resources. This will be discussed further in the next section.

5.2 A Lack of Mental Health Literacy: Explaining the Stigma of Mental Health

Participants in my study noted that there is a limited understanding of mental health in the South Asian community, with little to no emphasis on mental health literacy. Several participants noted that physical health takes primacy over mental health. As discussed earlier, this framing of mental health issues as physical health issues seems to be connected to stigma and understandings of mental health that have been carried over from South Asian countries of origin. Such framing tends to be preserved even after immigrating because mental health stigma is present here in Canada as well.

Some participants also mentioned that this could be the case because there is apparently little emphasis or prioritization of mental health in South Asia, with mental health awareness being shaped by factors such as economics. In addition, stigmatizing attitudes toward mental health is pervasive among decision-makers as well. Because mental health literacy predominantly falls within the realm of preventative care, which tends to take a backseat to medical care in developing countries, it is often underfunded. Participants suggested that impetus is placed on medical care rather than using a preventative approach, with a focus solely placed on physical manifestations of disease, indicating the prevalence of the disease or biomedical model. For example, in a qualitative study examining clinician's perceptions of South Asians seeking mental health services, Rastogi et al. (2014) reported that a participant recognized his preference to describe mood disorder as "an overactive nervous system." This is consistent with a

considerable number of findings in the literature with South Asian populations, that they often interpret their symptoms as somatic and report them as such, commonly remaining untreated or undiagnosed as actual mental health issues (Arora et al., 2016; Karasz et al., 2016; Ng, 1997; Patel & Shaw, 2009; Rastogi et al., 2014; Roberts et al., 2015). Kovandžić et al. (2011) coined a term for this behaviour, calling it "silent suffering" when participants described psychological distress but did not identify as having mental health issues. Patel and Shaw (2009) further report that this tendency for somatization of symptoms often results in an underrepresentation of Asians in statistics related to mental health help-seeking.

In connection with this lack of prioritization and associated cultural norms, participants in my study acknowledged that their parents often had ineffective solutions for dealing with mental health issues, such as suggestions to simply go to sleep earlier, study harder, stop watching TV, and pray more regularly. This demonstrates the general view that mental health issues arise as a result of individual choices rather than possible neurochemical imbalances, consistent with findings in a literature review conducted on mental health and stress among South Asians (Karasz et al., 2016), where depression was viewed as an outcome of a combination of personal, familial, cultural, and social circumstances. Thus, in keeping with what has been reported by several authors, the low perceived need for utilization of mental health services appears to be related with the manner in which mental health is conceptualized (Arora et al., 2016; Karasz et al., 2016; Larson et al., 2010; Na, Ryder, & Kirmayer, 2016; Nguyen, 2011; Patel & Shaw, 2009; Williams, Lindsey, & Joe, 2011).

Findings in my study presented level of acculturation as another possible reason for second generation South Asian Canadians to hold views about mental health different from their parents. In a study on family functioning and parent-adolescent acculturation (Crane, Ngai, Larson, & Hafen, 2005), it was found that immigrant parents retain cultural beliefs encompassing the notion of interdependence while their children become influenced by Western ideals about independence. This was also noted in a study on differential acculturation between immigrant parents and children (Khaleque, Malik, & Rohner, 2015). Similar findings are made in my study where some participants noted that Canadian social values are of an individualist nature as opposed to the collectivist norms found in their countries of origin, a conflict between the two types contributing to different belief systems about mental health; this is also consistent with findings in Caldwell-Harris and Ayçiçegi (2006) who suggested that "research on individualism and collectivism provides a framework for exploring the intersection of culture and mental health" (p. 332). In South Asia, emphasis seems to be placed on maintaining the family's reputation; you always do what is best for your family, not for yourself. This is comparable to findings in Han and Pong (2015) that describe how "Asians from collectivist cultures often view individual success and failure (e.g., having mental health problems) as a reflection on the larger group in which an individual belongs, such as family" (p.9), contributing to increased stigma of mental health issues, which is similar to views put forward by Gilbert et al. (2007) and Corrigan et al. (2014). In fact, the tendency to report somatic symptoms as opposed to psychological ones, as mentioned above, may be relevant to this as well (Karasz et al., 2016). As Karasz et al. (2016) explain, South Asian communities are collectivist, emphasizing family harmony and

obedience to the elderly, which may provoke people to suppress feelings of stress and more often report symptoms as somatic in nature. Seeking actual mental health services would be considered as a shortcoming on the part of the family and thus only sought as a last resort (Gilbert et al., 2007; Han & Pong, 2015; Ng, 1997). Relatedly, South Asians with greater levels of acculturation into Western culture tend to adopt Western diagnostic models that are more individualistic and focus on biological mechanisms of illness (Han & Pong, 2015; Karasz et al., 2016; Khaleque et al., 2015; Patel & Shaw, 2009; Rastogi et al., 2014). Additionally, Papadopoulos, Foster, and Caldwell (2013) comparably highlight that people in more individualist cultures tend to be less stigmatizing of mental health issues. They postulate that this is because individualistic cultures are fragmented and thus more likely to tolerate diversity, as opposed to collectivistic cultures where there is less fragmentation and anything deviating from the norm is readily pointed out, motivating families to conceal the existence of mental health issues and subsequently refrain from accessing mental health services. However, this explanation seems to be insufficient in explaining the mental health stigma that is also prevalent here in Canada, a western country where individualism is prevalent. This is exemplified by the tendency to 'other' those with mental health issues, a habit existent both in the community and the healthcare system. This insufficient explanation may then be because of the tendency to dichotomize individualism-collectivism that has actually been discouraged in the literature (Tse & Ng, 2014). Thus, Canada must also have some collectivistic ideals that contribute to the prevalence of mental health stigma, despite being predominantly individualistic in nature.

Participants in this study pointed out that mental health literacy within the South Asian community could be increased through increased exposure and education to western norms. This fits with the findings of Arora et al. (2016) who studied the roles of stigma on attitudes toward professional psychological help-seeking among South Asians. Their study indicated that education about mental health issues and contact with those who have been diagnosed have successfully reduced stigmatizing attitudes. It is also consistent with the identification of protest, education, and contact as three approaches to reducing stigma (Larson et al., 2010). In fact, Corrigan (2004; 2014) points to an "inverse relationship between having contact with a person with mental illness and endorsing psychiatric stigma" (2004, p.404). Because the second generation has a greater level of western acculturation and subsequently increased education and exposure with regard to mental health and its issues, a greater level of mental health literacy is attributed to them in comparison to their parents. Likewise, Han and Pong (2015) found that second generation Asian Americans were more likely to use mental health services than the first generation. This is similar to Lawton, Gerdes, and Kapke's (2017) finding that younger family members acculturate more readily than older family members, creating a difference between the two generations. These increased acculturation levels in the second generation often translate to an increased likelihood to use mental health services (Arora et al., 2016; Han & Pong, 2015; Islam, Khanlou, & Tamim, 2014; Nguyen, 2011; Tonsing, 2014). This low concordance rate between parents and children in terms of help-seeking is also recorded in Williams et al. (2011). Han and Pong (2015) further postulated that Asians who have a stronger adherence to Asian cultural values tend to be less willing to seek help because doing so "can be viewed as bringing disgrace to

themselves and to their families" (p.3), and those who were more acculturated to western norms and values held significantly less stigmatizing beliefs.

The fact that several participants in my study spoke of the serious need for increased mental health literacy suggest they may not have been aware of the current initiatives that are in development to address this concern; these services may not be a good fit for their community and/or they are not in close enough proximity. For example, programs such as the 'Collaborative for South Asian Mental Health' developed by CAMH (https://www.porticonetwork.ca/web/health-equity/initiatives/collsouthasianmh) seem to remain out of reach for some in the target population. This highlights the issues with the limited availability of resources as well as the lack of access to mental health resources in this community.

5.3 Positivity and Mental Health

Participants in this study highlighted that maintaining a positive mind is important for maintaining good mental health. The main strategies for maintaining positivity suggested were participating in activities that are rewarding/pleasing and promoting optimism; setting goals and keeping an active mind; maintaining good physical health; socialization; using religion as a source of structure; and helping others.

In terms of seeking out rewarding/pleasing activities and promoting optimism, an overview of findings in the literature also concludes that positivity is associated with an improvement in coping with stress (Achat, Kawachi, Spiro, DeMolles, & Sparrow, 2000; Gloria & Steinhardt, 2016; Gorman, Brough, & Ramirez, 2003; Jiang, Yue, Lu, Yu, & Zhu, 2016). In fact, Trompetter, Kleine, and Bohlmeijer (2017) stated that a number of studies found that positive mental health is associated with a sense of self-compassion

and doing good things for yourself; this aligns with participant suggestions in my study to engage in activities that are rewarding or pleasing to yourself. To elaborate on the idea of cultivating a sense of optimism, Jiang et al. (2016) posited a concept they called "belief in a just world," where believing in positive outcomes help people avoid feeling threatened or distressed; they suggested that optimism is a buffer against stress and depression, making it have a positive effect on mental health. Another study by Colby and Shifren (2013) on women with breast cancer, also found that those "who were more optimistic reported more positive mental health" (p.17).

Tying back to the support for optimism above, studies have shown that physical activity is associated with feelings of accomplishment and hopefulness, thereby positively affecting mental health (Gorczynski, 2010). Further research on asthmatic children found that those in poor physical health had higher levels of mental health issues (Glazebrook et al., 2006). The preference to use physical activity in order to overcome stress was also indicated by participants in Gorman et al. (2003). Additionally, it has been reported that aerobics have been touted as an effective treatment for depressive disorders (Deepthi, Ashakiran, Akhilesh, & Reddy, 2015). Miles (2008) expands on this notion by explaining that long-term physical activity increases the release of endorphins in the brain, thereby signaling neurotransmitters that work to reduce anxiety and tension.

Participants in my study indicated that socialization with others is also a valuable strategy for maintaining mental health; this corresponds with findings in the literature (Kawachi & Berkman, 2001). A study performed on mental health in South Asians found social activities to be an effective treatment model for individuals suffering from depression (Karasz et al., 2016). Social connectedness has also been shown to be

influential in the experience of positive mental health (Hall, McKinstry, & Hyett, 2016). Kawachi and Berkman (2001) stated that integration in a social network could directly produce positive mental health, giving people a sense of purpose, belonging, security, and self-worth. Socialization is considered to be a coping mechanism, providing an outlet for discussing issues with others and avoiding isolation (Gorman et al., 2003).

Participants in my study also identified religion as a source of structure to maintain positivity and mental health. Findings of several studies have suggested that religion may mediate how people use mental health services and act as a coping mechanism, in addition to the fact that many religious people pray and seek counsel from religious leaders when dealing with mental health issues (Behere, Das, Yadav, & Behere, 2013; Gorman et al., 2003; Karasz et al., 2016). Karasz et al. (2016) even suggested that collaboration between the healthcare system and religious leaders could significantly contribute to the development of mental health services.

Participants in this study highlighted that helping out others is another approach to maintaining positivity. This aligns with Meier and Stutzer's (2008) finding that volunteers are less likely to be depressed. They further pointed out that volunteering increases happiness and that helping others is psychologically rewarding because it contributes to feeling of competence that positively influence mental well-being.

Overall, participants' perspectives related to strategies to maintain positivity and consequently good mental health were comparable with findings that have already been substantiated in the literature.

5.4 Strengths and Limitations

Johnstone and Kanitsaki (2007) pointed out that "the health status of racial and ethnic minority groups (including immigrants and refugees) is often worse than that of the average population of the country they are living in" (p.96). Ahmad et al. (2005) found that the South Asians in their study failed to identify healthcare providers as a source of advice and information on mental health, highlighting the need to enhance cultural safety and cultural humility of healthcare providers to specific needs of immigrants. An important barrier lies in the fact that many healthcare providers lack understanding of culture; make judgments based on culture; and make generalized conclusions without understanding the complexity of experience (Chew-Graham, Bashir, Chantler, Burman, & Batsleer, 2002). This is an indication of the prevalence of the essentialist view on culture which, as described earlier, paints culture as static and uses sweeping generalizations to lump people into homogenous groups. It is important for healthcare providers to elicit more details and ask about cultural views in order to understand patient conceptions of illness. To support such notions, for example, I asked my participants what they think about how the South Asian community views mental health and what it means to them. Thus, I was able to identify and describe the ways in which they understand and define mental health. This information is useful for devising culturally safe interventions for individuals at risk by informing healthcare providers of the manner in which mental health can be viewed in this community. This entails the increased cultural humility of healthcare providers, meaning attitudes and skills that enable them to effectively handle patients from diverse backgrounds (Gustafson, 2005).

Furthermore, this study revealed the stigma that is present within the community, especially in terms of encouraging the seeking of treatment for mental health issues. Using this valuable information, sustainable anti-stigma interventions could be developed to help immigrants in general to seek out help, not just as a last resort (Chew-Graham et al., 2002), but as a means of proactivity. Ngui et al. (2010) pointed out that mental health issues greatly burden the economy: they reduce the available workforce; they increase hospital costs; and they contribute to increased poverty and incarceration. In fact, Sickel et al. (2014) projected that the burden of mental health issues will increase globally by 2020, so much that common mental disorders will disable more people than AIDS, heart disease, traffic accidents, and wars combined. Proactivity can only be implemented if there is significant mental health literacy which, as this study indicated, is relatively lacking within this community. Thus, this study points to the need for increased mental health literacy within the South Asian community; developing interventions to mitigate this concern could effectively reduce the burden of mental health issues by facilitating help for individuals who need it before it becomes a bigger problem.

Additionally, Bottorff et al. (2001) suggest using open-ended questions and attentiveness to aid extraction of the meanings patients make of their health issues and acknowledge differences in understanding. This study contributes to the understanding that there is a need to increase mental health literacy in Canada, specifically in the immigrant population. Considering that South Asians have been established as the largest visible minority group in Canada (Chui et al., 2008), helping them to become comfortable with discussing mental health issues and seeking help when needed would effectively

address the concerns about mental health as well as associated stigma within a significant proportion of the population.

There were a few limitations to this study. Given the small number of participants in the study, I did not expect to necessarily capture all the differences that occur as a result of the considerable heterogeneity across South Asian immigrant populations and diverse acculturation experiences. Also, geographic, time, and financial constraints limited variability in the locations from which participants were recruited. Furthermore, it is important to note that this study was not about generalizing—it simply sought to explore experiences and understandings of mental health within a particular group of people. To mitigate these issues, the research process was outlined in complete detail to allow replication of the study in other locations of significance and with a different sample population. The manner in which questions were asked during interviews may have affected the types of responses; caution was exercised to maintain consistency throughout all interviews.

Additionally, it was essential for me as the researcher to remain neutral and practice reflexivity during the entire research process to enhance credibility of the findings, especially because I am South Asian and may carry assumptions and biases that could influence my interpretation of the responses that my participants provided me. For example, I used a personal journal to document my views on the phenomenon of interest before data collection and continued to do so throughout the research process. I was careful not to lead, instead allowing the interviews to proceed based on my participants' responses. Though I was interested in studying the role of stigma and how it may stem from cultural beliefs to influence understandings of mental health, I did not disclose this

to my participants in order to avoid biasing their responses. I refrained from revealing personal information that might prompt an assumption of shared understanding and motivate participants to refrain from providing more in-depth responses. I made sure to establish ongoing informed consent to ensure I was not pushing too hard for responses. Additionally, when a participant indicated personal experience with mental health issues such as depression or psychosis, I was careful not to prod them for more details; instead I returned to the subject occasionally as the interview proceeded, creating what Thorne (2008) refers to as a 'time delay.' Furthermore, I refrained from using words like "I agree" or "I understand" in order to promote further clarification and elaboration of participant responses and eliminate any assumptions that I have expertise in the phenomenon of interest.

5.5 Conclusions and Implications

This study used an interpretive description approach to explore the experiences and understandings of mental health in second generation South Asian Canadians living in the Greater Toronto Area. Findings of this study outlined the multifaceted and complex nature of the manner in which mental health is conceptualized. It highlighted the presence of mental health stigma among the South Asian population that has roots in cultural beliefs and norms that South Asian immigrants have carried with them here from their countries of origin, where such beliefs remain pervasive. Such stigmatizing views on mental health remain a part of experiences and understandings of mental health because of the mental health stigma that is present in Canada as well, i.e., mental health stigma is a problem worldwide. Even in Canada, individuals tend to fear mental health so they 'other' those with mental health issues to distance it from themselves (Canadian

Electronic, 2012). This fear and consequent 'othering' stems, at least in part, from a lack of understanding of mental health and illness. Relatedly, participants in this study perceived a low level of mental health literacy, signified by the idea that many in the community, specifically immigrant parents, do not understand what mental health is. Also, many in the community fear disclosing and/or discussing mental health issues. Participants in this study associated this paucity in literacy to the prevalence of mental health stigma within the community. The difference in levels of mental health literacy in the community may be attributed to different acculturation histories between second generation South Asian Canadians and their immigrant parents, with the second generation reporting higher levels of mental health literacy than their parents. Thus, mental health issues tend to be ignored or hidden and treatment of mental health issues is lacking; this is a concern that needs to be addressed. Healthcare providers can assist in mitigating this problem if they understand the role culture plays in the conceptualization of mental health and its contribution to mental health stigma. This brings to light the value of implementing cultural safety and humility.

5.6 Recommendations

Considering that this study was conducted with South Asian individuals in the second generation, it is suggested that future research initiatives could focus on speaking to first generation immigrants about their conceptualization of mental health, in order to identify and compare views to those expressed in the current study. It would be interesting to see whether views of the parent generation align with that of their children with regard to experiences of mental health.

There are several other recommendations that can be made based on this study. Firstly, it is important to highlight the need for anti-stigma campaigning in the South Asian community. Such initiatives must be designed and implemented by and within the community, where members work together to design and develop strategies that would work for them. It is natural to first seek help at home, which signifies the value of community-based interventions to assess mental health needs and provide associated services (Canadian Electronic, 2012). In addition to combatting stigma, it is recommended that strategies be developed within the community to enhance mental health literacy. Moreover, it is important to consider an individualist-collectivist framework to address the conceptualization of mental health issues and associated help-seeking attitudes; however, again, it is important to note that second generation South Asian Canadians can simultaneously possess both individualistic and collectivistic beliefs. It also is imperative that current initiatives to address the lack of mental health literacy be more broadly disseminated because, as the findings of my study suggest, they are not effectively reaching their target populations. To mitigate this concern, perhaps it would be useful for program developers such as CAMH to make information available, in the form of brochures for example, to post-secondary institutions, community centers and religious institutions, to create greater awareness of the mental health resources that are available.

Finally, the findings of this study point to the importance of cultural safety and humility within healthcare. Cultural safety and cultural humility education/training needs to be informed by the South Asian community. This includes the sharing of knowledge about the conceptualization of mental health as well as preferences for treatment-seeking

methods among South Asians. For example, considering the position of family physicians often as the first point of care, I would recommend more rigorous education in the medical school curriculum that emphasizes the need to destigmatize mental health, as well as the recognition that patients may present with a somatization of symptoms rather than complaints explicitly stated as mental health problems. Additionally, addressing the manner in which mental health service providers are compensated for their services may mitigate issues surrounding accessibility of services. Furthermore, it is recommended that health profession education both in healthcare and educational institutions be implemented regarding the issue of difference and how we negotiate difference. Understanding the perspective of the other and where peoples' understandings originate will allow for enhanced cultural safety and humility within the healthcare system, which would subsequently make mental health services more accessible for the South Asian community.

APPENDICES

Appendix A: UOIT REB Approval Letter

UNIVERSITY OF ONTARIO INSTITUTE OF TECHNOLOGY

**RESEARCH ETHICS BOARD
OFFICE OF RESEARCH SERVICES**

from: researchethics@uoit.ca
to: "Dr. Victoria Smye (Primary Investigator)" <victoria.smye@uoit.ca>

cc: "Nurul Cader (Student Lead/Post-Doctoral Lead)"
<nurul.cader@uoit.net>,
researchethics@uoit.ca

subject: Research Ethics Board Approval Notice

Date: November 01, 2016
To: Victoria Smye
From: Shirley Van Nuland, REB Chair
Title: Exploring Experiences and Understandings of Mental Health in Second Generation South Asian Canadians
Decision: APPROVED (effective October 27th, 2016)
Current Expiry: **October 01, 2017**

Notwithstanding this approval, you are required to obtain/submit, to UOIT's Research Ethics Board, any relevant approvals/permissions required, prior to commencement of this project.

The University of Ontario, Institute of Technology Research Ethics Board (REB) has reviewed and approved the research proposal cited above. This application has been reviewed to ensure compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2 (2014)) and the UOIT Research Ethics Policy and Procedures. You are required to adhere to the protocol as last reviewed and approved by the REB.

Continuing Review Requirements (all forms are accessible from the IRIS research portal):

- **Renewal Request Form**: All approved projects are subject to an annual renewal process. Projects must be renewed or closed by the expiry date indicated above ("Current Expiry"). Projects not renewed within 30 days of the expiry date will

be automatically suspended by the REB; projects not renewed within 60 days of the expiry date will be automatically closed by the REB. Once your file has been formally closed, a new submission will be required to open a new file.
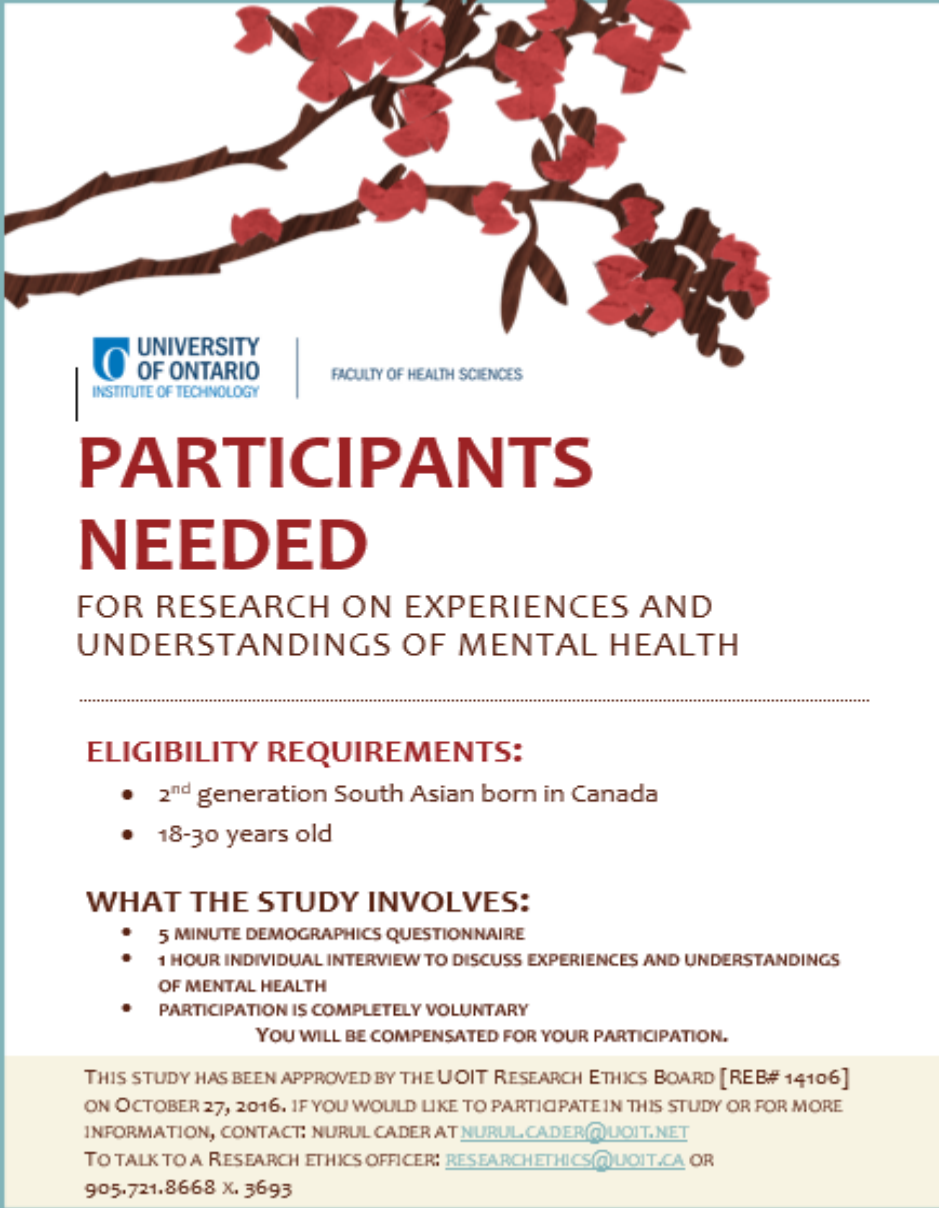
- **Change Request Form**: Any changes or modifications (e.g. adding a Co-PI or a change in methodology) must be approved by the REB through the completion of a change request form before implemented.
- **Adverse or Unexpected Events Form**: Events must be reported to the REB within 72 hours after the 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**: This form must be completed when the research study is concluded.

Always quote your REB file number (**/14106**) on future correspondence. We wish you success with your study.

Dr. Shirley Van Nuland	Janice Moseley
REB Chair	Research Ethics Coordinator
shirley.vannuland@uoit.ca	researchethics@uoit.ca

Appendix B: Recruitment Flyer

UNIVERSITY OF ONTARIO INSTITUTE OF TECHNOLOGY | FACULTY OF HEALTH SCIENCES

PARTICIPANTS NEEDED

FOR RESEARCH ON EXPERIENCES AND UNDERSTANDINGS OF MENTAL HEALTH

ELIGIBILITY REQUIREMENTS:

- 2nd generation South Asian born in Canada
- 18-30 years old

WHAT THE STUDY INVOLVES:

- 5 MINUTE DEMOGRAPHICS QUESTIONNAIRE
- 1 HOUR INDIVIDUAL INTERVIEW TO DISCUSS EXPERIENCES AND UNDERSTANDINGS OF MENTAL HEALTH
- PARTICIPATION IS COMPLETELY VOLUNTARY
      YOU WILL BE COMPENSATED FOR YOUR PARTICIPATION.

THIS STUDY HAS BEEN APPROVED BY THE UOIT RESEARCH ETHICS BOARD [REB# 14106] ON OCTOBER 27, 2016. IF YOU WOULD LIKE TO PARTICIPATE IN THIS STUDY OR FOR MORE INFORMATION, CONTACT: NURUL CADER AT NURUL.CADER@UOIT.NET
TO TALK TO A RESEARCH ETHICS OFFICER: RESEARCHETHICS@UOIT.CA OR 905.721.8668 X. 3693

PARTICIPANT CONSENT FORM

Title of Research Study: Experiences and Understandings of Mental Health in second-generation South Asian Canadians

You are invited to participate in a research study entitled (Experiences and Understandings of Mental Health in second-generation South Asian Canadians). This study (REB #14106) has been reviewed by the University of Ontario Institute of Technology Research Ethics Board and was originally approved on October 27, 2016. 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: Victoria Smye; Nurul Hinaya Cader

Departmental and institutional affiliation(s): Faculty of Health Sciences at UOIT

Contact number(s)/email: victoria.smye@uoit.net; nurul.cader@uoit.net

Purpose and Procedure:

The purpose of this study is to explore the experiences and understandings of mental health in second-generation South Asian Canadians, in the context that they are the children of South Asian immigrant parents who are more or less influenced by both their native and host cultures.

A qualitative interpretive description will be used to collect and analyze data in the form of one on one individual interviews, lasting approximately one hour each. You will participate in one interview with the researcher and complete a brief demographics

questionnaire prior to the start of interview. Before you participate in an interview, you will be asked to complete a questionnaire for demographic purposes. You will be asked to indicate your age, gender, education level, religious affiliation, parent nationality, and city of residence. This information will be paired with your interviews to allow the researcher to holistically answer the research questions in this study. During this interview, you will answer a series of open-ended questions regarding your experiences of mental health. With your permission, I would like to record your interview. In addition, you will have an opportunity to review and make changes to a verbatim transcript within 7 days of the interview, if you wish.

Potential Benefits:

The information acquired from this study may assist in improving cultural safety and understanding in our health care system. Participating in this study could provide an outlet needed to speak up about experiences, to reflect on oneself, to become educated on the issue, to advocate on behalf of the cause, and to possibly help others who may be in a vulnerable position in the future.

Potential Risk or Discomforts:

For some people, mental health may be a sensitive topic to discuss and may produce some discomfort and/or frustration. In the event that this occurs, you will be provided with available resources to address your concerns i.e. pamphlet on mental health resources. You will also be reminded before, during, and after your interview that your participation in this study is completely voluntary and can be withdrawn at any time. You will not waive your rights or benefits to which you are entitled should you choose to withdraw.

Confidentiality and Storage of Data:

Your input will remain confidential throughout the entire research process. All data collected will be stored in a personal, password-protected laptop kept in a secure location, accessible only to the researchers named above. After interviews have been transcribed verbatim and pseudonyms have been developed, audio-recordings, questionnaires, and interview guides will be destroyed. Data will be kept for a period of 5 years after the completion of the research study. After this 5 year period, data will be permanently deleted by reformatting, rewriting, deletion, and/or shredding. You will be assigned a pseudonym that will be used to identify your data. Once a pseudonym has been assigned, any direct identifiers will be destroyed and all data you have provided will not be traceable back to you.

The results of this study may be published in a scientific journal and/or presented at a conference. Any information that would identify you will NOT appear in these publications.

To safeguard your rights to confidentiality and anonymity, both verbal and written information about the objectives of this study will be available to you throughout the study period. You will be asked to provide explicit signed informed consent before participating in this study, and you will be provided with a copy of this consent form.

Your privacy shall be respected. No information about your identity will be shared or published without your permission, unless required by law.

Confidentiality will be provided to the fullest extent possible by law, professional practice, and ethical codes of conduct.

Right to Withdraw:

Your participation is voluntary, and you 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 may withdraw from the study before, during, or immediately after the interview without any consequences. You are not obliged to provide a reason for your withdrawal. If you choose to withdraw from the study during or immediately after the interview, simply inform the researcher of your decision and the data collected from you will be promptly destroyed.

Compensation:

As a token of appreciation for your participation in this study, you will be given a small gift at the conclusion of the interview. You will be given this gift even if you choose to withdraw from the study during the interview. Additionally, you will be provided with two TTC tokens to compensate for commute-related expenses.

Participant Concerns and Reporting:

This research project has been approved by the University of Ontario Institute of Technology Research Ethics Board on (REB File #: 14106). If you have any questions concerning the research study, or experience any discomfort related to the study please contact the researcher, Nurul Cader, via email (Nurul.cader@uoit.net). Any questions regarding your rights as a participant, complaints or adverse events may be addressed to

Research Ethics Board through the Research Ethics Coordinator - researchethics@uoit.ca or 905.721.8668 x. 3693.

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

Debriefing and Dissemination of Results:

The results from this study will be used to develop a Master's thesis that will be submitted to the graduate study program at the Faculty of Health Sciences of UOIT. If you wish to be informed of the results of this study, please feel free to contact the researchers named above at the given email addresses up to 6 months after the interview.

Consent to Participate:

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 my participation is voluntary, and that I may discontinue participation at any time without penalty. I also understand that I will receive a copy of this Consent Form for my records.
4.   I consent to having my interview audio recorded, and understand that only the research team will have access to the audio recording and transcript of my interview.
5.   I would like to meet a second time to review a transcript of my interview.
                    □ Yes   □ No

_____   _____

(Name of Participant)   **(Date)**

_____   _____

(Signature of Participant)   **(Signature of Researcher)**

Appendix D: Demographics Questionnaire

Demographics Questionnaire

Please answers the following questions.

1. How old are you?

   _____

2. What is your gender? (circle one)

   a. Female

   b. Male

   c. Other: _____

3. What is the highest level of education you have completed or are currently enrolled in? (circle one)

   a. Elementary School

   b. High school diploma

   c. Apprenticeship

   d. College diploma

   e. University undergraduate degree

   f. Master's degree

   g. Doctorate degree

   h. Other: _____

4. What is your current occupation?

   _____

5. What is your religious affiliation? (circle one)

   a. Buddhism

   b. Christianity

   c. Hinduism

   d. Islam

   e. Other: _____

6. What is the nationality of your parents? (Circle two if your parents are of different nationalities.)

   a. Afghanistan

   b. Bangladesh

   c. India

   d. Pakistan

   e. Sri Lanka

   f. Other: _____

7. What is your current city of residence?

_____

Thank you for completing this questionnaire. Your responses will remain strictly confidential.

Appendix E: Interview Guide

Interview Guide

<u>Introduction</u>

Thank you for meeting with me today. My name is Nurul, and I would like to talk to you about your experiences and understandings of mental health. Please keep in mind that I will not be asking you about your own mental health; rather, I'd like to learn your understanding of what is entailed by the notion of mental health. The interview should take about an hour, and I will be audio recording the session so I don't miss out on any of your responses. Even though I'll be taking notes during the interview, I won't be able to write everything down. Because we'll be audio recorded, please make sure to speak up so we don't miss anything when transcribing your responses. Rest assured that all your responses will be kept confidential. Your responses will only be shared with research team members and we will make sure that whatever information we include in our report does not identify you in any way. You do not have to talk about anything you don't want to and you may end the interview at any time. Here is a consent form that elaborates on the details I just gave you. Please read through it carefully and sign at the bottom for your free informed consent to participate in this study. You will be provided a copy of this signed consent form. If you have any questions, please feel free to ask me.

Before we begin the interview, please fill out this questionnaire on demographics to help us with our analysis.

Start Time: End Time:

<u>Interview Questions</u>

(start audio recording)

Question 1: **Tell me a little about what prompted you to attend this interview.**

Why is this important to you?

Probes: Can you tell me more about that?

Notes

Question 2: **What does the notion of mental health mean to you?**

Tell me more about that.

Probes: What would that look like?

Notes

Question 3:   **If someone close to you had a mental health issue, how might you respond?**

Probes: What motivated your response?

Why do you feel you would respond this way?

Notes

(Are you feeling okay with the questions so far? Do you wish to continue with the interview?)

How do you think other people in your community understand mental
Question 4: **health?**

Can you give me an example?

Can you tell me more about that?

Why does that stand out in your memory?

How did you feel about that?

Probes: Is there anything else?

Notes

Question 5: **What do you see as those factors that influence mental health?**

Can you give me an example?

Probes: Why does that matter?

Notes

Question 6: **What do you feel are important factors for maintaining mental health?**

Why is that important to you?

Can you give me an example?

Probes: Is there anything else?

Notes

_____

Conclusion:

Okay, those are all the questions I have; is there anything else you would like to add?

(End audio recording.) Okay, I'll be transcribing this audio recording into a verbatim transcript, which I will let you review to ensure we captured your responses accurately. Thereafter, this data will be used to develop a report on my findings. If you're interested in remaining updated with this study, feel free to get in touch with me using the contact information provided. Here is a small gift as a token of appreciation for your participation. (Provide gift and thank you letter.)

Thank you so much for your time. Have a wonderful day.

Appendix F: Mental Health Resources Pamphlet

Get the help you need.

Online Resources:

- **Ementalhealth.ca**

Provides confidential information about mental health every day of the year.

- **Good2talk.ca**

Provides professional counselling and referral services to post-secondary students

- **Mindyourmind.ca**

Provides tool and resources to promote youth mental health.

"Caring for the mind is as important and crucial as caring for the body. In fact, one cannot be healthy without the other."

From "Approaching the Natural: A Health Manifesto" by Sid Garza-Hillman

Mental Health Resources

Sometimes mental health can be a difficult or discomforting topic to discuss. In this pamphlet, you can find some resources available to you in the event that you need help with a mental health issue or just want to learn more about overall mental health.

If you need urgent access to care and/or are afraid you are in danger, please go immediately to the nearest emergency room or call 911.

Telephone Resources:

Mental Health Helpline:
1-866-531-2600
- Toll-free
- 24 hours, 7 days a week
- Speaks more than 170 languages

Gerstein Centre:
416-929-5200
- Crisis intervention to adults living in City of Toronto

Scarborough Hospital Mobile Crisis Program
416-495-2891
- Mental health crisis response for individuals aged 16 and over

Distress Centres of Toronto
416-408-HELP (4357)
- Services offered in 151 languages

Telehealth Ontario
1-866-797-0000
- Toll-free
- Medical information

In-Person Resources

Durham Mental Health Services
519 Brock Street S
Whitby, Ontario L1N 4K8
www.dmhs.ca

Canadian Mental Health Association
(CMHA) Durham
60 Bond Street W
Oshawa, Ontario L1G 1A5
www.durham.cmha.ca

Lakeridge Mental Health Program
3rd Floor
1 Hospital Court
Oshawa, Ontario L1G 2B9
www.lakeridgehehealth.on.ca

Ontario Shores Centre for Mental Health Services
700 Gordon Street
Whitby, Ontario L1N 5S9
www.ontarioshores.ca

Rouge Valley Health System Mental Health Program
2867 Ellesmere Road
Scarborough, Ontario M1E 4B9
www.rougevalley.ca

Victorian Order of Nurses (VON)
Whitby Mall, Lang Tower West Building
304 – 1615 Dundas Street E
Whitby, Ontario L1N 2L1
www.von.ca

Centre for Addiction & Mental Health
(CAMH)
1001 Queen Street W
Toronto, Ontario M6J 1H4
www.camh.ca

Community Resource Connections of Toronto
210 Dundas Street W
Toronto, Ontario M5G 2E8
www.crct.org

Family Association for Mental Health Everywhere
268 Royal York Road, 2nd Floor
Etobicoke, Ontario M8V 2V9
www.fameforfamilies.com

Appendix G: Thank You Letter to Participants

<div align="right">[Date]</div>

Dear Co-participant:

Thank you for attending this interview and providing valuable information to this research project. I hope that you found your time here worthwhile. Our main objective is to explore the experiences and understandings of mental health in second-generation South Asian Canadians. I hope that this information can be used to improve mental health literacy and increase cultural humility and safety in the Canadian health care system.

If you wish to remain informed about the proceedings of this study, please feel free to contact me at Nurul.cader@uoit.net up to 6 months after today, and I will be happy to provide you with a status update of this research project.

Please accept this small gift as a token of appreciation for your participation in this study.

I wish you the best in all your future endeavours.

Sincerely,

Nurul Cader

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