Punjabi Immigrant Women's Narratives of Mental Health and Health Care Utilization

by

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Abstract

Indian Punjabis constitute a large proportion of the immigrant population in the Lower Mainland of BC. By 2031, it is anticipated that South Asians will be the largest visibility minority group in Canada (Statistics Canada, 2005). As a result, the mental health needs of this population may soon have a large impact on mental health providers. The present study investigated how Punjabi immigrant women constructed the meaning of mental health through the following research questions: 1) How do Punjabi immigrant women define concepts related to mental health and illness?; 2) How are mental health services accessed and utilized by the participants?; 3) In what ways do the existing mental health services meet or fail to meet the needs of the participants?; 4) How can these services be made more culturally accessible?; and 5) How is mental health defined by prominent mental health organizations? Drawing from feminist post-colonial theory and utilizing a critical qualitative approach, the first segment of this study was a narrative analysis of qualitative interviews that enabled an understanding of the participants' views of mental health and experiences accessing mental health services and; the second segment of the study critically analyzed documents pertaining to the meaning of mental health as defined by three prominent mental health organizations. The results of this study suggested that the participants' conceptions of mental health shared some similarities with Western models. The meanings that the participants constructed for various concepts, and their underlying metaphors, however, differed from Western models of mental health. Further, cultural conventions and perceptions often affected how participants' viewed mental health issues and the type of help they sought. Recommendations, limitations and challenges, and future directions are discussed. As critical research, the results of this study contribute to the ongoing development of a culturally responsive approach to health care provision.

Preface

The study, Immigrant South Asian Women's Experience of Mental Health and Health Care

Utilization, received ethical approval from the University of British Columbia's Behavioural

Research Ethics Board (certificate number: H10-01701).

Table of Contents

List of Tables

List of Figures

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Dedication

To Chintoo, for giving me a kick start.

Chapter 1

Introduction

Health is a multifaceted phenomenon that is affected by a constellation of factors, including income level, socioeconomic status, and social support (WHO, 2010). Whereas each of these factors is seen as an important determinant of a variety of health outcomes, recent research in the Canadian context has begun to focus on the importance of immigrant status on health (Browne, Smye & Varcoe, 2005; Choudhry, 1998). Immigrants must adapt to a new environment, where they may face feelings of alienation, loneliness, and helplessness (Dhaliwal-Rai, 2001). Even when motivated to seek help in dealing with these stressors, the predominance of Western models of health, as well as the socially constructed metaphors and assumptions upon which they are based, pose a barrier to many non-Western immigrants (Jassal-Jhangiani & Vadeboncoeur, 2010).

South Asians are one of the fastest-growing ethnic groups in Canada, in general, and British Columbia (BC), in particular. In 2001, there were 900,000 persons of South Asian origin in Canada, representing 23% of the visible minority population (Statistics Canada, 2005). By 2017 it is projected that the South Asian population in Canada will have reached 1.8 million (Statistics Canada, 2005). Despite their large numbers, however, the history of South Asians in Canada has been marred by racial discrimination. This dissertation focuses on one particular aspect of the discrimination faced by Punjabi South Asian immigrants to Canada: their marginalization within the mental health landscape.

The institutionalization of racism within the mental health sector through the offering of discriminatory services, such as an over willingness to prescribe medications, may disregard many of the mental health needs of non-Western immigrants and may further limit the utilization

of health services by these populations (Whitley, Kirmayer, & Groleau, 2006). Psychological studies exploring the tensions caused by universal assumptions of mental health have revealed that health care providers frequently make broad over-generalizations about members of different cultural groups. For example, Westerners are typically considered to be forthcoming when they either lack good mental health, are unable to make autonomous decisions, or struggle with challenges that impede their capacity to realize their full potential (Wong & Tsang, 2004). On the other hand, South Asians are typically stereotyped as somatizing their emotional problems, or presenting with physical symptoms as a reaction to emotional distress (Burr & Chapman, 2004). While this may be true in some cases, the trouble begins when health care workers erroneously attribute the cause of the somatization and change their treatment of South Asian patients accordingly. For example, physicians in the United Kingdom (UK) tend to assume that South Asian patients somatize because they are unable to adequately express their psychological maladies (Beliappa 1991; Burr & Chapman, 2004; Ineichen 1990; Johnson, Bottorff, Browne, Grewal, Hilton & Clarke, 2004; Rack 1982). This stereotyped attribution appears to further hinder their interaction, and therefore also their access to and utilization of health care services.

For immigrant populations, implicit government policies and societal hierarchies may be additional sources of mental strain and frustration that have a negative impact on their physical and mental health (George & Ramkissoon, 1998; Man, 2004; Ng, 1993). Many South Asian women in particular face "double jeopardy" (Bannerji, 1987; 1991) with regard to institutionalized discrimination, marginalized as a result of both their gender and their ethnicity. As a result, the identities of women are partly created in dialogue and contestation with others. Aside from the societal image of South Asian women as being docile, submissive, illiterate, and stereotypically feminine, South Asian women are also frequently perceived as objects by a larger

2

Canadian society that tends to exoticize and distance their presence (Bannerji, 1993). The subjugation of immigrant South Asian women not only adds to the challenges they face as immigrants, but may also negatively impact their physical and psychological mental health. For example, South Asian immigrant women tend to suffer from a higher incidence of suicide, anxiety and depression, whether compared to their male counterparts or the mainstream population (Patel & Gaw, 1996).

These problems are compounded when health practitioners perceive that South Asian women are poor patients because they are not proactive about their health (e.g., they do not follow instructions, or take responsibility for their own mental health) or because they have personal characteristics that inhibit them from seeking medical aid, such as shyness (Johnson et al., 2004). These stereotypes often lead medical practitioners to treat South Asian women differently because of their ethnicity, including by speaking more loudly and slowly to South Asian women than Caucasian women (Ashram, 2008; Johnson et al., 2004). Previous experiences with members of this group are often generalized to all South Asian women and have the potential to affect health providers' interactions with them, including their overall provision of care. In this manner, Eurocentric beliefs embedded within the health care system tend to marginalize and silence individuals who do not conform to a specified set of cultural norms regarding how to present with and talk about mental illnesses.

Despite the pervasiveness and urgency of this problem, there are only a few studies pertaining to mental health issues faced by South Asian women. In addition, some of this literature is problematic in terms of essentializing immigrant women, for example, including women from Pakistan and India in a single study and assuming this sample to be homogeneous. This has resulted in varied beliefs about constructions of mental health. Even among the

psychological studies pertaining to South Asian women, few have examined how context, personal histories, and culture influence their understandings of mental health (Dossa, 2002). The research presented here builds on this nascent literature by examining how mental health was defined and understood by Punjabi immigrant women, as well as how mental health services were accessed and utilized by this group. An examination of both these factors is critical to understanding the needs of this group and may contribute to two key outcomes. First, it may help to unmask the ways in which Punjabi immigrant women have been influenced by the intersectionality of gender, race and class. Second, it may shed light on how best to serve them, including through the development of culturally responsive mental health care services.

Theoretical Framework

Positive psychology (Seligman, 2008) and acculturation theory (Berry & Sam, 1997) are commonly utilized to explain the mental health of immigrants. However, these theories tend to view culture as an extraneous variable that may be cast aside to reveal a core universal self that reacts to particular situations in a specific manner. Whereas positive psychology assumes concepts have shared meanings across cultures and carries a belief in a universal self, acculturation theory disregards the effects of factors such as history, race and gender on immigrants' mental health, thus dismissing culture as being an integral part of the individual. Rather than positive psychology and acculturation theory, this study utilizes feminist postcolonial theory as a theoretical framework.

Sociocultural factors, including history, race, gender, social class, and ethnicity (Wertsch, 1985), impact how Punjabi immigrant women define and experience mental health. In order to understand how Punjabi immigrant women construct mental health, it is important to understand the context within which they live. In general, women in India live in a society that reveres an

image of the feminine that exudes sacrifice, fidelity, duty to family, and selfless service to others. Sita, the central female character from the *Ramayana*, the famous epic of Hindu mythology, epitomizes this ideal image of a woman. Indeed, it may be said that the ideal of Sita continues to play a prominent role in women's decorum in modern-day India. It is important to understand how Indian ideals, such as those espoused by Sita, impact Punjabi immigrant women living in Canada. Thus, in the Canadian context, it is important to examine how culture, history, and social values impact how these women negotiate meanings of mental health, and how they attempt to deal with imbalances in their mental health.

In order to dispel many of the presuppositions inherent in the definition of mental health within Canadian culture, as well as the Punjabi immigrant population, it is important to integrate insights from feminist postcolonial theory. Postcolonial insights allow for the examination of how people construct culturally derived meanings for cognitive concepts such as "mental health" and "mental illness." These meanings are affected by how cultures evolve over time, the experiences of individuals within their cultural group, as well as the social practices that form the foundation of their day-to-day lives (Bhabha, 1994). Postcolonial insights also allow for the examination of how Eurocentric assumptions have helped to shape current meanings of mental health, as well as how hegemonic forces and power inequalities have impacted meanings of mental health. Additionally, feminist postcolonialism examines how Eurocentric assumptions have created health care inequities across gender and racial boundaries. In other words, it adds another layer of critical analysis to gender inequalities by recognizing the dual colonization faced by women who are discriminated against for both being a part of the colonized group, and also for being women (Bannerji, 1987, 1991). Finally, feminist postcolonialism challenges Western-based ideologies and knowledge production, and foregrounds some of the alternate ways of

knowing that are typically disqualified by Western perspectives (Anderson, 2002).

Focus of the Study

This study investigated how Punjabi immigrant women construct mental health. In the context of this study, the term "immigrants" refers quite specifically to those women who have immigrated to Canada from India and are of Punjabi descent. This study posed the following questions, each of which must be addressed before recommendations can be made for a culturally responsive approach to health care provision: 1) How do Punjabi immigrant women define concepts related to mental health and illness?; 2) How are mental health services accessed and utilized by the participants?; 3) In what ways do the existing mental health services meet or fail to meet the needs of the participants?; 4) How can these services be made more culturally accessible?; and 5) How is mental health defined by prominent Canadian mental health organizations?

Drawing on feminist postcolonial theory, this research utilized a critical qualitative approach. The first segment of the study employed qualitative interviews that enabled an understanding of participant's views of mental health and access to mental health care. The second segment of the study critically analyzed documents pertaining to the institutional meaning of mental health and immigrant mental health.

Points of Origin

The inspiration for this study emerged from my Master's thesis, which examined parent-adolescent relationships in the Punjabi community. It was during this time that I met with counselors and other social service professionals to discuss parent-adolescent issues faced by the Punjabi community. Despite my research findings, which suggested that parents and adolescents in this community deal with issues similar to the larger population, I was struck by the stories of

some of the mental health issues faced by this group. As a result of these discussions, as well as my own experiences working with various community groups, I felt it was important to investigate the impact of mental health issues on the family as a whole within the Punjabi community. However, before I could examine the impact that mental health problems can have on the family unit, I felt it was imperative to understand how Punjabi women constructed mental health in the first place, given the lack of available literature. In addition, as a South Asian female, I understand some of the issues that immigrant women face, as I, myself, have experienced discriminatory practices as a result of both my gender and ethnicity. It was for this reason that I began by exploring Punjabi women's constructions of mental health.

The critical paradigm (Bredo, 2006; Crotty, 1998) that I operate within was influenced in part by my frustration with the dominant discourse pertaining to people of Punjabi origin within British Columbia. Media reports often situate Punjabis as a socially disruptive group, whose youth are involved in gang and drug activities, whose parents are detached from their children, and whose husbands routinely abuse their wives. The schema for Punjabis created in the minds of mainstream Canadians is consequently primarily based on negative discourse. This is illustrated by a conversation I had with a colleague at an academic conference. When I mentioned that I live in the Lower Mainland of British Columbia, my colleague inquired as to why so many Indo-Canadian men in Surrey, BC are abusing and killing their wives. It amazed me that a fellow researcher would ignore contextual factors and not question the veracity of the media depiction or the statistics being reported. Further, it highlighted for me how Canadians in general must interpret media stories that refer to Punjabis. These incidents have helped to shape my views about reality and knowledge development.

In considering my research position, I feel that it is important to take into account my

context, personal history, and culture. I also feel that it is important to examine how dominant societal beliefs impact my worldview and may act to distort alternative worldviews. Finally, I am committed to conducting research that has a strong social commitment; research that aims to contribute to social change, for example, by making research findings available to government organizations and engaging in community outreach.

Organizational Scheme

Chapter one provided an introduction to the context of this study of mental health among Punjabi immigrant women along with an overview of the primary aims of this study. The remainder of this dissertation is organized as follows. Chapter two reviews the research literature on the general lack of cultural sensitivity in the mental health sector in Canada, as well as the specific need for understanding how Punjabi immigrants define mental health in order to develop and provide more culturally responsive services. Chapter three critically discusses positive psychology and acculturation theory, two theoretical frameworks that have traditionally been used to investigate immigrant mental health, and describes feminist postcolonial theory as an alternative framework that guides this research. Chapter four describes the research methodology employed in this study. Chapter five presents the personal narratives of the six participants, framed by Sita's narrative from the *Ramayana*. Chapter six examines the overarching themes that were prevalent in the narratives. Chapter seven provides an analysis of documents pertaining to the meaning of mental health gathered from three mental health organizations. As a part of this segment of the analysis, the responses from the participants, which were gathered during the narrative analysis, were compared with the themes that emerged from document analysis. Chapter eight, provides a summary of the key findings, a discussion of the limitations and challenges, recommendations, and suggestions for future research.

Chapter 2

Literature Review

This chapter explores the general lack of attention to cultural differences in the mental health sector in Canada, as well as the need for understanding how Punjabi immigrants define mental health in order to develop and provide more culturally responsive services. The effects of immigration and South Asian family life are also highlighted as research has shown these two factors to be important determinants of mental health among Punjabi immigrant women. Divided into six sections, this chapter begins with an overview of mental health outcomes for immigrant women. Second, I describe issues to consider when conducting research with Punjabi women. The third section provides an historical overview of South Asian immigration to Canada, followed by the fourth section on the implications of family dynamics for mental health. Fifth, the discussion then focuses on how South Asian immigrant women's mental health, in particular, has been impacted by immigration. Following this, the sixth section is an overview of the mental health services available to immigrants, and the barriers they face in accessing these services.

Immigrant Women and Mental Health

It is well-documented that women experience poorer mental health outcomes than men, and that women of colour and/or lower socioeconomic status suffer even more so (Meadows, Thurston, & Melton, 2001). Studies have found that women tend to suffer from chronic depression and anxiety disorders at a greater rate than do men (Piccinelli & Homen, 1997). Alongside Aboriginal women, homeless women, and women in poverty, one of the groups that appears to be particularly vulnerable to poor mental health is immigrant women (Aday, 1993; Bolaria & Bolaria, 1994; Meadows et al., 2001). Immigrant women are at increased risk of

suffering from depression, schizophrenia, and post-migration disorders, with depression and anxiety disorders being the most common ailments among this population (Beiser, 1999; Berry & Blondel, 1982; Bhui, Bhugra, Goldberg, Sauer, & Tylee, 2004; Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Cheung & Lin, 1999; Dhooper & Tran, 1998; Fox, Burns, Popvich, & Ilg, 2001; Legault, Gravel, Fortin, Heneman, & Cardinal, 1997; Li & Browne, 2000; Tracy & Mattar, 1999). Further, a study by Bhui and colleagues (2004) found that depression was more common among Punjabi women than men. In interpreting the results of this research, however, a cautionary note is needed. One should not interpret differences between minority women and non-minority women as suggesting that the former are inherently predisposed to higher levels of mental illness. Rather, it would be more accurate to attribute the increased incidence of mental health related problems among this group to various environmental and situational risk factors such as poverty, unemployment, discrimination, racism, and threats to cultural identity. In other words, it is vital in this work to understand factors that create inequalities, and not simply to perpetuate or reinforce stereotypes (Browne & Smye, 2002).

Immigrant women are likely to experience deteriorating health in accordance with the length of time spent in their non-natal country. The "healthy immigrant effect" is a well-documented finding that refers to the positive correlation between the length of time an immigrant spends in their non-native country and the likelihood of their health deteriorating (Dunn & Dyck, 2000; McDonald & Kennedy, 2004; Newbold & Danforth, 2003; Vissandjee, Desmeules, Cao, Abdool, & Kazanjian, 2004). Studies comparing immigrant women to Canadian-born women have found that those immigrants who have lived in Canada for ten years or more are more likely to be in poor health than Canadian born women (Vissandjee et al., 2004). Interestingly, there is no statistical difference in health status between immigrant and Canadian-

born males who reside in Canada for ten years or more (Vissandjee et al., 2004). It has also been

reported that immigrant women face different types of discrimination based on their stage of

migration, and that differences also exist for women at the same stage of migration (Thurston &

Vissandjee, 2005). For instance, younger women may be more impacted by gender

discrimination, whereas elderly women may be less affected by gender discrimination and more

so by ageism. It is important to note that despite strong findings for the healthy immigrant effect

and experiences of discrimination over time among women, many studies on immigrants and

mental health limit their population base to those who have resided in their immigrated country

for five years or less, limiting the variability in their sample.

Immigrant women, who since the 1960s have accounted for fifty percent of all international

immigrants (Zlotnick, 2003), have been found to be at a higher risk of settlement related

problems due to rigid gender roles (Kobayashi & Ray, 2000). This problem may be even more

severe when an immigrant's culture is strongly patriarchal, which is generally the case in South

Asian communities. Unsurprisingly, therefore, differences in power and responsibility have also

been shown to impact women's mental health status. When an income differential exists

between men and women, with women earning less, women are more likely to experience

symptoms of depression and anxiety (George & Ramkissoon, 1998; Man, 2004; Ng, 1993).

Women who find themselves in this situation often work in jobs where they have less

independence and experience poor working conditions (Man, 2004; Tewary, 2005). Unable to

obtain work in their desired fields, many immigrant South Asian women are often forced to seek

employment in the sales and service sectors or the processing, manufacturing and utilities

industries (National Visible Minority Council on Labour Force Development, 2005; VanderPlaat,

2007). As a result, many of these industries now host highly racialized and gendered jobs

(Cranford & Vosko, 2003; De Wolff, 2003; Galabuzi, 2001; Ornstien, 2000; Vosko et al., 2003).

In general, immigrant women experience more severe discrimination in the workplace than their male counterparts (Man, 2004; Reitz, 2001). They also tend to face social exclusion when they are channeled into part-time or flexible work in the private sector, which typically offers low wages—especially to female immigrants—no benefits, little or no job security, and that under-utilizes their skills (Man, 2004; Reitz, 2001). As Canadian national labour laws do not stipulate that employers must provide employees with any form of job security, they are frequently at the mercy of employers who may abuse their power (Bhannerji, 1993; Man, 2004).

Employment uncertainty for many South Asian women has the potential to translate into stress, anxiety and fear. In a study by Ahmad and colleagues (2004), South Asian immigrant women reported that economic uncertainty in general, and the fear of losing their jobs in particular prevented them from calling in sick or reporting unfair labour practices. The following statement made by a research participant reiterates the belief that for immigrants, physical and mental health concerns must take a back seat to job security:

> You feel more insecure because you may go to work one day and your boss will say "don't come tomorrow". . . But the thing is that we are immigrants and if anyone of us complains we are afraid we will lose our job. And at home if only one person [is earning], how are you going to run your house, how will you survive? (Ahmad, et al., 2004, p. 120)

This comment exemplifies how the relationship between power and responsibility impacts many South Asian immigrant women by overloading their personal resources and negatively impacting their mental health and sense of self.

Many South Asian immigrant women face pressure not only in the workplace, but also at home. They are typically solely responsible for running the domestic aspects of their household,

as well as taking care of their children and any in-laws that may be residing with them (Ashram, 2008; Spitzer, Neufeld, Harrison, Hughes, & Stewart, 2003). These factors may also contribute to the pressures experienced by these women, and, consequently, their mental health.

Issues to Consider When Investigating Mental Health Issues Among South Asian Women

A meta-analysis of studies of depression among South Asian women found discrepancies in the rates and presentation of the disease (Hussain & Cochrane, 2004). One of the problems in this literature that emerged in the review was the assumption made in many studies that South Asian women are a homogenous group. Studies that recruited women from different regions of India and Pakistan often had conflicting findings pertaining to depression rates and rates of readmission for treatment. By grouping all South Asian women together, however, the specific cultural and religious factors that may influence perceptions about depression were disregarded. The meta-analysis, thus, highlighted the importance of distinguishing between distinct ethnic groups (Hussain & Cochrane, 2004).

Understanding the importance of cultural, religious and migrational factors is particularly important when studying a topic such as mental health, where terms such as "depression" have no direct equivalent in some Asian languages (Ashram, 2008; Hussain & Cochrane, 2004). In fact, the most recent iteration of the Diagnostic and Statistical Manual of Mental Disorders (DSM) has a section devoted to culturally specific mental health disorders (American Psychiatric Association, 2000). Studies that fail to take this into account are confounded by a lack of conceptual standardization (Bhui & Bhugra, 2001; Jacob, Bhugra, & Mann, 1997). Cultural factors also appear to play an important role in determining what vulnerabilities may lead to depression. For example, factors such as social isolation, living with extended family members, unhappy marriages, and inter-generational conflicts were found to be cultural predictors of

depression among Pakistani and Punjabi immigrant women living in the UK (Dutt & Webber, 2009; Fazil & Cochrane, 1998). Historical, local, migrational and resettlement experiences also seem to have a profound effect on mental health among South Asian women in general (Beliappa, 1991; Fazil & Cochrane, 1998).

It is well understood that the presentation and reporting of psychological symptoms is culturally grounded (Fernando, 1990). Thus what may be defined as a mental illness in one culture may not be in another. Somatization is one such example. From a psychiatric perspective, South Asians have been largely described as a population that somatizes their emotional and social problems (Gaw, 1993; Hussain, Creed, & Tomenson, 1997; Ineichen, 1990; Johnson et al., 2004; Kawanishi 1992). Western models of mental health appear to clearly demarcate between somatic disorders and other psychological disorders that may, in part, be a reflection of a Western medical model that views the mind and body as separate entities. This conceptualization, however, is at odds with many other medical models, including traditional Chinese medicine and Ayurveda, that see the individual as an integrated system and that do not make such a clear distinction between somatic and psychological symptoms (Ashram, 2008; Weiss, Raguram, & Channabasavanna, 1995). In these models, a mental illness is typically viewed not only as a disease of the mind, but represents an imbalance between the body, mind and spirit. Within such models, relatedness of physical and mental complaints is plausible (Messant, 1992). By contrast, the creation of distinct categories in Western perspectives typically implies a separation between affective and somatic symptoms (Burr & Chapman, 2004).

The issue of somatization is further compounded by research findings that indicate that while women from many ethnic backgrounds are more likely to present with somatic complaints

when presenting with unrecognized depression (Betrus, Elmore, & Hamilton, 1995; Bhatt, Tomenson, & Benjamin, 1988; Wong & Tsang, 2004), family physicians are more likely to diagnose South Asian patients as having symptoms originating from a somatic cause (Bhugra & Cochrane, 2001; Comino, Silove, Mani- Cavasagar, Harris, & Harris, 2001; Cornwell & Hull, 1998). Unfortunately, the predominance of a mind-body separation in Western perspectives, coupled with somatic stereotypes about South Asian patients, has lead to greater incidences of under-detection and misdiagnosis of mental health issues within the South Asian community.

These studies raise many important questions about the role(s) of cultural factors in the diagnosis and treatment of mental illness. They also point to a larger problem within the mental health field: If clinicians and/or service providers are looking at how to define, diagnose, or treat mental health, then there needs to be an understanding of how individuals from different cultures view mental health and mental illnesses. Specifically, there appears to be a lack of understanding concerning how different cultural groups express mental distress. Disentangling the effects of culture, context, gender-specific issues, history, and migration experiences is fundamental in order to understand the etiology of mental health issues. With an understanding of the issues that affect women across cultures, and the issues that are culture-specific, clinicians and service providers may appreciate different views of mental health issues and more appropriately assess their clients.

An Historical Overview of South Asian Immigration to Canada

Cultural racism towards South Asians has been evident since the beginning of the 20th century, when members of these groups began immigrating to Canada. Cultural racism as a concept emerged in the 1960s when arguments based on biological differences between races were, for the most part, widely rejected; however, rejecting the biology of race or accepting race

as being socially constructed does not eliminate racism, but perhaps makes it more difficult to detect (Jones, 1999). Although most theorists and scientists have discounted arguments based on biological factors, biological arguments still persist within the phenomenon of cultural racism. Features such as ethnicity, which are often based on one's skin colour and phenotypic traits, are often associated with biology; thus race is often thought of in biological terms and unconsciously impacts judgment (Jones, 1999; Wren, 2001). Arguments within cultural racism concerning the inferiority/superiority of particular groups reflect biological racism and perform the same task: to create distinctly closed cultural groups (Blaut, 1992; Jones, 1999; Wren, 2001).

From the perspective of cultural racism, individuals from certain ethnic groups have not realized their potential to emulate the qualities of other groups, and thus have not learned the qualities that would allow them to be treated as equals (Blaut, 1992). The problem of inequality is thus framed as being one of culture. This argument acts to justify the differential treatment of ethnic groups based on their alleged capabilities (Blaut, 1992). In essence, cultural racism argues that unless non-Europeans adopt European cultural values and beliefs they will be unable to match the innate capacities of Europeans and will remain economically underdeveloped. Thus, non-Europeans should willingly submit to neocolonial domination of European countries and corporations "for their own good" (Blaut, 1992). The presumption that the only difference between non-European and Europeans is that of culture may be more apt if we lived in a colour-blind society. Cultural racist discourses aide dominant power structures by justifying the exclusion of those who are seen as culturally inferior, while dismissing oppressive forces—such as social and economic inequalities—as merely reflections of cultural differences (Wren, 2001).

Cultural racism perpetuates discrimination based on cultural differences, a fusion of cultural and phenotypic traits that assumes non-European races to be less evolved and seeks to

maintain a homogenous culture, and through it, national cohesion (Blaut, 1992; Jones, 1999; Short & Carrington, 1996; Wren, 2001). Cultural racism appears to play a pivotal role in the ongoing discrimination of South Asians in Canada. For example, cultural racism provides a means to justify actions that limit foreigners' integration within society by restricting their employment opportunities, and pushing them to the margins of society, where they are forced to seek employment in areas that are removed from the public eye, such as agricultural labour. What follows are examples of how discourses of cultural racism have been invoked against South Asians as a means of legitimizing discrimination in the Canadian context.

Few South Asians were accepted into Canada during the early 20th century and the growth of their communities was limited because disproportionately few women were allowed entry. Fears of South Asians taking away jobs and polluting the last Anglo Saxon frontier prompted Canadian officials to enact various pieces of legislation to limit South Asian migration (Buchignani & Indra, 1985, as cited in Jiwani, 1993). These laws included the prohibition of South Asians from voting, running for public office, or pursuing careers as accountants, lawyers, or pharmacists (Nayar, 2004). Another act of exclusion was the Continuous Passage Act, which prohibited South Asians from immigrating to Canada unless they came via a continuous passage, and even then required a head tax of $200 (Johnston, 1989). Famously, this law was challenged by a group of men who arrived in a ship called the Kamagata Maru in 1914. Unfortunately, in this case the Canadian government denied entry to 352 out of the 376 men.

Following the Second World War, the immigration laws were relaxed and a larger number of South Asians began immigrating to Canada; however, cultural racism against this group in Canada did not ease. Instead of being welcomed, they were most often shunned by the

mainstream society, with local newspapers often characterizing them as violent and unable to integrate into Canadian society (Jiwani, 1993).

From the beginning of the twentieth century through to the present day, South Asian immigrants in Canada have been something of a faceless entity. South Asian women in particular have been pushed even further to the background, as they have been by and large physically and socially invisible (Bhannerji, 1993; Goldberg, 1993; Tran, Kaddatz, & Allard, 2005). Part of the reason for this is that the history of South Asians in Canada is predominantly a history of men. South Asian men were the majority of immigrants to Canada from India at the beginning of the 20th century (Nayar, 2004). At the time, the sentiments of imperialist rulers in the subcontinent were such that Indians were not deemed worthy to be a part of the British Colony, and therefore many women were restricted entry into Canada (Johnston, 2000). Some South Asian men were permitted to travel back to India in order to facilitate the migration of their wives and dependent children under the age of 18 (Johnston, 1989), but there is little documentation of those South Asian women who lived in Canada during this period. It appears as though these women existed "in a vacuum, in a state of constant facelessness" (Bhannerji, 1993, p. 145). This historically silenced identity continues to pervade present day conceptions of South Asian women. Today we see few images of South Asian women in the mainstream media, including in advertisements, and when we do, the images tend to be inaccurate and biased. For example, there is a disconnect between the depiction of South Asian women in popular movies such as *Bride and Prejudice*, and their reality as "dependent immigrants" or "working hands" in the service and manufacturing industries (Bhannerji, 1993, p. 145).

On the whole, South Asians are an understudied group in Canada, whose presence has been historically compromised (see Wong & Tsang, 2004 for a similar argument made in relation to

Asian immigrant women). A neocolonial mentality marginalized this minority group as they attempted to make a place for themselves in Canada. Their daily experiences continue to be influenced by forms of cultural racism that are structured by institutional practices. A universalized theory of mental health tends to ground definitions of mental health, assumptions about mental health care access, and the way the mental health care system was initially structured even though the "significance of diversities such as gender, ethnicity, culture, and sexual orientation has challenged the validity of earlier findings and theorization" (Wong & Tsang, 2004, p. 456). This theory may not be consistent with the definitions and cultural commitments of Punjabi immigrant women.

Implications of South Asian Family Dynamics for Mental Health

South Asian society is largely governed by patriarchal cultural values that are an inherent aspect of everyday life in India. These values strongly reinforce gender roles and stereotypes. Many South Asian immigrants in Canada predominantly hail from a traditional society, and adhere strongly to notions of *Dharam* (duty) and *Izzat* (honour). A traditional society is defined on the basis of the following qualities: 1) a predominance of ascriptive behaviour, for example, recruitment is based on inherited characteristics, loyalties based on kinship, and obligations based on kinship ties; 2) stability and limited spatial mobility; 3) a basic and stable occupational differentiation, for example, occupation is impacted by one's social class and; 4) a diffused stratification system that includes a relatively stable hierarchical positioning for individuals in society with the result that there is a decreased ability to change one's social status (Parsons & Shils, 1951). In addition, knowledge is seen as constant, with elders being the best source of knowledge (Nayar, 2004). Based on the premises underlying a traditional society, it can be seen

how *Dharam* and *Izzat* are fairly stable notions that carry with them a particular set of kinship and status-based obligations that must be fulfilled.

To a great extent, the concepts of *Dharam* and *Izzat* impact and define South Asians' roles in life. *Dharam* for many South Asians implies the fulfillment of one's social duties as a husband, wife, parent, and grandparent (Nayar, 2004). *Izzat*, reflects a family's honour, and not only encompasses an individual, but also the individual's family, as a person's actions reflects not only upon him or her, but also upon their family (Hennink, Diamond, & Cooper, 1999; Wakil, Siddique, & Wakil, 1981). *Izzat* is an especially salient concept for women as they are often seen as the purveyors of Indian tradition and culture (Katrak, 2006). Traditionally, women have been seen as always needing to be cared for by a male: first their father, then their husband, and finally their son(s) (Doniger & Smith, 1991). Sacred Indian texts such as the *Manusmtri* and *Ramayana* reiterate this view.

Indian values typically position women as obedient, self-sacrificing, and always subservient to the wishes of others (Nassbaum, 2005). The restriction of women's bodies in terms of their movement, attire, education, and religion all act to create the embodiment of the ideal virtuous woman. The dishonour that can be brought to a family by a female member is seen as being worse than death itself (Doniger & Smith, 1991; IOLR 1891, as cited in Engels, 1989). These cultural values, combined with the perspective that mental health problems and seeking professional help for these problems are often taboo topics within South Asian culture, may help explain why some South Asian immigrant women are reluctant to seek help for mental health problems. The close knit South Asian community and their perpetual gaze on their women's movements may prevent many women from seeking mental health help, simply out of fear of bringing shame to their family (Ashram, 2008; Bottorff, Johnson, Venables, & Grewal,

2001; O'Mahony & Donnelly, 2007). Merely talking to outsiders about family-related issues and problems may also be interpreted as dishonourable behaviour (O'Mahony & Donnelly, 2007).

How the community perceives and defines a lack of mental health may also influence what actions are taken by women. For instance, many South Asian immigrant women define mental health as having a happy family. Consequently, if seeking help for mental health issues affects their social obligations, they may be less inclined to seek medical attention. This is not to say that South Asian women will never seek help, but that the type of help they seek may be different.

Tightly held beliefs about women ranks India 134 out of 182 countries on an index of gender empowerment, according to the Human Development Report India (2009). However, it is important to keep in mind that not all cultural practices hinder women's lives in India. For instance, Indian values that stress the importance of family also help to create strong and tight family networks that may be supportive and help to alleviate the burdens associated with nuclear families, including by easing childcare worries. Cultural traditions, for better or worse, influence women's movements from birth until death.

Another important factor related to South Asian family structure is illiteracy. UNESCO estimates that by 2010 the illiteracy rate for adults in India will reach 35.3%, with 25.9% of males and 45.3% of women being illiterate (Human Development Report India, 2009). Women are less likely to be educated than men, as their primary responsibilities reside in the domestic sphere (Sarkar, 2002). Due to these high illiteracy rates, there is a large oral tradition in India, especially among women (Nayar, 2004). In order to better understand the impact of oral cultures on individuals it is important to understand some of the key characteristics of this tradition. Individuals from an oral tradition are more likely to think in concrete terms, and are sometimes

unable to understand abstract concepts (Nayar, 2004). For them, knowledge may be constructed through experience; as such, metaphors and intangible concepts may have little relevance or meaning (Nayar, 2004). Reality may be based on what can be experienced through the physical senses. Hence, comprehension is achieved when one has experienced what is being discussed. This issue becomes particularly salient when observing the speech patterns of individuals raised within cultures with an oral tradition. Frequently, speech patterns consist of retelling stories and ideas that have been orally transmitted and elders, or those with greater real-world experience, are deferred to as holders of knowledge (Nayar, 2004).

Although immigrants to Canada often have higher levels of education than is the norm in their country of origin, this does not always hold true for those who enter Canada as dependents. This is often the case among Punjabi immigrant women. As a result, the common modes of communication utilized in Canada to reach diverse populations, including, for example, print media reproduced in different languages, may in fact be ineffective as many people may be illiterate or may not have enough literacy to make use of the information. Moreover, those who are able to read may be unable to comprehend the texts due to the peculiarities of the language used, such as the use of metaphors.

Immigrant Women's Perceptions of Mental Health

The research that has focused on South Asian immigrant women has found that mental health is associated with familial factors and health promotion practices appear to be related to their upbringing. Many women are socialized to focus on the mental health of others especially those in their immediate family (Choudhry, 1998). When mental health does become imbalanced, South Asian women may prefer to discuss their problems with family members and not friends. Interestingly, Furnham and Malik (1994) noted that the advice that South Asian

women reported to be most helpful to a depressed woman is being told to pull herself together. Certainly it seems clear that, as a result of South Asian women's focus on the mental health of others, they may be less likely to focus on themselves (Bottorff et al., 2001; Choudhry, 1998, Gilligan, 1982). For example, being mentally happy for many South Asian women is related to having happy families, children who spend time with them, children who are obedient, and freedom from family-related burdens (Beliappa, 1991; Bottorff et al., 2001; Choudhry, 1998). Being happy also involves not being a burden on anyone, which underscores the importance of easing the work of others (Bottorff et al., 2001; Choudhry, 1998).

From this understanding of mental health, it appears that the construction of a mentally healthy self occurs in tandem with others. Many of the Canadian immigrant women in Choudhry's (1998) and Dutt and Webber's (2009) studies noted that having a close-knit social network was imperative to happiness; however, situational and environmental factors often prevented these women from creating and maintaining such networks. For example, although many of the women surveyed lived in a large metropolitan area densely populated with South Asians, work schedules, family commitments, transportation issues, and poor weather hampered the development and maintenance of their close relationships.

Across many cultures, women generally define mental health based on holistic factors including physical, mental and spiritual aspects. For example, a study by Dossa (2002) found that women of Iranian origin typically defined mental health as being related to the spirit. To have a happy spirit is to be mentally at peace. For other Iranian women, mental health was equated with income and financial stability (Dossa, 2002). The South Asian women in Choudhry's (1998) study also held a strong connection between the mind, body, and spirit in relation to mental health. When they discussed dealing with life's adversities they noted the

importance of having faith in God. They commented on how the soul requires nourishment, and how this nourishment comes in the form of prayers. Prayers were seen as strengthening the soul and helping them to deal with life's adversities. It has been suggested that the strong mind-body-spirit connection within this group may be a determinant of the simultaneous manifestation of mental and physical symptoms (Tewary, 2005). In other words, if one aspect of the mind-body-spirit triad is out of balance, the other two components may also be affected.

Some South Asian immigrant women take on a fatalistic perception of spirituality. Ailments, both physical and mental, are often perceived as being elements of their destiny and a part of their life's journey about which not much can be done (Choudhry, 1998). This belief in destiny, a conviction that the events that occur in one's life are preordained and beyond one's control may also inhibit some women from seeking professional help (Choudhry, 1998; O'Mahony & Donnelly, 2007). Overall, however, the women in Choudhry's (1998) and O'Mahony and Donnelly's (2007) studies perceived spiritual and religious practices as sources of strength. These practices often strengthened and maintained their mental health, and provided them with resiliency to persevere during difficult or mentally distressing times (Acharya & Northcott, 2007; O'Mahony & Donnelly, 2007).

Health Services for Immigrants

Although many immigrant women suffer from poor mental health, they frequently fail to receive the care they need, and experience difficulties when accessing mental health services (Beiser, Gill, & Edwards, 1993; Meadows et al., 2001; Morrow & Chappell, 1999; Ten Have & Bijl, 1999). Twenty-five years ago, Lenininger noted that "Western health-promotion programs are usually dysfunctional for people with non-western values" (Lenininger, 1985, p. 269, as cited in Choudhry, 1998). Unfortunately, this statement appears true today, as little has been done to

change the delivery of health services. The changes that have occurred in the field of mental health, include the hiring of multilingual staff, providing mental health workers with access to interpreters, and producing multilingual mental health pamphlets and educational workshops on topics such as how to communicate with non-English patients (Ganesan & Janze, 2005). However, these are often relatively superficial and have tended to focus on increasing resources and training staff on how to communicate with culturally diverse clients. In contrast, the actual delivery of mainstream programs and services have undergone minimal changes. The seeming shift toward culturally sensitive approaches to mental health instead appears to focus on ways to better convey Western conceptions of mental health. Put differently, the lack of structural changes within the health care system reflects the adoption of a "culture blind" approach wherein cultural and religious factors are neglected and Western medical assumptions take precedence, based on the belief that "we are all the same" (Cochrane & Sashidharan, 1996). However, as discussed earlier, such all-encompassing blanket statements overlook significant cultural factors and the problems created by marginalizing the impact of culture, history, and context.

Health care services available to immigrants include both formal and informal networks. Formal networks refer to individuals or organizations that are mandated to deliver mental health services, such as psychiatric hospitals, psychiatric wards in general hospitals, clinics, community mental health organizations, and mental health practitioners in private practice (Canadian Task Force, 1988; Stewart et al., 2006). Informal networks refer to individuals or organizations that are not mandated to deliver mental health services, and include family physicians, family service counsellors, public health nurses, the staff of multicultural or ethnic community organizations, and second-language teachers (Canadian Task Force, 1988; Stewart, 2006). Immigrants may be more comfortable accessing informal networks, as they are more likely to present symptoms to a

general practitioner or other non-mental health specialists. The reasons for this are manifold; however, two explanations are fairly likely. First, a referral is required in order to see a mental health specialist. Even with a referral, a long wait period may be involved. Second, Canadian public health insurance does not cover the cost incurred of visiting specialists, for example, clinical psychologists, and new immigrants may be unable to afford such services (Oxman-Martinez et al., 2005).

Immigrants also tend to be hesitant to seek formal help for mental health issues due to a perceived over-eagerness of physicians to prescribe pharmaceutical drugs (Whitley et al., 2006). Many immigrants believe in non-pharmaceutical interventions, such as the curative power of faith or traditional folk medicine and healers (Li & Browne, 2000; Whitley et al., 2006). Interestingly, South Asian immigrants often prefer to use alternative healers in conjunction with medical interventions (Cochrane & Sashidharan, 1996; Greenwood, Hussain, & Burns, 2000; Hussain & Cochrane, 2002, 2003). For South Asians, traditional healers, being from the same culture, are members of the community, have an understanding of cultural norms and rules, and, therefore, may be more respectful of their client's belief system (Li & Browne, 2000). Additionally, some South Asians prefer to seek the assistance of traditional healers as they believe that someone has done something to the individual that has resulted in the abnormal behaviour (Ashram, 2008).

Another barrier to accessing help from the health care system is a perceived lack of time and interest on the part of physicians (Ashram, 2008; Li & Browne, 2000; Whitley et al., 2006). Many immigrants feel that physicians are dismissive and do not take the time to understand their patients' problems. They feel that prescriptions may not be beneficial if their problems are not fully understood by their physician (Whitley et al., 2006). The following statement exemplifies

this perception:

> I am working with older people. Mr X came here in 1953. When he retired he had a
> urinary problem. When he wants to go to the toilet he could not go upstairs so he would
> go to the garden. The family took him to the doctor the doctor said he had depression but
> the doctor did not realise that the cause was the inability to go upstairs to use the toilet.
> The result was the doctor gave him antidepressants. (Ashram, 2008, p. 7)

Language is yet another major obstacle that South Asians, in general, and many South Asian immigrant women face when they do decide to seek help. The lack of a common language may limit immigrants' ability to accurately convey their needs and concerns (Li & Browne, 2000; Vissandjee, Weinfeld, Dupere, & Abdool, 2001). Moreover, this lack of language fluency hampers both the client's, as well as the practitioner's, abilities to translate cultural expressions, creating further potential for miscommunication. Miscommunication, in turn, may result in missed or inaccurate diagnoses, misinterpretations of a client's condition, or simply a lack of understanding on the part of the client regarding the planned treatment.

When South Asians do interact with someone with whom they share a common language, not only are they more likely to appropriately and explicitly state their mental health concerns, but it also appears that the practitioner is more apt to notice cultural nuances that may be indicative of other underlying psychological issues (Ashram, 2008; Mumford, Bavington, Batnagar, & Hussain 1991; Wilson & MacCarthy, 1994). Matching patients and practitioners with similar cultural backgrounds does not always appear to be a pre-requisite for positive health outcomes, however, as a study by Callan and Littlewood (1998) found that patient satisfaction was a function of the degree of overlap between the patient and psychiatrist on their explanatory model of illness, rather than matched ethnicity between patients and practitioners.

Beliefs concerning the causes of the mental illness may also affect the types of treatment sought by South Asians. Studies by Battachaya (1986) and the Ashram Society (2008) within the South Asian community in the UK found that mental illnesses appeared to be allocated by members of this group into the following categories: ghost possession, black magic, and malfunctioning of the head. For the first two categories, help from traditional healers was typically sought and interventions involved reading religious texts, raising spiritual awareness, or administering herbal remedies. Only for the final category was a physician sought for treatment. In a similar vein, another study found that many South Asian immigrant women were less likely to approach Western-trained physicians if they believed that their beliefs concerning the spiritual causes of mental illnesses would not be acknowledged, as they feared being ridiculed for their beliefs (Hussain & Cochrane, 2002).

As mentioned earlier, the stigma attached to mental illness within the South Asian community is often an inhibiting factor in this group's access of mental health services. For some South Asians, mental illness is seen as incurable and/or a sign of madness (Ashram, 2008; Fazil & Cochrane, 1998). For others, public acknowledgment of a mental illness brings dishonour to the family, and negatively impacts their ability to find a suitable marriage partner for their daughters. Many marriages within the South Asian community are arranged, and, thus, marriage prospects may be negatively impacted if the prospective bride or groom is diagnosed with a mental illness. The mental illness may be seen as a burden and an inappropriate expectation from the perspective of the bride/groom and their family (Hussain & Cochrane, 2004). Accordingly, some researchers suggest that this stigma of mental illness may not be related as much to the disease itself as to the burden it may cause to others (Fatemilihin & Nadirshaw, 1994; Qureshi, 1988). Finally, some immigrants are also fearful that being

diagnosed with a mental illness may jeopardize their own or their family's immigration status, or that their entire community may be stigmatized leading to a government restriction on immigration from their country of birth (Canadian Task Force, 1988).

It is important to note that despite the barriers immigrants face when accessing mental health care services, two programs have been established that specifically address the health needs of diverse peoples. These two exceptions take the form of: 1) a program in Portland, Oregon that provides services to Indo-Chinese refugees, and is known for its large clientele base and innovative services and; 2) a program called *Across Boundaries* in Toronto, Ontario that offers mental health services to visible minority groups and recognizes the impact of racism on individuals while approaching mental health from a holistic perspective. The success of these particular programs may be related to their shared approach to health care.

Across Boundaries. for example, is integrated with community centres and incorporates a holistic approach to mental health that addresses racism (Fernando, 2002). It overcomes many of the barriers that deter immigrants from accessing mental health services. For instance, their holistic approach to mental health allows consumers to select a therapy option that closely matches their beliefs concerning mental health, while their staff is well trained to deal with issues related to anti-racism and anti-oppression and offer services in a variety of languages. As a whole, the culture of this organization acknowledges how various intersecting factors, such as culture, language and economics can impact an individual, their mental health, and their mental health needs (Across Boundaries, n.d).

Overall, *Across Boundaries* seeks to overcome many of the barriers that are often present in Western approaches to mental health, especially those that fail to take into account and treat the entire individual, and not just the mental illness. Aside from *Across Boundaries'* strong

mandate to serve individuals from a myriad of cultures, they also have a strong research mandate whereby they partner with local universities and service agencies in order to assess how the needs of those they serve can be better met, thereby constantly improving their services while being sensitive to the needs of their clientele. The success of programs like this illustrates that this work is not only possible, but also potentially sustainable.

Summary

There appear to be a multitude of factors, ranging from differing beliefs about what constitutes good mental health to barriers in accessing resources, that inhibit immigrants from seeking out mental health services. Understanding Punjabi immigrant womens' definitions regarding mental health may serve as a pre-requisite to understanding how to better adapt mental health services. Recognizing cultural distinctions between psychosocial, spiritual, and physical causes of mental health and illnesses may allow health practitioners to better understand the ways in which culture influences the experience of mental health and illnesses for Punjabi immigrant women (Hussain & Cochrane, 2002).

Overall, the lack of progress in academic research on the mental health services available to immigrants is a concern, particularly given the growing attention surrounding the deteriorating mental health condition of immigrants (e.g., the healthy immigrant effect). Whereas there are a few organizations, such as *Across Boundaries*, that do offer culturally sensitive mental health services to minority groups including immigrants, existing research appears to focus more on unearthing barriers to accessing mental health than investigating what services are available and which of these services immigrants find useful. More than anything, however, what is required is a more nuanced research approach that avoids aggregating sub-groups and that disentangles the factors that impede immigrants, in general, from Punjabi immigrant women, in particular,

while clarifying which of these factors are gender-specific, as well as the application of research findings generated to the development and dissemination of programs that offer culturally responsive approaches to mental health services.

Chapter 3

Theoretical Frameworks

Various models have been proposed to explain the mental health of immigrants; however, not all models place equal emphasis on culture. Some theorists view culture as a human byproduct that may easily be relinquished, whereas others conceive of culture as an integral part of the individual that cannot be dismissed or demeaned. This chapter begins by critically evaluating two prominent theoretical approaches to understanding mental health among immigrant populations: positive psychology and acculturation theory. In the third section, the theoretical framework for this dissertation is presented, along with a discussion of how feminist postcolonialism addresses many of the shortcomings of the former approaches.

Positive Psychology

Positive psychology asserts that a mentally healthy individual is one who is able to enjoy life and is resilient, balanced, flexible, and self-actualized (Canadian Mental Health Association 2006; Tewary, 2005). One of the main goals of positive psychology is to shift focus away from pathologies that require treatment in favour of positive characteristics that may be developed or enhanced (Seligman & Csikszentmihalyi, 2000; Slade, 2010). Supporters of positive psychology view it as "a science of positive subjective experience, positive individual traits, and positive institutions" (p. 5), while the rest of psychology or "negative" psychology, purportedly focuses on negative emotions and experiences in individuals who are typically perceived as "the victim, the underdog, and the remedial" (p. 13). The goal of positive psychology is to shift from a disease-based model to a health-based model that should be able to uncover factors that lead to optimal outcomes, such as the family conditions under which children thrive and prosper,

conditions that generate the best employee satisfaction, and factors that make life most worth living (Seligman & Csikszentmihalyi, 2000; Slade, 2010).

While this sounds promising, positive psychology may actually negate the belief that cultural groups have different belief systems and standards for acceptable behaviour (Manson, 1995). In assuming shared meanings across cultures, positive psychology commits a category fallacy (Hussain & Cochrane, 2004; Kleinman, 1987), one that may hinder the acceptance of cultural and religious perspectives when defining mental health and helping different groups with mental health-related issues. By defining what is and is not mentally healthy, as a single, universal phenomenon, a definition of mental health is created that perpetuates dominant social perspectives, thereby "reproduc[ing] socially constructed ideal personalities" (Tsang, 1986, p. 2). Indeed, although positive psychology is a relatively new perspective, its reliance on a universalized notion of mental health makes it similar to more traditional psychological perspectives that assume one single standard for psychological functioning.

Several researchers have noted that the manifestation of emotions varies across cultures (e.g., Manson, 1995; Ratner, 2000). For example, depression may produce more somatic symptoms in cultures that do not permit the open expression of feelings. South Asian women may exemplify this phenomenon when they exhibit somatic symptoms coupled with psychological problems (Bhui et al., 2004; Burr & Chapman, 2004; Choudhry, 1998; Li & Browne, 2000). In their case, physicians often misinterpret a lack of verbosity in discussing their health-related issues as shyness, and may attribute this misinterpretation to other women who are perceived to be members of the same cultural group. As a stereotype develops, they are assumed to be poor patients by their physicians, who, in turn, may alter their own behaviour towards them by speaking more loudly and slowly. Over time, physicians' negative perceptions of their past

patients may affect their interactions with new patients who are perceived to be members of the same cultural group. This, in turn, may affect the overall care they provide, leading to poorer outcomes in the long-term.

This problem is one of essentializing. Essentializing occurs when a group's identity, which is multifaceted, is reduced to a single essential quality that is believed to be shared by all members of that group (Wong & Tsang, 2004): a quality that is the "essence" of that group. Thus, believing that South Asian women, as a group, make poor patients makes this the defining characteristic of the group, and influences the delivery of their mental health care. Essentializing excludes different modes of expression, different lived experiences, and erases differences between individual members of a group. Whereas there exist a variety of legitimate modes of expressing one's problems, creating dichotomous groups—for example, homogenizing a dominant group's way of expressing a problem and comparing that with a homogenized minority group's way—leads to the categorization of communications as healthy versus unhealthy, normal versus different. In short, essentializing creates an "us" and "other" dichotomy. Mental health defined in terms of self-fulfillment reflects the adoption of a value-laden approach that is only applicable to a particular group (e.g., North Americans), and not all members of that group equally well. The assumption that this definition is universal, that based on the dominant cultural group's experiences it fits all members of all cultural groups equally well, may alienate people who are struggling with mental health issues.

Acculturation Theory

Several theories have been proposed to explain the adaptation process of immigrants, including the potential problems they may encounter. Of these, perhaps the most widely cited is acculturation theory (Berry & Sam, 1997; Salant & Lauderdale, 2003). Acculturation theory

proposes that immigrants adjust to their new host culture using one of four primary strategies: assimilation, separation, integration, and marginalization.

Assimilation occurs when an individual chooses to maintain ties with the dominant group over their own cultural group; separation, on the other hand, occurs when individuals sever ties with individuals from the dominant group and maintain ties with individuals from their own cultural group in order to "hold on to their original culture" (Berry & Sam, 1997, p. 297); integration occurs when the individual chooses to maintain strong contacts with individuals from both the dominant group and their cultural group; and marginalization occurs when the individual has been alienated from both their native culture, as well as the dominant culture. In other words, they "lose cultural and psychological contact with both their traditional culture and the larger society" (Berry, 1998, p.119).

Acculturation theory, as described by Berry (1998), has been criticized on at least six grounds. First, it assumes that cultures are pure or quintessential, unaffected by historical, cultural, or other factors (Bhatia & Ram, 2001). Second, given that the range of possible adaptation strategies it outlines is finite (Castro, 2003), acculturation theory inherently embraces the notion of a universal self, void of culture, that typically adapts to a host culture in a specified and predictable manner. Culture, thus, acts as a channel that either suppresses or unveils certain universal human characteristics. Third, acculturation theory, by perceiving culture to be an extraneous variable, dismisses the effects of history, race, gender, and power on immigrant adaptation (Bhatia & Ram, 2001). For instance, an affluent individual who was part of the majority group in their native country may find, upon immigrating to Canada, that they are now part of a minority group and, consequently, pushed to the periphery of society. Many of the variables that acculturation theory views as extraneous and, therefore, disregards may actually

have a large impact on the adaptation trajectory of immigrants. Fourth, an underlying assumption of acculturation theory is that all individuals adapt to their new culture by adopting one of the four acculturation strategies (Castro, 2003). Acculturations' universalistic stance stands in opposition to culture, ontologically; they cannot co-exist. Fifth, it is assumed that there is a logical end point to these four strategies. A great deal of research challenges this acultural, universal perspective, and advances a cultural contextual perspective instead (Ratner & Hui, 2003). Sixth, the category of marginalization assumes that the individual is without culture, an interesting paradox that bolsters the argument that Western perspectives tend to recognize and enhance cultural forms deemed appropriate. Similarly, acculturation theories disregard diasporic groups, who make conscious efforts to maintain ties with their homeland in order to recreate aspects of their homeland in their adopted country. In the case of South Asian diasporas in particular, religion and culture play major roles in the daily lives of individuals (Beliappa, 1991; Fernando, 1990; Hussain & Cochrane, 2004; MacCarthy & Craissaitti, 1989; Wilson & MacCarthy, 1994).

An Alternative Theoretical Framework

Feminist postcolonialism is an alternative theoretical framework to positive psychology and acculturation theory that may be used to conduct research into the definition of mental health, the meanings of mental health, and to create culturally responsive mental health services. A feminist postcolonial perspective allows a process-oriented approach for understanding how diverse groups negotiate their multiple and often conflicting identities. While postcolonialism enables an examination of how historical and political events shape immigrant histories and identities, feminist postcolonialism was used given its attention to the ways in which the intersection of gender, ethnicity, and social class may influence lived experiences. In the

following sections postcolonial theory is described generally, and then extended to include a discussion of orientalism. The section closes with a discussion of feminist postcolonialism and intersectionality.

Postcolonial Theory

Postcolonial theory examines how individuals and societies have been affected by colonial rule, and how a colonial mentality continues to reverberate after colonial powers have severed their physical ties to the colonized nation. Postcolonial theory challenges colonial values and assumptions, including its ways of knowing. By critiquing dominant Western knowledge systems, a new space is created, whereby alternative ways of knowing and understanding others' voices emerges. For example, postcolonial theory asserts that mental health services based on Eurocentric assumptions are unlikely to have genuine insights into the factors or circumstances that affect the mental health of South Asian immigrant women (Anderson, 2000).

Postcolonial discourse also brings to the foreground the processes through which individuals and groups have been dehumanized and suffered throughout history, providing a context through which to better understand health inequalities (Anderson, 2002). For example, postcolonialism calls attention to how the socially constructed concept of race was understood during colonial times, as well as the lasting effects this understanding had on individuals and their life opportunities (Anderson, 2002). Postcolonialism, thus, may be broadly defined as a conglomeration of theories that examine how the legacy and history of colonialism impacted and continues to impact the lives, mental health, and life opportunities of marginalized groups of people (Young, 2003).

Postcolonial theory challenges universal assumptions of knowledge development (Anderson, 2002). It pushes researchers and practitioners to question taken-for-granted

assumptions, and to examine the social and historical contexts within which these assumptions have been produced. It is through this process that postcolonial theory seeks to disturb the foundations of dominant discourses.

The "post" in postcolonial should not be mistaken for the demarcation of a clean separation between colonial powers and the colonized, but instead as a representation of neocolonial domination to which postcolonial societies are subjected (Young, 2003). Whereas postcolonial theory examines the effects of colonization and decolonization on the colonial subject, it is not focused on a particular time period. Consequently, the reverberations of colonialism differ by location and history. The following is a brief introduction to postcolonial concepts helpful in understanding disparities in the health care system, especially with relation to how South Asian women define mental health and access the mental health care system.

Orientalism.

Orientalism, a term originally coined by Said (1978), refers to the Occident's characterization of the Orient. He defined Orientalism as a corporate endeavor for "dealing with [the Orient] . . . by making statements about it, authorizing views of it, describing it, by teaching it, settling it, ruling it over it: in short, Orientalism [was perceived] as a Western style for dominating, restructuring, and having authority over the Orient" (Ashcroft, Griffiths, & Tiffin, 1998, p. 135). This hierarchical construction of the Orient as inferior to the Occident contributed to the dehumanization and suffering of those deemed to be inferior or seen as the "other" (Anderson, 2002; Said, 1978).

Through the utilization of various modes of discourse, including political, artistic, media, and academic, Orientalism and the assumptions and stereotypes embedded within it became normalized. Said argued that oriental discourse generates a line of thinking that structured the

known (Europe, the West, "us") as familiar and the unknown (the Orient, the East, "them") as strange (Loomba, 2005; Said, 1978). Orientalism continues to be a prominent concept in the present, as Western perspectives continue to subjugate the Orient. This can most clearly be seen in the case of Islam or, more pertinent to this study, with the treatment of South Asian youth. As noted earlier, South Asians began immigrating to Canada in the early 1900s, during which time the dominant European population met them with great hostility. Unfortunately, these feelings have persisted to the present day. During the 1900s, they were accused of being immoral and unable to assimilate. In the present these ideologies continue to resurface through, for example, media attention highlighting gang violence instigated by South Asians. Interestingly, during the 2009 gang war in the Lower Mainland of British Columbia (B.C.) in which no South Asians were involved, there were no sensationalized headlines drawing attention to the ethnicity of the assailants. Seen through the lens of Orientalism, the continuing defamation of South Asians in Canada perpetuates the existence of this group as second-class citizens, thereby invigorating neocolonial discourse and continuing the subjugation of those othered.

In terms of the present study, Orientalism is particularly relevant with regard to how South Asian patients are perceived by doctors and other figures of authority. For instance, when South Asians are perceived as poor patients or shy patients, the level of care that they receive from their doctors is impacted. These perceptions also help to reaffirm "us" versus "them" distinctions in the health care field.

Feminist postcolonialism.

Despite the flexibility offered by postcolonialism to acknowledge and theorize suffering from multiple contexts and address oppression across multiple dimensions, postcolonial theory falls short in its analysis of gender. The addition of a feminist perspective overtly focuses the

study on feminist concerns and draws attention to gendered social practices. The insertion of feminist postcolonialism allows for the examination of how various sources, including but not limited to patriarchy, act to oppress women by examining the intersection of colonialism and neocolonialism with gender, race, and class in different contexts of women's lives (Sharp, 2009).

Within the analysis of gender, race and class are intersecting factors and must be considered in tandem (Collins, 2000; Creese & Stasiulis, 1996; Harley, Jolivette, McCormick, & Tice, 2002). Without the insertion of race and class the assumption may exist that women of all backgrounds experience gender in the same way, and consequently face identical issues (Dua, 1999; Mohanty, 1991a, 1991b). However, even a cursory glance at Canada's postcolonial history reveals the importance of considering race and class along with gender, and the privileges afforded or denied based on these factors. For example, whereas Canada's immigration policy during the early 1900s allowed European women, married or single, to immigrate to Canada, it did not extend the same welcome to married or single South Asian women (Dua, 2000). Attention to race, or more pertinent here, ethnicity, is an important component of the theoretical framework of the present study as it allows for the analysis of how South Asian women have been positioned in Canadian society, and the subsequent impact their position may have on their mental health and access to mental health services.

For this study, intersectionality (Collins, 2000; Crenshaw, 1991) was used to delineate the various intersecting forms of oppression present between gender, race and class. This intersectional framework foregrounded the notion that oppressions cannot be reduced to a single type and that intersections act in tandem with one another to produce injustices and different types of lived experiences and social realities (Collins, 2000). In conjunction with intersectionality, the "matrix of domination" examines how oppressions are structured across

different power domains. It examines how power structures are organized within a society, how these structures interact with one another, and are affected by historical and social forces. Further, intersecting systems of oppression are seen as being structured through four different domains of power: structural, disciplinary, hegemonic, and interpersonal (Collins, 2000).

The structural domain refers to social structures, such as law, polity, religion, and the economy. This domain sets the structural parameters that organize power relations and is relatively slow to change. An example of the structural domain are laws that prohibit or restrict immigrants from migrating from another country, as was the case in Canada in the early 1900s when legislation was enacted to limit South Asian migration to Canada. South Asians who were residing in Canada during the early part of the 20th Century were prohibited from holding certain offices. For instance, South Asians could not vote, run for public office, or pursue careers as accountants, lawyers, or pharmacists (Nayar, 2004). Such power structures are typically resistant to change except when met with large-scale social pressure. Indeed, immigration laws for South Asians were not relaxed until after the Second World War when physical labourers were needed to fuel Canada's growth.

The disciplinary domain both manages and conceals oppressions. This domain consists of bureaucratic organizations that control and organize human behaviour through routinization, rationalization, and surveillance. Many bureaucratic organizations, despite public policies espousing equality for all, often manage and control their employees. For instance, despite many South Asian immigrant women's high educational status they are often channeled into low paying jobs in the service sector industry (Ahmad et al., 2004). Many of these women have little opportunity for advancement; their superiors may also keep close surveillance on them, more so than women from other backgrounds. This helps to create a class of women who are disciplined

to be quiet, subservient, orderly, and obedient. Nonconformists risk having their employment

terminated (Ahmad et al., 2004). However, once minority women achieve a position of power

within these bureaucratic organizations they also gain the ability keep surveillance on these

organizations and search for new and innovative ways to bring about change (Collins, 2000).

The hegemonic domain acts to legitimize oppressions and deals with ideology, culture, and

consciousness (Collins, 2000). It justifies the practices upheld by the structural and disciplinary

domains, which typically operate through system-wide social policies that are managed by

bureaucratic organizations (Collins, 2000). The hegemonic domain is a link between the

structural, disciplinary, and interpersonal domains by justifying the practices within these various

domains. It is shaped and manipulated by the use of images, ideas, symbols and ideologies. The

dominant groups often use taken-for-granted commonsense arguments to support and legitimize

their rule and, covertly, perpetuate the oppression of others. For instance, the lack of focus on

South Asians in Canadian history texts, coupled with their lack of presence in the mainstream

media, only helps to further subjugate them as a faceless entity within the broader Canadian

landscape, despite their presence in Canada for over a hundred years. The hegemonic domain,

like the other domains, can also be a site where commonly taken-for-granted arguments are

challenged, rendering new discourses.

The interpersonal domain refers to the daily, routinized interactions that influence our

everyday life, including the relationships we maintain, and how we respond to inequalities on a

daily basis. Changes within this domain are centered on the individual and how they perceive

themselves and understand their own experiences. Collins (2000) points out that individuals can

often identify their own oppressions, but are unable to see how they may be oppressing others.

For instance, at the interpersonal level, a Punjabi woman may be able to identify how she is

being unfairly channeled into low paying jobs in the service industry; however, she may fail to notice how her attitudes about other minority races also act to subjugate them.

Collins' (2000) interplay between intersectionality and the matrix of domination provides a context with which to examine how seemingly disparate entities—such as the public and private spheres—are in fact interconnected and influenced by one another. Further, intersectionality challenges assumptions regarding a single experience of oppression, and highlights how different individuals and groups experience oppression based on a variety of factors. Intersectionality as a theoretical concept, thus, offers many insights when coupled with feminist postcolonialism.

Feminist postcolonialism recognizes the importance of constructing knowledge from multiple sources, especially from the perspectives of those who have been marginalized and silenced in the knowledge production process (Anderson, 2002). This is especially important when examining practices and the construction of knowledge in the mental health field, which itself has been developed from the perspective of Western science and Eurocentric ideologies. Service providers may come to understand that the problems faced by South Asian women, when attempting to access mental health services, may not be a result of "cultural" factors, but in fact may be due to "historical processes that have produced systemic inequalities and oppressions" that are gendered (Anderson, 2002, p. 15).

Canada has a long history of discriminating against women in general, and "third world" women in particular; however, as racism and sexism are so deeply ingrained in Canadian society it has become normalized. Only through analyzing Canada's colonial and postcolonial history through a critical feminist postcolonial perspective, which is inclusive of an anti-racist standpoint, may these issues come to light. For example, during the "Hindu question" debate, which centered around the issue of whether married Indian women and their daughters should be

allowed into the country, it became apparent that the Canadian state was largely opposed to their

inclusion in Canada on the following grounds: First, by allowing Indian women to migrate to

Canada, it was assumed that immigration from other parts of Asia would also increase; second,

more South Asian men would be encouraged to immigrate to Canada if their wives were also

allowed to enter the country; third, they would create South Asian communities; and fourth, they

would increase the size of the Indian population and one day minorities would outnumber

Caucasian Canadians (Dua, 2000). Even those who advocated for South Asian married women

entering Canada expressed concerns about single South Asian men fostering relationships with

European-Canadian women.

Postcolonial feminism is, thus, a movement that challenges universalistic assumptions

made of "third world" women. Western assumptions tend to amalgamate "third world" women,

creating a homogenous image of them as ignorant, poor, uneducated, domestic, and leading an

abridged life due to their gender (Mohanty, 1991b). Even the term "women" has been used to

unify women globally, suggesting that they share similar desires and interests. While this can be

positive, it also blurs the boundaries that differentiate women from each another. Many

feminists, thus, argue against the notion of a monolithic "third-world woman" and even against

"women" as a universal group (Mohanty, 1991b; Trin Min Ha, 1989). They assert that by

defining women and men as universal groups, they become defined solely by their gender, and

not by factors such as race, or class (Mohanty, 1991b). Gender, then, becomes inscribed within a

male/female framework, where differences are constructed based on a heterosexual construct

(Wittig, as cited in Mohanty, 1995), and other identifying factors become invisible. When

women are grouped in this way they become ahistorical and acultural subjects; it is as if they

were unaffected by factors such as class, race, or location. Historicizing women and

understanding the conditions they have faced and continue to face through a "juncture of feminist and antiracist … postcolonial studies is of great significance," and necessary to create alternate frameworks that work against universalizing gendered struggles (Mohanty, 1995, p. 69).

Women's status as objects, and how women are affected or not affected by systems and institutions, are additional foci of feminist postcolonialism (Mohanty, 1991b). Object status leads to the victimization of women, for instance, as victims of patriarchy or male violence. Oppression is not seen as producing particular forms of gender, rather, gender is seen as the origin of oppression. For instance, a woman's relationships within the family unit are determined even before she becomes a part of the family and are based solely on her gender. She is not seen as being a producer of the relationship, but merely as a passive object in the process. When women are defined as victims it becomes easier to shift the blame to the individual and away from the situation or social structure. For instance, in one study of physicians' reactions to South Asian women patients, Johnston and his/her colleagues (2004) found that physicians assumed that "third world" South Asian women were less likely to be proactive about their health care needs, solely on the basis of their passive demeanour. Feminist postcolonialism is, thus, a theoretical perspective that moves away from creating sweeping generalizations about cultures, and instead considers the broader social context and accompanying contextual factors that impact groups and individuals.

Summary

Positive psychology and acculturation theory claim to provide a theoretical basis for understanding how immigrants can manage poor mental health, as well how immigrants adapt to the new stressors of their environments, respectively. The central issue with both of these approaches is their reliance on universal definitions of how individuals across cultures adapt to

varying life circumstances. The underlying assumption of universality within these theories

assumes that the ideals manifested by the dominant society are the only ideals and alternate ways

of thinking or being are problematic.

Feminist postcolonialism provides an alternate theoretical framework that considers how

individuals have been impacted by colonialism and how colonial sentiments continue to echo

into present discourses and lived experiences. A feminist postcolonial framework allows for an

account of how situational and cultural factors—as well as the intricacies and complexities

embedded within gender, race and class—impact an individual's perception of what constitutes

mental health and how imbalances ought to be treated. This theoretical approach not only

exposes the ways that Western perspectives on knowledge production have obstructed other

ways of knowing, but also it helps delineate how medicine in general and psychiatry in particular

have become Westernized.

Chapter 4

Methodology

The goal of this study was to explore Punjabi immigrant women's definitions, experiences and narratives of mental health, how they attempt to restore imbalances in mental health, as well as how they access and utilize the Canadian mental health system. This study was guided by the following research questions: 1) How do Punjabi immigrant women define concepts related to mental health and illness?; 2) How are mental health services accessed and utilized by the participants?; 3) In what ways do the existing mental health services meet or fail to meet the needs of the participants?; 4) How can these services be made more culturally accessible?; and 5) How is mental health defined by prominent Canadian mental health organizations?

As critical qualitative research, this study was grounded in a critical research paradigm informed by feminist postcolonialism and intersectionality. Two related commitments formed the foundation for the conduct of this critical research: first, a commitment to honouring the voices of the participants and; second, a commitment to challenging the tensions embedded at the intersection of race, class and gender inequalities (Blee & Twine, 2001; hooks, 2000). Although the intersections of race, class, and gender influence women's lived experiences (Harley et al, 2002; hooks, 2000), conceptions of immigrant women's experiences that are universalized and homogenized are the result of research that has not critically considered the effects of these social constructions in relation to history, experience, and culture. The effect of this research has been a history of contributions that further marginalize and oppress women, as well as the production of stereotyped health care practices.

In order to overcome universal and homogenized conceptions, this research explored Punjabi immigrant women's construction of mental health as a function of each of the

participant's definitions, experiences, and narratives. Along with overcoming universal conceptions of Punjabi immigrant women's experiences, a critical research paradigm informed by feminist postcolonialism and intersectionallity enabled an exploration of factors that may act to inhibit Punjabi immigrant women. This study has an a priori intent and purpose: to learn from the participants in order to improve mental health service provision. In doing so, care was taken to avoid imposing a dominant Eurocentric definition of mental health on the participants.

This chapter includes three sections. First, I describe my position as researcher for this research. Second, I describe and discuss the research design including an introduction to the participants, the mental health organization documents, and the forms of analysis. Third, I discuss how I confirmed my findings.

Researcher's Position

As with any research, the researcher's values inextricably impact the study through the research paradigm: the belief system or worldview that guides the researcher in terms of ontology, epistemology, axiology, and methodology (Guba & Lincoln, 2005). More specifically, the research paradigm is a "set of interrelated assumptions about the social world which provides a philosophical and conceptual framework for the organized study of that world" (Filstead, 1979, p. 34). The researcher's positionality—how people are defined and "the relational place or value one has that influences and is influenced by varying contexts" (Louis & Barton, 2002, p. 3)— impacts how one is situated within various power relations and, in turn, affects methodologies, interpretations, and knowledge production (Saltana, 2007). For this reason, it was important for me to position myself within the research, as an instrument of the research. In particular, the research paradigm grounding this work, my identity, and my experiences impacted the interpretation of the findings.

From a critical research paradigm, ontology, the nature of reality and being, is constructed within social-historical contexts and power relations and is shaped by ethnic, cultural, gender, social and political values (Bredo, 2006; Ponterotto, 2005). From this perspective, models of mental health that espouse a Eurocentric position, which appear to reproduce class, race and gender oppressions, may not speak to the experienced reality of Punjabi immigrant women, who may not relate to models derived from positive psychology and whose conceptions of mental health may differ from the dominant culture.

Knowledge, according to this epistemology, is socially constructed with the goal of capturing the participant's lived experience. In critical theory, the relationship between the participant and the researcher is transactional and subjective, as well as dialectical in nature and value mediated (Guba & Lincoln, 2005). Mental health is not a concept that simply exists, but is constructed within a social-historical context and is a reflection of the social institutions that give meaning to it within a particular culture (Phillips & Hardy, 2002). A critical paradigm recognizes how conceptions of mental illness, for instance, are contextually constructed based on cultural norms, whereas a Western medical model appears to have more rigid and fixed indicators of mental illnesses (Kellert, 1976). Through contextual research that seeks to understand the relationship between individuals and their social, cultural, and historical contexts a researcher may aim to examine the meanings that groups ascribe to their particular reality, and to focus on the processes that construct and maintain the social world (Phillips & Hardy, 2002).

Critical researchers view axiology, the role of the researcher's values in the research process, as inciting transformational changes that permit individuals to challenge the status quo and free themselves from ongoing oppressions (Guba & Lincoln, 2005; Ponterotto, 2005).

Further, facts and values are seen as inseparable, and it is understood that the values of the researcher influence the research (Guba & Lincoln, 2005; Ponterotto, 2005).

As critical research, the methodology needs to reflect the epistemology, ontology, and axiology of the paradigm. As such, critical research is dialectic in nature with the goal of defeating ignorance, whether intentional or not (Polit & Beck, 2004). The role of the researcher within a critical paradigm is to act as a facilitator, encouraging the participant to become a part of the research process (Guba & Lincoln, 2005). As such, inquiry methods typically involve intense participant-researcher interaction. Research methods can include intense in-person interviewing, which is the methodology that has been adopted for the present study.

Research positionality, my beliefs about knowledge, are based within a critical research paradigm that seeks to expose oppressive forces and structures that are maintained by those in power (Bredo, 2006; Hatch, 2003). Language is seen as one of the primary tools through which reality, as perceived both within and outside of the individual, can be represented, thus allowing for the examination of social conditions and inequality. Critical research challenges taken-for-granted assumptions and contributes to social change through language that exposes predominant ideologies and allows for competing ideologies to be heard (Crotty, 1998; Hatch, 2003). For me, creating social awareness and change is a crucial part of the research process. As a researcher, I feel I have a responsibility to ensure that the findings of the study go beyond the boundaries of academia and make a meaningful contribution to the area of cross-cultural mental health. This position is, perhaps, also a reflection of the researcher's power: my ability to be heard in arenas that are otherwise closed to the public and to use my position to contribute to a dialogue of change.

One of the goals of the current study was to honour the voices of the participants. Accordingly, attempts were made by the researcher to avoid constructing a hierarchical researcher and participant relationship wherein the researcher was seen as coming from a position of power and authority. In an attempt to deconstruct the researcher and participant relationship, I ensured that I was not positioned physically as an authority, such as sitting behind a desk, and reiterated the importance of participants' conveying their personal perspectives. However, participant comments such as, "I need to say what I think?" (Simran, line 7), "I don't know how you describe mentally unhealthy in books and text books and in psychological perspective" (Ramandeep, lines 358-359), or "I don't know, don't know much beyond this" (Mandeep, line 7) suggested that some of the study's participants may not have recognized the value of their own perspectives and may have perceived the researcher as more knowledgeable about the interview questions than them (Arvay, 1998). The statements made by some of the participants also suggested that there was a prescribed social script that dictated the researcher and participant relationship. Fortunately, the participants in the study tended to become more relaxed as the interview progressed and as they shared their personal experiences.

The researcher's power becomes an issue of greater significance once the interview process is terminated, as the story shared with the interviewer is now separated from the participant (Karnieli-Miller, Strier, & Pessach, 2009). The researcher now becomes the storyteller, having absolute power over the data. Although steps were taken to decrease my power, such as summarized member checks, as the researcher I have to acknowledge my role in the construction of the narratives. Aware of this, especially in relation to the construction of the participants' narratives, the procedure I used was my attempt to reduce my position and take the lead of the participants. Therefore, I included the participants' own language when narrating their stories,

which may have also limited the distortion of their voices, and provided the following statement of my position in the research in order to contextualize my role, and how my beliefs and values may have impacted the analysis process.

In terms of my identity, I describe myself as a second generation Canadian Punjabi female. The critical framework of this study supported my position as a South Asian researcher who speaks Punjabi, and facilitated my research goals. The phenomenon under investigation was influenced by my ethnicity, gender, education, and involvement within the South Asian community. For some years, I have worked closely with a not-for-profit organization that, among other mandates, seeks to provide resources for the South Asian community, including programs for low income families, employment workshops, and health fairs. My interest in examining Punjabi South Asian immigrant women's definitions, experiences, and narratives of mental health arose out my Master's thesis, which was an examination of adolescent-parent family dynamics. It was during this time that I became interested in how families cope with mental illnesses. Further, my contact with individuals with mental health problems also made me question and wonder how Punjabi South Asian women define mental health and how this impacts the care they seek, if at all, as well as the type of mental health resources they seek.

Through my experiences, I have come across several cases of women who have been depressed to the extent that they find themselves unable to work and care for their families. One woman who became overwhelmed by the stress of immigration and her family circumstances grew withdrawn, developed an eating disorder and felt that she was left without any options, especially since her family failed to offer her any emotional support. Another woman whom I met was deeply traumatized by a past experience, withdrawn, and closed off. A common thread among the women mentioned above and countless others was that they kept their experiences

and feelings largely to themselves, Uncovering why this was the case partially fueled my motivation for this study.

As a second generation Punjabi woman who has been raised in North America, it is easy for me to make assumptions concerning how Punjabi South Asian women define or experience mental health; however, my assumptions, at times, are based on North American ideals of what constitutes "normal." To me, it is important to understand how historical, social, and cultural factors have impacted Punjabi immigrant women's construction of mental health, given that one of my professional goals is to increase awareness surrounding immigrant mental health among the general public.

Research Design

This is a critical qualitative study that uses both interviews with Punjabi immigrant women and mental health education documents to examine the participants' construction of mental health, along with their access to and utilization of mental health services. Qualitative research is particularly useful when investigating an under-researched topic or when studying populations that have been marginalized and have limited power, including ethnic minorities (Morgan, 1998). The interviews with Punjabi immigrant women were analyzed using narrative inquiry (Arvay, 2003), and the documents authored by various prominent Canadian mental health organizations regarding the meaning of mental health were analyzed using thematic analysis (Braun & Clarke, 2006).

This section provides a discussion of the participants, the recruitment process, and the semi-structured interviews that were employed in this study. A discussion of the translation of the transcripts then ensues. This is followed by a general discussion of narrative analysis (Arvay, 2003) and its use with interviews, including the specific features that were utilized for the

interview analysis. The section concludes with a general discussion of thematic analysis (Braun & Clarke, 2006) and its use with prominent definitions of mental health from organization documents, including the specific features that were utilized in this study.

Participants, recruitment, and semi-structured interviews.

Semi-structured interviews were conducted with a convenience sample of six participants between 26-84 years of age. This sample size was consistent with qualitative research studies conducted in the area of immigrant mental health. The majority of the qualitative studies reviewed had a sample size ranging from 8 to 24 participants (Ahmad et al., 2004; Burr & Chapman, 2004; Hussain & Cochrane, 2003; O'Mahony & Donnelly, 2007; Whitley et al., 2006).

The researcher reached out to a variety of agencies and community groups in order to ensure that the participant pool represented a cross-section of Punjabi South Asian immigrant women, thereby providing a diverse range of experiences to be heard (Kirkham & Anderson, 2002). Previous studies illustrated the diversity of perceptions concerning mental health among different cultural groups that share the same ethnicity. This study focused solely on women of Punjabi origin who immigrated to Canada from India. This group was selected for several reasons. First, Punjabi culture is one example of a culture of honour, an attribute that may affect whether and how mental health issues are discussed with outsiders. Second, Punjabi culture is patriarchal, which increases the significance of studying immigrant women (Nayar, 2004). Third, Indian Punjabis constitute a large proportion of the immigrant population in the Lower Mainland of B.C.. Punjabi is the second most widely-used non-official language in B.C. (Pauzenboeck, 2006), and by 2031 it is anticipated that South Asians will be the largest visible

minority group in Canada (Statistics Canada, 2005). Their mental health needs may soon have a large impact on mental health providers.

Inclusion criteria for the present study included the following: participants had to be of Punjabi origin, been born in India, and to have immigrated to Canada after 20 years of age or later. Participants in this study were not restricted by the number of years for which they had lived in Canada, as the "healthy immigrant effect" has shown that immigrant women who live in their non-natal country for ten years or more have higher levels of mental distress than their native female counterparts (Dunn & Dyck, 2000; Vissandjee et al., 2004). Further, there appears to be evidence that women at different stages of migration face different types of discrimination (Thurston & Vissandjee, 2005)

Participants were not excluded from the present study on the basis of whether or not they had ever suffered from mental health problems. Flyers advertising the study and listing the inclusion criteria were mailed to a variety of not-for-profit organizations and individuals that work with Punjabi immigrant women. Interested participants were invited to contact the researcher. Three seniors' groups contacted the researcher in addition to four individuals who were a part of the younger cohort. Interviews ranged from two to two and a half hours on average, and were conducted either at community centres, private offices, or the participants' homes. All participants signed consent forms prior to the commencement of the interviews, and received a $20 honorarium for participating in the study. Although ten interviews were conducted, only six were included in the present study. A more in-depth discussion of the inclusion criteria for the interviews is provided in the narrative inquiry section that follows. Inclusion of interviews in the present study was based, in part, on diversity of experiences. Table 1 provides a brief introduction to the research participants

Table 1

Participant's Demographic Information

Name*	Age	Employment Status	Years in Canada	Marital Status	Education	Income Level
Ramandeep	26	Employed full-time	4	Separated	College graduate	$30,000-39,000
Simran	33	Maternity Leave	6	Married	Post-graduate degree	$80,000-89,000
Gurpreet	41	Self-employed	19	Separated	Post graduate degree	Less than $10,000
Amrit	68	Retired	26	Married	Grade 8	$10,000-19,999
Hardeep	79	Retired	31	Widowed	Post-graduate degree	$10,000-19,999
Mandeep	84	Retired	52	Widowed	Grade 5	$10,000-19,999

*Pseudonyms have been used to protect the identity of the participants.

The interview questions were based on questions developed to understand the participants' definitions of mental health, their access to and utilization of services, as well as questions that arose from analytic work undertaken for an earlier publication using critical discourse analysis (Jhangiani & Vadeboncoeur, 2010). The semi-structured interview questions included the following: What does being mentally healthy mean to you?; How would you describe a mentally healthy person?; If you have questions or concerns about your mental health whom do you talk to and where would you go?; Have you had any problems when seeking help for mental health problems?; What would help you to overcome these barriers? (see Appendix A).

Transcripts.

Interviews were conducted in English and/or Punjabi. The researcher is fluent in both languages and, thus, was able to transition from one language to the other during the interviews. When translating from one language to another there are a number of methodological issues that need to be considered, including translation procedures and translation-related decisions (Birbili, 2000). Before these issues are discussed further a cautionary note about transcripts needs to be made. Transcription is not an exact science; it is open to interpretation, and the end result is an attempt to replicate the individual's speech (Reinharz, 1992). The decisions made during the transcription process impact the final product, and are a reflection of the researcher's theoretical and epistemological position.

The procedure for the translation of the interviews from Punjabi into English was as follows: First, the hired transcriptionist, a native Punjabi speaker who was knowledgeable about Punjabi language and culture, listened to and translated the first draft of the Punjabi interview into English. The transcript was translated for conceptual equivalence and not lexical comparability. A lexical-based translation can be problematic in that there is often a failure to convey assumptions, feelings or values that may be apparent in the native language, but which are lost in translation (Birbili, 2000; Phillips, 1960). Second, the researcher reviewed the transcripts and edited them as needed. Additions were made in relation to intonation and gestures as noted in field notes kept during the interviews.

The transcriber's and researcher's familiarity with the language and culture assisted in conveying the meanings of the terms and phrases used by the participants' and aided in making cultural nuances more apparent to the reader (Frey, 1970). In order to avoid making generalizations about cultural terms, the researcher asked for clarification during the interview

process whenever cultural terms were used. Further, when the transcripts were transcribed any pauses or changes in intonation were noted, while the researcher also reflected upon her interview notes to further enrich the transcripts. For instance, if a participant made gestures or pointed to a body part during the interview, these details were added to the transcripts when possible.

It should also be noted that English sentence structures were imposed upon the transcripts. For both the Punjabi and English transcripts, the imposition of English grammatical and syntactical structure was added to improve the comprehension of the transcripts. However, the implications of such structures may include occasionally misrepresenting the participants' meaning and the loss of subtle information from the original context (Rubin & Rubin, 1995).

Any Punjabi phrases that proved too ambiguous when translated into English were noted and discussed between the researcher and the transcriber. A decision was then made as to the best way to translate the Punjabi phrase in order to retain cultural meaning (Temple, 1997). The final step of the translation process involved the researcher listening to the transcripts to ensure that conceptual equivalence was maintained and to produce the final drafts used for the analysis.

Narrative inquiry.

Narrative inquiry is an approach that views stories or descriptions of events as a fundamental unit for understanding human experiences and their experienced reality (Pinnegar & Daynes, 2007). Narrative inquiry provides a rich context for understanding how individuals experience the world and give meaning to the world through their stories, thereby focusing on the experiences of the individual and allowing their previously unheard voice to be heard (Creswell, 2002; Hatch, 2003). One of the greatest assets of narrative inquiry is "its focus on the dialogical nature of knowledge and its emphasis on the social world as a site where power relations are

played out" (Arvay, 2003, p.164). Narrative inquiry acknowledges that there are multiple sources of knowledge production and narrative researchers must be attuned to these various voices when they are interpreting and representing the findings (Arvay, 2003).

The focus of narrative analysis is not on generalizability, but to explore the meanings that a particular group, in this case Punjabi immigrant women, ascribe to the meaning of mental health (Holloway & Freshwater, 2007). Thus, narrative research could conceivably consist of data generated from a single individual who is illustrative of the phenomenon under study. The goal of narrative inquiry is to examine the intersection between culture and society, to focus on the details and context of the participants' stories. No two interviews are alike; consequently, generalizability is not a focus or outcome of narrative inquiry (Holloway & Freshwater, 2007; Lieblich, Tuval-Mashiach, & Zilber, 1998).

Despite having conducted ten interviews for the current study, a decision was made not to include four of the interviews. One of the interviews failed to yield adequate data about the phenomenon under study. The latter three interviews were not selected because the participants did not seem to understand the interview questions in spite of additional prompting. Given that "the insights of qualitative inquiry have more to do with the information richness of the cases selected… than with sample size" (Patton, 2002, p. 245), if it became difficult to tell stories about the stories, the participant's interview was not included in the data analysis (Hatch, 2003; Holloway & Freshwater, 2007).

In this study, narrative inquiry allowed for the exploration of the ways in which mental health was constructed through narratives, thus, revealing how the participants defined and experienced mental health, and how various discourses impacted their access to and utilization of mental health services.

Using narrative inquiry with interviews.

The mircolevel analysis of the interviews was conducted using narrative inquiry. In order to examine areas of concern in women's lives and understand their construction of mental health, semi-structured interviews were conducted, wherein participants were asked to share their personal experiences with mental health. During the interview process the researcher encouraged the participants to share their experiences in a manner that was without judgment or leading the story in a particular direction, while eliciting detail, elaboration, and reflection from the participants (Hatch, 2003). While learning from those who have been marginalized and subsequently silenced was central to this study, I was mindful of the need to make a conscious effort to avoid usurping the voices of the participants by reverting to dominant ideologies or assumptions that occluded their worldview (Racine, 2003).

Specific features of narrative inquiry to analyze definition and experiences.

The narrative inquiry analysis for this study was guided by the work of Arvay (2003). This specific approach to narrative inquiry draws attention to the position of the self in the text, how personal experience and tacit knowledge impacts responses to the research questions, while a critical reading of the text draws attention to the dependence of texts upon society and history in the form of the resources made available within the order of discourses. Narrative inquiry crucially mediates the connection between language and social context, and facilitates a more satisfactory bridging of the gap between texts and contexts.

The analysis process, which was adapted from Arvay (2003), involved multiple readings of the transcripts produced from the interviews. First, the text was read and re-read in order to allow the researcher to become familiar with the content. This phase of analysis was guided by

the following questions: what is the story about and who is telling the story? The goal of this initial reading was to provide a summary of the overall story conveyed by the participant.

Second, the data was read to establish the narrator's position. That is, how the participant was situated within the narrative, what her struggles were, how they were presented, what facets of the participant's experiences and beliefs about mental health were revealed, what the participant was feeling, how the participant revealed herself, how the participant revealed her story, the aspects of her story revealed or concealed, and the interpretations that may be made from these omissions or gaps.

The third reading examined the participants' responses in relation to the research questions posed, as well as how mental health was constructed. This phase of the analysis was guided by the following questions: what is meant by the terms mentally healthy and mentally unhealthy, how are mental health services accessed if at all, how are mental health services utilized if at all, are the participants aware of mental health services, and how well does a meaning of mental health as put forward by the Canadian Mental Health Association resonate with the participants?

The fourth reading of the text critically examined the previous readings for power relationships and inequalities. This phase of the analysis was guided by the following questions: in what ways does the participant struggle with power relationship and inequalities, where is the participant silenced, when does she silence herself, is the participant conscious of the power or political imbalances in her life and of the influence of culture, how is the participant's socialization process understood, and how is her reality challenged?

For each participant a detailed spreadsheet was created to highlight the findings from each of the four readings. A narrative summarizing the four readings was then constructed for each participant, which reflected what the researcher had learned from the narrative analysis.

Thematic analysis.

Thematic analysis can generally be described as a method of "identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). Thematic analysis is a widely used analytic strategy; however, it has often been critiqued for being poorly defined (Attride-Stirling, 2001; Tuckett, 2005). Often researchers report themes as "emerging from the data" (Braun & Clarke, 2006, p. 80) while providing little or no insight into the process of analysis and dismissing the active role of the researcher in the analysis process. After all "data are not coded in an epistemological vacuum" (Braun & Clarke, 2006, p. 84). To imply that "themes emerge" from the data

> can be misinterpreted to meant that themes "reside" in the data, and if we just look hard enough they will "emerge" like Venus on the half shell. If themes "reside" anywhere, they reside in our heads from our thinking about our data and creating links as we understand them. (Ely, Vinz, Downing, & Anzul, 1997, p. 80)

For this reason it is important to make assumptions regarding thematic analysis evident.

The specific form of thematic analysis that was employed in the current study included a latent theoretical thematic analysis. A theoretical thematic analysis involves reading and re-reading the data and coding it for data related to mental health. The final result was a series of themes related to the concept of mental health. Further, in line with the epistemological goals of the study, the thematic approach also identified themes at the latent level. Latent themes move beyond semantic analysis, identifying themes "within the explicit or surface meanings of the

data" (Braun & Clarke, p. 84), to identifying or examining "the underlying ideas, assumptions, and conceptualizations—and ideologies—that are theorized as shaping or informing the semantic content of the data" (Braun & Clarke, 2006, p. 84). Latent themes in the present study focused on how factors, such as sociocultural contexts, culture, history, and structural conditions, impacted the data. "Sensitizing concepts" (Patton, 2002) were used to focus latent themes in relation to tacit theories that grounded the participants' interview responses. Examples of sensitizing concepts included, mental health, gender, respect and power.

Using thematic analysis with documents and interviews.

In order to understand how ideologies are produced and taken up, the data provided by educational documents pertaining to the meaning of mental health from the Canadian Mental Health Association, Centre for Addiction and Mental Health, and the World Health Organization were analyzed using thematic analysis. Not only was it important to understand how these texts and the organizations they represent conceptualize mental health, but also it was equally important to investigate how these conceptualizations resonated with those for whom they were potentially written. Hence, as a part of this stage of analysis, the interview responses from the participants, which were analyzed through narrative analysis, were compared with the themes that emerged from a thematic analysis of documents. This included a section of the interview, which specifically asked participants to comment on their interpretation of a picture and accompanying catch phrase used by the Canadian Mental Health Association. A thematic analysis of the personal narratives was also conducted to highlight the main themes.

Specific features of thematic analysis to analyze documents.

The thematic analysis for this study was guided by the methodology of Braun and Clarke (2006). This approach entailed six phases of thematic analysis that should not be viewed as a

linear process, but rather as a recursive process of moving back and forth through the stages as needed. The six phases of analysis were as follows. The first phase was to become familiar with the data, which involved transcribing the data, reading and re-reading the text, and generating a list of ideas regarding what the data was about and what, in particular, stood out from the data. The second phase included generating initial codes, coding aspects of the data in a systematic manner across the entire corpus, and organizing data pertinent to prospective themes and sensitizing concepts. The third phase was to search for themes by grouping codes into potential themes, and pulling together data relevant to each theme. The fourth phase included reviewing themes, checking to see if the themes worked in relationship to the coded extracts, as well as the entire data set, and creating a thematic map of the analysis. The fifth phase included defining and naming themes, with continued analysis to refine the themes, then defining and labeling themes. Finally, the sixth phase, was to produce a report using data to exemplify themes, research questions and literature.

While the analytic procedure used in this research followed Braun and Clarke's (2006) process almost exactly, I did deviate somewhat. More specifically, the first phase of my analysis looked for patterns, meanings, or any unique characteristics that stood out during the initial readings of the interview text. For instance while reading Ramandeep's transcript, I noted that during the initial stage of the interview she referred to herself in the third person, while another participant, Harpreet, tended not to provide personal examples during the interview. Other features that were noted as the transcripts were being read were words that were used to describe good and poor mental health, and how participants dealt with mental health problems. Sensitizing concepts also helped to guide this initial process.

During the second phase of analysis initial codes were produced from the raw data. This level of coding aided in organizing the codes into meaningful groups. Questions that guided the research helped to initially focus the coding process. For example, when examining how and whether participants accessed mental health resources, it became apparent that the issues surrounding privacy and societal perceptions seemed to impact participants' access to mental health resources. During this phase it was important to be meticulous about the coding process and to code all data extracts, because I did not know which codes would be of interest later. Decisions regarding inclusion and exclusion of codes were made at the end of the process.

The third phase of analysis entailed examining all of the codes that were created and collated and looking for broader themes into which to incorporate the codes. This process involved going back and forth with the data and conceptualizing and reconceptualizing the coded extracts. Tables and lists were used during this phase of the analysis to help conceptualize potential themes. Different levels of themes also emerged during this phase. For example, when conceptualizing what constituted good and poor mental health, it became apparent that these concepts were multifaceted and subthemes were needed to fully grasp their depth.

Phase four entailed reviewing the themes that had been created. This was a multi-step process that involved ensuring that the themes had an adequate amount of data to support them, ensuring that the coded extracts formed a coherent pattern, and ensuring that this process held true for the entire data set.

Phase five of the analysis process involved defining and naming the themes. That is, identifying and labeling what the themes were about. During this phase it was also important to consider what the themes reflected, how the themes were connected, and how the themes fit into

the larger research project. Attention was paid to how the names and labels for themes translated between Punjabi and English.

The final phase, phase six, involved writing up the findings. It was important that the relationship between the themes and, in this case, the narrative analysis was apparent, and that there were enough data to support the themes. Further, the analysis mandated moving beyond describing the data and towards supporting the overall goals of the study, which differed a bit from the phase defined by Braun and Clark (2006). I needed to organize the data into two categories: data to be used for the narratives and data to be woven in elsewhere. Although I did not produce a single report, data was selected to exemplify themes, address the research questions and literature, and provide examples woven throughout the chapters.

What constituted a theme was an important question that arose during the thematic analysis process. It was difficult to quantify what was and was not a theme. Generally, themes require data to support them; however, how much data is required, and how this may differ according to theme, is another question. Some themes were relevant to the research question, but were composed only of a small subset of the data. Thus, issues regarding space within and across the data set were not entirely relevant. Alternatively, if several participants raised the same issue, this also contributed to the categorization of a particular theme. In the current study, some of the factors that were considered in deciding what constitutes a theme included prevalence across the data set and the importance given to the topic. For example, whereas only three of the six participants discussed finances, it captured an important element of how mental health was constructed, and was included as a theme. Themes noted here were in keeping with the principle that they should "capture something important in relation to the overall research question" (Braun & Clark, 2006, p. 82).

A decision regarding which themes to include in the present study also required

consideration. Some themes, while interesting, were left out as they detracted from the flow of

the overall themes and their relationship to the research questions, while other extracts seemed to

be outliers and did not fit into a particular theme's conceptualization. Further, some of the coded

extracts required additional information in order to make meaningful insights into the themes and

were thus eliminated.

Confirming the findings.

As this study constituted critical qualitative research with an emancipatory aim, it was

important to have a process in place that ensured that the study's findings would be of value and

to disseminate the findings in a manner that may contribute to social transformation relating to

Punjabi immigrant women and their mental health services. Consequently, this study adopted an

alternative approach to assessing validity as suggested by Lather (1986). She suggested that it is

important to generate data that are valid and credible, in that they reflect the realities of the

research participants (Lather, 1986). Further, in order to ensure that the participants' voices were

being represented, and to keep the researcher aware of her own position, the following concepts

were incorporated into the research process: triangulation, face validity, construct validity, and

catalytic validity.

Triangulation involved the incorporation of multiple sources of data to address each

research question. This was accomplished by using methods including field notes—observations

made about the interview, the participants, and insights the researcher had throughout the data

collection process—interviews, and document analysis. Face validity provided an opportunity

for participants to engage in the research process and ensured that participants' voices were

accurately represented. In the current study, participants were provided with a summary of their

interview at the end of their interview session and were asked to assess the veracity of the summary. Changes to the interpretation of the summary were recorded for further reflection and consideration. When conflicts between my interpretation and the participant's occurred, a discussion was offered as to why this may have happened. For construct validity, a critical self-reflective process, the researcher considered how her beliefs may have impacted the interpretation of the data. The researcher's position statement is one example of exploring how my position influenced the research process. Other methods included journaling, and asking self-reflective questions. Finally, catalytic validity was an emancipatory process with the aim of spurring social change. In the present study, catalytic validity involved the researcher's active participation in forums, such as attending the Canadian Mental Health conference on shaping mental health, and commitment to distributing the information gathered from this research through future community outreach.

Essentializing, and the common stereotypes that are formed through essentializing groups of people, is a serious concern and a common pitfall that many researchers fall into when conducting research with immigrant or marginalized populations. Women's experiences are often seen as crossing over race, class and location; however, as discussed in previous sections, this is not always the case. In order to avoid essentalizing women in the present study, the researcher avoided using universal or decontextualizing language. It was also important not to take culturally specific meanings out of their context. For instance, the data gathered regarding these participants from Vancouver, B.C., their definitions, experiences, and narratives about mental health, should not be uncritically assumed to apply to other Punjabi immigrant women in Vancouver, B.C., Canada, Britain, or India. The current sample of women, and their contributions to this research, represent only how the women in this study constructed mental

health. The primary concern of the present study was not to generalize the findings of the study, but to reflect the participants' definitions, experiences, and narratives about mental health (Maxwell, 2005).

Summary

This study was based on a critical paradigm and drew upon two sources of qualitative data: interviews with participants and documents pertaining to the meaning of mental health. Narrative inquiry and thematic analysis were utilized to address research questions regarding the definitions, experiences, and narratives of mental health and mental illness as articulated by Punjabi immigrant women. The researcher was positioned within this research as a critical researcher with her own cultural and historical positionality. Strategies outlined by Lather (1986) were employed by the researcher in order to reflect on the ways in which position may have influenced the participants' answers and/or the interpretation of the results. Grounded in a critical research paradigm and framed by feminist postcolonial theory, the work undertaken here had an explicit intent of contributing to the improvement of health care access and services for Punjabi immigrant women.

Chapter 5

Personal Narratives

Following the narrative analysis process, six personal narratives were constructed to represent the six women who participated in this study. These narratives were developed from numerous readings of their interview transcripts, including four focused readings, and with input from additional field notes taken during the interview. The four readings focused on general content familiarization, the narrator's position, the narrator's responses during the interview, and references to power relationships and inequality, respectively. It is important to note that, although a summary of the interview was presented to each participant, the personal narratives were not co-constructed with the participants and, thus, represent the researcher's interpretation of the participants' narratives. Despite this, the informal tone and loose grammatical structure of the participants' speech has been preserved in order to provide a sense of participants' voices.

This chapter begins with a presentation of the story of Sita, a mythological figure from the *Ramayana*, whose story of self-sacrifice creates a context for the narrative of many of the participants. This is followed by the personal narratives of the participants, reflecting the integration of the four interpretive readings. The narratives were constructed in the first person and have been arranged in chronological order according to age, from youngest to oldest. A brief biographical sketch precedes each narrative.

The *Ramayana's* Sita

Sita was married to Prince Rama, the eldest of four sons and the next successor of the throne of Kosala. However, Prince Rama's stepmother wished her son, Bharata, to be the next successor. As the King had promised Rama's stepmother two wishes that he would never refuse, accordingly, she told him of her desire to have her son ascend the throne and for Rama to be

banished from Kosala. The King, unable to revoke his promise, reluctantly granted his second wife both of her wishes. Bharata, who later learned what his mother had done, sought out Rama and begged him to return to Ayodhya, the capital of Kosala, to take his rightful place as King. However, Rama refused, saying that he was obligated to obey his father's command, and would not return until he had served his period in exile.

Upon hearing of Rama's decreed exile from Kosala, Sita requested that she be allowed to accompany him. Initially, Rama refused Sita's request on the grounds that he did not know what lay ahead for him, that someone must stay in Ayodhya to care for his parents, and that it was "the foremost duty of a wife" to serve her husband (Keshavadas, 1988, p. 70). However, Sita took this opportunity to implore Rama by stating,

> a wife should be with her husband serving him. The forest where you dwell is Ayodhya for me and Ayodhya without you is a veritable hell for me… I shall never ask anything of you but I shall go ahead of you in the forest to remove the sharp stones and thorns and make your way smooth… I will be of immense help to you because I come there to serve you rather than to be served. (Keshavadas, 1988, p. 69-70)

Rama, finally, relented and permitted Sita to join him.

While living in exile, Sita was abducted by the evil king, Ravana. She was eventually found by Hanuman, the great monkey warrior from the army assembled by Rama, who offered to carry her back to her husband. However, Sita refused Hanuman, stating that it was Rama's destiny to rescue her, and that she was reluctant to allow another man to touch her. Eventually, Rama came to Sita's rescue and they were reunited. However, Sita's chastity was then brought into question. In order to prove her innocence, she underwent the *Agni Pariksha*, the fire test.

Sita threw herself into the sacrificial fire, whereupon *Agni*, the Fire God, rejected her because of her purity.

After serving fourteen years in exile, Rama and Sita returned to Ayodhya, where Rama finally ascended the throne. Questions surrounding Sita's purity surfaced once again, however, as the people of Kosala remained unconvinced of her chastity. Rama, as King, felt his duties lay toward those he served. Consequently, he banished his then-pregnant Queen to live in the forest. Several years later, Rama finally freed Sita from exile and accepted her twin children as his own. Instead of returning to Rama, however, Sita, requested her "mother" *Bhumidevi*, Mother Earth, to take her home, as her life on earth had been unjust and marked by sorrow. At this point the earth suddenly opened up and took Sita back. Rama cried out, asking for Sita to return, but the earth remained closed.

The story of the *Ramayana* highlights the importance of *dharma*, *izzat*, and loyalty in Indian society. Sita in particular exudes these qualities, as she remains loyal to Rama despite his continued insistence that she prove her innocence. In many ways, Sita is the narrative embodiment of what the ideal Indian woman should strive to be. Sita's narrative provides a context for the lives of the six participants in this study.

Personal Narratives

Ramandeep.

Biographical sketch: Ramandeep was a twenty-six year old woman who was a college graduate from India, and worked for a social service agency. She immigrated to Canada four years ago after having an arranged marriage with a Canadian citizen. She did not have any immediate family living in Canada, and was dependent on her husband for emotional and financial support. At the time of the interview, she was separated from her husband. Although

Ramandeep was not divorced from her husband, she referred to him consistently as her ex-husband throughout the interview, and this phrasing has been maintained in her narrative.

Ramandeep's narrative.

I immigrated to Canada after having an arranged marriage to a Canadian. As I was growing up in India, I was constantly bombarded with stories about how girls have to get married and raise children. This seems to be the only future you have. The roles for women in Indian society were kind of limited. I thought life might be different for me, as my father worked very hard to get me into a convent school, which I thought was so I could obtain a job posting with the government. However, I later learned that my father thought it would look nice if my matrimonial advertisement said I went to a convent school.

I grew up with the belief that marriages are forever, and that I would have an idyllic life with my husband in Canada. I put a lot of faith and trust in my ex-husband. I expected to have a trusting and open relationship like I had with my parents, especially my father. This illusion was soon shattered. I found myself in a controlling relationship, with little freedom. However, I clung to the hope that things would get better, that I should just ride out this phase of my life. To the outside world, I presented the image of a happily newlywed woman, after all, women in India don't get divorced. I made scrapbooks of our life together.

Slowly the innovative aspects of my work began to slip away. I no longer looked for new and unique ways to approach my work, nor did I find the time to write any longer. I was an avid writer in India, with published works. I had lost my drive and enthusiasm and couldn't focus. If you were to ask me what it means to be mentally unhealthy at this point I would describe a person who always has something at the back of their mind, there's constant stress, and extreme mood swings. By extreme mood swings I mean one minute you're laughing, the next you're

crying. From my personal experience of dealing with someone like this—actually it was my ex-husband; I remember one day he flipped out at me one day for having a tattoo. I explained to him that it was a temporary tattoo, but he insisted that this was sign of where my life was headed and he called my parents in India and his parents, who lived close by. It became a huge issue. He had very extreme opinions on this matter. I just couldn't understand his reaction.

I think one of the main pivotal points in the unraveling of my own mental health state was an incident that occurred when my ex-husband, my in-laws, and I were in India. We were at my parents' house and my ex-husband and my in-laws turned on me. I expected my father to support me, like he always had, but that's not how things turned out. Since my marriage, my ex-husband has constantly threatened to send me back to India. A married woman returned to India, alone, is as good as a pair of used worn out shoes: no one wants or respects you. So when my father came home that day I assumed he would support me; instead he slapped me. I was dumbstruck. He'd never hit me before. This man who seemed so modern to me and whom I doted over, slapped me.

Every time I thought about this incident I started crying. When we returned to Canada, I remember one day I was on the Skytrain and I just started crying. The people around me were probably wondering what was wrong with me. I found myself crying all the time and being unable to sleep. Sleeping was like a hobby for me, so I knew something was wrong. Up until this point I was waiting for my husband to change, I believed I could wait for him to change. But at this point I knew that was unlikely to happen. Despite having no hope in the relationship and the situation, I had no energy to leave. I felt drained; whom could I trust? The man I had trusted all my life, my father, turned on me, he had gotten me into this situation, by forcing this marriage on me. My confidence was already shattered, and what remained was gone. I had nowhere to

go. I couldn't go back to India and I didn't have anyone here. If my husband kicked me out of the house, I would have nowhere to go. I was feeling very insecure.

I told my ex-husband that I was going to go and see the doctor. Since I was new to Canada, my husband introduced me to my doctor and he knew him personally as well. My husband questioned my motives for going to the doctor; telling me the doctor could not help me if my chief complaint was that I was crying at night. But I knew something was wrong with me, and I needed to talk to someone, so I thought the doctor would be able to help me. I told the doctor about what had been going on in my personal life. I thought the doctor would be able to help me. He offered me medication to help me sleep, but I didn't want medication. I didn't want medication. To make matters worse, when I got home, my husband kicked me out. It was unacceptable for me to have cried in front of the doctor and spoken about our relationship. The doctor betrayed my trust and ruined things for me; he disclosed the details of my visit to my ex-husband.

I stayed with a friend, but constantly my mind shifted back to my ex-husband. I felt that he should come at any moment to get me. How could I survive on my own? Who would put a nail in the wall for me? Who would take care of the bank accounts?

When I did go back to my ex-husband my mental state began to further deteriorate. At work I was constantly thinking about my home life. What state would my ex-husband be in? I would be afraid all the time. I wanted to rebel; this wasn't fair, my life wasn't supposed to be like this. I wanted to leave, but I couldn't, this is a marriage, marriages are supposed to be forever and I had no energy to leave. I wanted to be with my husband, but I didn't. I was dependent on him; he had control over so many aspects of my life, including my finances.

I was living in a toxic environment. I had no support. If you have no one to confide in, no one to trust, then you're living without hope. At least, if I had someone at home to confide in, to share my worries with, things would be better. Although I work in a supportive environment and my co-workers were used to dealing with these types of situations, I couldn't confide in them. I didn't want their pity; I didn't want to be judged. Along with the lack of support, I felt controlled, like there was always something expected of me. I was afraid as well, there was no confidence in the relationship, I couldn't express myself, and there was always an element of danger. What will he do next? I was living in such a toxic state.

Then one-day things changed suddenly. My ex-husband took me out; we were having a great time. I thought things might improve. The next day he left me. Took all my immigration papers, he took all the money. I felt so used.

I was in a state of shock. I went to the police; the woman I spoke with wasn't helpful. She repeatedly asked me if I had a prenuptial agreement, I had no idea what this was. We don't have this in India. She wouldn't listen to me; she came on very strong, and was very aggressive. I felt like I was the one at fault. She was judgmental. I was really upset by the way she treated me. I am still upset by how I was treated by her. Why would she do that?

After my ex-husband left me I always felt lonely. Despite the fact that I had so much support from the people I worked with, I always felt alone even when I was with others. My life became very mechanical, I went through the motions of life, but I didn't feel anything. I went to work everyday, I was afraid that if I missed work I might kill myself.

One day I decided to seek out legal aid because I wanted my immigration papers back, as I thought I might go back to India, and through this process I also received counselling services. When I met with the counselors I felt like dying fish receiving a drop of water. Someone was

finally listening to me. That's all I wanted, was to be heard. I was very grateful for the support I received from the social service agency. Through this agency I went to a transition house for a few days because I was feeling unsafe. Through this experience and my counselling I learned a lot about what other people were going through, and that although my situation wasn't great, it could have been worse. It helped me cope.

The counselors also provided me with a safety plan, legal aid, and provided me with medical help. During this time I also kept a diary of what was going on, I began meditating, and went to the Gurdwara (Sikh Temple) regularly. My mother also came to visit me and she was a great source of emotional support. With her here I began going out more, I was becoming more outgoing, independent and I was growing confident. I started taking greater initiatives at work.

Once I accepted the fact that my ex-husband had left, I began to feel relief, and honestly I don't think I would have ever left him. I just didn't have the energy or the guts and most importantly, I didn't have the support. In the end it was a good thing. As I started to feel better, and moved out of my depression, I felt happier. The mental tension of going home to someone and being on eggshells about what their emotional state would bring was gone. I was able to devote time to my hobbies and more importantly to myself.

I still don't feel comfortable sharing my story with others. If I ever needed help in the future about mental health problems I would seek out professional help, not personal. I don't want to be judged or blamed. When I was married I remember going to a baby shower and the women there expressing displeasure at the birth of a girl; saying they're not good, they're a burden to the family. The South Asian community here seems to be fifty years backwards. People don't have these kinds of attitudes towards girls in India. The South Asians here haven't progressed. Women in India are more independent, some are single, some are divorced and

that's okay, it's acceptable. Women were not abused like they are here, it seems like it's acceptable to beat your wife in Canada. In India, I was proud to be a Punjabi. We say this prayer every morning about women, which stresses that they should be respected, you should never put them down. I felt like we were equal to a man; that's how I found everyone in India, especially the people around me, but here it's different.

For this reason I don't want people to know about my story. I don't want to be judged or blamed. I felt that if I sought help from those around I would be blamed. She's a girl, it's her destiny, and she should have stayed with her husband. In fact after my ex-husband left me, some of my friends would no longer pick up or return my calls. This makes me really angry, how dare they not respond to me? Did I do something wrong, did my ex-husband say something to them, like I drove him away? I also felt that divorce in our community is such a taboo, that people may not want to associate with me either, they would just shut me out, if they knew the truth.

I did confide in my parents about what was happening though. I don't think this is normal. For me, I felt like they got me into this and they should be responsible for what happens to me. Not everyone agreed with what I did, some people told me I should not tell my parents what was going on, as they became very disturbed. It affected their mental health to the extent that they constantly feared they would get a call saying I had been shot. So I was very frank with them, but I don't think that's normal for people in Canada.

One of the people who helped me when I was first separated treated me like I was his daughter, and protected me. However, one day his sister called and she had been abused and she asked for his help, she was suicidal, but he wouldn't help her. He told her he would not support her. Women reach out to their families in desperation, but the door is shut. Society has a big impact on this.

South Asians want to maintain the outward image that they're happy and their family is in sync and in harmony with one another. There's a lot of pressure to maintain this image. So even if people do have the opportunity to seek out mental health resources I don't think they would, because you wouldn't want other people to find out, it would change the way society thinks of you. I think that's the reason why I've never really heard about other South Asian women talking about their experience with mental health services. Why risk being seen accessing these services, when you can just go to your family doctor and get a prescription?

All I know is I am grateful for the counselling that I received. I am a more confident person now.

Simran.

Biographical Sketch: Simran was a thirty three-year-old married woman, with a post-graduate degree from a Punjabi speaking university in India. She immigrated to Canada six years ago after having an arranged marriage to a Canadian. At the time of the study, she lived in a joint family household, and was on maternity leave from her jobs as a health care attendant and retail clerk. Simran had two young children, and had suffered from bouts of post-partum depression after the birth of each of her children.

Simran's narrative.

For me, good mental health encompasses three main aspects: freedom, time for myself, and financial independence. I think it's important to have the freedom to do as you please and to be upfront with others. While I was growing up in India my family was very liberal. They never made me feel like other girls, who were restricted in their personal freedom or speech. I was allowed to pursue my studies. In fact all of my siblings were encouraged to study. We all have at least a Master's degree. My parent's also allowed us to be frank and up front regarding our

opinions and feelings. I really value not being made to feel stuck, like I have no options and must do as I am told.

Currently, living in a joint family, I often feel stuck, as though I must do things to appease others at the cost of my own desires or priorities. To me, my children come first, and I feel upset when I am pressured to attend to household chores first, and then to my children. When I had my first child, I often felt conflicted and became negative over the pressures of motherhood and the duties towards my joint family. Now, with my second child, I have learned to develop a thicker skin, and put my children first. I still struggle with maintaining a positive outlook when either my in-laws or other members of the Punjabi community criticize me.

I find it difficult to say anything when elders criticize me with regards to my child rearing skills or how I fulfill my duties towards my family. I've been brought up not to question those older than me, and, really, what can I say when they tell me that they've raised kids too? It's as if I'm being accused of insulting their knowledge. I wish I had more support from my family and others in the community.

I don't have many friends here; my life mostly revolves around my children, family and work. So to me receiving support from others for my decisions is very important. At times the lack of support I receive impacts my mental health. I tend to get very negative. I wish others could see that there is more than one way to do things. I do find support from my husband and my family in India, but they live so far away at the same time.

When I was suffering with post-partum depression with my first child and then again with my second, I really didn't have much support. My husband was my only source of support. I was already feeling depressed, and matters were only made worse by the lack of understanding regarding my condition. I was told that I was just being lazy. Punjabis have very high standards.

When I go to work the Caucasian women always remark that "Oh, you have two children you must have your hands full!" However, with Punjabis their comments typically entail, "Oh, you have two children, no big deal."

I really wish others could understand what I'm going through. In fact, I didn't even know what was wrong with me after the birth of my first child. My husband recognized that there was a change in me. I was more irritable and easily upset, and would cry often. My husband encouraged me to talk to my doctor about how I was feeling. If it were not for his encouragement, I would never have mentioned anything to my doctor. My doctor encouraged me to be active and keep myself busy and that this would pass. He offered me medications, but I refused. I didn't want to take them. Now that I'm going through it for a second time I know how to handle it and that it will pass.

Post-partum depression makes me feel negative, apathetic, antisocial, and above all I just want to sleep. I find it a real struggle to carry on with my daily routine and chores. I wish others could understand what I am going through and offer their empathy as opposed to their criticism.

I think this lack of empathy is attributed to Indian culture. We have a tendency to be complacent when dealing with mental health issues. I knew of people back in India who had mental health problems, they had an imbalanced life, where they would over indulge in alcohol, had the wrong priorities, couldn't make the right decisions, were unwise, irritable, lacked self-care, and were self-centered. If you tried to talk their family about the problem, the family member would simply reply that that is the way they are and there is nothing that can be done about it. They have been this way for years and they will never change.

Indians also seems to think that if you talk to them about mental health issues you are implying that they are *paagal*, crazy. *Paagal* is seen as an extreme state of mental dementia;

you're completely gone, your mind doesn't work. Indians seem to feel insulted if you comment on their mental health or imply that they need help. Their honour appears to be insulted.

Personally, I was grateful that my husband spoke to me about the change he had noticed in me and encouraged me to talk to my doctor. In fact, during my bouts with post-partum depression my husband was and is my greatest source of support. He allows me to talk through my feelings and encourages me to get out and be active. When I'm feeling negative about my family circumstance, like balancing my duties towards my children and my responsibilities to my in-laws, I again talk over my feelings with my husband. He encourages me to be positive. It is hard work to maintain a positive outlook, but I feel it's important; you have to work hard at it everyday.

I'm grateful to have my husband's support. You need someone's support, especially someone close to you. I think a husband's support is very important, if they don't support you, who will? If you don't have any support it's only a matter of time before you begin to doubt yourself and question your actions.

The second factor that I found important in maintaining my mental health is having personal time. I think it's really important to have time to your self, to take care of your needs. I know for some people it's not important, but for me, I don't feel happy with myself if I don't have time to exercise. I prefer to do yoga, as it is something that I can do at home, which is preferable when you have young children. I think exercise is important in maintaining your mental health, as being over weight impacts how you feel about yourself. Since having my second child I've put on an extra 25 pounds, and it makes me feel unhappy. My appearance is important to me.

The third factor that I think is imperative to maintaining good mental health is financial independence. I think it's important that women are able to support themselves, in the sense that they are not dependent on their husbands for every need. I don't mean to imply that you're able to indulge in luxuries, just that if you want to purchase something you don't need to ask your husband. Like sometimes my son wants something and I don't want to say to him I'm sorry we can't buy that, I don't have any money, or we have to ask your father. I should be able to provide for my children.

I'm struggling with being strong mentally and being firm in my convictions. It's easy to get negative when you have little support, but I'm learning and having the support of my husband really helps.

Gurpreet.

Biographical Sketch: Gurpreet was forty-one years old, and immigrated to Canada after having an arranged marriage with a Canadian citizen nineteen years ago. She had a post-graduate degree from India, and since immigrating to Canada she had worked as an esthetician. While she was married she lived with her husband's family, and she had three children. Her married life was marred by abuse. At the time of the study, Gurpreet was separated from her husband and struggled financially.

Gurpreet's narrative.

I came to Canada in 1991, after having an arranged marriage with a Canadian. The first few months of my marriage were okay. I had to deal with a lot of verbal abuse from my in-laws and my husband. Soon this verbal abuse escalated to physical abuse. While growing up in India my mother always told me that it is common for families to fight and for husbands to get mad all

the time. It's a part of life and you just deal with it. My mother in-law reiterated this belief when I tried to talk to her about the problem.

Constant abuse, both verbal and physical, was the hallmark of my marriage. I lived in this abusive state for 14 years. It has been six years since I left him and I'm still trying to get my mental health back. This is my story about my struggle with mental health.

When I first immigrated to Canada I dealt with a lot of verbal abuse. I lived in joint family with my husband and his parents. I remember one day I was calling my husband to ask him if he could pick me up from my class; however, my mother in-law refused to give him the phone. I had to walk home that day, as I had no money for the bus. After many similar incidents, I decided to call a social service agency that I saw advertised in a local Punjabi paper. I met with one of the counselors at this agency and she offered me a lot of help, and told me if things get worse I would need take certain steps, including calling the police. This wasn't what I was looking for. I felt overwhelmed, and thought they were trying to ruin my marriage. I never contacted this association again.

As the abuse got worse and with the birth of two children, I soon forgot about this resource. I started to cope with my situation by overeating. I would constantly eat foods high in sugar. I needed the constant rush. I was becoming imbalanced. I knew it was bad for my health, but at the same time I couldn't really think about the long-term consequences of my actions. I just needed something to deal with the here and now.

I started getting migraines due to all the stress. I went through hell during my marriage. When my husband would beat me sometimes, depending on the injuries, I would go to my family doctor. I wouldn't tell them what happened, I usually told my doctor that I fell or tripped. Sometimes my doctor would press me on the matter, I gave in sometimes and told her that I was

beaten, but I begged her not to tell anyone or do anything about it. I didn't want the police involved.

I was constantly worried about what was going to happen next. I didn't have family support, either from my own parents or from my in-laws. In fact, my in-laws would just stand by as my husband beat me. I was cut off from my family in India. I have friends who I could talk to, who would help me out, but really there was nowhere I could go.

I did eventually see a psychiatrist while I was with my husband. My daughter who was in elementary school at the time was referred to a psychiatrist because she was having problems at school; they said she had issues. But my daughter is fine, she doesn't have any problems, it was the teacher who had problems. Anyways, when she went to see the psychiatrist, I decided to make an appointment for myself as well. I found the sessions helpful, the psychiatrist put me on antidepressants, but I'm trying to get myself off of them now. I don't want to be on them, I want to see if I can do it on my own, and I've also gained 40 pounds since I started taking them. I don't feel good about myself anymore. I didn't stick with counseling in the end; I didn't put much effort into it. Part of me just wanted a magical cure, which is probably why I used to see *Pundits* (astrologers and practitioners of black magic). I remember going to see this Pundit one time after my husband had slapped me, I thought now he's going to get it, but I realized later that they really couldn't do anything.

One day I was coming home from work and my mom called me on my cell phone from India. I stayed in my car talking to mom. My husband misconstrued this as a sign that I was talking to an "imaginary boyfriend." He took away my keys, became violent, and kicked me out of the house. Throughout this entire incident I began to think I shouldn't have spoken to my mom. I shouldn't have answered the phone. Instead of thinking that he was abusing and

mistreating me, I began to think that I shouldn't have upset him. Do you see how mentally unhealthy I was? I couldn't even distinguish between right and wrong. I should have taken my kids and left him, but I didn't.

The next day my husband came to shop where I worked and vandalized it. I was really upset and I called a friend and told her what happened. She called the police. I never had the courage to call the police during our marriage, I was too afraid. When the police came and took him away I made sure I wasn't around; I couldn't bear to see the police take him away. I had too much fear. They released him that same night at 2 o'clock in the morning. He came home and threw me out of the house in my nightgown. I had no shoes on and there was a lot of snow on the ground. I had to walk ten blocks in the snow, barefoot, to a friend's house. I now know that my husband is a sick man mentally. He's self-centered. That night, like so many others, he didn't care to think about what might happen to me.

Despite feeling sad, angry, crying all the time and even wanting to hurt myself, I just didn't have the courage or confidence to leave. I had no control over my life; I couldn't make the right decisions. In fact, at times I couldn't tell the difference between fiction and reality. I was in a really bad place mentally. Sometimes my husband would tell me that my recollection of events was incorrect and that this is how it really happened. After a while, I started to doubt myself and I began to believe him.

Sometimes I just wished that my life would end.

After the birth of my third child, my daughter threatened to run away if I didn't leave my husband. She told me that she and her older brother didn't have a good childhood, at least we can save this one. I didn't want my daughter to run away; I've seen what happens to girls who are on the streets, I didn't want that for her. I left my husband shortly after this. We left while

my husband was out of the house. For a year, I lived on my own, without him. I learned that I could have a normal life without him and be happy. I was still in contact with my in-laws during this time though. Looking back I felt like I was under their spell, I couldn't cut myself off entirely; they were still able to control me.

I was under a lot of pressure to reconcile with my husband. My in-laws were constantly at me to return to my husband. Even my parents wanted me return. To my parents, marriage is forever and they felt that their grandchildren should have a father. Even people in the Indian community felt it was my fault. They would say it was bound to happen; she talked too much; they had to throw her out of the house. It was actually our Hindu priest that brought us back together. Though I would never go to my Hindu priest for counselling, I feel all religious leaders have mental health problems, plus what can they do to help me?

Another thing that really bothered me about the Indian community is that we recite prayers saying we should respect women and Hindus pray to countless female deities, yet there really is no respect for women. Like I said, the Indian community and others blamed me for the problems in my marriage. Even my parents, they knew my marriage wasn't great. I never fully disclosed to my parents what my husband did to me as I didn't want them to worry, and I'm an adult I want them to think that I have a good life in Canada, but even they wanted to me to keep my marriage. There really is no respect for women, and when you try to do something good, like I tried to help a woman whose husband used her to become a Canadian citizen, people would just ask me, what do I have to gain from this situation and told me that I should mind my own business.

Due to all the pressure, I went back to my husband and the honeymoon period lasted for about a month, during which time I refused to speak to him. I wanted him to go to counselling, but he wouldn't go. After about a month the abuse started again. One day he started throwing

my belongings out. I waited for him to leave and took the kids and left. I told my in-laws that I was leaving and I was never coming back. This time I decided to set boundaries with my in-laws. I refused to allow them to visit me. If they wanted to see their grandchildren they could meet them at a predetermined public location. I've never spoken to my husband or my in-laws since I left. They have this power over me, I don't know what happens to me, but I lose my confidence and control. I remember one time I had gone to a women's shelter and my husband came to get me. He started crying and I gave in and went back to him. That's how it is; I just lose my confidence, my strength around him.

Even though I left my husband I'm still afraid all the time. I'm always looking behind my back. What's he going to do next? When is my life going to change, how long do I have to live in constant fear and depression? I can't just forgive and forget the past; I wish I could.

I started seeing a counsellor after I left my husband for the second time. I was connected to a women's center during one of the police incidents. So I knew about the resource from them, and then when I was separated I contacted the agency, as I needed legal aid. When I spoke to the woman about legal aid she suggested that I see one of the counsellors at the women's centre and that's how I began counselling. I've found counselling to be a positive experience. I feel like the counsellor understands what I'm going through. When the police were called during one of my domestic disputes I didn't always find them very helpful. I remember in particular there was this one officer, he really gave me a hard time. He didn't believe me, and I felt like he was accusing me of having an affair. It was a very difficult situation, that officer really made my life difficult, and made me feel like I was the culprit.

Counselling has been great though. I'm forty years old and I'm still learning, so I see that as a positive outcome. Through counselling I am learning to not be so rash, but to take the time

to think about the consequences of my decisions. I feel that my mental health is improving; I think I'm about 20% of the way there. My goal is to become a more positive person, who is calm and does not become easily unnerved by any situation. I also think it's important to read books that instill you with good knowledge that you can apply to your life. Along with this, I also think exercise is very important for one's mental health. I believe that the endorphins released from exercising make you feel good, thus elevating your mood.

I do wish I had access to a psychiatrist though. I feel that they have the ability to assess you for any mental health disorders and I would like to know if I do have any problems. I also feel that family doctors should keep brochures about mental health at their offices as a lot of people go to their doctors to discuss their problems. I don't think a lot of Indians know about mental health issues either. Like, I only realized that I was depressed when I completed one of those magazine questionnaires for depression. Whenever I go to any medical office and see brochures on mental health and mental health services I always take them. I think it's good to have knowledge about these things. In fact, I keep all these brochures in a box and whenever I am having difficulties, I go through all these brochures. The newspapers is another place where mental health issues should be discussed and resources should be advertised, especially in the free papers, which more people have access to. Besides the resources that I have been accessing I am not sure what other mental health services exist out there, but I am grateful for the help that I have received.

Amrit.

Biographical Sketch: Amrit was a sixty eight-year-old woman, who immigrated to Canada twenty-six years ago, and had a grade eight education level. Before Amrit retired she worked as a berry picker. Amrit was retired and, at the time of the study, lived apart from her husband.

Despite not living with her husband, she still considered herself married. Amrit's husband had a lot of animosity towards her, and, thus, they could not live together.

Amrit's narrative.

I don't really believe that anyone is healthy. At some point everyone will have problems. Perhaps when you're younger you're okay, but as you age, something is bound to go wrong. Unfortunately, there's not a lot you can do about these things. Everything is predetermined, it's written on your forehead. Whatever God has planned for you, you must bear. It's their fate, what can be done? I prayed everyday, but still tragedy struck.

Since coming to Canada in 1942, I've had a tough life. My son passed away and my husband could not handle it. It was difficult for the both of us, but I was able to tolerate the situation better. He wasn't strong in his mind.

In general, when people are not right mentally they're slow, they become confused when they're talking, they can't keep their focus, and they keep repeating the same old things. As a result when you're talking to someone who is not right in their mind their conversation often strays. Other people become imbalanced, they either eat too much or too little. You know a person is mentally ill by their actions, they bang things, break things, swear, people don't speak well of them. This is what I think anyways.

When you suffer some sort of emotional pain, you get afflicted with ailments. This describes my husband. He couldn't handle the death of our son; he developed numerous health issues, including back problems. Sometimes while talking nicely to me my husband's mind would wander. He would start talking about people who have passed away as if they were still alive. Then I would know something is not right. As his mental state got worse he would become hostile, he wouldn't let me pick up the phone, he'd start cursing at the phone when it

rang. He cut himself off from his own family as well. He refused to talk to his brothers in India when they called. What could you do?

My husband was a good man before all this happened. He was educated. When I think of someone with good mental health, I think of people who are well respected. Like my grandfather, people always spoke highly of him. During the partition, he hid many Pakistani girls, and then sent them safely to their places. He did good work. My sister is also a good woman, despite what happened in her personal life, she always looked after others. If you're a good person, it comes out in what you do. You can only know about a person's mental health by the way they talk, what they do, and listen to what other people have to say. People will know. It is impossible to do good work if you're not happy in your heart.

If you want to be happy you shouldn't think too much. That's why they say not to think too much. I had to work really hard to control my mind after my son passed, otherwise I would have become like my husband. If you can't tolerate what happens in life then you will catch a disease. You might get high blood pressure, or a stroke, and your mind is also affected. I was very depressed when my son died, I cried all the time, and I would stare at his belongings. I became so weak I couldn't walk without the support of the wall. I improved my mental state by going out, I would go for walks; I would take the bus and go to the mall.

I don't usually talk about my husband. I feel my blood pressure will be high today. I need some water. It's been so long since I've spoken about this.

Like I said my husband was well educated. When he became unwell, he would lie down all day, he wouldn't go out, and he kept eating the same thing for a week at time. If you tried talking to him he just kept repeating the same things, he wouldn't listen, he was confused. My son tried to convince him to take his medications, he tried so hard, but he wouldn't listen. My

husband also started drinking a lot; he became very hostile and aggressive. It was very hard to live with him. It was a difficult time. It was a hard life. I had to deal with him on my own, as my son lived away from home at that time.

I didn't know what to do. If my husband wanted food I would make it for him, but whenever I served him anything he would always take my plate. He thought I was trying to poison him. He was paranoid. I tolerated his behaviour. I never answered back, I did once or twice, but then I thought why should I contaminate my mouth. He is not well, his head did not work; I am not like him.

My sister would tell me to get out of the house, but where would I go at night? I'm not a man, I can't just go out at night, whose house could I go to, what will people think? I couldn't just sit outside; people would wonder why I was sitting outside. At times I would shut my bedroom door, I became so afraid of what my husband would do, his condition was really bad at the time. My children would tell me not to be afraid.

We tried to convince my husband to take his medications, but he didn't believe he was sick, so what can you do? We consulted with doctors, but they didn't tell us anything in the beginning. I don't really have much faith in doctors myself. They said they could cure my son, but they didn't. He ended up in a wheelchair, poor thing. When we have to go, we have to go, there is nothing that can be done. The doctors did surgery on me; it did not go well. Who can trust doctors? I only ever go to the doctor when I get a letter for a check up. The odd time I may have mentioned something about my husband to my doctor, but she never said anything. My daughter would tell me to see a counsellor, but I was fine, I didn't need to see anyone.

We, my children and I, did talk to doctors about my husband. Like I said at first they said nothing, then later they told us that this is the thing, bring him to the hospital for treatment. He

wouldn't go, so we had to call the ambulance, the police. The doctors didn't tell us what was

wrong, they should have told us that he was depressed and needed to be put on medications.

After my husband went to the hospital he became very hostile towards me. He now lives with

my son and I live in a senior's residence. I rarely go home, only for birthdays.

I don't really know much when it comes to the medical system. I just know if something is

wrong with someone you should consult with your family or close friends and then decide what

to do from there. If you need to go to the doctor, you have to go to your family doctor, they have

your file, after all, and then they will tell you what to do. That's all I know. I really don't know

much.

Hardeep.

Biographical Sketch: Hardeep was seventy-nine year old widow. She came to Canada

thirty-one years ago, and had a post-graduate degree from India. Hardeep had worked on a farm

as a berry picker for a about week when she first arrived in Canada, but found the work too

strenuous and quit. She lived in a retirement community, which was a decision she made, against

the wishes of her children who would have been happy to have her live with them. Hardeep was

very active in her community and was well respected among her peers at the retirement

community.

Hardeep's narrative.

I think the difference between being mentally healthy and mentally unhealthy is a delicate

line; you may notice a fine difference in a person's character. Sometimes you might notice a

slight difference in how the person is acting, like they might be walking in a slightly different

manner, but otherwise their personality seems fine. In these cases, the person may not even be

aware that they have mental health issues, due to their imbalance. I feel that it is important that

people who are at this stage get help immediately, before their condition worsens and develops into depression. When I see people like this where I live in assisted living, I try to help them by keeping them in good company and making them laugh. I think laughing is very important, and it's good for people to understand the value of laughter. I laugh a lot, it's my nature, and I find I get a lot of relief from it.

I've seen a lot of cases of people struggling with mental health issues. I know they're not doing well mentally because they become confused easily when you talk to them, and they can't make proper decisions. They also cry often and are lonely. If you look at their faces they get scared easily and they keep to themselves. They don't want to talk to others. Where I live currently, the people are very simple people, but you can see the sign of anxiety and worry on their face and they can't say what they feel. When I see people like this over here at assisted living that are so depressed, we try to talk to them, so that they can bring out whatever is inside of them. This is how we try to help. Otherwise if the depression worsens, in Punjabi we refer to them as *Paagal-pun*, they become very imbalanced, crazy, they may start to break things or become violent. Then they need to be hospitalized.

It's hard to help people who are having mental health issues though. Sometimes their mind has become so imbalanced that they don't want to listen to anyone, or their mind is so weak that others easily influence them. For instance, if a person is mentally weak, and you tell them that they do not look well today, this thought will grow in their mind and affect their entire body, and they will feel sick for the rest of the day. This is why I refuse to label people who are going through mental hardships; I don't think it is helpful to use such language as "mentally retarded." Instead we should focus on their positive qualities and help bring those out. People who are

depressed or mentally unhealthy also need to be in a good environment surrounded by supportive people who are there to help them.

Sometimes Punjabis, upon learning that someone is not well mentally, may not be so supportive, and the person who is suffering mentally may not be well received by others. This is not to say that all Punjabis will react this way, some will be very supportive. Our reaction to mental health problems is something that has been ingrained within us over generations.

We, Punjabis, are very closed when it comes to discussing mental health issues, or personal problems. People gossip and talk about others, so we have the belief that it's better not to discuss problems with others. It's seen as an ugliness, a slur. If people find out about my mental health problems or my family's what will they think about me, about us? Our parents, our grandparents, and forefathers have all reiterated this belief: that whatever happens in your house, for better or worse, should remain in your house. In fact, when I got married my mother, and also my mother in-law both told me to keep my mouth shut, then everything will be fine, but the moment I open my mouth and tell people about an illness I have, then those around me will change their perception of me very quickly.

The older generation has taught us not to air our dirty laundry. A woman is to take all her secrets to her grave. When a woman gets married she is told that her house now is where her husband and in-laws reside. She is welcome to visit her parents, but she can never return home. No matter what happens in her marital life, no matter how she is treated, she is to remain with her new family, and will only leave in a coffin. The daughter in-law is instructed never to disclose family secrets to anyone, not even her parents, because it is their honour that is at stake. These beliefs have been engrained within us over generations and are very hard to break. Even for those who are educated. They may try to change, but it's slow and very hard. For those who are

uneducated and older, they are stuck in these old ways of thinking. It's not really their fault either because this is what they were told.

These tightly held beliefs often prevent people from seeking help, especially from mental health doctors. Many people, if they do seek out a doctor, will go to their family doctor. They're seen as an expert, and they have a lot of faith in them. Even though the care we often receive from our doctors is not great. Doctors are often in such a rush that we feel pressured by them and don't fully tell them everything. They then prescribe medications for us and that's it. What would be ideal is if the doctors would listen to what we have to say properly and then give us their advice and prescription. Most people when they see their doctor are seeking out prescriptions.

Sometimes Punjabis may want to see a Homeopathic or Ayurvedic doctor, but since you have to pay to see these practitioners it's unlikely they will go to them. In terms of Punjabis seeking out mental health resources it's unlikely for the reasons I mentioned earlier, but those who would be open to it, don't really know where to go besides their family doctor. For this reason, it would be good if doctors told their patients about mental health resources, especially since they believe in them so much, they may be open to these services then. There probably should be more education by the government on mental health resources as well, and they should make advertisements like a story, so it catches your attention. Most advertisements for mental health services are very dry. I, myself, am not sure about where to go for mental health resources either, but I do know of a not-for-profit agency that would be able to direct me, so that is who I would call if I needed to find out about mental health resources.

When it comes to maintaining mental health I feel that three aspects are of the utmost importance. These are mental, physical and emotional health: your mind, body, and soul. If all

three of these aspects are in balance your mental health is fine. If the body is suffering from ailments, then your mind becomes weak. If your mind is not working then your body is useless. If your soul, emotions are weak, then you are quick to accept what other people tell you, and this will affect your mind and body. They're all interconnected, and need to be in balance.

A person who is mentally healthy will be strong and healthy in all three aspects, even when faced with difficulties. Problems are an inevitable part of life, but your health will impact how you handle them. I have a friend who has faced many struggles in her life, but when you talk to her, she saw those struggles in a positive light, walked towards them, and solved them. Those who are not healthy, on the other hand, see every problem as a challenge.

My philosophy when it comes to maintaining my mental health is to be active. I exercise to keep my body fit, and I am very active socially. Here at assisted living I help organize events, I'm very social with the other residents and with my family. Sometimes I do get worried about my memory, its not as sharp as it use to be, my doctor tells me this is normal. It takes me longer to make decisions now; I have to think about what I am doing and what I want. Sometimes I also catch myself doing the wrong things, like putting a juice carton in the cupboard, when it should go back in the fridge. At times like this I get worried. But when I get worried I have one consolation and that's not to spend too much time or energy on worries, otherwise they will grow. So when I have a worry I just blow it away and then I'm at peace.

Mandeep.

Biographical Sketch: Mandeep was an eighty-four year old woman, who immigrated to Canada fifty-two years ago. She had a grade five educational level, and when she immigrated to Canada had worked as a berry picker. Mandeep was retired and widowed. She suffered her first mental health problem in India, and again upon immigrating to Canada. Despite having

immigrated to Canada with her husband and her four children, she often felt lonely. Her daughter was her primary source of support.

Mandeep's narrative.

One day I woke up suddenly and I had broken out in a cold sweat. I would walk around with one eye closed to see if my vision was affected or not. I had heard that there was someone in the village who prescribed medicine for mental health problems, so I decided to visit him. However, no one in my family would come with me, so I had to ask a *Raamdaasan*, a woman from a lower caste, to come with me. I was very hurt that no one from my own family would come with me. It still brings tears to my eyes that my own family wouldn't support me.

We went to see this healer, and he told me that my problems were a result of the nerves in my brain not getting enough circulation. They were swollen. He gave me some herbs to take and also told me to buy some Indian sweets and incense, which he then took. He gave me back some incense and told me to use them to cleanse my thoughts as they were clouded. He also gave me a book of excerpts from the *Guru Granth Sahib*, Holy Scriptures for Sikhs.

My thoughts were focused on the wrong things; I think that's why I was having problems. I had too many negative thoughts. I started reading the Holy Scriptures for two hours everyday; my mind would be distracted during that time. I slowly started to feel better. It took me about two years till I was better.

I got sick again after coming here. I used to think that everyone was talking about me. My daughter took me to the doctor; out of my four children she's the only one who helps me. My family doctor gave me some medicine to help me cope, and he along with my daughter said I could be admitted to the hospital. But I didn't want to go to the hospital. I wasn't crazy; I wasn't seeing ghosts and witches. That's when you need to go to the hospital for mental health

problems. I did see a ghost once, but I know they don't exist and it was all in my head. I didn't really see a ghost. During the same period I had negative thoughts that kept repeating like a tape player in my mind. My husband had also passed away during this time. I felt very sad and alone.

Along with reading the Holy Scriptures I started to keep myself busy as well. When I first got sick upon coming to Canada, I couldn't do anything. I stopped my daily routine; I couldn't eat or cook. At one point I would just drink milk. That's all I could have. I had a hard time sleeping at night as well; I would lie down for long periods for time; I became very inactive.

It's really hard work, but if you want to get better you have to try. I started going out, I joined a seniors group, going to lectures. I also slowly started to ease back into my daily routine, going out for walks, cooking for myself. Probably one of the most important things that I did for myself was keeping myself busy. I think it's really important to keep your mind distracted otherwise you're constantly thinking about the past, and also to only listen to the good things that people have to say, ignore the bad.

During this time, my family doctor gave me a referral to a psychiatrist. My daughter set up the appointment for me, and accompanied me to the appointment, as the psychiatrist did not understand Punjabi and I can't speak English well. I only went for two sessions, I felt better after that. Also my daughter is very busy, she works full time and also has to take care of her mother in-law. I didn't want to trouble her.

Because of my experiences sometimes people will come and talk to me about their problems. I let them know that mental health problems are a result of a mind that is not working properly, and that they need to see a psychiatrist in order to get help. They should not waste their time on *Pundits* (Indian astrologers and practitioners of black magic). These kinds of people will

just waste your time and take your money. They don't know what they are doing. A psychiatrist is the right person to see. They will interview you and listen to what you're saying and then they can determine what is wrong with you. Your family doctor can't deal with mental health issues, they can't tell you anything by listening to your pulse. You need to see your family doctor to get a referral; beyond that there is not much they can do. You need to see someone who specializes in problems with the mind.

In terms of accessing other sources of support I really think going to a psychiatrist is the best option. I also went to the temple sometimes, but to me it really doesn't matter if you go the temple or read the scriptures at home, if you don't understand the scriptures then they're not going to help you. In the end, your mind has to be open to what the scriptures say; otherwise it's pointless. I don't really know where else a person would go for help when their mind is not working properly otherwise. If there were resources in Punjabi and you can understand them that would also be helpful.

For me, signs that a person is suffering from poor mental health would be that they keep repeating the same things. You wouldn't be able to carry a conversation with a person who is like this. They would also give you poor advice, so you should never ask them for help. You also need to be very careful around a person who has poor mental health as they get agitated quickly, you need to leave them be. I've also noticed that if you have poor mental health you become inactive, you don't want to get out, you just tend to sit there. You let your daily routines go, just like I did.

I think mental health problems begin when you have a wrong thought that gets embedded into your mind. This is why I say that it's important you don't pay attention to people when they say bad things. You need to ignore negative comments. This is something that I have struggled

with and continue to. I have a lot regret over a decision that I made in the past, my daughter tells me to forget about it, it was a long time ago, but I can't. It's hard.

Summary

This chapter provided seven narratives. The first narrative, Sita's, is a mythological story that represents a woman's role in Punjabi society and still guides cultural traditions to some extent in India and after women immigrate to Canada. In addition, six narratives were presented that were constructed using the narrative inquiry procedure to reflect the participants' definitions and experiences of mental health. The following chapter explores themes that were present across the seven narratives.

Chapter 6

Themes Across Narratives

This chapter explores five dominant themes that related the seven narratives, and that

reflect the research questions, the literature, and the overall goals of the research project. These

themes include: 1) Needs + thoughts, feelings, and behaviours; 2) Fear of judgment: "It's an

ugliness"; 3) Just deal with it; 4) Family physicians: "They are the experts" and; 5) Divergences:

Differences in mental health meanings and practices among the younger and older participants.

Each theme is defined and exemplified with data, and then followed with a discussion.

Needs + Thoughts, Feelings, and Behaviours

The first theme, Needs + thoughts, feelings and behaviours, described how the

participants defined good and poor mental health. For the participants, mental health was based

on an assessment of two aspects: the first was what they perceived as their needs, and the second

was a triad of thoughts, feelings, and behaviours. Paagal, a sub-theme of needs + thoughts,

feelings and behaviours, described an extreme mental state that is often negatively associated

with mental health problems in Punjabi culture. Consequently, the association of paagal with

mental health may affect an individual's disclosure about mental health issues.

Needs.

Meeting specific needs was described as a basic requirement for mental health. Needs

were structured into two tiers: basic and higher level needs. Basic needs were social support and

freedom. Social support referred to emotional or physical comfort offered by family or close

friends. For many of the participants in the study, social support was especially important during

times of emotional or physical distress. For Ramandeep, the loss of support from her father

marked a clear turning point in her mental health state:

So he [Ramandeep's father] was that supportive person. He kind of hit me, right, which

he has never done, even to me as a child. So it was very weird for me. So that lead, for

me, it was a huge shock because I trusted him and I was hoping that he would support

me, but it didn't turn out that way. So that lead for me, it lead me to break down. That

was a breaking point for me. So, that lead me to be mentally unhealthy. (lines 384-389)

Support was perceived as imperative in order to be able to find the strength to deal with a

stressful situation and seek help.

Without support, many women reported feeling hopeless or stuck, which in turn related to

the second basic need of freedom. Freedom, for the most part, referred to having the ability to

make decisions regarding one's day-to-day life, for example, when to perform daily chores such

as washing the dishes. If the women felt that they had no control over their daily lives they felt

stuck, for example, unable make decisions regarding trivial aspects of their lives. They also

described this as having "no energy" given their inability to make decisions. Simran often felt

like she was stuck do to her lack of options:

Sometimes, like I don't want to do something. And people around you, and they want that

you have to do [what they ask of you]. I feel stuck. I don't want [to]. Like Bobby, [my

son], he wants to go out, and some[time], like mom, she told me that you have to clean

the stuff and do that. Like that. Then I am stuck. If I don't do that, maybe the argument

goes up. (lines 440-444)

Ramandeep also commented on feeling stuck. After having lost hope in her marriage, she noted:

"I can't do this, but I had no energy to leave the situation" (lines 441-442).

The higher level needs, which included time for self and financial freedom, featured more

prominently in discussions of what constitutes good mental health. Time for self referred to the

ability to prioritize time for one's needs or desires, which included caring for oneself or indulging in hobbies. For example, comments made by participants stressing the importance of having time to oneself included: being able to "go home and put on some music and maybe cook or read" (Ramandeep, line 165), "I have a very bad hair, so if I do [my hair] properly I feel better. If I miss something like I didn't [get] my eyebrow[s] [done] … I feel oh I have no time for me" (Simran, lines 102-105). Financial freedom referred to the ability of participants to have access to their own monetary funds for their personal needs, such as purchasing gifts for their children. The women in the study wanted to be self-reliant financially when it came to minor purchases, and not feel the need to ask permission of their spouses for small insignificant items, such as moisturizers or children's toys. Comments made by participants stressing the importance of being financially independent included: "they [women should] have bank balance, so they can spend on what they want [and feel independent financially]" (Simran, line 375).

Higher level needs did not appear to be linked directly to mental health needs during times of distress. It could be posited that higher level needs are easier to achieve once one's basic needs are fulfilled. For instance, once you have support, you may have more time for yourself.

Thoughts, feelings, and behaviours.

The interrelated triad of thoughts, feelings, and behaviours represented the second major aspect of mental health. When participants in the study were asked to list words that reflected what it means to be mentally healthy and unhealthy they noted various words. In general, the words could be divided into three categories: those that reflected thoughts, those that reflected feelings, and those that reflected behaviours. For thoughts, words included: right decisions, alert,

and confused. For feelings, the words used were positive, content, negative, and sad. For behaviours, the words included helping others, trying new things, antisocial and violent.

In addition to thoughts, feelings, and behaviours, there were also two global factors that impacted mental health: being balanced and well adjusted. Being balanced referred to stable thoughts, feelings, and behaviours, and was indicative of positive attributes associated with mental health. For instance, when participants spoke about being balanced and well adjusted, they used words such as, mentally alert (Hardeep, line 52), "they make very quick mental decisions … and in any situation they do well" (Hardeep, lines 75, 101), "who talks perfectly," (Amrit, line 25) or "gives you good advice" (Mandeep, line 380).

Imbalance, on the other hand, related to being mentally unhealthy. For instance, inflicting pain on oneself: "I would get so mad, why you doing it [beating me], let me do it for you. You just sit back and watch" (Gurpreet, lines 215-216), "I would sit and eat so much sugar" (Gurpreet, line 199), "I just couldn't think straight… all I had to do was pack my bags and leave. I was so mad I would bang my head to the wall" (Gurpreet, lines 237-239). Others described extreme behaviours associated with poor mental health, as "becom[ing] uncontrollable or sometimes they break things" (Hardeep, line 161), or having severe mood swings, "like some days you would find them very happy and you know more normal, like exuberant, joking, making jokes. And the next day you seen they go down, a lot" (Ramandeep, lines 266-268) or "somebody is laughing one moment and the next moment they are crying" (Ramandeep, line 273). These are examples associated with being imbalanced. Imbalanced qualities were typically seen in individuals who exhibited extreme behaviours: such as 1) confused thought patterns, like "talking about the dead, like that person is [alive]" (Amrit, line 43) or "they just go haywire, like you're talking about something else and they're talking about something else" (Ramandeep, lines

216-217); 2) extreme moods swings, like "bang[ing] the dishes, break[ing] things" (Amrit, line 255) or; 3) a lack of routines, such as "sitting idle all day" (Mandeep, line 392).

Paagal.

Paagal, a sub-theme of thoughts, feelings and behaviours, is an Indian term that is analogous to being crazy: it is a derogatory term. It is seen as an extreme mental state usually requiring hospitalization. Although the participants in the study listed a range of terms to describe how one may be mentally unhealthy, the Punjabi societal perception of a link between being mentally unhealthy and *paagal* appeared to create a great deal of fear around the acknowledgement of mental health issues. For example, in discussing how Punjabi's react to mental health problems, Simran noted that Punjabis tend to feel insulted if their mental health is questioned. She further explained how many people in the Punjabi community often equate mental stress with being *paagal*. Hardeep also touched upon being *paagal* as an extreme mental state requiring hospitalization. Finally, Mandeep, when discussing her experiences with mental health problems, was adamant that she was not crazy and that she did not see ghosts or witches. When the subject of hospitalization arose, she again spoke resolutely that this measure was not needed.

Discussion: A tacit theory of mental health.

The identification of needs, as a prerequisite for mental health, appears to be in direct contrast to the virtues espoused by Sita, whose primary duties were those of self-sacrifice for the well being of others and delayed gratification. For example, Sita twice submitted to Rama's orders concerning the legitimacy of her chastity. She also delayed the gratification of her own needs until her duties toward her husband and family were fulfilled, at which point she requested release from her earthly existence. Indeed, according to the narrative, Sita's gratification and

fulfillment were events that she could look forward to after her death; they were not supposed to be a part of her existence while she was on the earth.

From the perspective of Sita's narrative, women are nurturers and serve others; it is a woman's responsibility to gratify the needs of others and postpone her own until the after life. Consequently, in Punjabi society, women's requirements may often be overlooked as their gendered role and cultural values dictates a particular position or behaviour that is absent of needs. As immigrants, many of these women were without any extended family support, and defiance of their familial obligations may have resulted in mistreatment or abuse. Further, many of the study participants were economically tied to their husbands and in-laws. With this intersection of gender, ethnicity, and social class, it appears as though many of the women in the study had but few options in how to respond to others' expectations. These expectations were illustrated in Simran's experiences. Her in-laws' expectations outweighed her own desires. By not both prioritizing and serving their needs she risked familial discord. Similarly, Ramandeep, was constantly threatened with being sent back to India where her life opportunities would have been severely limited as a divorcee.

The study participants, including Simran, however, did have needs and were able to articulate them, for example, the ability to organize one's own schedule of chores or time to do one's hair. While these needs seem rather simple in relation to some stereotyped needs in North American culture, needs related to consumption, for example, they also reflected a fusion of Sita's narrative. For many of the study's participants both basic and higher level needs were required in order to promote mental health. Postponing the gratification of their needs until life after death was not considered to be a viable option. Women in the study were not dismissive of their social obligations, but sought out a middle path that allowed them to fulfill their needs and

obligations at the same time, thereby attempting to satisfy and maintain harmonious interpersonal relationships.

Financial freedom, a higher level need, incorporated discourses on social class and race. For women like Ramandeep and Gurpreet, having access to money, and in particular the money that they themselves had earned, was an important factor in mental health. Ramandeep, who was required by her husband to hand over her paycheck each payday, described her situation as being analogous to a "money earning slave" (line 478). For Ramandeep and Gurpreet, who had both lived in abusive situations and had no access to their incomes, the need to maintain the socioeconomic status they contributed to while married may have prevented them from leaving their respective relationships earlier. Their lack of opportunities for economic advancement may have also impacted their decision to remain within these relationships. Cultural racism within bureaucratic organizations often prevents minorities from ascending the economic ladder by limiting their growth within organizations and enforcing discriminatory wage practices that act to limit their financial freedom (Collins, 2000). As immigrants, even though Gurpreet and Ramandeep were both college graduates and Gurpreet had a post-graduate degree, neither one had a high paying job: Ramandeep was employed as an outreach worker at a not-for-profit agency and Gurpreet was self-employed as an esthetician. Given their personal income noted in Table 1, they needed to couple their income with their husbands' income to reach a modest middle class classification. When Ramandeep and Gurpreet did leave their husbands, they faced and continue to face the possibility of financial instability and low-income. At the time of the study, for Gurpreet, this had become a reality: she worried constantly about how she would meet her family's basic needs, and when her next pay cheque would arrive. When she was

interviewed, Gurpreet had twenty-five dollars to her name, twenty of which had come from her participation in this study.

An interesting feature of the theme of thoughts, feelings, and behaviours is the similarity of this model to mental health models already used in North America. As an example, the ABC (affect, behaviour, and cognition) model is used across multiple disciplines, including psychology, psychiatry, and counseling. The combination of thoughts, feelings, and behaviours derived from the participants' interviews suggests a tacit model of how mental health was conceptualized. Though similar, differences did appear in the content and the ways in which maladies were diagnosed. For example, North American models of mental health often focus on the mind and body as two disparate entities, whereas, for the women in the study, there seemed to be an inseparability in the mind-body-spirit. If any one of these three components were troubled, this would unsettle the other components. Interestingly, the tacit model derived from the participants appears to reflect a more balanced and holistic approach to mental health than North American models that privilege cognition over emotion. In the participants' model, each component was interrelated and equally valued in the system. Emotions and behaviours were equally valuable with thoughts.

Finally, when Mandeep recalled her initial episode of being mentally unhealthy while in India, the lack of a basic need in the form of support from her family and the need to rely on a woman from a lower caste in order to pursue care exemplified a woman who was socialized in an environment where the acknowledgement of mental health problems resulted in judgment, dishonour, and disgrace. This example further highlights the stigma associated with acknowledging mental health problems and the repercussions that individuals may face. The next theme, *It's an ugliness*, explores this in greater depth.

Fear of Judgment: "It's an Ugliness"

When talking about mental health issues, questions regarding access to and utilization of services often led to discussions about Punjabis being closed to these resources. Hardeep summarized a mindset that many Punjabis share:

> mostly, people, even educated, but uneducated people, people talk about the people… So they are not open. They want to be very, very closed. They are, they don't want to share these things. They say it is, it is an ugliness, it is a slur. They don't want to share… because it is, that person will find out and what will they think about me. No, no, I shouldn't tell. This is you know, from the old fathers we have taken this… whatever there is good or bad you should just keep it to yourself, even if someone finds out about your illness they will say she/he is sick. The feelings that other people have towards us will be very wrong. Because of this whatever is a household matter, or whatever is a personal matter should remain within in the house, and should not go outside of the house. This is the condition of all Punjabis. (lines 424-428, 446-456)

The shame associated with mental illness and the expectations of judgments, criticisms, and humiliations of others, as well as the subsequent social repercussions, appeared to be far greater and outweigh the costs of openly seeking help or treatment for a mental health condition. The majority of the participants in the present study either willingly or unwittingly submitted to these fears.

Punjabi culture, like many South Asian cultures, is a culture of honour. Outward appearances and *izzat*, having the respect of others, are vital to one's social position, especially in traditional cultures where one's social status is dependent upon their *izzat*. In the *Ramayana*, Rama highlights the importance of maintaining his integrity and peace among his followers by

110

submitting to their wishes and banishing Sita from Kosala. If Rama had ignored the growing

discontent among his followers he may have had a mutiny on his hands for allowing a queen with

a sullied reputation to remain in power.

Similarly, acknowledgment of mental health problems may lead to alienation from one's

social circle. Ramandeep, who was well educated and liberal in her views, touched upon her

cultural struggles when seeking mental health services through contradictory statements. On the

one hand, she stated that she did not care about what others thought, but she also acknowledged

that "Normally, I wouldn't talk about these things, I would say, 'Oh, I live in a perfect family'"

(Ramandeep, lines 410-411). Despite having the reassurance of her counsellor, and fellow

students at the school she attended in Canada, that it was acceptable to talk about mental health

problems and going through a separation, she still feared being judged by others and blamed for

her situation. The fear of being judged affected Ramandeep to the extent that if she ever did need

to seek mental health services again she would ask a "legal worker or like somebody who can

help me in a professional capacity not personally [for a referral] " (lines 1729-1730). This

example highlights how, despite interacting within the Canadian culture—a culture that appears

to be more accepting of mental health issues—and being well educated, it was still difficult for

her to alter her cultural beliefs. For Ramandeep, there appeared to be an acknowledgment of this

contradiction at some level, but her upbringing instilled particular beliefs that were deeply

engrained. Hardeep, similarly, commented on this struggle in her interview:

> [it's] hard even for educated people to break free of these traditions, but they try to move
>
> forward, slowly. But people who are less educated and older are stuck in these old ways
>
> of thinking, these traditions. It's very difficult for them to get out of this way of thinking;
>
> it is not their fault, because they were told like this. (lines, 471-474).

Discussion: Gender and shame.

Sita's narrative teaches that women are the purveyors of culture and honour in Indian society. Thus, the shame associated with acknowledging mental health problems seems to act as a controlling factor that may silence individuals, especially women, from disclosing their mental health problems to others. Women risk being alienated from social circles and being cut off from potential sources of social support when shamed publicly. The stigma associated with mental health problems appears to be further compounded by texts such as the *Laws of Manu* or the *Ramayana*, mass media, and family histories that reiterate and reinforce particular values that are held and maintained by these dominant cultural discourses. This appeared to be the case for Ramandeep, whose friends refused to return her phone calls and was ostracized from her social circle after her divorce, perhaps as a consequence of her ex-husband's influence over their mutual friends. This exemplifies the power interpersonal relationships can have on others, and their ability to "uphold someone else's subordination" (Collins, 2000, p. 287). However, Ramandeep did receive the support of a male family friend who treated her compassionately while she was initially reeling from her separation from her husband. Ironically, this same individual refused to help his own sister when she solicited his help with a domestic abuse situation. This suggests the existence of a strict demarcation regulating who should receive help and for what reasons help should be given. While it may be acceptable to help a woman who is an outsider, the shame brought on by admitting that one's sister is in need of help and helping her is unacceptable. In a different case, however, Simran, had a supportive husband who helped her to recognize her own post-partum depression and encouraged her to talk about her feelings while she was experiencing it.

Although many of the participants in the study discussed how fear of judgment and shame inhibited them from either seeking help or discussing their problems with others—in particular, as they may be blamed for their situation given that women are seen as a burden—there were instances during which some of the participants did find social support for their problems. These examples demonstrate the possibility of relationships moving beyond that of Sita and Rama, moving beyond a wife's silent acceptance of her husband's authority, to a more open and supportive relationship in which women do not have to fear being completely shunned socially for experiencing a problem and seeking support.

Despite the shame often associated with the acknowledgment of mental health problems, exemplified in Hardeep's statement that Punjabi culture is closed about such matters and that Punjabi's find it difficult to break free from traditional values, many of the women in the present study did exactly this. Gurpreet and Mandeep both sought out mental health services to deal with their problems, and openly discussed their experiences with others. Although Ramandeep sought help in a manner that maintained her privacy, she was not as closed to accessing mental health services, as Hardeep suggested all Punjabis are. Finally, there was Amrit, who withstood years of torment living with a husband who suffered from poor mental health. Amrit, finally, called for an ambulance and then even the police when he refused to go to the hospital to get help. The positions taken by Gurpreet, Mandeep, Ramandeep and Amrit, who represent a diverse age range, illustrate the potential ways in which it is possible to overcome the silencing effects of shame, patriarchy, and culture in order to regain mental health or the health of a loved one. The actions of the participants also highlight how essentialist qualities, such as those described by Hardeep, which are used to define an entire group, are being challenged by women when faced with mental health issues.

Just Deal with It

In several respects, Ramandeep, Gurpreet, Simran, and Amrit were duty bound to their situations. The theme *Just deal with it* represents an aspect of Punjabi culture that many of the participants in the study learned or felt: that they should simply accept their situation and continue with their lives in a dutiful manner. Even if they considered acting and/or took action to overcome a difficult situation, this cultural narrative framed their thoughts, feelings, and behaviors.

Ramandeep, who lived in an abusive relationship, received little support from her family. She looked up to her father for support, but was shocked at his lack of support for her situation. The message she received from her once liberal father, in the form a literal slap across the face, was to accept her husband's wishes and behave accordingly. Without any support from her family, especially her father, Ramandeep felt trapped, as if she had nowhere to go. Her family in India seemed to reject her and as an immigrant in Canada she had no one to turn to. She clearly stated that she would never have had the energy or gumption to leave her husband because she had no support and nowhere to go.

Sita's quiet acceptance of her husband's wishes, and the societal pressures that they faced as a couple, continue to affect women's lives today. Simran, who lived in a joint family and was the mother of two children, continually faced the pressures of having to choose between her children and her duties as a daughter in-law. She felt pressured by her in-laws to prioritize household tasks and was further pressured by the elders in her community who echoed these attitudes. Under Indian code of conduct and the rules of a traditional society, knowledge is unchanging and elders are the best source of that knowledge (Nayar, 2004). Accordingly, they and their views should be respected. These tightly-held beliefs and values acted to further entrap

and silence Simran. In Punjabi culture, women who disagree and act in opposition to these values are likely to be perceived as disrespectful and at risk for being (mis)treated accordingly.

Gurpreet, whose husband severely abused her during their marriage, and whose in-laws watched the abuse passively, was criticized by the Indian community that she was a part of, especially by other women, for separating from her husband. Gurpreet was made to feel that she was responsible for what had happened, and that she should try to restore some of her self-respect by returning to her husband. Ramandeep cited similar fears as her reason for not being more forthcoming to others about what was happening in her personal life:

> Because I was listening all these things that girls are not good, they're a burden on the family… [and] I was in a very unfortunate situation because my husband was flipping very controlling. So okay, if I seek out help, then who is going to help me, because in any case they're going to blame the girl. She's a girl, it's her destiny, or oh she's a girl she must have done something. So I felt very isolated. If affected me hugely. (lines 1249-1255)

Ramandeep felt that females were seen as a burden and held responsible for their situation in life. With little support, many of the participants had no one to which they could turn. Their typical response was to attempt to deal with their problems and any mental health issues in privacy.

Gurpreet, however, despite receiving little support for leaving her husband, was vocal about the injustices that she suffered and shared her story with many women in an attempt to educate others about how it is unacceptable to be abused. She also strongly advocated for mental health resources, once again in order to educate others about how they could help themselves and to enable them to see that they did not need to live a life of depression and abuse. She noted that much of this work negatively affected her reputation in the Indian community. Yet, she also

stated that for change to occur people needed to take a stance. Her actions confirmed her conviction that silence reaffirmed, rather than disputed, community and cultural beliefs.

Discussion: A path of thorns or least resistance?

The embodiment of the mythological Sita, who under trying and difficult situations remained loyal to her husband, was the narrative culturally projected onto the participants in the study. However, the women in this study had immigrated to Canada and were immersed in a North American context with both similar and different values and expectations for the roles and behaviors of women. Ramandeep's fear of being seen as a burden and held responsible for her situation in life was a classic reiteration of Sita's story. However, this traditional notion of Sita, as subservient, obedient and dutiful, was also challenged by the participants.

Women in the study appeared to be seen as objects that fulfill an obligation, but are void of individual or personal needs or desires. They appeared to be dehumanized and objectified, and to feel "stuck" and trapped as result of their lack of freedom. Despite the best of their intentions, when the participants in the study challenged Sita's values they were faced with several consequences.

First, the women lost the support of their family and friends. This was evidenced by both Ramandeep and Gurpreet whose families did not support their decision to leave their husbands, even when their personal safety was at risk. Marriage was seen as a permanent contract that was to be maintained for better or worse. Thus, staying in a bad marriage was seen as better than the alternative of sullying one's reputation, and, more importantly, that of their family's.

Second, with regard to losing social support, there was also the potential for friends and members of the Punjabi community to turn against the individual. This seemed to contrast Sita's position, as one who is venerated and respected by Indians, especially Hindus, who pray to her.

116

Indeed, Hinduism reveres several female deities, to whom both men and women pray regularly. Both Hinduism and Sikhism provide prayers in honour of women. Ironically, despite these public displays of respect and honour, women are frequently treated as objects, and a means to an end. When Gurpreet decided to leave her husband, she became the object of gossip and scrutiny in the Punjabi community. Gurpreet reported that women, especially, suggested that she had been forced to leave her husband as a consequence of her mannerisms, and that she should and would ultimately return to her husband.

One might have assumed that women would be more sensitive to the plight of their fellow females; however, this did not appear to the case. Perhaps, on some level, the women in Gurpreet's community were sensitive to her situation. However, open acknowledgment may have been perceived to be a challenge to male authority and to the rigid values of obedience and service. The lack of solidarity from women in the Punjabi community, in general, may be related to the potential consequences they might face from their husbands or other male authority figures in their families. Perhaps, they engaged in oppressing those already oppressed and further subjugated them, as easier than the alternative: speaking out against the oppressors.

Further, the tendency to "uphold someone else's subordination" (Collins, 2000, p. 287) may also stem from the tendency for people to identify most with the form of oppression that they have experienced and to view other forms of oppression as less important. Consequently, the oppressed then may become the oppressor. For instance, a Punjabi immigrant woman who remains in an abusive relationship may discriminate against a separated or divorced Punjabi immigrant woman. "Oppression is filled with such contradictions because these approaches fail to recognize that a matrix of domination contains few pure victims or oppressors" (Collins, 2000, p. 287).

Third, in relation to subjugating and blaming women for their problems, the issue of objectification surfaced. When women are objectified it often leads to their victimization, as it is easier to shift blame to the individual and away from situational or social structures (Mohanty, 1991b). A case in point is a recent comment made by a police officer at York University in Toronto, Ontario, who explained to a crowd that "women should avoid dressing like sluts in order to avoid being sexually harassed" (A Toronto police, 2011). Ramandeep also commented on the objectification of women. She observed that the Punjabis who live in Vancouver appear to be stuck in a time warp reflecting what India was like 50 years ago, particularly when it comes to attitudes concerning female rights. She felt that Indians living here, both men and women, perceived females to be a burden and believed that spousal abuse is acceptable in Canada: "I feel that people accept it. He can beat me" (Ramandeep, line 1181).

Comments such as those made by the police officer at York University and by Ramandeep fail to take into account intersecting domains of influence and impact how women may be perceived by society, leaving them vulnerable to harassment as function of their objectification and not their attire or place of residence. For instance, social structures like the justice system act to manage oppression by reinforcing sexism and racism as can be seen from Ramandeep's and Gurpreet's experiences with law enforcement officials. Both of these women reported being harassed and treated as perpetrators as opposed to victims. In Ramandeep's case, her own cultural experience may have influenced her perception of the acceptance of domestic violence in Canada. The police, when responding to issues of domestic violence within the Punjabi community, may have assumed a Western value against domestic violence as universal and perceived Punjabi women as oppressed by their religion and men. More generally, these beliefs may impact how the justice system, and those who uphold the system, react to minorities

and the rights minorities are afforded within the judicial system. The occurrence of domestic violence in European Canadian families seemed to be forgotten.

Finally, patriarchy also plays a role in further subjugating these women. Indian society, as these women describe it, appears to be a man's world. Amrit, who lived in fear of her husband openly acknowledged that she could not leave: "I am not a male who can go out, [I] am a female. A female sitting outside, what would people say, what's she doing sitting outside?" (lines 610-611). Women are bound by tight social decorum, and deviation appears to lead to gossip that can be detrimental to one's reputation and status in society. While women must conform to rigid gender roles, males, despite their behaviour or irrational decisions do not seem to be held similarly accountable. This both stems from and contributes to the reification of the convention that it is women who uphold *izzat*, the respect and honour of the family.

Ramandeep acknowledged how these beliefs about Punjabi women entrap them in Canada, she also felt that women in India had greater freedom. Ironically, it was her father, the man she respected and admired, who slapped her to put her in her place. Ramandeep's statement reflected the contradictory nature of competing ideologies, and the potential of certain dominant ideologies, such as patriarchy, to prevent how much cultures actually do shift as they meet in new contexts. For women in the study, their decision to act in opposition to the values espoused by Sita, proved a path of challenges. If women spoke out or acted against the status quo they feared facing family and community criticism, judgment, and, for some, additional abuse. Their dilemma was one that many women do not face: while silence and obedience reaffirmed dominant cultural discourses, challenging discourses came at a cost.

119

Family Physicians: "They are the Experts"

Despite the lack of acceptance of mental health problems and women's elevated status of holding and maintaining family honour, the participants still sought mental health services, albeit privately. When the participants were asked if they knew of others' experiences with mental health services many mentioned that they did not. One participant expressed astonishment at this realization, as she worked with many women who had poor mental health. Then she reasoned that it was also "to be expected" that Punjabi women would not openly discuss mental health issues. Within this cultural mindset, it was perceived to be an insult to both self and family to be seen accessing these services. If observed, others would know that something was wrong. Receiving a prescription, on the other hand, allowed for greater privacy and anonymity. The theme, *Family physicians: "They are the experts,"* highlights the faith that participants placed in family physicians, as well as the reality that family physicians were often the first and only medical professional that many of them visited when seeking help with mental health problems.

From the interviews, it appears that the participants were largely unaware of the mental health resources that existed and where to go to access them. When asked where would they go if they or a friend had mental health problems, the overwhelming response was usually a family doctor. There appeared to be a lot of faith in doctors, as Hardeep stated, they are "the expert to us" (line 341). At the same time, because there was so much faith in doctors, they seemed to be held to unattainable standards. Doctors were seen as a panacea, and when they failed their patients, the patients' trust in them was broken. For example, in Amrit's situation, when the doctors failed to save her son, she lost faith in them. Consequently, when her husband became mentally ill, doctors were rarely consulted, if at all. Moreover, his doctors were subsequently held responsible for not alerting the family to his depression and clarifying that he should be

under medical care. While it is difficult to discern with Amrit, there may also have been a language barrier that impacted her relationship with medical professionals and that may continue to do so.

Aside from Amrit, many participants were happy with the care that they received from their physicians. Interestingly, the younger participants in the sample were adamant that they did not want to take medications for their problems, and accordingly refused any prescriptions that were offered to them: "and he [the doctor] said all I can suggest to you, I can give you medication, and I said no, I don't want medication. I don't want medication, but something else, and he had nothing else to offer" (Ramandeep, lines 1016-1018). Many of the older participants, however, expected to be given medications for their mental health problems. Of the four women who sought help from family physicians for mental health problems, only two received a referral to a mental health specialist. The other two were not given any information about mental health resources. In fact, Ramandeep's doctor breached the doctor-patient confidentiality agreement and disclosed the nature of her visit to her husband, which created further problems in her marriage. At the time of the study, Ramandeep was still unable to trust doctors as a result. The three women in the study who did seek out mental health counselling were grateful for the help they received and rated their experiences positively.

Other ways that participants coped with mental health problems included by seeking out counselling services and *Pundits*, Indian astrologers and practitioners of black magic. Homeopathic and Ayurvedic doctors were also considered; however, for some, the cost of accessing these services became another barrier. Amrit strongly believed that what happens in life is due to fate, and that nothing could be done to alter it. Ultimately, this belief decreased the likelihood of seeking professional help or even visiting her family physician.

Discussion: Medications and alternative therapies.

The faith that several participants placed in family physicians appeared to parallel the degree of faith that many Punjabis have in elders or those who are considered to be more knowledgeable. In the Canadian context, it appeared that the women in the study placed a great deal of confidence in their family physician's ability to help them overcome poor mental health. For many of the older participants, prescriptions seemed to be an acceptable form of therapy to alleviate mental health problems. Of significance, prescriptions may have been seen as one way to deal with mental health problems in privacy. Pills can be hidden, and visiting a family physician may not necessarily arouse suspicion in relation to mental health concerns. On the other hand, visiting a psychiatrist for an hour once a week may be more difficult to conceal and more likely to arouse suspicion.

There is a potential overlap here in relation to social class in accepting medication for a mental health problem. Medication enables privacy and it also costs less than other therapies. A lack of access to income may confound the type of therapy that is sought in relation to mental health problems. For many of the participants who were retired and had limited incomes, the participants in the older cohort, prescriptions may have been the only viable option they had, as visiting a psychiatrist or an ayurvedic practitioner may have been beyond their means. In addition, while family physicians seemed inclined to offer medication as a treatment for mental health problems, and the practice may secure a patient's privacy, this practice should also be questioned. It may be that some family physicians essentialize Punjabi immigrant women as a group that only seeks pharmaceutical therapies, thereby limiting the amount and type of information that they offer to their patients: for example, not offering information and referrals regarding alternative therapies. It may also be the case that Punjabi immigrant women are not

being offered mental health resources if physicians spend little time assessing their mental health needs in ways that are culturally responsive.

Divergences: Differences in Mental Health Beliefs and Practices Among the Younger and Older Participants

Differences surfaced between younger and older participants most notably in the areas of fate and how mental health problems should be handled. Many women from the older cohort, who ranged in age from sixty-eight to eighty-four years old, spoke about the impact of fate and God on one's mental state. Amrit was perhaps the strongest advocate for the role that fate played in one's life, and accordingly one's mental health. Amrit stated that "It is all fate [whatever happens to us in life], I believe. Whatever God has predetermined for us, we just live that" (line 293). She also noted, "It is said that no one can change what is written on your forehead [a phrase used to imply predetermination]" (Amrit, lines 301-302). Amrit's intense belief in destiny may have negatively impacted her faith in doctors; after all, how can a doctor overcome one's destiny?

Mandeep and Hardeep, on the other hand, made similar statements concerning the role of God in mental health. For both women, mental health was not so much an issue of destiny, but rather a result of God's grace. Mandeep had a strong faith in God and constantly recited prayers and evoked God's name when she felt mentally distressed. She believed God would give her the strength to overcome her problems. Hardeep, in relating a story about a friend's good mental health, stated that "hopefully God will always keep her happy" (line 114), suggesting that God plays a significant role in one's mental health state. In comparison, none of the women in the younger cohort, who ranged in age from twenty-six to forty-one years of age, discussed the impact of God or fate on their mental health. While two of the women from this cohort did go to

the temple while they were experiencing mental distress, they did not attribute their situation to destiny, but instead sought solace in prayers.

Another area of divergence between the groups was in relation to how mental health problems should be handled. Many women in the older cohort talked about taking medication for poor mental health. Once again, this preference may be a reflection of socioeconomic status, as the majority of women in the older cohort were retired and lived on a sum of roughly 10,000 CAD a year. Women in the younger cohort, however, were insistent that they did not want any prescriptions when they were offered by a family physician. These women appeared to be open to receiving alternate forms of therapy for their mental health problems, but were often left without any options by their family physicians. The old adage "time will heal all wounds" seemed to be the treatment option provided by their family physicians.

Discussion: Faith and medications.

For the participants, faith in God seemed to represent the understanding that events in life were not predetermined, and that through God's grace and blessings one was better able to cope with one's circumstances. In a difficult situation, an action to take may be contemplation or prayer. While God may never give you what you cannot handle, some of the participants suggested different ways to manage difficulties, including reading scripture.

On the other hand, if fate is seen as the guiding force in one's life then it could be argued that prayers are ineffective: they cannot change destiny. The belief in destiny as a force that predetermines your path in life also seemed to impact how mental health problems were perceived. In the case of Amrit, poor mental health was her husband's destiny, and her destiny was to help him deal with it. As a result, she felt that she should just deal with her

circumstances. Amrit's beliefs about fate also impacted her utilization of medical services; she only visited her family physician when she received a letter regarding her yearly physical.

As noted above, socioeconomic factors may have also played a role in determining whether medication was seen as a viable or the only option to treat mental health problems. Some of the study's participants may have dismissed alternative forms of therapy to combat poor mental health due to financial concerns. Yoga, meditation classes, and naturopaths are all forms of therapy that are not covered under the current Canadian medical services plan and, thus, the costs for these activities must be incurred out of pocket. On the other hand, pharmaceutical treatments are a less costly option given that medications may be covered in part or in whole by public health care.

Summary

The participants constructed mental health in a manner that was similar to North American models of mental health; however, their categorizations of the symptoms that were indicative of good and poor mental health appeared to differ. Their construction of mental health appeared to be based on basic and higher level needs, which served as prerequisites to good thoughts, feelings, and behaviours, all factors that assisted in the maintenance or promotion of one's mental health. Further, their definitions of mental health appeared to be more holistic in nature, encompassing a balance between the mind, body, and spirit. Their construction of mental health also represented a break from Sita's narrative of self-sacrifice and delayed gratification, as they explicitly stated the need to have time for one's self, and more importantly, to have their needs met during this life time.

When it comes to seeking assistance for mental health problems, the stigma associated with the notion of poor mental health prevents many Punjabis, in general, and Punjabi immigrant

women, in particular, from accessing mental health services. Shame, complicated by the intersection of social class and ethnicity, acted to silence many of the study's participants. For the participants in this study, the problem appeared to be confounded by a variety of challenges. First, because women are seen as the purveyors of culture and honour, seeking help for a mental health problem or admitting a mental health problem would have not only impacted how they are perceived by society, but also how their family was perceived. The cost of seeking help for some of these women was too high. Another barrier influencing the participants when they considered seeking assistance for such problems was the potential correlation between poor mental and being labeled as *paagal*, an offensive label which has far reaching implications and social repercussions.

Women in the sample appeared to have faith in their family physicians, which may have been a cultural reflection of respecting those who are seen as more knowledgeable. Accordingly, when the participants did seek help for their mental health problems, they were most likely to approach their family physician. However, the most common response was a prescription; only Gurpreet's and Mandeep's family physician made a referral to a mental health service providers. This may have been a reflection of the belief that Punjabi immigrant women only seek drug therapies or an indication of physicians' prejudiced beliefs that Punjabi immigrant women would not benefit from mental health services.

There was also a difference noted in how the two cohorts thought about mental health issues and how they approached mental health problems. A belief in fate affected both the direction of one's life and, consequently, impacted mental health. For some participants, there was an inherent belief that the events in one's life are predetermined or out of one's hands. On the other hand, those who believed in God felt that life was not a matter of destiny, and that they

126

may be better able to deal with problems with God at their side. Many of the women in the younger cohort did not refer to fate or God when discussing causes of mental health issues, but did use prayers as a form of seeking comfort during difficult times.

Overall, gender, race, and social class impacted how mental health was constructed, as well as the therapies sought in difficult circumstances. Gender impacted how women were valued and positioned in society. Commonly accepted gender stereotypes in Canadian society acted to further subjugate women. For example, the belief that women should be accepting of their circumstances in life and carry on with their duties towards their families made challenges to this deeply held belief problematic for women in the study. Openly defying gender roles seemed to make the women more susceptible to alienation from social networks, financial hardship, and victimization. Gender roles were further contested in the ways the participants challenged Sita's narrative and the essentializing characteristics that seemed to be associated with Punjabi women and culture. For example, the notion of Punjabi women as self-sacrificing was clearly contested by the women's construction of mental health, which included a place for their own needs. Challenges to essentialized characteristics, those that acted to silence or inhibit women, were also seen in the ways in which the participants accessed mental health services, defied gendered roles, left their husbands, and challenged conceptions of patriarchy.

Racialized expectations and cultural racism may have impacted how family physicians and authority figures, such as police officers, interacted with the study participants. For example, both Ramandeep's and Gurpreet's negative experiences with law enforcement officials may have been, in part, a reflection of the officers' perceptions of their ethnicity and/or cultural group. It may have been assumed that their ethnicity, as Punjabi, and also their gender, as objectified and powerless servants, made them likely targets as victims of their own cultural traditions.

Issues related to social class closely reflected one's social worth. When women in the present study challenged predetermined gender roles, they were seen as deviating from the norm and were further pushed to the margins. In patriarchal cultures, women are positioned hierarchically below men, and their contestation of commonly held beliefs may act to further marginalize their position. When women in the study left their husbands, they became further oppressed for their actions, especially by other women, suggesting that their social worth was tied to how well they upheld cultural values. In addition, challenging and/or leaving husbands had financial consequences for the participants, many of whom retained responsibility for their children after a separation. Frequently, being able to provide financially for the wellbeing of their children was a priority over the concerns of the participants.

Chapter 7

Meanings of Mental Health: The Mental Health Landscape

As a method for examining the social context of Canadian mental health services, and a partial reflection of the mental health landscape surrounding the six participants in this study, documents from three organizations were analyzed for their meanings of mental health. The three organizations that are the focus of this chapter are the Canadian Mental Health Association (CMHA), the Centre for Addiction and Mental Health (CAMH), and the World Health Organization (WHO). These organizations were selected for this analysis because they represent various levels of influence on the management of mental health in Canada. The CMHA plays a pivotal role in the delivery of mental health services across Canada, while the CAMH influences policy development and educates professionals in the area of mental health and addictions. The WHO coordinates health initiatives for the United Nations, which consists of 192 member states, including Canada.

This chapter focuses on three levels of thematic analysis associated with meanings of mental health as put forward by three different social service organizations. The first level of analysis focuses on how the three organizations define mental health. The second level of analysis compares the themes from the first level of analysis with the interpretations of mental health of the participants in this study. The third level of analysis examines the extent to which the participants identified with a catch phrase and accompanying visual elements from the literature of one of the mental health organizations: the Canadian Mental Health Association.

This chapter includes four sections. The first section provides a brief description of each of the three organizations. The second section includes excerpts from each of the organizations' web sites, along with a description of themes. Parsing of the web based text has been maintained

as in the original document, but line numbers have been added and spacing has been condensed

to fit the current page parameters. The third section compares the themes from section two with

the interview responses of the participants. The fourth section includes a focused analysis on a

catch phrase and visual elements from the literature provided by the CMHA.

Descriptions of Organizations

    Canadian Mental Health Association.

    The CMHA is a voluntary organization that has been in operation since 1918 (CMHA,

2011a). The CMHA was initially known as the Canadian National Committee for Mental

Hygiene (CNCMH). The co-founders of the association, Dr. Clarence M. Hincks and Clifford

W. Beers, both suffered from mental illnesses, and this served as an impetus for the creation of

the committee. The primary goals of the CNCMH included war works, providing examinations

of military recruits and providing care for soldiers returning with mental disabilities, providing

mental examinations of immigrants in order to ensure a better selection, providing adequate

facilities and care for those suffering from mental disabilities, and facilitating prevention of

mental diseases and disabilities (CMHA, 2011c).

    The current CMHA is comprised of a voluntary board of directors each of whom is elected

for a one-year term. Consumer participation plays an integral role in the CMHA, and in 1987 a

Consumer Participation Task Group (CPTG) was created. In 1991, this became known as the

National Consumer Advisory Council (NCAC) (CMHA, 2011b). The purpose of this group is to

ensure the involvement of those living with mental health illnesses within the CMHA. Over the

years the NCAC has brought the perspectives of consumers to all issues and concerns undertaken

by the CMHA.

    Currently, the CMHA serves over 100,000 Canadians per year through the various

initiatives of its 135 branches across Canada (CMHA, 2011a). The goal of this organization is to promote the mental health of all Canadians and to support those dealing with and recovering from mental health problems (CMHA, 2011c). The CMHA also provides workshops for public education.

Centre for Addiction and Mental Health.

The CAMH (2009a) is one of Canada's leading addictions and mental health organizations. Affiliated with the University of Toronto, it is Canada's largest mental health and addictions teaching hospital. As a teaching hospital, the CAMH provides training, education, internships and residencies for students. The CAMH is also a Pan American Health Organization and World Health Organization Collaborating Centre. Its primary goal is to help transform the lives of people affected by mental health problems and addictions. The CAMH (2009b) has a focus on client-centered care; there is a recognition that every client is different and, thus, has different social, physical, emotional, spiritual and psychological needs. Further, the CAMH tries to incorporate preferences, needs, and cultural beliefs into the treatment plans for each individual, and provide care that is sensitive to diversity. As such, they attempt to be sensitive to issues related to culture, ethnicity, gender, age, abilities, religion, and sexual orientation. The CAMH works closely with the Canadian government in the areas of public policy and resource development to ensure health promotion and work towards eliminating the stigma associated with mental health problems and addictions.

The CAMH (2009c) is governed by a board of trustees who are elected for a one-year term that is renewable for up to three years. The board of trustees is responsible for the governance of the CAMH, and provides leadership in creating the values, missions, and defining policies that impact the CAMH. Board membership is contingent upon the demonstration of bringing a

provincial perspective, having direct experience in the addictions and/or mental health areas, previous experience working on other boards, community involvement, and/or providing the perspective of consumers and families. Board members must also show sensitivity towards cultural, gender, ethnic, linguistic and religious characteristics of the communities that they serve.

Among the various programs offered by the CAMH is *The Culture Counts Project*, which aims to research the best ways to provide knowledge about addictions and mental health in a manner that is sensitive to cultural and linguistic differences. To this end, the CAMH has produced a document on best practices for working with culturally diverse populations, which includes a section on adapting and translating material in order to be culturally relevant.

World Health Organization.

The WHO is the authority for directing and coordinating health within the United Nations. The WHO provides management and guidance on global health matters, shapes health research agendas, sets norms and standards, conveys evidence-based policy options, provides technical support to countries, and monitors and assesses health trends (WHO, 2011a).

The creation of the WHO was discussed when diplomats met in 1945 to create the United Nations, and the WHO came into existence on April 7, 1948, which is now celebrated as World Health Day (WHO, 2011b). The primary objectives of the WHO (2011c) in terms of public health are to provide leadership on issues that are critical to health and to engage partners when joint action is needed, shape research agendas, ensure the dissemination of valuable information, establish norms and standards, ensure their promotion and implementation, communicate ethical and evidence based policy options, provide technical support, and monitor and assess health trends and conditions.

The WHO is committed to research that seeks to reduce the gap between what is needed and what is available in order to decrease the burden of mental health problems worldwide and promote mental health. To this end, the WHO (2011d) has created the *Mental Health: Evidence and Research Team* (MER). Another initiative undertaken by the WHO is the *WHO Mind Project*, the objective of which is to promote programs that prevent and treat mental health problems. The WHO Mind Project focuses on four thematic areas and one united theme: 1) Action in countries: Nations at work, the purpose of which is to improve the lives of people with mental disorders; 2) Mental health policy, planning, and service development, which articulates the future vision of mental health for the population, as well as implementing frameworks that will be utilized to prevent and manage mental and neurological disorders; 3) Mental health, human rights, and legislation, which advocates for the rights of individuals who suffer from disabilities; 4) Mental health, poverty and development, which aims to increase support for mental health problems, particularly in developing nations, in order to decrease the effect of mental health disorders on poverty and development, and; 5) Quality rights project, which is the culmination of the four previous themes, and aims to increase awareness and education surrounding the quality of care that individuals with mental health disorders receive, especially since many mental health patients often have their human rights violated (WHO, 2011d).

Themes Relating to the Meaning of Mental Health

The data provided by the CMHA, the CAMH, and the WHO pertaining to definitions of mental health were analyzed using latent theoretical thematic analysis (Braun & Clark, 2006). This approach entailed reading and re-reading the data for concepts related to mental health. The analysis produced a series of themes related to how mental health was defined in the organizational documents excerpted from the three web sites.

Canadian Mental Health Association.

The document, *The meaning of mental health,* is located on the CMHA's website, under the heading Take Care of your Mind. The text is produced on a single webpage. The top of the webpage has a pictorial border, with several images of athletes working out at a gym. Underneath the pictorial border, a caption reads: "It's one thing to look after your body. Just don't forget about your mind. Practice mind + body fitness" (CMHA, 2006).

The main text of the document begins by describing the changing meaning of mental health. This is followed by the heading: Positive approach to psychology. In this section the CMHA describes their adoption of health model approach, as opposed to a disease model of mental health, called positive psychology. Next individuals are asked to consider five key characteristics when assessing their mental health, these include: ability to enjoy life, resilience, balance, self-actualization, and flexibility. Finally, the document concludes by inviting readers to try the new "Mental Health Meter," which appears to parallel body mass index calculators, and is used to assess one's mental health state. Three primary themes that emerge from the CMHA (2006) document, *The meaning of mental health,* are: 1) mental health is positive; 2) mental health is action; and 3) individual agency. Each theme is described briefly. A textual excerpt of the definition of mental health is included in Table 2.

Table 2: *The meaning of mental health* (CMHA, 2006)

It's one thing to look after your body. Just don't forget about your mind. Practice mind + body fitness.

The Meaning of Mental Health

1   Definitions of mental health are changing. It used to be that a person was considered to have
2   good mental health simply if they showed no signs or symptoms of a mental illness. But in
3   recent years, there has been a shift towards a more holistic approach to mental health.

4	Today, we recognize that good mental health is not just the absence of mental illness. Nor is it
5	absolute – some people are more mentally healthy than others, whether you are mentally ill or
6	not. These realizations are prompting a new kind of focus on mental health that identifies
7	components of mental wellness and mental fitness and explores ways to encourage them.

| 8 | **Positive Approach to Psychology** |

9	A group of psychologists, led by Martin E.P. Seligman, a psychology professor at the
10	University of Pennsylvania and past-president of the American Psychological Association,
11	wants to shift the emphasis in their discipline from a disease model to a health model, called
12	"positive psychology."

13	Instead of looking at how society's negative aspects affect us, their aim is to investigate the
14	positive qualities that help people flourish. These include courage, optimism, hope, honesty,
15	interpersonal skills, work ethic and perseverance.

| 16 | Consider these key **characteristics** when assessing your own mental health: |

17	*Ability to enjoy life* – Can you live in the moment and appreciate the "now"? Are you able to
18	learn from the past and plan for the future without dwelling on things you can't change or
19	predict?

| 20 | *Resilience* – Are you able to bounce back from hard times? Can you manage the stress of a |
| 21 | serious life event without losing your optimism and a sense of perspective? |

22	*Balance* – Are you able to juggle the many aspects of your life? Can you recognize when you
23	might be devoting too much time to one aspect, at the expense of others? Are you able to
24	make changes to restore balance when necessary?

| 25 | *Self-actualization* – Do you recognize and develop your strengths so that you can reach your |
| 26 | full potential? |

| 27 | *Flexibility* – Do you feel, and express, a range of emotions? When problems arise, can you |
| 28 | change your expectations – of life, others, yourself – to solve the problem and feel better? |

29	You can gauge your mental health by thinking about how you coped with a recent difficulty.
30	Did you feel there was no way out of the problem and that life would never be normal again?
31	Were you unable to carry on with work or school? With time, were you able to enjoy your
32	life, family and friendships? Were you able to regain your balance and look forward to the future?

33	Taking the pulse of mental health brings different results for everyone; it's unique to the
34	individual. By reflecting on these characteristics, you can recognize your strengths, and
35	identify areas where your level of mental fitness could be improved.

The CMHA has adopted an approach to mental health based on positive psychology that

surfaces in the first theme: "mental health is positive." This approach focuses on positive

characteristics that help people flourish. The CMHA focuses on qualities such as the ability to

"learn from the past and plan for the future without dwelling on things you can't change or

predict" (lines 18-19), to deal with a stressful situation "without losing your optimism" (line 21),

and "to make changes to restore balance when necessary" (line 24).

The notion of positive psychology is further advanced by the underlying metaphor, "good

is up, bad is down" (Lakoff & Johnson, 1980, p. 16). This metaphor reiterates that mental health

is associated with positive characteristics such as happiness and control (Lakoff & Johnson,

1980). On the other hand, a lack of mental health is associated with negative characteristics such

as disease and a lack of control (Lakoff & Johnson, 1980). Although it may appear to be

beneficial to adopt a positive approach to mental health, focusing primarily on one end of the

spectrum, the positive, may act to disregard other views of mental health. In addition, the focus

on "control" as an attribute of mental health reflects cultural assumptions that may not be

consistent with all cultural perspectives.

The second theme, "mental health is action," surfaces, in particular, through the use of

verbs. The CMHA uses a variety of verbs to characterize mental health that describe mental

health as being active and, more specifically, physically active. Contemplative verbs are largely

absent from the text. The following verbs are likely to be associated with physical activity: to

bounce back, to manage, to juggle, to make change, to reach, to express, to change, and to solve

(CMHA, 2006). The following are verbs likely to be associated with being active: to live, to

learn, to plan, to feel, and to develop. However, verbs that are contemplative, such as: to reflect,

to deliberate, to contemplate, to meditate, to observe, or to study are absent from the text. The

use of physically active and active verbs signifies a particular way of being mentally healthy, thus, reiterating the belief that in order to be mentally healthy you must be active.

The third theme, "individual agency," is in accordance with the philosophy espoused by positive psychology and foregrounds how each individual can flourish in her environment(s). The text constructs an image of a mentally healthy individual as being one who is agentic. For instance, the lines "Are you able to make changes to restore balance when necessary?" (line 22), and "do you recognize and develop your strengths so that you can reach your full potential?" (line 25), imply that an individual does and should have mastery over her own life, including the ability to assess her state of mental health and correct any imbalances. Readers are, thus, presented with a conception of mental health that is based on individualism and individual control that assumes that all Canadians share similar cultural constructs and are socialized to accept one particular way of being. Alternative notions of mental health are disregarded, as are barriers that prevent individuals from being individually agentic.

Centre for Addiction and Mental Health.

The CAMH (2009b) document, *About mental health and mental health problems,* is available for download from their website. This document can be located by clicking on the heading on the left hand panel of the screen titled, *About mental health and addiction*, and then selecting the title, *Information in other languages*. The CAMH provides handouts in various languages, including Punjabi, that outline what is meant by the term "mental health," what contributes to mental health problems, and types of mental health problems.

In the document, *About mental health and mental health problems*, the first heading, *What is mental health?*, articulates how the CAMH defines mental health, which is primarily in a global sense, and involves finding balance in all aspects of one's life and in different situations.

The next section, *What contributes to mental health problems?*, discusses factors that contribute

to mental health problems; various causes are listed in addition to a series of examples with

which individuals may identify. The document also notes that mental health may be affected by

how much love, support and acceptance one receives from their family and others. The CAMH

acknowledges that not all cultures view mental health problems in the same way and stresses that

mental health problems are not the fault of the individual. The final section of the document,

Types of mental health problems, lists different types of mental heath problems, and uses

language that is descriptive of the different symptoms people may experience. This is followed

by a discussion about how views regarding living with a mental health problem have changed,

and also the recognition that not everyone may have a positive experience when seeking medical

attention for their mental health problems. The two main themes pertaining to the document,

About mental health and mental health problems, are: 1) Web of interrelationships; and 2)

Differences and acceptance. A brief description of each theme follows. A textual excerpt of the

definition of mental health is included in Table 3.

Table 3: About mental health and mental health problems (CAMH, 2009b)

About mental health and mental health problems

1	**What is mental health?**
2	Mental health involves finding a balance in all aspects of your life — physically, mentally,
3	emotionally and spiritually. It is the ability to enjoy life and deal with the challenges you face every
4	day—whether that involves making choices and decisions, adapting to and coping in difficult
5	situations or talking about your needs and desires.
6	Just as your life and circumstances continually change, so do your moods and thoughts, and your
7	sense of well-being. It's important to find balance in your life over time and in a range of

8	situations. It's natural to feel off balance at times: for example, sad, worried, scared or suspicious.
9	But these kinds of feelings may become a problem if they get in the way of your daily life over a
10	long period.

11	**What contributes to mental health problems?**
12	There are many beliefs why people have mental health problems. Scientific studies suggest that
13	many serious mental health problems involve biochemical disturbances in the brain.
14	Professionals also believe that various psychological, social and environmental factors affect your
15	well-being. As well, mental health is affected by the physical, mental, emotional and spiritual parts
16	of your life. Stress can affect how you cope in any or all of these areas and can make it harder to
17	manage day-to-day activities. You may have difficulty coping because you lack new skills and
18	information that could help you.

19	You may be struggling with such difficulties as
20	• going through a divorce
21	• dealing with the death of a loved one
22	• having a car accident
23	• coping with a physical health problem
24	• growing up in a war-torn country, leaving the country you came from or adjusting to a new country (which often means dealing with immigration and resettlement experiences)
25	• dealing with racism or other forms of prejudice (because of sexual orientation, age, religion, culture, class, etc.)
26	• having a low income or being homeless
27	• not having equal access to education, work and health care
28	• having a history of mental health problems in the family or
29	• being a victim of violence, abuse or other trauma.

30	Your mental health can also be affected by how much love, support and acceptance you receive
31	from family and others.

32   It is important to know that not all cultures view mental health in the same way. For example, in

33   some countries, people who have schizophrenia are seen as having special powers and insights.

34   Alcohol and other drug use do not usually cause a mental health problem. However, they are

35   often used to help cope with the problem. And they can make the mental health problem worse.

36   You and your health care provider need to work together to identify the problem, what may have

37   caused or contributed to your difficulties and how you can be helped. Whatever the cause, you

38   should know that mental health problems are not your fault. No one chooses to have a problem.

39   **Types of mental health problems**

40   Mental health problems often take different shapes and forms at different times.

41   Some people feel depressed. Others feel anxious and fearful. A child might act out in class or

42   avoid others. Some don't eat much. Others overeat. Some depend on alcohol or other drugs to

43   numb their painful feelings. Still others lose touch with reality. For example, they may hear voices,

44   see things that aren't there or believe things that aren't true. Some have suicidal thoughts — and

45   some act on these thoughts. Some feel angry and aggressive. And some people are traumatized

46   because of a single event, such as a serious car accident. or because of a more long-term

47   problem, such as years of being abused as a child. Many people have more than one of these

48   problems at a time.

49   For many years, we thought mental health problems would either keep coming back or would

50   never go away. We now know that many people recover from these challenges. Many people

51   with mental health problems get better by using their own strength and resilience, the support of

52   family and friends, psychotherapy, techniques to lessen their stress and possibly

medication.

53   Some people may be relieved to know how doctors identify their problems. They may be glad to

54   get a diagnosis that provides a theory about what's wrong and suggestions for how their

55   problems could be treated. But others may not find it helpful to know a diagnosis. They may see it

56   as a label or category that doesn't describe their situation. Or they may believe that their condition

57   is due to difficult life situations rather than an illness.

58   In truth, some people are wrongly diagnosed and then given the wrong kind of treatment.

59   Sometimes their mental health diagnosis changes so many times over the years that they lose

60   confidence in the system. However, others find that an accurate diagnosis helps them choose

61   the right treatment and results in the best care.

The document created by the CAMH recognizes that mental health is a multifaceted phenomenon based on a complex set of relationships and factors: a "web of interrelationships." The CAMH (2009b) moves beyond biological and individual factors to the recognition of factors that are psychological, social, and environmental, as well as physical, mental, emotional and spiritual. The recognition of the vast array of factors impacting mental health shows a respect for different cultures and different ways of being, and, thus, creates a more inclusive definition of mental health. For example, "racism or other forms of prejudice (because of sexual orientation, age, religion, culture, class, etc.)" (line 25) are highlighted as potential stressors and difficulties, along with "having a low income or being homeless" (line 26), and "not having access to education, work, and health care" (line 27).

In recognizing the multifaceted features of mental health, there is a move away from individual agentic factors as being the sole cause of mental health problems. Organizations, like the CMHA, assume a strong relationship between mental health and the individual, wherein the individual plays a prominent role in the maintenance of their mental health. This is indicated in their document by the frequent emphasis on the pronoun "you," which suggests that one's mental state is completely a result of their own internal state, and not any external factors. The CAMH, on the other hand, recognizes the role of both internal and external factors, and emphasizes the importance of "what may have caused or contributed to your difficulties and how you can be helped" (lines 36-37).

Although not explicitly stated in the definition put forth by the CAMH, the issue of gender is addressed implicitly. By acknowledging the external factors that may contribute to poor mental health, there is an acknowledgment that mental health may be impacted by societal expectations and perceptions of gender. The impact of gender on mental health is highlighted in a review study by Piccinelli and Homen (1997), who found that over a lifetime women predominated over men in their incidence rate of depression. A gendered component to meanings of mental health allows for the exploration of ways in which women's lives are influenced by society and the impact this has on their mental health, for instance, how gender impacts what freedoms are afforded to women.

The second theme, "differences and acceptance," is woven throughout the CAMH document. There is constant acknowledgment of the different ways in which mental health may be construed, including the explicit statement "not all cultures view mental health in the same way" (line 32). For example, in discussing what constitutes good and poor mental health the CAMH provides a variety of examples that are inclusive of a range of thoughts, feelings and

behaviours that individuals may experience, such as feeling angry and/or aggressive, believing things that are not true, and being able to adjust to different situations. By focusing on different modes of expressing mental health there is also a greater potential for individuals to identify with the definition of mental health being presented. If the CAMH only focused on one aspect of mental health, such as behaviours, and not feelings or thoughts, they would in effect be limiting the range of individuals who could identify with their definition. By including a range of experiences, the CAMH once again is stressing the importance of recognizing and honouring different ways of experiencing mental health or a lack thereof.

There is also an emphasis on the ways in which individuals from different cultures react to mental health problems and experiences with accessing services. There is a recognition that some cultures perceive individuals with mental health problems to hold special powers, whereas others may be more critical, resulting in the individual being labeled and stereotyped: "in some countries, people who have schizophrenia are seen as having special powers and insights" (lines 32-33). There is also an admission that mental health problems are no longer viewed as they might have been in the past: "For many years, we thought mental health problems would either keep coming back or would never go away. We now know that many people recover from these challenges" (lines 49-50). However, having said this, there is also caution provided in that not all mental health problems can be solved easily and that by visiting mental health practitioners your problems may not be cured: "Some people may be relieved to know how doctors identify their problems…. But others may not find it helpful to know a diagnosis. They may see it as a label or category that doesn't describe their situation" (lines 53-56). "In truth, some people are wrongly diagnosed and then given the wrong kind of treatment" (line 58). Whether the CAMH is discussing what constitutes good mental health, issues that contribute to mental health problems,

or how people experience mental health, there appears to be a focus on a continuum of experiences.

World Health Organization.

The document, *Mental health: Strengthening our response,* appears on a single webpage on the WHO website, under the heading, *Fact sheet* (WHO, 2010). According to this document, the WHO defines mental health as the promotion of mental well-being, the prevention of mental health problems, and the rehabilitation of those suffering from a mental illness (WHO, 2010). The fact sheet, *Mental health: Strengthening our response,* begins by listing key facts related to mental health. This is followed by an iteration of what it means to be mentally healthy, which stresses that mental health is not merely the absence of mental disorders or disabilities, but also entails a degree of agency (WHO, 2010). The next section, *Determinants of mental health,* discusses a series of factors that may place an individual at risk of developing mental health problems. The remaining two sections of the document, *Strategies and interventions* and *WHO response*, were excluded from the analysis as beyond the scope of the current study. The WHO also promotes an understanding of mental health that reflects a holistic, global approach. The two main themes highlighted in the documents entitled *Mental health* and *Mental health: Strengthening our response* produced by the World Health Organization are: 1) Web of interrelationships, and 2) individual agency. Both of these are briefly described in what follows. A textual excerpt of the definition of mental health is included in Table 4.

Table 4: Mental health: strengthening our response (WHO, 2010)

Mental health: Strengthening our response

1	**Key facts**
2	• More than 450 million people suffer from mental disorders. Many more have mental problems.
3	• Mental health is an integral part of health; indeed, there is no health without mental health.

4	• Mental health is more than the absence of mental disorders.
5	• Mental health is determined by socio-economic, biological and environmental factors.
6	• Cost-effective intersectoral strategies and interventions exist to promote mental health.

7 Mental health is an integral and essential component of health. The WHO constitution
8 states: "Health is a state of complete physical, mental and social well-being and not
9 merely the absence of disease or infirmity." An important consequence of this definition
10 is that mental health is described as more than the absence of mental disorders or
11 disabilities.

12 Mental health is a state of well-being in which an individual realizes his or her own
13 abilities, can cope with the normal stresses of life, can work productively and is able to
14 make a contribution to his or her community. In this positive sense, mental health is the
15 foundation for individual well-being and the effective functioning of a community.

16 **Determinants of mental health**

17 Multiple social, psychological, and biological factors determine the level of mental health
18 of a person at any point of time. For example, persistent socio-economic pressures are
19 recognized risks to mental health for individuals and communities. The clearest evidence
20 is associated with indicators of poverty, including low levels of education.

21 Poor mental health is also associated with rapid social change, stressful work conditions,
22 gender discrimination, social exclusion, unhealthy lifestyle, risks of violence and physical
23 ill-health and human rights violations.

24 There are also specific psychological and personality factors that make people vulnerable
25 to mental disorders. Lastly, there are some biological causes of mental disorders
26 including genetic factors and imbalances in chemicals in the brain.

The theme that mental health results from multiple relationships and factors, a "web of interrelationships," surfaces in this document, as well as the document by the CAMH. Mental health is seen as being a critical aspect of health. Without good mental health the overall health of the individual and society in general is seen as compromised. The statement "there is no health without mental health" (line 3) advances the importance of examining the various determinants of mental health, such as socio-economic status, education, nutrition, housing and gender inequalities, and understanding their impact on mental health. The assertion is that good

mental health cannot flourish without having these needs met; thus, a holistic approach toward achieving mental health is required.

Similar to the CAMH, the WHO (2010) also stresses the importance of a multifaceted approach to mental health, wherein socio-economic, biological, psychological, and social factors are considered in determining the mental health status of an individual. Their position also recognizes that mental health and determinants of mental health are constantly in flux. By creating a model of mental health that takes into account a host of factors, there is a move away from Western biomedical models and positive psychological models to a more holistic model that takes into account the relationship between an integrated person—mind, body, and soul—and the social context, including "persistent socio-economic pressures" (line 18), "rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risks of violence and physical ill-health and human rights violations" (lines 21-23).

In discussing factors that affect poor mental health, noted above, the WHO (2010) makes explicit reference to gender discrimination. As mentioned earlier this is an important distinction that needs to be stated and clearly articulated, as gender differences have been noted repeatedly in the literature on mental health outcomes (Piccinelli & Homen, 1997). Through highlighting gender discrimination, the importance of justice and equality are also stressed as determinants of mental health. The application of a definition of mental health that incorporates a gendered perspective highlights the relationship between the position women occupy in society, their experiences, and the ways in which these are both constituted by and constitutive of the material conditions of their lives. Gender is a powerful determinant of mental health that interacts with other factors such as family structure, education, and social support. A gendered model of

mental health provides the only viable framework through which a multitude of factors that impact women's mental health can be examined.

A gendered approach to mental health would consider the contextual factors of the individual's life, such their life circumstances, including their employment, obligations as caregivers and parents, financial security and housing, each of which may impact their service needs. For instance, women who are employed full time may only be able to seek out mental health services on the weekend, thus access to services should not be limited to typical working hours. Services that offer a holistic approach to mental health care, where the entire individual is treated and not just the illness, have the potential to produce integrated care. Ideally, women should be offered a choice in regarding the gender of their practitioner, and should be able to play an active role in the planning of their care. Ideally, it should be easy to navigate the mental health care system; the services should be easily accessible by being located near public transportation routes, and offer child friendly spaces for women. The staff should also be sensitive to cultural factors that impact mental health (Women's Centre for Health Matters, 2009).

Interestingly, "individual agency," the second theme, surfaced in the CMHA document, though in a somewhat different way. A sense of control stresses the importance of an individual having mastery over their environment. That is, they feel able to make decisions and take the appropriate actions to shape the direction of their lives. The WHO also stresses the importance of being able to intrinsically cope with one's circumstances as a feature of mental well-being. Altogether, being able to realize one's ability, cope with normal stressors, work productively, and make positive contributions to society are seen as the hallmarks of good mental health (WHO, 2010).

Ironically, this appears to be in contradiction to the earlier theme of mental health being multifaceted. A sense of control seems to imply that all mentally well individuals are individually agentic. According to a multifaceted model to mental health, however, it is conceivable that individual agency may not always be a factor in the attainment of good mental health, in particular, when the social context includes the complexities of cultural racism, as well as rigid classed and gendered expectations. For instance, Mandeep, one of the participants in the sample, did not have the ability to leave her husband when he became violent due to social constraints. Would this then preclude her from ever having a state of good mental health? Perhaps, for this woman, good mental health entailed a position that may appear to be a compromised form of agency: being agentic in some ways while also living and navigating particular kinds of limitations.

Summarizing across organizations: Global themes.

All three organizations appeared to acknowledge, in one form or another, that mental health is "more than just a lack of mental illness." That is, given that there is no absolute measure of mental health, the excerpts from the CMHA, CAMH, and WHO documents proposed that an individual may be mentally healthy despite having a mental illness, and, conversely, be free of mental illnesses but still exhibit mental distress.

All three organizations also stated that mental health is a multifaceted phenomenon. The CMHA, however, only identified components such as mental wellness and mental fitness as means to achieve mental health, and failed to recognize contextual and environmental factors that impacted mental health. The CAMH and the WHO, on the other hand, made explicit attempts to represent mental health more holistically and in a manner that incorporated, social, psychological, biological, spiritual and environmental factors, thus creating a more culturally

148

responsive account of the determinants of mental health. However, whereas the CMHA focused solely on positive attributes, the CAMH and WHO tended to also focus on negative attributes or risk factors. A more balanced approach, reflecting the range of experiences from positive to negative, may be more practical and may provide a more accurate range of mental health experiences than focusing on just one end of the continuum.

Comparing Participants' Perceptions of Mental Health Across Mental Health Organizations

There appeared to be some parallels between the structure of the themes based on the analysis of the participants' interview responses and North American models of mental health; however, there were differences in the content. For instance, although both focused on behaviours that either hindered or promoted mental health, the content of the categories appeared to diverge. The following section compares the documents defining mental health with the responses from the participants in relation to the five themes discussed earlier: 1) individual agency; 2) positive attributes; 3) mental health is action; 4) web of interconnections; and 5) more than just a lack of mental illness.

Individual agency.

The Punjabi immigrant women in the study related to the notion of agency in the sense that they sought the need for freedom, to have a small amount of control over their situation, for example, to have the autonomy to make decisions regarding their day to day lives. However, the participants in the study sought a form of mediated agency: it was negotiated and shared with their families, in keeping with their social obligations, and it reflected a willingness to balance these obligations with their own needs. Their agency was not focused on a sense of individualism, a separation from social obligations or networks, or on a sense of domination over

one's future and one's environment. Having said this, agency as mentioned in the document produced by the CMHA (2006) focused on the ability to self-assess for mental health problems, which entailed reflecting on and self-evaluating one's mental health, and correcting any imbalances that may be present. The WHO also advanced a similar definition, wherein agency included but was not limited to "an individual realiz[ing] his or her own abilities" (line 12).

The problem with a singular definition of agency, an individual agency, is that this form of agency assumes a position that was not culturally relevant for the participants. Indeed, Punjabi culture teaches women to deny their own needs and problems, and that seeking medical attention for mental health concerns is shameful and potentially destructive of one's own reputation, and the family's reputation. Self-assessment, self-evaluation, and self-correction are inconsistent with traditional cultural expectations. In addition, several of the participants were not aware of the different types of mental health. For example, neither Simran nor Gurpreet was aware of the specific mental health problems from which they suffered. This would have made it difficult for one to self-evaluate and correct for imbalances. The organizations' definitions also assumed a particular level of self-awareness and, as the women in the study suggested, sometimes when you have an imbalance you are not even aware that anything is wrong. Similarly, if you cannot recognize your weakness, you may not be able to recognize or realize your own ability or abilities.

The definition of agency advanced by the WHO (2010) also stressed the ability to adjust to different situations. This aspect appeared to have more parallels with how the participants defined agency, in terms of social negotiation. Having freedom allowed them to adjust to different situations by making decisions concerning the manner in which they handled their everyday responsibilities and obligations. Despite having the freedom to make their own

decisions, however, it appeared that the participants may still have felt pressured to give in to social obligations, as in the case of Simran, who needed to appease her in-laws in order to avoid confrontation, but wanted to do so at her discretion.

Agency was mediated for the study's participants. Agency was negotiated by working in tandem with others; it was social in nature. For better or worse, Punjabi culture stresses the importance of family and social ties. Agency was not about being one's own agent, but about negotiating with others to gain some control (Pope, 2007). Simran, for example, was not opposed to her domestic duties, but wanted to negotiate when these duties were to be completed. Similarly, Ramandeep conformed to many of her husband's wishes, such as changing the way she dressed and her mannerisms, but in return she wanted some freedoms, including to continue her education and to pursue her writing. Unfortunately, Ramandeep was unable to negotiate any agency. This leads an important observation about agency in a North American context. Agency in North America is often conceived of as a right to be one's own agent; however, agency appears to be held in contestation with others (Pope, 2007). To negate this understanding denies how social structures impinge upon one's agency. Agency, for these participants, was not inherent, but was negotiated with parents as children, and governments and social relationships as adults. For example, rules regarding citizenship and rights and freedoms restricted individual agency (Pope, 2007). Hence, to assume that all individuals have complete and total agency over their lives is a fallacy and denies the impact of factors such as gender, race, and class, as well as both cultural racism and cultural traditions.

Positive attributes.

Similar with the CMHA, the participants highlighted a variety of positive attributes when talking about being mental healthy. For the CMHA, positive attributes were those that enabled

people to flourish and were centered on positive qualities such as, courage, optimism and hope (line 14), which were more intangible in nature. However, the participants, when discussing the mental health attributes of others, focused more on positive qualities that were tangible in nature, such as smiling, laughing, helping others, social, mentally alert, and adventurous. For the participants, the assessment of another person's mental health appeared to be focused primarily on qualities that can be clearly observed and attributed to an individual, as opposed to qualities that are based more on intuition, which may be more difficult to assess. There seemed to be a clear focus on behaviours that could be observed, such as "like Hardy, he [is] overweight, but he never go to like sad, or something, like he is so cheerful and [more] positive than me" (Simran, lines 121-122). However, some participants did talk about using intuition when asked whether one can tell if someone was genuinely happy by a smile: "Because you see on the face,…. They are smiling, and they have no like pain. Sometimes, if you smile at a person, and they smile right away, you can see" (Simran, lines 110, 114-115).

Personal qualities, such as being happy, content, and confident, were also present in participants' responses, but these were discussed in relation to factors that distinguished one's own good mental health, reflecting participants' willingness to comment on their own internal state, but lack of willingness to make assumptions about the internal states of other's without observable actions.

Mental health is action.

In defining mental health, the CMHA focused on action-oriented states such as the ability to "bounce back from hard times" (line 20), "juggle the many aspects of your life" (line 22), being able to enjoy life, resilience, self-actualization, and flexibility. The participants, on the other hand, mainly focused on internal dispositional qualities, such as being happy, calm, jovial,

content, and balanced. When the participants did focus on actions, they were more tangible in nature and not focused on mental health as action, such as juggle multiple aspects of one's life. The actions that the participants focused on included speaking well, helping others, and being social. Exercising was also mentioned, but referred to in terms of physical exercise, rather than mental exercise, as is implied by the CMHA (2006). Exercising was seen as means of occupying or distracting the mind from focusing on negative life events.

In the case of poor mental health, the actions that were foregrounded included crying, being aggressive or violent, walking fast, and fidgeting. As such, there appeared to be a divergence in how the two groups, the CMHA and the participants in the study, described a positive portrayal of mental health. Once again there is appeared to be similarity between the organizations' theories and the participants' tacit theory of mental health, but not in the content within those categories.

Web of interrelationships.

The participants acknowledged a variety of sources that contributed to mental health problems, but the range of their interconnections did not appear to be as vast as that of the three documents analyzed, particularly those authored by the CAMH and the WHO. The participants reflected on how social pressures impacted their mental health, such as obligations to their family, cultural restrictions that prevented them from seeking outside help, and gender discrimination. Only two of the six participants mentioned biological and only three of the six participants mentioned financial issues as impacting mental health. Psychological, personality, and larger overarching social issues—such as poverty, gender inequality, education, and housing—were largely absent from the participants' discourse on the determinants of mental health. However, implicitly, these larger social issues may have played a role in at least a few of

the women's states of mental health. For instance, Ramandeep's husband controlled her finances to the extent that she did not have any access to her income. The lack of control over her finances must have impacted her feelings of helplessness and inability to leave the relationship. Similarly, Simran also had her income confiscated by either her husband or her in-laws. Again, this may have prevented her from leaving her husband sooner, or played a role in her returning to her husband.

More than just a lack of mental illness.

Two philosophies on mental health emerged in the interviews conducted for this study. Four of the six women, three from the younger cohort and one from the older cohort, suggested that one can be mentally healthy while dealing with mental health problems. Two of the six women, both from the older cohort, expressed the opposite perspective: that it was incommensurate to have poor mental health and also be mentally healthy. The following is a comment by Amrit in response to a question regarding how people who are not mentally healthy can do good work: "People who are not happy at heart, how would they be good at work?" (line 233). This comment exemplifies the idea that a person who is mentally unhealthy cannot function in any other capacity. You either are or are not mentally healthy. Thus, there appeared to be differences concerning the belief that mental health is more than just a lack of mental illness.

Discussion.

Sociocultural factors impact the meanings individuals and societies ascribe to mental health. When organizations such as the CMHA, CAMH, and the WHO advance meanings of mental health that homogenize how a diverse group of individuals defines mental health, questions surrounding the legitimacy of their claims need to be addressed. Notions of individual

154

agency as reflected in documents authored by the CMHA and the WHO appeared to conform to a biased Eurocentric notion of individual rights. There appeared to be an assumption that all individuals have the privilege of the same rights and freedoms; however, this assumption fails to recognize the various factors that act to oppress one's agency, raising questions about the intended audience of these documents.

Further, standardized approaches that privilege ethnocentric models of mental health also need to be called into question. The participants in the study, although producing a tacit theory of mental health that mapped onto the models espoused by many of the organizations, differed in terms of the conceptual framework with which mental health was defined. This, in turn, suggests that different ways of knowing are excluded from these organizations' models. For example, themes such as individual agency, positive attributes, mental health is action, and to an extent web of interrelationships exclude the impact of sociocultural factors on individuals, and how the intersectionality of gender, race, and class may potentially marginalize groups, thus affecting how they construct mental health. Often it appears that "culture" and "globalization" are thinly veiled constructs that are used to further enthocentric beliefs, demarcate differences, and to reassert the colonial mentality of the oppressed being rescued by the oppressors. Further, Eurocentric approaches to models of mental health may be ineffective when applied to minority groups as they may include covert and overt biases and discrimination (Harley et al., 2002). For example, these approaches are likely to conclude that interventions aimed at improving one's mental health have failed as a result of the consumer not self-assessing, self-evaluating, and correcting their imbalances, rather than realizing that the model of mental health being employed fails to recognize culturally different meanings of mental health.

Identifying with the Canadian Mental Health Association's Meaning of Mental Health

In an effort to evaluate how well different meanings of mental health resonated with the participants, a catch phrase put forward by the CMHA "It's one thing to look after your body. Just don't forget about your mind. Practice mind + body fitness," and the accompanying pictorial image of individuals working out at a gym was shown to all six participants in the study (see Figure 1). The three main themes that emerged from their discussion of these materials were: 1) mind-body connection; 2) meaning of mental fitness; and 3) images and meanings of mental health.

Figure 1: *The meaning of mental health* (CMHA, 2006c)

Mind-body connection.

The responses to the catch phrase yielded three sets of responses. One response was in agreement with the CMHA phrase, in that it was important to be both physically and mentally active in order to have sound mental health. Simran and Gurpreet, from the younger cohort, and Mardeep, from the older cohort, stated that it was important to exercise as it keeps your mind alert, which according to them is one of the indications of good mental health. In addition, they noted that it also prevents you from dwelling on negative emotions or aspects of your life, and that physical exercise makes your mind feel good through the release of endorphins. The second set of responses was in disagreement with the CMHA phrase. Amrit and Hardeep, from the older cohort, stated that if your mind does not work then you cannot take care of your body, resulting

in your body becoming useless. The third set of responses, from Ramandeep and Simran, of the younger participants, discussed the irrelevance of the mind-body connection when you are suffering from poor mental health. These participants noted that it was more important to take care of your mental fitness than your physical fitness in order to maintain good mental health during times of distress.

Meaning of mental fitness.

The definition of mental fitness had no one meaning for the study participants. Instead, the meaning of mental fitness was composed of a multiple definitions. For Gurpreet and Mandeep, mental fitness entailed keeping oneself busy and alert by engaging in hobbies, reading good books, and putting good knowledge into action. For Ramandeep, mental fitness meant taking time for oneself and reflecting on one's goals, and where one is going in life. For Simran, it meant being positive, having good thoughts, which was something that needed to be worked at on daily basis as it was very difficult to achieve otherwise. For Hardeep, mental fitness encompassed being able to handle emotional news well, being balanced in one's response and not becoming overly negative. Finally, Amrit was unable to comment on the phrase and replied that she found the task difficult.

Images and meanings of mental health.

The pictorial image accompanying the catch phrase yielded two main types of responses. One was that the pictures and words had no correlation. Several participants—Ramandeep, Hardeep, Amrit, and Mandeep—failed to see any connection between the images presented and the phrase accompanying the pictures. In fact, when looking at the pictures Ramandeep commented that the people depicted looked desperate, as if they were seeking something. Gurpreet and Hardeep commented that the individuals in the picture were not exercising

properly. Hardeep, especially, found this problematic, while Gurpreet felt it related to the individuals in the picture being in a poor mental state. Others, such as Amrit and Mandeep were left dumbstruck, not really able to comment on any relationship: Amrit stated: "I don't know about these things" (line 198). Interestingly, when participants were asked what it meant to be healthy, many of the participants commented on the importance of being physically healthy, yet were unable to see the connection in the pictorial image.

The second set of responses focused on the relationship between the phrase and exercise. Simran and Ramandeep felt that there was a correlation between the two, in that the pictures represented how exercising and taking care of your body made your mind healthy, although they did not relate to the type of exercising depicted in the picture. Ramandeep did mention that, in order to keep your mind healthy, "hard core exercising" (line 754) as depicted in the pictures was not necessary and that practicing yoga would be preferable, especially as she perceived yoga as a means of exercise that also focused on calming the mind. Simran made a similar comment: "So [in] my opinion like yoga is good [better] than heavy exercise" (line, 76). Nonetheless, a healthy mind was equated with a healthy body.

In conclusion, the "mind as body" metaphor promoted by the CMHA seemed to define mental health as a state of fitness, suggesting that a mentally healthy mind is an active mind and must be worked similarly to how one would work one's physical body in order to remain healthy. When looking at the interpretations provided by the participants, the metaphor and the accompanying image as presented by the CMHA did not seem to resonate for the participants from a cultural point of view. Although when asked what it meant to be mentally healthy the participants provided terms that indicated being active and mentally alert as important components, they did not equate mental health with physical fitness, and thus the metaphor did

not make sense. Although there was recognition by some participants of the importance of being physically active, this was not equated to mental health as a state of fitness. The participants in the study spoke more about the impact of physical exercise on the mind; for instance, its ability to distract the mind from negative thoughts. The range of definitions for mental fitness produced by the participants also supported the lack of cohesion and misrecognition of the metaphor being advanced by the CMHA.

Summary

After describing three organizations that contribute to Canadian and global perspectives on mental health, policy and services, the present chapter focused on three levels of analysis. The first set of thematic analyses focused on the definitions of mental health advanced by the CMHA, the CAMH, and the WHO. This analysis highlighted themes that were common across all or the majority of the organizations, and included: individual agency, web of interrelationships, and more than just a lack of mental illness. There were also areas of divergence, most notable with the text authored by the CMHA, which stressed a health model based on positive psychology and produced themes related to positive attributes and mental health as action, while appearing to disregard all social, cultural, or contextual factors.

The second set of analyses focused on how the participants' definitions of mental health compared and contrasted with those presented by the three mental health organizations. There were varying degrees of overlap between all of the themes presented. Although the participants were able to identify with the themes overall, their conceptualization of the themes differed. For example, although the women in the study discussed issues surrounding a mediated form of agency in terms of personal freedom, it was not to the same degree or extent as was outlined by

the CMHA, wherein individual agency entailed being able to both assess and correct one's mental health imbalances.

The third analysis examined the participants' identification with a catch phrase and accompanying pictorial image related to mental health as presented by the CMHA. Based on the responses by the participants, it appeared that for many of these women there was not a strong relationship between their own construction of what it means to be mentally healthy and that presented by the CMHA. The metaphor that mental health is fitness seems to be a culturally grounded metaphor that may actually serve to distance groups unfamiliar with it, rather speak to all individuals in an equally effective, inviting, or culturally responsive way.

The analysis presented in this chapter was undertaken in an effort to gain a sense of the mental health landscape in Canada that framed the access to and use of services by the participants. As Punjabi immigrant women, constructions of mental health may have been more or less culturally responsive given the extent to which they relied on a Western perspective of individual agency, for example, as well as a universalized individualistic perspective of the meaning of mental health. While the first two analyses highlighted the perspectives advanced by the three organizations, the third analysis directly foregrounded the participants' perceptions of the perspective of the CMHA on mental health.

Chapter 8

Conclusion

Mental health is the "foundation for individual well-being and the effective functioning of society" (WHO, lines 14-15). In order to facilitate the development of healthy individuals and communities, there first needs to be an understanding of how different cultures construct mental health. Disentangling the effects of culture, context, gender, race, class, history, and migration experiences is an important step toward understanding the factors that influence mental health, as well the ways in which mental health services may be designed, offered, and accessed in culturally responsive ways.

The main goal of this study was to investigate how Punjabi immigrant women construct the meaning of mental health. To this end, six Punjabi immigrant women were interviewed in order to investigate their definitions, experiences and narratives related to mental health. In addition, documents pertaining to the meaning of mental health, as defined by three organizations—two Canadian and one international—were analyzed.

This chapter summarizes the major findings of the study, in relation to the research questions, and addresses research limitations, recommendations, and future research directions in five sections. The first section of this chapter highlights the main findings concerning how the participants constructed the meaning of mental health along with their experiences with mental health and mental health service provision. In this section, the first four research questions are addressed in relation to implications. The second section of this chapter highlights the main findings from the thematic analysis of mental health organization documents and the comparison of this analysis with participants' definition of mental health. In this section, the fifth research question is addressed in relation to implications. The third section describes limitations and

challenges of this study, including the difficulties of engaging participants with culturally disparate interview content and representing their voices with a sense of cultural validity. The fourth section focuses on recommendations based on the study's findings. Finally, the fifth section highlights potential directions for future research.

Narrative Analysis: A Difficult Balance

Women in India are typically provided with fewer opportunities than men. The contexts of women's lives in India are structured through cultural traditions and expectations that are explicitly taught through narratives like the *Ramayana*. When women immigrate to Canada from India, these cultural traditions intersect with dominant Canadian social structures, some of which may act to oppress Punjabi immigrant women. Expectations about gender and gender roles play out differently in relation to ethnicity and social class (Collins, 2000), and they play out differently in India and Canada. Factors such as gender and social class are not simply intertwined, but embedded within a complex matrix of domination that oppresses women at many levels (Collins, 2000), including oppression related to Punjabi cultural traditions and oppression related to the dominant culture in Canada. This section continues with a brief generalized description of Punjabi cultural traditions that influence the roles of women in India, and then moves to the Canadian context. The first four research questions are addressed and implications are described.

In her discussion of the matric of domination, Collins (2000) argued that the structural domain, which consists of social structures, such as religion, sets the boundaries that organize power relations. For example, the *Laws of Manu*, a prescription by the sage Manu on how society should be governed that defines the roles of men and women, states that a man should not "live with people who have fallen" (Doniger & Smith , 1991, p. 81). Further, when it comes to

women and marriage, men are cautioned against marrying a woman who is sickly or talks too much (Doniger & Smith, 1991). Texts such as the *Laws of Manu* and the *Ramayana* are ancient texts that emerged somewhere between the 4th C. B.C. and the year 300 C.E.. Since then, they have become integral parts of Indian culture. The values these texts espouse have formed an implicit narrative of Indian society, reflecting the impact of the hegemonic domain, and are reified through values and beliefs that are often upheld with little contestation.

The excerpts listed above reiterate the importance of maintaining one's *izzat* and closely adhering to one's duties, as well as the malicious treatment society may bring upon those who fail to do either. The impact of the various matrices of domination seems especially apparent within the hegemonic domain, where authority functions as a result of the expectations people hold within it, such as the values that are embedded in cultural narratives, the language that is used, and the images of women, such as Sita, that are revered by society. Within the interpersonal domain, relationships that act to maintain these values and images serve as a further reminder of women's roles and functions in society. For instance, despite the constant accusation that Sita faced regarding her chastity, she continued to remain loyal to Rama and to serve him faithfully. The powerful effects of this mythological narrative—to describe gendered expectations for women—cannot be overstated. Sita is the "ideal" woman and, as such, her actions may be difficult to follow. As the cultural ideal, however, the way she lives her life, the decisions and choices she makes, and how she fulfills her obligations form a rigid instructional narrative: through her story Punjabi women learn how to be Punjabi women.

The structural domain, which organizes power relations, and the disciplinary domain, which manages and conceals oppressions, may act in concert to limit the types of opportunities that are afforded to women. For example, women in India tend to have higher rates of illiteracy

than men (Human Development Report India, 2009). Lower illiteracy rates for women may also be a reflection of their role in society, which largely relegates them to serving the needs of others, performing domestic chores, and fulfilling social obligations, as modeled through Sita's narrative. Low educational attainments coupled with gendered and economic oppression further act to control and organize women's behaviours through surveillance, routinization, and rationalization. For example, on the interpersonal domain, women have reported being watched and critiqued by in-laws and Punjabi community members and having their domestic chores managed and organized by others. A frequent circular argument for keeping women *in* the domestic sphere, rather than seeing it as a result of their relegation *to* the domestic sphere, is their illiteracy. Ultimately, as a result of women's roles, and relationships to husbands and in-laws, women have fewer opportunities for advancement in Punjabi society, thus requiring that they maintain their relationships, at all costs, lest they be confined to the lowest echelons of society.

In the Canadian context, many of the cultural ideals that were embedded within the structural domain of domination and acted to subjugate women in India appeared to be consistent with the gendered expectations established. In Canada, the complexity of immigration and the cultural expectations of Canadian society positioned Punjabi immigrant women in ways sometimes similar to and sometimes distinct from the gendered expectations in India. For the women in this study, the hegemonic domain, which included traditional patriarchal values, seemed consistent with, if not the same as, the patriarchy in dominant Canadian culture. The narratives of the participants, Punjabi women, reflected oppression as the result of the interpersonal relationships with the men in their lives—some husbands and one father—and, in a more indirect way, the oppression of the dominant Canadian patriarchy.

Culturally, the participants struggled with traditional Punjabi expectations regarding gender norms in relation to considerations of mental health. This was evidenced in their struggle to find a place for themselves in their lives. Although Sita was not allowed to acknowledge or define her own needs during her time on the earth, the participants acknowledged modest needs, along with a unifying need for balance. More specifically, the struggle was evidenced in the tenuous balance between what they defined to be mental health and mental illness. For example, the first research question asked, How do Punjabi immigrant women define concepts related to mental health and illness? The participants defined concepts related to mental health and illness according to each individual's needs, and thoughts, feelings and behaviours. Basic needs were indicative of factors required for the maintenance of mental health. This included having the support of others, especially during difficult times, and freedom, the right to make decisions about their own lives, such as when to complete household obligations. Higher needs on the other hand were more prevalent once one's basic needs were met, and included time for self, such as engaging in hobbies, and financial freedom, having access to one's finances. Thoughts, feelings and behaviours reflected the participants' perspectives on how a mentally healthy or ill person would be perceived. A mentally healthy individual, for instance, was seen as being alert, able to make the right decisions, was positive and content in life, and was social in nature. A mentally ill person was described as confused, negative, sad, antisocial and violent.

Along with thoughts, feelings and behaviours, balance was also related to mental health. Individuals who were perceived as being mentally balanced were able to handle negative situations while maintaining stable thoughts, feelings and behaviours, for instance, "they make very quick mental decisions … and in any situation they do well" (Hardeep, lines 75, 101). However, individuals who are mentally ill were perceived as being imbalanced, and this

imbalance was also related to a lack of stability in their thoughts, feelings and behaviours. For instance, Gurpreet noted, "I would sit and eat so much sugar" (line 199), "I just couldn't think straight… all I had to do was pack my bags and leave. I was so mad I would bang my head to the wall" (lines 237-239). An individual was also described as exhibiting extreme mental states, such as, "somebody is laughing one moment and the next moment they are crying" (Ramandeep, line 273**).** Connected to the idea of balance was the importance of the mind-body-spirit connection. Many of the participants spoke about the importance of having all three aspects in alignment in order to have good mental health. If one aspect were troubled or out of balance it impacted the other areas.

Traditional gendered expectations clearly influenced and shaped the extent to which and the ways in which the participants accessed and utilized mental health services as well. This topic related to the second research question: How are mental health services accessed and utilized by the participants? When it came to issues regarding the access and utilization of mental health services, the participants in the study were often unaware of the mental health resources that were available to them. The participants visited their family physicians for mental health problems. Family physicians referred their patients to mental health professionals in only two of four cases. Access to mental health services was compounded by feelings of shame. Some participants may have been reluctant to discuss their mental health problems with others for fear of being shamed by others in the Punjabi community. The potential for being seen as paagal, or in an extreme mental state linked with mental health problems, was risky as it may have led to social isolation and potential ostracism. In addition, some participants were unaware that they were suffering from a mental health issue. This was the case for two of the participants, Simran and Gurpreet. Aside from the services that were offered to the participants in the study,

which typically involved prescriptions and, less often, referrals to counselors, the participants in the study expressed a desire to have alternate forms of therapy, such as homeopathy, Ayurveda, or a non-medicinal form of therapy as therapeutic options.

Patriarchy worked through interpersonal relationships, in particular given the roles available to the participants in relationships with their husbands and in-laws, and expectations within the Punjabi community, in particular given their relationship with family practitioners. They were so intertwined with almost every aspect of life that this acted to further sustain them. Given the ideal of Sita, a woman with no individual needs—a woman with a single minded interest in supporting her husband and family regardless of the cost to her self—the participants in the study were positioned untenably. While there is some question about the extent to which some of the participants were sure of their own or others' ailments, their participation in the mental health system for any reason posed a challenging dilemma: participation may have resulted in mental health care, however, the cost of health care was social reputation and network.

The social repercussions of being judged by others seemed to be a factor that concerned the women in this study enough that they were silenced when faced with conditions that impacted their mental health or when dealing with mental health problems. The feared backlash from the Punjabi community in the form of negative perceptions and gossip also resulted in silencing: the women found it difficult to speak about their experiences. Despite the desire for change among the participants who, for example, cited freedom as a need, they themselves may have been complicit in reaffirming patriarchal values and acts that further oppressed them. In a rigidly bounded system, a system they were unable to transform alone, their actions may have contributed to its maintenance.

The factors that acted to silence many of the women in the study may have also impacted their perception of the Canadian mental health system. This raised important insights related to the third research question: In what ways do the existing mental health services meet or fail to meet the needs of the participants? One of the primary concerns that participants' voiced in relation to accessing mental health services was the need for privacy when accessing mental health services. The need for privacy within the Punjabi community can be seen by clearly demarcated cultural boundaries that appeared to be reinforced by experiential knowledge limiting the production of new ways of speaking, thinking, and acting as members of a cultural community. This was especially true for those who come from an oral tradition where knowledge rests with elders, and with males having more authority than females, as was the case with the majority of the women in the sample.

Even Hardeep, who was well educated and spoke insightfully about cultural issues, refrained from discussing personal matters or citing examples from her own life during the interview. This reflected the advice given to her by her elders: "keep your mouth shut then everything is fine, once you open your mouth then everyone finds out" (Hardeep, lines 449-450). This perspective was a common one that reiterated the importance of not discussing family matters with outsiders and of maintaining one's privacy while accessing mental health resources. Participants also felt that the mental health system failed to provide information about the resources available. Indeed, most participants were unaware of the mental health resources available to them. This position may have been complicated by the participants' reluctance to investigate the mental health resources given the shame associated with accessing mental health services.

In light of the factors that may have acted to constrain the study's participants' from

utilizing mental health services, it is important to explore how these services may be made more

culturally accessible, which was the fourth research question. One of the ways that privacy could

be achieved is by operating mental health services out of an organization that also offers other

services, such as immigrant settlement programs, thus offering patients who are accessing mental

health services greater privacy. Another factor that may make mental health services more

culturally accessible is creating greater awareness around mental health issues. Some of the

participants in the study commented that they were not aware that they suffered from mental

health problems. Thus, there needs to be greater education around mental health problems and

the communication of mental health problems needs to be culturally grounded. Further, family

physicians could play a larger role in informing Punjabi immigrant women about mental health

services, as well as providing patients with information about these services, especially since

many of the women in the study reported that they had gone or would go to their family

physician for mental health issues. In addition, a list of mental health providers that can either

speak Punjabi or offer translation services may enable more interaction and more precise

diagnoses when women do engage with the mental health system. The ideas offered by the

participants in relation to this research question are further elaborated in the recommendations

noted later in this chapter.

While some of the oppression the participants experienced occurred in relation to

traditional cultural values and expectations, the dominant Canadian cultural context also

complicated the positions of the participants, in particular, given their social class and ethnicity.

The intersection of gender and social class occurred most frequently when the participants

articulated the mental health issues that surfaced as a result of marriage problems. For two

participants, the decision to end their marriage was made in relation to ongoing verbal and/or physical violence. During their marriages, several participants were not allowed to keep their wages and, instead, had to hand over their paychecks to their husbands. They did not have their own bank accounts or their own savings accounts. Ending a marriage, regardless of the reason, came at a significant financial cost and meant a change in their socioeconomic status. This result was magnified for Gurpreet who, with her children, left her husband. The financial consequences of a failed marriage had an effect on the participants that was influenced by their gender, by their role in their immediate and extended families, and by their position in a network of traditional cultural assumptions related to the ideal of service and obedience portrayed in Sita's narrative: because women do not exist separately from their first family or outside of the family they marry into, there is no need to prepare them to exist independently.

Indeed, as long as they remained connected to family there was no need to have access to finances and their own income, or to have an understanding of financial matters. However, without access to financial means, the participants in this study found it difficult to take the steps they needed to end even the most abusive relationships. Some of the participants' in this study appeared to be placed in a compromised position brought on by the intersection of gender, social class, and patriarchy as well as the various domains of oppression. The hegemonic domain—linking the structural, disciplinary and interpersonal domains (Collins, 2000)—served on the one hand to demarcate cultural boundaries that needed to be challenged, but also served as a reminder of values that had been deeply embedded over centuries and potentially resulted in a backlash to those who attempted to oppose them.

The participants were also silenced by socially constructed factors, including both the perceptions of others from their own cultural group, and the perceptions of others regarding their

ethnicity through cultural racism. Living as a member of a traditional cultural group embedded

in dominant Canadian society placed several opposing expectations on the participants. From

within Punjabi culture there was a concern for one's status and position; both dependent upon the

image one portrayed. Kinship and community ties made the discussion of taboo topics, such as

mental health, difficult. As a member of a traditional culture, even in Canada, there was little

opportunity for social mobility for the participants. The members of the older cohort were all

employed at some point as berry pickers, and the younger cohort were employed in lower income

positions. This was the case despite the fact that four of the participants in this study had high

educational levels. With little mobility within the Canadian context, oppressions within the

interpersonal domain were maintained, as any actions that may cause one's status to diminish

within the Punjabi community were likely avoided. Culture and social class and gendered

oppression thus intersected, creating barriers to access for help; traditional and patriarchal values

and familial needs were prioritized over women's needs (Burman, Smailes, & Chantler, 2004).

The perceptions of the participants in relation to both their gender and ethnicity may have

been a foundation for their interactions with police officers. Both Ramandeep and Gurpreet

reported negative experiences when dealing with law enforcement officials. Ramandeep

commented on her anger and resentment towards the constable with whom she interacted:

> She was always very strong, you know, she used strong words. Do you have a pre-
>
> nuptial agreement? And I didn't even know what is a pre-nuptial agreement, because I
>
> just, I come, I just came from India and we don't have pre-nups there. So, very, um,
>
> judgmental. Yeah. So and it bothered me so much, it bothered me so much. I don't
>
> know what to do, the police, whatever, inspector, the higher inspector, why, why would
>
> you do that? (lines 859-864)

Gurpreet also spoke about a similar experience: "I came across a really, very rude police officer. He was very polite, but he would say things that would just stab me…. That man he gave me a big time problem" (lines 1250, 1264). It does not appear to be a coincidence that these two women refer to such similar experiences. A cursory glance at these cases suggests that the police may have been imposing stereotyped views of Punjabi culture onto Ramandeep and Gurpreet, perhaps, reinforced by cultural racism.

This phenomenon seems to surface in relation to women from other minority cultures as well, for example, a study by Blagg (2002) found evidence of police in Australia downplaying violence against Aboriginal women on the grounds that it is a part of their culture. Similarly, in B.C., Canada, Aboriginal groups, as well as women's advocacy groups have cited gender, race and classism as reason for the police disregarding missing women's reports in the Pickton case (Lakeman, 2010). These findings seem to reinforce the view that a woman's social worth is a reflection of the extent to which she is similar to the dominant culture, in particular, in terms of gender, social class, and ethnicity. Further, gendered stereotypes and cultural racism regarding Punjabi women may also have affected how police interacted with the participants. The presumption of Punjabi women, for example, as being submissive and passive, may make police less willing to arrest men for domestic violence; there may be an underlying assumption that violence is perpetrated against them because of these cultural traits (Burman et al., 2004). The police may also have assumed that "these women" will likely return to their husbands or will not file criminal charges as they are trapped by their own culture (Burman et al., 2004). Further, the stereotype of Punjabi women as docile and submissive may have also affected how the police reacted to these two women. Therefore, in addition to being powerless within their patriarchal Punjabi households, even when outside help was sought, the voices of Ramandeep and Gurpreet

were discounted by authority figures given the patriarchy and ethnic stereotyping in Canadian society. Discounting the voices of those who are oppressed only acted to further silence these women and reaffirm beliefs about domestic violence being a "cultural thing" that must be dealt with within the community (Burman et al., 2004).

Women are often the site where tradition is contested, but women themselves do not seem to be the subject of the debate exemplifying their object status (Loomba, 2005). For instance, men may have heated debates about whether women should initiate divorce, but women never seem to enter into the debate, their voices are often absent. This leads to the question of whether the subaltern can be heard, as their voices appear to be absent from debates that determine their very lives. However, in the face of the overwhelming evidence of the forces of gender, social class and ethnicity in their lives, the participants in this study constructed ways to navigate sometimes overwhelming conditions. Though Punjabi culture does not support separation and divorce, at the time of the study, both Ramandeep and Gurpreet had ended their relationships with abusive husbands. In addition, Amrit was able to negotiate a way to live separately from her husband when she decided that was required. Ramandeep was employed full time and on her own terms, and Gurpreet was financially struggling, but self-employed. These three participants were able to partially negotiate various domains of domination, including the hegemony of family history, cultural tradition, and the dominant Canadian discourse.

Thematic Analysis: The Meaning of Mental Health

The presentation and reporting of mental health and the symptoms of ill health are culturally grounded, therefore, what may be defined as mental health in one context may not be in another (Fernando, 1990). Three mental health organizations' definitions of mental health were analyzed in this study, each providing a unique perspective on what constitutes mental

173

health, and directly related to the fifth research question: How is mental health defined by prominent Canadian mental health organizations? The definition of mental health offered by the Canadian Mental Health Association (CMHA) reflected universalistic, individualistic, and hegemonic ideologies, whereas the Centre for Addiction and Mental Health (CAMH) and the World Health Organization (WHO) incorporated definitions of mental health that acknowledged a multifaceted approach to definitions of mental health.

The CMHA viewed culture as stable, static, and homogeneous. Given its foundation in positive psychology, the CMHA also appeared to assume that cultural differences did not impact mental health issues and that mental health concepts may be universally applied. Again this is reflective in the hegemonic domain where the CMHA tended to purport claims of universality in terms of mental health definitions and experiences. By assuming that cultures are fixed and bounded in permanent ways, there lies the potential to deny alternative conceptions of mental health, resulting in the further marginalization of minority groups. Further, by denying alternate conceptions of mental health, individuals who are seen as different from the status quo may be seen as inferior because the way they act, think and feel diverges from the cultural norm (Jones, 1999).

An underlying assumption of positive psychology appears to suggest that individuals can and should have the ability to transform themselves into highly ambitious goal oriented individuals who can control their emotions and redirect all their energy into their goals (Miller, 2008). Individuals who are seen as incapable of transforming themselves to manifest these goals may be perceived as lazy, inferior and the cause of their own demise. For instance, the CMHA appeared to advocate a brand of mental health consumerism founded in assumptions about individual agency that are linked to the structural domain and the ideals of liberal individualism.

In the present context, mental health consumerism was defined as individuals being accountable for their own mental health and taking steps to improve their own state of mental health as an individual activity. In other words, every individual should be able to analyze their mental health problems and seek out the appropriate remedies. From this perspective, the failure to take this sort of action enables the blame for ill health to be placed on the shoulders of individuals as well.

This perspective is grounded in the assumption that all individuals have the same ability to transform and shape the direction of their lives, and thus to overcome mental health problems on their own if they chose to do so. In the document, *The meaning of mental health,* the CMHA (2006) placed a great deal of emphasis on values that stressed the importance of individuals being able to assess their own needs, abilities and imbalances and working autonomously to resolve mental health difficulties. The document even provided a link to a "mental health meter," a self-assessment tool that allowed individuals to determine their level of "mental fitness" along with areas that needed improvement.

Whereas mental health consumerism may be advantageous in that individuals can deal with mental health issues privately and within their own comfort zone, it also suggests that mental health problems are largely a result of an individual imbalance. This perspective ignores social structural factors, like institutionalized sexism, classism, and cultural racism, and decreases social awareness around the issue, as less funding and support may be provided for mental health education, resources, and services. When individuals begin to accept the ideas and values of the hegemonic domain, such as mental health consumerism, they may begin to perceive their mental health experiences through these value-laden cultural assumptions that potentially result in legitimizing oppressions.

Many of the beliefs embedded within mental health consumerism reflect a Eurocentric ideology, which negates other definitions of mental health, and ignores factors that act to oppress others. Consequently, caution should be applied when engaging in a discourse of consumerism as it has the potential to use arguments embedded within cultural racism and place blame on the individual for their condition and may suggest that mental illness is a condition that one inherits, which in some cultures only acts to further stigmatize and alienate individuals and their families (Fernando, 2005). Further, placing the onus on the individual may serve as a further justification for discrimination by the dominant culture by insinuating that the individual is under duress due to their cultural values and belief systems. These stereotypes may act to legitimize and normalize differences between groups, whereby, Punjabis may be othered and seen as being mentally inferior to the dominant cultural group. This reflects a belief that this is how the culture is and the individual will just have to deal with their condition, thus overlooking issues related to poor mental health (Burman et al., 2004). Consequently, the effects of cultural racism within the mental health sector may be well disguised in the form of a colour blind system that advocates fair treatment for all, but which suggests that cultural differences and not structural differences or bureaucratic organizations are the reasons why a particular group's mental health needs are unmet.

Organizations, such as the CAMH and the WHO, however, incorporated definitions of mental health that acknowledged the variety of definitions and the importance of understanding factors that can act to oppress individuals and, thereby, impact their mental health. For instance, documents authored by the CAMH and the WHO advocated an integrative approach to mental health. Here, an integrative approach to mental health was defined as considering a variety of factors as having an impact on mental health, including but not limited to social, cultural,

biological, psychological, housing, education, socioeconomic, and environmental factors. This particular approach addressed situational factors that affected one's mental health, acknowledging that mental health problems were not solely a result of individual deficiencies. Accordingly, both the CAMH and the WHO attempted to represent values that were in opposition to those presented by the CMHA, and potentially challenging many of the assumptions inherent within the hegemonic domain upheld by the CMHA. Overall, an integrative approach accepts that there are a variety of conceptions of mental health and aims to serve the needs of the majority of individuals from divergent backgrounds while alienating the fewest possible number of individuals and/or cultural groups.

Despite the integrative approach of the WHO, they did seem to subscribe to a definition of agency that at times paralleled the CMHA's definition, and seemed to suggest that an individual is aware of the factors that may constrain their mental health. In the case of the CMHA, an individual should also be able to correct these factors in order to facilitate a more optimal mental health state, while the WHO focused on a sense of awareness regarding one's ability and being able to adjust to one's situation in order to be a productive individual and community member. Although the concept of agency did surface in the interviews, for the participants it appeared to be connected with having the freedom to make personal decisions or how and when obligations would be met, while trying to maintain social harmony or reduce social disruption. Thus, although the concept of agency was present for the participants, it did not reflect a sense of agency consistent with a Western ideology of liberal individualism. The participants' lack of conformity to liberal individualism seemed to be in opposition with such beliefs, thereby potentially lessening the power of such discourses. At the interpersonal domain the participants' break from traditional concepts of agency were more apparent in their efforts to

negotiate agency and experience a form of personal freedom that broke away from traditional conceptions of womanhood that focused on self-sacrifice.

Overall, the range of perspectives of mental health and mental health services offered by the three organizations was, perhaps, beneficial, in that the disparities between them were evidence of the variety of perspectives on mental health more generally. However, if an individual seeking mental health care, or information regarding mental health care, were only to engage with one perspective from one organization shared on the web, they would have accessed only a portion of the information available. Depending on whether they accessed the information published by the CMHA, CAMH, or WHO, the perspective and information available may have been more or less culturally appropriate. Therefore, it is important that mental health care organizations that aim to meet the needs of a large and diverse population, like the population of Canada, are cautious and critical of the perspectives and ideologies they use to ground their definitions, services, and policies. The reasons for this are manifold. Most notably, it is important for people to be able to identify with definitions of mental health; otherwise there is the risk of alienating and marginalizing vulnerable individuals and populations. Second, and equally as important, discourses have the power to shape attitudes, behaviour, and power relations. Consequently, their effects and implications are significant on many levels, including for mental health services, funding, and research.

Limitations of the Study

Limitations surfaced in the conduct of this study. The four main limitations were: 1) the difficulty of recruiting participants, 2) the difficulty of engaging the participants in what was largely considered to be culturally inappropriate content, 3) the difficulty of representing the participants' voices and their contributions to the study in a culturally appropriate manner and

honouring the diversity of their experiences, and 4) ethical considerations. Each of these limitations is discussed in turn.

Recruitment was one of the challenges of the current study. It proved to be especially difficult to recruit younger women with different educational and socioeconomic backgrounds. Despite being actively involved in the Punjabi community for the past six years, reaching out to a variety of organizations and individuals who work with Punjabi immigrant women in a professional capacity, and offering to interview women in either Punjabi or English, it proved to be a difficult task to recruit participants from this particular background. Given the topic of the study, this outcome may not have been too surprising. Even with confidentiality, participation may have been perceived to be too risky to potential participants.

Another challenge of the study was engaging women with the content of the study. The participants in the older cohort, in particular, found the questions regarding mental health difficult to answer at times, especially when asked to comment on culturally specific topics. The segment of the study that asked participants to comment on a catch phrase and image from *The meaning of mental health* document by the CMHA was one such example. For at least half the participants, the picture was culturally inappropriate, difficult to comprehend, and even slightly disturbing in at least two ways: first, because the "bodies" did not appear to be exercising properly and; second, because the catch phrase and image did not make sense, culturally.

Representing the participants' voices with a sense of cultural validity or trustworthiness was another challenge of the study. As a consequence of translating the Punjabi interviews into English, certain cultural nuances may have been lost, thus somewhat narrowing the cultural diversity of the narratives. Further, the translation process may have also reduced the impact of the participants' statements and stories as certain Punjabi phrases or terms did not have an

English equivalent. The imposition of the English language, sentence structure, and grammar, as well as the form of analysis for constructing the participants' narratives, may have shaped the data in ways that reduced the diversity of participants' experiences.

Ethical issues were another challenge of the present study. Some of the participants in the study experienced sorrow while discussing their experiences with poor mental health. The researcher reminded the participants throughout the study that the interviews could be concluded if they so chose. However, in spite of this, the participants continued to share their stories. Coupled with this, some of the participants in the present study, particularly those from the older cohort, found the questions difficult to answer. For example, Amrit commented that "this is really tough, sister, we don't know such things" (line, 276). Consequently, other than working with participants to confirm a summary of their interview, the researcher did not attempt to contact the participants for a second interview when questions regarding the transcripts arose or issues surrounding clarification of facts surfaced. The researcher felt that further contacting the participants may elicit additional discomfort, especially since one of the participants commented that she was not feeling well while discussing a past experience with poor mental health and another became tearful when describing feelings of ostracism. These issues, related to the difficulties associated with interviewing participants on topics that are potentially emotionally fraught, speak to the importance of the preparation of the researcher prior to entry into the field. A researcher must be able to address feelings as they emerge and provide support and/or information regarding counselling services as needed. The topic of this study highlighted this complexity.

Participant identity and confidentiality was another issue that needed to be addressed. Although the Punjabi community in the Lower Mainland is large, they are a closely connected

group, and often personal stories filter quickly through various social channels. Consequently, decisions regarding how much to disclose about the participants' identities had to be considered. Caution was taken to change as much identifying information as possible, especially because social stigma was a serious concern for many of the participants in the present study. Their participation in the study itself was a risk and, as a result, their courage must be acknowledged. While it is unclear that participation in a research study itself would have potentially damaged the reputation of the participants, it is likely that participation in a research study related to mental health and access to mental health services would have been potentially shameful. Each of the participants had to overcome their concerns about participation in order to be interviewed. In relation to participant identity, participation in the research process required another ethical consideration. As a part of the research protocol, in order for the participants to be reimbursed for their time, they were required to provide their name, social insurance number, and address to the researcher, who would, in turn, need to share the information with a number of financial administrators at the university in order for a cheque for remuneration to be processed. For all participants, and especially for those who had been in abusive relationships, providing such information violated a privacy boundary that five of six participants were unwilling to cross. An alternative way to reimburse these participants was created as needed.

Recommendations

Using feminist postcolonial theory and the concept of intersectionality to ground this study enabled two central principles to frame this research. First, I was able to approach culture with a lens that both expects and respects variation in cultures and cultural understandings as a method for overcoming the tendency in both psychological and counselling research to essentialize differences between women from different cultural backgrounds (Harley et al.,

2002). Second, I was able to recognize cultural interactions, both within and between members of cultural groups, as sites that have the potential to afford and constrain the possibilities for cultural and political transformation.

In 1985, mental health practices in Canada were reported to be dysfunctional for individuals with non-Western values (Choudhry, 1998). Unfortunately, many of the issues that were present 26 years ago are still present today. This suggests that, though waves of immigration continue, cultural and political transformation appears to be slow to change. Indeed, in some respects it seems that the dominant discourse and social relations—in particular between women and men, the working classes and upper classes, and European Canadians and South Asian immigrants—have maintained their power and been resistant to change. Ways of constructing mental health and the services to deal with mental health problems seem to be reaffirmed despite repeated attempts to disrupt and challenge these powerful discourses.

In order to overcome essentialist assumptions about Punjabi immigrant women, preliminary recommendations based on their experiences, along with a consideration of gender, social class, ethnicity, language and religious difference are outlined next. These recommendations are preliminary given the qualitative research upon which they are based and, as such, they should be used as the basis for further research as well. There are six main areas of recommendations from this research including: 1) the importance of privacy, 2) the ongoing influence of language barriers, 3) the importance of language accessibility, 4) the availability of mental health literature, 5) the role of family physicians, and 6) the potential role of coordinated primary care services.

One of the major issues that repeatedly surfaced from the participants' accounts in regard to mental health and access to mental health care was the importance of privacy. The need to

protect one's honour and not be publicly shamed was a central concern for many of the study's participants, in particular, when considering accessing mental health care services. Consequently, implementing a program or a service whereby Punjabi immigrant women can access mental health services, which are provided out of a centre that also offers other programs, such as immigrant services or settlement programs, may offer greater protection to one's privacy. The ability to control the therapeutic effects provided by medicine may be one of the main reasons why South Asian women appear to be more accepting of prescriptions for mental health therapies. Providing alternative means to access and address mental health issues may only become possible when confidentiality can be maintained. One such organization that has met this mandate and continues to serve a large ethnically diverse population is *Across Boundaries*, which is a full service mental health organization that provides treatment programs, outreach services and support services.

Language barriers continue to be at the forefront of problems related to cross-cultural mental health issues. Language barriers prevent individuals from understanding perspectives on what constitutes poor mental health and what types of services are available for mental health problems, and accessing needed services and resources. Of the three women from the older cohort in this study, two communicated in Punjabi. For these women, and many other Punjabi immigrant women who speak English at a basic level, perhaps because their need to interact using English is limited, it is important to have access to service providers who speak Punjabi. Both Mandeep and Amrit were women whose needs may have been better met had they interacted with either a mental health provider or a family physician who could speak Punjabi and who was familiar with their culture. Mandeep was referred to a counselor who did not speak Punjabi and discontinued therapy after only two sessions. Mandeep's daughter, who acted as a

translator, was present at the counseling sessions, which may have posed multiple problems. For example, Mandeep may have thought that she was a burden on her daughter and intentionally reduced her time in counseling so as to reduce the burden she perceived her counseling to place on her daughter. In addition, her level of disclosure may have been affected by the presence of her daughter at the counseling session, reducing the potential of the counselling from the start. Amrit lived with a husband who suffered from mental health problems for years before learning that he suffered from depression. Perhaps, communicating with a family physician who understood Punjabi would have lead to an earlier intervention for Amrit's husband.

Language accessibility is another issue. While the service provider should be able to speak Punjabi and/or have available the services of an independent translator, the availability of resources and services should also be published, in print and on the web, in a language that is used for communication. Directly translating pamphlets and metaphors from one language into another is not the answer. Many of the participants in the older cohort mentioned that they would be open to reading literature on mental health, as would their friends. Added to this was the stipulation by Mandeep, "if it can be understood," suggesting that mental health literature should be accessible in terms of the language employed to communicate the issues at hand (line 868). Moreover, the translation of metaphors from one language to another also needs to be performed with caution. Metaphors are culturally grounded and reflect how a particular society uses and understands cultural tools. It may, therefore, be more appropriate to ensure that any metaphors that are used to discuss mental health are culturally grounded for their respective audiences. It is likely that this sort of translation for meaning, rather than literal translation, is best completed by a person who understands the language and cultural experiences of Punjabi immigrant women.

Another problem that was referred to was that many Punjabi immigrant women may not read the literature pertaining to mental health and that a more interactive channel of communication may be preferred, such as educational forums or lectures, which may better serve some members of this group. Further, due to the oral tradition with which many Punjabi immigrants have grown up, many tend to relate their experiences through the telling of stories. Thus, it may also be beneficial to provide examples and stories that Punjabi immigrants can relate to when discussing or writing about mental health issues, including individuals' experiences dealing with a mental health problem. Articles or advertisements in newspapers are another avenue that should be explored; however, once again these need to be culturally appropriate, and should appear in both Punjabi, as well English publications.

Family physicians were revered by the participants given their knowledge and expertise when accessing mental health services in spite of the fact that they had little to offer. This may have reflected a general pattern among Punjabi immigrant women. In addition, it may have reflected the structure of the Canadian health care system, more generally, in which family physicians provide comprehensive patient care, as well as helping to reduce and screen patients prior to referring them to specialists. When the participants discussed where they would refer someone who had mental health problems, the majority cited family doctors. Since the participants had gone or would go to the doctor for mental health concerns, it seems that family physicians can play a larger role in informing their patients about available mental health resources. Especially since these participants placed so much faith in their doctors, perhaps the suggestion of seeking counselling from a doctor would have a greater impact on their utilization of these services.

It may also be helpful if doctors could recommend mental health providers who also speak the language of their patients. Mandeep, an elderly woman who did see a counsellor at the advice of her doctor, only attended two sessions. It appears that language barriers may have been an issue in this case, however. This highlights the importance of family physicians informing their patients about mental health services, and perhaps even providing them with literature that further clarifies mental health issues, their prognosis, and possible outcomes, thereby helping to dispel any misinformation or erroneous beliefs that they may hold and providing them with another perspective on mental health issues. Many women in this sample were unaware of the different forms mental health problems might take. Thus, educational material that is mindful of a diverse range of language barriers and perceptions of mental health may benefit this group.

Finally, it would also be beneficial if mental health services were incorporated into primary care services. Primary care in a Canadian context refers to health care services such as health promotion, illness and injury prevention, and the diagnosis and treatment of illnesses and injuries (Health Canada, 2006). Currently, however, *mental health* is not included in the definition of health and illness (Garfinkel, 2002). Primary health care provides direct contact with health care providers, such as family physicians, and ensures the coordination of services and mobility through the system (Health Canada, 2006). Despite this, it appears that many patients are not receiving the quality of care they need. This includes the access to mental health resources through their family physicians.

Consequently, a coordinated primary care services approach may be more valuable, wherein patients have direct access to mental health care providers, as opposed to receiving a referral. A collaborative primary care approach that includes mental health care may better address consumer needs and, perhaps, even decrease the stigma associated with mental health

while providing greater privacy for those seeking these services. Provisions also need to be made whereby translation services are made available for those for whom English is not a primary language, and lists of multilingual mental health practitioners are created. Addressing language issues is especially pertinent for this group given that they are motivated to seek mental health care; however, due to privacy issues and concerns, issues in access, such as language barriers, need to be addressed.

Potential Directions for Future Research

The findings from the current study suggest a series of potential directions for future research. Future studies in this area should target a greater range in educational background among participants. In the current study there was less variation among the younger cohort of 25-45 years of age; however, it proved to be a challenge to recruit from this particular demographic. The lack of familiarity with research studies coupled with the nature of the topic may have deterred individuals from volunteering for the study.

Future studies exploring meanings of mental health should also sample second generation Punjabi immigrant women in order to assess inter-generational changes in perceptions of mental health issues, and access to and utilization of mental health services. An exploration of male perspectives regarding mental health would also be beneficial. Once there is a greater understanding of how meanings of mental health are constructed and of individuals' experiences with mental health access and utilization, large scale quantitative survey research may provide further insights. However, in order to for a quantitative study to provide meaningful insights, qualitative findings must be used to inform the construction of the quantitative survey questions.

Finally, an examination of how the family unit is impacted when a parent or child suffers from a mental health problem may be one of the main objectives for this line of research. It is

hoped that this line of research may, ultimately, provide family physicians and mental health providers with insights into the types of questions to ask Punjabi immigrants—women, men, and children—who they suspect may be dealing with mental health problems, as well as how to raise awareness around mental health issues, what types of mental health services may be appropriate for this group, and the best ways for Punjabi immigrants to access and utilize mental health services.

Summary

Women's mental health is a multifaceted phenomenon that cannot be reduced to a single causal factor. Punjabi immigrant women face various forms of oppression that impact their mental health and limit their ability to access or even discuss the use of mental health services. These include but are not limited to gender inequities, social class, ethnicity, language differences, religious differences, and cultural expectations. Further, women's mental health concerns are impacted by structural factors that govern the education of mental health issues, and the delivery of and access to mental health services. Structural factors impact women's interactions with mental health care providers and the extent to which the services offered are gender and culturally appropriate. This stresses the importance of mental health providers being educated to recognize and be sensitive to the factors that affect women from culturally diverse backgrounds. Without a model of mental health that incorporates a gendered and multifaceted approach, including an acknowledgment of the mind-body-soul interconnection, mental health services are likely to be less effective than they could and should be for the people for whom they are most important.

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Appendix A
Questions

Interview Questions

Mentally Healthy

1. What words would you use to define mentally healthy

2. What does being mentally healthy mean to you?

3. Do you know someone who is mentally healthy? Can you describe them?

4. Are there other ways of thinking about mental health?

5. What makes you or someone you know mentally healthy? How do they act?

6.   How would you describe someone who is mentally healthy?

7. What is it that they/you do that makes them/you mentally healthy?

8. Have you ever experienced mental health, what was that like?

Mentally Unhealthy

1. What words would you use to define mentally unhealthy

2. What does being mentally unhealthy mean to you?

3. Do you know someone who is mentally unhealthy? Can you describe them?

4. Are there other ways of thinking about being mentally unhealthy?

5. What makes you or someone you know mentally unhealthy? How do they act?

6.   How would you describe someone who is mentally unhealthy?

7. What is it that they/you do that makes them/you mentally unhealthy?

8. Have you ever experienced being mentally unhealthy, what was that like?

Mental Health and Canadian Mental Health Association

1. Here are some words and pictures that are used to describe mental health, what do they mean to you?

Access of Mental Health Services

1. Have you or anyone you know accessed mental health services? If so, what was that experience like?

2. Has anyone ever shared a story of their experience accessing mental health services/resources with you? What was their experience like?

3. Have you or anyone you know accessed mental health services? If so what services did they/you access?

    a. How did you or your friend access these services?

    b. How were you or your friend made aware of these services

    c. If you had questions or concerns about mental health issues where would you go?

    d. What are the different ways you or people you know might do to handle mental health problems?

        i. Would they speak to family, relatives, or friends?

        ii. Would they seek a South Asian healer?

        iii. Would they speak with a religious leader or go to a place of worship?

        iv. Would they visit a Western doctor or mental health centre?

4. What was your or your friend's experience like when you/they accessed mental health services

    a. Did the services you or your friend accessed meet or fail to meet your needs?

      b. If accesses failed your/their needs, what could have made your or your

      friends experience more positive

Utilization of Mental Health Services?

1. If you or a friend has ever utilized mental health services, whom did you/your

   friend see?

      a. What information/service were they provided with?

      b. How did they get the care?

      c. How often would they utilize this service?

      d. What was your/their experience like?

2. What made you or your friend decide to utilize mental health resources?

3. What were your or your friends experience like when you/they utilized mental

   health services?

4. Was there a particular type of mental health services you were hoping to utlize?

5. Are you aware of the different types of mental health recourses that are available

   to you?

Demographic Questions

1. What year were you born? _____

2. Where were you born? _____

3. What age were you when you immigrated to Canada? _____

4. What is the highest level of education you have completed? _____

    ☐ No Schooling
    ☐ Some elementary school
    ☐ Elementary school
    ☐ Some high school
    ☐ High school graduate
    ☐ Some college
    ☐ Trade/technical/vocational training
    ☐ College graduate
    ☐ Some postgraduate work
    ☐ Post graduate degree

5. What is your employment status?

    ☐ Employed part time
    ☐ Employed full time
    ☐ Self-employed
    ☐ Out of work and looking for work
    ☐ Out of work but not currently looking for work
    ☐ A homemaker
    ☐ A student
    ☐ Retired
    ☐ Unable to work

6. What is your total household income, including all earners in your household?

    ☐ Less than $10,000
    ☐ $10,000 to $19,999
    ☐ $20,000 to $29,999
    ☐ $30,000 to $39,999
    ☐ $40,000 to $49,999
    ☐ $50,000 to $59,999
    ☐ $60,000 to $69,999

☐ $70,000 to $79,999
☐ $80,000 to $89,999
☐ $90,000 to $99,999
☐ $100,000 to $149,999
☐ $150,000 or more

- What is your current marital status?

  ☐ Married
  ☐ Divorced
  ☐ Widowed
  ☐ Separated
  ☐ Never been married
  ☐ A member of an unmarried couple

- What is your religious affiliation? _____