HELPING RELATIONSHIPS IN
PORTUGUESE CANADIAN COMMUNITIES

by

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Abstract

A qualitative study using ethnographic methods was conducted within the Portuguese Canadian community to describe how individuals engage in helping relationships related to personal or emotional problems. Using Spradley’s (1979) Developmental Research Sequence (DRS), participant observation, informal group interviews, and formal individual interviews were conducted with Portuguese community members and helpers. Ten informants of Portuguese descent were interviewed. Research codes and domain structures were subjected to participant checks, peer review, and expert review in order to establish the credibility and trustworthiness of this study.

Ten domains were described as follows: Reliance on Family; Focus on Physical Ailments; Using Substances and Gambling to Cope with Problems; Accessing the Portuguese Community to Prevent or Cope with Problems; Receiving Help from the Church; Using Forms of Traditional Healing; Accessing Help through Family Physicians; Help Outside the Community; Reasons for Seeking Professional Help; and Barriers to Seeking Help. Cultural themes that arose from the domains were Cultural Rules for Disclosure in Different Contexts, Role Clarity, and Fatalism.

This study contributes to counselling psychology research in the following ways: 1) by providing a thick description of helping relationships in the Portuguese community, a topic that has not previously been present in the counselling psychology literature; 2) by presenting barriers to counselling and reasons for seeking counselling that are specific to this population; and 3) by describing aspects of the therapeutic relationship which are culturally relevant to this group. These descriptions provide an easily accessible resource enabling mental health care providers to interact with Portuguese immigrants in a culturally safer and
more competent manner. This study with a difficult-to-reach population serves as an example of learning to improve or modify mental health services to meet specific cultural contexts.
Preface

This dissertation is an original intellectual product of the author, Marie Morrison. The fieldwork reported herein was approved by the University of British Columbia Behavioural Research Ethics Board under UBC BREB number H02-80778.
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List of Abbreviations

2SLS  Two-Stage Least Squares

DRS  Developmental Research Sequence

MCC  Multicultural Counselling Competency

OLS  Ordinary Least Squares

WAI  Working Alliance Inventory
Acknowledgements

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Dedication

To my mother, for leading the way.
Chapter 1: Introduction

Overview of the Dissertation

Chapter 1, the Introduction, contains a definition of the construct of culture, and the purpose of this study. The rationale for this research is also explained in the context of current trends in research and practice in counselling psychology, and the research question is provided. Chapter 2 continues with an in depth review of the literature concerning multicultural counselling psychology, contributions to the field from cultural psychology and medical anthropology, the role of the therapeutic alliance and multicultural counselling competencies in effective mental health care, and the mental health of Portuguese Immigrants in Canada. The research question that arises out of this exploration is restated.

Chapter 3 is a description of the methods including an explanation of the ethnographic methods that were applied to counselling psychology. A description of Spradley’s (1979) Developmental Research Sequence (DRS) is provided. Selection criteria and recruitment of participants is described, as well as the interview processes and protocols. Steps to achieve credibility and trustworthiness are also covered. In the Findings chapter, Chapter 4, in depth descriptions of domains are presented that emerged from the data using Spradley’s DRS. In Chapter 5, the Discussion, findings are highlighted in the context of existing research, novel contributions to the literature are stated, and also the limitations of the study and implications for future research and professional practice are discussed.

Definition of Terms

Culture.

There is an ongoing debate in the counselling psychology literature as to how specific or general definitions of culture should be. Current definitions of culture range from very
broad to very narrow. For example, Arthur and Collins (2010) embrace an inclusive definition of multiculturalism that includes age, race, ethnicity, gender, sexual orientation, socio-economic class (SES), religion, and spirituality. As a result, nearly all encounters in therapy are multicultural. This follows the lead of other multicultural experts including Ancis and Rasheed Ali (2005) and La Roche and Maxie (2003). However, other leading figures in the field of multicultural counselling have argued that an inclusive definition obscures the profound dimension of race (Helms & Richardson, 1997). D. W. Sue (2001) stated that while other variables must be considered, race is a less comfortable topic to explore compared to other differences, such as socioeconomic status, gender, and religious orientation. To consider all together leads to the overlooking of racial prejudice and oppression. He advocated for a focus in psychology on the group level rather than just the individual or the universal levels. I argue that a very broad definition of culture also makes research much more complicated, as it becomes more difficult to operationalize what is being studied in research on culture and counselling psychology, and to study how different variables impact the counselling process.

In the multicultural counselling literature, Pedersen (1991) defined culture as learned perspectives that are unique to a particular group, leading to shared universals within that group. He delineated groups according to system variables including nationality, ethnicity, religion, and language (1997). This is the definition of culture that has been used in prior ethnographic research with the Portuguese (Bezanson, 2008). Such a definition also enables the within-study exploration of individuals who differ in culture as defined in the broad sense, in that individuals from different ages, socioeconomic strata, gender, and sexual
orientation can be included together with consideration but not separation of these differences.

Gerstein, Rountree, and Orrdonez (2007) have lamented the infrequency with which the field of counselling psychology has referenced anthropology for definitions of culture, given that the study of culture is the main focus of anthropology, a field that has been in existence far longer than counselling psychology. Gerstein et al. posited that the philosophical tenets of anthropology are at odds with counselling psychology, thus the difficulty in integrating definitions. He stated that anthropology perceives culture through a societal or systemic frame whereas counselling psychology perceives culture from the individual’s perspective, isolated from the social context.

A key author in the field of anthropology, Geertz (1973), defined culture as a transmitted pattern of meanings embodied in symbols. According to Geertz, cultures are “webs of significance” that permeate our social functioning and give meaning and coherence to our daily lives. He stated that culture permeates human existence so thoroughly that the attempt to separate individuals and culture is incoherent and distorts our understanding of human nature, a system of inherited conceptions. This definition means that culture shapes all parts of life. The medical anthropologist Arthur Kleinman (2004), who investigated culture-bound syndromes in China and developed the sociosomatic framework, wrote further about the meaning of culture:

But culture is not a thing; it is a process by which ordinary activities acquire emotional and moral meaning for participants. Cultural processes include the embodiment of meaning in habitus and physiological reactions, the understanding of what is at stake in particular situations, the development of interpersonal connections, religious practices, and the cultivation of collective and individual identity. Culture is inextricably caught up with economic, political, psychological, and biologic conditions. Treating culture as a fixed variable seriously impedes our ability to understand and respond to disease states such as depression. (p. 952)
For the purpose of this study, culture in the Portuguese Canadian context will be defined primarily as ethnicity, but also as a process in which gender, socioeconomic status (SES), and immigration status or generation play an important part.

Purpose of the Study

The overarching purpose of this research was to make a contribution to the literature on culture research in the field of counselling psychology. This study provides a resource for counselling psychologists who are engaged in practice or teaching with a focus on increasing cultural competency with Portuguese immigrants. Specifically the purpose of the study was to obtain a thick description of helping relationships in which Portuguese Canadians engage for the purposes of receiving help for emotional or personal problems. This research topic is original and unique as this is the first study on helping relationships among Portuguese Canadians. While culture-bound syndromes have been well-studied within this group, as well as acculturation and family dynamics, we did not know how Portuguese Canadians conceptualize helping relationships and how these relationships function. In this study, ethnographic methods were used that included individual interviews, fieldwork, and participant observation with Portuguese community members, leaders, and healers, in order to investigate healing and helping relationships in the Canadian context.

Rationale for the Study

Immigrants comprise 19.8% of Canada’s population. Approximately a quarter of a million people immigrate to Canada each year (Statistics Canada, 2008). While research on culturally competent mental health care is growing, it lags behind the needs of our increasingly multicultural population. To practice ethically, professionals in the mental health field should be aware of the cultural diversity of their clientele, and particularly of the
challenges that come with intercultural communication in the helping relationship (Ishiyama & Arvay, 2003). This study is an investigation of the helping relationships that exist within a hard to reach population in Canada: Portuguese immigrants. Portuguese Canadians form a substantially sized immigrant group in Canada. Members of this group are reluctant to seek help outside of the family, and therefore their mental health needs often go unmet (Morrison & James, 2009). When help is sought, providers' lack of cultural competence often results in misdiagnosis, non-compliance and ultimately ineffective treatment (James, Navara, Lomotey, & Clarke, 2006).

This ethnic group has a unique mental health profile which includes syndromes not found in any other culture and not described by North American psychiatric diagnostic criteria. Agonias (translated, the agonies) is a culture specific somatic phenomenon within the Portuguese community that has been systematically investigated over the past several years by the University of British Columbia Culture, Spirituality, and Mental Health laboratory under the supervision of Dr. Susan James (2002; James, Navara, Clarke, & Lomotey, 2005; James et al., 2006; James, Slocum, & Zumbo, 2004). The symptoms are broad and idiosyncratic, ranging from lack of air, burning from within, and loss of sight, to troubles sleeping (James, 2002). Agonias does not map well onto disorder nosology described by the DSM-V (American Psychiatric Association, 2013), although it is frequently misdiagnosed as anxiety and depression by mental health care providers in Canada, even those who are Portuguese themselves. Meanwhile, Portuguese community members rarely equate agonias with anxiety and never equate it with depression (James et al., 2006). Practitioners have reported that agonias is the most difficult form of distress to treat in this population (James et al., 2006).
This research investigated helping relationships in which Portuguese Canadians engage. An in depth account of how helping relationships take place will serve as a valuable resource for mental health care providers to interact with Portuguese immigrants in a culturally safe and competent manner. The results of this study have the potential to provide more in depth knowledge for treating culture-specific idioms of distress, and to generally improve therapeutic outcomes with this group and access to care.

**Research question.**

The question addressed by this study is, *What are the helping relationships for personal and emotional problems in the Portuguese Canadian community?*
Chapter 2: Literature Review

This literature review is a survey of recent research that addresses the amelioration of cross-cultural mental health service delivery. First is an overview of research on immigrant mental health and help-seeking, including current models and findings in multicultural and immigrant contexts. Next is a review of the current status of multicultural competency research in counselling psychology, given that this is the most active area of research within multicultural counselling. A key contributor to therapy success, the therapeutic alliance, is examined, with a comprehensive review of the literature regarding how it is measured and researched in cross-cultural contexts. Finally, research conducted to date with immigrant populations and specifically with Portuguese immigrants and Portuguese culture-bound syndromes is presented. This examination of the literature is done in light of contributions from the perspectives of medical anthropology and cultural psychology.

Causes and Correlates of Immigrant Mental Health

This section provides a comprehensive review of research conducted investigating moderators, mediators, and causes of immigrant mental health.

Mental health trends of immigrants.

Well-documented in the literature (Alegría, Canino, et al., 2008) is the healthy immigrant paradox, a term describing a repeated finding in the literature that immigrants to North America have lower incidences of mental and physical illness than those born in North America; this finding is strong also when looking at only Canada (Ali, 2002). The trend is strongest for those who immigrate as adults, declines over time to approximate host country levels (McDonald & Kennedy, 2004), and dissipates with subsequent generations of immigrants in the new country (e.g., second generation immigrants). While little understood,
the theory is that the country of origin provides a protective context. Akhtar-Danesh and Landeen (2007) documented lower rates of both lifetime prevalence and recent depression for immigrants than those born in Canada; for detailed information on the results of this study, see Table 1. The hypothesis that these trends are due to underreporting of mental illness by immigrants has been disproven (Breslau, Javars, Blacker, Murphy, & Normand, 2008).

Table 1. Immigrant versus Non-immigrant Rates of Depression (Akhtar-Danesh & Landeen, 2007)

<table>
<thead>
<tr>
<th></th>
<th>Immigrants</th>
<th>Non-Immigrants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Lifetime Prevalence of Depression</td>
<td>6.5%</td>
<td>9.1%</td>
</tr>
<tr>
<td>12-Month Report of Depression</td>
<td>3.2%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Means</td>
<td>4.0% (CI = 3.0–5.0)</td>
<td>5.4% (CI = 4.5–5.7)</td>
</tr>
</tbody>
</table>

Even controlling for sociodemographic factors, immigrants have lower rates of depression. Akhtar-Danesh and Landeen (2007) conducted a logistic regression analysis for lifetime and 12-month depression on multiple sociodemographic factors, reporting 12 coefficients for each of two regressions (one for each type of depression). For lifetime depression, the coefficient on immigrant status was –0.52, SE = 0.14, p =.0001, with an odds ratio of 0.60 (CI = 0.46–0.78). For 12-month depression, the coefficient on immigrant status was –0.19, SE = 0.19, p = 0.3266, with an odds ratio of 0.83 (CI = 0.57–1.20). While depression rates were lower for the immigrant group than for Canadian-born individuals, depression was still shown to be a health concern for immigrants.
Mossakowski (2007) compared Filipino American immigrants with Filipino Americans born in the United States (US), using data from the Filipino American Community Epidemiological Study (FACES) that was conducted during 1998 and 1999 in San Francisco and Honolulu. The sampling of 2,129 Filipino Americans was random and interviews were conducted in the language of the respondent’s choice. The researcher’s dependent variable was the depressive symptoms scale from the Symptom Checklist-90-Revised (Derogatis & Unger, 2010). Independent variables were immigration status (yes/no), gender, age, marital status, income, education, employment status, and state of residence. Mossakowski found that Filipino American immigrants had significantly fewer symptoms of depression ($b = - .144, SE = .028$) than Filipino Americans born in the US. Twenty-two percent of this coefficient is explained by gender, age, marital status, socioeconomic status, and place of residence ($b = -.113, SE = .038$), with an increased adjusted $R$ squared (.012 to .158).

Employment status was the most significant dimension of socioeconomic status that mediated the mental health benefit status of immigration status; Filipino immigrants were more likely to be employed than Filipinos born in the US. Pernice and Brook (1996) also found employment status to be a powerful moderator of mental health for immigrants and refugees. Mossakowski then included individualism, collectivism, ethnic identity, and perceived racial/ethnic discrimination which further decreased beta to $-.100$, and increased adjusted $R$ squared to .184; degree of ethnic identity was associated with lower rates of depression, and perceived discrimination with higher rates. Individualism and collectivism interacted with place of residence to significantly influence depression.

Mossakowski (2007) also conducted the same analysis on immigrants only. The author successfully accounted for the variation in immigrant status (immigrant versus non-
immigrant) not associated with mental health status by evaluating the effect of age at immigration. The author found that immigration during childhood predicted higher levels of depression than immigration during adulthood, independent of subsequent years spent in host country. The author argued that age at immigration allows for the study of selective migration because adults select to migrate whereas children do not. Once again SES reduced the coefficient on childhood immigrant from .212 (.040) to .117 (.039) although interestingly the coefficient on employment is negative (−.099) and highly statistically significant. Inclusion of individualism and collectivism reduced the coefficient on childhood immigrant further to .091 (.039) although none of these are statistically significant aside from racism (.170, SE = .030).

These findings are comparable to prevalence rates of mental illness for Latinos in the US. Alegria, Sribney, Woo, Torres, and Guarnaccia (2007) found that those who immigrated are less mentally healthy than those who did not immigrate, and are comparable to US born Latinos. Also, the longer Latinos spent in their country of origin, the less likely they were to develop mental illnesses. Orozco, Borges, Medina-Mora, Aguilar-Gaxiola, and Breslau (2013) similarly found that the 12-month prevalence of any mental disorder was more than twice as high among third and higher-generation Mexican-Americans than among Mexican nationals with no migrant family members. To the contrary, but for an older sample, Wu, Chi, Plassman, and Guo (2010) found Chinese immigrant elders to have significantly lower rates of depression than their counterparts in Shanghai, China.

In conclusion, there are mixed findings regarding the mental health of those who immigrate compared to those who remain in their countries of origin; those who immigrate as adults have better mental health than those who immigrate as children; and an increased
length of time in North America as an immigrant is associated with a decrease in mental health.

Breslau et al. (2007) investigated the effects of immigration on mental health and vice-versa: the effects of mental health on immigration. They compared relative differences in immigration rates between those with anxiety and mood disorders and those without, compared the mental health of immigrants to non-immigrants \((n = 75, \text{ in Mexico})\), and also asked for retrospective mental health history. The analysis was conducted using “discrete time-survival” with person-year as the unit of analysis, mental disorders as time-varying predictors, and immigration as the dependent variable. The reverse was then done (immigration as time-varying predictor and mental disorders as the dependent variable).

Breslau and colleagues found that pre-existing anxiety disorders predicted immigration \((OR = 3.0; 95\% CI = 1.2–7.4)\), and immigration predicted the later onset of anxiety \((OR = 1.9; 95\% CI = 0.9–3.9)\), mood disorders \((OR = 2.3; 95\% CI = 1.3–4.0)\) and the persistence of anxiety disorders \((OR = 3.7 95\% CI = 1.2–11.2)\). These findings disprove the selective migration or healthy immigrant hypotheses, namely that mentally healthy people immigrate. Findings support the hypothesis that the stress of immigration and living in a foreign country contributes to poor mental health.

**Age at immigration and mental health.**

Findings on the mental health status of immigrants vary depending on the age at immigration. Takeuchi, Hong, Gile, and Alegria (2007) found that when immigration occurs at an earlier age, adult risk for psychiatric disorders goes up among Asian Americans. Immigration during childhood and adolescence coincides with the risk period for the onset of affective and anxiety disorders. In this study, adult US-born and immigrant Asian Americans
who arrived earlier in life were more likely to have both lifetime and 12-month mental disorders compared with immigrants who arrived later in life.

Leu et al. (2008) investigated how age at immigration influenced the association between adult subjective social status (a subjective measure of SES) and mental health. They used age at immigration as a proxy for the “developmental context” of immigration, that is, the cultural and socioeconomic challenges that accompany immigration. The authors hypothesized that immigration at an early age causes disruptions that adversely affect social development in youth but not as an adult; these disruptions have such a great impact, through cultural and social challenges and lower SES during childhood, that mental health would not be moderated by adult measures of SES, as it would for those who immigrated as adults. The authors set the cut-off to 25 years based on theory that social and cognitive development reaches maturation at roughly the age of 25 years. This is a psychosocial marker between immigrants’ formative years (childhood adolescence, and early adulthood) versus later-adult years. They divided their sample into those who immigrated before age 25 and at or after age 25. The authors used Asian American data (N = 1451) from the National Latino and Asian American Survey.

Mood dysfunction for the total sample was 11% in the last 12 months. Of those who immigrated before age 25, 13% had experienced mood dysfunction in the past 12 months; of those who immigrated at or after age 25, nine percent had experienced mood dysfunction in the past 12 months. T-tests on mood dysfunction and social status between the two groups (immigrating before/after age 25) yielded significant results. Subjective social status was found to moderate mood dysfunction for those who immigrated as adults, but not for those who immigrated as children.
A shortcoming of this study is that age at immigration was not a continuous variable in either the models or in determining the cutoff. Also, the support for a causal relationship between age at immigration and social status and mood dysfunction was very weak. The relative influences of current age, age at immigration, and time in host country and their impact on mental health are unclear.

**Acculturation and mental health.**

It is important to consider research on acculturation theories and their impact on immigrant mental health (Berry, 2001), given that improving immigrant mental health is the ultimate goal of this study. Acculturation has evolved from a uni-dimensional concept of assimilation to a more complex concept of biculturalism or cultural identity involving multiple factors (Berry, 2003). Berry (2001) has developed a prominent two-level model that addresses acculturation at the level of the individual and the group. His definition of acculturation according to this model is: “Acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous, first-hand contact, with subsequent changes in the original culture patterns of either or both groups” (p. 149). Berry’s (2001; 2003) work has generally identified integration (biculturalism) as the most helpful attitude towards acculturation. Note that Berry’s definition attends not only to the levels of host culture acquired but also to the levels of culture of origin retained. Berry also highlighted Canada’s multicultural policy and its impact on acculturation. Berry, Kim, Power, Young, and Bujaki (1989) conducted a study developing an acculturation assessment tool using French-Canadian, Hungarian, Portuguese, and Korean Canadian participants. They found that for their Portuguese-Canadian sample socioeconomic status and formal schooling were uniformly low. In their sample, most of the parents (60 of
preferred to be interviewed in Portuguese, and all 55 children (aged 13–25 years) preferred to be interviewed in English. For the parents, age and length of time spent in Canada were positively correlated with assimilation attitudes, and for the children, length of time spent in Canada was negatively correlated with integration and marginalization attitudes. With Portuguese Canadians, integration was strongly preferred as an acculturation approach, and assimilation, marginalization, and separation were “clearly unacceptable” (p. 198). This manifests as “integration or nothing.” At the time of this study, Berry et al. were not able to find anything in the data or other sources to explain for this extreme distribution that differed from the other groups they studied.

Using Berry’s acculturation model, Obasi and Leong (2009) found that those with an integrationist acculturative strategy endorsed a greater level of psychological distress compared to those who had a traditionalist acculturative strategy ($p = .003$). The integrationist strategy describes the integration of cultural beliefs and practices from different ethnocultural groups. The traditionalist strategy describes the preference towards maintaining one’s heritage ethnocultural group with minimal interest in and participation in the society of a different cultural group.

Shim and Schwartz’ (2008) study on Korean immigrants used multiple regression analysis to determine the relationship between acculturation, adherence to Korean values, and mental health, and found that together with increased years of living and education in the US, less acculturation and greater adherence to Korean values were predictive of poorer mental health. This is a contradictory finding to the Obasi and Leong (2009) study above, assuming that less acculturation and greater adherence to Korean values is comparable to a traditionalist acculturation strategy. Shim and Schwartz also observed that fewer years of
education together with fewer years living in the host country are significantly associated with lower levels of acculturation to the host culture.

**Language and mental health.**

Bleakley and Chin (2008) found that age nine was the approximate cut-off for the critical language acquisition period, such that immigrant parents who arrived in the US before age nine attained language skills similar to US-born individuals. Bleakley and Chin also found through regression analysis that the better the parents’ English, the more likely the children were to speak English well and have attended preschool, and the less likely they were to have failed a grade or dropped out of high school.

Takeuchi, Zane, et al. (2007) used the National Latino and Asian American Study to describe the lifetime and 12-month prevalence rates of mood, anxiety, and substance abuse disorders among Asian Americans. They found that results varied strongly by gender. Women showed a strong relationship between nativity and lifetime prevalence of mental health disorders, such that immigrant women were healthier than US-born women. Men showed a relationship between English language proficiency and mental health, such that higher English proficiency was related with better lifetime and 12-month reports of mental disorders.

Brown, Schale, and Nilsson (2010) found similarly with Vietnamese immigrant and refugee women (N = 83) that greater English language proficiency and younger age at arrival both were correlated with better mental health. They concluded that women’s ability to speak English was important to their mental health regardless of age of migration. To summarize, the degree of proficiency of host culture language appears to be related to several protective factors such as school success, and to mental health.
Overall, factors that influence the mental health of immigrants include employment status, socioeconomic status, age at immigration (those who immigrate as children fare worse), time spent in the new country (mental health decreases towards native levels), language (greater host language proficiency is correlated with better mental health), and level of acculturation (mixed findings).

**Models of Seeking Mental Health Services**

Mental-health help-seeking is influenced by a number of factors. In general, mediating and moderating variables involved in help-seeking include the qualities of the helper (Yagil & Israelashvili, 2003), social status (Lee, 2002), gender (Clement et al., 2015), age (Clement et al.), outcome expectation (Vogel & Wei, 2005), and stigma (Clement et al.). Trends with respect to age and gender have been confirmed in the Canadian context in addition to number of mental disorders, marital status, geographical location, and education level (Park & Nelson, 2006). Israelashvili and Ishiyama (2008) found that while help-seeking brings up more negative emotions than positive emotions, it is the positive emotions that are significantly correlated with a readiness to seek help, while negative emotions are not significantly correlated. Negative views of help-seeking include perceptions that to seek help indicates a weakness of character, and a sign of incompetence, dependence, and inferior status (Lin, 2002; Sheffield, Fiorenza, & Sofronoff, 2004).

The concept of acceptability has been found to form the most significant factor in unmet mental health care needs in Ontario, Canada (the other two being accessibility and availability). Therefore, the gap in mental health care cannot be bridged solely by increasing services. Peoples’ beliefs about mental health and mental health care must be addressed (Nelson & Park, 2006).
There are numerous models of seeking help for mental health problems. Four of the most significant models in the literature are summarized by Maddocks (2009) and are as follows: Kadushin (1969/2006), Saunders (1993), Howard et al. (1996), and Saunders and Bowersox (2007). These are all discussed below according to their emphasis.

Kadushin (1969/2006) provided the first in depth examination of the reasons and ways that people seek psychiatric help. Using survey responses from 1,500 patients in ten psychiatric clinics in New York City, Kadushin created a four-step model, beginning with the recognition of the problem, and ending with the determination of the specific professional or office to contact. The steps are as follows:


<table>
<thead>
<tr>
<th>Steps</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Realization of an emotional problem</td>
</tr>
<tr>
<td>2.</td>
<td>Consulting one’s social support network (receiving “free” advice, being affecting by friends’ opinions of psychiatrists)</td>
</tr>
<tr>
<td>3.</td>
<td>Selecting a type of helping profession (gathering information, evaluating prior experiences, weighing images of the profession, and accounting for financial coverage of different types of services)</td>
</tr>
<tr>
<td>4.</td>
<td>Choosing an individual practitioner or clinic (based on knowledge, expectation and evaluation regarding cost and quality of a particular clinic, and personal influence to go to a clinic)</td>
</tr>
</tbody>
</table>

The entire process is described as a learning process through which the individual is changed, with the process itself being therapeutic, the work of therapy beginning before therapy itself begins.

The help-seeking process for accessing mental health services is described by Howard et al. (1996, p. 698) as including the following steps: (1) recognizing there is a problem; (2) deciding external help is necessary; and (3) contacting the service sector. These
authors describe two overlapping routes to treatment, one being the individual’s initiation of the help-seeking process, the other being the institutional initiation of the help or treatment-seeking process (see Table 3). These two routes converge at stage three of the pathway, when the individual becomes in contact with the mental health specialist. Note that the last two stages continue beyond initial help-seeking to evaluation of treatment effects (Stage 5) and resultant outcomes (Stage 6). Howard et al. clarifies that the activation of the person’s social network (Stage 2) may help or hinder making contact with mental health professionals. The social network may also be a sufficient source of help in itself.

Table 3. Modified Generic Clinical Pathway for all Mental Health Services (Howard et al., 1996, p.699)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Route One (Personal)</th>
<th>Route Two (Institutional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Individual recognizes distress</td>
<td>Institution recognizes distress</td>
</tr>
<tr>
<td>2</td>
<td>Individual activates social network</td>
<td>Institution activates institutional network</td>
</tr>
<tr>
<td>3</td>
<td>Individual or institution makes contact with the service sector</td>
<td>Individual or institution makes contact with the service sector</td>
</tr>
<tr>
<td>4</td>
<td>Treatment is initiated</td>
<td>Treatment is initiated</td>
</tr>
<tr>
<td>5</td>
<td>Treatment is evaluated</td>
<td>Treatment is evaluated</td>
</tr>
<tr>
<td>6</td>
<td>Improvement occurs</td>
<td>Improvement occurs</td>
</tr>
</tbody>
</table>

In Howards and colleagues’ summary of the research in the area, they concluded that most individuals access mental health services through a general practitioner. The authors commented that low socioeconomic status and low education contribute to less willingness to seek mental health services. They concluded that “person-centered barriers play a major role in perpetuating the gap between service need and utilization” (p. 699). This supports the call for research at the community and individual level to better understand what are the pre-
existing forms of help-seeking for emotional and personal distress, and what are the person-centered barriers.

Saunders delineated two models for mental health help-seeking. The first, developed in 1993, is the “process of seeking psychotherapy.” The latter, developed in 2007 by Saunders and Bowersox, is a more elaborate “steps in seeking help for a mental health problem.” Both are described below.

Saunders’ (1993) Model of the Process of Seeking Psychotherapy entails four consecutive stages. Through questionnaire research, Saunders found that the first stage, realizing there is a problem, is the major barrier in getting help. This is the most challenging and time-consuming stage in the process. Nearly all participants in Saunders’ research (N = 275) accessed other means of coping with their problems, such as trying to solve the problem alone or accessing their social network for informal help, before making the decision to attempt therapy (Stage 2). Interestingly, Kadushin and Howard and colleagues gave the social network approach more validity as a problem-solving technique by including it as a stage in their models, unlike Saunders, who perceived it as a barrier to accessing professional help. Instead, Saunders found that the level of social support was negatively correlated with stage 2, deciding that therapy would be an appropriate way to solve the problem. Once a problem was identified (Stage 1), the process moved more quickly, and particularly once therapy was determined to be an appropriate way to address the problem (Stage 2), the actions of seeking and making contacting with the mental health system happened rapidly.
Table 4. *Process of Seeking Psychotherapy* (Saunders, 1993, p. 556)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Realizing there is a problem</td>
</tr>
<tr>
<td>2.</td>
<td>Deciding that therapy would be an appropriate way to solve the problem</td>
</tr>
<tr>
<td>3.</td>
<td>Deciding to seek therapy</td>
</tr>
<tr>
<td>4.</td>
<td>Making contact with the mental health system</td>
</tr>
</tbody>
</table>

In 2007 Saunders and Bowersox elaborated on their original model based on combined research in the area to date and created a series of steps in seeking help for a mental health problem. They cautioned against a simplified view of help-seeking as dichotomously either seeking help or not. They pointed out that typically several years pass between symptom onset and help-seeking. These authors produced a seven-step model (see Table 5), and also provided summaries of alternative decisions and actions that could occur at each step. Finally, they provided emotions, attitudes, and environmental factors that could impact each step. For example, for the step of *problem recognition*, the alternative decisions would be denial, minimization, and lack of awareness. The factors associated with achieving this step would be insight, distress, and level of impairment.
Table 5. *Steps in Seeking Treatment for Mental Health Problems (Saunders and Bowersox, 2007, p. 102)*

<table>
<thead>
<tr>
<th>Step</th>
<th>Treatment-seeking process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Recognizing problem</td>
</tr>
<tr>
<td>Step 2</td>
<td>Deciding problem is related to mental health</td>
</tr>
<tr>
<td>Step 3</td>
<td>Deciding change is needed</td>
</tr>
<tr>
<td>Step 4</td>
<td>Attempting to effect change</td>
</tr>
<tr>
<td>Step 5</td>
<td>Deciding professional help is needed to accomplish change</td>
</tr>
<tr>
<td>Step 6</td>
<td>Deciding to seek professional help</td>
</tr>
<tr>
<td>Step 7</td>
<td>Seeking professional help (make and keep an appointment)</td>
</tr>
</tbody>
</table>

While these models are valuable for understanding the steps and factors involved in help-seeking for mental health problems in general, they do not take culture into account. As will be seen below, help-seeking in the multicultural context involves additional significant factors.

**Help-seeking in the Multicultural Context**

A significant variable that impacts the mental health of immigrants is help-seeking behaviours. Underutilization of mental health services is well-documented among immigrants (Abe-Kim et al., 2007; Alegria, Chatterji, et al., 2008; Beiser, 1988; Chen, Kazanjian, Wong, & Goldner, 2010; Globerman, 1998; Li & Browne, 2000; U.S. Department of Health and Human Services, 2001; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). While the Healthy Immigrant Effect may account for some of this disparity, there are repeated findings in the literature that, when matched for symptoms and diagnosis, immigrants still seek mental health resources less than native-born individuals (Abe-Kim et al.). For example one major study found that non-Hispanic whites were seven times more likely to access outpatient mental health services than Mexicans who spoke mostly Spanish
(Guarnaccia, Martinez, & Acosta, 2005). Sánchez et al. (2014) summarize the factors contributing to these disparities at four levels (see Table 6).

Table 6. Factors Involved in Mental Health Disparities for Ethnic Minorities (Sánchez et al., 2014)

<table>
<thead>
<tr>
<th>Level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Lack of mental health services available in the community</td>
</tr>
<tr>
<td>System</td>
<td>Lack of insurance; inability to pay</td>
</tr>
<tr>
<td>Provider</td>
<td>Lack of cultural competency</td>
</tr>
<tr>
<td>Patient</td>
<td>Mental health stigmatization</td>
</tr>
</tbody>
</table>

Sánchez et al. (2014) claimed that these research findings have not translated into real changes at the level of community mental health services.

General findings in the literature are that use of mental health services is related to many factors including: culture, economic status, acculturation, stigma, and experience of systemic and personal discrimination. These are covered in detail below. There is a great deal of racial and ethnic diversity in the Canadian population, but surprisingly few studies of mental health service use by immigrant populations. Notable exceptions are Chen et al. (2010), Li and Browne (2000), and Sadavoy, Meier, & Ong (2004).

**Help-seeking and cultural barriers.**

Kirmayer, Weinfeld, et al. (2007) in their study of pathways and barriers to mental health care in Montreal found that the rate of mental health service used by immigrants (Caribbean, n = 264, Vietnamese, n = 234, and Filipino, n = 278) was lower than that of non-immigrant populations (5.5% vs. 14.7%, for immigrants and non-immigrants, respectively). This lower rate of use was not explained by any of the following factors: sociodemographics, physical or psychological symptoms, length of stay in Canada, or use of alternate forms of
help. Since this study was conducted in Canada where there is universal health insurance, the authors suggested that the lower rate of usage was due to cultural and language barriers.

According to cultural barrier theory (Leong, Wagner, & Tata, 1995), aspects of one’s culture may predispose one not to seek mental health services. These aspects can include having alternative resources, holding traditional values, and experiencing a lack of acculturation. Ramos-Sánchez and Atkinson (2009) found that acquisition of dominant American values had no bearing on attitudes towards help-seeking for Mexican-Americans, but that the maintenance of Mexican-American values increased the likelihood of a positive attitude towards help-seeking. These findings were contrary to other research and to Cultural Barrier Theory. Chen, Kazanjian, and Wong (2009) found that cultural factors accounted for lower mental health care usage by Chinese Canadians in British Columbia, after accounting for severity of mental illness, immigration status, and language barriers. Lower mental health care usage persisted beyond the first generation of immigrants, and the authors suggested that this is because cultural values around mental illness also account for lower mental health care usage.

Researchers have hypothesized numerous other reasons for immigrants’ underutilization of mental health services. One hypothesis is that immigrants are hesitant to contact mental health professionals because of a disparity in views regarding the cause and care of mental illness (Chen et al., 2009; Edman & Kameoka, 1997; Giacco, Matanov, & Priebe, 2014; Landrine & Klonoff, 1994; Leong & Lau, 2001; Lin & Cheung, 1999; Millet, Sullivan, Schwebel, & Myers, 1996). Such an example is provided by Alvidrez (1999), who found that Latina and African American women were less likely than European American women to access mental health services, with Latina women doing so far less often than both
other groups. For all groups (N = 187), believing in a religious or supernatural cause of illness was associated with lower rates of mental health utilization. Factors that were connected with higher rates of mental health utilization were having a self-reported substance abuse problem, knowing a friend or family member who had made a mental health visit, and believing that mental health problems are caused by imbalances or lack of moderation in lifestyle or environment.

Should immigrants believe that a mental illness requires attention from the formal mental health care system, they may be still be reluctant to do so because of language barriers (Giacco et al., 2014; Selkirk, Quayle, & Rothwell, 2014) or discrimination (Spencer, Chen, Gee, Fabian, & Takeuchi, 2010; Woodward, 2011). Other researchers have reported on the negative impact of racism for those entering and receiving treatment within the mental health care system (Rastogi, Massey-Hastings, & Wieling, 2012; Spencer & Chen, 2004). Finally, the accessing of alternative remedies and modes of treatment, through religious leaders, elders, and folk healers, may reduce the need for services through formalized mental health care (Snowden, 1996). A study of Ethiopians’ help-seeking in Toronto (N = 342, Fenta, Hyman, & Noh, 2006) showed that Ethiopian immigrants were more likely to see family physicians than mental health care specialists for mental health problems, and were also more likely to see traditional healers than either of the above.

**Help-seeking and economic status.**

In the US, economic status has been reported to be a major barrier to mental health services (Guarnaccia et al., 2005; Alegria et al., 2002; Becker & Newsom, 2003). Except for health care services such as eye care, dentistry, and prescription drugs, this is less of an issue in Canada because Canada's health care system provides universal medical coverage to all its
citizens under the terms of the Canadian Health Act (Canada House of Commons, 1985; Globerman, 1998). However, immigrants to Canada have other hurdles to overcome in accessing the health care system, such as understanding their rights to service, the role of practitioners, scheduling appointments, and meeting service provider expectations. This understanding can be complicated by lack of English or French language fluency (Bowen, 2001; Ginieniewicz & McKenzie, 2014). Various institutions have arisen to help bridge the gap between new immigrants and the health care system including settlement agencies, community organizations, and family members, but since they are eclectic and unstandardized, the quality and comprehensiveness of coverage is variable (Bowen).

Insurance rates and socioeconomic status have significant effects on help-seeking trends for ethnic minorities (Guarnaccia et al., 2005; Vega, Kolody, & Aguilar-Gaxiola, 2001; Vega & Lopez, 2001). However, even in insured, non-poor populations, ethnic minorities use outpatient mental health services less than majority groups (Padgett, Patrick, Burns, & Schlesinger, 1994). Therefore researchers in this field have looked for other reasons for the help-seeking discrepancies.

**Help-seeking and acculturation.**

Mental health treatment seeking has also been connected to acculturation. Sánchez et al. (2014) reported increased treatment seeking for Brazilian immigrants who were ranked as “more” acculturated. Other researchers have found the same trend (Guarnaccia et al., 2005). Vega et al. (2001) found that US born Mexican Americans used mental health services far more than their immigrant counterparts. Sánchez et al. suggested that greater acculturation leads to higher rates of help-seeking through its correlation (as documented by Vega and
Lopez, 2001) with higher health insurance, higher education levels, and higher English language competence.

**Help-seeking and stigma.**

Personal and family stigma regarding mental illness can also discourage immigrants from accessing mental health services, with either mental illness itself being stigmatizing, treatment being stigmatizing, or both (Alvidrez, Snowden, & Patel, 2010; Giacco et al., 2014; Sadavoy et al., 2004; Thornicroft, 2008). As stated by Sánchez et al. (2014, p. 18), “Stigma is a formidable barrier that stops much needed care from being accessed, and is associated with willingness of an individual to seek and use counseling services.” A systematic review of qualitative and quantitative studies (144 studies in total) concluded that ethnic minorities are disproportionately deterred from seeking mental health treatment by stigma (Clement et al., 2015). One example is a study by Nadeem et al. (2007) who examined the data regarding 15,383 low-income women screened for depression in county entitlement services. They found that stigma was a more powerful moderator of desire for mental health treatment for immigrant women than for US-born white women. Nguyen (2015) found that psychoeducation was effective at reducing stigma regarding seeking help among Vietnamese refugees.

For some immigrant groups, accessing other health specialists seems to be easier; often immigrants are more likely to access general practitioners or family physicians for mental health problems than mental health specialists (Fenta et al., 2006; Vega et al., 1999). Other findings, however, have been that an increased rate of medical consultations was correlated with increased mental health care usage by immigrants, for instance, Chinese immigrants in British Columbia (Chen et al., 2009).
Limitations of current literature on help-seeking in the multicultural context.

In conclusion, help-seeking disparities for immigrants can be attributed to dysfunction at the multiple levels of community, system, provider, and the individual. More specifically, barriers include cultural differences, economic status and insurance, acculturation level, and experiences of stigma, discrimination, and racism in the health care system. While much research has been conducted on help-seeking in the multicultural context, the vast majority has been quantitative, involving a limited number of well-defined variables. Limitations of the research in this area include a dearth of qualitative research; a lack of applicability to the Canadian context, particularly given the differences in mental health care, immigration policies, and multiculturalism, between Canada and the United States; and a lack of research on culture-specific barriers to help-seeking.

Multicultural Counselling Psychology

There is conflicting evidence indicating that ethnic minority clients have better therapy outcomes (i.e., longer therapy duration) when matched with therapists of the same ethnicity; while previous research claimed a clear relationship (S. Sue, 2006; S. Sue & Lam, 2002), a more recent meta-analysis has revealed overall no improvement on therapy outcome with ethnic matching, but high variability dependent on ethnic group (Cabral & Smith, 2011).

The field of psychology is responding to the needs of ethnic minorities who come into contact with the mental health system with a call to cultural competency (D. W. Sue, Carter, et al., 1998). The area of multicultural counselling competencies (MCCs) includes three major domains: theoretical frameworks, instruments/measures, and core critiques. Theory and research in MCCs has mostly developed in the US with some work occurring in Canada (Collins & Arthur, 2010a). Its development has occurred over the past 25 years, strongly
guided by Derald Wing Sue and Stanley Sue (D. W. Sue et al., 1982; S. Sue, 2006). This field burgeoned with a key position paper on cross-cultural counselling competencies written by Sue and colleagues in 1982 (D. W. Sue et al., 1982). More recently, research on cultural competency in counselling psychology has vastly proliferated (S. Sue, Zane, Hall, & Berger, 2009).

The first tripartite model of multicultural counselling competency (D. W. Sue et al., 1982) was composed of (1) beliefs/attitudes: awareness of one’s own and the client’s beliefs and attitudes and comfort with differences in beliefs and attitudes (2) knowledge of the socio-political context, client’s culture, institutional barriers, and of counselling; and (3) skills in verbal and non-verbal responses and interventions. D. W. Sue’s recommendations spawned a great deal of research, theory development (D. W. Sue, Ivey, & Pedersen, 1996), and eventual adoption of guidelines for multicultural practice by the American Psychological Association (2003). The Canadian Psychological Association also has guidelines for non-discriminatory practice (2001) which reference “specific knowledge, skills, and attitudes” (p. 3) as necessary for competent practice. However, the current status of the field is such that hypotheses are being developed far more rapidly than research is being done to substantiate these hypotheses and turn them into theories. A review of the literature yields a plethora of multi-stage, multi-dimensional models of multicultural competency that contain many overlapping constructs and are highly similar to one another.

Constantine and Ladany (2001) developed an updated model of multicultural counselling competence with a greater emphasis on attention to helping processes believed to be common across cultures (which is otherwise defined as etic) as a response to a call for a common factors approach bridging emic and etic viewpoints (Fischer, Jome, & Atkinson,
Emic in this context refers to culture-specific. There is a potentially problematic leap of logic here where common factors that by definition are etic across counselling theories are also assumed to be etic across cultures without research support. Constantine and Ladany’s model is composed of six dimensions: (1) counsellor self-awareness of attitudes, beliefs, and values; (2) general knowledge about multicultural issues through education, personal, and professional experiences; (3) multicultural counselling self-efficacy; (4) understanding unique client variables; (5) an effective counselling working alliance composed of agreement on goals, tasks, and emotional bond, allowing for the exploration of racial and cultural issues; and (6) multicultural counselling skills including the ability to identify culture-related content and dynamics. In this model, the working alliance plays an important role as a key part of multicultural counselling competence.

In a rigorous study using the Multicultural Counseling Inventory with over 900 participants, exploratory and confirmatory factor analysis revealed the multicultural counselling relationship to be a fourth competency domain (Sodowsky, Taffe, Gutkin, & Wise, 1994). The other three were those previously established by D. W. Sue et al. (1982), multicultural counselling skills, multicultural awareness, and multicultural counselling knowledge. While compelling, this finding’s credibility is called into question given that this is a therapist self-report scale, which is the least related out of therapist, client, and observer rated scales to outcome. The domains uncovered in this instrument may be of reduced utility if they are not highly related to outcomes, given that the entire goal of studying multicultural counselling competencies is to improve therapy outcomes. The concept of and the term “alliance” originated in western psychology, and this research presumes that it is important to the client as well without investigating that directly.
Stanley Sue claimed that the practical demonstration of how to implement theoretical concepts of cultural competencies in the counselling process is still in its infancy (S. Sue, 2006). It is theorized in the literature that higher levels of cultural competence in counsellors will contribute to improved utilization of mental health resources and lower rates of premature termination by ethnic minorities. However, Sue claimed that this has not yet been empirically demonstrated.

The concept of multicultural counselling competencies continues to evolve; Stanley Sue (2006) has critiqued the “aspirational” and “hortatory” multicultural guidelines currently in effect (American Psychological Association, 2003), that are based closely on D. W. Sue’s and coauthors’ (1982) original multicultural counselling competencies of beliefs/attitudes, knowledge, and skills described above. The lack of operational specificity makes multicultural counselling competencies concepts difficult to measure and research. Stanley Sue posited instead that “cultural competency” is composed of two levels: processes and content. The first level, processes, can be further broken down into three elements: scientific mindedness, dynamic sizing, and culture-specific skills. Scientific mindedness is described as developing hypotheses, finding creative ways to test them, and only developing theories based on existing data. This has implications for research on multicultural counselling as well, especially regarding assumptions that western constructs of counselling apply to cross-cultural relationships. One could easily reframe this in social psychological terms as avoiding both the fundamental attribution error and bias. I review a study (below) that tests scientific mindedness and demonstrates how it could impact multicultural counselling competence. Sue described dynamic sizing as striving for appropriate balance between generalization and exclusivity. I observe that dynamic sizing also reflects recent attempts in the literature to
bridge the dichotomy between culture-specific, or emic, writings that risk stereotyping in application, and culture-general, or etic, writings that run the risk of missing salient cultural differences. The same rigidity or polarization between extremes can happen in the counselling room. In this work, Sue also set forth a series of concrete and trainable strategies. This takes multicultural competencies theory a step further in concreteness and testability.

Multicultural Counselling Competencies (MCCs) are the major contribution the field of counselling psychology has made to understanding the cross-cultural therapeutic encounter. Canadian authors Collins and Arthur have adapted MCCs to the Canadian context by incorporating the working alliance as a scaffold (2010a, 2010b), which extends the research summarized above by Constantine and Ladany (2001) and Sodowsky et al. (1994). Research on the working alliance and its components in the cross-cultural context will be reviewed below.

Findings from social psychology contribute to our understanding of the multicultural counselling relationship. For example, using simple self-report measures, Nelson and Baumgarte (2004) found that individuals (N = 147) reported less emotional and cognitive empathy when reading vignettes about others whose distress resulted from an incident that involved unfamiliar cultural norms versus familiar cultural norms, t(146) = 7.98, p < .001. They also attributed the other’s distress to dispositional rather than situational factors, essentially assigning blame for the problem to the person rather than the situation, more so when the person was culturally dissimilar, t(146) = 15.16, p < .001. The extrapolation to the counselling context may mean that lack of awareness of cultural differences and lack of similarity between self and other can impair one’s ability to mediate empathy. Therefore white counsellors may have difficulty empathizing with the experiences of an ethnic minority
client who is dealing with a painful discriminatory event or cultural experience with which the therapist is unfamiliar.

**The Alliance**

The therapeutic alliance will be defined and described, and seminal research on the alliance will be surveyed. Given that this concept developed out of Western psychology, the relevance of the alliance to the multicultural context will then be investigated in terms of current research and gaps in theory.

**Terms distinguished.**

The working alliance is a purposive and collaborative effort on the part of the client and therapist, whereas the therapeutic alliance is the affective bond the client develops for the therapist (Gaston, 1990 as cited in Gelso & Samstag, 2008). This latter term is deemed problematic by some, because it is often equated with the overall therapeutic relationship or general affective tone of interactions, and therefore is not theoretically specific and easily measurable (Gelso & Samstag). However, in the literature the term “therapeutic alliance” is often used interchangeably with the term “working alliance” or simply, “alliance.”

**The therapeutic alliance.**

The therapeutic alliance has been revealed by common factors research to be one of the most important contributors to therapeutic effectiveness (Hill & Williams, 2000; Horvath & Bedi, 2002; Warwar & Greenberg, 2000). Summers and Barber (2003) conducted a comprehensive review of research on the therapeutic alliance and concluded that it is the "holy grail" of psychotherapy competency. It is a well-validated concept that is more powerfully predictive of outcome than other common factors and techniques (Messer & Wampold, 2002). Specifically, the client’s perception of the alliance early in therapy is the
best predictor of therapy outcome (Horvath, 2001). A meta-analysis of over 200 studies has allowed for the conclusion that the effect size of the correlation between the therapeutic alliance and therapeutic outcome is 0.275, $p < .0001$, a moderate but highly reliable relationship (Horvath, Del Re, Flückiger, & Symonds, 2011). Most of this research has been done on majority-culture counselling dyads in North America.

**The working alliance.**

Greenson (1967) first coined the term “working alliance” when he subdivided the therapeutic relationship into three interrelated components: the working alliance, the transference-countertransference configuration, and the real relationship. The real relationship is reducible to realism and genuineness, and is everything that is not transference-countertransference. Gelso and Hayes (2002) have since named the real relationship as the personal relationship. Since Greenson’s work, the working alliance is the component of the three that has been most clearly operationalized and extensively studied (Gelso & Samstag, 2008). The term working alliance has become part of the vocabulary of diverse schools of therapy, demonstrating its pantheoretical application to therapy.

Coming after Greenson, Bordin (1979, p. 253–254) defined the working alliance as the collaboration between client and therapist based on their agreement on the tasks and goals of counselling. This simple statement incorporates three key related components:

1) Client and therapist agreement on goals of treatment,

2) Client and therapist agreement on how to achieve the goals (task agreement)

3) Development of a personal bond between the therapist and client.

This conceptualization implies a factor structure characterized by one general alliance factor and three secondary factors, each corresponding to one of the components. One can
see that at this level there may be significant differences in different cultures with respect to how clients and therapists come to an agreement on goals (i.e., are they generated by the client or by the therapist), how they are to be achieved (who does the work), and the significance of the bond relative to other elements of healing.

Constantino, Castonguay, and Schut (2002, p. 86) have more recently expanded and updated Bordin’s definition of the working alliance as follows:

. . . the alliance represents interactive, collaborative elements of the relationship (i.e., the ability of the therapist and client to agree on the goals of therapy and to participate in tasks toward those goals) in the context of an affective bond or positive attachment.

This definition embeds tasks and goals within the context of the bond, giving the bond greater importance with possible implications for how the working alliance is measured. Research indicates that client self-report of the working alliance is a better predictor of outcome than therapist self-report, particularly during the early phases of treatment (Horvath & Symonds, 1991).

Research.

Research on the alliance with high ecological validity (in the context of multicultural settings) is very important. This is especially true given the comparative difficulty in obtaining information alternative to the currently popular therapist self-rating of multicultural counselling competency. As pointed out by Constantine, Miville, and Kindaichi (2008), this is in high need. These authors called for an exploration of the “common factors” approach to therapy in a multicultural context, to establish their effects on client retention, satisfaction, and change. This is one of the few voices in psychotherapy research aware of the need to explore these basic constructs in other cultures to see if they are applicable.
**Culture and the alliance.**

There is general agreement in the literature that addressing cultural components of the client-therapist relationship is key to increasing the effectiveness of therapy (Comas-Diaz, 2006). Comas-Diaz provided specific recommendations on how to do this. These included the modification of the therapeutic relationship to the client’s culture, understanding the client’s ‘voice,’ developing trust and credibility, and promoting cultural empathy. Here we see that the therapeutic relationship plays an important role. There is the acknowledgment that this relationship may appear differently in different cultures and that the therapist’s task is to attempt to engage in the therapeutic relationship with the client in a way that is harmonious with the client’s culture. Once again, these recommendations are based on theory and have not been substantiated by research. As might be expected however, the basic relationship between a mental health service provider and client has been empirically demonstrated to be important in cross-cultural counselling.

Collins and Arthur (2010a) discuss how researching the working alliance in multicultural counselling is the key to improving outcomes for ethnic minorities in Canada. Their model of culture-infused counselling attempts to link emic and etic perspectives, and they use the working alliance as a conceptual framework for culture-infused counselling. They also claim that the working alliance is a central organizing feature of multicultural competency. An emic perspective is important in achieving an in depth understanding of a given culture. However, an etic perspective can be helpful in linking research to the broader field of counselling psychology and also in providing examples or models of how to investigate helping relationships within other cultures. Collins and Arthur’s model shows that the basic multicultural competencies—cultural awareness of self and others, attitudes and
beliefs, knowledge, and skills—are required to establish a culturally-sensitive working alliance, that is, a trusting relationship, agreement on goals, and agreement on tasks. This working alliance then serves as a client-driven process that facilitates movement from where the client is at the beginning to where the client wants to go in the future. These authors acknowledge that this model is conceptually and theoretically supported rather than empirically supported. It could be problematic to apply a well-developed theoretical model to research in cross-cultural counselling since the theory may not represent other cultures’ constructions of helping relationships. An eloquent example of how a counselling concept may look different in another culture is the recent ethnographic study by Ng and James (2013a) that examined the role and construct of empathy from the client’s perspective within Chinese counselling dyads. She found that empathy was not a common or important concept for clients. It took a different form, both conceptually and linguistically. For example, informants’ comments showed how having unconditional regard or acceptance were constructs that overlapped with empathy. They expressed the importance that their counsellor was neutral and accepted their feelings. Rather than using the term empathy, informants more typically used the closest term in Chinese, which is literally translated as “having a heart to help,” which relates to compassion, humaneness, kindness, and sincerity. This may be influenced by Confucian beliefs of the importance of compassion, benevolence, humaneness, and sympathy.

Vasquez (2007) wrote an article entitled, “Cultural differences and the therapeutic alliance: An evidence-based analysis” which contained a total of five research study citations (four related to culture) out of a total of 40 references overall and therefore does not appear to have been an evidence-based analysis. I believe this lack of referencing empirical research
is not an error on the part of the author but rather a reflection of the current state of the field, where hypotheses are coming forth at a greater rate than empirical studies. She concludes her paper with a call for more research on the quality of the therapeutic alliance and its effects on clients of colour.

**Research on the working alliance with immigrant clients.**

While it is acknowledged that individual characteristics of clients and therapists may influence the development of the working alliance, our knowledge of how the working alliance develops in the context of cultural variations is limited. The key studies in this area of research are reviewed below.

O’Mahoney and Donnelly (2007) used Kleinman’s explanatory model (1978) to conduct a qualitative investigation on how immigrant women seek mental health help. In this study they found the therapeutic relationship to be very important. They interviewed mental health care providers; Two Chinese, three South East Asian, and two White health care providers regarding their experiences providing mental health services to immigrant women. They found that the mental health care provider-client relationship exerted great influence on how immigrant women sought mental health care. The major issue appeared to be different values and perspectives between the mental health care provider and the client. Providers talked about misunderstandings leading to breakdowns in communication, resulting in negative feelings within the relationship. In some cases differences in communication style led to perceived discrimination because the provider was more confrontational than what the client was accustomed to. It is a major shortcoming of this study that mental health care providers were guessing about reasons why therapeutic relationships may not have been
more successful than they were, and why immigrant women may not have returned for treatment.

Chang and Berk (2009) provided further qualitative evidence for the theoretical structure of the working alliance through their phenomenological study of clients’ lived experiences of cross-racial therapy. They interviewed 16 clients, all racial minorities, who had received counselling from white therapists, and formed two groups, satisfied and dissatisfied, of eight clients each who were matched with respect to gender and in most cases ethnicity. Clients’ reports of their experiences were reduced to core issues that mattered most, which included affective involvement in the relationship and the belief that the counsellor is addressing core needs and assisting in the achievement of treatment goals. The findings of this study highlighted the centrality of the therapeutic relationship in clients’ perceptions of their therapy experiences.

Another relevant qualitative study was an investigation of the effects of culture on the working alliance for Asian American clients and Western therapists (Shonfeld-Ringel, 2001b). This researcher interviewed fifteen therapists from university counselling centres, community mental health settings and private practice. A positive aspect of this study was that the working alliance structure was not imposed on the interview structure. Instead the themes that arose from the interviews were compared to the theory of the working alliance. The major finding was that the cross-cultural working alliance is intersubjective in nature, with clients and therapists mutually influencing one another during the counselling process with regards to respective communication systems, values, worldviews and cultural paradigms. The researcher claimed that both the client’s and the therapist’s native cultures played an important role in the working alliance and in the treatment process. One
shortcoming of this study, given conclusions pertaining to mutual influence and what the client brings to the counselling relationship, is that the clients were not interviewed. The methodology was also unclear, described as in depth, semi-structured interviews in a psychodynamic and multicultural theories conceptual framework.

The same author used the above findings to publish an expanded theory of the working alliance (Shonfeld-Ringel, 2001a). In an attempt to address a gap in the literature regarding the working alliance in cross-cultural therapy, the author proposed the inclusion of specific relationship domains into the definition of the working alliance. These domains were empathy, mutuality, the dynamics of power and authority, the use of self, and the process of communication. Subsequent literature on the working alliance has not picked up this recommendation. It is possible that to do so would compromise the specificity of the construct of the working alliance. The construct of the working alliance as being composed of task, goals, and bond is buffered by decades of quantitative research using the Working Alliance Inventory (WAI). To change the definition of the working alliance based on a qualitative study would require significantly more quantitative research. Another problem with this theory development is that each of these new domains may be structured very differently in other cultures. An example is the different form and importance of empathy in Chinese counselling as discussed above (Ng, 2013a). One could well expect that the other dynamics of mutuality, power, use of self, and communication process would take very different forms and levels of importance in different cultures.

White counsellors who discuss racial and ethnic differences with their clients of colour are rated as having stronger working alliances compared to counsellors who do not discuss these differences (Zhang & Burkard, 2008). This finding was based on administration
of the Working Alliance Inventory – Client Form (WAI-C) to 51 counselling clients, and their reports of discussions of race in sessions.

One study (Fuertes et al., 2006) examined the role of therapist multicultural competence (TMC) through evaluation of the working alliance. Fifty-one therapy dyads completed measures of therapist multicultural competency, the working alliance, and their satisfaction with therapy. In addition to these assessments, clients also completed measures of therapist attractiveness, expertness, trustworthiness, and empathy. The researchers found strong relationships between clients’ ratings of TMC and ratings of the working alliance, therapist empathy, and satisfaction. No associations were found between clients’ combined ratings of therapist expertness, attractiveness, and trustworthiness and TMC, but client combined ratings of therapist expertness, attractiveness, and trustworthiness were significantly associated with therapists’ self-rated TMC ratings. The findings of this study do therefore lend some credibility and utility to therapist self-rated multicultural counselling competency.

Wintersteen, Mensinger, and Diamond (2005) drew six hundred adolescent substance abusers and their therapists from a large randomized clinical trial, grouped them according to matches and mismatches on both gender and race, and asked both clients and therapists to fill out alliance rating measures (the WAI short version). They found that those who matched on race were more likely to continue with counselling (79% completed two thirds of the sessions, versus 55% for the mismatched dyads), but the patient-rated alliance was not higher than when mismatched on race, $t(2, 334) = 1.15, ns$. Interestingly, therapists in matched dyads believed the clients would form a significantly higher alliance with them, $t(2, 327) = 3.59, p < .01$; this contradicts what the clients reported. It would be useful to understand why
clients may rate the working alliance as equally high in cross-cultural counselling dyads, yet terminate prematurely.

The WAI has been used with aboriginal populations in Norway to evaluate cross-cultural therapy dyads (Sorlie & Nergård, 2005). Twenty-five Saami and twenty-five Norwegian (white) patients who had received treatment in a psychiatric hospital were compared on treatment, treatment satisfaction, and recovery using paired t-tests of scores on several inventories. Even though both groups were the same in type and amount of treatment and symptom changes during hospital stay, the Saami patients reported less satisfaction with all investigated treatment aspects. These included staff contact, alliance (as rated by the WAI-S therapist and client versions), information, and overall treatment satisfaction. The Saami patients reported lower alliance scores than their therapists ($M = 21.8, SD = 12.9$ vs. $M = 29.1, SD = 9.1$, $t(24) = -2.8, p < .02$). Interestingly, the mean WAI-S score for the Norwegian patients and their therapists was equal, although individual therapy dyads only had correlations of .25. The Saami dyads had a higher overall correlation of .35 (moderate). Four of the Saami/Norwegian therapists and their four Saami patients agreed highly on the WAI-S ($r = .95$ and equal mean scores). However, the same four therapists and their nine Norwegian patients had a low level of score agreement ($r = -.47$, and unequal mean scores). There was also only partial recognition on the part of the therapists of the extensive use of traditional healers by both the Saami and Norwegian patients. This research leads to the interesting question of what would the Saami patients consider a satisfactory treatment experience.

Ward (2003) investigated multicultural competence, working alliance, and cultural mistrust in cross-cultural counselling dyads. Twenty-six therapists completed questionnaires
that assessed their multicultural training experiences and multicultural competence. Fifteen client-counsellor dyads also completed questionnaires that assessed therapist multicultural competence, working alliance, and cultural mistrust. Pearson’s correlation and linear regression revealed a positive relationship between multicultural training and clinicians’ self-reported multicultural competence, which is a well-established trend observed in previous literature. This researcher found that therapists’ multicultural competence did not predict clients’ perception of the working alliance when cultural mistrust was controlled for. This is an interesting finding that suggests, contrary to the substantial theory linking the two reviewed earlier, and other research findings (Fuertes et al., 2006), that there may not be a strong link between therapist multicultural competence and client ratings of the working alliance.

Wong, Beutler, and Zane (2007) conducted one of the few studies that test culture-specific hypotheses regarding how different ethnic groups may respond to therapy. In this case, they investigated Asian Americans’ purported preferences for directive counselling. They tested these factors as mediators (variables that explain the relationship between a predictor and outcome) and moderators (variables that alter the strength or direction of relationship between a predictor and outcome). The outcomes tested were perceived counsellor credibility (measured by the Counsellor Effectiveness Rating Scale, Atkinson & Wampold, 1982) and working alliance (measured by the Working Alliance Inventory – Short Version (WAI-S, Tracey & Kokotovic, 1989)). They randomly assigned Asian and European American college students \(N = 182\) to view simulated directive or nondirective therapy approaches and administered several rating scales. They then used mediation analyses to investigate whether ethnic group differences in initial perceptions of counsellor credibility
and working alliance were accounted for by previous therapy experiences and therapist
understandability (defined by the authors as perceived comprehensibility, or how well the
client could understand the therapist). They used moderation analyses to investigate whether
ambiguity tolerance, expectations for directive therapy, and resistance influenced initial
perceptions of counsellor credibility and working alliance across directive and nondirective
counselling. Overall, Asian Americans rated the counselling approaches significantly less
favourably than European Americans. They found a significant mediation effect for therapist
understandability, and a significant moderation effect for expectation for directive therapy on
initial perceptions of counsellor credibility. In other words, Asian Americans generally found
the counsellors less easy to understand, and therefore rated them lower on counsellor
credibility and working alliance. Although Asian Americans exhibited lower ambiguity
tolerance than European Americans, within the counselling context this difference did not
account for ethnic group differences in responses to directive and nondirective approaches.
These findings support the need for research on ethnic group differences within the context
of counselling from an emic perspective. While D. W. Sue and D. Sue (2012) again discuss
Asian American characteristics including collectivism and emotional restraint that may affect
therapy with this population, unless these characteristics are studied in the counselling
context, assumptions should not be made about how they will be manifest in counselling.

**Summary of research in multicultural counselling psychology.**

Research in multicultural counselling psychology has shown the therapeutic
relationship to be very important (Chang & Berk, 2009; Fuertes et al., 2006; O’Mahoney &
Donnelly, 2007; Shonfeld-Ringel, 2001b). White counsellors who address racial and ethnic
differences with their clients are rated as having stronger working alliance (Zhang &
There are mixed findings for a correlation between therapist multicultural competence and client ratings of the working alliance (Fuertes et al., 2006; Ward, 2003). Measuring the relationship between ethnic matching and the working alliance also has produced mixed findings (Sorlie & NergÅrd, 2005; Wintersteen et al., 2005). A major limitation of the literature on multicultural counselling psychology is that so little qualitative research has been done. The general trend in the field has been that experts have developed theories and concepts that have then been developed into assessment tools and tested. The originating theories may have more comprehensive or culture-specific coverage if they are based on qualitative research findings. For example, clients from different cultures could describe why their successful counselling experiences were indeed successful. These findings could then inform multicultural counselling theory and the relative importance of the therapeutic alliance.

One problem with cross-cultural research using the construct of the working alliance is that the possibility that this construct may appear different in the cross-cultural context is not addressed; rather it is assumed to be the same across all cultures. Given the call for Evidence-based practices in psychology (EBPP) for research to be conducted in the context of client characteristics and culture (American Psychological Association, 2006), we ought to avoid the assumption that common factors across psychotherapy theories are also common factors across cultures without first investigating the construction of traditional healing relationships in other cultures from an emic perspective.
Integration of Cultural Psychology and Medical Anthropology into Multicultural Counselling Psychology

The fields of cultural psychology (Shweder, 1991) and medical anthropology (Kirmayer, 2007; Kirmayer, Lemelson, & Barad, 2007; Kleinman, 1991) both adopt relativistic approaches where knowledge is contextually driven, unlike MCCs and the WAI which originated in an essentialist psychology lens. Both cultural psychology and medical anthropology are based on over a century of cross-cultural work, whereas multicultural counselling psychology is young in this endeavour (25 years). Bezanson (2008) wrote about the cultural encapsulation of counselling psychology, noting that this critique emerged 50 years ago with writings by Gilbert Wrenn (1962) and continues today. Despite changes in language to promote pluralism above marginalization, and despite the burgeoning research in this field, we still adhere to domain-specific views and a vocabulary of description. Wrenn wrote about counsellors’ tendency to encapsulate themselves within their own subculture in an effort to protect themselves, cushioning themselves in “academic cocoons” that bear little relevance to the total culture, and assuming that it is safe to draw upon their own education and experiences in counselling others (p. 444). While multiculturalism has since burgeoned and flourished as a topic within counselling psychology, especially in 1997–1998, the critique of cultural encapsulation persists (Leung, 2003). Leung exhorts the globalization and nationalization of counselling psychology as the cure; through such steps, counselling psychologists will be forced to examine their attitudes, abandon their sense of self-sufficiency, and learn from other methods of healing. Currently, most research published on multicultural counselling psychology is based on the American experience. Another example of the cultural encapsulation of counselling psychology is the paucity of literature that
addresses issues of language and acculturation. Not addressed by Leung is the benefit that would accrue to counselling psychology if it were, as a discipline, to break out of its “cultural capsule” by learning from other disciplines such as anthropology.

Ponterotto (2002) wrote about the Eurocentric individualist perspective we continue to bring to descriptions of culture within multicultural counselling models. Gerstein et al. (2007) critiqued modern multicultural counselling approaches for conceptualizing culture through an individual rather than group lens, even while considering the family and group in which the individual participates and experiences change. Examples include addressing concepts such as self-esteem and identity development with cultures for which these concepts do not exist in any form and in fact violate cultural norms. They pointed out, as Gone (2010) later did more explicitly, that the counselling process becomes an enculturating one that risks the adoption of values by the client, which do not fit within the client’s cultural context.

Cultural psychology.

Cultural psychology is the study of the psychological aspects of a person’s interaction with the cultural environment (Toomela, 2012). Cultural psychology focuses on “the understanding of not only how mind constitutes culture but more importantly of how culture constitutes mind” (Kral, Burkhardt, & Kidd, 2002, p. 154). Cultural psychology arises out of medical anthropology and offers a more in depth study of culture than that demonstrated in the MCC-informed literature. It utilizes qualitative rather than the predominantly quantitative methodologies found in multicultural counselling psychology, and typically investigates the culture of origin in depth rather than through a comparative lens in the American context. The epistemology of cultural psychology is the study of illness and healing in its cultural context whereas MCCs still apply western theories to the major minority groups of the US.
Cultural psychology focuses on emic approaches to psychology, and culture-specific knowledge, the latter of which fulfils a key requirement of MCCs. For example, Christopher and Shweder stressed through their examples and theories the importance of acquiring culture-specific knowledge in order to heal. John Christopher (2001) critiqued psychologists for not accessing resources from cultural anthropology, since anthropology as a field has a great deal of knowledge and experience to offer in the understanding of diverse cultures. The American perspective on culture is that it is a construct external to the person, with the power to influence the person and potentially diminish the person’s autonomy. In contrast, a hermeneutic approach to culture views it as a collection of shared meanings that enable social life to function. Without these shared meanings, we cannot structure our existence or orient ourselves to the events of our lives.

**Medical anthropology.**

The works of Krause (1995), Csordas (1988), Kirmayer (2007), and Kleinman (1991) in the field of medical anthropology provide in depth views of culture and culture-specific applications to psychotherapy and mental healing. Seminal works in this field include Kirmayer’s article (2007) *Psychotherapy and the cultural concept of the person*, Kleinman’s book *Rethinking psychiatry: From cultural category to personal experience* (1991), and an article with Lewis-Fernández as first author, *Culture, personality, and psychopathology* (1994). Csordas and Kleinman (1996) have written from an anthropological perspective about what happens in therapy. They describe the therapeutic process as capable of being a form of oppression, a response to powerlessness, and a form of empowerment. They point to the therapeutic process as the element of care that challenges the notion that body and self, or physiology and mind are separate. For example, they argue that even biomedical
interventions have a symbolic element. Inga Brit-Krause (1995) provides one of the only true integrations of medical anthropology concepts into therapy, complete with several case examples. Research on traditional healers is an especially important contribution which, when applied to western models of healing, permits an expanded view of what constitutes healing beyond diagnosis and treatment of disease to an understanding of the roles of illness and suffering. An early example in this domain is an article by Kleinman and Sung entitled, “Why do indigenous practitioners successfully heal?” (1979). They investigated the healing practices of a tâng-ki, a shaman in Taiwan. They also interviewed 12 of his patients and found that while their symptoms often remained the same or worsened, most informants evaluated their treatment to be effective. Several reasons for this were suggested. The social aspects of the treatment seemed to contribute significantly to the patient’s improvement, even though 11 out of the 12 individuals presented with somatic complaints. In this study it seemed that the tâng-ki worked with these somatic symptoms and that this was the medium through which treatment and healing occurred. While the shaman did focus on the physical symptoms, there were several psychological healing processes occurring as well; the healing took place in a social group setting where patients who had been attending regularly would ask newcomers to tell the story of their illness and its causes; the patient was instructed to return for treatment every evening in this group setting; and the shaman told the patient that he or she was cured after every treatment. The shaman himself spent very little time with his patients, however, he had assistants who routinely spent an hour per patient talking with them about their ailments.

Kleinman and Sung (1979) concluded that indigenous healers in Taiwan were as effective as Western healers, and that ratings of patient satisfaction were much higher than
for Western healers. The only exception was in the treatment of severe acute disorders, which indigenous healers stated they were not equipped to cure. Patients with serious physical ailments would frequently seek out Western medicine concurrent with their traditional healing program of treatment.

Kleinman and Sung (1979) also pointed out the methodological problems with studying traditional healing, which are unresolved to this day. First is the question, “what is healing?” This may differ for the healer, the patient, and the researcher. Also is the question of how to tell when a patient is healed. Traditional healers consider a patient healed when they stop coming for treatment; a patient however may stop coming for treatment because it is no longer working. Successful treatment depends on the explanatory framework of the healer; if it is the expulsion of bad spirits, and if he or she believes this has been done, then treatment may be deemed to be successful even in the absence of symptom relief. In addition to these conceptual difficulties, it is difficult to run clinical trials in traditional healing, and findings are often skewed toward the positive, since patients who have had negative healing experiences are less likely to be found by or to communicate with researchers (Kleinman & Sung).

Another early example of an anthropological account of traditional healers is E. Fuller Torrey’s (1972/1986) *The mind game: Witchdoctors and psychiatrists*, a book that engaged in a lengthy comparison of the two and found mostly similarities. Torrey defined psychotherapy as, “a series of contacts between a socially sanctioned healer and a patient who seeks relief. This definition distinguishes psychotherapy from other helping relationships such as a chat with the milkman or some advice-giving by the bartender.” (1972, p. 2). He observed that therapists in other countries almost always incorporate
religious functions into their work, such as with many African healers and Christianity, Latin American *curandeiros* and Catholicism, and *baliants* in Bali and Hinduism. Sometimes healers in other parts of the world serve as both a religious functionary and therapist, such as with the Buddhist monks in Thailand and the *hodjas* in Turkey. While this exists to some extent in Western culture, with pastoral counsellors as one example and sections within the Canadian Counselling and Psychotherapy Association (CCPA) and the Canadian Psychological Association (CPA) on spirituality, such integration forms the minority of psychological care.

Torrey (1972) also pointed out the primacy of a shared worldview in psychotherapy. Communication is the essence of psychotherapy. He described the Rumpelstiltskin effect, whereby the act of naming what is wrong with the client has a therapeutic effect. “It says to the patient that someone understands, that he is not alone with his sickness, and implicitly that there is a way to get well” (p. 16). He pointed to work with American Indians by a father of anthropology, Lévi-Strauss (1963), which examined how shamans heal. He noted that the shaman provided words to express a patient’s suffering, thereby allowing the patient to access a previously inaccessible psychic state and allowed the patient to explore, express, and resolve it. Torrey contended that in order to know the right name, the therapist must share the same worldview as the client. A stunning example of this concept is the description by Marc Augé (1989) of the process by which “prophets” on the Ivory Coast of Africa heal others. They see their patients (as termed by Augé) in families and groups, and they “translate the baffling phenomena represented by the patients’ pathologies into words that are charged with symbolic meanings familiar to both PRPs [prophets] and patients.” (p. 9). He stressed that they ensure that interpretations make sense within the patient’s social and familial context.
So while the Rumplestiltskin effect is seen across all therapies, its content, or the repertory of names and labels used, are culture-specific. I believe that this also describes a process whereby transfer of culture occurs. A therapist enculturates a client by teaching the client the name for what ails them and all the accompanying social, medical, and prognostic meanings.

Another example of the power of the therapist’s interpretation is the use of Morita therapy (Ishiyama, 2003) for the treatment of anxiety or, more specifically, for helping *shinkeishitsu*-type clients, or nervous trait clients (p. 218). These individuals are characterized as having phobic obsessions, anxiety, avoidant behaviours, panic attacks, hypochondriasis, and related somatic complaints (Ishiyama). This therapy is characterized by the principles of positive reframing of anxiety into constructive desires, encouraging movement from a thinking mode to an experiencing mode, and setting as a therapeutic goal the restoration of balance in life. This therapy is grounded in Japanese culture but offers to those outside Japanese culture a new way of conceptualizing human nature, mental health, and change (Ishiyama).

Bezanson (2008) described in her research with Portuguese community members how *curandeiros* have changed the terms they use to adapt to a new generation. In the words of one of her informants:

> Old *curandeiros* use old technicians [techniques]. The old dies and the new is more for the new generation. Because some words being used years ago, the new generation don’t understand. And the new *curandeiros* use the new words for the people to understand. (p. 82)

For some informants, if the words used by the healer weren’t the right ones, healing would not occur. Using the right words created comfort and a space for healing.

Regarding therapist characteristics of empathy, genuineness, and warmth, Torrey (1972/1986) posited that the evidence that has accumulated for their importance in Western
therapy serves as an argument for the importance of therapist characteristics in therapy in other cultures. He stressed, however, that the actual characteristics are likely to be different, because people in different cultures think and perceive these qualities differently. Commonalities that he did see across cultures include the importance of inspiring hope in the client, partly in response to the credibility of the profession, and the training and reputation of the healer.

Thanks to globalization, more research is being conducted on the topic of traditional healing around the world. Much of this work takes the form of observational studies that allow the westernized psychology profession the opportunity to learn about other modes of healing in other cultural contexts. Recent examples include an investigation of why people seek out traditional and faith healers in Ghana (Ae-Ngibise et al., 2010). In this study, the psychosocial support offered by these healers was considered to be a major reason for their popularity. Another example is a study investigating how Arab women healers in Israel help their clients, through the perspective of their clients (Popper-Giveon, & Al-Krenawi, 2010). They shared stories about how they had undergone a social and personal change in response to their visits, which in turn helped them with their symptoms. Vontress (1999) published an in depth interview with a traditional healer in West Africa. Among his conclusions, he observed that clients seek treatment for interrelated problems that are not separated out into physical, psychological, or spiritual categories. He concluded that the therapeutic environment in which treatment occurs is open; it is not fixed in time or space, and it is open to friends and relatives. Despite a very different cultural context, a similar process of meetings, talking, and treatment as in western therapy occurs, and positive results are obtained.
The role of culture in the expression of somatic symptoms has traditionally been viewed as one more demographic variable (Ware & Kleinman, 1992), something for which the field of cross-cultural psychology has been critiqued (Ratner & Hui, 2003). Studies today still tend to focus on quantifiable variables of minority help-seeking behaviours, or cross-cultural comparisons of prevalence rates of psychiatric disorders, using an ethnocentric and simplified North American paradigm of symptom expression and treatment that individuals from other cultures may not necessarily follow. A countering trend to this comes from the field of medical anthropology (Becker, 1998; Kleinman, Das, & Lock, 1997; Ware & Kleinman) that incorporates explorations of the profound embeddedness of one’s experience of illness within one’s culture.

Medical anthropology incorporates a social constructionist lens of illness (Gergen, 1985, 2001), in which illness has a social as well as a biological course and there is a reciprocal relationship between the body/mind and society. Kleinman’s (1986) sociosomatic formulation follows from this. From this perspective, the individual’s contexts, including relationships with others, stressful life events, and social support, are integral to the ways that the body/mind is experienced. Through the lens of the sociosomatic formulation, somatization is connected to a person’s religio-moral and social domains, as well as existing at the individual level. Therefore, symptom expression is not universal across cultures, but rather is embedded within a given culture’s knowledge about the body and pathology, and connected to that culture’s religious and spiritual beliefs.

There is research support for the sociosomatic formulation through the description of symptoms that reflect the social context of the patient. For example, there are many studies comparing North American psychiatric diagnoses with the symptoms of members of diverse
communities that have found that the symptom clusters of these communities do not map onto standard psychiatric nosology. Becker's (1998) investigation of postpartum depression in Fiji is one such example. Other examples include Lock and Wakewich-Dunk’s (1990) description of “nerves” with Greek immigrants, and Kleinman’s description of “nerves” with Puerto Rican immigrants (Kleinman, 1988a). Another culture-bound syndrome has been observed in Vietnamese individuals, named “hit by the wind,” which also does not find parallels within the DSM IV-R (Hinton, Hinton, Pham, Chau, & Tran, 2003).

**Traditional healing in counselling psychology.**

Only recently has the field of counselling psychology begun to explore and integrate traditional healing practices, despite the fact that there have long been proponents of this approach in the literature. These proponents argue that truly culturally competent care can be achieved through integration of traditional healing. Gone (2010) presented one of the few models of integration of traditional healing with contemporary psychotherapy that exists in the literature. His model is for use with American Indians. He pointed out the paucity, but necessity, of further integrations. Gone argued that therapeutic integration of traditional healing methods with psychotherapy remains in its infancy, with little consideration given to the complexities involved in such integrations. He also called for establishing as a starting point, the publication of descriptive case studies of concrete instances of traditional healing. The February 2010 issue of *The Counseling Psychologist* provided this opportunity, affording Gone 60 pages, just under half the size of the entire issue, to comparatively examine traditional healing instances and culturally specific psychotherapy, both pertaining to the same population. With respect to Açoreans, Bezanson began this process with her ethnographic investigation into traditional healers in the Açores (2008; Bezanson & James,
She spent five months in the Açores seeking out curandeiros. She found that she encountered a phasic response from community members to her queries. First they would laugh at her questions about curandeiros; then on a separate encounter, they would acknowledge that they had heard of curandeiros but never met one personally; then on a third encounter they would describe their own visits to curandeiros openly. Informants simultaneously denied belief in powers and healing gifts of curandeiros while also showing a great deal of respect for these powers and gifts and recounting narratives which demonstrated healing. One recounted an instance when she shared her story with a curandeiro, afraid all the while that he had the powers to read her mind that she did not believe he had special powers. Informants would also deny that they visited curandeiros while recounting times that they had done so. One clarified that this discrepancy was because the visits to the curandeiro were under special and unusual circumstances and were therefore not perceived as a part of regular life.

This reluctance to speak openly or clearly about curandeiros could be better understood in light of the historical legacy of the Spanish Inquisition and the three-decade long dictatorship of Salazar in Portugal. As Bezanson (2008) explained, under both conditions the health care needs of the poor were neglected and local healers increased in number to meet those needs while necessitating a culture of secrecy for their survival. In the end, Bezanson did not knowingly meet a curandeiro, although she learned a great deal about them from informants who had received treatment from them.

Bezanson (2008) found that her informants who had received treatment from curandeiros experienced emotional relief although not necessarily relief of the symptoms; this was enough to believe in the effectiveness of the curandeiro as a result. The curandeiros...
were able to treat people holistically, taking into account physical, emotional, and religious concerns. Their benefit over health professionals was also seen in their availability to listen to clients’ stories, a counselling role that is very new in the Açores and is accompanied by a great deal of stigma when embodied in a “head doctor” (psychologist). The mental health professions were unheard of in the Açores until the 1970’s, and are still not broadly accepted. For “problemas,” community members’ personal experiences of distress, a visit to a curandeiro was deemed acceptable; health care providers in the Açores also defined “problemas” as not diagnosable or translatable, and therefore not requiring treatment. Similarly, both community members and health care providers saw disease as something that must be treated by health care professionals and not traditional healers. The Açores has embraced modern medicine and as a result researchers from North America are more interested in learning about their traditional healers than they are.

Existing integrations of anthropology and counselling psychology.

The suggestion has been made by anthropologists that anthropological perspectives could help to guide the work of mental health professionals working across cultures (Varenne, 2003). The counselling psychologist Gerstein, and colleagues Rountree and Ordonez (2007), have written a comprehensive article describing the valuable contributions anthropology can make to counselling psychologists’ perceptions of multicultural counselling. They lamented that anthropology literature was not consulted when counselling psychology was compiling its first definition of multicultural psychology in 1991 as incorporating “the mental health issues and developmental needs of those racial or ethnic groups in American society that do not trace their origins to Europe” (p. 13). This definition
leaves out the dominant culture except as a parameter against which to compare “other”
groups.

Anthropological theories of culture are also abstract and not easily operationalized
and thus amenable to study or practice (Gerstein et al., 2007). Another reason for the lack of
consideration of the wealth of anthropological research and theory development in the area of
culture is the possibility that counselling psychology has merely overlooked this field and
failed to consider an integration (Gerstein et al.). Gerstein et al. noted that at the time of
writing their article, of the 14 most widely-distributed counselling psychology texts, only one
mentioned the word anthropology, which was Ponterotto, Casas, Suzuki, and Alexander’s
*Handbook of Multicultural Counseling* (2001). As of 2015, texts include Ponterotto, Casa,
Suzuki, and Alexander’s more recent 2010 edition of the *Handbook of Multicultural
Counseling; Principles of Multicultural Counseling and Therapy* by Gielen, Draguns, and
Fish (2008); and the *International Handbook of Cross-cultural Counseling* by Gerstein,

Gerstein et al. (2007) purported an anthropological approach to be more culturally
sensitive than current conceptualizations of diverse groups within the field of counselling
psychology. They described the usefulness of thick description as performed through
ethnography, and discuss how an in depth understanding of and approach to studying culture
through ethnographic methods can be applied to research within counselling psychology.

Gerstein et al. (2007) encouraged the adoption from within counselling psychology of
anthropology in order to “shift its lens from an individual microscope to a vibrant,
multicultural, kaleidoscope of social patterns” (p. 375). A multicultural counselling approach
may consider the historical context of a client’s culture in how that client is experiencing life
today; an anthropological approach however would look at the current cultural context of the client in a holistic way, recognizing the lack of distinction in many cultures between mental, physical, and spiritual health (Gerstein et al.).

The Mental Health of Portuguese Immigrants

Portuguese Immigrants are one of the largest and least studied groups in Canada (Statistics Canada, 2006). This people group is described in the literature to have certain characteristics. One is fatalism toward life (Araújo, 1996), arising out of years of fascism and poverty, and a resultant inability to change their situation. Moitoza (1982) described Portuguese immigrants as experiencing an intense pull towards both their origins and their new home, which results in an alienation from both worlds. Adjustment is further complicated by the difference between the agrarian and fishing communities from which the Portuguese originated, and the urban environments into which they have settled (Moitoza). Araújo described a tendency towards isolation in reaction to unfamiliar political and religious elements of the new society, as Portuguese immigrants fear losing their own culture. Reeve (1998) observed that Portuguese workers in North America experienced bias and consequently received less work and lower pay.

There are four character values in Portuguese culture: honra (honour), respeito (respect), bondade (generosity), and confiança (trust) (Araújo-Lane, 2005). Araújo-Lane describes three main challenges to therapy: stigma, time, and hierarchy. Regarding stigma, there is a cultural taboo against seeing an outsider for help, and an old saying, “Entre mulher e marido não se mete a colher,” (“You don’t intervene in matters between a husband and a wife,” p. 632). Seeing an outsider also violates the honour of the family. Regarding time, Portuguese immigrants often hold two jobs and work long hours, making therapy difficult to fit in. Regarding hierarchy,
individuals may consent to therapy to avoid saying no to authority but then have difficulty engaging fully in the therapy.

The mental health of Portuguese immigrants is influenced by language. Gonçalves, Cook, Mulvaney-Day, Alegría, and Kinrys, (2013) found that Portuguese-speaking immigrants had better outcomes when accessing a culture-specific mental health resource ($n = 854$) than a general mental health clinic ($n = 541$). In this case that resource was the Portuguese Mental Health Program (PMHP) in Boston, Massachusetts, which provided therapy services in the Portuguese language. The population that made up the Portuguese-speaking group was composed of immigrants from Brazil, the Açores, and Cape Verde. Unfortunately the specific breakdown, and findings based on immigrant group, was not provided. Given the very different cultures and conditions from which these groups emigrated, this oversight is problematic, and the application of the study’s findings to Portuguese immigrants can only be tentative. The group that received care from the PMHP had a longer duration of therapy, although frequency of emergency room visits and inpatient care was not affected. Therefore the authors suggested that culturally competent care influenced outpatient treatment but not the treatment of severe mental illness.

**Family dynamics.**

My research with Portuguese Canadians (Morrison & James, 2009) showed how immigration and acculturation acted as stressors on the family unit, especially as different family members adopted different acculturation strategies and attempted to resolve conflict according to cultural traits they had adopted. Previous qualitative investigations of Portuguese Canadians showed a vast difference in the adoption of Canadian culture and the English language between generations, leading to a culture gap between parents and their
children (Noivo, 1997). Family conflicts inevitably become ethnic conflicts. Noivo also mentioned the Canadian sponsorship program that has promoted the dependence of new immigrants from the Açores on Portuguese families already settled in Canada. This has led to tensions within what are usually strong family units. In my research (Morrison & James), I also observed a reluctance to seek help outside the family or to even attempt to resolve problems or conflict within the family. There was instead an attitude of acceptance and stoicmism. I observed that mothers sacrificed themselves for their children, and were preoccupied with the welfare of their children, supporting Noivo’s comparable observation in her ethnographic study of three generations of a Portuguese family.

**Culture-specific syndromes.**

Although the amount of attention given to culture-specific syndromes is increasing, Portuguese disorders remain virtually ignored. Exceptions include McIntyre’s identification of Martyr Adaptation Syndrome (McIntyre & Augusto, 1999). She found that the symptoms of Portuguese immigrant women that had been traumatized did not map onto post-traumatic stress disorder nomenclature but rather reflected an adaptation syndrome that was related to their religious beliefs.

*Agonias* is a culture-specific somatic phenomenon within the Portuguese immigrant community. James (2002) was the first to identify and describe the term *agonias* (meaning “the agonies”), used by Portuguese immigrants to describe their symptoms. An understanding of and research into *agonias* evolved at a Portuguese mental health clinic in Massachusetts, at which clients commonly presented with this self-described affliction. Despite the lack of previous documentation of this condition, its prevalence in the Portuguese immigrant community is quite high, with 63% of individuals in one study reporting having
had *agonias* (James et al., 2004). This idiom of distress has idiosyncratic meanings and symptoms for different people, including asthma (a “lack of air”), heart problems, and gastrointestinal problems such as burning from within or indigestion. It is baffling to clinicians because the severity of *agonias* is also remarkably broad, ranging from troubles sleeping, to being literally “on the brink of death” (James & Prilleltensky, 2002), and does not map onto DSM categories. Until recently there has also been little documentation of *agonias* in North American or Portuguese health/mental health literature, thus posing an additional challenge for mental health professionals attempting to understand it. As one provider shared, *agonias* is “the single most difficult problem to treat with Portuguese immigrants” (James, 2002).

There are substantial differences between lay and professional understanding of *agonias*. In a previous study, clinicians in Canada were interviewed about the way in which they conceptualise and treat *agonias* (James et al., 2006). Unanimously, they stated that they understood *agonias* to be anxiety and/or depression and that the treatment is psychopharmacology and psychotherapy, but that their treatments are often unsuccessful. The meanings clinicians ascribed to *agonias* were very different from those of the community members. Only 4% of community members described *agonias* as anxiety and none described it as depression. Rather than an individualistic conceptualisation of *agonias*, community members’ explanations were more related to their socio-religious context. Some said that a person could experience *agonias* because of spousal maltreatment or if they have had a premonition that an impending catastrophe will strike another community member. Others linked *agonias* to their religion; some said that it was God-given so that there was no cure; others said that prayer was the cure; while others said that they experience *agonias* because they have sinned. Patterns of responses emerged which showed three types of
agonias (agonias of illness, agonias of death, and agonias from a premonition), which were supported by the results of a cluster analysis (James et al., 2005).

Dias (2009) applied habitus to the case of agonias, demonstrating how the embodiment of agonias “can be understood via the habitus where the body takes center stage as a meaning (re)producing social agent” (p. 22–23). Agonias therefore becomes a re-creation of social structure.

Problemas de nervos is another culture bound syndrome that has been presented by Portuguese clients in North America (James, Fernandez, Navara, Harris, & Foster, 2009). Through interviews and questionnaires completed with 32 Portuguese immigrant women in Waterloo, Ontario and Boston, Massachusetts, James et al. found many meanings of problemas de nervos. These resulted in four main categories which were: 1) mal da cabeca referring to problems with or in the head, such as having visions or a sense of a lack of control, which could be treated by seeing a health care provider; 2) aflição meaning to be afflicted by nervous attacks or heart problems, among other problems, which could be treated by receiving emotional support or prayer; 3) immigration stress, causing sleep problems, which could be addressed through medication; and 4) conflicts with others, leading to pressure within the body, which could be treated through relaxation. Since this research bridged two countries, it also highlighted the interesting finding that Portuguese Canadians were more likely to cite health care providers and medication as a possible resource for healing, while the Portuguese Americans cited no cure or home and indigenous remedies such as prayer or teas. This indicates that the culture of the client is not the only determinant of what kind of help is sought for emotional distress.
Theoretical Framework

The theoretical framework for this entire project is the aforementioned Kleinman’s sociosomatic framework (Kleinman, 2008; Kleinman & Becker, 1998). According to this framework, healing processes develop in social worlds. Beliefs, diagnoses, disordered behaviours, treatments, and sanctioned cures are all shaped by cultural contexts. Health care systems develop from a dynamic process in which cultural notions about specific disorders impact healing. Health care systems therefore become a representation of the society in which they exist. According to Kleinman (1988b), healing involves not only curing the disease but also curing the illness, a cultural healing process that occurs not only for the individual but also for his or her family and social group. Therefore the ways that members of a specific culture seek help is central to how they conceptualize and receive healing.

Ethnographic Methods in Counselling Psychology

Ethnography is the cornerstone of anthropological research. It is referred to as “perhaps, the original and quintessential qualitative research method” (Taylor, 1994, p. 34). It offers the reader an intricate, nuanced understanding of cultural phenomena from an emic perspective. It may focus on specific cultural aspects or provide a broader description of the lifestyle of a particular culture group. Ethnography is fundamentally qualitative and is an interpretive-phenomenological approach (Bernard, 1995), however, it may also include quantitative methods and results.

Ethnography requires prolonged contact and activity in field and extensive participant observation. The depth and length of engagement required has in the past made this method a rare one in the field of counselling psychology. However, ethnography is excellently suited to multicultural research and developing a contextual understanding of diversity (Suzuki,
Ahluwalia, Mattis, & Quizon, 2005), and therefore several counselling psychologists including Suzuki and colleagues have advocated for increased incorporation of ethnographic methods into counselling psychology research. Stewart (2003) also advocated for ethnographically informed methods in psychology, arguing that ethnographic methods agree with the value that psychologists place on the social context of individuals. This study aims to understand human agency and intentionality in the context of relationships, and to gain cultural understandings from the vantage point of the informant’s subjective experience (Young, Marshall, & Valach, 2007). Ethnography is a method that allows for this to occur. Gerstein et al. (2007) discussed means for incorporating anthropological methods into counselling psychology research, and points to a seminal study by Pope-Davis and colleagues (2002) as an example of the benefits of using a qualitative, inductive approach. Such an approach allows for concepts to come into awareness that are not currently part of recognized models, and in the study by Pope-Davis and colleagues was particularly useful because they were studying multicultural counselling competencies from the client’s perspective. Likewise, ethnography does not superimpose pre-existing constructs onto data collection and therefore allows new culture-specific content to come to light.

Ethnography focuses on information as embedded in context—historical, political, social, and economic contexts—and its interpretation is dependent on these contexts (Suzuki et al., 2005). While ethnography allows for consideration of the culture of the investigator, and the interactions between investigator and informants, it relies on informant accounts to generate information, as opposed to testing the researcher’s pre-existing models and theories. This method therefore can be used for research in multicultural contexts where the researcher may not presume to have the same historical, political, social, and economic context as the
research participant. The information is coming from the informant, and not the researcher, with the exception of the impact of the researcher on the research environment.

We should aspire to practice not only multiculturally competent counselling but also multiculturally competent research. Gerstein et al. (2007) recommended that to practice the latter is to use a research method compatible with the ways a participant or group of participants communicate. For example, when engaging in research with a group of people who have a rich oral tradition, it may be more culturally competent to gather information through oral interviews than through paper and pencil surveys. External validity is then increased. These authors join a growing group within the discipline espousing the use of qualitative methods for multicultural counselling research (Morrow, Rakhsha, & Castañeda, 2001; Ponterotto, 2002; Pope-Davis et al., 2002; D. W. Sue et al., 1996).

An example of ethnography in counselling psychology includes Kirk Beck’s investigation of child abuse reporting (Beck, 2000). Counselling psychology researchers Ainslie and Brabeck (2003) used a “psychoanalytical ethnographic approach” to explore the impact of the murder of James Byrd on the multiracial community of Jasper, Texas. Siddique (2011) demonstrated how ethnography and auto-ethnography can be used for psychotherapy research using field notes from an in-patient mental health setting for women. Pipher’s (2002) in depth study of the lives of refugees in Lincoln, Nebraska, is another example of ethnography in the field of counselling psychology.

**Summary and Research Question**

Seeking help for mental illness involves several steps, a process which in the multicultural context involves many hurdles. For immigrants, these hurdles occur at multiple levels, including the community, the system, providers, and the individual, resulting in a
much lower rate of mental health resource use than in the native population. Barriers to mental health care include cultural differences, economic status, acculturation, and stigma. Research in the multicultural counselling field has shown that multicultural counselling competencies and the working alliance have a great impact on therapy outcomes, but knowing how these concepts apply to different culture groups is still growing.

My specific population of interest, Portuguese Canadians, forms a substantial immigrant group in Canada, numbering 410,850 (Statistics Canada, 2006). Through prior research with Dr. James’ lab I found that Portuguese immigrants are reluctant to seek help outside the family (Morrison & James, 2009), therefore their mental health needs often go unmet. Unfortunately, when they do seek help, providers’ lack of cultural competence is likely to lead to misdiagnosis and poor outcomes (James et al., 2006). This is because this ethnic group has unique mental health needs for the treatment of which many clinicians are not trained, including agonias and problemas de nervos. Therefore, the current research addressed the question that arose out of our lab group’s previous research with this population: What are the helping relationships for personal and emotional problems in the Portuguese Canadian community? This question and the study were developed using Kleinman’s theoretical framework, and ethnographic methods were used to describe helping relationships in their cultural context. Specifically, Spradley’s (1979) Developmental Research Sequence was used as a guide for question formulation and analysis. The purpose was to obtain a thick description of helping relationships in the context of the Portuguese Canadian community.
Chapter 3: Method

This study of helping relationships in the Portuguese community was conducted using Spradley’s (1979) Developmental Research Sequence (DRS). This method was used to answer the study’s main research question: *What are the helping relationships for personal and emotional problems in the Portuguese Canadian community?* To answer this question, the author lived in a Portuguese-Canadian community for one year and during that time engaged in participant observation, attended festivals and events, conducted informal interviews in the community, and conducted one or more in depth interviews with ten key members of the community. The research question guided the observations, engagements, and direction of the in depth interviews.

This methods chapter describes the rationale for the research method used to explore the research question. The recruitment of participants is described, as well as the steps to Spradley’s (1979) method and how they were carried out in this study. Examples are provided to illustrate the procedural steps in action. Finally, the stance of the researcher, as well as steps to establish trustworthiness and credibility, are described.

**Rationale for the Use of Ethnographic Methods**

A qualitative method is the preferred starting point for exploring previously undocumented phenomena (Creswell, 2013). Given that little research exists with Portuguese Canadians, and no research regarding their engagement in counselling or therapy, a qualitative approach using ethnographic methods was selected as the best way to begin to understand this area. The use of ethnographic methods was specifically chosen because these methods are consistent with the theoretical framework of this study. As explored in the literature review above, briefer forms of ethnography are increasingly being used in non-
anthropology disciplines such as counselling psychology. However, in honour of the true concept of ethnography it is acknowledged that the quantity of time spent in the field did not permit a holistic description of the culture, rather it permitted exemplars to be observed and described that addressed the research question. Therefore this study was not a full ethnography but rather a qualitative study using ethnographic methods.

**Paradigm of ethnography**

Given that this study used ethnographic methods as much as practical and possible, this method is described below. Ethnography not only describes a method of data collection but also a philosophical framework (Atkinson & Hammersley, 1994). It falls within the post-positivist and constructivism-interpretivism frameworks (Suzuki et al., 2005). Ethnography is a form of social research that explores particular social experiences, gathers and uses unstructured data, uses a relatively small number of research participants, and addresses the meaning of human behaviour (Atkinson & Hammersley). Any method of gathering and describing information may be used for data in ethnographic research. However, the hallmarks of ethnographic methods are fieldwork, prolonged engagement in the field, and participant observation (Suzuki et al.). The nature of the researcher’s training background determines the specifics of how these concepts are operationalized. Suzuki et al. discuss discipline-dependent discrepancies in perceptions of what prolonged engagement means: according to psychology texts, prolonged engagement ranges from six months to two years, while the anthropology field expects prolonged engagement to last a minimum of one year (Suzuki et al.). One benefit of prolonged engagement is that it allows for trust to be established between researcher and informant. This latter aspect is particularly important for the Portuguese Canadian community, as a group who rarely seeks out professional
counselling support is also unlikely to readily embrace a researcher who is not from their culture.

While classical ethnographies, including Boas (1888/1964) and Malinowski (1922), examined entire societies, modern ethnographic research tends to focus on specific questions or problems. Suzuki et al. (2005) wrote specifically about how this shift away from examining stable communities of others provides a shared goal for counselling psychology and ethnography, as they both seek to understand how individuals experience changes in their identities, roles, and functions as a result of external socio-political changes. Ethnographic approaches have been expanded, elaborated upon, and invented in recent years to address new problems (Bernard, 1995). One shift in particular has been towards the importance of language as the medium through which all knowledge is communicated. Therefore, cultural anthropology has shifted from a focus on beliefs and customs to a focus on discourses and practices (Ortner, 1994, as cited in Frank & Polkinghorne, 2010). This is exemplified by an important and oft-quoted figure in the field, Clifford Geertz. In his collection of essays, *The Interpretation of Cultures* (1973), Geertz referred to Max Weber who wrote about the individual as “suspended in webs of significance which he himself has spun” (p. 5). This exemplifies an interpretive view that emphasizes experience and meaning (Frank & Polkinghorne). Geertz (1973) also urged that ethnography should be “thick description,” after British philosopher Gilbert Ryle’s distinctions between thick and thin description. Actions should be interpreted in context, and meaning should be examined. Current anthropology research also examines power and knowledge, which requires more than just the study of interview transcripts; it requires creative engagement with the data in its social context, with a consideration of relevant social theories (Frank & Polkinghorne).
Because the current qualitative study used ethnographic methods, the above developments of this method were taken into consideration. The research was constructed according to Frank and Polkinghorne’s (2010) recommendations for improving qualitative research in the health sciences:

1. To pay close attention to language in interviewing, analysis, and interpretation;
2. To provide a “thick” description of the research situation and its dynamics, the lives of the research participants, and their socio-cultural contexts;
3. To provide observations of how the phenomena under study play out, not only participants’ descriptions of it;
4. To use qualitative data interpretatively to solve problems and develop theories, rather than solely naturalistically;
5. To take steps to establish and evaluate the trustworthiness and credibility of the research.

**Rationale for the use of Spradley’s developmental research sequence**

Many recent ethnographic studies, particularly in the fields of nursing and education, have used Spradley’s developmental research sequence (DRS) protocol. Examples in related fields (particularly nursing) include Banister and Schreiber (2001), Bernstein, Lee, Park, and Jyoung (2008), Salzmann-Erikson, Lützén, Ivarsson, and Eriksson (2011), Santas Kraatz (2001), and Wallace, Tuck, Boland, and Witucki (2002). Benefits of this approach for research are the step-wise process, level of detail, applicability to all cultural phenomena, and broad coverage of types of questions and ways to analyze the data. It is suitable to research in counselling psychology because the method allows for a rich description of a culture or aspects of a culture that can inform practitioners working with this group. Members from all
aspects of the community can be interviewed, and all ages (within ethics approval restrictions), allowing for a view of the lifespan development of the phenomenon of interest. This method is recommended for those new to ethnography, coming from other disciplines like counselling psychology, who require a detailed guide, as well as for those experienced with ethnography (Spradley, 1979). Banister conducted an ethnography with Peavy (1994) using this approach, which was published in the Canadian Journal of Counselling. This was a study of the experiences of five women who were married to alcoholics. A study by Santas Kraatz (2001) focused on a similar topic to the current research study, the structure of health and illness in a Brazilian favela (urban slum). This researcher used Spradley’s methodology to interview 10 informants, thus developing a contextual picture of health and illness according to the favela’s residents. A recent use of Spradley’s Development Research Sequence in the field of Counselling Psychology was Connie Ng’s study of Chinese clients’ counselling experiences (Ng & James, 2013a; Ng & James, 2013b). Through ethnographic interviews with eight informants she learned that Chinese clients perceive counsellor empathy as a different phenomenon from the western conceptualization.

**Qualitative Study of Portuguese Canadians using Ethnographic Methods**

Building on the research of James and colleagues’ earlier projects, including Portuguese immigrants’ experiences of *agonias* (James, 2002; James et al., 2005; James et al., 2006; James et al., 2004), and familial acculturation (Morrison & James, 2009), this study is an investigation of Portuguese Canadians’ perceptions of and use of helping relationships. Using ethnographic methods, I interviewed men, women, community leaders, and healers in groups and individually, and engaged in participant observation.
Geographic description of the community.

The community in which the majority of the field research was conducted was about a five-minute drive away from the downtown of a large western Canadian city. It had been a vibrant, close-knit Portuguese area in the 1960’s and 1970’s. At the time of my research it was still the Portuguese business core, but many Portuguese Canadians had moved their homes further away from this district. I lived in the community for one year from September 2011 to August 2012 during my pre-doctoral internship.

In the 1980’s the main street in this community hit its lowest point with high rates of drug dealing and prostitution. While I lived there, people in the community spoke often of the drug dealing and prostitution prevalent in the community during that period, which had declined in recent years but was still visible. Due to the revitalization of the community, community and arts organizations were moving in which gave my family and I the good fortune to qualify to live in a new, government-subsidized condominium cooperative. I learned the benefit of extended time in the field for the study I was conducting. For example, it took me four months to actually “see” evidence of either prostitution or drug dealing. However, once I did, I saw both on a daily basis; small groups of men huddled together in the playgrounds, and the same few women walking purposefully up and down the main street which I crossed to deliver my daughter to her day-home (at-home day care) early in the morning.

Beside our condominium was the busiest Portuguese bakery and catering service in the area, run by a man who originated from mainland Portugal. I stopped here almost every day for a visit with my toddler or to pick up some bread, or a Portuguese flame-grilled chicken. Directly across the street from our building were the community centre, playground,
and park. Also across the street and one block down was the day-home where our toddler spent her mornings. Three blocks farther was another Portuguese bakery and catering service, as well as the Portuguese hairdresser. Then three kilometres further along the main street was the third Portuguese bakery; and close to that bakery was the large Portuguese Catholic Church, which was a centre of social activity, and around which many parishioners’ homes were located. In this area also was the Portuguese club, a large multi-function building somewhat on the outskirts, in a semi-industrial area. Two blocks in the other direction from our building was a Portuguese barber, where Portuguese Canadians who had moved to outlying areas came in for haircuts and to reconnect with the community. Here there was also a community-run arts café where community organizers met and where I conducted several of my interviews. One block further along was a major cross street at which were located the Portuguese sports bar where gambling was suspected, and the more reputable local charcutaria where people could sit and watch football and have soup and a drink, and which sold traditional Portuguese meals such as bacalha à bras (a salt cod and potato dish that we regularly enjoyed). This was run by and mostly frequented by Açoreans. This area was also adjacent to the Italian district that included a large grocery store with a substantial deli and bakery, and Italian-run pawn shops. Then several blocks in the other direction was an upscale Portuguese restaurant run by mainland Portuguese proprietors, as well as the Portuguese language school and music society.

I followed Spradley’s (1979) guidelines for the types of questions asked and analyses conducted. Below I have outlined the major steps of ethnographic inquiry as informed by Spradley:
Step 1: Locating informants.

Selection criteria.

For the purposes of this study, members of the cultural group of Portuguese Canadians included any individual who was from, or had parents from, the Açores or mainland Portugal. Also included were any individuals who consider themselves to be a member of the Portuguese Canadian community, or who are considered by other members of that community to be so. Since the community was close-knit and connected through café visits, club participation, and church, I did not expect it to be difficult to delineate who was a member of this community and who was not. I excluded Portuguese-speaking individuals who were not from Portugal or the Açores, until I learned from informants that the parish priest was from Brazil, and that priests to Portuguese parishes tend to be Brazilian because there are more Brazilian priests than Portuguese priests. I sought out informants by talking with café and club owners and other Portuguese businesses, and community leaders, and by posting study recruitment flyers at these locations. These flyers conformed to UBC Behavioural Research Ethics Board (BREB) requirements. I attempted to interview these individuals directly, and also to be introduced by them to other informants in the community. I also contacted physicians, psychologists, and counsellors who work in the area of the Portuguese community, as well as those in the city who were Portuguese-speaking, in order to gain their perspectives on how members of this community engage in helping relationships. Preliminary visits to businesses within the Portuguese community, with the assistance of a Portuguese visiting postdoctoral scholar, were beneficial and demonstrated that this was indeed an active and vibrant Portuguese community with many members. Informants were offered a small honorarium to compensate for their time spent in interviews.
The majority of the informants lived in surrounding neighbourhoods, about a five minute drive away from the Portuguese area; a few lived approximately a 10–15 minute drive away. About half of the informants worked in the Portuguese area; the remaining individuals visited regularly, which is how they saw my recruitment posters. Most of the informants had siblings or parents who lived in, or near, the Portuguese community and were involved in the community.

Given that Portuguese Canadians do not readily seek out help outside the family, I expected this trend to be mirrored in their receptiveness toward research. Differences in these comparable situations were that I was advertising and seeking out participants, whereas professional helpers rarely do so; I was offering an honorarium whereas one typically must pay a professional helper; and I was taking the position of “learner” and “student” in these encounters and not offering advice or solutions to individuals’ problems, although I sometimes did provide referrals. In these encounters, the informant was the expert. I also engaged in slightly more self-disclosure than I necessarily would in a therapeutic encounter. However, I do tend to engage in more self-disclosure in therapy when my culture differs significantly from my client’s culture, in response to the client’s questions about my family, my experience, and where I am from.

**Hard-to-reach populations.**

Hard-to-reach populations include immigrants and the homeless, among other groups. Those who do not speak the dominant language or move in the dominant culture tend to be considered to be hard to reach (Tankimovich, 2013).
Definitions.

Using Sydor’s (2013) definitions, a hard to reach population is one that is difficult for researchers to access. In the present study, this was the case due to cultural differences, language differences, and the undesirability of talking to members of the counselling psychology field. This latter factor taps into the concept of the “sensitive subject,” which is a subject that people avoid discussing publicly, because they deem themselves to be at risk in some way should others find out about the nature of the discussion (Sydor).

Ways to access hard-to-reach populations.

There are several major ways to access hard-to-reach populations beyond the typical poster or advertisement recruitment (Sydor, 2013). The first is to partner with a community organization or charity that serves the population of interest (Benoit et al, 2005). This approach was used in the current study, which was beneficial given that Portuguese community organizations hold a very important role in the community. An administrator provided access to the priest and connected me with bilingual facilitators of the seniors’ lunches. The second major way to access a hard-to-reach population is through snowball sampling. This approach was attempted in the current study; each informant was asked if they could recommend the study to friends and family members in the community. Two informants successfully referred a family member. Other informants listed significant individuals in the community that I could contact, who held major helping or organizing roles (a Portuguese radio announcer, a notary public, and a Portuguese family physician who served the community). The third route to recruitment is internet recruitment, which has gained popularity in recent years and in certain forms incorporates anonymity, privacy, and accessibility. However, this approach is only useful for reaching those who use the internet,
which was not common in this population. This approach was therefore not used in the current study.

**Step 2: Interviewing informants.**

Data collection occurred through participant observation and individual interviews. Informants signed a consent form (Appendix A) and were given a series of demographic questions to answer either in written or verbal form (Appendix B). Informants were given the opportunity to be interviewed in their native language (Portuguese) with the assistance of an interpreter, however, only those who spoke English fluently and bilingually responded to the recruitment posters, so while I had a translator available, he was not needed. I used prompts to orient the discussion to the informant’s experience of seeking helping relationships for emotional or personal issues. The ethnographic interview was composed of three elements: its explicit purpose, ethnographic explanations, and ethnographic questions (Spradley, 1979). The first element involved the formal explanation to the informant of the explicit purpose of the project; the second element, ethnographic explanations, involved explaining the purpose of that particular interview, the purpose of the questions, how information is recorded, and asking informants to speak the way they “normally do” or in their native language. Then three main kinds of ethnographic questions were asked: descriptive questions, structural questions, and contrast questions (Spradley), which facilitate a deeper understanding of the informant’s cultural context. These types of questions are described in further detail below. Appendix C is a list of guiding questions for the individual interviews. Informants were offered the opportunity to give feedback regarding the resultant domains of the research. Interviews were audio recorded.
In all, 10 informants were interviewed. The average age of interviewee was 46 (SD = 12.3, 24–63). Informants were evenly split by gender, five women and five men. They held a variety of roles in the community, including counsellor, urban/land use planner, office administrator for an important Portuguese community position, retired quality inspector and leader of a Portuguese organization, medical office administrator, pastor, business owner and church leader, owner/operator of a hair salon, recent graduate of a Master’s degree in Public Health, and Priest to a Portuguese parish. Regarding religious positions or beliefs, two informants were practicing Catholics, two were Catholic but attended church only occasionally, one had a Catholic background but was currently practicing as Neo-Apostolic, one had a Catholic background but had transitioned to integrative spiritual beliefs, two did not express any religious beliefs, and two were Pentecostal. Their levels of education were generally higher than the norm; one had not completed Grade 12, one had completed Grade 12, two had technical or business certifications, one had some university, two held Bachelor’s degrees, two held Master’s degrees, and one was completing a PhD dissertation. Regarding country of origin, two informants were born in the Açores, three in Canada from Açorean parents, three informants were born in Portugal, one was born in Canada from Portuguese parents, and one informant was born in Brazil. All informants claimed Portuguese as their first language with the exception of one individual who stated that English was her first language. Four informants spoke Portuguese at home, four spoke both English and Portuguese, and two spoke English. Seven informants were married or common law, and had children, and three were single and did not have children. Five of the informants had helper roles in the community (the counsellor, the two clergy, the church leader, and the hairdresser). Five informants—two who were also helpers—had been recipients of
counselling (the counsellor, the hairdresser, the urban/land use planner, the medical office administrator, and the leader of a Portuguese organization). Two informants were neither helpers nor helpees. Demographic details are provided in Table 7.
### Table 7. Research Participants’ Pseudonyms and Demographic Information

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Julia</th>
<th>Paul</th>
<th>João</th>
<th>Rodrigo</th>
<th>Maria</th>
<th>Carlos</th>
<th>Margarida</th>
<th>Angelina</th>
<th>Elizabeth</th>
<th>Tony</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age range</td>
<td>40–50</td>
<td>30–40</td>
<td>50–60</td>
<td>60–70</td>
<td>50–60</td>
<td>40–50</td>
<td>40–50</td>
<td>40–50</td>
<td>20–30</td>
<td>40–50</td>
</tr>
<tr>
<td>Sex</td>
<td>F</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Occupation</td>
<td>Counsellor</td>
<td>Urban/land use planner</td>
<td>Office Administrator</td>
<td>Retired quality inspector</td>
<td>Office Administrator</td>
<td>Pastor</td>
<td>Business Owner</td>
<td>Owner/Operator Hair Salon</td>
<td>Unemployed</td>
<td>Priest</td>
</tr>
<tr>
<td>Education</td>
<td>MA Counselling</td>
<td>BA</td>
<td>2 yrs NAIT – business</td>
<td>Technical school in Portugal</td>
<td>Some univ</td>
<td>Post-secondary</td>
<td>Gr. 11</td>
<td>Gr. 12</td>
<td>Master’s Degree</td>
<td>PhD Theology student</td>
</tr>
<tr>
<td>Country of Origin</td>
<td>2nd gen.; Açores</td>
<td>2nd gen.; Portugal</td>
<td>1st gen.; Açores</td>
<td>1st gen.; Portugal</td>
<td>1st gen.; Açores</td>
<td>1st gen.; Portugal</td>
<td>2nd gen.; Açores</td>
<td>2nd gen. Açores</td>
<td>1st gen.; Brazil</td>
<td></td>
</tr>
<tr>
<td>Other countries lived</td>
<td>N/A</td>
<td>Portugal, Brazil, &amp; Mozambique</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>England</td>
<td>None</td>
<td>N/A</td>
<td>Brazil, Italy</td>
</tr>
<tr>
<td>Pseudonym</td>
<td>Julia</td>
<td>Paul</td>
<td>João</td>
<td>Rodrigo</td>
<td>Maria</td>
<td>Carlos</td>
<td>Margarida</td>
<td>Angelina</td>
<td>Elizabeth</td>
<td>Tony</td>
</tr>
<tr>
<td>-----------</td>
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<td>------</td>
<td>---------</td>
<td>-------</td>
<td>--------</td>
<td>-----------</td>
<td>---------</td>
<td>-----------</td>
<td>------</td>
</tr>
<tr>
<td>First Language</td>
<td>Portuguese</td>
<td>Portuguese</td>
<td>Portuguese</td>
<td>Portuguese</td>
<td>Portuguese</td>
<td>Portuguese</td>
<td>Portuguese</td>
<td>Portuguese</td>
<td>English</td>
<td>Portuguese</td>
</tr>
<tr>
<td>Other Languages</td>
<td>English</td>
<td>French, English</td>
<td>English</td>
<td>English</td>
<td>English</td>
<td>French, English, Spanish</td>
<td>French</td>
<td>English</td>
<td>N/A</td>
<td>Italian, English, some Spanish</td>
</tr>
<tr>
<td>Languages spoken at home</td>
<td>Portuguese</td>
<td>Portuguese</td>
<td>Both</td>
<td>Portuguese &amp; English</td>
<td>English</td>
<td>Portuguese/English</td>
<td>Portuguese/English</td>
<td>Portuguese</td>
<td>English</td>
<td>N/A</td>
</tr>
<tr>
<td>Relationship status</td>
<td>Married</td>
<td>Single</td>
<td>Married</td>
<td>Married</td>
<td>Married</td>
<td>Married</td>
<td>Married</td>
<td>Divorced &amp; Common-law</td>
<td>Single</td>
<td>Single</td>
</tr>
<tr>
<td>Children</td>
<td>1 toddler</td>
<td>N/A</td>
<td>2 adults</td>
<td>2 adults</td>
<td>1 teen, 1 adult</td>
<td>1 teen, 1 adult</td>
<td>1 teen, 1 adult</td>
<td>2 teens</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Family members in the home</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4 to 5</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Two of the informants requested a second interview; one of the informants gave a recorded interview after an initial meeting. I contacted all informants after analysing the data to check domains, and this led to six more interviews. The first interview duration ranged from forty-seven minutes to one hour and fifty minutes. Table 8 gives interview transcript length, duration, and number.

Table 8. Length of Interviews

<table>
<thead>
<tr>
<th>Interview</th>
<th>Number of pages (double spaced)</th>
<th>Duration</th>
<th>Second Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>32</td>
<td>1:20:47</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>41</td>
<td>1:35:58</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>31</td>
<td>1:02:47</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>41</td>
<td>1:50:54</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>39</td>
<td>1:21:57</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>37</td>
<td>1:35:09</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>26</td>
<td>1:13:07</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>24</td>
<td>47:27</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>27</td>
<td>1:09:19 + about 15 minutes unrecorded</td>
<td>Written feedback</td>
</tr>
<tr>
<td>10</td>
<td>22</td>
<td>1:11:06</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Table 9. Quantity of Fieldwork

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field work (hours)</td>
<td>Approx. 250</td>
</tr>
<tr>
<td>Visits to Portuguese events, churches, shops</td>
<td>Approx. 114</td>
</tr>
<tr>
<td>Pages (double-spaced) of field notes</td>
<td>23</td>
</tr>
<tr>
<td>Pages (double-spaced) of interview transcripts, initial interviews (10)</td>
<td>320</td>
</tr>
<tr>
<td>Pages (double-spaced) of notes, second interviews/participant checks (8)</td>
<td>39</td>
</tr>
<tr>
<td>Formal interviews</td>
<td>17 (14 audio-recorded)</td>
</tr>
<tr>
<td>Total length of formal interviews</td>
<td>21 hours and 25 minutes</td>
</tr>
</tbody>
</table>

Step 3: Making an ethnographic record.

Throughout the research process I made an ethnographic record that incorporated the following four written forms: (a) field notes; (b) a record of the language and terms informants use when talking about mental health and helping relationships; (c) a field work journal with my own reactions to the research events; and (d) a log of my analyses and interpretations throughout the research process (Spradley, 1979). Examples of these records can be found in Appendix E through G. I endeavoured through these multiple forms of recording to achieve Geertz’s (1973) thick description.

Step 4: Asking descriptive questions.

Spradley (1979) lists five types of descriptive questions, intended to elicit detailed descriptions of the cultural context and experience. They are: 1) grand tour questions that elicit verbal descriptions of significant features of the cultural scene; 2) mini-tour questions that access a smaller aspect of experience than the grand tour question; 3) example questions; 4) experience questions, where the informant is asked to recount an experience they had that
illustrates answers given to grand tour, mini-tour, and example questions; and 5) native language questions that ask the informant to explain how something is talked about in their own language. Informants often monitor their language when speaking to an outsider, using globally used terms. This step encourages informants to give the terms they use within their own culture. In the current study, grand tour questions focused on what people do when they have social, emotional, or personal problems; the more specific types of questions were incorporated as informants described their answers to the grand tour questions. The following is an example from one interview of a grand tour question that also elicited significant detail and a personal example, a common occurrence in the interviews I conducted:

*Int*: What do people in the community do when they have personal problems or emotional problems or? Like, do they talk to each other? Do they go to the doctor, do they?

*Inform*: It first start with each other, What I sense is that it starts with each other, and then I have seen actually people recommending you know, you should go see the doctor or you should go talk to a lawyer and you know, like uh, but some people seem sometimes, I don’t say its true the whole community is like that but, I have known of cases where people even call me saying, “Hey, I have a problem, what do you think?” You know. But then again, you talk to five different people in order to get one answer, “Well no its not like that because I talk to so and so and he or she told me this and that, and I think you are not up to par on that,” I said, “I know, but I also talk to this so and so, and they says,” I said, “Whoa whoa whoa, you calling me to tell me how it is or are you asking for an opinion because you already talk to so and so and they give you all this information and now you’re asking me to give you an okay on that? You know, I’ll give you my opinion and this is it.” Sometimes, it can be confusing. (Rodrigo)

The following is an example from my interview with the priest of a native language question and the response:

*Inform*: Umm. You know, when a person look for a priest, they look to the priest to confirm that thing they are thinking because they ... they need someone to confirm that thing they think because they are not able to take the things by themselves.

*Int*: So they need the encouragement? The support?

*Inform*: Not encouragement but there is a word I can’t I don’t know this word in English, but—

*Int*: What is it in Portuguese?
Inform: Inseguros.
Int: Insecure. Inseguros—okay.
Inform: Yeah, yea. They would like to have—with... in Portuguese, segurança [security]. They are not able to—they are sure that they want that thing, but they are not able to, themselves, to get that. Sometimes, it’s like a confession, so if someone comes to you and tell you “Father I did this, does this seem, is it sin or not?” I tell them, “Your conscience should know if this is sin or not. I am not here to tell you what is sin or not, you should know.” (Tony)

**Step 5: Analyzing ethnographic interviews.**

Analysis occurred inductively so as to allow for the development of indigenous categories of local meanings, without relying on non-indigenous assessment tools. Spradley’s (1979) approach to analysis involves discovering and using the pre-existing cultural categories of knowledge. Overall ethnographic analysis is defined as “a search for the parts of a culture, the relationships among the parts, and their relationships to the whole” (Spradley, p. 142). The analysis in this study was conducted using QSR International’s NVivo 10 (2014). The first eight interviews were coded inductively. These codes were then subjected to the more specific analyses below. The four kinds of ethnographic analysis used by Spradley are domain analysis, taxonomic analysis, componential analysis, and thematic analysis. These are described below.

**Step 6: Making a domain analysis.**

A domain is a symbolic category that contains other categories. Domains incorporate a cover term and included terms. Included terms are defined by Spradley (1979, p. 100) as folk terms that are a part of the body of knowledge labeled by the cover term. The semantic relationship indicates how an included term is linked to the cover term (Spradley). Spradley suggests starting with searching for semantic relationships that can be reduced to three basic types: (1) taxonomy or inclusion (x is a type of y); (2) attribution (an x has y); or (3) queuing
or sequence (an x goes through the stages of y and z). Overall, Spradley (p. 111) lists nine semantic relationships:

- **Strict inclusion**: X is a kind of Y
- **Spatial**: X is a place in Y, X is a part of Y
- **Cause-effect**: X is a result of Y, X is a cause of Y
- **Rationale**: X is a reason for doing Y
- **Location for action**: X is a place for doing Y
- **Function**: X is used for Y
- **Means-end**: X is a way to do Y
- **Sequence**: X is a step (stage) in Y
- **Attribution**: X is an attribute of Y

In the current study, the codes were searched and categorized, using NVivo, according to the above relationships, for the first eight interviews. The last two interviews were then analyzed according to the existing domain structure to evaluate the comprehensiveness; all codes in the last two interviews did fit into the existing domains.

**Step 7: Asking structural questions.**

Structural questions are tools for discovering information about a folk domain (Spradley, 1979) such as eliciting examples of a cover term. In this study the major structural question was “What are forms of helping relationships” and, as the research continued, “What are the qualities of a good helper?” Participants were also asked to give personal examples of each.
Step 8: Making a taxonomic analysis.

A taxonomy demonstrates the internal organization of a domain, that is, the ways in which included terms are related to one another and the cover term (Spradley, 1979). Folk taxonomies typically have different levels. At this stage the researcher focuses in on domains of interest to the research question, and produces a visual representation of the relationships between included and cover terms (Spradley). A visual representation of the taxonomy of the domain “Accessing the Portuguese community to prevent or cope with problems” is below:

Table 10. Taxonomic Structure of the Domain “Accessing the Portuguese Community to Prevent or Cope with Problems”

<table>
<thead>
<tr>
<th>Included terms</th>
<th>Subdomains</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1. Connecting to the community</td>
<td>4.1.A. Connecting through shops and businesses</td>
</tr>
<tr>
<td></td>
<td>4.1.B. Belonging through clubs and common goals</td>
</tr>
<tr>
<td></td>
<td>4.1.C. Acknowledging helpers within the community</td>
</tr>
<tr>
<td>4.2. Barriers to connecting with the community</td>
<td>4.2.A. Taboo topics</td>
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<td>4.2.B. Lack of group membership</td>
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<td>4.2.B.iii. Sports</td>
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<td>4.3. Insularity</td>
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The organization of the other domains is represented in the tables in the findings section of this dissertation.

Step 9: Asking contrast questions.

Asking contrast questions allows for a better understanding of cultural symbols by ascertaining how they differ from other symbols (Spradley, 1979). One contrast question I
asked in this study was how one kind of helping relationship differed from another. Contrast questions such as this were asked throughout the interview process. For example, Maria was encouraged to describe the difference in receiving help from different kinds of professionals, after recounting a bad experience with a social worker:

Inform: I have since found that, if there is a hierarchy of counsellors—social workers, psychologists, and psychiatrists, and all of those and I understand the distinctions between all of them and I have a fairly good idea of the training that each type precedes, I would have to say that social workers would probably be an entry level. There wouldn’t be a choice at all. Maybe working with children or families in distress, maybe but. . . .

Int: Have you had any experiences with other people in the profession?
Inform: Oh yes, yes. Over the years, I needed to seek counselling. . . . I learned the hard way to investigate their background, their area of specialization, and to ensure that I am not dealing with somebody with an MEd or an MA because it’s not what I want—needed. That might be suitable with someone else’s situation but what I wanted was a chartered psychologist. Whether it be for family or personal or whatever it was. That’s what I wanted, that’s what I sought. So, I learned a lesson with that woman, I guess, and I guess it’s the upside of that situation with the social worker. (Maria)

Step 10: Making a componential analysis.

A componential analysis entails the systematic search for attributes, or components of meaning, of cultural symbols (Spradley, 1979). These are essentially qualities that distinguish and describe symbols, and these attributes are revealed through Step 9, the asking of contrast questions. The result is that the various terms in a domain are delineated from one another. Therefore a complete componential analysis becomes apparent near the end of the entire analysis. In the present study, the specific meaning of the cultural symbols is conveyed through quotes and summaries of the discussions around the symbols discovered.

Step 11: Discovering cultural themes.

This step comprises the search for recurring themes among domains and the investigation of how they link to the whole. A cultural theme can be a cognitive principle that
acts as a point of connection among subsystems of cultural meaning (Spradley, 1979). Cultural themes of the present study are presented in the discussion.

**Step 12: Writing the ethnography.**

This final step produces the results of the research and the product is this dissertation. According to Spradley (1979), the ethnography follows five levels of statements, starting with 1) universal statements; then 2) cross-cultural descriptive statements; 3) general statements about a domain; 4) specific statements about a domain; and 5) illustrations using specific incident statements as well as quotes from informants. To that end, the *Findings* chapter begins with a description of universal values of the community, then more detailed descriptions. The latter three levels of statements are represented by the domain tables that follow. At this stage I aspired to Richardson’s (2000, p. 254) criteria for writing a good ethnography of aesthetic merit; I used analytical practices (Spradley’s domains and semantic relationships) to open up the text and invite interpretive responses. Through ten in depth interviews, engagement in the field, and extensive use of quotes and field notes, I aspired to write a text that was correspondingly complex, complete, and informative. Richardson (p. 254) also describes the criterion of “expresses a reality”: does the text present a fleshed out, embodied sense of lived-experience? Is it a credible account of a cultural, social, individual, or communal sense of the “real”? Through aspiring to Geertz’s (1973) “thick description,” again using detailed field notes, quotes, and spending a year in the field, my aim was to express the reality for this community within the confines of the research question, of describing helping relationships.
Stance of the Researcher.

Suzuki et al. (2005) recommend that the researcher address the following questions for self-reflection before engaging in ethnographic research:

What are my personal motivations for studying this topic? Why this place? Why this community? Why these people? How, if at all, will this study benefit me personally? What cultural or personal perspectives and biases do I bring to this process and how might those shape the various phases of this work? Why am I doing this research at this historical, personal, or professional moment? In what concrete ways will the community be benefited or harmed by this work? (p. 208)

I come to this study as an outsider. There are problems inherent in being an outsider, for example the risk of never truly being able to understand the experiences of the group being studied (Suzuki, Prendes-Lintel, Wertlieb, & Stallings, 1999). However, there are also advantages; I come without presuppositions, without the overpowering reality of my own experience as a member of this group. To answer the first question, my primary personal motivation for this study was to engage in meaningful research that has the potential to improve access to counselling resources and to make counselling more culturally sensitive, safe and competent. Also, the field of counselling psychology may learn a great deal from how specific cultures conceptualize helping and healing. In other words, I wish to make a difference through this research. The only personal benefit this study will provide to me is the completion of my doctoral degree. This is a major benefit, but also a transparent one. I brought pre-existing beliefs about the Portuguese community to this study as a result of my previous research engagement with this group. However, that previous experience has also taught me to expect surprises. I conducted this research at this time because Canada has made a dramatic shift to a plural society where culturally sensitive counselling approaches are increasingly important; every therapeutic encounter should be approached as a cross-cultural one (Arthur & Collins, 2010). While some culture groups in North America have
representation within the academy and consequently growing bodies of research, with
Portuguese Canadians this is not the case. There are few Portuguese or other researchers
conducting psychological or social research with this group. Finally, the Portuguese
Canadian community stands to benefit through having their voices heard, and risks harm
through not being heard. Risks of the research include loss of confidentiality, lack of respect
for privacy, and being heard incorrectly. I took steps throughout my engagement with this
group to minimize these risks.

One of Richardson’s (2000, p. 254) five criteria for evaluating ethnography is that of
reflexivity. This concept includes the question of how the author’s subjectivity has been both
a producer and a product of this text, and whether there is adequate self-awareness and self-
exposure for the reader to be able to make judgments regarding point of view. To meet this
criteria I made my biases known up front to the reader, I disclosed my experience with
Portuguese culture to the informant, and I detailed the evolution of my relationship with the
Portuguese community in the methods.

**Becoming a trusted researcher in the Portuguese community.**

I established trust in the community through several means, which I later realized
were also qualities of trusted helpers and helping relationships described by informants in in
depth interviews. I established trust as a researcher via the following processes:

*Learning about Portuguese culture through personal history.*

During the formative years of my undergraduate education I formed close friendships
with second-generation Açorean students. Through these friendships I learned about a very
different approach to family relationships compared to my own: frequent telephone calls with
family members, not only parents but siblings, grandparents, godparents, and aunts and
uncles. I likewise got to know their siblings, grandparents, godparents, aunts, and uncles! I also learned about Portuguese food, pride and generosity. Sharing this origin of my exposure to Portuguese culture with Portuguese community members over the course of the present study facilitated connections and trust.

**Learning about Portuguese culture through study of the literature and research.**

I joined Dr. James’ research team during my Master’s degree and conducted a volunteer research project analysing interviews with Açorean Canadians in Waterloo, Ontario. Through this process, as summarized in the literature review, I became familiarized with the current status of literature on family and socioeconomic dynamics of this immigrant group—including the fact that there was not much in written form. I also learned through the voices of interviewees about the social issues in the communities and families, including isolation of seniors and fragmentation of families. This prepared me to develop my own research objectives and to enter the field knowing basic terms, sociodemographics, and history of the community.

**Living in the community.**

Letting my participants know that I lived right in the community, in a highly recognizable building, helped establish trust. They knew I was centered there and could understand their points of geographical reference. My building was well known and was positioned immediately beside the community building and the Portuguese bakery. My internship site was also very close to the Portuguese community. Through my internship I engaged in rehabilitation psychology with clients who had suffered workplace accidents. My clients were almost entirely blue collar, and as such this was a cross-cultural learning experience for me; I needed to simplify my language, use shorter, less circuitous phrases, and
learn a lot of terminology (which my clients taught me) from the trades and the field. I also incorporated more behavioural, and cognitive-behavioural, elements into therapy and avoided solely insight-oriented approaches. Over time, I realized that these clients shared several characteristics with members of the Portuguese community who were also largely blue collar workers. This experience helped me to understand the broader work culture of many Portuguese Canadians.

**Having a spouse and a child.**

At the outset of interviews, or in setting up the interviews, I let informants know that I had a spouse and a small child. I noticed that this often triggered references to the informants’ own family situations. In informal interviews, such as meeting with the seniors, it was a starting point for conversation. Informants would then tell me about their own children and grandchildren, who their offspring had married, and their problems and triumphs.

**Having professional helper qualifications.**

This quality produced the most noticeable effect with informants who were helpers themselves, or connected to the helping profession. For example, Maria, a medical office assistant and spouse of a physician, noted the following:

> And I think that, when I saw you walk to that table, I thought to myself, there’s a certain skill involved in approaching an entire table and asking them to quiet down, you know what I’m saying. You know, to tone it down. And it’s a skill that not everybody has, right? And I watched you over there and you came back and you know, nobody got mad, right? And I thought that’s wonderful that you have that skill. I mean, I expected that you would but it was wonderful to see it in action. (Maria)

This put her at ease and helped to increase trust; my demonstration of interpersonal skills compatible with helping increased her confidence in my ability to use what she told me to better the helping profession.
**Having experienced translocation.**

All of the seniors I met with had moved from the Açores or Portugal (the majority from the Açores). About half of the informants with whom I conducted in depth interviews had moved once or more during their lifetimes, often from the Açores or Portugal to central or eastern Canada and then again to the west. The fact that I had grown up in Nova Scotia provided a point of connection for many informants. It led to a shared understanding of moving away from family and home, though not necessarily quite so far. This particular Portuguese community was in a region filled with many east coast migrants. Points of connection and intermarriages occurred particularly between Açoreans and Newfoundlander, both fishing economies and isolated Atlantic islands.

**Sharing religious beliefs and church involvement.**

I was well-received in the Catholic environment because of my Anglican background. Informants were surprised that I could follow the mass, due to its similarity to the Anglican mass. Interestingly, while my protestant religious beliefs are theologically more closely allied with the Pentecostal than Catholic Church, the Pentecostal clergy demonstrated less recognition of my religious beliefs when stated.

And we follow the principles of Jesus, Jesus Christ, you know, we believe in him, that he’s our example in life, our saviour, our Lord, you know, Catholic people, they believe differently, they believe in saints, they believe in the Pope, they have all those rules and prayers and (pause) I was never Catholic, that’s what I hear, I never practiced the Catholic religion ever. You know, I was born, fortunately and thankfully, thank God I was born in a Christian home, and when I say Christian, I would say Evangelical Christian. We don’t use the word Protestant. (Margarida)

The language used was setting themselves aside as different from the world, “we” and “they.” This is possibly due to the very small Portuguese Pentecostal population and feeling alone and somewhat threatened by majority religious (or non-religious) culture. The
persecuted minority/remnant is also a recurrent motif in the broader Evangelical subculture, despite its large size, termed “heroic alienation” (Carpenter, 1997). In North America this can be traced back to events of the late 19th and early 20th century such as the Fundamentalist–Modernist Controversy and the Scopes Monkey Trial (Bratton, 2011). For these informants, the minority culture of evangelicism may take on marginal status in the centuries-old state Catholic status. Catholicism became the national religion of Portugal as part of the Estada Novo under Salazar.

Making connections in the community.

Over the course of my year in the community, I formed connections with community members, such as the bakery workers and owner beside my building, and community organizers who were not necessarily themselves Portuguese but were hired by the city to organize community events and festivals. There was a community coffee shop run by volunteers with whom I became acquainted, a community art gallery that opened that year, and a well-run childcare centre for low-income families, where I met the organizers and caregivers and where my spouse brought our daughter for playgroups. I also attended meetings by community planners for planning playground and park space, and joined in a community garden project. I was mentored by a neighbour who had been hired by the city to interview long-term community members about the history of the area; similar in many ways to what I was doing. While many of the stakeholders in these projects were not themselves Portuguese, my exposure helped me understand the community structure, history, and context of the Portuguese community.
**Attending church services, festivals, and social functions.**

I attended several church services at both the Portuguese Catholic Church and the Portuguese Pentecostal Church. For my own worship purposes I attended yet another church in the community, one that was focused on the arts. I also attended church parades and community festivals, spoke with other celebrants and took photographs. My own attendance at these events helped me understand the importance of them to members of the Portuguese community, and helped with trust in the community through increased points of contact.

**Steps in becoming a resource and helper to the Portuguese community.**

I learned what was helpful and not helpful for connecting with the community through my own process coming in as a researcher.

Ethnographic researchers thus recognize that they are part of the social world they are studying, and that they cannot avoid having an effect on the social phenomena being studied. The issue is: “rather than engaging in futile attempts to eliminate the effects of the researcher, we should set about understanding them” (Hammersley and Atkinson 1983: 17); so that this approach is not a matter of methodological commitment but an existential fact. (Taylor, 1994, p. 36)

**Common ground and initial contact.**

The first connection with informants was typically formed through the recruitment step, where they telephoned me in response to my poster, through snowball sampling, or through an introduction at a function or Portuguese establishment. Holding common ground, as covered above through living in the area and previous exposure to Portuguese culture, facilitated initial contact.

**The interview.**

Throughout the interview I avoided using interventions or empathic reflections, in order to maintain a distinction between self as counsellor and self as researcher. However, it
was very difficult to avoid minimal encouragers, particularly with the positive reinforcement of greater disclosure on the part of the informant.

**Connecting through children.**

One informant was renovating her house and had come across her now-grown children’s old toys. She asked me if I would be willing to receive books, and I said yes. A few weeks later she contacted me for a meeting and we met at the Portuguese bakery across from my building. I brought my daughter, we talked about family, and she gave me a book and a pack of educational flashcards. She also decided in that interview to recommend her daughter for a research interview. Her daughter had just completed a Master’s degree and was interested in the research process. A few days later her daughter contacted me and we arranged and later conducted the interview. Clearly the second meeting with the mother helped her decide to open research access to other family members.

**Connecting to the community through gatekeepers.**

I made contact with an administrator of a major Portuguese association early in the research process. He did not want the identity of his association to be known in connection with him because that would identify him. We met three times; in the first meeting he recounted the history of the Portuguese community in the area and showed me photographs of the first wave of immigrants and the early buildings used by the community. He also explained the role of the leaders of his association and recommended ways to connect with the community. He arranged for me to join in a social event and ensured a bilingual English/Portuguese speaker would be present. This meeting was not recorded. We set up a time and date for a formal interview to take place a few days later. I continued to see him at community functions.
Solicitation for advice and counselling referrals.

One informant announced during his interview that his daughter’s wedding was coming up soon and he and his wife would be travelling east to attend the wedding. About a month later, after the wedding, he contacted me for a second interview, saying that he’d had an experience that he thought would inform my research, an update on “cross-cultural interactions.” We met at the community coffee house and I audio-recorded the interview; unfortunately the recording did not work but I recorded notes after the meeting. He recounted the experience of staying with the family of the groom over the course of the wedding week; conflicts between the son-in-law and himself and his wife; wondering whether these conflicts and lack of hospitality were due to culture conflicts or idiosyncratic causes such as a possible drug addiction. He asked me for my perspective because I shared the same regional background as his new son-in-law. I was able to tell him that the events, as he recounted them, and the son-in-law’s actions, seemed unusual. Culturally-speaking he said, “In my house, if you come to visit we will offer you drink, offer you food; this young man does not do that.” Also he repeatedly said, after recounting a conflict, “All is good, all is good,” somewhat ironically. He appeared tense and agitated as he recounted these conflicts. I attempted to tease out what “all is good” means; was it irony, or an attempt to avoid conflict? I was unsuccessful. The informant asked for a referral to family counselling and I gave him several recommendations.

One informant I met at a seniors’ lunch asked, “You are in psychology, right?” before disclosing, very emotionally, how the mental illness of a child had “changed everything.” This was one of several examples of an increased willingness to disclose instances of personal or family members’ mental illnesses based on my training and qualifications.
Towards the end of my interview with the parish priest, he began to discuss his difficulty with having adequate support preparing couples for marriage.

Inform: Yes, once a year ‘cause all the weddings I have here, we prepare the people here. We don’t send them to other church. For example, I have this couple, we have for example, uh maybe the program is nine hours? It’s a weekend, it’s Friday and Saturday, but I need someone to come to help them, but, for example, in this area, where there is the relationship, you know, between man and woman, so because we have the religious part but it’s not too much. I come here, I talk to them about the, the sacrament, but I cannot come here to talk about other things, because it’s not my, my role here. This couple has a program that they follow to teach them, but I need help, I need one person to talk about them, about relationships, about that stuff you are (pause)

Int: I’m asking all about?
Inform: Yeah (laugh). (Tony)

In response I was able to suggest places he could contact for group counsellors, such as the local university’s counselling program. It was interesting, however, to notice that through these interviews there may have arisen a way to engage as a helper with the community.

**Trustworthiness and Credibility**

While concepts of reliability and validity do not apply to qualitative research, there are comparable concepts, often referred to as trustworthiness and credibility. One step towards increasing trustworthiness and credibility is carefully documenting the research process and steps of analysis so that the reader can interpret the results in light of this information. The steps taken to increase the trustworthiness and credibility of my findings are detailed below:

1. **Triangulation.**

   The use of ethnographic methods by design incorporates triangulation (Flick, 2007). In this study, information was gathered from the following sources: examination of the historical and scientific literature, participant observation, and both formal and informal interviews with multiple informants who hold different positions in and connections to the
community. Specifically, members of the community had written two documents recounting the settlement of the area.

2. Peer debriefer checks of low-level coding.

A peer debriefer was asked early on in the process to check the degree of abstraction of the low-level codes and the quality of selection of codes in relation to the primary documents (Carspecken, 1996). Two interviews were selected using a random number generator, and the entirety of the codes for these interviews were examined. This individual was using Nvivo for her own dissertation research and had significant experience with the software and the coding process. She was oriented to my research and coding process through several meetings. Her overall feedback was that the codes were a good fit. She provided specific feedback that was incorporated and used to guide the coding process.

3. Member checks of domains.

All of the informants were also asked to review a summary of the findings containing the domains, composed of a cover term and included terms (Carspecken, 1996). I received feedback from eight of the ten informants. All informants stated that the domain structure was thorough and complete. They agreed with all of the domains, with some clarifications that were incorporated into the findings. At this stage, full second interviews occurred with six of the informants. This second contact was also used to ask follow-up contrast questions and to clarify meanings of terms such as curandeiro. However the informants initiated much of this themselves during their review of the domains, for example, clarifying that gambling is not a significant problem in the community because the sums are small; emphasizing that almost all alcohol use and misuse is by men, and that women misusing alcohol is very rare;
and clarifying differences in help-seeking between generations (the younger generation is more willing to see counsellors than the older generation).


Two experts in the field of Portuguese psychology were asked to review the overall domain structure, and to comment on their credibility given the expert’s knowledge in this field. One expert held a PhD in Counselling Psychology and had conducted ethnographic research in the Azores. She agreed with all the domains within her range of experience, with one exception that was a novel finding for this study, the prosperity of the community.

The other expert was Portuguese, held a PhD in Psychology, and was a Post-Doctoral Fellow at a university in Portugal. She also agreed with the domains as being representative of and congruent with Portuguese culture, with some clarifications that were incorporated into the findings and discussion where relevant.
Chapter 4: Findings

In this chapter, I present the findings of the study, beginning with a description of the Portuguese community so that the domains may be understood in context, and then proceeding to a presentation of the domains, included terms, and supporting quotes from participants. Analysis of the data, comprised of interviews conducted with the ten informants, further informal interviews with more than thirty informants, field notes from interactions, visits to shops, and events attended, yielded ten major domains. Some domains contained sub-domains. Most domains are labeled with cover terms drawn from informants’ own words. These domains describe kinds of helping relationships in response to the research question, What are the helping relationships for personal and emotional problems in the Portuguese Canadian community?

The characteristics of this community cover, briefly, the Portuguese trait of being a hard worker, which in turn has lead to the characteristic of increased prosperity of the community, and more recently increased fragmentation through moving to more affluent areas, which often leads to attending different churches, and moving or separating for work.

The domains that come after the description of the community begin with proximal sources of help, starting with the family, then the community, the church, and traditional healers, and moving to distal sources of help, namely physicians and the mental health field. The last two domains cover reasons for seeking help and barriers to seeking help, respectively. Domains covering the use of physical symptoms and use of substances, namely alcohol, to manage emotional distress are included also included after the first domain of Reliance on family.
Characteristics of the Portuguese Community

The trait of being a hard worker.

Many informants described a strong work ethic as a fundamental trait of the Portuguese, rooted in the very poor context from which the Açoreans emigrated:

You go to work on the fields of the tea leaves at [age] 11, and, ‘cause your families are poor. Because we come from, my parents came from a very poor little place. So, it’s work, work, work at a young age. (Angelina)

The conditions of poverty continued during the first few years in Canada, when many families were raising young children. As Angelina explained, “It was only my father that worked and my mother raised the six kids at home, so it was one income. It was really tough, yep. Our first home I think had two bedrooms.” The household expectations growing up were work before play, “It was chores, learning how to cook, helping parents with the garden, that all came first before you had fun.”

Maria shared a similar perspective of her home and parents growing up, where both of her parents modeled hard work, particularly her father: “He is to this day, and I recognized it even when I was growing up, probably the hardest working man you would ever meet.” I asked Maria if she thought this was a Portuguese trait:

Yes, they are very hard workers. Yes, they are. Not so much my generation. But my parents’ generation, and the Italians too, they have these huge, they buy these houses, 50 foot lots, 150 feet deep. And I’m sure 120 feet of their backyard was all garden, you know. And growing up, my mother had, and they still do to this day, huge garden. My dad plants everything, corn, everything. . . . My mother did three courses everyday, full meals, and she baked five loaves of bread a week. Because we had seven people to eat. . . . Oh, she worked very very hard. (Maria)

Margarida and Carlos, who were recent immigrants from the mainland, noticed this hard work value in the Açorean immigrants. In Margarida’s words:

They are concerned about working very very hard, you know, very very hard. Sometimes they work like seven days a week. Sometimes they work I don’t know how many hours, ten, twelve, fourteen hours a day. And their concern is making
money, you know, growing their bank accounts, and I don’t see them like having fun for example. (Margarida)

Margarida shared in more detail at a later point in the interview the focus on making money:

The majority of people I would say that, you know, they left their country because they were not able to make a lot of money because the economy is bad, so they moved here, Canada is the place to be for that matter. (Margarida)

The other informant, Carlos, who had recently emigrated from the mainland, discussed how this focus on work and money on the part of Açorean immigrants may have been responsible for a lack of interest in exploring and integrating with their new homes and surrounding areas. There is also a perceived imbalance of work and leisure, with work and church being the only activities. Carlos stressed the importance of making a better life: “They were only here to work and make a good life for their kids. That was number one, was making a better life for their kids…It’s all about the kids, you’ll see, more and more.” Margarida noted the difference between the Açoreans’ focus on work and her focus, as a mainland Portuguese, on enjoying social life.

We would say that Portuguese people that live in Portugal and people from Lisbon, that’s the place that we are from, they live life in a different way [than the Açoreans] we would say that they enjoy life more. They live life, they wanna enjoy the moment, they wanna enjoy friends and family, they wanna enjoy social life, they wanna enjoy being able to go to a café at night which that doesn’t happen here. (Margarida)

I noticed also that the Portuguese cafés closed at dinnertime and generally the neighbourhood was very quiet in the evenings. The value of being a hard worker is one of which the Portuguese, particularly Açoreans who emigrated from poor circumstances, are proud. Those who immigrated in the 1960’s were seen to prioritize children and improving the family financial situation, and to sacrifice leisure for this goal.
The increasing prosperity of the Portuguese community.

For the Portuguese communities in prosperous western Canadian cities, one outcome of the focus on work over leisure and education has been success, even to the point of being able to build and maintain multiple houses in Canada and in Portugal. Building up wealth over time is one main characteristic of this population, demonstrated by the move to larger houses and more affluent suburbs as discussed below, and the acquisition of multiple homes in Canada and abroad.

The increasing fragmentation of the Portuguese community.

I observed numerous levels of fragmentation, which were also independently described by informants.

Fragmentation of the community.

During my time living in the Portuguese community, I noticed that there were many Portuguese shops and businesses but not many Portuguese residents. Carlos and other informants explained to me that these shops and businesses were established when many residents of the area were also Portuguese, in the 1960’s and 1970’s. In the 1980’s and 1990’s they started to move away to more affluent neighbourhoods. Most of the informants I interviewed lived in more affluent areas of the city. Carlos said, “They’ve moved, because as the life progressed and they started having a better life, better income, they started moving to other places, new places in town.” As Angelina said of the move out to the suburbs, “And then Dad built my mom a castle. Which is not a castle nowadays. But it was for her.” While many moved in order to build larger houses in better neighbourhoods, some also moved west or north for better work. Paul spoke about his own sadness of living away from home for work. “That’s, what is it, the term ‘the golden handcuffs.’ . . And I’ve got them. And I have
them, I am bitter. You know what, I like [province name], it’s great, but ultimately it’s not home for me.”

**Fragmentation of the church.**

Informants noted the decreasing size of the Portuguese Catholic Church as the community spread out into the suburbs and started to attend Catholic churches in their areas. While the language barrier encouraged continued attendance at Portuguese language services, lack of mobility and transportation for the elderly led to compromises and resulted in attending English services closer to home for some. The priest commented philosophically on this change:

> Our community, it is a old community. I think that I don’t know, 10 or 15 years, we won’t have this community… A parish like this one can survive when we have immigrants. We don’t have immigrants anymore. (Tony)

I asked him how the people feel about this change:

> They know, they see these like natural. . . the things of life. We are born, we live, we die. They know this, because sometimes they come to me, “Oh 20 years ago, this church, it was full siamo?” It was full because 20 years ago, we had a lot of people here, young generation. The people used to live closer to here. Now the people moved to outside. . . We have areas, new areas, they moved to there. So the new generation, they lost the language so they don’t come here. They go to a Canadian church. (Tony)

Other informants also commented on the size of the Catholic Church being an indicator of the size and cohesiveness of the community.

**Fragmentation of family.**

The practical logistics of separating for work purposes was well known among informants. One informant described how she rented an apartment in Fatima for a vacation from a man whose wife and children had moved back to Portugal, while he continued to work in Canada. This man had a home in Canada, and a city and country home in Portugal. In the Canadian setting, long workdays were described as the norm. Margarida spoke about
The fragmentation of family relationships she saw due to lack of family time, noting that it is changing with the current generation of parents:

We can sense that something is changing with this generation like in their thirties. . . we see that like spouses that try to be together. . . . They are more focused on families, yeah, and they make an effort to be more together as a family. The previous generation, like 50’s and 60’s and 70’s. . . . They had to be separated from their families because of work. (Margarida)

She talked about a negative impact on the children and the marriage relationships when the men worked away from the family. Carlos also spoke with some frustration about the lack of time he saw men spending with their families, with their priorities on material provision, “There is lots of things we need to provide. We need to provide times of entertainment, times of refreshing, stuff like that.”

In the second interview round some of the informants pointed out that the women also worked long hours and more than one job, and that material provision was a very meaningful way for men to care for their families. Many of the senior women I met in the community had worked many years in a sewing factory.

Summary.

Many members of the Portuguese community immigrated, or had parents who immigrated, from very poor circumstances, particularly in the Açores. In relation to this they had developed a very strong work ethic that continued after immigration to Canada and included long work hours, running the household, gardening, and preparing food from scratch, all to keep costs down. In some prosperous Western Canadian cities with favourable job markets, this lead to high wages and increasing prosperity. Families were seen also to experience separation for the sake of paid work. Higher wages in turn led to a gradual dispersal, beginning in the 1980’s, of Portuguese families to the outlying suburbs where they
could buy larger houses and live in more upscale neighbourhoods. While all of the businesses and shops and some families have remained in little Portugal, this dispersal has lead to reduced connections among the Portuguese community, including a reduction in the size of the Portuguese Catholic parish.

**Domains**

The following domains are ways in which members of the Portuguese community engage in helping relationships for the care of their emotional or personal problems. Seven of the domains are ways in which people in the community receive help or cope with problems (X is a way to do Y); the remaining three domains describe ways people develop problems, reasons for seeking professional help, and barriers to seeking help of any kind. The domains are listed in Table 11.
<table>
<thead>
<tr>
<th>Domain 1: Reliance on family</th>
<th>Included Terms</th>
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<tbody>
<tr>
<td>1.1 Close family and extended family relationships</td>
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<td>1.2 People talk to family members about personal problems</td>
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<td>1.3 Care for seniors; concern about isolation of seniors</td>
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<td>1.4 Family members’ negative opinions of counsellors</td>
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<td>1.5 Occasional/historical reports of spousal abuse and infidelity in community</td>
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<tr>
<th>Domain 2: Focus on physical ailments</th>
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<td>2.1 As a way of coping with emotional problems</td>
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<td>2.2 As a social norm</td>
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<td>2.3 Agonias</td>
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<td>2.4 Problemas de Nervos</td>
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<tr>
<th>Domain 3: Using substances and gambling to cope with problems</th>
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<td>3.2 Gambling</td>
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<td>3.3 Drugs</td>
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<td>4.3 Insularity</td>
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<th>Domain 5: Receiving help from the church</th>
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<td>5.2 Social connections</td>
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<td>5.3 “Nossa Senhora de Fátima”</td>
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<td>5.4 Religion as a source of strength and comfort</td>
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<tr>
<th>Domain 6: Using forms of traditional healing</th>
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<tr>
<td>6.1 Definitions</td>
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<td>6.2 Tensions between religion and curandeiros</td>
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<td>6.3 Other negative views of curandeiros</td>
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<td>6.4 Positive or neutral views of curandeiros</td>
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<th>Domain 7: Accessing help through family physicians</th>
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<tr>
<td>7.1 Physicians serve as a pathway to psychiatrist, counsellors, and social workers</td>
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<tr>
<td>7.2 Physicians are a way to get help without the stigma of seeing psychological helpers</td>
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<tr>
<td>7.3 Physicians provide medications for psychological problems: anxiety, depression</td>
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<th>Domain 8: Help outside the community</th>
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<tr>
<td>8.1 Directness</td>
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<td>8.2 Cultural and personal similarities</td>
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<tr>
<th>Domain 9: Reasons for seeking professional help</th>
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<tbody>
<tr>
<td>9.1 Family problems</td>
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<td>9.2 Major adverse life events/many crises happening at once</td>
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<td>9.4 In order to become a better helper</td>
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<td>9.5 Fear of repeating negative patterns</td>
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<td>9.6 Fear of losing family</td>
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<td>9.7 Being mandated</td>
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<tr>
<th>Domain 10: Barriers to seeking help</th>
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<tbody>
<tr>
<td>10.1 Lack of host culture knowledge</td>
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<td>10.2 Interpersonal barriers</td>
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<td>10.3 Acculturation differences</td>
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</table>
**Domain 1: Reliance on family.**

Domain Cover Term: Reliance on Family

Semantic Relationship: X is an attribute of Y (Attribution)

**Description.**

This domain covers all ways (X) in which reliance on family helps people cope with or deal with emotional and personal problems (Y). It also covers limitations of the family’s ability to accomplish this, and ways in which reliance on family discourages making use of outside resources. All of the informants contributed terms to this domain.

**Table 12. Included Terms for Domain 1**

<table>
<thead>
<tr>
<th>Included terms</th>
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<tbody>
<tr>
<td>1.1 Close family and extended family relationships</td>
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<td>1.3 Care for seniors; concern about isolation of seniors</td>
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<tr>
<td>1.4 Family member hold negative opinions of counsellors</td>
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<tr>
<td>1.5 Occasional/historical reports of spousal abuse and infidelity in community</td>
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</tbody>
</table>

**1.1 Close family and extended family relationships.**

The tendency for family to fill up free time, and for family to be more important than friends, was commented on by six informants in formal interviews and by several other informants as well. Elizabeth, who was half Portuguese and half Jewish, described the differences she observed in her Portuguese friends’ families compared to her own:

There’s certain issues in terms of being able to relate to some of my friends... there were certain ways that I couldn’t relate to them because they’d have very large families... a strong friendship at school but then outside of school, they were very much engaged with their familial relations. Whereas I’ve never found my friendships
to be restricted in that way with non-Portuguese friends. Because I think family just plays such a strong role in their lives. (Elizabeth)

She also described the tension within her own family: her sense of pressure from her Portuguese mother to stay connected to relatives who lived far away.

The expectations of familial solidarity or cohesion is also something that I find a big challenge. . . expectations of my obligations to them as a family member is very different from what I’ve seen in my non-Portuguese, amongst non-Portuguese families that I’ve come to know through friends. (Elizabeth)

At the time of our interview, Elizabeth had recently returned from another country to spend time living with and helping her grandparents; they clearly were a part of her close family, given that they helped raise her, demonstrating that the lack of connection or obligation described above only applied to more distant relatives.

João described how his wife was greatly distressed over not being able to see her sister, who was dying of cancer back in the Açores, until they arranged for her to fly there for a visit. He explained how it relieved her distress: “You give the support to the one that’s ill, and see, at the same time, you’re giving yourselves support, and in this way, it’s family with family, they understand better.” Rodrigo also described a very close relationship between his wife and his wife’s family of origin in mainland Portugal, “Yes, it’s almost mandatory, no more than two years without going to Portugal. . . . She’s very attached to her family and she belongs to this group.” When their daughters were young, his wife took them to Portugal for three months every summer while he continued to work in Canada. The daughters were fluent in Portuguese, went to Portuguese university, and married Portuguese men. They eventually moved back to Canada with their Portuguese husbands. One marriage ended recently and the daughter married a Canadian.
Julia described her close relationship with her sister. She and her mother supported her sister through the birth of her first child while the sister’s spouse was out of the country for work. João described the close sibling relationship of his two sons, which was unusual given the age gap: “Four years apart, they’re very close, always been. They never fought. They hid secrets from us; they’re like twins.” Likewise Angelina described the very close relationships among herself and her five siblings, which persisted through a financially constrained childhood and the eventual death of her parents.

Many informants also reported very close relationships between grandparents and grandchildren. For Julia her grandparents were like second parents to her; she was also very close to her aunt and uncle. Elizabeth stated: “I spent a lot of time with my grandparents growing up, actually they were probably I would say, they were in some ways, my primary caretakers.”

There was also the trend of closeness between adult children and their parents; children continue to live at home until marriage; Julia recounted breaking a taboo when she moved out of the house in her twenties. João also discussed general awareness of tensions in the community when parents with adult children were widowed and wished to remarry. Sarah was from Newfoundland and was dating an individual in the Portuguese community. She could only see him three times a week because he had promised his children, now in their mid-twenties, that he would not have another woman live in his house as long as they were at home. Sarah stated that the oldest of the two daughters was very mean to her; her boyfriend had a very soft heart however and that was why she loved him. She speculated that it is a Portuguese phenomenon that family ties are very close.
Seven of the informants who gave formal interviews gave in depth descriptions of how either they were currently helping a family member or were being helped by a family member. One particularly touching example came from João, who cared regularly for a distant relative who moved from the Açores to Canada. This relative had been asked to emigrate from the Açores to look after her brother in Canada:

Her brother called her over to take care of him, and then three months after he called her, he dies of a heart attack in the car, while she was in a beauty parlor, so she comes out of the beauty parlor, and she found him dead in the car. So because she knew nobody, she only spoke one language, Portuguese, and she starts panicking and yelling, and they got a hold of the parishioner or priest that was here at the time, and they got a hold of my sister-in-law and my sister-in-law got a hold of me. And I’ve been with her ever since, because she...like she had no kids, she was very old fashioned, she never married, so all she has is a great niece. The niece, then great niece, and great nephews, but they are all in Europe. (João)

While she lived in her own house, he helped her with her banking and groceries. “At the time I said I’d take care of her, I thought, three to five years until she went back. She decided to stay, now it’s been 24 years.” João also was raising his own family during this time. At the time of our second interview he and his wife were also caring for their preschool-aged granddaughters full-time while the parents worked, and were greatly enjoying it.

Angelina described growing up in her home with a lot of cousins, close family, babysitting younger siblings, and helping her mother out with meals and chores.

Overall, community members helped one another in substantial, time-consuming, practical ways. Through these practical means, family ties were strengthened and emotional help, whether explicit or not, was provided.

1.2. People talk to family members about personal problems.

Talking to family members was cited by four formal interviewees and other informants as a first line of action when a person in the Portuguese community has problems;
going outside the family was described as very unusual. As Julia stated, “You don’t seek help outside the family. Everything is sort of solved in-house (laugh).” And Carlos, speaking about the Portuguese community, “What happens inside the family, stays inside the family,” and “It’s resolved among the family, no one else needs to know.” I found when talking to Portuguese individuals in the neighbourhood that people tended to deny family problems. An informant in his early 40’s from mainland Portugal who ran a bakery said that the only kind of problems he has are work-related, and they all complain at work and work their problems out at work. Sometimes he goes to his family members with his problems, but he doesn’t really have any serious problems.

Those of the older generation or having parents of the older generation said that, growing up, they were more likely to approach their siblings than their parents. For example, Angelina described getting her period:

*Inform:* Well when I had my period, I went to my oldest sister. . . I had thought that, because I borrowed my brother’s bike, and it was the boy’s bike, the ten speed with the bar, and I fell, and hit my—(yeah). And I was bleeding. And I thought, “Oh my God, I hurt myself” and I told my sister and she started to laugh at me, ‘cause, the next day I was still bleeding. And I had bad cramps, I thought I had damaged something inside. And she says, “you dummy, it’s called your periods.”

*Int:* And that’s how you learned?

*Inform:* That’s how I learned. . . because, back then, they never taught their kids. (Angelina)

At another point she discussed the lack of communication and passing on of information from parents down to children within the typical Portuguese family. She described resultant relationship problems that children had as they grew up, “and God forbid if you were to ask your parents,” that is, for help in sorting through relationship problems. This same informant picked up the phone without hesitation during the interview to ask her sister if she’d ever heard of *agonias.*
Informants in their 20’s and 30’s reported a greater likelihood to go to their parents with problems, or at least certain kinds of problems. Elizabeth described her parents as more integrated into Canadian culture (one parents is Açorean, the other is Jewish-Canadian). She observed amongst herself and friends a positive relationship between confiding in parents and their degree of Canadian acculturation. She talked about her consultation of her parents as an expression of her appreciation for their wisdom and respect for the things they have done for her. She said that first she would try and solve her own problems before seeking help from “outside.” Who she would consult depended on the nature of the problem: friends for relationship problems, parents for family problems, her father for employment and money management problems, future education and career planning, and her mom, for social problems: “I think her social skills are stronger and the knowledge that she has, in terms of negotiating and interacting with other people. Yeah so, I’ll probably consult with her on those issues.”

Julia recounted a situation where her family held conflicting views regarding intervention with her father’s drinking. She said that her mother had a fatalistic mindset based on childhood elements beyond her control, having grown up in the Açores with a single mother and a father who did not acknowledge her, and she brought that mindset to Julia’s father’s condition:

We all tried to change him and do all sorts of things, and mom could do it, but she was like “No, uh uh. We’re not playing this game you know, he is a grown man. He does what he does, and you know, he’s your father and you should love him anyway and, but I’m not calling doctors and I’m not getting involved.” (Julia)

In conclusion, informants emphasized the importance of family as a resource for talking about personal problems, paired with a reticence towards confiding in sources outside the family. For older generations, siblings were confided in before parents.
1.3. Care for seniors; concern about isolation of seniors.

Informants described complex situations with seniors and accessing help in their community. A major stressor or emotional issue for seniors was described as concern for their family members, particularly that children and grandchildren would develop liberal values and resultant problems, as well as a lack of respect for their elders:

The senior people, where they don’t want to see their kids, what they call, “go astray,” because they still have the old fashioned values, that would be the struggles, I would say. Talking back to the parents, you didn’t do that years ago. (João)

The priest observed the traditional values he saw in his parish regarding treatment of seniors:

The children, even if they have their kids, but they respect the old generation. They respect. For example yesterday, I went to a man, he is 90 years old but they, his daughters have kids, he is a grandfather, great grandfather, but they respect him like it was maybe 50 years before, ago. . . . they keep the old people at home, they don’t put them to the nursing homes. (Tony)

From the perspective of the elderly, Carlos described the phenomenon he saw in the community of parents feeling abandoned by their children:

But people that need the two jobs like I was saying yesterday, they need to move on. They want to go on holidays, husband, wife, and kids. The mother had their life, but she doesn’t understand that. She wants that son and daughter still with them. So it’s hard, because then they feel abandoned, and it’s not because the children are abandoning them, they’re just saying “mom, dad, I need those two to three weeks for myself” or “mom and dad, I can do the banking for you, but use your brain to do the rest” right? They’re trying to give that independence to the parents, but some of the parents don’t want that independence. (Carlos)

João described his own experience with his mother’s grief at being placed in a nursing home. His mother had become blind, needed insulin shots, and was too heavy to lift, so the nursing home became the only feasible option. “We discussed as a family, brothers and sisters, seeing what was best for her.” Unfortunately she refused to eat at the nursing home unless a family member fed her. “So we took shifts. . . . I would stop and feed her every suppertime. Lunch would be one of my other brothers, and breakfast would be another brother. We did
this for five years.” He explained, “She wasn’t happy because she was used to being at home. Again, the language barrier in the nursing home, she didn’t understand.”

Understandably, language was stated to be a major barrier for seniors accessing help. This becomes highly problematic if seniors have to enter nursing homes where no personnel speak Portuguese, which is often the case in western Canada. The same informant, João, described an incident that took place in a nursing home with the woman he helps, where she had a sudden spike in her blood pressure as a result of being bathed by a male orderly. He described the breaking of the cultural taboo,

A man does not touch a woman’s body. . . . For the Portuguese, they just feel that pride. . . . They’ve lost all their power. . . . And for one hour, she was just bawling, so I had to calm her down, and I said please don’t do that again, you have to ask. If you are not sure, ask me, because things like that, that could destroy them. They could just die, like 88 years old, she doesn’t have a good heart, that’s the stuff we have to be sensitive to, the cultural shocks. (João)

Here the term culture shock takes on a literal meaning; the cultural difference leads to an event that causes a literal, physical shock.

Julia pointed out that in the Portuguese community families are very good at looking after their seniors, as part of the family cohesion discussed above. She suggested that overall, seniors are seldom isolated, though the trend may be increasing. In a feedback session she hypothesized that other respondents talked about isolation because Portuguese culture is more attuned to the needs of seniors. She stated that one seniors’ group in the Portuguese community is currently organizing to create a Portuguese seniors’ home. Otherwise people are still dying at home, not in seniors’ homes. Many of the old generation were called over to Canada by their working adult children, and lived in their children’s homes; they were never independent. Trends are changing now with the generation that is in their 70’s and 80’s; these individuals have built large houses and big gardens and do not want to leave them. Such was
the case with Julia’s aunt. Her aunt was like a mother to her, the aunt did not have children of her own, and they were very close. Julia planned to move with her spouse and child into her aunts’ home in order to care for her aunt, who refused assistance such as in-home care. Julia talked about a “sense of not giving up” and, for seniors, “we will stay as healthy as possible,” “there’s no taking help.” So even with her now-deceased grandmother when she was becoming feeble she still “baked bread on her good days.”

João, an administrator for a Portuguese organization, shared a story where, due to his role in the community, he became a key helper for a woman whose husband had passed away. The husband left her with money but no financial experience, so she relied on João and the funeral director for advice.

These examples highlight the concern and care for seniors in the Portuguese community, and the unique challenges of language barriers, requirements of nursing care, and increased independence of the newer senior population.

1.4. Family members’ negative opinions of counsellors.

Five informants described family members’ negative opinions of seeking professional mental and emotional help. Julia described how her mother reacted to her decision to apply to the master’s program in Counselling Psychology.

My mom, you know, was very confused when I came home and said I was going into counselling psychology, “What is counselling? What is psychology? And what is it? And what are you doing? You were supposed to be a teacher! Come on now! (Julia)

She also described her mother’s reaction when she told her she was going for counselling:

I really felt it would do everybody good and because this was my field and my mom’s response was, um, “Well dear if that helps you, I on the other hand, am strong. And your sister’s also not the emotional nutcase you are,” basically (laughs). . . I think from an early age, she was like, I can’t control this, I can’t change things, this is the way it is, and talking about it, crying about it, isn’t gonna make a difference. (Julia)
Paul explained that he learned to deal with emotions from his father, who used alcohol to cope with depression. When he first encountered significant emotional problems himself, he thought he could deal with them on his own. Eventually they got bad enough that he did seek counselling. He described how he viewed counselling:

I only sought counselling as a last resort. I just couldn’t deal with it anymore. I think that’s just challenging overall for a guy to admit a lot of these things and growing up, you know, I’ve never seen my father depressed, he never dealt with it, well I knew exactly how he dealt with it, with a bottle of wine. (Paul)

About his father’s perspective of counselling, he said, “I wish I would’ve been able to tell my parents about that, I wish my father would have been able to tell me, ‘hey go talk to somebody,’ that there wasn’t a stigma associated with it.” Paul explained how he eventually shared with his parents that he had been to a counsellor.

I don’t think I told my dad. I think I only told my dad quite some time later. I told my mom (exhale, pause) probably half way through seeing the person, the counsellor. So I was a little ashamed because I couldn’t deal with it myself and at the same time, I didn’t want to burden them, I didn’t want them to kind of worry and get dragged into it. With, you know, looking back at it, I think if I had told them, it would have been easier on them cause they wouldn’t have been worrying about me. (Paul)

However, when Paul had problems later recovering from a relationship break-up, his father actually recommended that he go see a counsellor. His perspective on counselling had changed since his son had told him about his previous, positive, counselling experience. Paul recounted his father’s telling him to “Go fix this problem” with an angry, or frustrated tone, indicating disapproval on the father’s part of emotional weakness.

Elizabeth shared more cautiously a general Portuguese perspective on helping within versus outside the family:

I think there is very much a mentality there that you know, you solve your own problems or we keep things within the family and sort of seeking outside help through professionals such as a psychologist is not, I don’t know if it’s necessarily—I think it’s probably viewed as not being a necessity. (Elizabeth)
She had never sought outside help such as counselling or psychotherapy herself.

1.5. Occasional/historical reports of spousal abuse and infidelity in community.

Three of the informants who gave formal interviews contributed to this area. Carlos, a helper in the community, recounted a story of a woman who sought their help with a domestic abuse situation at home, related to drinking. This informant also reported that he had heard a few cases of this in the community, always related to drinking, indicating that it does happen but not necessarily more commonly than in other culture groups. João, who formed a gate-keeping role to a helper in the community, was in a position to hear peoples’ problems, and also reported occasional occurrences of spousal abuse. Angelina discussed the trend of infidelity in the community:

Like with [quieter voice] cheating spouses. It was very, very common back then, right? You know, to women, they never got help because they thought it was normal. Because they talked to their parents, or to their mother, or they talked to other women, their aunts. And they said, “Oh it’s normal, men are allowed to do that.” No they’re not. A lot of that happened back in the day, but women just—, right? Instead of talking about it. That’s what I mean, it’s the communication part. They need to— no, that’s not right. (Angelina)

She also shared her own experience of getting out of a marriage where her spouse was being unfaithful:

*Int:* Was there something memorable that you overcame to do it or that prompted you to—

*Inform:* My children. My daughter was only one at the time when we started having—no, we had problems, but one at the time when I started to, “I can’t do this anymore”. And then she was three when he left, gonna be four, yeah. Because, having other, having other relationships in a marriage, having affairs is not what married men do. Yep, so I couldn’t do it anymore. ‘Cause my children, what if they picked something up that he gave me? That’s, it was my children. Yep. (Angelina)

This quote reminds us again of the importance of family; here it was concern for her children that mobilized her to act.
These serious instances of disruption of the family unit were connected with accessing help outside the family unit.

**Summary.**

In summary, the domain *Reliance on family* focuses on how family helps individuals in the Portuguese community deal with personal problems. The fact that family ties are strong and close is a major factor. Some generational difference in who is the confidant are noted (for more recent generations, parents, and for earlier generations, siblings). Examples of very practical forms of help, such as care of seniors, are described. Family resistance to outside help or sharing is also described, as well as exceptions, which included seeking outside emotional or psychological assistance for issues such as spousal abuse and infidelity.

**Domain 2: Focus on physical ailments.**

Domain Cover Term: 2. Focus on Physical Ailments

Semantic Relationship: X is a way to do Y (Means–End):

**Description.**

This domain includes ways in which a focus on physical ailments (X) helps individuals with their emotional problems (Y). Four main cover terms focusing on physical ailments are described here, including two terms of distress uniquely described by the Portuguese community. All of the informants, as well as many community members, commented on this phenomenon.
Table 13. Included Terms for Domain 2

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<thead>
<tr>
<th>Included terms</th>
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<tbody>
<tr>
<td>2.1. As a way of coping with emotional problems</td>
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<td>2.2. As a social norm</td>
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<tr>
<td>2.3. <em>Agonias</em></td>
<td>2.3.A. Descriptions</td>
</tr>
<tr>
<td></td>
<td>2.3.B. <em>Agonias</em> and the Catholic Church</td>
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<tr>
<td>2.4. <em>Problemas de nervos</em></td>
<td>2.4.A. Descriptions</td>
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<td></td>
<td>2.4.B. Causes</td>
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2.1. As a way of coping with emotional problems.

The discussion of physical ailments played an important role in the community with regard to communicating about and coping with emotional problems. “Portuguese are more willing to talk about their body ailments” (Julia). I observed in my interviews that when asking about problems generally in the family, informants readily discussed the health problems of family members and how these ailments impacted family dynamics. Elizabeth was fully aware of her grandparents’ various physical symptoms: “With my grandparents, it’s probably listening more to their problems as opposed to actually asking them for advice. I rarely do.” The following quote from Julia shows how the physical ailments, including the attention and treatment given them, serve as a holding space for psychological distress:

I think that’s where they put their psychological—It’s okay to be sick and it’s okay to go visit doctors a lot, and in some ways, the more then they can get advice about what to do about their body ailments, what other people have done, it seems to be a common area of discussion. (Julia)

By communicating primarily about physical ailments, people can elicit emotional support from others. This also ties into the fact as discussed above that seniors tend to be particularly vulnerable to isolation and loneliness. Talking about physical ailments with
others is a way to feel less lonely. João said, in response to the question of whether people in
the community talked about physical ailments,

All the time. I think they’re looking for sympathy and sometimes they have nothing
to say, so they just talk about their health, you know, some of them are lonely, yeah.
They have nothing exciting going on, but yes, that’s what you’ll hear if you come [to a
seniors’ lunch] on a Wednesday, you’ll see it. (João)

Indeed, I found at the seniors’ lunch that many of the women I connected with talked about
their physical problems, including recent surgeries and long-term health conditions. They
also discussed the health problems of close family members. These were the major points of
conversation and provided a way for the seniors to connect with one another, show caring
towards one another, and to feel heard. The physical problems of their own bodies or loved
ones were normalized and at times displays of sadness or anxiety over physical ailments were
expressed and resolved in the group context.

A trend in the interviews was the perspective of the younger generations on the
conceptualization of suffering of the older generation; that the older generation does not
separate out emotional suffering from physical suffering, but rather sees “the nerves” as
another physical system with flaws. For example, when asked about problemas de nervos,
the priest (Tony) had not heard of the exact expression, but related to the phenomenon:

Yes, not talk about this, but sometimes they come to me, “Oh, I have hurt here, hurt.”
It is not because it’s hurt, because it’s something like—is their nerves—is not in good
way, because they (sharp intake of breath) for nothing. . . they are afraid, sometimes
for nothing. The smallest thing is something big to disturb them, especially the old
people. (Tony)

The Pentecostal pastor (Carlos) stated:

I guess it’s more a kind of an excuse. You know, human beings we don’t like to admit
our problems, our failures, our weaknesses and that expression that I know it’s a
expression that Portuguese people use all, that’s my nerves, “é os meus nervos,” they
say in Portuguese. “That’s my nerves.” . . . It’s something in me that I have no control
of it, what can I do? (Carlos)
Both informants stressed this phrase was used more by the older generation. The suffering is described by the older generation in physical terms and interpreted by the younger generation (the speaker) in emotional terms. While this does not deepen our understanding of *problemas de nervos*, the question that originated these quotes, it brings up the theme of helplessness, choosing not to actively seek help due to a belief that things are beyond one’s control. This concept is covered more under the domain *Barriers to seeking help*.

### 2.2. As a social norm.

Related to the previous domain, talking about physical ailments has value as a social norm in this community even apart from its utility in enabling people to cope with emotional problems. It is accepted, expected, and a common area of discussion. It serves as a way of connecting with others socially in community. João pointed out that dealing with health issues may be the primary focus in their lives and only thing they can readily share with others. He explained, “If it’s not their health or their, their families, they would have nothing to say. So it’s just one way to keep their brain sharp and their tongue, because they are expressing themselves right?”

I had the opportunity to witness this first hand when I reconnected with a senior I had met at the seniors’ lunch, while attending a church festival. I wrote in my ethnography notes:

One woman approached me warmly—[name] with the heart surgery—and when I asked her how she was, she said okay but not very good. I asked why, and she said she had just had surgery on her eyes and now had severe neck pain but couldn’t take anti-inflammatories because of her diabetes. I sympathized and she said it was nice to see me and moved on. (Ethnographic notes)

During the participant check process Elizabeth wondered why other aspects of life are not deemed as significant and do not contribute to one’s sense of well being or fulfillment. She herself did not have an answer for this. It appears that physical health, for the older generations, is first and foremost on the mind and an accepted way to connect.
One of the male informants shared his own personal experience and observations in the community of middle-aged men talking about health. He was frustrated by the anecdotal advice-giving, arguing and misinformation they shared among one another:

Men that I talk about [meaning men that I talk to], “how you doing?” You know, “What’s going on,” “How is your health and stuff?” Everybody complains about prostate around my age. “What are you going to do about it?” “Oh, so and so did this, so and so did that, and I’m gonna do it,” “Oh, are you informed?” So I keep saying “Geez,” you know, “Why can’t we have an association or kinda bring somebody to speak to everybody and everybody learns the same language?” Because I see a lot of arguments amongst them, “No it’s not that!” “It’s this!” “I understood this!” “I understood that!” Because nobody’s hearing it from the same person. Nobody’s listening to the proper sources. (Rodrigo)

The men initiate conversations about one another’s health and appear to enjoy a sort of verbal jockeying over the possible solutions and treatments to their health problems, such that seeking professional information is not as important as the social value of these debates. In this way arguing about health remedies is comparable to arguing about politics or sports.

2.3. Agonias.

All participants were asked if they had heard of the term agonias. What came from this question was a variety of descriptions and causes. Agonias was described by Susan James (2002) in her research in Boston, Massachusetts with the older Portuguese population, as a somatomoral experience where social, physical, moral, and religious aspects are interconnected. This suffering therefore connects the sufferer to the community as well as to God. The informants were not given this description. Here is what the informants in this study reported:

2.3.A. Descriptions.

The priest (Tony) gave an interesting description of a person with agonias:

It is not a real feeling of physically feeling, more psychological, this agony, you know. So, they—what can I say?—when you talk with someone or when you, when I
He provided an example of a parishioner who came to mind:

For example, I have a lady, she is 87 years old. For three years or maybe for four years, I went, I used to go at her home once a month. But every time when I got there, because I used to go there only to give her the Holy Communion, I couldn’t stay there. . . . but every time I went there, she kept me there, kept me there for one hour, one hour, sometimes two hours, and speaking, speaking, and when I tell her, “Oh I should go,” because, “No! Why you go now?” It’s not, “You have no time to be here, every time you come here you don’t spend too much time here?” . . . . Every time she always complained, “Oh, because I’m here alone and because I’m here I have nobody to talk to.” In this way, I saw this feeling, is agony, in this way. It’s not a physical illness, but it is something more psychological. For me, it’s because they are lonely. And like I told you, their world is too small. (Tony)

Agonias was also described as worries in a medical or non-medical context; a bundle of worries, a lot of unknown, beyond your control; distress, feeling emotional pain, “dark moments of the soul”, and “Ai, que agonias que tenho,” as in “I have so much stress.”

Angelina shared,

“My mother always used to say, ‘cause if she got bad news, “Ai que agonias que tenho.” Like, “Oh, I’m so stressed, I have such stress on my plate,” and, “Oh, I’m so stressed, “Ai, que agonias que tenho,” your brother went and broke the neighbour’s window with a rock.” You know, those kinds of things. (Angelina)

Maria was familiar with the term through her mother’s use:

“The way my mother uses it is to speak of worries in a general sense. You know, your anxieties, your worries. And sometimes. . . it may be a medical condition is inducing a lot of anxiety. But generally it has been in a non-medical context. My pronunciation is from the islands. . . but she’d say, “Eu tenho muitas agonias,” “I have a lot of worries.” (Maria)

Maria described possible causes of agonias as worries about children, or one issue that brings up a lot of other ones, “so you’ve got kind of a bundle of worries.” She stated it is often worry about how a situation will develop, “You know, that kind of thing where you’ve got all kinds of worries, a lot of unknown, a lot of things that are beyond your control, right? It
seems to arise due to things that they can’t control.” Julia affirmed this sense of lack of control and *agonias* for Açoreans.

2.3.B. Agonias and the Catholic Church.

Informants gave a range of situations and problems they see in the community that can cause *agonias*. These are described below. The most in depth descriptions were to do with religion. *Agonias* was linked to fear of death, which brought up the topic of mass intentions, masses dedicated to the deceased. It is common practice to give a small donation when asking the priest for a mass intention; a definition of this practice is provided in Appendix H. Three informants described mass intentions to me as a source of stress among parishioners. João expressed the frustration of trying to convey to a parishioner that the amount of donation is not important for the mass intention, suggesting that some parishioners believe that what they can pay relates to what happens to the souls of their loved ones:

I feel sorry for this poor lady, and then she phones me, “How much do I owe the priest for mass intentions,” still, I say, “It’s alright, you give whatever you wanna give. Mass intentions is a donation, it’s not a salary.” . . . “Well, it depends on how much you have and how much you wanna give, like you can give five bucks, 10 bucks, whatever you want. The priest is not going to say anything, neither am I,” but she says, “Okay its been six months, I must owe this much,” and I says, “No you don’t.” . . . I says, “No no, it’s a donation, you give what you want, if you don’t want to give this much, you don’t give this much.” “Oh, but I need to.” She won’t stop there. So I say ok give 10. . . . If I was not a person that cares for people, I’d say give a hundred, not thinking that lady needs to survive for the rest of the month. . . . It frightens me big time, because the woman is so vulnerable. (João)

Maria also talked about how importance the donation of money for mass intentions was to her mother and her mother’s generation. About herself she said, “I’m not that Catholic. I don’t believe in it, but that’s her generation.” Carlos, the Pentecostal pastor, discussed what he saw in the Catholic community:

People, they are afraid to die. They are afraid to where they go, because they don’t know where they go. Because that’s the Catholic doctrine. When people die, they go
to a place that doesn’t exist, actually, in the bible. It’s called purgatory. . . . Then it depends how much masses your family are gonna pay for your soul to get out of the purgatory to get into heaven. (Carlos)

He described the *agonias* that dying people feel in relation to their spiritual beliefs:

> I’ve been visiting people in bed, in deathbed, in hospital in [city name], Catholic people, and they are afraid to die. Because they don’t know, where they are going. They don’t know what’s gonna happen to them, you know. They don’t have peace with God, they don’t have peace in their hearts. And even some of them they are concerned what’s gonna happen with their families that’s gonna stay behind. So, they don’t have any kind of hope, they don’t have any kind of peace. That’s a spiritual problem. It’s not, you know, it’s not just a cultural problem, it’s a spiritual problem. . . . You know, most of them, they left this earth interment, you know, in agony. (Carlos)

He went on to explain that many converts from Catholicism to the Evangelical Church that he has seen have been from the older generation because of this issue.

Another relationship between *agonias* and the Catholic Church was guilt, as succinctly described by Paul, who grew up in the Catholic Church and Catholic school system: “There’s always that little bit of guilt thing, getting into you, “You’re not doing good,” “God’s not gonna like ya,” “You’re gonna go to Hell,” and that’s maybe on a very way in the back corner of my mind, religion’s playing a bit into this.” Similarly Julia recalled being told at the age of seven or eight, “look what you’ve done, you’ve put Christ on the cross.” Informants including Julia described *agonias* as a holding place for that guilt and worry.

Four informants had never heard of the term *agonias* used as an expression in their community. This question instead was received as an invitation to describe causes of deep distress in the community. One informant (Rodrigo) talked about a significant cause of distress he saw in the community, when couples reach an age where they can no longer live in both Portugal and Canada (often people split the year evenly between both countries), and must make a decision of where to stay; sometimes the family is divided between the two
countries. Similarly, the question of agonias prompted Margarida to share her knowledge of community members’ experiences of depression, and her own experience with depression when she immigrated to Canada.

2.4. Problemas de nervos.

The older generation recognized the term problemas de nervos to be a commonly used term in the community, while the younger informants varied in their familiarity with the term. Below are informants’ descriptions and reported causes of problemas de nervos.

2.4.A. Descriptions.

Because this term was less commonly known in the community, there were very few descriptions of its manifestation. The question was instead received as an opportunity to discuss problems in the community, which are described elsewhere. The descriptions that were elicited suggested that someone with problemas de nervos is anxious, afraid, and easily upset or disturbed.

2.4.B. Causes.

Informants said that people often speak about their nerves with regards to stress, and, at a seniors’ lunch, one of the women motioned to her granddaughter saying jokingly that granddaughters are a source of stress. Her granddaughter was approximately eight years old and was playing with two other grandchildren while the grandparents ate and conversed. Angelina, whose parents came from the Açores and who herself was in her 40’s, described problemas de nervos as being stress, brought on by having children with problems such as colic or Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) and not understanding these problems, but did not indicate she had heard the expression used in the community:
Oh meus nervos, that kind of thing… these older generation, they need more education on that. And it’s too bad that still, some people my age don’t understand what these things mean and refuse to educate themselves on it because that’s the way it was. (Angelina)

The common theme was that problemas de nervos is stress brought on by worry about children and grandchildren.

Summary.

Focusing on physical ailments in the community was a well-recognized way of connecting and socializing, one that I also observed through my own interactions in the community. Agonias was a recognized phenomenon, problemas de nervos much less so. When asked about both, it was observed that each informant described something in the community that they believed caused people distress.

Domain 3: Using substances and gambling to cope with problems.

Domain Cover Term: Using Substances and Gambling to Cope with Problems

Semantic Relationship: X is a way to do Y (Means–End)

Description.

This domain describes ways members of the Portuguese community use drinking, drugs, or gambling as a way to cope with problems. It is not necessarily common or more common than in other communities. The contextual, or social factors, are discussed for each, as are the outcomes. The semantic relationship is X (drinking, drugs, or gambling) is a way to do Y (cope with problems). This domain was described by community members I met through participant observation, as well as by six informants of the ten with whom I conducted in depth interviews.
### 3.1. Drinking.

Drinking was described by five interviewees as an important part of Portuguese culture.

#### 3.1.A. Contextual factors.

Alcohol use was also described as a social norm and way of socializing in the Portuguese community. This finding agrees with other research, as discussed in Chapter 5. Through my field work I paid many visits to the local *charcutaria*, which served meals, take-out, catering, and most importantly, had a lounge area where people often came for a drink and to watch sports, mostly football (soccer). I learned that many Açorean and mainland men like to stop at the *charcutaria* for soup and to have a drink before they go home, and that the wives disapprove, particularly non-Portuguese wives.

Making one’s own wine is common: “They make their own wine, as you know. . . and so sometimes they struggle to withhold the liquor” (João). Another informant discussed her environment growing up; that wine at the table was normative, but distinct from this were her father’s “drinking days”: “You’re all brought up with wine at the table and all that kind of stuff. But the drinking days were there, definitely, oh yeah” (Angelina). Alcohol use was described as a common way of coping with emotional problems. One example was self-medicating for depression; Paul described how he would see his father drink more when he

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was depressed. Angelina recounted times in her childhood when her father, who was diagnosed with bipolar disorder after a disabling worksite accident, would start drinking and her mother would say, “Ah, he’s not on his meds; that’s what the problem is.” He was using alcohol to self-medicate.

3.1.B. Outcomes.

Various adverse outcomes of excessive alcohol use were described by informants. These included increased domestic abuse, increased stress in the family, breakdown of marital relationships, job loss, and children’s worry for fathers’ health. Carlos recounted an incident where he provided assistance to a woman who had experienced abuse by her spouse who had also been abusing alcohol:

I had a situation a couple of days ago. . . the guy is, he has an alcohol problem; he’s not a gambler. Just work, come home and drinks by himself. He has an alcohol problem, and when he’s drunk he gets very violent. And one day she, at night, we were in bed already and she rang the bell, in bare feet and she just left the house because he was trying, you know, to beat her and she called the police from our place and they came and they took care of the situation. (Carlos)

Several informants discussed the various treatment and counselling processes their family members and friends went through. In one case the priest reached out and tried to help but it led to a separation from the church:

My dad was an alcoholic and so I grew up with that, and there was a lot of shame that my family had with that and we were told, my sister and I, not to share that with anybody else, ‘cause what will people think? And yet the community knew, so the priest did call and that caused my dad to stop going to church. (Julia)

During the participant check/second interview process João clarified that drinking in the community is almost entirely (“ninety nine point nine percent”) among the men and very rarely among women. “When men are upset they don’t release their emotion until they have a drink.” He described alcoholism as one of the few things that does get men in the door to talk
to the priest, particularly when their marriage is at stake. He recalled an incident involving drinking and domestic abuse that led the individual to seek help from the priest.

Julia described the physical consequences of alcohol use for her father, which was very hard for her to see:

My dad was a slight man, he was very thin, and he had had an ulcer in Portugal and apparently two thirds of his stomach were removed, so he just couldn’t physically tolerate alcohol at all in his system, so as soon as he drank, which he thought he had the right to do as a Portuguese man, his whole personality would change and he would just drink until the point of collapse, until he was comatose, which, so we’d see him dying, and we’d feared for his life from a very early age. (Julia)

3.2. Gambling.

Gambling was seen to some extent as a social norm and way of socializing in the Portuguese community. It was raised as a major concern or problem by one informant only.

3.2.A. Contextual factors.

Many of the men played cards in the clubs and bars for small amounts of money as a way of socializing. Bingo was also popular. One informant discussed his wife’s propensity for playing bingo across the street when their restaurant business was slow, which was a source of stress for him. Others discussed a general awareness of the context for gambling: working long hours and many days in a row in isolated areas, receiving big cheques, and going straight from work to a Portuguese bar to enjoy a beer with co-workers and gamble:

They receive good cheques, big cheques, and they spend it on gambling. Because they’re spending three or four weeks in a row there, and at the end of the day, or during the weekend, they went to bars and start gambling, or casinos and stuff. And here in town, even in town, they work 10 hours a day, after work, before going home, they go to a Portuguese bar, to have a beer, with co-workers and they start gambling there. (Carlos)

Carlos and I discussed my recent visit to a specific Portuguese bar in the community:

Yep, all men, you don’t see a woman there. And you know what, in 13 years, that’s probably the only Portuguese place in town that I never stepped in . . . because I know lots of stories, lots of ladies sharing, “Oh, my life is completely in a mess, because my
husband spends money on gambling there, in that place.” And it looks like it’s something not legal. I know for sure it’s not legal. (Carlos)

3.2.B. Outcomes.

Carlos was the primary source of information about the outcomes of gambling in the Portuguese community. He cited general awareness of resultant financial difficulties, loss of house, business, women seeking help and counselling because of it, and sometimes divorce. As Carlos said, “there's the only story, bad, bad story that has a very bad end.” It is not known if gambling is more of a problem for Portuguese than other cultural groups. Carlos gave an example of someone he knew who lost a great deal due to gambling:

He used to own his own construction company, a cement company, he was a cement finisher. Used to have four or five guys working for him. And he lost everything, he lost the company, he lost the trucks, he lost his own house because of gambling… and lots of stress in the family, no. Kids and woman, of course that guy got divorced because she couldn’t take it anymore. (Carlos)

Carlos cited a recent example of awareness of gambling in the community, of a newcomer who visited a gambling venue:

Even just a couple of weeks ago, a guy from our church, he’s new here, he came from Toronto, he came from the Açores island of Sao Miguel… At the end of the day with the company truck, all of them, four guys, they went there for beers and they started playing cards. And he doesn’t play cards and he doesn’t do that kind of stuff, he’s a member of our church. He was surprised and he came, completely no, he was, he was in shock and he said, “Pastor, this is stupid. Someone needs to do something because it’s illegal, they are, you know, wrecking their lives.” (Carlos)

During the participant check process I asked other informants if they agreed with the perception of gambling as a problem in the community. João, Julia, and Maria perceived gambling not to be a problem. They clarified that the card playing is for social purposes and the amounts are small; the serious gambling happens in the casinos. They and the other informants were not aware of any serious gambling problems in the community. It is possible that the clergy have more information about gambling due to their trusted roles as confidants;
they also may have more prohibitive views of social gambling so as to perceive it as more problematic than does the general community.

3.3. Drugs.

One informant knew of a teen who had committed suicide related to drug use, but only secondhand. Another informant stated the belief that drug use among second and third generation Portuguese youth may be increasing, but did not exist previously. The area in which the Portuguese shops and old community are located has more recently become known for citywide drug dealing. In light of this trend it is significant that only two informants had anything to say about drug use at all.

Summary.

Many informants described drinking to be both normative and at times problematic in their community, and a reason people seek help. The vast majority of the time this only became problematic for men, not women. Gambling was also described by a few informants to be, again, normative, and by one informant to be problematic. Finally, there was very little said about drugs and from my exposure to the community this does not appear to be a problem.

Domain 4: Accessing the Portuguese community to prevent or cope with problems

Domain Cover Term: Accessing the Portuguese Community to Prevent or Cope with Problems

Semantic Relationship: X is a kind of Y (Strict inclusion)
**Description.**

This domain covers kinds of help and relationships provided through the Portuguese community (X) and how they contribute to helping relationships (Y). Problems with connecting in the community are also covered, including taboo topics and lack of group membership, as is the problem of insularity. Nine out of ten of the informants who were interviewed in depth spoke about the role of the community and clubs in contributing to helping relationships. The priest did not speak about social connections in his interview. The following terms fall within this domain:

Table 15. *Included Terms for Domain 4*

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4.3. Insularity

4.1. **Connecting to the community.**

Different forms of connecting with the community were described by informants and observed through my fieldwork, which fell into two main categories: connecting through shops and businesses, and belonging through clubs and common goals.
4.1.A. Connecting through shops and businesses.

Informants discussed the important role of Portuguese businesses in bringing the community together. I also visited many Portuguese shops, cafés, charcutarias, and other small businesses. There were often Portuguese-speaking clientele present and recognizing other customers. Rodrigo described how he makes a special effort to come to the community even though he has moved into the suburbs:

There we go, when there’s barbers down there [meaning in his suburb], why I come here? To go see who is at the café, you know, talk with people there. But it’s fine, it’s my roots, I must make known to them that I’m not despising them or not superior. (Rodrigo)

Paul compared the Portuguese community where he grew up to the smaller community to which he moved:

I thought when I moved there that I could adapt to that lifestyle, live in a smaller community, more remote, it’s not for me. I miss the certain, my coffee, my espresso, my deserts, my interaction with, the simple things like going to a grocery store and being able to access things that I appreciate that I grew up with.”

He talked about how he would make trips to the larger city, “to go to the Portuguese bakery and speak for 10 minutes in Portuguese, that was very happy, I was very content with that.”

He eventually chose to move to the larger city to be less isolated. “Even though I’m not part of the community at least I can come in and come out, as I need to.”

Maria, whose parents brought her grandmother over from the Açores, described how her grandmother then moved far away, still within Canada, so that she could be in a major city with more Portuguese services and establishments. “She could go everyday to the bank and talk to the girls at the wicket and they would all be Portuguese-speaking.” When she could no longer live on her own, the family was able to talk to social workers in Portuguese and find a nursing home with a lot of Portuguese personnel. Maria said about her own
parents, “Whereas, when the day comes that I have to put my parents into a nursing home, I will be doing all of that.”

Paul spoke about the meaningfulness of the connection and being known in the Portuguese shops, even though it is at a superficial level. He also noted how it brought up a feeling of being back home where there are more Portuguese connections:

Some people do, they recognize, it’s THAT guy, you know, like people recognize my face and recognize who I am but not everybody and it’s only the people that work there, it’s the same four or five people. It doesn’t really do much in the grand scheme of things. Even though for that moment in time, I kind of feel, hey I’m kind of back in [province name], kind of back home, I’m kind of where I want to be, but not really. (Paul)

Speaking Portuguese in shops with familiar faces is a part of one’s identity, reconnects one to self and to the past: “I have a smile that would just pop right up, because it’s bringing back part of who I am, right? Doing something that I used to do.”

Carlos described the insularity of Portuguese communities starting with the first generation of immigrants, due to a lack of ability to speak English; they could not communicate outside the home, going to the doctor or the store was very difficult. Likewise the seniors told me about their first experiences trying to purchase things from the store when they arrived in Canada. In the words of Carlos,

So, basically they lived in Canada, but always inside the community, the Portuguese community. And in the 60s as the community started growing and in the 70s, and being organized with different associations, they always lived inside that closet, you know, the community, so, it was one problem. (Carlos)

This contributed to problems with language differences between the generations:

It was lots of problems when they started having kids, because the kids, they started having a different kind of mindset because they were born here, they know the language, then at home, always fights, because the parents they speak Portuguese, the kids they speak English between them, and they reply to their parents in English. Their parents will always say, “No, this is Portugal. This is my house, this is a Portuguese house. This is Portugal. So you need to speak Portuguese.” I know lots of
stories like that. And they tried to maintain the culture and the language, but the kids, they face problems speaking the language, because they just speak with their parents at home. And the language of their parents, their Portuguese, it’s very basic, some of them. So the kids, they don’t have a good knowledge of the language to speak it. It’s easy to speak English. (Carlos)

Through Carlos’ summary we see that while the community supported immigrants in maintaining their native language, problems with cultural and language changes arose through subsequent generations and clashes within the household.

Informants also described some problems with the Portuguese establishments not encouraging enough community:

…and the coffee shops here really aren’t—calling a spade a spade—they’re a bakery, you go in, you get out. They got some seating but it’s not really geared towards people hanging out for three to four hours having a coffee and shooting the shit, right? (Paul)

Margarida, who had recently emigrated from Lisbon, noted that there were no Portuguese cafés open in the evenings. The chairs are uncomfortable and the seating is not conducive to long visits. I noticed this also, and observed in my visits to these places that the primary source of income for these cafés is take-out food orders and people picking up their baked goods and breads.

People in the community help one another. There are certain topics kept within the family, or that are taboo in conversation, as will be discussed below. However, community members do talk about their family members and life problems with one another and receive help through normalization, hearing each other’s stories, and sharing advice. Rodrigo answered in response to the question, “Where do people go when they have problems?”:

It first starts with each other. What I sense is that it starts with each other, and then I have seen actually people recommending you know, you should go see the doctor or you should go talk to a lawyer and you know, like uh, but some people seem sometimes, I don’t say it’s true the whole community is like that but, I have known of cases where people even call me saying, “Hey, I have a problem, what do you think?” You know. But then again, you talk to five different people in order to get one
answer, “Well no it’s not like that because I talk to so and so and he or she told me this and that, and I think you are not up to par on that,” I said, “I know,” “but I also talk to this so and so, and they says,” I said, “whoa whoa whoa, you calling me to tell me how it is or are you asking for an opinion because you already talk to so and so and they give you all this information and now you’re asking me to give you an okay on that?” You know, “I’ll give you my opinion and this is it.” Sometimes, it can be confusing. (Rodrigo)

Here Rodrigo describes a process whereby community members consult with multiple other people to develop a knowledge base or opinion regarding a problem. This also builds community networks as people learn who gives what advice or opinions.

4.1.B. Belonging through clubs and common goals.

In addition to the commercial Portuguese businesses, there were clubs/societies that brought Portuguese together, as well as informal gatherings, such as morning coffee for the senior citizens at the local mall. The club was instrumental in planning social events and celebrations. One community leader expressed a real desire for the Portuguese to become more visible in the city as a beneficent and active force.

We have to pay back to the community by organizing these kind of things and give back to the community for what we received from them and become known, see that we have a sense of establishment, a sense of belonging, being. And some people are very reluctant, “We don’t do that anymore,” Why is that? (Rodrigo)

He described a benefit concert that he organized to raise funds for a local hospital.

But I like to see the Portuguese community more vibrant, more participating, more, you know, not the fact that we are better than the others, but perhaps the other ones, the other communities, other cultures would follow. You take pride in what you do well and people would respect you for it. . . . And it’s going to be viewed as, you know, the Portuguese community’s kind of nice and helping. But I’d like to see more of that, you know, I don’t see enough, personally. (Rodrigo)

This informant discussed how he joined the Portuguese club to meet his own need to belong to something larger than himself, and how it fulfills that need.
4.1.C. Acknowledging helpers within the community.

Informants identified helpers in the community and several identified the same individuals and the roles they play. Examples were the Portuguese radio announcer:

I think the community revolves about those people, [person’s name], whatever he says on the radio that Sunday, looks like on Monday on, for the whole week, people will be talking about it. . . . If he says on the radio that so and so died, well before they close the station, people are calling everybody, oh did you know this, did you know that? (Rodrigo)

Others included a choir director and active community member, the local Portuguese physician with a primarily Portuguese clientele, and the local notary, who was fluent in English and Portuguese and could translate official documents: “he’s been a very cohesive force in the community, in terms of being able to handle documents for people, write formal letters, and all that kind of thing. So he’s not a medical-social worker, but he is sort of.” (Maria) This same individual was also identified by Rodrigo:

He is an old pioneer, he belongs to the pioneer group of [city name] when he settled and he has the driving school and he’s the public notary for [city name] and he is a very knowledgeable man and seems that everybody in [city name] doesn’t do anything without going to see him. (Rodrigo)

Like the example above, community leaders were identified independently by more than one informant. Several of the informants I interviewed directly were recognized helpers in the community; a professional counsellor, a hairdresser, a leader in the Portuguese club, a Pastor, a Pastor’s wife, a Priest, and an administrator of a Portuguese organization. Some of these informants discussed their own desires to help the Portuguese community; a counsellor through psychoeducation and family work, and a leader in the social club through needs assessment and better meeting the needs of the Portuguese seniors. The leader also expressed a desire to continue with the Portuguese culture:

And then they say, “Well once the old people are gone, we don’t have to continue with our Portuguese culture, the Portuguese way of doing things,” and I said, “No,
there is always children coming up, who are Canadians, that they have to have the roots somewhere and they don’t have to live with the sense of who am I. My parents abandoned me, they died and my grandparents or great grandparents.” You know there is some sort of heritage that we have to leave behind, and that kind of preoccupies me, to the point, I say, “Well something’s gotta be done.” (Rodrigo)

One informant described a tendency within the community to use one another for practical purposes without building relationships.

There’s one other Portuguese individual that I’ve dealt with, I helped him, I met him through the bakery, one of the girls, she put me in contact with this guy because he needed a hand, so I helped him work on his resume. . . . And then he disappeared and I got a phone call, and he needed help with something else right? . . . So I get a call when he’s got a problem, right? Which is quite common in the community from what I understand, which is not what I want to get dragged into, so you know I want to be a part of it, but I don’t, because I don’t want to be the guy that does people favours or I’m only there for them in part. I’d like to be the—hey, this guy is having dinner tonight, come on over. (Paul)

Another informant spoke proudly of her ability to help others in the community. Her work and location made her a central helping figure in the community: “A lot of people still today, call me and, “What did you do with this?” and, “What did you do about that?” And those kinds of things” (Angelina). It was clear that her life experience and example were considered valuable to others. “Cause they could not believe how strong of a person I was for being a just separated divorced single mom.”

4.2. Problems with connecting.

A major problem described in connecting with the Portuguese community was lack of group membership; if one did not share similar interests to other Portuguese Canadians, it was difficult to join a group or find talking points. The issue of taboo topics, similar to the preference of discussing physical rather than emotional ailments as discussed above, also formed a problem in connecting. Both of these are described below.
4.2.A. Taboo topics.

The topics of marital relationships, sex, and mental health are taboo among community members mostly of the older generation. João warned me about my upcoming visit with the seniors’ lunch group,

Sex, mental issues, that’s not talked about with friends. It’s within the household. You’ll see if you go tomorrow, maybe you’ll see, and if you talk about sex with them, they’ll say goodbye to you. They don’t want to talk about that. (João)

He delineated between accepted topics and taboo topics:

They can talk about their children, they can talk about their husbands, um, they can talk about their sisters or their family members, but when it comes to mental issues or relationships with husband and wife problems, no. If he is no good, he is a gambler or he is a drunk, oh yeah, they will open up and spill their beans. (João)

And he clarified that this applies more to the older generation than the younger one. “With the younger, your age, they are free; they are not free, but they are more adaptable to that kind of conversations, where you don’t with the seniors.” (João)

4.2.B. Lack of group membership.

Lack of group membership was expressed by informants through three main sub-domains:

4.2.B.i. Loss of Portuguese language.

Paul cited his loss of some of his Portuguese fluency as a barrier to participating in the Portuguese community, particularly compared to when he was younger and more fluent:

It’s simple things like just going to the fish store, going to the bakery, going to the butcher, and doing it in a way that I want to do it . . . telling somebody this is what I want and them knowing what I want, where here, I don’t have that. (Paul)

And he described a downward cycle with his Portuguese fluency: “. . . another issue, because I’m not part of the community here, is that my level of Portuguese has degraded significantly.”
Likewise, another informant (Elizabeth) who had only one Portuguese parent and who therefore never learned fluent Portuguese (she took Portuguese lessons and learned some Portuguese from her mother and grandparents) cited the same:

I think I, at that time, I mean, I still feel in some ways I don’t consider myself Portuguese. … I think I always felt that I wasn’t as authentically Portuguese because the language wasn’t spoken at home, which was a big difference between my friends and I. And also that I didn’t attend Catholic Church and I didn’t attend cultural events. . . . When I was in junior high and I had a lot of friends in that community, I, in some ways, I did sort of, I did feel excluded. But I don’t think that was necessarily, that was probably you know my own, that was just me internalizing, my own circumstances. I don’t think, I wasn’t in any way made to feel that way by the community. It was just the nature of my family, my family background and dynamics. Just as opposed to theirs. (Elizabeth)

When she visited her friends, “The first thing I’d always be asked was, “Não fala Português?” “Don’t you speak Portuguese?” You know, it was always, especially from other people’s parents or grandparents, that was always the question. But of course, I never spoke it.” This also produced a problem with connecting with her great-grandmother:

She didn’t speak a word of English. So whenever I’d see her, I could never interact with her. Obviously there would be physical displays of affection, expressions obviously, yeah. I think especially amongst sort of my, first generation relatives, they’re very sort of affectionate, and expressive, very warm. But I could never speak with her. And she only passed away in my first year of university. So she was still around for quite a bit. (Elizabeth)

Elizabeth spoke about her experience of feeling unwelcome in Portuguese school for not speaking Portuguese at home:

I’d sort of picked up bits and pieces from, when I’d be at my grandparents. But even then, I would mostly communicate with them in English, because obviously, I wouldn’t be able to understand otherwise. And it was a big barrier for me in the school. And I actually had, in my second year, I had a teacher actually tell me, that if I didn’t speak Portuguese at home, I actually shouldn’t be there (laughs). So that was really interesting, I actually very distinctly remember that. Yeah, that was a bit, that was really unfortunate. But also because of the age that I entered, they didn’t want to put me in first grade because they were very young kids. So in order to match age appropriately, I was advanced a year. But even then, I think most of my peers were
already even advanced level, getting Portuguese for high school credit. Because they were native, yeah, I guess a lot of them were native speakers. (Elizabeth)

From the Portuguese speaker’s perspective, even though Paul reported he was losing the Portuguese language, it was difficult for him to be close to people who didn’t speak Portuguese at all:

It’s the, “Oh, you’ll be speaking Portuguese and you’re not going to be including me,” and that’s heartbreaking for me because I do want to include the person I’m with in my conversation, in what I’m doing, but at the same time, I don’t want to be translating every thought, every sentence, every little thing. Um, so it’s very difficult and more and more it feels like we’re just incompatible. So, and as my cousin said, I need a nice Portuguese girl, whatever that is. (Paul)

4.2.B.ii. Not sharing the Catholic religion.

As Carlos said, “If you are not Catholic, or if you are Catholic but you don’t attend the Portuguese Catholic Church, that’s it. You know, you are completely segregated.” Many community events and points of connection revolve around the Portuguese Catholic Church.

I wish I was part of it and I’m not. I don’t want to get involved with the church because I’m not religious, and I would just—I’d butt heads. Not say I don’t wanna be involved and I wouldn’t do a good job, but I just have certain views. (Paul)

Some individuals shared Catholic beliefs but were not regular church attendees. Julia explained the paradox of having been so deeply involved in the community growing up that she is hesitant to engage at all now:

Well I’m no longer in, I haven’t for years, engaged in the Portuguese community, I’ve tried to go back . . . it’s just when I walk in, and they haven’t seen me forever, that’s the question, “We haven’t seen you forever,” you know, “Where have you been?” And now, yeah my sister and I have a different take on it because she in many ways wasn’t so brought up into it that she really has taken I think the best of both worlds and wants to share that with my niece, which I would like to be able to do, and so yeah, she is all into the festivals, and to community parties, which is great. (Julia)

She reflected on the paradox of her sister now being involved more than she: “which is weird, Marie, ‘cause I was so involved, so involved and volunteered and taught Sunday school forever and so it was a huge part of my life, yeah, growing up.” When she considered
re-engaging she was somewhat overwhelmed. She had found her own non-Portuguese spiritual beliefs and had married a non-Portuguese man. Her values had changed a great deal since her youth, when she was wholly immersed in Portuguese culture. She admired her sister who in contrast was able to enjoy the Portuguese events on top of her own mixed cultural identity.

4.2.B.iii. Lack of interest in sports.

Sports, particularly soccer and the European cup and the world cup, were a major interest in the Portuguese community, and people would gather to have a drink or coffee at various Portuguese establishments and watch a game. Paul, who had no interest in sports but wanted connection, felt there was no other way to spend time with other community members in a relaxed atmosphere to get to know them better. Regarding the sports crowd that meets at the charcutaria: “I’ve been there, the crowd is very crude and rough and it’s like you know what? It not, right? It’s just not who I am.”

4.3. Insularity.

Community members commented on fragmentation between different Portuguese groups. The major two groups were Açoreans and mainlanders, but some individuals also noted that mainlanders were divided into different regions such as north and south. Informants also commented on the tendency for the community in general to not involve other cultures, and also for those who spoke only Portuguese to keep within the Portuguese community because of communication limitations.

Paul spoke of the difficulty connecting with the Portuguese community partly because of not sharing common interests as discussed above but also because he did not grow up in that particular community (he moved from another province). He said, “If you’re an
outsider, it’s always difficult.” At another point, he said, “You’re the person that’s trying to reach in, and where are you reaching to?” meaning that he had a strong desire to connect with the Portuguese community, but with an awareness that he had little in common with the members of the community. He did not know what he was reaching for, but the need for connection was strong. Another informant commented on the state of the community as she saw it:

We already, yeah we were involved, let’s say, we don’t have a very united Portuguese community, like people are very dispersed and you know they have their own things going, but we try to be involved, actually my husband he tried to make an effort to be involved more in the Portuguese community, but people were not in agreement. There were lots of different ideas and different plans so there was not a big group that were united in what they were doing. (Margarida)

She explained that eventually her husband stopped attending the society meetings. I spoke to an informant at the charcutaria, a construction crew leader in his 50’s and who immigrated from San Miguel in the 80’s spoke about the lack of unity in the Portuguese community. He complained that, “there is no community, no one sticks together,” and, “everyone drifts apart.” He said that he had been trying to unite the Portuguese, that they “don’t do anything.” He started the Portuguese musical society with a Philharmonic group and they built a brand new building near the Portuguese Catholic Church and nobody comes out. He had posted a notice by the bar about an upcoming important meeting for everyone to attend to determine the future of the group. Paul discussed his perception of fragmentation of the community based on region of origin:

I don’t feel part of the community, and the community from what I understand talking to various individuals is quite fragmented. You have individuals that are from the island, from the Açores, you have some from the mainland, and they segregate themselves and then the ones from the mainland will segregate themselves even further to some extent. . . . The guys from the north and the south. . . . It’s very different and for a smaller community, it’s more challenging, maybe because nobody’s ever able to connect, where that segregation does happen in Toronto, that’s
the reality, but the community is such, significantly larger that you don’t really notice
it too much. (Paul)

In comparison, when he was growing up, his family interacted primarily with other
mainlanders but there were no subdivisions among the mainlanders. Later he summarized his
view of the fragmentation of the community:

We were talking about the community and fragmentation, it’s broken up, the islanders
do their thing, we do our thing and it shouldn’t be that way, we’re all really just one
person, one community, why do we break ourselves apart and then it became political
and certain families, and just, it becomes a mess. (Paul)

He stated, “Here, I don’t have the community that’s there.” Rodrigo observed that
both the mainland and Açorean Portuguese avoided one another, and that they would say,
“Oh I have my family and I have my friends and it’s enough.”

An informant in his early 40’s who ran the Portuguese bakery, who was from
mainland Portugal, presented a very strong view about the difference between mainland
Portuguese and Portuguese from the islands. He stated that people from the islands are often
poorly educated, very poor, and have lots of problems. He dated three girls from the Açores,
and visited there. The families were large, one had seven children, and the husbands worked
in the fisheries and drank and were mainly not present or involved in the parenting, whereas
the women did everything on their own. He said that the second generation here in Canada
mixes in and is like everyone else, and is not really worth me researching; if I was going to
research something, the Açoreans were the most unique group. He suggested I go to the
Charcutaria, which is run by a man from the Açores, which I did. He also told me about a
church that has a large Açorean population and a lot of seniors who meet in the basement. I
did eventually meet these seniors and discuss my research topics with them. He also said
there will be a festival at that church over Father’s Day, which was coming up. He said that
the Portuguese separate according to where they are from, the people from the North of
Portugal built one church, those from the middle built another, and those from the Açores go wherever. I did not find direct evidence of this; I was only aware of the one large Portuguese Catholic Church in the community that also had a seniors’ group.

Moving from separation within the Portuguese community to separation between the Portuguese and other groups, Rodrigo noted that the Portuguese tended not to associate with the other ethnic groups. He connected the insularity within the community to the language difficulty; many individuals from the first wave of immigration, who had been in Canada for 30 years, did not speak English. I also found this when meeting with the seniors. “[They] have to go to a friend for whatever things that they need and they cannot pick up the phone and speak the language and get around.” He expressed a wish for the cultural events put on by the Catholic Church to expand beyond the Portuguese community, for there to be a Portuguese MLA, and for the Portuguese community generally to be more connected to the larger community.

Julia talked about the fear she saw in her own church of including members beyond the Portuguese community:

There was a real fear of opening the doors to other cultures which is part of the reason why I left, since it just felt like, as it was brought to my attention by the nun, this is crazy, like you have nobody in the pews, and you have a whole community of people. . . . Does it really matter whether they’re Portuguese or not? And boy oh boy, people were in uproars, you know, that they built it and what are you talking about? Sweat, blood, and tears have gone into this building and it’s their place, and so more and more it was becoming dead and it was also really trying to tighten, I think, the fear of inter-community or inter-culture or inter-anything. (Julia)

Rodrigo described an incident in the press recently in which a Polish Minister of Education was publicized by the press for name-calling, and this reflected poorly on the whole Polish community. He speculated that Portuguese leaders are hesitant to come up and be known beyond the community for fear of bad publicity and reflecting poorly on the Portuguese
community. He speculated also that popularity beyond the Portuguese community would be poor.

Another problem cited by a young, second-generation Açorean was the difficulty of finding a fit in the community for second-generation Portuguese:

I think there are challenges that arise with trying, especially for young people, trying to balance their upbringing in Canadian society while trying to appease or maintain some links to their cultural group or their families. I think that sort of contributes to isolation, you know like social isolation in any way. (Elizabeth)

She wished there were services or organizations in the community to support youth in this position.

Summary.

The Portuguese community provides many points for social connection including club membership and activities, and Portuguese businesses and cafés. Problematic aspects of these social intersections do exist however, and include taboo topics for discussion, and lack of group membership for some if they do not share the same interest in sports, religion, or language ability. Finally, isolation of the community from other groups, as well as factions within the community according to place of origin, both serve to limit social connections.

Domain 5: Receiving help from the church.

Domain Cover Term: Receiving Help from the Church

Semantic Relationship: X is a kind of Y (Strict inclusion)

Description.

This domain describes ways that the church and clergy (X) help individuals deal with problems, prevent problems, and have healing relationships (Y). The primary divisions are the clergy providing guidance and counselling, and the religious institutions providing social
networks, meaning, and function. All informants who were interviewed in depth spoke about the importance of the church and clergy in helping.

Table 16. Included Terms for Domain 5

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5.2. Social connections
5.3. Nossa Senhora de Fátima
5.4. Religion as a source of strength and comfort

5.1. Clergy.

I was able to interview the priest of the Portuguese Catholic Church and the pastor of the Portuguese Pentecostal Church, both the main Portuguese churches in the community. I also interviewed an additional key leader/organizer in each of the churches.

5.1.A. Catholic clergy.

I asked an informant who was knowledgeable about the priest’s counselling meetings the standard question, “Who do people go to when they have a problem?” and he responded, “They usually come here. . . . And whatever is said between them, it’s in that office there and I don’t pry, I turn on the music so I don’t listen to them. It’s between them” (João). These meetings are more than just confessions; they take a form very similar to counselling sessions. The priest himself saw his role as encompassing both the religious celebrations and counselling:

I came to help them with their spiritual needs, so to, to help the parish, to perform the celebrations like masses, baptisms, weddings, funerals, and to help the sick people, anointing them, visiting them, with advices, sometimes they come to me to have some advice, like a counsellor (small laugh) in this way. But especially to, my mission here is to be with them, in their lives and in their moments of celebrations of sadness sometimes and of parties, so to be involved with them. (Tony)
Julia discussed her perception of the help provided by priests during the time she was more engaged in the church, about ten years prior; she stated that people would turn to the priest, in a “confessional kind of situation,” when they “felt horrible and terrible about perceived guilts” (Julia). In a similar vein João said, “They want to see what the priest would think about this,” and the priest stated that part of why people go to him is to receive permission to do things that they are not sure are accepted by the church:

When a person look for a priest, they look to the priest to confirm that thing they are thinking. . . They would like to have. . . segurança [security]. . . They are sure that they want that thing, but they are not able to, themselves, to get that. Sometimes, it’s like a confession. . . “Father I did this, does this seem, is it sin or not?” I tell them, “your conscience should know if this is sin or not. I am not here to tell you what is sin or not, you should know.” What the people want is someone to confirm on their behalf what they think. For example. . . okay, the man is not good with the wife. Oh, I have some problems with my wife, you get divorced. Okay, come the other one, oh I am not good with my husband, I will get a divorce. What can I do? I tell them, come together, because I am not a lawyer, I am not a judge to tell you what is right or wrong, I should hear both. . . I didn’t come here to take parts. I came here to help the community, to build a unit. I cannot divide. For me, everybody is right, because if I tell someone, “Oh you are right,” then that person will tell to the other, “You are wrong, because the priest told me I am right.” (Tony)

I noticed that the priest’s position came with power and authority. This was apparent by the process of getting a meeting with him, and by his role in the church. I met the priest after a church service, along with my husband and daughter, and we discussed our respective doctoral degrees and he told me he was willing to meet with me if I set up a meeting with the administrator. I then met with the church administrator who made the decision about whether I was appropriate for meeting with the priest (I was asked to speak about my research and my background). I waited one month for the meeting because the priest was writing a draft of his PhD dissertation; he was then absent for our meeting because of an emergency home visit to one of his parishioners, so I was offered an appointment for the next day.
The priest explained that if he did not demonstrate authority with the parishioners, there would be division and indecision.

If I do this, I won’t have authority before them. So I show them that I have authority. This is important not because here is a church, but this is important at the family also, ‘cause if the teenagers don’t see authority in the parents, they do what they want and the parents has no control. . . . We must show them limits. (Tony)

Many informants explained that Catholic clergy are sought for counselling because it is socially acceptable, limits gossip, and ensures confidentiality. João explained why it is easier for many people in the community to go to the priest rather than a psychology professional: “Their background is if you see a counsellor or a psychologist, you’re not all there. There’s still that old school thing, you’re crazy. So they would rather go to a priest.”

However, Carlos emphasized that still overall not many people in the community speak to others, including clergy, about their problems: “Some of them, they would accept to speak to the priest or to the pastor, according to their religion, and that’s it, that’s about it. But just a few of them, not many.” Similarly, Julia explained how the priest was more likely than anyone else to provide counselling, and was considered an acceptable person from which to seek help:

If anyone is going to do counselling it’s the priest. . . it’s kept as close-knit as to the family and if they do look like they might be needing an outside opinion, you would go to the priest and some of them would say, you know, have faith in God or believe in whatever. (Julia)

She had a personal and painful experience of talking to a priest when her father passed away, and did not receive the comfort she was looking for:

Inform: So I did talk to a priest at that time and he basically said, you know, people die and have faith in the afterlife and that he [informant’s father] is going to a better place.
Int: So how helpful was that for you?
Inform: Oh it was horrible. . . . It was really close to his death and then he came over—and I think the police were still there, the body was still there and he arrived at,
yeah at twelve thirty at night. And talked about his own family and he was quite young, talked about his own family and how he never wanted to be a priest. (Julia)

She recalled only one priest who had a psychological orientation. “I think they had really one who tried at the time, and he had psychology books on his bookshelf. I mean they are called to do things that they were saying that they were just not attuned to.” This speaks to the interesting role the clergy holds as helpers responsible for pastoral care but not as trained psychologists/counsellors.

The priest in the present study identified trustworthiness, reliability, transparency, and listening as important helper qualities.

_Int:_ What makes people comfortable coming to you with their problems and struggles? What are your qualities or what are the things about you that make people open up to you?

_Inform:_ Sometime—I don’t know—because they trust me... everything I ask here, they do. For me, it’s this confidence... Because everything that I told them I should do, I did... I am sincere with them... what I have to say, I say in the church. I don’t save words. I am very—what is this word—transparent with them. I don’t hide things... that’s why they come to me and they talk, because I have my time to hear them... ‘cause this is the problem in these days, you don’t find someone to hear you.

_Int:_ Ah, so they want someone to listen.

_Inform:_ Yeah, to listen you, because we live in this world, sometimes we look for only our selfishness. We don’t want to listen to people and sometimes in these days, someone to listen to them, on this, even if you have nothing to say to them. (Tony)

Julia also identified a nun as a source of help because she showed a more positive side of Catholicism.

... she was very cool... She wanted to work in the education system and she kind of came knocking on the door and found how backwards and behind we were, so she was sort of the innovations to Catholicism and spirituality, that it didn’t have to be dry and boring and she could have, you know, you could be in celebration. Her big thing was celebration, which was a new concept. (Julia)

The Pentecostal pastor shared his perception of the Catholic Church that gives some context for reliance of congregants on the priest. He explained that until very recently, unlike the
English-speaking Catholic Churches, the Portuguese masses used to be in Latin, and there was a significant reliance on the rituals of the church.

Speaking about the first generation again, first of all, lots of them . . . they are illiterate, they don’t know how to read or to write. And even if they know how to read they never got the bible in their hands to read. They never got to read the bible in Portuguese so that’s why, that’s one of the things that we do to Portuguese people that visit our church after the second, third time, I offer them a [Portuguese] bible. (Carlos)

In contrast, Angelina, a second-generation Açorean, provided an example where she chose a direct connection to her religion rather than reliance on the priest:

I’ll never forget when I had my confirmation and they do a one-on-one with the priest and the child. . . and he asks you all the, you know, to say your prayers, and then, confession. And he says ok now we’re going to confess your sins. And he said to me, “ok, you can confess your sins to me,” and I said, “no.” And he says, “why not?” . . . “Because it says it right in the bible that I can confess my sins to God and he’ll hear them and forgive me” (both laugh). He had a little bit of a chuckle, and he had a little discussion with my mom. But I never did confess my sins to him. Because I refused to . . . It was strong at that time. Still am strong. And I still believe that, hey, it says it in the bible. So, why not? He was probably shocked that I did my homework; I was young. (Angelina)

The Pentecostal Pastor pointed out that many Catholics are not active church attendees but their religion is still very important to them:

If you do you ask . . . what’s your religion, “I’m Catholic.” And some of them, they never went to the Catholic Church in [city name] in 30 years that they have that building, or 35 years. Or they go twice a year or once a year. Or they go to a funeral or to a wedding and that’s it, or to a kid’s baptism. (Carlos)

Spoken from the perspective of a nominal church attendee, Rodrigo said, “I’m not involved with the Catholic Church as a goer on a weekly basis, I do go at Christmas time, Easter time, give my donation to the church.”

Views were given regarding how clergy were welcomed into the Portuguese community. The Pentecostal pastor’s wife described how they were welcomed when they visited the congregation and made the decision to move:
So the whole atmosphere was really, I don’t know how to describe it, we could feel that God was in that. Because like people were so loving toward us and they never saw us before and it was like we were their family or something (laughs). Yeah so people were really caring and loving towards us and we could feel God’s love through the people. So it made us comfortable, mostly me, more comfortable in saying, “Yes we will come, we will come.” (Margarida)

In contrast Julia described how priests were received by her community when she was involved, ten to fifteen years ago: “There was usually a lot of criticism about the priests and that’s, you know, especially every second one, they loved one, they hated the other, and loved the other, and then hated the other.” The current priest in a different community shared how he had connected with the parishioners despite their different origins, his being from Brazil:

But during this time, we created some ties, I don’t know, the people accepted me and I accept them, even sometimes we have not the same roots because when I came, I have big trouble to understand them, especially the people from the islands because they speak a hard Portuguese, that Portuguese is not spoken anymore. (Tony)

An informant who did not attend the church regularly spoke with praise about the good job this priest was doing. It appears that clergy from both faiths were well-received in the community.

5.1.B. Pentecostal clergy.

Margarida, the Pastor’s wife, talked about her approach to helping congregants:

We are concerned about not only the spiritual part of people but every part, right? God is concerned about every part of us. And so by God’s grace, we try to help couples and individuals bringing their focus to what is most important in life and helping them see what is more valuable. (Margarida)

Similarly, the Pastor described a holistic approach to helping:

Of course we try to bring topics and issues onto the table that can help people in different ways, not just speaking about, okay, you need Jesus, you need a relationship with God, you need to get salvation. That stuff, it’s important for your soul and spirit, but there is other stuff in life. And the way I see it, as a pastor, I need to help people as a whole, not just one part, otherwise, I’m missing something. (Carlos)
The pastor’s wife cited her key qualities as a helper to be “a friend” and to hear people:

Well, I want people to feel and to know that I wanna be a friend. And I’m not a counsellor, some people call me pastor; I don’t feel myself like pastor. My husband is a pastor, but . . . I never took a bible course. I have experience in the Christian, yes I do, I have a little bit of experience, but you know, I really want people to feel that they can count on me to hear them. (Margarida)

She gave a specific example of helping a couple who was on the verse of separation because the husband was away a great deal for work:

We were asked if we could go to their home and just talk to them and see if we could like help them in some way. So we did, we did that, me and my husband, we were able to spend some time with them and talk to them about God, about the bible, about God’s principles and you know it happened that their lives changed really a lot. So the wife she accepted Jesus right away . . . She accepted her husband the way he was and we know that God gave her the grace that she needed to deal with her marriage and over the time the husband was changed too, for the better, thank God. And now they live, have a family have two boys and they live happy lives you know, they are together and they are very close now. And so it’s really very neat and very—it’s an amazing thing what happened. (Margarida)

The Pastor, who was interviewed separately, shared the same story without knowing his wife had done so. Clearly, the event created a meaningful memory for both helpers.

A member of this church asked me to go and see a couple, some nephews that that person has, a couple, that they were in problems. Marital problems, they were almost about to divorce. They were in their 30’s at that time, with two kids. . . . And we went, they gave me the address, I went. Completely without knowing the person, I rang the bell, I asked does this person so and so lives here? “Yeah.” And I present myself. “Your auntie asked me to come to speak with you.” We were very well-received. And you know, we spoke with them, the first meeting that night, I spoke for seven hours, with the man.

He described their model of counselling:

Myself and my wife, we started speaking with the couple, for couple hours. Then we decide, that’s the way we do counselling, marriage counselling, we divided. My wife went for into a room, with the lady, I stayed with the man, in another room. And my wife ended up the time of her counselling with the lady. She went home. And I stayed with the guy. He was so open . . . And we got to help them out with that marriage problem. . . . They are completely in love again, they have a good marriage, a good family. They started in our church. I never talked to them about the church. They used to go to the Catholic Church. (Carlos)
The pastor was careful to clarify that he does not help others in order to win congregants: “There is another case that I went there myself, or myself and my wife. We helped them as much as we could and they are still in Catholic Church, that’s okay with us. But we got to help them” (Carlos).

He discussed the difficulty of being unable to help those who did not accept help:

Which is tough sometimes because people are not willing to receive. Or they are not willing to admit it that they need it, it’s tough… and you want to help. You see there is a need there, but to go there and reach that point. It’s tough, because you can’t force people, you need to respect people’s will. (Carlos)

The Pastor said that he tries to help people not only through one-on-one counselling but through sermons: “During my messages, give them some counselling in that area. And you know, trying always to insert stuff in my message, trying to make them think different.” Similarly, “My wife, during, in their ladies’ meetings, always speaks about practical things and trying now to change their mindsets. Men’s meetings, I do the same with men.” He discussed what he saw to be problematic traditional beliefs such as overwork for men and not sharing family time, and wearing black for the duration of one’s widowed life. He described how he tried to challenge this beliefs but introducing alternative ways of thinking through his sermons.

Prayer is an important aspect of helping for the pastor:

With some people I end up praying with them. Others, I don’t feel like it, I think it’s not appropriate or people that are not open to it, I respect. Sometimes, I ask them if they would like me you know if by myself at home, to pray for them or not, yeah. Some of them say yes. (Carlos)

And similarly for the pastor’s wife:

And when people ask us for help and we pray, we’re able to pray with them and if they give us a chance to advise them and helping them through the word of God and by putting the word of God in practice, we know that the results are always good. (Margarida)
The pastor separated out helping from evangelizing, and juxtaposed pride in drawing people to his church with caution in imposing his religion on those he helps. “I try to be very sensitive on that area, because I don’t want people to think that I’m there to try to change their religion or make them change from one church to another church.” But he noted his core beliefs about the source of problems, “I can’t separate the things and I know most of the problems that people have, personally speaking, individually or as a family, it’s due to a lack of a relationship with God.”

He explained how he tries to connect with people:

Usually I try to avoid bringing God into the table on the first time I met them, I try to get connections with the person. See what I can connect, you know, speaking about soccer, for instance or speaking about food or wine. Things that Portuguese people are familiar with. (Carlos)

He stated that at a certain point however he cannot separate helping from his spiritual beliefs. The two are integrated. The important aspect, however, is spiritual beliefs, not religious denominations.

Some of them, because they don’t see the difference, they can’t recognize that I’m not speaking about Catholic Church versus Evangelical Church, but for them it’s religion. And some of them, they tell me right away, “Don’t speak to me about religion, don’t speak to me about church.” Okay, I respect. And unfortunately, I find that in those situations, it’s difficult to go forward and to help that person. . . . When people they understand, okay, what I’m speaking about, when it comes to the spirituality, no it’s about relationship with God, nothing to do with churches, denominations, they get to receive the help. (Carlos)

The pastor noted the importance of separating out spirituality from religion in order to provide help outside of his denomination. He observed that while it is difficult to seek help from anyone, it is easier for people to seek the help of a pastor or a priest than those in the psychology professions.
The pastor described how a major qualification he has as a helper is his life experience as a married person and parent. He is the “padre casado,” the married priest, to whom people go to for marital and parenting concerns.

As a pastor I’m in a good situation to help people, somehow, because they recognize me as a pastor, someone with spiritual knowledge or that can help spiritually-speaking but at the same time I’m a regular man. . . Even some among the Portuguese Catholic Church community. . . When I go to some stores, they call “Oh, padr,” and they call me “Padre,” that’s Portuguese for priest. “Oh, padre, padre casado.” The married priest, that’s what they call me. (Carlos)

The priest also commented on his lack of experience in the marriage area and how that limited his ability to do premarital counselling:

I need someone to talk to them about relationship between husband and wife because it is a wedding preparation. I need someone who understands about counselling. . . ‘cause all the weddings I have here, we prepare the people here. We don’t send them to other church. . . in this area, where there is the relationship, you know, between man and woman. . . I talk to them about the, the sacrament, but I cannot come here to talk about other things, because it’s not my, my role here. This couple has a program that they follow to teach them, but I need help, I need one person to talk about them, about relationships. (Tony)

An Açorean community member brought this up as a limitation as well:

How can priests give you advice if they don’t have the experience of marriage, with partners and with children? So I always I still disagree with the priests not being able to marry. That’s my biggest thing. I wish they could. Because it would be so much easier with society with a lot of things. (Angelina)

5.2. Social connections.

The religious institutions also provided numerous ways to connect socially. One important way was through impérios.

Inform: There was a good job done by the priest presently at [Portuguese Church name]. . . he kind of made people get more organized and have different groups looking after different means towards the church, whether it is St. Joseph, or St. John or, ‘cause in the past, it was only the Açoreans who were very strong about the Espírito Santo (Holy Spirit) and the Sagrada cos anjo (Sacred Angel) but Açoreans only had two or three impérios now there are about seven or eight, and each império has a mordomo person that is leading it.

Int: Império means?
Inform: Império is like... society within the church that looks after that particular event, like fundraising... That’s one of the things I see the Portuguese community church being more visible, I would say, and underneath the church, they organize festivities almost every two weeks. ... there’s so many of them that I don’t even know, because I’m not into that, but this is church-driven. Personally, I’m okay with that... I even participate, I go and pay, go in and they have auctions of different things to gather money, and they have shows of folklore and singing and it’s good, brings the people in. (Rodrigo)

João, who was very involved in the Catholic Church, described the commitment of its congregants:

Inform: They’re very close when it comes to working with the church, they give 110%. They create the feasts, like there’s four feasts we have here, Santo Christo, Our Lady of Fatima, The Holy Trinity, and Sacred Heart of Jesus, and they bring in over one hundred thousand dollars a year to help the church, and these ladies and gentlemen, they work hard... They cook, they do parties, they do raffles, they do everything to bring in revenue and that’s how involved in the church they are. So even some of them may struggle themselves, finance-wise, they still give all they can to the church. And the church doesn’t ask, they just do it because they want to... 
Int: So the church is really important to the community?
Inform: Very important, you bet. (João)

I attended the Sacred Heart of Jesus festival (Festa do Sagrado Coração de Jesus), and there was a very large turnout; the church service was full, as compared to a fairly small turnout on Sunday morning masses. After the service everyone made their way outside—it was summer—and the processional with a statue of Jesus, flag bearers, and a young woman appointed “queen” (in honour of Queen Isabella) for the festival made their way through the residential streets, with the congregation behind, singing songs. It was a calm and cheerful gathering. In our second interview, Julia explained that these festivals are a significant way that people in the community seek help. They make promises that if they are healed or their prayers are answered, they will hold a large feast with a great deal of meat that has been blessed.
Maria described the community’s commitment to the church from the perspective of a daughter seeing her mother’s church attendance over the years:

Well, my mother is a very regular churchgoer, good attendance. My father goes because she goes. But if he would miss a service, it wouldn’t bother him, here she has to go every Sunday, she always has insisted we go to church every Sunday. (Maria)

Maria said at another point, “I go to church infrequently, but I’m still very attached to the tenants of my religion, even if I don’t go as often as I probably should.” Her words convey a sense of guilt over not attending church more frequently. Another informant, Angelina, expressed the importance of her religion: “I married a non-Catholic. And it was very trying, a lot of times. But I have remained Catholic and I remained, and I taught my children my beliefs as well.” There was also a sense of pride in helping establish the church as expressed by Julia: “My family, my grandparents, especially my aunt and uncle, really helped found the church.” Church and Catholicism were very important: “Going to church was very important every Sunday. Um, church picnics, church events, like of all these festivals and stuff. Those were very important. Belonging to that, was very important to carry on, yes. Being Catholic” (Angelina). As described by the priest, church is not only about religion:

And this space of the church, they use the space to maintain their cultural ways of life, so here they have their folklore, they have their traditions, because is not only a religion practice, but is more than this, is a cultural religion practices, they have some, like you saw Sunday, they like to have their processions and some processions is part of their culture. So they were upset because if they don’t have a priest who speaks their language, they cannot maintain their culture or their way of religion or their way to practice their religion. I came here with this mission. (Tony)

This cultural combination of religion and way of life posed a problem for one informant who wanted to break away from some of her traditional Portuguese past:

With my Catholicism, the difficulty and the challenge I found was it was hard to know where culture/tradition and Catholicism started and stopped from each other because everything took part around the church, the dances and the convenience that we’re Catholic but had the parties after or the baptisms and the weddings, like everything, and a lot of weekends took up, and so it was hard to separate for me what
I would have done, would I choose being Catholic if I wasn’t Portuguese? So I explored the Catholicism things, and the more I did, the more, it was like, no this isn’t fitting and so I really sought out spirituality in different forms and it’s been awesome. (Julia)

Margarida, who was involved with the Pentecostal Church, gave an example of the two churches working together:

We started this mission nine years ago and we had this fundraising banquet in the Catholic Church. Some people that belong to that Catholic Church, they thought of us being together making this big dinner and fundraising for that mission in Angola and that’s what we did. Portuguese Evangelicals and Portuguese Catholic people, we got together for that purpose… It shows that yeah, when God is involved in this project like God was involved in that project, people got together. Very different point of view but you know, with the same goal, and that was really neat, was really neat, was really good. (Margarida)

Margarida also discussed the important role of bible studies for connecting the church community, making it a “body,” through which they could encourage one another and help one another. This applied particularly to a women’s study.

I really enjoy it and the ladies enjoy it too. It’s very important. We pray for each other, for our own families’ problems, for our friends, and neighbours. We like to do that because it’s important, it’s part of what Christ calls us to do. (Margarida)

There are the multiple motivations of social connection and caring, and fulfilling a spiritual/religious role.

5.3. *Nossa Senhora de Fátima.*

*Nossa Senhora de Fátima*, or in English, Our Lady of Fatima, provides common cultural knowledge, faith, and comfort. Our Lady of Fatima is a very important saint and church in Portugal and also a major festival at Portuguese churches across Canada. It is the exemplar of Portuguese festivals oriented around prayer and thanksgiving, especially regarding healing from medical conditions. Several informants—Rodrigo, Maria, and Julia—explained the phenomenon to me in detail; despite my own research, I needed their
explanations to fully understand the significance of Our Lady of Fatima to the Portuguese community. A summary of the original event is in Appendix H.

Because she is known for miracles, when people are seeking resolution to a problem or sickness, they may donate to Our Lady of Fatima. People may pay homage to her by walking to Fatima or by paying an amount they have promised to give, a practice so widespread that Our Lady of Fatima is celebrated all over the world. Many Portuguese and other churches that were built after this event were named Our Lady of Fatima. Most Portuguese churches in Western Canada bear this name.

Rodrigo described the important role Our Lady of Fatima had played in his own life. After making the commitment to Our Lady of Fatima, he felt able to study hard enough to rank among the top three in his military class such that he would not be sent abroad but rather remain in Portugal as an instructor:

_Inform:_ When I was in the Army, there was a possibility for me to go to Africa, Portuguese colonies, Angola and Mozambique, and I had my girlfriend, my wife today. It was very sad for people to leave the country to go fight the black people for their own territory. And you have to do what the country does, you know, you are enlisted and you have to go. . . I asked permission for our Lady of Fatima to help me and see if she could enlighten me to do whatever possible, be lucky enough not to go. . . it wasn’t her that told somebody, hey don’t touch that man, I know that, but it was the belief, and of course you can ask for something, but you have to give something. You never ask and say, “Oh I’m not going to do anything about it.” . . . I think the believing that she would intercede and would help me, was probably the strength that I got to study hard and be well positioned. . . so my promise was that I would walk to Fatima in my military attire in retribution to this deed. Well, it worked, it worked. (Rodrigo)

Rodrigo described another incident regarding the health of his daughters:

Before we got married, I promised the Our Lady that you know, if we had children, and you know, help us, my daughters, they were perfect, nice, beautiful, healthy, no complications. So, I did pay my homage and my retribution to, and I’m a very devoted believer in the miracle of Fatima. Oh yes. (Rodrigo)
He talked further about miracles he’d heard of regarding Our Lady of Fatima, such as the lame being healed, and the popularity of the pilgrimages that happen: “Socially, it’s a very big event in Portugal at that time. There is no other thing as organized in the country.” Maria shared a similar story regarding a healing and pilgrimage:

There are a lot of people and my mother is one of them, who, if someone’s sick and they pray to God and that person is cured. . . that they will make the pilgrimage to Portugal. And I think it has something to do with my brother, like that where she made a visit to Portugal to Fatima because her prayers had been granted. (Maria)

5.4. Religion as a source of strength and comfort.

Julia agreed with the descriptions of agonias as a bundle of worries, a lot of unknowns, worries beyond your control, distress, and fear of purgatory. These resonated with her. She stated that in the Açores and in agricultural communities, “It’s all out of your control” meaning the crops, weather, and fisheries that determine one’s wellbeing, but, “If you do it the right way, God’s way, things should be better.” She said that growing up the priests talked about there being a “right way” to sacrifice, have lots of children, and give to the church. Religious practices and rituals provide a sense of control over life; there is comfort in religion. Maria shared a specific ritual of her mother’s that helped her deal with her daughter’s cancer. Prayer played an important part:

Inform: My sister, one of my sisters had breast cancer and had surgery for it, a few years ago. And ever since then, my mother has lit a candle and says her prayers in front of the candles. Just as if she was at the church. Every single day. . . . Special candles, there’s Virgin Mary on them, or something like that. But she has these candles and they’re lit all the time. . . . And every day she has a time when she goes into that bedroom where they are, and closes the door and then prays. She always prays for my sister’s health, so that there’s not a recurrence of cancer and all of that. Int: Now, how do you feel about that? About what she does? Inform: She needs it. It’s important to her. It’s part of her belief system. And my mother’s a person of very deep faith. (Maria)
Elizabeth saw religions as serving as a source of strength and providing a “moral framework” for her mother’s and grandparents’ generations:

I think religion does still, for my grandparents especially, and for my mom in some ways, I think religion is an important part of their lives and they’re more concerned about adhering to the tenets of Catholicism than I would be, but yeah… I think that definitely is a source of strength for them and provides them with a moral framework. (Elizabeth)

This faith ties in to help in the community. When Angelina’s father was injured on the job, she said that lots of people helped out with meals and babysitting, but also with prayer: “Lots of prayers, like lots of people helped out with prayers.”

From the Pentecostal Christian perspective,

Good moments, bad moments. . . . I never feel alone. I can be by myself but I know that He’s always there. God is always there so and so I encourage people just sharing my testimony and saying that what God did with me He can do with everyone else, as long as people place their trust in Him and His word. (Margarida)

Similar to the Catholic perspective, there is a sense of comfort and also belief in things getting better contingent on, in this case, “trust in Him and His word.”

Summary.

This domain is the largest and most in depth of all the domains of ways of helping. Religion is very important within the Portuguese Canadian community. The clergy plays a significant role in helping parishioners one-on-one, and referring out when necessary. The church provides opportunities to connect socially through the structures of Imperios and bible studies. Finally, at a spiritual level, Nossa Senhora de Fátima has significant meaning for many community members for healing.
Domain 6: Using forms of traditional healing.

Domain Cover Term: Using Forms of Traditional Healing

Semantic Relationship: X is an attribute of Y (Attribution)

Description.

This domain covers the uses of traditional healing for emotional problems. The attributes (X) of traditional healing (Y) include the conflict between curandeiros and religious beliefs, as well as other negative, and positive, attributes. The attributes are also demonstrated through examples and accounts of folk healing within the family. Community members commented on this topic, as did eight out of the ten informants with whom I conducted in depth interviews. Only one informant (Elizabeth) had no knowledge of curandeiros.

Table 17. Included Terms for Domain 6

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6.1. Definitions.

The Pentecostal pastor saw curandeiros as synonymous with bruxas, mediums, and witch doctors. Similarly, when asked about “traditional healers,” Margarida redefined them
as “bruxas” and “feiticeiro/feiticaria,” both terms being synonymous by her definition with witch doctor. According to the Portuguese language the terms are used more or less interchangeably with “bruxa” meaning “witch” and “feiticeiro” or “feiticaria” meaning wizard or sorcerer with supernatural powers.

6.2. Tensions between religion and curandeiros.

I learned that curandeiro is a “charged” term that means far more than healer and that is at odds with religious beliefs. These are described as follows:

6.2.A. Good Christians don’t go to curandeiros.

When meeting with the seniors at their weekly lunch, I asked the women about traditional healers. When using this term they did not know what I meant. I then used the term curandeiros and they responded with, “no, never, we are good Christians, we would never go to a curandeiro.” One of the women who was younger (in her 50’s) and helped with meal preparation—and who was also helping me with introductions and interpreting—said she went to see a curandeiro once who gave her a variety of herbs and teas to take. She then saw the priest (not the current priest whom I interviewed) who said none of them were good for her, so she stopped then.

6.2.B. Curandeiros are the work of the devil.

Carlos held a very negative view of these people, and referred to their work as “the work of the devil, of evil, it’s of the dark side of life.” He explained that the bible forbids the use of “witchcraft doctors” and that he does not advise anyone to use them. Similarly Margarida shared, “they have these supernatural powers, yeah, so they work on, of course with the evil side of you know, supernatural abilities.” Carlos noted that some of his congregants had gone to the local curandeiro while still in the Catholic Church and not been
helped. Margarida recounted the outcomes for those who saw a *curandeiro*, “they just lost their money and never got any help.” She explained how people would go because they were desperate for help.

Carlos spoke about one couple specifically, where she suspected her husband was having an affair and she wanted to find out from a *bruxa* if this was indeed the case or not. “Things went worse to worst.” However, she started attending Carlos’ church and receiving help through the church; through this the relationship improved, she learned that there was in fact no affair happening, and both became involved in the church and eventually became church leaders. This happened thirty years ago before Carlos came to the church, and it is clear that their story became a source of inspiration for healing and also a cautionary tale for seeking help from *curandeiros*.

He recounted another story where someone had “demon possession” and went for help to the *bruxa*, which similar to the above story made their situation worse; this person then received help through the Pentecostal Church. “They came here, just to receive help, you know, special help, and they went back to their lives and they never came back. That’s okay with me, that’s okay with us. Somehow, we got to help them out” (Carlos).

Margarida shared what she knew of the local *curandeiro* from the stories she had heard:

> . . . we know it’s not cheap. You go there, you pay, it’s not for free, and then you supposedly get help from these spirits. . . . She would read their palm of their hands and she would say this and that’s gonna happen to you in the future sometime someday. . . . and sometimes she would require like a picture of your family member that you want to see blessed and happy and she would have that picture and she would pray to her gods and do these magic kind of things . . . and lots of lies, mainly lies, you know (laughs). (Margarida)

Margarida also shared a story of a specific family she knew personally of which the adult daughter sought help for her parents’ marriage from a “sorcerer, witch doctor, whatever her
name is.” She expressed a disbelief that “this year, in the 21st century, people are doing these kind of things,” indicating that it is an outdated, archaic belief.

Margarida spoke about her feelings about curandeiros:

All of sorcery is condemned by God… It happens and it makes me (sigh) you know, the bible says that our fight is not against people. . . . We have to show love to people basically. I’m not going to be against anyone because that person doesn’t believe what I believe. I have to show God’s love and it’s God that’s gonna touch her heart. (Margarida)

It was clear from conversations with the seniors, and interviews with Margardia and Carlos, that their opinions were that nothing good can come out of seeing a curandeiro.

6.3. Other negative views of curandeiros.

There was a range of negative views of curandeiros presented by informants.

6.3.A. Curandeiros charge too much money for no good effect.

One woman from the seniors’ lunch group told me that curandeiros charge a great deal of money, thousands of dollars, with no good result. One person knew a lady who had gone for a bad leg, paid a lot, and it was not healed. As noted above, Margarida noted that the treatments always cost a lot of money.

6.3.B. Curandeiros are a throwback to more primitive ways.

Curandeiros were seen as a throwback to the old ways, to be old-fashioned. This was a negative view; there was no value perceived in these practices, particularly as presented by Rodrigo below; similarly, Maria described more traditional medical approaches such as the use of midwives and home births (as her mother had done) as implicitly primitive and lacking value.

6.3.C. People practice bruxaria in order to harm others.

Rodrigo recounted an incident where his wife shared her knowledge of a local Portuguese woman doing her own bruxaria:
I was at one of the Portuguese stores, where this lady was buying rosemary, was buying coriander, and all these other spices, and my wife turned to me and says, “Oh, she’s gonna do something about some kind of bruxaria, bruxa.” I said, “How do you know?” “Oh you can tell.” . . . They have this ritual, they burn this and they pray that this disappear from so and so and this other person, whatever, and they put that into a paper and wrap it and go place it at this other bad person’s house or door. (Rodrigo)

He included prayer in the description, as did the Priest whose quote is below. Prayer appears to be the form through which intention is conveyed. Rodrigo provided ambiguous information as to whether he believed bruxaria to have any effect:

Inform: I, I don’t care about that.
Int: You’re not a believer?
Inform: I know that exists, that doesn’t intimidate me or I don’t feel, “Oh I gotta be nice to that person because she is one of those.” (Rodrigo)

The implication here is that for some, these people deserve extra fear and respect because they can do harm through their spiritual powers. He added that some people in the community avoid those who they believe to have done bruxaria, to avoid bad things happening to themselves: “I came across a situation when one person mentioned that she done whatever, so this person wouldn’t go into that place anymore.” He expressed disapproval and annoyance that people would do this to one another. Rodrigo went on to note the connection between these beliefs and cultural changes over time. He noted that while use of herbs is commonly recognized “in the Almanac,” when used in the Portuguese community it is assigned spiritual or mystical powers.

Yeah that can be one way of a lot of the older people living. Again, because they are not in tune with the reality, with the way of doing things nowadays, and they keep going, using that traditions from way back. Yeah the remedies and the herbal treatments and lotions and all this stuff, you can read that in the Almanac, you can read that in almost anywhere, but it comes from so and so in the Portuguese community, “Oh yeah she’s bruxa, she’s oh yeah, curandeiro,” like you mentioned. (Rodrigo)

He acknowledged a validity to these functions in previous times:
I look at that as, well, something that your doctors, that’s how they became doctors, you know, making all these lotions and people are doing what some people were doing 100 years ago, well that’s fine, yeah, well okay, but I don’t know any of that, any people that actually practice that, or that I go to, or that I know of that anybody that goes to. Apparently, there is one in [city name] that does it. (Rodrigo)

He called those who use curandeiros “narrow-minded. They don’t know the reality of life. They still live in that little cocoon.”

6.4. Positive or neutral view of curandeiros.

6.4.A. Seeing a curandeiro is a way to talk about one’s problems.

Paul’s mother recommended he go talk to a bruxa to help him with his personal problems:

I lost it all and I got to that point where I just couldn’t take it anymore. Who can I turn to? Where can I seek help? . . . My mother on the other hand was, go talk to somebody, in her terms, was, well, why don’t you go see a bruxa. Go see a witch. (Paul)

At the time, her son was living away from home; this recommendation was seen as an opportunity to get help from someone unknown but within the culture.

6.4.B. Curandeiros are more common in Latin and specifically Brazilian cultures.

Two informants, both clergy – Carlos and Tony – stated that curandeiros are more of a Latin or Brazilian phenomenon. The priest used the term sincretismo, meaning syncretism in English, to describe the combination of different religions that make up the practice of curandeiros. He presented two very different definitions of curandeiro: the first as someone who heals and makes and administers medicine from herbs, the second as someone who practices spiritual work connected to espiritismo, meaning spiritism, spiritualism, and telekinesis. When asked how it relates to Christianity, he explained that there is a mixture of beliefs, “It is not only Christianity, but I never been there (laugh), but what I know is because
I read about this. It’s like someone that they believe has some power. Sometimes they bless you with some prayers.”

Several informants were not aware of *curandeiros* in the Portuguese community. The women who attended the seniors’ lunches said that they were aware of the *curandeiro* in the community and where she lived. Three other informants, Rodrigo, Carlos, and Margarida, confirmed this. According to Carlos and Margarida there used to be two people, a lady and a man, but the man returned to Portugal a few years prior. The lady was believed to still be active and taking appointments. Those who appeared most knowledgeable about the *curandeiro*’s identity and location also had the most negative views of her work, therefore I was hesitant to try and find out from them exactly how to contact her.

6.5. *Folk healing.*

Rodrigo described rituals and phrases that he was made to do as a child according to his grandmother’s instruction, to take care of physical ailments:

I kinda hurt my foot one time, and there was this ritual that my mother would do around my foot, on the boiling water, and a pot upside down, and she would do this ritual, and the next morning, my foot was good. (Rodrigo)

He recounted another incident:

It was something about, I forgot how you say that in English, but in your tongue *aftas* [thrush]. . . . I was feeling bad, and I told my grandmother, “I have this in my tongue,” and she said, “Well, in the evening there is a star that comes in the North and you have to say these words, say it three times, and that goes away.” Sure enough, it did go away. (Rodrigo)

Maria discussed the use of an amulet by her mother to ward off spirits. She linked this to old-fashioned beliefs, with which she included the concepts of midwives and home births.

When I was very little, like before I came to Canada, my mother believed in wearing a sort of amulet, to ward off spirits, that kind of thing. But that was very old-fashioned, even then. You know, Portugal back in the 50s, was very, very old-fashioned. They’re much more progressive today, but back then, they were, you know, midwives, with home births. I was born at home. (Maria)
Julia explained, in our second interview, the stigma that comes with the term *curandeiros*. She also recounted how her grandmother and mother were known for their herbal remedies and healing knowledge in the community. The term *curandeiros* was not used, however, to describe them or what they did.

**Summary.**

By asking informants about *curandeiros* I learned that the majority of community members held negative opinions. For most people, the practices of *curandeiros* were seen to be at odds with religious beliefs, whether Catholic or Evangelical. Informants explained that the term in this culture means more than just healer, that there is a spiritual component. On a practical level, several people stated that *curandeiros* charge too much and do not produce results. Several people reported awareness of *curandeiros* in the community, although it was also reported to be more of a Latin American, and specifically Brazilian, phenomenon. Informants also described the use of herbs, amulets, and rituals to heal that were passed down in their families that did not have the stigma of *curandeiros* and which were thought to be helpful.

**Domain 7: Accessing help through family physicians.**

Domain Cover Term: Accessing help through family physicians

Semantic Relationship: X is a kind of Y (Strict inclusion)

**Description.**

This domain describes the ways (X) that family physicians help with emotional problems (Y). Physicians serve as pathways to mental health professionals, and they provide mental health assistance themselves, particularly with medications. It is noted that while physicians are more accessible than mental health professionals, language barriers are still an
Nine informants discussed the role of physicians in mental health care in the community.

Table 18. Included Terms for Domain 7

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**7.1. Physicians as a pathway.**

Several informants talked about one specific Portuguese physician who served the community and provided referrals to counsellors. Often when informants discussed their experiences of seeing a psychiatrist or psychologist it was through a physician’s referral. For example, Rodrigo’s experiences with a social worker and a psychiatrist were both through his physician’s referrals. This practice among medical doctors assists with the barriers regarding lack of knowledge about counselling resources, and also is more likely to be a route that is covered financially by public health care. Only one informant (Elizabeth) stated that she would only see a physician for physical, and not emotional, concerns.

**7.2. Physicians and stigma.**

Physicians were cited as a common source of help for emotional or personal problems because it is possible to go to a physician without revealing that one has emotional or personal problems. This is connected to the problem of gossip in the community, as discussed more fully under the domain of barriers to seeking help. Rodrigo described community members who will not talk to anyone, even family members, about their problems, which means that the family physician is the only helping professional who may
have the opportunity to assist with emotional or psychological problems. Even in their case, in Rodrigo’s words, they “have to kind of pick up on it.” Generally, he said, people in the community will only go to physicians for problems, never counsellors or psychiatrists. João, who is himself in his 50’s, described a common scenario:

A lot of ladies, they go through menopause. A lot of them, they go through cold and sweat and all that, some go through depression, and the men, here, the older men, they think their wives are just going nuts. They don’t understand . . . there’s a lot of struggles, and so the woman cannot say I need to go see a psychiatrist, no. She goes sees her medical doctor, her medical doctor will give her the antidepressants, and keep it hush hush. (João)

This quote emphasizes the shame that people feel with regards to psychological symptoms, even when connected to a very natural life transition. For some community members, the physician serves as the main resource because the individual is not socialized into counselling or feels able to share personal problems with family or friends in the community. Julia described how the family physician was very involved in her alcoholic father’s treatment but long-term counselling was not seen as helpful. Many informants discussed themselves or family members seeking the help of medical doctors for emotional problems, or drinking problems for example. There was also a general lack of awareness of the counselling profession so that physicians were seen as the main resource for more serious psychological issues as well. As expressed by a helper in the Evangelical Church:

The people that came to us and shared their problems with their families or their own lives, some of them we were able to help them. They that have, you know, deeper problems like emotional problems, mental problems, they have help from doctors. They go and they get treatment and medication, they would get from Canadian doctors, so English-speaking doctors. (Margarida)

Counsellors were not part of Margarida’s discourse and the focus was on treatment and medication from doctors as the cures for “emotional” and “mental” problems.

Several informants described being prescribed psychotropic medication by their family physicians. Rodrigo described being prescribed Cymbalta and finding it helpful; Angelina described the importance of medication required for her father who was bipolar.

Summary.

Informants were very familiar with the medical system and going to physicians for personal or emotional problems. Frequently, if informants had been to a mental health professional, it was through a family physician’s referral. Informants also described several examples of getting help for personal or emotional problems directly through the family physician, such as receiving prescription psychotropic medication, and this helped them avoid the stigma of seeing a mental health professional.

Domain 8: Help outside the community.

Domain Cover Term: Help outside the community

Semantic Relationship: X is a kind of Y (Strict inclusion)

Description.

This domain describes informants’ experiences with counsellors, psychologists, psychiatrists, and social workers. It also includes talking to friends, and any other way of accessing help outside the community. The semantic relationship is defined as the following qualities and experiences (X) are aspects of outside help received (Y). It includes positive and negative experiences, and, taken from those experiences, positive and negative qualities of helpers. All informants contributed to this domain, either as recipients of professional or lay help, or from the perspective of the helper. They all commented on the quality of this
help or the qualities they themselves endeavoured to embody to facilitate the helping relationship.

Table 19. Included Terms for Domain 8

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**8.1. Directness.**

The first cover term explores all the aspects and encounters of helping outside the Portuguese community pertaining to directness.

**8.1.A. Giving advice.**

Maria described the concept of being a “straight-shooter” as being the most important and helpful quality: “Friends and family . . . have their own agenda sometimes, there’s a lot of emotions that colour, based on their relationship to you, their advice.” In contrast, she explained, a good helper from the “outside” is objective. At another point she described this quality in her psychologist as being willing “to tell you when your thinking’s upside down. He does it very diplomatically and everything else, but he doesn’t hesitate to tell you, that you know, you’re just not thinking about it in the right track.” She talked about her previous unsatisfactory experiences: “If I could figure it out on my own, I don’t need to come and see them six or seven times and be paying each for each session, honestly at $160 a pop, that’s a lot of money, right?” She speculated about the training of the counsellors she had seen in the past: “Perhaps, to give them the benefit of the doubt, their training seemed to be that they
were not there to tell people what to do, but to guide them toward their own solution.” She pointed out, “I can write a journal and then in retrospect, read that journal and I’ll see the patterns, you know what I’m saying, I’ll see a link. And I’ll see what the problem is. It would just take me longer. But it will be a lot less expensive, right?” She stated that on previous occasions she told therapists:

I’m coming here for your advice. Not for you to sit there and listen to me. I can talk to myself at home too, you know.” I told them flat out, because I’m a very direct person. And “Oh well, it wouldn’t be right, it wouldn’t be professional.” I said, “Nonsense! (Maria)

She also recounted her current experience with her psychologist who is more direct:

I’ll present my problem, this is my view of it, and he’ll give me a totally different perspective on it and I’ll walk out, realizing sometimes, I’m totally wrong, you know what I’m saying? But that’s okay, because that’s what I need to hear. I mean, I can be subjective until the cows comes home, but how’s that gonna help, right? (Maria)

She gave a specific time when she appreciated his advice and it helped her problem:

So when I’ve been wrong, he’s told me. When my child was falling off the rails in his last year of high school, I had a lot of concerns. And I went to see, to talk to this counsellor and he, you know he told me that sometimes I was a little bit trying to hang on too tight out of anxiety for him. (Maria)

Similarly, Paul talked about how important it was that the counsellors he had seen were honest, welcome, and direct: “... they just told me how it was. I think it was about, that they were honest, right? I thought they were approachable.” He said that he had been worried they would try to “get into my head.” But instead,

It was an open dialogue. It was a welcoming environment and they tried to make a sterile office look as welcoming as possible and it was really the fact that they kind of spelled things out. At one point in time, it was just, “This is it, this is what you have to do.” At certain points in time, they didn’t sugarcoat things, which, growing up in an environment where things weren’t sugar coated, was nice. (Paul)

He connected this approach to his upbringing in which he “wasn’t brought up in a touchy feely environment,” and his father would tell him, “This is the way it is.” He said, “Talking
with the counselors that did say that this is what my issue is, this is what’s going on, this is maybe what you’re thinking, and not dancing around it; it worked.” Similarly Angelina discussed the value of getting an outside opinion as she felt a non-biased opinion was especially hard to achieve in the Portuguese community. She did this through parenting after separation-divorce classes, and counselling sessions. Elizabeth shared a similar perspective, in this case that she needed to talk to people other than her parents to get non-biased career advice (the recording failed at this section of the interview, so this quote is a paraphrase from interview notes):

> Good helpers are open, and have a lot of patience. There is a sense of deep trust. They’re willing to listen, not quick to impose their own values. The difficulty with parents is that their notions of fulfillment differ, academic interests differ, so they are not as helpful with concrete decision-making career advice. (Elizabeth)

Normalization was another important aspect of seeking professional counselling that couldn’t always be achieved within the community. Angelina talked about how important it was that when she sought help she learned that:

> I wasn’t the only one in this world that this happened to. I wasn’t the first, and I wasn’t the last, and I wasn’t alone, where you always think that you’re alone, you’re the only one that this is happening to. (Angelina)

Informants were uncomfortable with a lack of advice, of direction, and too much empathic reflection. Rodrigo had three or four sessions of couples’ therapy with a social worker, with his wife, and they terminated early due to a lack of direction and concerns about disclosure:

> We were looking for some sort of guide, you know, this is your homework, this is your homework, come back to me next week or next month, and we’re going to discuss that, whatever, but no, he never did that. He wanted to know more and more and more and and uh, to the point that actually we stopped going to see him. . . . what the hell does he want to know all this, obviously, he wrote all that down. . . . he didn’t seem to be using the information that he got from before and exploring it. (Rodrigo)

Maria puzzled about the possible reasons for using empathy and avoiding advice-giving:
Because this idea of sitting back and letting you come to your own conclusion—I don’t even understand that kind of training. . . . Their prof must have explained some very valid reason for them to use this approach. I can’t imagine what. (Maria)

8.1.B. Identifying and clarifying the problem.

Maria described the value of seeking professional help to understand a problem from another person’s point of view, particularly when the problem involved other parties:

. . . he helps you to see things from, if you’re talking about another individual in your life, to see it from their perspective. And that helps, right. Because, we all tend to be focused on our perspective of things, right? And we all like to think we can put ourselves in another person’s shoes, but not as well as most of us like to think we can, right? (Maria)

Paul also described how counselling gave him perspective on his relationship problem, that much was beyond his control and he needed to let go:

Yeah, it did help. It put things in perspective because a lot of it was, you know, at the time, I was with my girlfriend and it was the intimacy issue, and basically, what the counsellor taught me was to just don’t worry about it, that’s her problem. You can’t control it. You have to learn to control what’s within your control, where you had to let go of things you can’t control because that’s just the way it is. You can’t control what other people wanna do, you can’t control what other people are going to think, what other people are going to feel, just gotta deal with what you have to do for yourself, and that was a pretty good lesson. I’m glad that that counsellor was able to tell me. (Paul)

8.1.C. Understanding the client.

Informants cited expertise and training, and developing a thorough understanding and assessment of the problem as indicators of professionalism. Informants also noted flexibility and levity as valuable characteristics in helpers.

In depth assessment and diagnosis was discussed as a valuable characteristic of helpful counselling, where the client felt understood and the experience was perceived as valuable. Rodrigo recounted an experience with a psychiatrist who took the time to learn a lot about his background and, he believed, conducted a very thorough diagnosis. He felt that this
process led to the right prescription. He talked about the importance of understanding context: “Mainly, you have to understand the subject and the person and know where this person comes from, what habits and ways and so on, and then go from there.”

Informants identified expertise, either through years of experience, age, or professional credentials, as contributing to positive therapy experiences. Maria said that she saw a direct relationship between level of training and the quality of her own counselling experience.

I learned the hard way to investigate their background, their area of specialization, and to ensure that I am not dealing with somebody with an MEd or an MA because it’s not what I want—needed. That might be suitable with someone else’s situation but what I wanted was a chartered psychologist. (Maria)

She also emphasized years of experience as important, “There should be more like him. He has a very busy practice, and he’s been in the practice for many, many years.” Note that the amount of business the practitioner has is also an indicator of how good the practitioner is, partly because clients keep returning, and partly because the practitioner is gaining a great deal of experience.

João talked about the importance of the qualities of compassion, being respected, and understanding a person and showing them the way. “If you have the gift to understand that person, see where they’re coming from, and not prying into their business, but to show them the way, that’s a good priest.” He saw these qualities in the priest who helped the parisioners:

They respect him [the priest] and so they listen. . . he’s full of compassion and at the same time, very bright. . . if there is a problem with a parisioner, he says, “No, talk to each other first, and then if nothing helps, then come and see me.” (João)
Sometimes João inadvertently found himself in the position of listener: “But then they tell me their whole story, their life story . . . and all you can do is listen.” Margarida talked about how a psychologist:

. . . must have the ability to hear people, you know, try to understand people’s point of view, being patient, being loving and caring. ‘Cause sometimes we hear stories of counsellors and doctors that they should not have that job because you know sometimes they are as stressed as their clients . . . a counsellor should be someone that has good health—physically, mentally, spiritually, emotionally, stable person. (Margarida)

In this statement she touches the necessity of the counsellor being in a state of congruence, and the client in a state of incongruence. Rodrigo also stressed the simple value in a helper of remembering details. He talked about a very practical helper in the community who is a public notary and provides translation/writing services, and how impressed he was that this individual considerately asks questions that show he remembers personal details from their previous meetings.

From the helper’s perspective, Carlos described how he tries to make a connection with the person he’s helping, and that he does not follow any set routine: “It depends on the situation. I never treat, you know I don’t have a pattern to do things, it depends. It depends how things go, if people are open to receive it or not.”

While receiving advice was valued, it was still important for the informant to feel in control of the situation. Rodrigo recounted a negative experience where he felt the power was in the hands of the therapist:

I had the sense at the time that he seemed to be the one that would be deciding between me and my wife or, in our case, what is going to be, I’m gonna tell you, you’re not gonna tell me. . . . Him and I, we didn’t get along, or didn’t agree too much, or he wanted me to agree with him. . . . For me it was good, in my wife’s case, she didn’t like him. She said that he was telling her that you should divorce him, leave him. He never told me that, he told her that. (Rodrigo)
He felt criticized by this therapist, recalling being told, “‘Well, you’re very structured, you shouldn’t be like that. You are very structured, you are very demanding, you are very detailed.’ Well, that’s my education, that’s how I, that’s me.”

Rodrigo talked about the flip side to the value of professionalism when he saw a psychiatrist. He described his feelings of uneasiness at being asked so many questions:

I felt, yes, when he was doing his interrogations more or less, which were, I felt like I was being interviewed (release of breath). Oh yeah, maybe that’s how they operate, I don’t know, but I thought, this guy is not communicating at the same level, he’s like, (stern voice), “I’m English and I’m a psychiatrist and he is just a guy that I’m going to fix.” You know. That put me in a situation of uneasiness occasionally, because I was, “oh what the heck,” you know, “why is he acting like this?” (Rodrigo)

8.2. Cultural and personal similarities.

Cultural or personal characteristics of helpers was the other major determinant of the quality of the helping experience.

8.2.A. Culture generalizations; stereotyping.

Paul talked about how culture differences with his counsellor prevented better understanding of his situation, particularly the norms in Portuguese families:

I would have liked to turn to somebody that kind of understood how I grew up, what I was thinking on some levels. The counsellor was great. She did a good job, but there was just something lacking right? Because I just—I couldn’t explain everything in detail I guess, um, you know, I guess really if there were a counsellor in the community, if there was somebody in the community that understood how I grew up, how I thought, what interactions with family were like, or how I interacted with my father, like it—I think it would have been a little bit better. (Paul)

He described more specifically,

Because I’m the oldest son, and these are generally across cultures this stuff applies but you’re always supposed to do the job well, you’re always suppose to be perfect, you’re always supposed to do things right, you’re always supposed to take responsibility for your actions... it’s always the pressure, I’m the oldest one.
He said about his counsellor’s cultural understanding: “Great understanding of the culture would have been nice, but I think, I still think it would be the same. I still think the discussion would have been the same. At least the end result.” He also thought that someone in the community would have been easier to relate to as a helper:

As it was, it was a very generic, this is how we deal with it, this is what’s going on. Here is some medication and we’ll talk it out, where, I think if it was somebody in the community, they would have been able to delve down a little bit deeper and maybe just personal experiences or anecdotes or something that I might have been able to relate to. (Paul)

Maria described a disturbing experience of cultural stereotyping that ruptured the alliance and resulted in only one session and a complaint to the social worker’s supervisor.

. . . when she found out I was Portuguese she made a presumptive statement that, to this day I’ll never forget. She decided that my mother wore black, and all the women wore black. She had such a stereotypical view of Portuguese, that I found it incredible that someone with her educational background would actually just think that we—that all the women wear black. And it’s very common of course when their spouses die, but women don’t all wear black, and even less common now. . . . It was a very strange comment and lacking insight, and such a sweeping stereotypical comment. (Maria)

She only saw the social worker for that one session, and then complained to her supervisor.

“The feedback I got from her supervisor, I had the reaction that ‘the apples didn’t fall far from the tree’ professionally speaking.” This experience tarnished her view of the social work field.

8.2.B. Life experience and training.

As mentioned under Domain 5, clergy helpers also discussed the importance of experience from their perspective. Here is the Evangelical pastor summarizing his experience with marriage:

I received several phone calls from the community people, “Okay, can you come and help me I have problems with my kids, or with my wife or with my husband. Can you come and help us?” . . . They recognize I’m a man of God, someone that can give
them some spiritual guidance and help. But at the same time because I’m married, I know what it is to be married. (Carlos)

And also with raising children, “I have kids. I know what it is to raise kids so they are open and of course, it’s an advantage for me.” He also had worked with youth and addictions in Portugal, a fact known in the community, which led to a few initial sessions of one-on-one counselling and then referral to youth addictions programs.

Comparable life stages make being the helper easier, as explained by Carlos talking about helping a specific individual: “We had kids, same age. . . . We are basically from the same generation, same age, the way we see world, we see life, lots of things in common.”

Similarly, Angelina described how her experience helped her to help others: “I’ve helped a lot of my customers that have gone through separation and divorce in the past ten years and, how did you do it?” She was able to share her story and show them that they could get through it too. Margarida also shared how her experience with depression helped her empathize with those she helped: “There is my testimony; I know what it is to have depression, not very deep depression, but I’ve been there, you know, so mild depression I would say.” Regarding similarities, the pastor and his wife considered shared religious beliefs to be helpful in the counselling relationship.

It was important informants felt that the type of professional they were seeing was adequately trained to help with their problem. Maria felt that a social worker, for example, would be well suited to help with families and children, but perhaps not her individual mental health concerns. Her preference after her various counselling experiences was to see a psychologist. Rodrigo commented on the fact, negatively, that the social worker he and his wife had seen was young enough to be his son.
Summary.

The positive and negative helping experiences were complimentary to one another; informants cited the qualities of being direct and giving advice as helpful, and lack of direction as unhelpful. Likewise, experience and training were helpful, while youth and lack of training were considered drawbacks. Cultural understanding was considered helpful and cultural stereotyping by professionals was unhelpful.

Domain 9: Reasons for seeking professional help.

Domain Cover Term: Reasons for seeking professional help
Semantic Relationship: X is a reason for doing Y (Rationale)

Description.

This domain includes informants’ reasons for seeking help outside the community, both from their own experiences and what they observed in the community. The semantic relationship for this relationship is X is a reason for doing Y (Rationale), where X is the motivation for seeking help, which is Y. Reasons ranged from motivation to deal with family and life problems, to becoming a better helper and breaking negative generational patterns, to avoiding serious consequences of problems such as losing family members or having to deal with the legal system. All those informants who had personal experiences receiving counselling/therapy (five informants) contributed reasons, and helpers or those affiliated with helpers in the community also contributed reasons they saw for those they helped (four of five informants). Since some helpers also received counselling, this resulted in a total of eight contributors to this domain.
Table 20. Included Terms for Domain 9

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<th>Included terms</th>
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<tbody>
<tr>
<td>9.1. Family problems</td>
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<td>9.2. Major adverse life events/ many crises happening at once</td>
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<td>9.4. In order to become a better helper</td>
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<td>9.5. Fear of repeating negative patterns</td>
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<td>9.6. Fear of losing family</td>
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<td>9.7. Being mandated</td>
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9.1 Family problems.

Rodrigo recounted a stressful period involving the family restaurant business that was affecting his family life, which prompted himself and his wife to seek help. They told their problems to their family physician who advised them to go for counselling. Rodrigo reported that in this case their problems were resolved through that counselling.

As described in Domain Five, the Pentecostal clergy also described marital difficulties that brought couples in their congregation and in the community to seek their help. Maria described a different kind of family problem, that of trying to figure out how to raise a teenage son and understand “the adolescent male psychology.” “So speaking with this counsellor helped me a lot, going through that with my son.” For Angelina, it was divorce and starting out as a single parent that drew her to counselling and support groups.

The priest described conflicts in the family between parents and children, and between husbands and wives, as the main reasons people sought him for advice and counselling. Specifically he talked about how different rates of acculturation become a
problem for parents and children. “We are in a different time today. The reality is not the same, like you left in Portugal 40 years ago, 50 years ago, no?”

One problem in the community, according to João, was adult children’s disapproval of widowed parents remarrying. He cited this as one of the few reasons that a man would come in and ask to talk to the priest for guidance. “They’ll ask where he thinks they should go and if the kids are giving them problems because they want to marry, then they ask the priest, what do you think I should do” (João)? At another point João said that people seek the priest for help for spiritual guidance. When asked for examples, he described the remarriage dilemma:

Well it’s the values, spiritual, like for example, they were raised, if the husband or wife die, they should refrain from marrying and living with another person because it’s respect for the partner. So when you think of marrying or living with another person after a year or two, it’s looked upon you never loved that person, it’s just a lot of meddling and a lot of old fashioned traditions, which makes that person’s life like hell. Because if they have older kids, then their kids are saying, “Dad, you’re an old fool,” blah blah blah, so it just makes more struggles at home. (João)

9.2. Major adverse life events/many crises happening at once.

Julia recalled going through the hospitalization of her father the same weekend she moved out of home—which was a cultural taboo—at a time that she was very busy with school requirements. She was in her late twenties at the time. “So even though I was renting and had committed to that, I was still back and forth and carrying both responsibilities and that’s when I was really, really wanting, wanting counselling, and couldn’t get enough of it.” Her father passed away soon after this time.

Paul described how one thing after another overwhelmed his ability to cope, leading to the feeling of everything spiralling out of his control. Eventually he sought counselling:

It got to a point where all these things plus schooling and how my performance put me into a certain situation with school, I had to leave the university, then went to
college. Everything kind of started from that shoulder injury to be quite honest (chuckle), and everything kind of spiralled out of my control. . . . I got to that point where I just couldn’t take it anymore. Who can I turn to? Where can I seek help? (Paul)

He then sought counselling more readily a few years later when he went through a difficult breakup and was dealing with feelings of guilt. This time he did so outside of the university counselling system, indicating more resourcefulness on his part.

Rodrigo cited intense workplace stress, related to his level of responsibility, as his reason for seeking help:

Inform: I went to the doctor, I said, “This can’t go on like this.” . . . It was actually a time when after I retired, I was very active at work, it was very demanding. When you come to the point where you’re responsible, or you feel the responsibility for the whole plant, that if it blows up, if somebody gets hurt, because it was your fault, signing something or looking at a document and approving it, and there was something done you feel that responsibility. (Rodrigo)

9.3. Wanting to become a better helper.

Julia described her experience of her father dying, just a few years after her uncle had passed away, as an important period where she decided to better prepare herself to be a counsellor by seeking counselling. She explained,

So later, when I completely changed was when I had to go back and tell everybody “well remember when my dad was dying? Well really that was my uncle. Now I have this other man who’s dying.” That’s when I really got, for whatever reason, really truthful and really authentic and really real and really, “If I’m going to do this work in counselling I need to go and seek my own.” (Julia)

In retrospect she reflected both sarcastically and truthfully, “Umhmm couldn’t have happened better (laugh) now, it was all worth it. It was all worth it. To be in a relationship I’m in, it took a lot of work and years.” Here she was speaking about her marital relationship that has taken a different form (non-Portuguese, few Portuguese values) than what she grew up with.
9.4. Fear of repeating negative patterns.

Both Julia and Paul described a fear of repeating negative patterns. For Julia, this was a fear of repeating negative patterns in relationships:

I don't know if I had a negative perception of family so much as I had a negative perception of what marriage forever looks like, and couples that aren’t conscious. And I don’t think I would have used those words at the time, but just the fear that I would repeat the patterns and the fear that . . . no matter how much work I do, the fall-back is (laugh) what I grew up with, as it is for all of us. And I just don’t wanna do that. (Julia)

For Paul, this was a fear of repeating negative patterns from his father in coping with emotional problems and stress:

I always see him depressed. I have seen him depressed but he’s never sought help. He was always, he worked through it right? And there were periods of time when I could tell my father was more depressed and he would drink more. You could tell it was from stress . . . and that was something I didn’t want to deal with, I didn’t want to experience. Hence, I sought for help, but even then, it was too late. I didn’t get it when I needed it, because I thought I would just deal with it myself. (Paul)

9.5. Fear of losing family.

According to two of the informants, the only times—with a few exceptions—that men will go to the priest for help is with alcohol abuse or spousal abuse. As João said,

Men don’t have problems, it’s the women who have the problems (laughs). That’s how we see it. You have a problem, go talk to the priest. For them, it’s the only time I see men come see a priest is if they have alcohol abuse and they need help. They’ll ask where he thinks they should go. (João)

He spoke further about the consequences of alcohol abuse and how these consequences push men to see the priest for help:

Sometimes they lose their jobs, sometimes they lose their wives, kids, if they’re violent, and so, but they still love their wives. . . so when they see that, they look for help, because they don’t want to lose their wife and kids. (João)

The seriousness of the situation overcomes any pride the person may have:
You have to understand, it’s their pride. So once they bring down that wall and show the priest that, listen, I have a drinking problem, they are willing to do what they can.

João gave an example of a man who came to the priest to try and get his wife back after he had beaten her and she had gone to a women’s shelter. The priest did not try to reunite the couple but did help the man get help.


Carlos explained that most of his congregants, and other Portuguese in the community, only go for counselling “just in very extreme situations,” such as being mandated by a family physician, as a result of the children becoming involved in crime, or as a result of the involvement of police and social workers due to domestic abuse.

When informants spoke of the more severe repercussions such as losing family or legal issues, they spoke about men specifically, who were viewed by these male informants to be more reluctant to seek help than women. Some of the informants brought up the term “male machismo,” which is discussed in the next domain, Barriers to seeking help.

Summary.

Informants’ motivations for seeking help ranged from wanting to better manage family problems and life stressors to dealing with loss such as death and divorce. While the informants I interviewed could not speak from a personal perspective of the fear of losing family and involvement of the law, they described instances where these two issues did propel or require people in the community to seek counselling.
Domain 10: Barriers to seeking help.

Domain Cover Term: Barriers to Seeking Help

Semantic Relationship: X is a kind of Y (Strict inclusion)

Description.

This domain includes all the barriers to seeking help; the semantic relationship is the terms below (X) are kinds of barriers (Y). The main included terms are (a) lack of host culture knowledge, (b) interpersonal barriers, and (c) acculturation, or cultural, differences. All informants contributed to this domain by either describing their own initial barriers to seeking help, or barriers they see in people and the community around them.

Table 21. Included Terms for Domain 10

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<thead>
<tr>
<th>Included terms</th>
<th>Included terms—2nd level</th>
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<tbody>
<tr>
<td>10.1. Lack of host culture knowledge</td>
<td>10.1.A. Language barriers</td>
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<td>10.1.B. Lack of information about problems</td>
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<td>10.1.C. Lack of information about treatments</td>
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<td>10.1.D. Lack of services</td>
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<td>10.2. Interpersonal barriers</td>
<td>10.2.A. Fear of gossip</td>
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<td>10.2.B. Pride and shame</td>
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<td>10.3. Acculturation differences</td>
<td>10.3.A. Being closed and conservative relative to host culture</td>
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<td></td>
<td>10.3.B. Seeing outside help as a “Canadian” thing</td>
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10.1. Lack of host culture knowledge.

10.1.A. Language barriers.

João summarized the typical language acquisition patterns of first-generation immigrants, those who came over in the 50’s and 60’s:
My dad could say a few words to survive. My mom never did. She was a housewife. And that’s what you’ll find, you’ll find in that era, whoever’s alive, they don’t speak the language because the husbands worked, the wife’s at home to raise their families. (João)

Carlos stated that not only the women were isolated from learning English, but the working men were as well. “They always worked with Portuguese people so they didn’t have opportunity to put into practice, you know, the new language, English.”

No informants were aware of active Portuguese-speaking therapists in the community. Language was reported to be a common barrier to counselling particularly for the older generation. Julia listed this as a barrier to her father participating in Alcoholics Anonymous. Maria, who was fluent in English, stated that even though her first language was Portuguese, it was not an impediment to receiving therapy in English. She said, “I dream in Portuguese and English.” However she stated she had a tendency to think first in Portuguese, “There are just certain expressions, that, maybe because I grew up with listening to my mother so much that I just could think of the expression in Portuguese a lot better than I can think of it in English.”

Elizabeth also emphasized the continuing language barrier for the older generations, though not the younger like herself whom she described to be “pretty well integrated into Canadian culture so it’s not, or that you know they are familiar with it enough [counselling] that I don’t think culturally it’s a big issue.” Maria talked about the role of family members in helping the older generation understand the medical system and what their physicians tell them:

If they didn’t have us, I don’t know how they would navigate their way through that system, especially as they get older they have more specialists to be referred to. But the nice thing about the Portuguese, is that they rely on family members a lot, right. Those that don’t have them, I don’t know. (Maria)
Family help is not as feasible with counselling. The language barrier plays a significant role in the other barriers listed below, by limiting information about problems and treatments or services.

10.1.B. Lack of information about problems.

Julia made the following general statement regarding immigrants’ exposure to the counselling field:

We have a huge immigration population and so there are people in my office saying that they never thought that they would seek, or are so against, the things I was saying when I first started counselling. And the more people are exposed, the easier it becomes and the less the stigma and the less the mystery and the less the fear of doctors. I just don’t know how many people are exposed to different paradigms of thinking and different belief systems. (Julia)

She made a similar point about her own experience growing up, not knowing there was another way to address her problems and get help:

I would have loved to have known that there were different ways of doing life under the paradigms, and it didn’t have to be what I grew up with, I guess, or that I didn’t have to think there was no support. (Julia)

Rodrigo pointed out that people in the community, to his frustration, share advice with one another to the exclusion of seeking outside answers to their problems, even when it is clear they do not have the knowledge themselves. While this builds community (as described in Domain 2), it does not connect individuals to mental health resources. Angelina learned to research mental illness because she grew up with a father with bipolar disorder. She was relieved to learn about her father’s condition and also became aware through this experience that many people in her community did not understand mental illness.

When I was old enough to research it and figure out that, yeah, my dad’s not “cuckoo.” He’s not Jekyll and Hyde (laugh). . . . And you put everything into consideration it was a shock to his life. He just about lost both of his legs. And my father was crippled for the rest of his life. So it was a big, “Wow, my dad has that.” And a lot of people don’t know about mental illness. (Angelina)
Angelina went on to explain her theory of why people in the community did not learn about psychological problems, for example, psychological disorders their children may have had.

People back then, because they didn’t know that those things happened, because they were never, when they were growing up, it was work, work, work... You’re never taught about all these things. ... Not unless, somebody knowledgeable, which is nowadays, their children have gone to school. They’ve become RNs, doctors, dentists, all these things. Now they can explain. But sometimes their parents are already gone. (Angelina)

She described the approach of the older generation, “Simple education, (quieter voice) like she’s very simple [referring to an elderly Portuguese woman sitting in the shop during our interview], grade nine education, very straightforward—very—“this is all I know and I don’t wanna learn any more” kind of thing. She said that to some degree people her own age (mid-forties) also “don’t understand what these things mean and refuse to educate themselves on it because that’s the way it was.”

10.1.C. Lack of information about treatments.

Several informants mentioned the lack of knowledge about services as being a barrier to counselling. In the words of Angelina, “I think a lot of people just aren’t aware of the purpose and scope of the services that are available to them.” João described an important aspect of his position as accessing resources for those who shared their problems with him, “If you want that profession, I go into the Internet, drop everything and I look for what’s available for them.”

10.1.D. Lack of services.

Informants pointed out that the Portuguese are not seen by outsiders as a population that needs help in the form of public services like other newer immigrant groups. Julia shared her wish to fill this gap based on her own experience:
That’s what I would love to do, ‘cause when I was going through my stuff, I kind of put out the calls to resources, because I was working on a crisis line, and going, “Well you know, there must be a group right? For second generation immigrants” and they kind of laughed like you know, because it was, you know, Indo-Canadian, Asian-Canadian. Portuguese and Italian, and Greek, who’ve been here a long time aren’t really seen as, we’re part of the mainstream. (Julia)

Elizabeth described the smaller scope of services in the Portuguese community compared to the larger and “culturally a lot more entrepreneurial” Chinese community, which even had their own nursing home. The small size of the Portuguese community in Western Canadian cities means that language-specific or culturally sensitive care services are not available. Elizabeth and Maria both commented on how larger cities with larger Portuguese populations have more services in Portuguese, including banks, shops, nursing homes, and social workers.

10.2. Interpersonal barriers.

Interpersonal barriers to counselling included fear of gossip, pride, and shame.

10.2.A. Fear of gossip.

Gossip was raised by many informants (eight out of the ten formal interviews) as a common problem in the community. Elizabeth stated, “There’s that big tendency to gossip.” That had always bothered her. She talked about a “running joke” between her mother and herself, “If you don’t want anything to be on the front page of the [local newspaper], don’t tell your grandmother.” She noted that the problem wasn’t unique to her family but common with other Portuguese and Italian families. Elizabeth noted that the gossip involved passing judgment on the subject of discussion, however the intent was not malicious but rather a social norm. “Especially amongst, in my grandmother’s generation, that’s how she relates to her other Portuguese-speaking friends.
Some informants explained that gossip is common because there is nothing else to talk about. Others explained that it comes from “the old country,” in Portugal, or small island ways in the Açores, where villages were 100 to 400 people.

My cousin was dating somebody who was much younger that she ended up marrying but nobody thought that he would marry her. And then she had a very bad reputation, so the funniest thing was people stopping me on the street to want to talk about her.

(Julia)

Julia expressed similar frustration to Elizabeth, “but you know, it’s not [pause], isn’t there more to life than this?” Rodrigo similarly expressed his opinion, “Oh god, I hate, I don’t like that, to say I hate it.”

The priest talked about how those who do not speak English only have a few people to talk to, thus increasing the gossip.

For example, if someone dies, sometimes they know before me that someone died, ‘cause when someone dies or pass away, they call me to have the funeral, for example, if he or she is Catholic. Sometimes, I don’t know that someone died yet, and they know and then they call the church, “When will be the first service for that person?” Oh my goodness, I don’t know if, you know. (Tony)

Julia described her own struggle against gossip as inspired by her grandmother:

My grandmother was an excellent role model for this, is that she would absolutely, she would leave conversations in the village and she would leave conversations here and go and pray. And say, “You know, if I’m going to say something, then everyone should say something about us,” so she would just not engage which was very unusual. . . . When you lived in glass houses, as we do, we should not be the ones saying anything about anybody else. . . . So there was very little judgment that she had about other people or their lives. (Julia)

Julia explained that gossip does come from the positive qualities of the community pulling together to support those in need, those who are ill, and families going through funerals. She reflected however, “it just seems to be, look how great we are ‘cause so and so’s going through this. “Gossip was also described as a form of helping itself, in that it is a way of connecting. However, overall it was seen and described as a barrier to helping. In the words
of Julia, “The gossip is rampant in the community so there’s a real sense that, a fear that people will look down upon people who say that they need help.” According to João, “They don’t go, because if, can you imagine? If that lady finds out that I went to see a psychiatrist, they would be—that would be all over the community, I’m done.”

Maria described an example where knowledge of gossip directly hindered communication and helping in the community: her parents avoided using a realtor in the community because, “everybody in the community would know what they were asking, how much it sold for.” She said that for them, “privacy is a big thing.”

Carlos talked about how people cut themselves off from the community because of fear of gossip:

When, every time you go to the bakery, you’re gonna hear someone speak, “Oh, here he comes, that guy, or that lady” . . . I know people they were being involved with family problems, and they just stop attending community events because of that, because they are ashamed and they don’t, because they know people they’re gonna speak and look to them, give them that look that they don’t want. (Carlos)

Rodrigo’s solution was to introduce new information into the society. “That has to, in my opinion, has to stop. So the only way you can do that is through some educational activities, some sort of organized events where people can see that, oh this actually is different.” Angelina recommended community groups, what she called “community counselling,” as a way to help people in the Portuguese community connect and open up about their problems. However, she clarified the need to prevent such a group from becoming a gossip group:

Community counselling, not community gossip (laugh). Don’t get together to gossip, get together to, or talk about recipes and stuff like that. Get together to, it’s not, it’s shame, it’s their pride. They don’t want to. They don’t want to open up. (Angelina)
This illustrates the very close tie between fear of gossip and shame and pride, which is the next sub-category.

\textit{10.2.B. Pride and shame.}

Carlos described the pride he saw in those in his community and how it blocked acceptance of problems and attempts to change:

\begin{quote}
It’s difficult for them, for men to accept that they have problems, they did things wrong, and they need to change and they need help. It’s too proud to admit it. I think it’s, I don’t know how to put it, old mindset, mentality due to the culture. Because even in mainland you can see now people from old generation like that. They still have that kind of mentality. (Carlos)
\end{quote}

He explained that it is not just in Canada but back in Portugal that the old generation are reluctant to admit they need help due to pride. Julia described her father’s self-reliance as a major barrier to counselling. “He probably did get a lot of that [counselling] whenever he went into treatment. But he wasn’t stating that it was helping and he, most of the time, said he could do it alone, which he couldn’t.” Angelina also stated similarly that pride prevents people from seeking help, and linked it to how she felt when she went through a difficult time:

\begin{quote}
It’s shame, it’s their pride. They don’t want to. They don’t want to open up. ‘Cause that’s all they know. So, like I said, even kids my age, [mid-forties], still having a hard time opening up. Just the way they, this is how I was taught, this is how I felt like . . . I kept my problem closed up for probably about, two years, before I aired out my dirty laundry. (Angelina)
\end{quote}

At another point I asked her what makes people afraid to go to helpers and talk and she answered, “Their pride, it’s their pride. ‘Cause it was my pride too.”

João qualified contexts in which a person’s pride is not hurt and therefore is not a barrier to receiving help:

\begin{quote}
If you were to leave your home to go see a psychiatrist, what’s wrong with you? But if you’re in a hospital atmosphere, it’s part of the treatment. Okay, so, that’s how they look at it. It’s more okay because nobody knows, except for them and their families,
\end{quote}
and it’s mostly regarding um, questions that they will ask is if you are on life support, what do you want to do?”

The differentiating factors here are privacy, voluntarily seeking the service, and topics of discussion.

The Evangelical pastor described a form of pride, the “macho latino” mindset, which was a barrier to his helping some parishioners. “They think, ‘I’m the man of the house. I’m the boss. I do whatever I want to do and you do whatever I want you to do.’” He talked about how Portuguese women would acculturate differently due to exposure to television and speaking with Canadian women.

So now at home, they have a problem dealing with their husbands, because they say, ‘This is the way I want it done and that’s it.’ And so lots of problems, but because of that “macho” mindset, they never recognize that they need help. Even with problems with their kids, or with their spouses. (Carlos)

He stated that he had tried to help families in the past but the man had denied that anything was wrong, even though the children and spouse claimed there was. “If people, they do not allow, they’re not willing to receive help and to seek about the situation, what can you do?”

The other clergy member I interviewed, the priest, also used a similar term, machismo:

Sometimes the ideas, they are more—what can I say?—reserved, they don’t express themselves, so maybe you could see these in some interviews, they don’t talk about them, especially the men. They have some machismo. . . . So sometimes it’s difficult to go deep in that particular world. (Tony)

He shared how he overcomes this barrier:

We share almost the same life because, so I am here at home, but I start to talk with them; sometimes I joke with them and sometime going to their houses because they like to invite you to go to their houses, I start to go there to see the, I start seeing the way of life of them, I start to enter this particular work. (Tony)

He also talked about the importance of determining who is in control in which domain:

If you are not strong here, they will be more than you. So but now, here I’m the boss. If I would like to do this, I will do it, and I started to do things here. Someone called
me, “Oh you will do this and why.” I told them no. I came here to manage the church. I have this mission from the archdiocese, I’m the priest, you command your home, I command the church. You know what is better to your home, and I know what is better to the church. (Tony)

He commanded respect from parishioners through his clear leadership, and also created a greater likelihood of them opening up to him in areas in which they were “the boss,” that is, their homes and personal lives.

I observed in speaking with the first generation men that they were much more quiet than the first generation women. They would speak with pride about the history of the church and the community, but not about community dynamics, specific family members, or mental health issues. In contrast the women did address these topics to varying degrees. Through the second interview/participant check phase, when checking the concept of machismo with Julia, I received a different picture of the Portuguese man. She contrasted a Latino concept of machismo with a Portuguese concept where the machismo takes the form of silence. The man grows up learning to put family needs first, and does not have a voice or anyone to hear him. Thinking is viewed as the cause of problems. It is enough to put food on the table and provide for one’s children. Otherwise, one is perceived as too sensitive.

10.3. Acculturation differences.

Some barriers to seeking help are a result of acculturation differences between Portuguese Canadians and other Canadians.

10.3.A. Being closed and conservative relative to host culture.

Carlos stated that the older members of his congregation typically were not open to receive help. He instead tried to introduce concepts through his sermons to “change the way they see the world, and see life.” Julia talked about how the desire to hold onto Portuguese culture, “little Portugal,” has stopped the “evolution.” She talked about the persistence of
values within the community of wanting “children to get married to Portuguese, you know, to keep the language and culture and the values and the Catholicism alive and well.” Rodrigo expressed frustration with the desire in the community to continue doing things the same way. His wish was to introduce new ideas and initiatives to revitalize the community.

As described in Domain 9, Paul initially did not seek counselling because he was following his father’s example of dealing with it himself in the Portuguese way. The priest described similarly what he saw to be the greatest barrier to counselling and how it played out at church:

I don’t find an openness from the people for different things here. Because for them, they have their tradition this way, “Oh my connection with the church is to go there for the mass, it’s okay,” or when we have something in our routine, sometimes to do something outside their routine they have, it’s difficult. For example, I tried, because always I have different priests here, they tried in the past to do some speech about, for example, about evangelization in the church with a new priest, and I invited people to come, they didn’t show up. Sometimes it is difficult to do something outside their routine. . . . They don’t like new things. (Tony)

He gave a specific example of the congregants’ desire for change but reluctance to act; they expressed a wish for more young people in the church, so they started a Sunday school, but then there were not enough volunteers to serve in the Sunday school due to long summer trips to Portugal.

Carlos, the Pentecostal pastor, noted that when he and his family immigrated from Portugal, they felt like they had gone back in time 20 or 30 years due to the cultural differences in “the way people live, even the mindset,” and also the difference between the islands and the mainland. João, who immigrated as a young child, described the effect of age at immigration on openness to a different culture:

My generation, is only [open to counselling] if they came as children, if they came in their early 20’s, early 30’s, they’ve still got that old school. Yeah, like I say, you have to come as a child to experience both worlds and see the logic in both. If you came
when you were a teenager or a young adult, you got your map already created in your brain. (João)

Carlos pointed out that the Portuguese conservatism is amplified by the conservatism of the city and province that is home to this Portuguese community:

I came from a big city in Europe, and all the big cities in Europe we have a much open mindset than in North America. . . . I travelled all over the places and I came to a small city in [province name], you know, western Canada. Um, very conservative country and I’d say province and city, so, it was—it was tough. And I could notice in our Portuguese community in all of that stuff. Very, very closed, very conservative. (Carlos)

Carlos and others also discussed the differences between the generations:

They isolate themselves from the community, and that’s the only community that they’ve been involved, basically isolated from the world. And of course, they go to work everyday, they don’t speak about the situation, about the problem. Ladies are at home are suffering, kids at home suffering, you know. But again, that kind of situation just gonna see it more on the first generation of immigrants. . . . I don’t know any case of a first generation immigrant that went to a counsellor or psychologist, or to get some help, voluntarily. (Carlos)

There were also conflicts between conservative religious values and liberal or modern values that served as barriers to seeking counselling. Margarida, who worked in the Evangelical Church, expressed regrets that there were no Christian doctors, psychologists, or counsellors in the community who also spoke Portuguese. Elizabeth stated that a difference in values also served as a barrier to counselling; conservative Roman Catholic values conflicting with liberal or modern values believed by community members to be present in the counselling/therapy field.

10.3.B. Seeing outside help as a “Canadian” thing.

Some informants believed that counselling was not considered to be an option because it is culturally a “Canadian” phenomenon: “They never allowed the other family members to get help if they need it, because now this is a Canadian thing; you don’t need it” (Carlos). Likewise, the recognition of bona-fide mental disorders was seen as outside the
realm of the Portuguese experience: “So my father, therefore, got depressed. Became a manic-depressant, and then my father was diagnosed with bipolar. So a lot of these things, Portuguese don’t deal with those things. They just think you’re going (whistle—cuckoo)” (Angelina). Angelina went on to discuss the lack of education of the first generation as contributing to a lack of awareness of mental illness. Similarly Rodrigo expressed frustration at the lack of knowledge of his Portuguese friends of different health issues; they would instead consult one another and not reach any definitive conclusions regarding their health questions. Maria spoke of her parents’ generation’s view of counsellors:

My parent’s generation who don’t believe in counsellors and have never used them and all of that, when I say they don’t believe, they would never think—they think that counselling is for somebody else, right. They would never think to go to a counsellor. From my perspective, the easiest way to come about it would be through almost like a medical-social worker does. To come at it from that angle, to sort of to guide them through that system. (Maria)

**Summary.**

This domain covers all terms that constitute barriers to seeking help. They include a lack of host culture knowledge including language barriers, lack of knowledge about problems and lack of knowledge about resources, and a lack of resources. There were personal barriers, including fear of gossip, pride, and shame. Finally, there were acculturation differences including Portuguese, particularly the first generation, being described as “closed and conservative,” perceiving the seeking of outside help as a Canadian thing, and experiencing or fearing a values clash between conservative religious beliefs and liberal helper beliefs.

**Summary of the Findings**

The findings presented an overview of the Portuguese community, including the immigration history and more recent movements. Also included was my process of becoming
a trusted researcher in the community. Then the ten domains were presented that address the research question, “What are the helping relationships for personal and emotional problems in the Portuguese Canadian community?” These domains were listed in order from help progressing from the smallest, most personal units (the family) to outside help. These domains demonstrated that: (1) individuals in the Portuguese community rely heavily on family for help and support; (2) they tend to focus on physical ailments over emotional ones, but that this focus helps meet emotional needs; (3) moderate use of alcohol is normative, with some reports of alcohol abuse; (4) there are significant clubs, groups, and shops in the community that provide ways to connect and deal with problems; (5) the church is a significant source of help, via clergy support, social support, and spiritual comfort; (6) forms of traditional healing exist in the community, from the use of herbs and amulets to the controversial use of curandeiros and bruxas; (7) the important role of physicians is a professional means of helping emotional distress as well as a pathway to mental health professionals; (8) listening, concrete advice-giving, and cultural similarities are important in counselling relationships; (9) reasons for seeking help included a range of motivations from becoming a better counsellor to avoiding family breakdown; (10) and barriers to seeking help included lack of host culture knowledge, interpersonal barriers, and acculturation differences. This collection of domains gives a comprehensive picture of how individuals in the Portuguese community engage in helping relationships to deal with personal and emotional problems.
Chapter 5: Discussion

This dissertation was a qualitative study using ethnographic methods that explored helping relationships in the Portuguese Canadian community. Forms of helping relationships, reasons for seeking or not seeking help, and qualities of helpers were described in this context. In this discussion is an examination of these findings in the context of relevant literature in the areas of multicultural counselling psychology, Portuguese immigrant mental health, and help-seeking. Methodological contributions are discussed, as are implications for research and practice. Limitations of the current study are then presented, as well as areas for future research and concluding remarks.

Context of the Study

Very little research has been done in the area of mental health for Portuguese Canadians. Generally speaking, culture-specific research in the area of mental health lags behind the needs of a growing multicultural population. There is also very little research exploring help-seeking in cultural contexts, particularly with hard-to-reach populations. Extended from this, the question of what do people do if they do not seek counselling has received little attention in the literature. Minority culture groups’ preferences for counsellor qualities or counselling experiences also have received little attention. This study explored these concepts within the Portuguese Canadian culture.

Summary of the Findings

This study was an exploration, using ethnographic methods, of the helping culture of Portuguese Canadians. In the Portuguese Canadian context, family is a very important practical and emotional support, and also an insulator. Gossip is rampant and considered damaging in the community. Pride and shame also serve as deterrents to seeking outside
help. Family physicians are an important and socially acceptable source of help, referrals, and medication for mental health concerns. People express and manage emotional and personal problems through somatization; substance use, particularly alcohol with men; through community connections; and through the church. The clergy also serves as an accepted helping resource where confidentiality is respected, although the confidentiality differs by community. In their helping relationships, individuals prefer a direct approach, expertise, and similar life experience and culture. Significant barriers to seeking help include knowledge of the host culture, interpersonal dynamics, and cultural or acculturation factors.

**Contributions to the Literature**

**Contributions to the literature on help-seeking.**

This study gave examples of barriers to mental health care at all four levels listed by Sánchez et al. (2014): the community (lack of mental health services available in the community), the system (lack of insurance; inability to pay), the provider (lack of cultural competency), and the patient (mental health stigmatization). In this study, most conversation revolved around “patient” factors. Even if there were mental health services in the community in the Portuguese language, individual stigma toward mental illness, and the cultural concepts of pride and shame, would still be present as barriers. Another individual factor is education. The literature documents a trend that low socioeconomic status (Guarnaccia et al., 2005; Vega et al., 2001; Vega & Lopez, 2001) and low education (Sanchez et al., 2014) reduce willingness to seek mental health services. As discussed in the findings, several informants emphasized the low education levels of Açorean immigrants and connected this to a reduced initiative to learn about mental illness. Generally speaking, the findings of this study build on Howard et al.’s help-seeking model by describing the
activation of the social network and how it affects help-seeking; for example, family members’ negative opinions of counsellors deter individuals in the Portuguese community from seeking professional mental health help. Howard et al. stated that the activation of the person’s social network may be a sufficient source of help in itself. This is one of the few acknowledgements in the literature of non-professional sources of help. These models however tend to focus on the role “friends’ opinions” of mental health providers play (Kadushin, 1969/2006), whereas the current study points to the important role of family’s opinions of professional mental health providers. In this study, accounts were presented where the social network was important; whether sufficient or not is a contextual, more difficult judgment to make. It appeared from informants’ reports that relying on family, gathering in groups to discuss physical ailments, and connecting to community groups all had healing aspects. Howard et al. also referenced “person centered barriers” as the major cause of the gap between service need and utilization, which is supported by the findings in this study regarding the lack of host culture knowledge, interpersonal barriers, and acculturation differences.

Included terms for Domain seven, *Ways that General Practitioners Help with Emotional Problems*, support research by Fenta et al. (2006) in which they concluded that most immigrants access mental health services through a family physician.

The present study also aligns with the findings by O’Mahoney and Donnelly (2007) in their study with immigrant women. They found the therapeutic relationship to be very important, and a strong influence on whether clients returned for treatment. Specifically, the providers listed communication breakdowns leading to perceived discrimination by the client. In O’Mahoney and Donnelly’s study the providers surmised that they were too
confrontational; in the present study it may be the opposite, that providers were not adequately confrontational. It may also be that providers were missing a closely related concept to confrontation, that of genuineness.

Cultural barriers came up under Domain ten, *Barriers to Seeking Help*, in the present study. As previously discussed, cultural barrier theory (Leong et al., 1995) states that aspects of one’s culture may predispose one not to seek mental health services. Examples of these aspects are: accessing alternate resources, holding traditional values, and not acculturating to the mainstream. Previous research has documented the trend for “more is better” amongst Portuguese immigrants (James, 2002), suggesting that seeking help through a traditional healer, the church, or within the family, would not be a barrier to accessing a mental health provider, although that seemed to be the finding here. The concept of traditional values as a cultural barrier to help-seeking was raised in the present study, for example, seeing counselling as “a Canadian thing.” Combined with a lack of education, individuals—particularly of the older generation—are unaware of the culture of counselling and whether impositions would be placed on their own values and beliefs. This is concurrent with Chen et al.’s (2009) findings that preservation of Chinese cultural factors accounted for lower mental health care usage by Chinese Canadians in British Columbia. Their study also demonstrated maintenance of cultural values and low mental health care usage beyond the first generation of immigrants. In the present study, the informants frequently distinguished between the “older generation” and second and third generations, indicating a significant shift in the understanding of western mental health views for the Portuguese community.

Under Domain ten, *Barriers to Seeking Help*, pride and shame were important barriers to seeking help, and connected to one another. These concepts are also connected to
the fear of gossip that many informants discussed. The fear of gossip was the mediator for
the contextual nature of shame in seeking help: João clarified that if a person is in a hospital
atmosphere already and psychiatric help is part of the treatment, that is acceptable, but if they
were to leave their home to see a psychiatrist, people would wonder what was wrong with
them. The stigma associated with seeing a professional helper was brought up as a barrier to
help-seeking, mediated by a lack of knowledge of this source of help. These findings support
the literature on stigma (Alvidrez et al., 2010; Giacco et al., 2014; Nadeem et al., 2007) that
have found both the stigma of seeing a mental health provider, and the stigma of mental
illness, to be significant barriers to help-seeking.

Contributions to the literature on multicultural counselling psychology.

These research findings serve as a tool for practitioners to increase their knowledge of
the cultures of clients with which they work, thus helping counselling psychologists meet the
“specific knowledge” portion of the Canadian Psychological Association’s guidelines for
non-discriminatory practice (2001). The importance of the relationship, or alliance, came to
light particularly through the domains of Help Outside the Community (8) and Barriers to
Seeking Help (10). This study supports the incorporation of the relationship into multicultural
counselling models (Collins & Arthur, 2010a, 2010b) and previous research that revealed the
multicultural counselling relationship to be very important (Chang & Berk, 2009; Fuertes et
al., 2006; O’Mahoney & Donnelly, 2007; Shonfeld-Ringel, 2001b) or, as Sodowsky et al.
(1994) stated, a fourth competency domain.

Contributions to the literature on Portuguese immigrant mental health.

One novel finding of this study is the comparative success of Portuguese Canadian
communities in regions where blue-collar workers thrive. The Portuguese Canadian
communities in Western Canada present a different economic picture than those of Ontario (Berry et al., 1989). The connection between prosperity and fragmentation in turn has increased the amount of integration and assimilation into Canadian culture, as emphasized by the distinctions informants made between the “new” and the “old” generations.

The second Domain, Focus on Physical Ailments, is well-documented in the literature through Dr. James’ and colleagues’ research (James, 2002; James et al., 2009; James et al., 2005; James et al., 2006; James, & Prilleltensky, 2002; James et al., 2004). The observation in Domain two that focusing on physical ailments is a social norm is supported by James’ (2002) research with Açorean immigrants in Massachusetts. She observed, and informants reported, that physical symptoms were an accepted topic of discourse and perceived by many as the only way to merit help and relief. Informants described the same trends here, namely that community members discuss physical ailments more easily than emotional ones and connect through this discourse; I also engaged in and witnessed this discourse directly when meeting community members and asking how they were. In addition, one informant labelled problemas de nervos as a way to blame emotional stress on physical causes, in this case, one’s nerves.

James (2002) described agonias as a “dynamic multivocal symbol” that “connects the sufferer with others and with God transforming the interpersonal and divine space” (p. 87). This study provided support for agonias, and more generally physical complaints, as a way of connecting socially with others. The diversity of causes, including social worries, was also supported by James’ work. In the present study the priest shared an example of an isolated elderly woman with, in his judgment, agonias. This supports the importance of agonias establishing social connection as James described. Agonias was not a well-recognized term in
the current study as compared to James’ work. Possible reasons may be that younger
generations were interviewed (although some of the older, original immigrating generation,
did not recognize the term either). Also, in James’ study the prevalence of *agonias* was
related to the degree of suffering and poverty. While the community she studied struggled
financially, the western Canadian community in which my work was situated was more
prosperous. In the present study, community members were more likely to connect *agonias*
with anxiety, which was a less nuanced conceptualization than James’ community members
and similar to the perception of health providers; this is likely connected with their lack of
personal experience with the syndrome.

The phenomenon described by the Pentecostal pastor, Carlos, of *agonias*
encompassing fear of death and purgatory, does not necessarily support James’ (2002)
finding that *agonias* provides a connection to God, the emphasis of *agonias*. She did,
however, document the same belief as expressed by a health provider she interviewed, as
anxiety about purgatory, a fear of being punished, and as described by a priest as fear about
sin.

*Problemas de nervos* was a term that fewer of my informants had heard of as
compared to *agonias*. In contrast, James et al. (2009) described the phrase as, “part of any
Portuguese community member’s vernacular” (p. 286). The descriptions and causes
identified in the current study were stress, anxiety, being afraid for nothing, having physical
nerve problems, avoiding emotional issues, separation of family between Portugal and
Canada, and being stressed by children and grandchildren. They can be categorized into all of
James et al.’s four classifications, which were: *mal da cabeça* (problems in the head,
meaning psychological or personality deviations); *aflição* (afflictions, includes illness and physical symptoms); immigration stress; and conflict with others.

Domain six, *Using Forms of Traditional Healing*, was also described in the literature through Bezanson’s work (Bezanson, 2008; Bezanson & James, 2009) and James’ work (2002). In the present study, informants were unanimous that *curandeiros* and religion were incompatible, in contrast to James’ documentation that most (but not all) informants considered the two complimentary. Similarly, *curandeiros* were mostly viewed negatively by the informants I interviewed, whereas they were seen to have merit by many informants James interviewed. It is interesting that research in the past 10 to 15 years has seen a resurgence of interest in learning from traditional healers, while the cultures in which they exist may have more complex views. I therefore went into the field with a positive view of *curandeiros* that my informants did not share. The expert reviewer from Portugal gave feedback that in mainland Portugal, *curandeiros* are viewed positively as healers in the popular culture. The term does not necessarily have the negativity attached to it that was described in this study. Bezanson, however, in her research in the Açores, found that residents initially denied knowledge of *curandeiros*. It may be that the immigrant population in the present study reflected more of the island perspective, and an older perspective, of *curandeiros*.

The role of the church in helping relationships (Domain five) among this population has not received much attention in the literature. There is a theme among both the Catholic and Protestant groups of relying on the church and turning to the church or clergy for help. The many descriptions of clergy helping relationships give a very positive picture of how clergy help community members, particularly by being viewed as acceptable sources of help,
being confidential, and being situated within the culture. In the participant checking process, Julia reported that in the past she had been aware of priests who did not respect confidentiality. This perhaps points to the high degree of variability among different clergy.

**Cultural Themes**

The eleventh stage of Spradley’s (1979) ethnographic method is the identification of cultural themes across domains. These are discussed in light of the relevant literature and include role clarity, cultural rules for disclosure in different contexts, and fatalism.

**Cultural rules for disclosure in different contexts.**

The domain *Reliance on Family* is a phenomenon previously documented in the literature (Morrison & James, 2009); however, its connection to help-seeking has not been directly examined until this study. Previous work in this area (*N* = 49, Morrison & James) described the tendency of individuals and families not to seek help outside the family; and even not to seek help outside the self. Instead, most informants stated they would rather focus on solving the problem, getting it off the mind, or resolving it alone. A few of the women stated they would see a priest or talk to a friend (p. 161). Note that in this study, individuals reported a reticence not only to share beyond the family, but even to share beyond the self. In the present study, reliance on family was connected to help-seeking through Domain ten, *Barriers to Help-seeking*, which covers the included terms of gossip, pride, and shame. These are all reasons to keep things within the self, or within the family versus outside the family, or with the clergy versus a mental health professional.

Domain four, *Accessing the Portuguese Community to Prevent or Cope with Problems*, is in interesting juxtaposition to Domain one, *Reliance on Family*, because relying on the family suggests a certain degree of insularity and reluctance to connect outside the
family. However, both co-exist as social-emotional resources because the nature of the information that is shared follows specific cultural rules. This ties in to Domain two, *Focus on Physical Ailments*, because physical complaints are an accepted topic of discourse outside of the family. There are also taboos on topics of discussion that do not necessarily exist within the family or at least amongst some family members. Even within the family there exist rules about what is shared with whom. Regarding community, while emotional or highly personal topics may not be discussed, it is important to note that community relationships still “help” with providing a sense of belonging and removing loneliness. These progressively distal spheres of relationships all have different rules for the structure and content of the helping relationship.

**Role clarity.**

A significant finding for this study was the picture that emerged of the qualities of positive therapeutic relationships (Domain eight, *Help Outside the Community*). Particularly notable is that informants recounted incidents and stated a preference for advice-giving and clear therapy goals. This agreement on goals is a core focus of the working alliance (Bordin, 1979; Castonguay, Constantino, & Holtforth, 2006). While Rogerian empathic responding (Rogers, 1957, 2007) as a primary approach was not appreciated, the qualities of congruence, as discussed by Maria, and empathic understanding through reflective listening, as discussed by Rodrigo, were important. The findings in this domain, of what informants recalled from their helping experiences, agree very well with Chang and Berk’s (2009) findings. To recap, in their study, clients reported that the most important aspects of their counselling experiences had been components of the working alliance: affective involvement in the relationship and the belief that the counsellor is addressing core needs and assisting in the
achievement of treatment goals. In the present study, several accounts were related in which early termination occurred because treatment goals were not being addressed. Another key finding with regard to therapeutic relationships was that similarities between client and therapist were important, on numerous levels: age, life stage, and culture. These findings support the phenomenon of ethnic matching and better therapy outcomes for some groups as reported in the literature (Cabral & Smith, 2011). The accounts of informants regarding culture, ranging from feeling subjected to cultural stereotyping (“all Portuguese women wear black”) to feeling limited in the depth of therapy due to cultural barriers and lack of understanding (the pressure on the eldest son of Portuguese families), all point to the importance of achieving better understanding through ethnographic research with the cultures with which one conducts therapy. It was also clear in this study that expertise, as demonstrated through age, experience, and training, was important. If the client’s intention is to receive clear advice from the helper, expertise becomes all the more important. This connects to the theme of role clarity and authority in relationships as explored in other domains; for example, the priest’s account of needing to establish authority in the domain of the church in order to gain respect of parishioners and to be effective, and several informants’ accounts of the “macho” Portuguese man.

**Fatalism.**

The cultural theme of fatalism recurred throughout the domains. It manifested as a lack of effort to actively seek solutions to problems and a tendency to somatise problems. There is a connection between physical ailments and a sense of helplessness or lack of control, as physical ailments are perceived to be more outside of one’s control than emotional ones. Therefore, the concept of *problemas de nervos* was viewed by one informant as an
attempt to escape responsibility. It can also be an extension of Araújo’s (1996) concept of fatalism that characterizes this population, based on a history for mainland Portugal of frequent occupation by invaders, and for the Açores, by helplessness in the face of storms, earthquakes, mainland control, and piratism. This fatalism is extended in the new country by a lack of awareness of resources and sources of help. Julia’s story of her mother who decided not to actively help her father with his drinking problem illustrates this fatalism in context.

Methodological Contributions

This study presents an example of using ethnographic methods to further counselling psychology research. Drawing from a research tradition older than the field of counselling psychology that focuses on culture (Gerstein et al., 2007) has facilitated the development of a thick description of helping in Portuguese Canadian communities. Due to the unstructured nature of the interviews, the findings are all that more robust, as informants raised various means of helping or coping and concepts independent of one another, such as the importance of family, use of wine, role of clubs in the community, and the prevalence of gossip. This study, conceptualized within the theoretical framework of Kleinman’s (1986) sociosomatic formulation, supports the concept of somatization as being connected to the religio-moral and social domains. This framework provided a means for understanding how people seek help for psychological distress within the culture of the community. The use of ethnographic methods in this study answers a call to expand “epistemology concerning knowledge production” in response to “psychology’s cultural turn” (Kral, 2007, p. 257).

Limitations

While this study provided an in depth look at the phenomena of help-seeking and helping relationships in one community, the research design did not allow for causal
statements or generalizations, given that it was qualitative research design and had a small sample size. However, because of the qualitative nature of the study, an in depth exploration of the topic was afforded. I expected and observed a diversity of approaches and attitudes within this one group. This was partly beneficial as each individual had different characteristics or held different positions in the community; however, this rendered some aspects of triangulation more difficult. For example, I interviewed only one priest, and while other informants supported his statements from other perspectives, only one person represented the priest’s view. Informants who were formally interviewed were also self-selected creating a biased sample; eight of the ten informants had either received or provided counselling, which is a much higher rate than in the Portuguese Canadian population.

Ethnographic methodology allowed for other means of information gathering that helped offset this bias, such as attending group functions, visiting Portuguese establishments, and talking to a broad range of community members in informal interviews.

The cornerstone of ethnography is fieldwork; the greater the time one spends in the field, the deeper the understanding of that culture. While I lived in the field for a year, my engagement was limited by other concurrent obligations. Therefore this study cannot be called a true ethnography, but is rather a qualitative study using ethnographic methods. Another limitation was my lack of the Portuguese language. While the informants whom I interviewed were fluent in English and declined an interpreter, I believe my understanding of the concepts they shared would have been deepened had I been fluent in their native language. Finally, generally speaking, my outsider status put constraints on the depth to which I could enter and understand the community. However, this step takes us a great
distance beyond what we formerly knew of the experiences of those who tend not to readily seek out psychological help.

Implications for Research

This study advances existing literature by integrating anthropological theories and methodologies into a psychological study to expand the field of enquiry. A key benefit is the adaptation of ethnography methods to the counselling psychology field. This study provides an example whereby participant observation, informal interviews in the field, and formal interviews using ethnographic questioning (Spradley, 1979), have allowed for a rich and broad, contextualized description of helping relationships. A focus only on clients in counselling would have resulted in the lack of within-community descriptions of helping; a focus on questionnaires would have resulted in no novel means of helping being described. This study provides an example for the use of ethnographic methods in counselling psychology research with other culture groups. This study meets the call by Howard et al. (1996) for research on how services can be tailored to meet the needs of the mentally ill.

Another contribution to research is the inclusion of social and religious contexts of informants in the investigation, and consequently in our understanding of psychological help. A consideration of overlapping identities such as Portuguese Canadian and Catholic, or Portuguese Canadian and Pentecostal, is important in conducting culturally competent research. Another contribution to research is understanding the social construction of men and women’s mental health experience. This study serves as an example of how the sociosomatic formulation can be used by researchers to study other ethnic groups.
Implications for Community

Building on the findings of this study, and given the positive effect of education on reducing stigma in other immigrant populations (Nguyen, 2015), education regarding mental illness may help reduce the stigma of mental illness, the stigma of help-seeking, and also to increase knowledge of mental health problems and the services available. This would overcome significant barriers described in this study. Education could take the form of information nights at coffee houses, churches, and community centres in the community.

Finding ways to partner with the community and reduce the stigma of mental health providers would also be beneficial. An example would be joining with the Catholic Church to provide premarital or general counselling. Another way to partner with the community would be through forming connections with the medical professionals that work in the community and establishing office space adjacent to other health services that serve the community. While there are risks of reduced confidentiality and increased visibility of mental health service usage, the increased visibility, and tacit approval by the health professions, may outweigh the risks.

Implications for Practice

This work bears important theoretical and methodological implications for the development of culturally sensitive treatment programs (Rogler, 1999), and generally highlights important principles for psychosocial mental health interventions. This study provides a step along the way to developing a culturally sensitive form of mental health provision for Portuguese immigrants by adapting the nature of the service to what community members find most helpful, including the form of service delivery and the relationship itself. The intention is that counselling psychologists and other mental/health
providers will be able to read this “thick” description of helping relationships in the Portuguese community and in response adapt their own approaches to better suit the cultural context of their Portuguese clients and patients. Findings of this study point to the importance of the following concepts in therapy:

**Understanding the importance of family.**

It is important that the practitioner be aware that immediate and extended family often provide more important relationships than friendships. For example, considerable tensions may exist in meeting relationship needs of adult children and parents’ desire to remarry. Also important here is the reputation of the family within the community and how consideration of that plays into decision-making. The individual receives strong messages from family members regarding how to seek help.

**Understanding the cultural characteristic of fatalism.**

The practitioner can bear in mind the hardships experienced by the first generation both in the home and host country, and the cultural characteristic of fatalism. This may reveal itself in a reluctance to express dissatisfaction with any aspect of therapy, which makes the repair of therapy ruptures difficult (Safran, Muran, & Eubanks-Carter, 2011). To compensate for this, it is important for therapists to be sensitive to subtle changes in the alliance, and to take the initiative for exploring changes in the relationship when they suspect a rupture has occurred (Safran et al.). The characteristic of fatalism may contribute to accepting life’s difficulties, not taking initiative to learn about alternatives or solutions to problems, and this may also contribute to the difficulty of moving towards change. Instead an acceptance of the present situation and feeling “heard” may be of greater psychological value.
Accommodating a preference for directness.

While listening was perceived as valuable in the Portuguese community, the preference to also receive a fresh perspective, professional opinion, or information was a strong theme. For the counsellor who has been trained in person-centred Rogerian empathy, this can be a challenge. In multicultural counselling with Chinese clients the concept of giving “gifts” in therapy has been explicated as a way to strengthen the alliance and meet different cultural expectations of the relationship. The “gift” is receiving immediate benefit from the counselling relationship, by achieving a meaningful gain early in therapy (S. Sue & Zane, 1987), shown by recent research to be related to the perception of a stronger working alliance as compared to insight-oriented therapy (Kim, Li, & Liang, 2002). As Jim and Pistrang (2007) found in their study of Chinese clients, what is important to the therapeutic relationship is “not simply the therapist’s cultural knowledge but the therapist’s skill in understanding the client’s unique dilemmas and distress within the context of cultural values” (p. 470). These are labeled “cultural formulations,” and as such help the client achieve increased awareness of the cultural aspects of their difficulties, thus enabling them to reduce their distress (Jim & Pistrang).

Attending to rules for disclosure.

The therapist should be aware that the Portuguese client may have more complex rules for disclosure than a fully acculturated Canadian client. While these rules may differ slightly from the findings of the present study, simply being aware of their existence will be helpful to the therapist in understanding the client and engaging with the client in a way that does not threaten taboos and heighten anxiety. According to the findings of this study, these rules include the following: (a) it is more acceptable to discuss somatic complaints than
psychological complaints; (b) it is not acceptable to talk about sex and intimate relationships; (c) maintaining one’s own pride is important, and it may be difficult for a client to share anything even with a family member that threatens that pride; (d) maintaining the pride of the family is important, and disclosure that reflects poorly on the family is difficult; and (d) talking about others’ problems (gossip) is culturally normative. Above all, these rules for disclosure, and particularly awareness of gossip in the community, highlight the need for counsellor confidentiality, including, if possible, the fact that an individual is attending therapy sessions.

**The importance of avoiding stereotyping and overgeneralizing.**

While the importance of avoiding stereotyping and overgeneralizing is well-established in the literature (Collins & Arthur, 2010a), and also is dictated by our common sense, it is still important to explicitly state here. Counselling psychologists are called to reflect on their biases and values in an effort to be culturally competent practitioners (Canadian Psychological Association, 2001). However, if we are always mindful that we do not and cannot know everything about the client’s culture, and approach the therapeutic encounter with humility and willingness to learn, then we do not commit the error of believing we are providing fully culturally competent service. Regularly checking in with clients can be helpful in this regard, however clients may have difficulty articulating the lack of cultural understanding they feel.

**Areas for Future Research**

According to Richardson’s (2000, p. 254) criteria for evaluating ethnography, an ethnographic work should generate new questions, suggest new research practices, and move
research forward. This work has indeed generated questions that could be answered by conducting larger and differentially focused studies.

Berry et al. found that Portuguese Canadians endorsed an “integration or nothing” approach; Obasi and Leong (2009) connected an integrationist approach to poorer mental health. While not ascertainable in the present study, it would be beneficial to investigate whether those living outside “Little Portugal” in the suburbs fare differently with respect to their mental health. It would also be of interest to examine relationships among sociodemographic, location, and mental health variables.

One direction for future study is to investigate further how the cultural theme of fatalism permeates Portuguese Canadian culture and how it influences help-seeking and helping relationships. The finding of the preference for directness in therapy needs to be further investigated in studies with larger samples and other Portuguese communities. Also of benefit would be research that examines this quality in action through process research. At what stages of therapy is directness preferred? Are there therapeutic interventions and approaches that work better with clients who prefer directness? Would these approaches work with Portuguese Canadians? These questions come to light given the information shared by informants who clearly did not prefer the person-centred approach. Further investigation as to the reasons Portuguese Canadians seek help, and what kinds of problems Portuguese Canadians have, would also be beneficial for targeting mental health education to this population.

Given the stress informants placed on the “old generation” values and newer generation values—and even “Canadian” problems such as drug addiction in the youngest generations—it would be beneficial to investigate on a larger scale the mental health trends
and service utilization according to generation. The research has found conflicting relationships between maintenance of cultural beliefs and help-seeking, some positive (Ramos-Sánchez & Atkinson, 2009), and some negative (Chen et al., 2009). While the qualitative findings here certainly indicate a strong negative relationship, a larger study could confirm this finding. Likewise, different cultural groups demonstrate different degrees of the passing on of cultural values between generations (Chen et al.), moderated by locale. Again the qualitative finding here is that there are significant changes between generations, but it would be beneficial to investigate the impact of locale, for example larger communities where there may be less pressure to integrate into Canadian culture.

Finally, an investigation into helping relationships in Portuguese communities with lower SES, or differentiating between individuals with different SES, would be useful given the relationship between SES and help-seeking for ethnic minorities (Guarnaccia et al., 2005; Vega et al., 2001; Vega & Lopez, 2001). The informants of this study were of high SES and were more familiar with counselling than the average Portuguese Canadian community member. Therefore, it seems likely that an even richer description of alternatives to professional mental health help-seeking would be discovered with low SES individuals. More barriers and a different composition of therapy preferences may also be revealed.

Summary and Conclusions

This study addressed the research question: What are the helping relationships for personal and emotional problems in the Portuguese Canadian community? The strengths of this study are as follows: it provides comprehensive coverage of sources of help within and beyond the Portuguese community; there are rich descriptions of motivations to access outside help, descriptions of helpful and unhelpful qualities and experiences with helpers,
and descriptions of barriers to help-seeking; and the findings are contextual in nature, demonstrating the connections between cultural variables and help-seeking and helping relationships. The counselling psychology lens of the findings allows for a focus not only on what does not work but what does work, and the emphasis is on psychological components of help. The other significant strength of this study is the use of ethnographic methods for the attainment of a thick description of the helping culture in the Portuguese Canadian community.

This project forms a bridge between research and practice, providing a means for practitioners to provide culturally competent health care to Portuguese immigrants in Canada. These findings contribute to our general understanding of culturally competent service provision and constitute a model for culturally competent research, which can then be explored with other immigrant groups.

A criterion for evaluating ethnography (Richardson, 2000) is Substantive contribution: “Does this piece contribute to our understanding of social-life? Does the writer demonstrate a deeply grounded (if embedded) human-world understanding and perspective? How has this perspective informed the construction of the text?” (p. 254). This study has presented a grounded perspective by starting with a description of the Portuguese community, presenting domains that progressed from proximal sources of help to distal sources of help, allowing the informants’ words to speak in the text, and staying close to informants’ descriptions and terms in the analysis. By these means I have presented a study that contributes to our understanding of helping relationships in the Portuguese community.
Epilogue

After reflecting on the method used in this dissertation and the role of culture in ethnography, I have formulated a commentary on the limitations of Spradley’s ethnographic method as it was used in this dissertation.

Spradley’s DRS was developed in an era when culture was conceived as a single construct, i.e., someone had a culture, or belonged to one culture group. Culture was essentialist. Spradley defined culture as “acquired knowledge” (p. 6), a “shared system of meanings” that is “learned, revised, maintained, and defined in the context of people interacting” (p. 8). He then stated that “ethnography is the work of describing a culture” (p. 3). When incorporated into a methodology, this concept of culture was amenable to categorization, hence the formation of domains, taxonomies, and contrast analysis as per Spradley’s DRS.

The concept of culture has evolved since that time. Now culture is seen for its multiplicity. Culture is fluid, changing, and socially constructed. There are multiple contexts and processes that form concepts of culture. At the beginning of this dissertation (under Definitions), I presented a definition of culture based on Kleinman’s description and works, one of which reads:

But culture is not a thing; it is a process by which ordinary activities acquire emotional and moral meaning for participants. . . . Treating culture as a fixed variable seriously impedes our ability to understand and respond to disease states such as depression. (2004, p. 952)

Instead of something to discover, then, culture is a process. This latter concept is lost in Spradley’s static conceptualization.
While one could stretch and search for domains of exclusion, voice, and power, such relativistic and critical concepts are not easily conceived of through Spradley’s approach. In particular, the context of the information is lost. I attempted to maintain context through the heavy reliance on quotes and descriptions of contexts. For example, clarifying whether it was the Catholic priest or the Pentecostal pastor speaking was crucial for interpreting their message. Similarly, whether a man or woman spoke, whether the speaker was young or old, whether the individual was a member of the “old generation” or “new generation,” and whether someone had lived for a significant period in the Azores or Portugal prior to immigration or not, were all important lenses through which they perceived and interpreted helping relationships in the Portuguese community. Informants continually made these distinctions when communicating the characteristics of helping relationships to me, and while I made note of whether these categories applied to specific domains or not, they did not form a lens through which the domains were viewed.

May the reader bear context in mind when reading these findings. It is particularly important for those practicing in the mental health disciplines with this population to consider context, change, and process when applying the domains of cultural knowledge presented herein.
References


Ae-Ngibise, K., Cooper, S., Adiibokah, E., Akpalu, B., Lund, C., & Doku, V. (2010). 'Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. International Review of Psychiatry, 22(6), 558–567.


Appendices

Appendix A: Consent Form

Consent Form
An Ethnographic Study of Helping Relationships Experienced by Portuguese Canadians

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This study is being conducted in order to fulfill the requirements of a Ph.D. degree in Counselling Psychology. It will be part of a thesis. The information generated from this research will be used for educational and research purposes.

**Purpose**
You are being invited to participate in a research project, which is being conducted by Susan James and Marie Morrison in the Faculty of Education at the University of British Columbia. They are conducting research to investigate helping relationships and counselling experiences of Portuguese Canadians. They are working with leaders from Portuguese organizations (such as Portuguese Associations and local churches) to conduct this research and those leaders thought that you might be interested in participating.

**Study Procedure**
Your involvement will include completing a brief, 5-minute demographic questionnaire, a 60-minute individual interview with a trained and experienced interviewer who is sensitive to the issues involved in living as a Portuguese immigrant in Canada. A Portuguese-speaking translator will also be present, so that you can speak in the language of your choice. The questions will be about helping relationships you have experienced. You will
also be offered the opportunity to participate in a 90-minute focus group. The focus group will discuss how people seek help for personal, family, emotional, or work-related concerns. Several months after the interview, the researcher (Marie Morrison) will assemble themes from the interviews and invite you to look at these themes and comment on them and add anything that is missing. This second interview can happen in person or over the phone, and will take up to 45 minutes.

Your participation is completely voluntary and you may refuse to participate at any time without penalty or loss of benefits to which you would normally be entitled. You may "pass" on any question or on any part of the study without any penalty. If you withdraw from the study the information gathered up until that point will be destroyed.

Your signature gives permission for the researcher to audiotape record the individual interview, and to videotape the focus group for the purpose of the research. Only the researchers and their assistants will hear and have access to the audiotape and the videotape and it will be stored in a locked office. The tapes will be erased upon completion of the study. You are not to put your name on the demographic questionnaire so that your answers are anonymous.

If you wish you will receive a written summary of the overall results of the research when the analysis is completed. You will receive the summary no later than December 2012. In addition, you will be paid twenty-five dollars for taking part in the project.

**Potential Risks:**
There may be risks to your involvement in this project. For example, discussing your personal reactions to the issues may be uncomfortable. If you feel any distress during this study and wish to seek professional assistance, you may contact the UBC counselling services at (xxx). You may also contact Dr. Susan James at (xxx) for assistance.

**Potential Benefits:**
While there may be no direct benefits to you for taking part in this study, your participation may benefit other Portuguese immigrants now living in Canada and their families. It is the intention of the researchers to publish the research findings in scientific journals in psychology or sociology. The researchers will also inform healthcare providers about the findings and how they can better serve Portuguese immigrants in the future.
Confidentiality:
All documents and audiotapes will be identified only by code number and kept in a locked filing cabinet on UBC property. Subjects will not be identified by name in any reports of the completed study. The notes and tapes from the interview will be kept confidential and you will not be identified in any publication, discussion, or conference presentations related to this research. If any direct quotations are used, you will not be identified, either by name or by any other information that will make your identity known. If there is any doubt whatsoever that using the quote could identify you, then the usage of the quote will be checked with you.

If you participate in a focus group, we encourage you and all participants to refrain from disclosing the contents of the discussion outside of the focus group; however, we cannot control what other participants do with the information discussed.

You have the right to have all questions answered by the researcher or research ethics committee in sufficient detail to clearly understand the answers.

Remuneration/Compensation:
In order to defray the costs of inconvenience each participant will receive an honorarium in the amount of $25. Compensation is not dependent on completion of the project; if you withdraw before the end of the study, your honorarium will be pro-rated to reflect the extent to which you participated.

Contact for information about the study:
If you have any questions or want further information about this study, you may contact Dr. Susan James (xxx) or Marie Morrison at (xxx)

Contact for concerns about the rights of research subjects:
If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line at the UBC Office of Research Services at (xxx) or by e-mail at xxx. or toll free 1-(xxx).
**Consent:**
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

____________________________________________________
Subject Signature Date

____________________________________________________
Printed Name of the Subject

Participant’s full address and phone number (for feedback purposes):
Appendix B: Demographic Questionnaire for Informants

Age:

Sex:

Occupation:

Education:

Country of Origin (if Açores, give island):

Year immigrated to Canada for yourself or your parents:

Other countries lived in:

First Language:

Other Languages:

Language spoken at home:

Relationship status:

Number of children and ages:

Family members in the home:
Appendix C: Guiding Questions for Individual Interviews

1. Background questions:
   a. Tell me about your immigration experience if you immigrated to Canada.
   b. What has it been like living in Canada?
   c. Tell me about your family life.

2. Questions about who you talk to:
   a. Who do you talk to when you have troubles? What do you talk about?
   b. Who do you go to when you have social, emotional, personal or work-related problems?
   c. How does this person help? What do they do? What makes it comfortable for you?
   d. What language do you use when receiving help?
   e. What else do you turn to when you have troubles?
   f. What kind of person would be most helpful to you when you have social, emotional, personal or work-related problems?

3. Questions about previous counselling:
   a. Have you ever been to see a doctor, priest, counsellor, psychologist or other kind of helper for help with a personal problem?
   b. Qualification of the helper? Male? Female?
   c. Personal/social issues? Career counselling? Other?
   d. Setting? (university, community, etc.)
   e. When did this occur, and approximately how many sessions did you receive?
   f. What was the helper like?
g. How was the experience? How did it help or not help?

4. Questions about health and *agonias*:
   
a. Tell me about your health.

b. Are you on any medication for illnesses? If so, what are they?

c. If you have health troubles, who do you see?

d. Are there any problems that are specific to the Portuguese community? How do people get help for those problems? Have you ever heard of *agonias*? Problemas de nervos?
Appendix D: Biographies of Informants

Julia

Julia was in her forties, working in the counselling field. Her parents came over from the Açores just before she was born, along with other relatives, including aunts and uncles. Julia grew up speaking Portuguese but was also fluent in English. She had been heavily involved in the Portuguese community, including the Catholic Church, until her mid-twenties, when she started to investigate other faith traditions and cultures. She was married with one child. At the time of the interview she was working as a counsellor for young adults at a learning institution with a large international population.

Paul

Paul was in his thirties, and was working as an urban and land use planner. He was also pursuing a master’s degree in business. His parents were Portuguese; and came over from Portugal shortly before his birth. He grew up speaking Portuguese. He had grown up in central Canada where there were more Portuguese, and noted the difference between the communities through our interview. A theme of our interview was his feeling a lack of connection to the present community. At the time of the interview he was unmarried.

João

João was in his fifties, and worked in an office administrator role in the Portuguese community. He immigrated from the Açores with many siblings as a very young child. His first language was Portuguese; he spoke both Portuguese and English at home with his wife. He had two adult sons, one of whom was still living at home at the time of the interview.
Rodrigo

Rodrigo was a retired quality inspector in his sixties. He had attended technical school in Portugal, and come over to Canada as a young adult. His wife was also Portuguese, and they raised two daughters who at the time of the interview were adult, married with children, and out of the house.

Maria

Maria immigrated to Canada from the Açores as a young child with her family. She married a Jewish Canadian, and had two children who at the time of the interview were a teenager and adult; the teenager lived at home. She worked as an office administrator. Her first language was Portuguese but she spoke English at home.

Carlos and Margarida

Carlos and his wife Margarida, both in their forties, were a married couple that emigrated from Lisbon, Portugal, approximately 13 years ago as of the time of our interview. He worked as a pastor in the Pentecostal Church, and she was also involved in the ministry. They had two children who were a teenager and adult. Their first language was Portuguese; at home they spoke both Portuguese and English.

Angelina

Angelina had a business right in little Portugal and as a result was very connected with the community and often found herself in a helping role. She was in her forties at the time of interview. Her parents immigrated together from the Açores before they had children. Her first language was Portuguese, and through her childhood she spoke Portuguese at home. Her first marriage was to a non-Portuguese man. At the time of the interview she was in a common-law relationship with a Portuguese man and spoke Portuguese at home. She had two
teenagers from her first marriage, both living at home, along with, at times, her partner’s child.

Elizabeth

Elizabeth was a young woman in her twenties who had just completed her master’s degree abroad and had returned home to spend time with her parents and care for her grandparents while determining her next step. Her mother had emigrated from the Açores as a young child, her father was Canadian. At the time of the interview she was unmarried with no children. By the time of the participant check she had again gone abroad to do a PhD.

Tony

Tony was the parish priest, from Brazil. He was completing a PhD through Italy at the time of our interview. He was in his forties, and had moved to the community from Brazil five years ago. His first language was Brazilian Portuguese; he had to learn the Açorean dialect when he came and initially he found it difficult. He also spoke Italian, English, and some Spanish, and helped out in one of the Spanish parishes as well.
Appendix E: Sample of Field Notes

May 14, 2012

Went with [colleague name], [Arts association] member & England ex-pat, to Portuguese cafés. [colleague name] has been doing an [area in little Portugal] history project, interviewing three senior citizens who have lived in the area for many years. We went to the Portuguese bakery first and met [name], the owner, who immigrated from the mainland in the 1970’s as a [young child]. He is in his early 40’s now, has a [toddler], and another one expected. His wife was also working at the bakery at the time. He was very curious about my research and what my questions were. I explained that it was around help-seeking, what works, what doesn’t, who people go to for help. He said that the only kind of problems he has are work-related, and they all complain at work and work their problems out at work. Sometimes he goes to his family members with his problems, but he doesn’t really have any serious problems. He said that he immigrated from the Mainland. He said that there is a big difference between mainland Portuguese and the islands, that people from the islands are often poorly educated, very poor, and have lots of problems. He dated three girls from the Açores, and visited there. The families were large, one had seven children, and the husbands worked (fisheries) and drank and were mainly not present or involved in the parenting, the women did everything on their own. He said that the second generation here in Canada mixes in and is like everyone else, not really worth me researching. He suggested I go to the Charcutaria that is run by a man from the Açores. He also told me about a church out on [cross streets] that has a large Açorean population and lots of seniors who meet in the basement. He also said there will be a festival at that church over Father’s Day, coming up. He thinks there are 15,000 Portuguese in [city name]. He said that they separate according to
where they are from, the people from the North of Portugal built one church, those from the middle built another, those from the Açores go wherever. Despite his willingness to talk he was not willing to consent to scheduling a formal interview.

I also met a Chilean there who was very interested in my research and in providing me with access to Chileans. . . . [Colleague’s name] and I then went to the Charcutaria, and met the proprietor who was serving drinks to two men. The proprietor looked to be in his 60’s, the men in their early 50’s. I told the proprietor about my research and he took my poster and hung it up. The proprietor had come over from San Miguel in the 1970’s. I then told the two men about my research and one said that there is no community, no one sticks together, everyone drifts apart. He said that he has been trying to unite the Portuguese, that they don’t do anything. He started the Portuguese musical society and they built a brand new building out at [street name] and nobody comes out. He had posted a notice by the bar about an upcoming important meeting for everyone to attend. He said it was a philharmonic group.

He is also from San Miguel, immigrated in the 80’s. He said he runs a construction (?) crew of 30 people, only three are Portuguese. He said that what they like to do, eat soup and have a drink before going home, the women don’t like. Lots of young people now marry outside their race, not like in the old days, and they aren’t interested in keeping the Portuguese customs, and the wives who aren’t Portuguese resent them. At the restaurant up on [street name], half the patrons at least are not Portuguese. The other man is from the North of Portugal, near Spain. Later a woman and another man came in. They were eating soup and then having a drink. [colleague’s name] connected with the two men and the proprietor by discussing soccer; the European cup is coming up soon. I found myself wishing I was a soccer fan.
Friday July 6, 2012

Entered the Portuguese sports bar on [street name] to post a poster. Was very difficult to get stroller in door. Many men sitting around two tables, playing cards at one table and dominoes at the other, watching sports and eating peanuts. I waited quietly for a while; a few men glanced at me and away; then one man yelled to another that I was wanting to talk to him. He came over and I said I wanted to put a poster up. He seemed more positive and everyone was more friendly after I had stated my reason for entering. One man talked to April (age 2) and rubbed her cheeks. Another teased me that he couldn’t help me, he was Italian. Another asked me if I spoke Portuguese. I said I needed a translator, he asked how much I was paying, while I was interested in recruiting a translator, I was concerned by his question that he was either teasing me or just looking for money whereas I wanted an interested and impartial translator, so I responded with, not a lot, I’m a student. The proprietor was very nice and put my poster up for me.
Appendix F: Excerpt from Language and Terms used by Informants to Reference

Mental Health and Helping Relationships

“cuckoo” – used by informant #8 – what people in the community think if you have a mental health problem

“curandeiros” – negative reactions from Pentecostal members, Catholic members. Good Catholics don’t go to curandeiros. Connected to supernatural, not of God.

“bruxa” – deemed synonymous with “curandeiros” even though definition is “witch” as opposed to “one who heals”

Talk about helping professionals – most frequent term: psychiatrist. Second-most frequent term: social worker. Some talked about counsellors. More my word than theirs.

“the boss” – priest talked about hierarchical relationships, the tendency for parishioners to take charge if the priest does not
Appendix G: Excerpt from Log of Analyses and Interpretations

Hypothesis of relationships between domains/concepts:

- Small island ways
- pride
- macho latino mindset
- Gossip
- Keep things in the family
- hierarchy
- Shame
- Easier to talk about physical symptoms
- stigma of mental illness
- “cuckoo”
- Want clear advice from therapists
Appendix H: Definition of Mass Intentions

The following definition of mass intentions is from Hardon’s Modern Catholic Dictionary:

Mass Intention: The object for which a priest offers the Eucharistic Sacrifice. . . . Mass intentions refer to the particular purpose for which a specific Mass is offered. This may be to honor God or thank him for blessings received. But technically a Mass intention means that the sacrifice is offered for some person(s) living or dead. . . . Other things being equal, the more often the sacrifice is offered the more benefit is conferred. The intention for which a priest offers a Mass is determined either by the common law of the Church, or by specific precept, or, most often, by the intention of the donor of a Mass stipend, or by the priest's own devotion (Hardon, 2014).
Appendix I: A Summary of the History of Our Lady of Fatima

The original event, which occurred on May 13th, 1917, and was officially declared “worthy of belief” by the Catholic Church in 1930, was the apparition of the Virgin Mary to three children shepherds, each of whom were supposed to keep the apparition a secret. There were repeated apparitions on June 13th and then July 13th. When these children revealed this apparition, they were initially jailed, but then reports began to circulate that the Virgin Mary had promised a miracle on October 13 that year so that all would believe. On that date, a crowd numbering in the tens of thousands witnessed a miraculous event involving the sun changing colour and appearing to rotate like a wheel (Santuário de Fátima, 2015).