Cultural Influences on Help-Seeking, Treatment and Support for Mental Health Problems — A Comparative Study using a Gender Perspective

by

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Abstract

Title: Cultural Influences on Help-Seeking, Treatment and Support for Mental Health Problems – A Comparative Study using a Gender Perspective

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This qualitative research used the Long Interview method to study cultural and gender influences on mental health, health beliefs, health behaviour, help-seeking and treatment expectations for mental health problems in newcomers to Canada who are members of an ethnocultural, visible minority population - the Sri Lankan Tamils. The study employed a comparative design and analyzed data from interviews with Tamil men (N=8) and Tamil women (N=8) who self-identified as having been diagnosed with depression, and service providers (N=8) who provide frontline mental health and related services to the Sri Lankan Tamil community. The objectives were to a) understand cultural and gender factors inherent in the Sri Lankan Tamil community; b) investigate how these cultural and gender factors impact mental health and influence the trajectory of help-seeking and treatment for depression in the Sri Lankan Tamil community; c) explore the intersection of culture and gender as it relates to health behaviour; and d) explore service providers’ perceptions of the influence of culture and gender in relation to help-seeking for mental health problems and the application of this understanding to service delivery. The study found that the respondents equated social function with health and that this concept informed help-seeking and treatment expectations. Socially appropriate functioning was seen as an indicator of health, and this differed by gender. Gender-differentiated social stressors contributed to depression. Women played a role as enablers of care, both for family members and acquaintances. Men were more resistant to help-seeking and tended to disengage from care. There was a distinct preference for service providers who understood the culture and spoke Tamil. Religious groups served a social support function. Family physicians and Tamil service providers in the social service sectors were identified as key players in the pathways to care. Service providers did not appear to understand the community’s holistic view of health; however, they did use their knowledge of the community to make adaptations to practice. Recommendations that result from these findings include health promotion and prevention strategies beyond the traditional health care system, targeted culture and gender-informed interventions, and the need for multisectoral collaborations.
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Chapter 1

Introduction

1.1 Background and Rationale for the Study:

Immigrant patterns have undergone a sea change in recent years and Canada has witnessed a sizeable increase in its visible minority populations. There is a definitive shift in source countries from European to non-European countries, with more immigrants coming from Asia, Africa and the Pacific (Ethnic Diversity Survey, 2003). If this continues, the number of visible minorities in 2016 is projected to triple and pass the 6 million mark (Statistics Canada, 2005). A preponderance of these visible minorities are from traditional, collectivist cultures that are largely different from the Canadian host society, which is more individualistic and egalitarian in orientation.

This difference can result in misunderstanding and inefficacy in the provision of health care in general and mental health care in particular which, to be optimal, requires client and care provider to speak the same cultural language. The U.S. Surgeon General’s report on mental health and ethnicity says that there are greater disparities in the availability and access to mental health care services than for other health services, and these are often related to racial and cultural diversity, age and gender (U.S. Department of Health and Human Services, 2001).

Relatively little is known about the mental health of Canada’s immigrants (Ali, 2002), despite the fact that they represent about 18.4% of Canada’s population (Ng E., et al, 2005) and constitute an integral part of Canada’s social, cultural and economic institutions (Ali, 2002). A Canadian Task Force report showed that mental health
services to immigrants and refugees are often ineffective because of language and cultural differences between service providers and clients (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988). There is an increase in studies and literature that pertain to immigrant and refugee mental health; however they tend to focus largely on social determinants, the rate of mental illness, and barriers and enablers of services (Hansson et al., 2010). Most of the published research is based on quantitative studies even though qualitative methods might have been more appropriate (Britten, N, 1995).

The magnitude of change in demographic trends in immigration to Canada evident in the table below underscores the need to develop a greater understanding of visible minority cultures.

**Table 1: Place of Birth of Immigrants to Canada by Region**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>United States</td>
<td>3.9</td>
<td>3.5</td>
</tr>
<tr>
<td>Europe</td>
<td>90.5</td>
<td>16.1</td>
</tr>
<tr>
<td>Asia</td>
<td>3.2</td>
<td>58.3</td>
</tr>
<tr>
<td>Africa</td>
<td>0.5</td>
<td>10.6</td>
</tr>
<tr>
<td>Caribbean, Central and South America</td>
<td>1.4</td>
<td>10.8</td>
</tr>
<tr>
<td>Oceania and other countries</td>
<td>0.4</td>
<td>0.7</td>
</tr>
</tbody>
</table>

(Source: Statistics Canada, 2007)
Studies of Asian Americans have shown that cultural factors such as language, emphasis on family as a unit, and social stigma and shame all impact mental health and help-seeking (Kramer et al, 2002).

An additional layer of complexity is the role of gender in the cultural equation. In the cultural context of many developing countries from which visible minorities derive, gender roles and expectations are clearly demarcated where women are primarily defined as “wives” and “mothers” (Avotri and Walters, 1999). In a participatory action study of South Asian women who had immigrated to Canada, qualitative data revealed that a very important emergent theme was women placing family needs before self (Choudry et al., 2002). Even within the realm of identified women’s health issues — reproductive, maternal and child health - women are often not permitted to choose. In many cultures, men continue to be the decision-makers and still control women’s reproductive and sexual health decisions (Laudari, 1998). This reliance on the dictates of men and the relative lack of autonomy clashes with the values of the host culture and can result in emotional stress and the mental health problems precipitated by stress.

The effect of gender in the cultural context can also influence help-seeking, expectations of the client — provider relationship and the recovery process. A study (Ahmad et al., 2004) of South Asian immigrant women found that despite access to health care providers, women failed to identify health care encounters as opportunities to seek help and discuss their mental health concerns. Sensitivity to the interface of culture and gender is imperative from a health promotion and service delivery perspective. Review of the literature shows that while there are studies that propose culture as a factor in the underutilization of services by immigrant and refugee populations (Andermann, 1996; Edman & Kameoka, 1997; Landrine & Klonoff, 1994; Aponte and Barnes, 1995), in defining normative behaviour (Sastry & Ross, 1998) and in influencing perceptions of mental health (Pang, 1994), there are few studies that investigate the interaction of gender and culture. Researchers are increasingly stressing the need to explore the
interconnectedness between ethnicity, gender, culture, migrant and racialized status on health and mental health promotion (Barn & Sidhu, 2004; Guruge & Khanlou, 2004). Further, understanding existing variations among individuals, as well as among population categories and social groups, will assist policy makers and program developers alike to provide more effective and efficient delivery of programs and services that best meet the needs of these groups (Rummens, 2004).

The health systems already in place in the receiving society need to be informed about the cultures and contexts that their various immigrant populations bring with them. This will help develop a cultural and gender sensitivity that will make service delivery more competent, meaningful and effective.

1.2 Statement of Intent:

This qualitative study seeks to find an answer to the overarching question:

*How do cultural and gender factors influence mental health, health beliefs, health behaviour, help-seeking and treatment expectations for mental health problems in newcomers who are members of an ethno-cultural, visible minority population?*

Separate dimensions embedded in this larger exploration are as follows:

1. To understand cultural and gender factors inherent in the Sri Lankan Tamil community.

2. To investigate how these cultural and gender factors impact mental health and influence the trajectory of help-seeking and treatment for depression in the Sri Lankan Tamil Community.
3. To explore the interface between culture and gender as it relates to health behaviour.
4. To explore service providers’ perceptions of the influence of culture and gender in relation to help-seeking for mental health problems and the application of this understanding to service delivery.

While the primary objective is to identify cultural and gender factors and their impact on issues related to mental health, help-seeking and treatment, it was considered important to validate this through the experiences of persons who have experienced mental illness. It was also considered important to choose the experience of a particular diagnosis, namely depression in all its forms, and examine the trajectory of problem identification, help-seeking and treatment to further substantiate the findings. Depression was chosen as it is readily identifiable as a diagnosis almost universally. The other factor was that, as self-identification with the diagnosis was a criterion for participation, recruitment was expected to prove easier than if a more stigmatized diagnosis had been chosen.

**Expectations:**

In this qualitative study employing the long interview method (McCracken, 1988), there are fundamental expectations under consideration:

- Culturally-defined perceptions, attributions and norms have the potential to influence help-seeking among respondents.
- Cultural and gender influences interact.
- Cultural and gender factors are likely to influence the professional-client relationship and the treatment process.

**1.3 Guiding Concepts:**

The study rests on the premise that understanding culture and gender and the intersection of the two is imperative from a mental health promotion, treatment and service delivery
perspective. The work primarily arose not from one theoretical framework, but, rather, from the researcher’s direct experience working with the immigrant Sri Lankan community. This prior understanding was used to explore the various dimensions of culture and the intersection of culture and gender, in the context of help-seeking, treatment and availability of supports. Starting out with a particular framework in mind might have, it was thought, confined the exploration.

Leininger’s (1985) framework of culture, wherein culture is defined as the learned, shared and transmitted values, beliefs, norms and life way practices of a particular group that guides thinking, decisions and actions in patterned ways, is utilized to explore culturally-informed health beliefs, health behaviour, help-seeking and treatment expectations for mental health problems.

The study also explores the impact of learned and shared cultural and contextual factors on mental health and well-being. The history and shared experiences of a community are core aspects of its culture. The Canadian Nurses Association defines culture as, “shared patterns of learned behaviours and values that are transmitted over time, and that distinguish the members of any one group from another. In this broad sense, culture can include ethnicity, language, religion, and spiritual beliefs, gender, socio-economic class, age, sexual orientation, geographic origin, group history, education, upbringing and life experience” (Canadian Nurses Association, 2004). This study undertakes an exploration of culture within this broad context.

The framework of this study is further strengthened by utilizing a gender lens; the review of literature suggests that the effect of gender in the cultural context affects help-seeking, health perceptions and health behaviour (Avotri & Walters, 1999; Choudry et al, 2002; Laudari, 1998).
1.4 Definition of Terms:

Newcomer:

In the context of this study, “newcomer” refers to a person from an immigrant population whose length of stay in Canada has been ten years or less.

There is significant debate about what time period best defines a person as a newcomer though no consensus has been reached. Federally-funded settlement programs are mandated to serve new immigrants for only up to 3 years, whereas provincially-funded programs in Ontario may serve immigrants whose length of stay in Canada has not exceeded 5 years. Health research views immigrants as newcomers for a 10 year period (Gee et al., 2003)

Visible minorities:

Visible minorities are those who are identified by the Employment Equity Act (1995) as non-Caucasian in race or non-white in colour. This research focuses on a sample from a visible minority population that is ethnoculturally distinct from the receiving society based on recent arrival in Canada.

Ethnocultural:

The term ethnocultural refers to the culture of an ethnic group that is distinctive (Source http://en.wiktionary.org/wiki/ethnocultural). An ethnic group may be defined as a group that is socially distinguished from others, on the basis of cultural or national origin
characteristics (Feagin & Feagin, 2003). In this study, ethnocultural refers to the culture of the Sri Lankan Tamil population of South Asian ethnicity.

**Culture:**

Culture is defined as the learned, shared and transmitted values, beliefs, norms and life way practices of a particular group that guides thinking, decisions and actions in patterned ways (Leininger, 1985).

From a health perspective, the word encompasses value orientations with regard to health and help-seeking, health beliefs, norms with regard to adaptive and maladaptive behaviour, and how this informs decisions and actions related to health. The definition of culture by the Canadian Nurses Association (2004) is also utilized to explore the broader aspects of culture.

**Gender:**

Gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women (WHO, 2011).

The following definition further elaborates this concept:

Gender is the division of people into two categories, men and women. Through interaction with caretakers, socialization in childhood, peer pressure in adolescence, and gendered work and family roles women and men are socially constructed to be different in behaviour, attitudes, and emotions. The gendered social order is based on and maintains these differences (Borgatta & Montgomery, 2000).
1.5 Choice of the Sri Lankan Tamil Population:

Focus on a specific population group was deemed central to the study as many investigations have tended to cluster different populations, usually by major geographic region (Hansson et al., 2010). As well, studies on Asian populations in Canada have tended to focus largely on South East Asian population groups. This blanket approach to categorizing groups might not allow for a fine-grained analysis of the cultural and gender factors pertinent to specific sub-populations. Moving from the specific to the general was considered a more logical approach in order to understand differences and specific needs before applying a broader lens; otherwise generalizations might prove inaccurate.

About one quarter of the world’s population of Sri Lankan Tamils now lives in the diaspora (Kuo, 1995, Noh et al., 1998). The greatest number (about 250,000) is in Canada, followed by India (150,000), the UK (110,000), the EU (110,000) and Australia (30,000). During the last two decades of the twentieth century, Sri Lankan Tamils were second only to the Chinese population in terms of the number of newcomers settling in Toronto (Beiser et al., 2003). While the largest Tamil diaspora is in Canada, with the majority of settlement in the Greater Toronto Area (Mason et al., 2008), there has been very limited research on the mental health of this population. They constitute a visible minority population with a culture distinct from that of the receiving society and have experienced civil war in the home country with immigrants coming to Canada largely as refugees. In addition, Sri Lankan Tamils are part of the larger South Asian diaspora in Canada and share cultural and linguistic commonalities with other populations from South Asia. Hence, studying this community will yield rich insights into cultural and gender factors as they relate to mental health in one of the largest visible minority, immigrant population groups in Canada. The researcher’s prior work with the Sri Lankan Tamil community and the resultant findings on culture and gender factors which are
highlighted in the section on Research Methods lends further support for the choice of this particular community.

1.6 Organization of the Thesis:

Chapter 1 focuses on the study rationale, the framework and the objectives of the study.

Chapter 2 provides the reader with a detailed review of literature, which highlights findings from studies that explore culture and gender issues in mental health. A concerted attempt has been made to capture studies that pertain to visible minority populations.

Chapter 3 addresses the Research Design and Methodology utilized in the study. It elaborates on the choice of the Long Interview Method as a tool for both data collection and data analysis.

Chapter 4, Results and Findings, answers the specific objectives of the study. It draws upon two data sources: a) community respondents who have been diagnosed with depression at some point in their life and respondents who have self-identified as having experienced depression and b) service providers who provide mental health and related services to populations that include the Sri Lankan Tamil population. Findings from respondents who have self-identified with depression illustrates both the general aspects of culture and gender and their relation to health and mental health, as well as findings particular to the experience of depression. Findings from the service providers are of a more general nature and speak to the various aspects pertinent to culture and gender and their influence on mental health, help-seeking, service engagement and service delivery for members of the Sri Lankan Tamil community. As most of the service providers
work with diverse communities, their comparisons of population groups is also highlighted.

Chapter 4 lays the foundation for Chapter 5, the Discussion and Conclusion section, which presents a culture and gender-informed framework for mental health service delivery by moving from the themes and patterns presented in Chapter 4 to a higher level of abstraction. It concludes by identifying limitations of this study and recommended directions for future research.

1.7 Summary:

This introductory chapter highlights the increasing diversity of Canadians and the importance for mental health professionals to understand the cultures and contexts of the populations they serve. The interactions of culture and gender and the dearth of literature in this field of study are highlighted. The chapter elaborates on the overall focus and specific objectives of this study, as well as the guiding concepts that are utilized. It concludes with an explanation for the choice of the Sri Lankan Tamil population as the focus of the study.
Chapter 2

Review of Literature

"We simply assume that the way we see things is the way they are, or the way they should be. And our attitudes and behaviours grow out of these assumptions.”

Stephen R. Covey (n.d)

This review of literature covers what was known in the field at the time this study was undertaken. Gaps were identified and subsequently helped to shape the questions addressed in this thesis and to formulate the interview guide used in the study.

This section starts by exploring the concepts of culture and gender. Subsequently, it explores literature on pre-migration trauma and resettlement in ethnocultural visible minority populations in an effort to understand the importance of culture in the context of the mental health of these refugee communities. It then looks at specific cultural influences on help-seeking for mental health problems, service utilization and supports in ethnocultural visible minority communities; it next moves to studies that address the impact of gender in this cultural equation. It then discusses the literature on the provision of services to culturally diverse populations with a specific focus on newcomer ethnocultural visible minority populations. Finally, it explores such findings as exist that pertain specifically to the Sri Lankan Tamil population in the Diaspora.

2.1 The Concept and Importance of Culture:

Definitions of culture have always centred on the uniqueness of cultures, the etiology of culture, and the impact of culture on attitudes and behaviour. Leninger’s seminal
definition of culture (Leininger, 1985), which describes culture as "the learned, shared and transmitted values, beliefs, norms and life way practices of a particular group that guides thinking, decisions and actions in patterned ways" has been widely used in the health care field as a tool for understanding cultures and developing culturally competent services. The field moved on to expanding this notion of culture to embrace etiological aspects that contribute to the development of such beliefs, norms and life way practices (Canadian Nurse Association, 2004) and also to underscore the dynamism and uniqueness of the concept of culture (Williams, 2006). This dynamism of culture is supported by Anderson's (1991) definition of culture as "a framework of values and practices that forms a context for people's lives and which they adapt in changing historical and regional circumstance." In a broad sense, culture comprises and is influenced by ethnicity, language, religion, gender, socio-economic class, age, sexual orientation, geographic origin, group history, education, upbringing and life experience. Social markers such as age, race, sexual orientation and class intersect with (Kelly, 2009) and influence culture, contributing to cultural uniqueness among members identified as belonging to the same culture. Rummens (2003) emphasizes that research that looks at connections and interplay between ethnicity, culture, and health is of paramount importance for societies as ethnoculturally complex as Canada.

This broad concept of culture with its dynamism and intersectionalities alerted the researcher to the need to study culture as a constantly changing and evolving entity, subject to multiple influences, beginning from childhood, influenced by group history and socialization, and continuing through the lifespan of an individual, modified and challenged by life experiences such as immigration and resettlement. Such fluidity is especially relevant to understanding immigrant and refugee communities and their health behaviour.

2.2 The Concept and the Importance of Gender:

Gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women (WHO, 2011).
The following definition further elaborates this concept:

Gender is the division of people into two categories, men and women. Through interaction with caretakers, socialization in childhood, peer pressure in adolescence, and gendered work and family roles women and men are socially constructed to be different in behaviour, attitudes, and emotions. The gendered social order is based on and maintains these differences (Borgatta & Montgomery, 2000).

In the field of health this definition is particularly useful as there is a direct association with health, help-seeking and service utilization, which are functions of the social construct of gender.

Gender differences in the prevalence of specific mental health disorders in the presentation of symptoms, gender-specific risk factors in health and health-seeking behaviour have been documented in many studies (Afifi, M., 2007; Beiser et al., 2006; Seeman, 2006; Lehti et al., 2010). Protective and risk factors differ for men and women. Marriage and employment have been shown to be protective factors for men (Beiser et al., 2006; Williams, 2003), while marriage puts women’s mental health at risk (Williams, 2003). The care giving role of women, which extends to spouses, children and the elderly, may induce increased stress (Seeman, 2006).

Another consistent finding has been that men seek help less often than women and underutilize medical and mental health services (Mansfield et al., 2003). The U.S. department of Health and Human Services (1998) found that, regardless of age, nationality and ethnic background, men make fewer contacts with physicians in their lifetime and are two times more likely than women to have a period of two years or more since last contact with their physician. The argument has been put forward that masculine gender socialization explains underutilization and decreased help-seeking in men (Addis & Mahalik, 2003; Benett & Rosalind, 2006). Men score high on stoicism and perceived stigma and are less open than women to help-seeking (Judd et al., 2008).
Kehler (2004) points out that gender is an increasingly important concept in understanding how men and women experience and respond to health promotion programs and interventions and their outcomes. Exploring the social construct of gender in the context of health and help-seeking in ethnocultural visible minority populations is vital to ensuring that services are both culture and gender responsive.

While this review explores relevant literature between 1990 and 2010 in order to establish context in terms of work in the field, it particularly targets studies published more recently, between 2000 and 2010, with the expectation that methodology has improved over time and that more recent findings will be more pertinent to my own inquiry. The following databases were searched for this review: Scholars Portal, Google Scholar and the Gender Studies Database. Reference management was undertaken using Ref Works and making hard copies. Search terms included, but were not limited to: visible minority and mental health; gender and immigrant and mental health; culture and mental health; Tamil, culture and mental health; service provider and mental health; culture, service provider and mental health; cultural competence; culture and depression; culture, problem identification and mental health; culture and treatment expectations in mental health; culture, gender and mental health.

2.3 Mental health impact of pre-migration trauma and resettlement challenges:

Both pre-migration trauma and resettlement challenges profoundly impact mental health. Studies have largely relied on quantitative data to demonstrate the association (Beiser et al., 2006; Fenta et al., 2004). Quantitative data also speak to the impact of discrimination in the host country on immigrant mental health in the context of resettlement (Noh et al.,
In addition, fear for the safety of family members remaining in the home country can be a significant source of stress and has shown to predict risk of post-traumatic stress disorder (PTSD), disability, and health risk in refugee communities (Nickerson et al., 2010).

A survey of a random sample of 342 Ethiopian immigrants and refugees to Toronto seeking to determine risk factors for depression and its prevalence found that pre-migration trauma, refugee camp internment and post-migration stressors were all stress factors leading to the development of depression (Fenta et al., 2004). Gender differences were found in the experience of pre-migration trauma, with a greater incidence of traumatic events in the lives of men in comparison to women. Single status and unemployment in the post-migration period predicted risk for depression. Cultural factors specific to the traditions of the Ethiopian community were not discussed in relation to possible impact of trauma and immigration losses. Some gender differences were noted, but not elaborated upon. The study mainly focused on systemic factors in resettlement, but did not comment on the impact of cultural factors on resettlement issues. Culture of origin and gender, and how the two intersect in the process of immigration and adaptation to a new culture, which is a primary concern of this thesis, were not explored in this study.

McKenzie, 2008 reported on a qualitative study that sought to investigate the social realities of ethnoracial populations served by the agency, ‘Across Boundaries’. It used focus groups with diverse racialized clients, focus groups and interviews with service providers, and review of literature as tools. It highlighted the impact of pre-migration events on mental health, as well as the impact of losses including family, material and symbolic losses on migration to Canada. Resettlement stressors identified were largely systemic and included discrimination, unemployment, inadequate housing, language barriers and barriers to accessing services. Role reversals, with specific reference to men having to give up their position as heads of households, and family conflict and
breakdown were discussed. The report highlighted an interesting finding that Black immigrant women often ignored physical and emotional needs in order to take care of and support their families, both in their home country and in Canada. This suggested an instrumental role for Black women, and highlighted the need to understand such dynamics in different ethnocultural communities, understanding that gender roles are culturally informed. This study comprised a simultaneous exploration of service user and service provider perspectives. Since the focus was diverse ethnoracial populations, not necessarily newcomers to Canada, this study, while yielding important insights into common experiences of trauma and resettlement, may have missed the particular challenges faced by recent immigrants. Also, as the study combined the experience of population groups of different origins, it was not possible to consistently capture culturally singular phenomena. Finally, this study used an anti-oppressive framework to inform its inquiry, which led to crucial insights into systemic barriers to resettlement, concluding with a call for changes to service delivery that would address these systemic issues. This is an important lens with which to view resettlement difficulties, but a different one from the present thesis, which proposes to view pre-migration trauma and losses and resettlement stressors in a specific newcomer community through the lens of culture and gender.

2.4 Cultural influences on help-seeking for mental health problems, service utilization, and support:

2.4. i. Concepts of Health and Illness

It is well documented that culture influences how health is viewed, how symptoms of illness are expressed and when and how help is sought (Fabrega, 1995; Beiser et al., 2003; Ivanov and Buck, 2002; Kirmayer & Looper, 2006). The literature on mental health-related help-seeking in immigrant and refugee communities consistently refers to underutilization of mental health services and a reluctance to seek help.
Much of the literature speaks to the belief that non-Western cultures adhere to a holistic understanding of health and lack the concept of a mind/body divide (Raghuram et al., 1996; Jambunathan, 2003; Shin 1999, Pandalangat, 2006). A recent study of immigrant women in Nova Scotia (Weerasinghe and Mitchell, 2006) used focus groups to explore concepts of health and found that health was defined as comprising physical, social, and emotional aspects and that not even one participant defined health as being free of illness, the definition more common in European Americans (Karasz 2005). This apparent difference among cultures has led to the recommendation that the social dimensions of depression needs always to be addressed when treating members of visible minority populations (Sellers et al., 2006)

Another health belief reportedly held in ethnoracial communities is that illness can be caused through supernatural means (Kleinman, 1980), thus influencing the choice of where to go for help. A qualitative study, using data from in depth interviews of 15 West Indian immigrants to Montreal, partially attributed the reluctance of interviewees to use mental health services to their belief in the curative power of non-medical interventions, notably God, and, to a lesser extent, traditional folk medicine (Whitley et al., 2006). Another study alluded to the perception that mental illness is a punishment from God and must, therefore, be endured (Castro, 1997). It has been argued that Asian Indians use a religious framework (spirit possession or violations of religious or moral principles) to explain psychological distress and specific disorders (Ramisetty-Mikier, 1993). Physical and mental illness are believed to be a result of God’s will or past Karma, and thereby are linked to a fatalistic attitude, which could deter help-seeking (Jambunathan, 1998). One qualitative study looked at the conceptualization of health in Ethiopian refugees to the U.K. This study used semi-structured interviews, documentary analysis and ethno-history as tools of data collection. Ethiopians were found to hold the cultural belief that happiness and good social relations are a pre-requisite to and a reflection of good health (Papadopoulos et al., 2003; Papadopoulos et al., 2004). Health beliefs, especially supernatural ones, are an interesting area of inquiry that the current study will pursue in the context of the Sri Lankan Tamil community in Toronto.
In a qualitative study consisting of a convenience sample, with vignettes and interviews as tools for data collection, people from the Hispanic culture were found to attribute depression to interpersonal and social issues (Cabassa et al., 2007). There have been no qualitative studies that looked at the experience of depression and its causes in refugee populations from Sri Lanka. Studies of the East Indian population (which shares a similar ethnic ancestry, but very dissimilar migration experiences) are largely from the U.S., and quantitative in nature. In one qualitative study of depression in Asian Indians, the sample population was service providers from multidisciplinary mental health backgrounds. In depth interviews and review of medical records were the tools of data collection. Service providers in this study identified social stressors rooted in culture as contributing to depression in their clients (Conrad & Pacquiao, 2005). While this study yielded important insights, information came solely from the perspective of the service provider. A simultaneous inquiry of people who had themselves experienced depression was missing.

A large scale quantitative investigation of a probability sample of 3750 women in California found that Hispanic and Asian women were less likely than white women to report perceived need of mental health services and that African American and Asian women were less likely than white women to seek out services (Kimerling & Baumrind, 2005). This finding was true, independent of insurance coverage. Multivariate analyses indicated that, even after mental distress was established, both Hispanic and Asian-American women reported lower levels of perceived need for help than did their white counterparts. However, the study could not arrive at reasons for ethnic disparities and concluded that additional research was needed to develop cultural and gender- specific models that can inform service delivery. The investigators speculated that Asian-American and Hispanic women may be less likely to think of specialty mental health services as an efficient, relevant or culturally consistent response to their needs. A
qualitative exploration might have shed light on the issue of health beliefs and how they influence help-seeking.

Differences in rates of utilization of mental health services are known to exist in different ethnic minority communities (Tiwari & Wang, 2008; Sen, 2004), highlighting the need to understand help-seeking in specific cultural groups, rather than parceling groups together as "visible minority" or "ethnoracial" communities.

2.4. ii. Pathways to Care

Pathways to care involve traditional healing in many cultures (Beiser et al., 2003, Dyck, 2004). A quantitative study of people coming for treatment of mental illness in a hospital in Pakistan showed that both men and women sought traditional healing methods including homeopathy, naturopathy, Islamic faith healing and sorcery prior to availing mental health services (Farooqi, 2006). Proportionately more male than female patients used multiple traditional healing practices, and they sought the services of traditional healers more frequently. As this study did not explore reasons behind the choice, it speculated that this difference in help-seeking could be attributed to gender discrimination which restricted mobility among women, and also to taboos attached to women consulting male traditional healers. The investigators concluded that Islamic religious traditions and Pakistani cultural norms affected the health care choices of Pakistani psychiatric patients. This study is of particular interest to the present thesis as a proportion of the members of the Sri Lankan community that will be interviewed for the study will have been first diagnosed with depression while still in Sri Lanka, prior to immigration.
There is evidence from South Asian communities in the U.K. that non-Western healing approaches are used in conjunction with Western medicine (Waqar, 1991). There is increasing evidence for the pivotal role of family physicians in the pathways to care (Beiser et al., 2003; Shin, 1999; Steel et al., 2006; Hansson et al., 2010; Fenta et al., 2007, Papadopoulos et al., 2004). However, a majority of these citations are either quantitative studies or commentaries based on reviews of the literature. While they highlight the importance of the family physician, they do not provide insights into factors that make the family physician the service provider of choice. The present study will explore all the important players in pathways to care in the Toronto Sri Lankan Tamil community and seek explanations for expressed preferences.

2.4. iii. The Role of Mental Health Stigma

Research points to stigma and a culture of silence around mental health problems, which impacts help seeking (Sellers et al., 2006; Aghanwa, 2004; Conrad & Pacquiao, 2005, Sanchez & Gaw, 2007). Most studies consider stigma a static entity, thereby perhaps overlooking changes in cultural perceptions over time and the impact of such changes on stigma and help-seeking.

In a qualitative study of 5 African American women in the United States (Sellers et al., 2006), which used focus groups as a tool for data collection and employed dimensional analysis, depression was identified as a major problem in the community. Participants reported that, in the African immigrant community, mental health problems are highly stigmatized and they expressed fear that talking about depression could result in increased social isolation. The participants suggested that depressive symptoms that manifested in a somatic manner were less stigmatizing and would result in greater empathy from the family and other social support networks. While this reveals an important dimension regarding perceptions of stigma in an ethnocultural community, it does not directly verify the experience of stigma from people who have themselves experienced depression. Potential gender differences were not explored.
Other work on stigma consists of literature reviews (Sanchez & Gaw, 2007), quantitative studies (Aghanwa, 2004) or explorations of service provider perspectives (Conrad & Pacquiao, 2005).

2.4. iv. The Role of Religion

Understanding the role of religion in help-seeking and service utilization varies, as does the function of religion as a source of support. In the preceding sub-section on concepts of health the argument that belief in supernatural causation and supernatural interventions can impede help-seeking has been underscored.

In a quantitative analysis, data from structured interviews with 2,285 respondents for the Filipino American Community Epidemiological Survey (FACES) were used to examine help-seeking for emotional distress among Filipino Americans. Rates of help-seeking from religious clergy were comparable to rates from mental health professionals. However, higher religiosity, though associated with help-seeking through religious means, did not translate into lesser help-seeking from mental health professionals (Abe-Kim, 2005). This is a very important finding as other studies do not focus on such comparisons and make the (wrong) assumption that a preference for alternate sources of help diminishes utilization of mental health services. This warrants further qualitative exploration into how religion functions as a source of support. It is expected that exploring cultural sources of support in the Sri Lankan Tamil community will shed light on the nature of support religion provides.
Another large scale quantitative study of a random sample of 1600 adult Sri Lankan Tamils in Toronto (Beiser et al., 2006) found that around 1% percent reported going to a religious leader for emotional or stress-related issues. Other sources of problem relief that were identified were astrologers (5.5 percent), rituals (30 percent), wearing religious stones and bracelets (10 percent) and use of herbal or traditional medicine (15 percent). Religion, therefore, seems to be a source of support in the Sri Lankan Tamil community, but a qualitative exploration is required to understand the specific mechanism through which it functions as a source of support for people who have a mental illness and whether a reliance on religion inhibits help-seeking. Other studies have also found that religious beliefs have a positive effect on depressive symptoms (Jang et al., 2006; Bennedsen et al., 2006).

### 2.4. v. The Role of the Family

The importance of family support in protecting mental health has also been noted, especially in cultures that are collectivistic (Vega, 1995; Rivera, 2007; Francis, 2000). Interdependence, an externalized locus of control, and family involvement are significant cultural factors that has been held responsible for a better prognosis for people with psychiatric disabilities in developing nations when compared to Westerners (Stanhope, 2002).

Studies in North America on different ethnocultural immigrant groups have yielded contradictory findings. In a quantitative study using multivariate analysis that examined association among acculturation, family support and depressive symptoms in a sample of 850 South Florida Latinos, a significant relationship was found between acculturation and depression that was mediated by social support (Rivera, 2007).

Another qualitative study of an Asian Indian population in the United States, which used interviews with service providers in a psychiatric facility and a review of medical records as tools of data collection (Conrad & Pacquiao, 2005), presented a more ambiguous
picture. Family involvement was seen as both a strength and a barrier to help-seeking and service utilization. Family participation was crucial to history-taking because of the nature of illness in the patients; however family conceptualization of illness and its causes and perceived stigma led to delayed help-seeking, non-adherence to treatment regimens, and drop-out from treatment.

This suggests that the role of family can differ in different ethnic groups and can be influenced by factors such as perceived stigma.

2.4. vi. The Role of the Community

The model of migration contingencies and mental health (Beiser, 1990) suggests that social resources, such as family and ethnic community support, exert beneficial influences on mental health. The large scale quantitative analysis of Ethiopian immigrants in Toronto (Fenta et al., 2004) found a significant relationship between a strong ethnic identity and a reduced risk of depression. It suggests that, while like ethnic community provides practical advantages such as provision of employment in ethnic enterprises, the real value is in the sense of identity, belonging, and a sense of historic continuity that the community provides. Again, as this was a quantitative study, the actual ways in which the community functions as a source of support is not made clear. The support function of community has also been shown in South Asian cultures, where a reliance on one’s friendship networks for support and coping is noted as an important dimension of the collectivistic-communal bent of South Asian culture (Inman et al., 2007).
2.5. Gender in ethnocultural populations – The intersection of culture and gender:

There is increasing recognition of the need to look at the intersection of culture and gender factors in health (Andermann, 2010; Chandra & Satyanarayana, 2010, Yee & Chiroboga, 2007). Andermann (2010) stresses the need for cultural formulations that include a social construction of gender, a construction that varies among cultures and that could be an important key to understanding the determinants of health in the two genders. Chandra & Satyanarayana (2010) point to the fact that social roles and culture-specific issues have received little attention in gender research.

There are few studies focusing specifically on the gendered dimensions of culture and even fewer that address immigrant and refugee populations.

2.5. i. Gender-Informed Contributing Factors

Traditional gender role expectations, specific to individual cultures, can augment mental distress. An investigation (Shin et al., 2004) using a probability sample of 3312 women from 2 areas in Korea assessed the prevalence and correlates of depression. Depression in Korean women was found to be associated with pressures to conform to traditional role expectations as well as to marital status (Shin et al., 2004). A study in India found that economic hardship and marital disharmony contributed to the occurrence and chronicity of depression amongst women (Patel et al., 2002).

It should be noted here that, among cultures, there are differences in what is perceived to cause depression, even within the same gender. Studies from India and Korea (Patel et al., 2002; Shin et al., 2004) show that marital harmony and economic hardships are seen as contributing to depression in women; whereas in Sweden, one study found that women attributed their depression to internal factors such as personality and coping (Danielsson et al., 2009). In a study of women in Ghana, factors contributing to their psychosocial
distress included disempowering gender role expectations such as an inequitable gender division of labour, heavy workloads, and the "compulsory" nature of their work. In addition, in Ghana, women bear considerable financial responsibility for their children (Avotri & Walters, 1999), which contrasts with traditional gender role expectations in many other cultures.

2.5. ii. The Culture-Gender Interface in the Context of Resettlement

While cultural and gender interactions are important in understanding health, exploring the differential impact of this intersection in the context of resettlement adds another layer of complexity when working with immigrant and refugee communities.

A quantitative inquiry by Masood (2009) used nationally representative data from the National Latino and Asian American Study (Alegria et al., 2004) to explore correlates of distress in the South Asian American subgroup \((n = 164)\). A multiple regression model found significant gender differences. For women, lack of extended family support was related to higher levels of distress, whereas for men, greater conflict with family culture, and a lower community social position predicted higher distress scores. It was interesting that, for women, family factors alone accounted for the variability in distress, whereas, for men, extra familial factors were strongly associated with increased distress. Though the sample was from South Asia, only three individuals belonged to the Sri Lankan community. The majority were from India. A qualitative exploration would allow a more detailed analysis into gender factors that contribute to distress.

In a qualitative study of 5 African American women, it was noted that unmet expectations in the context of resettlement, parenting responsibilities, gender role strain, social isolation, racism and stereotyping contributed to depression (Sellers et al., 2006).
In a study of 150 immigrant Latinos (Hiott et al., 2006) who were in the United States for less than five years, cross-sectional data obtained through Spanish-speaking interviewer-administered survey questionnaires found that social marginalization was associated with more depression symptoms in men, and separation from family was associated with more depressive symptoms among women. The investigators recommend that, when caring for immigrant Latinos, questions about social isolation and separation from family may provide insight into stress.

In the context of immigration, stressors contributing to depression were found to be associated with conflicts in family relationships and these were based on gender roles and expectations as found in a qualitative study of Asian Indians in the United States (Conrad & Pacquio, 2005). This study, which focused on service provider perspectives and data from medical records, found that female patients experienced stress related to family relationships, gender roles, and hierarchy. Common sources of stress among males were socioeconomic and occupational expectations that were not matched by opportunities in the new environment. The study noted that gender role change as part of adapting to a new culture causes family conflicts. Traditional relationships between husbands and wives are challenged by the new social order.

With respect to employment outside the home, quantitative studies of ethnocultural immigrant communities have found that unemployment has a greater impact on the mental health of men than of women (Beiser et al., 2006)

2.5. iii. Help-Seeking

Service Utilisation

The literature points out that, in the context of immigrant and refugee communities, it is important to understand the intersection of culture and gender in help-seeking. It
underscores the importance of understanding cultural and health care contexts of home countries in order to be sensitive to gender differences in help-seeking. Douki et al. (2007) refer to the subordinate position of women in Arab communities and its impact on help-seeking behaviours and their outcome. Under the Taliban regime, women were disempowered and health care for women was restricted due to a number of factors: female health care professionals were very scarce, male doctors were not allowed to touch a female patient during examination and could examine women only in the presence of a male relative (U.S. Department of State Report, 1999; Feminist Majority Foundation, 1999). While much gender and health literature talks about greater service utilization by women in comparison to men, the global literature on women’s help-seeking varies. Hence, it is important to understand help-seeking by gender in specific cultures and to examine catalysts and barriers. While gender may be a significant predictor of seeking professional psychological help, it is important to understand that it is strongly impacted by an individual’s cultural background (Nam, 2010). Differences in roles and identities of women from their countries of origin to the countries of migration impacts health, health behaviour and help-seeking (Bhugra, 2004a; Bhugra, 2004b; Ekblad, 2009). In addition, while most studies have been consistent in finding more positive attitudes towards professional help-seeking in women, some findings suggest that this could differ in specific cultures. A study in the Hmong community did not find more positive attitudes towards seeking help from professional mental health care providers among women (Thao, 2006). Mexican American women have been shown to be more likely than Mexican American men to talk about mental health concerns with other women, their families and therapists (Castro, 1997). Both African American men and women, on the other hand, have reported positive attitudes towards psychotherapy (Healy, 1998).

A qualitative study among British South Asian women (Gilbert et al., 2004) which used data from focus group discussion found that stigma and the need to maintain family honour was related to a decreased uptake of services. Participants expressed anxieties about professionals maintaining confidentiality, especially when the family doctor was of
the same ethnic background as the client. However, the study did not include South Asian men so no gender comparisons could be made. This study also puts into question notions about cultural similarities between service provider and service user as invariably helpful in augmenting help-seeking.

The Role of Religion

Religious practices appear to modulate psychological distress in women but not in men. In a quantitative study in Montreal, multiple regression models were used to examine the relationship of religious practices to distress. It was found that attendance at religious services was inversely related to psychological distress for females, Protestants, Catholics, Filipinos and Afro-Caribbeans, but not for males, Buddhists and Jews (Jarvis et al., 2005). However, as this study examined diverse variables including ethnicity and gender, it is not clear whether gender differences with regards to the role of religion were more or less pronounced in the various ethnocultural populations that were studied.

In a qualitative study in U.K., where interviews from 10 South Asian women who experienced depression were analyzed, Hussain and Cochrane (2003) found that religion and prayers were included in the women’s coping strategies. The investigators concluded that a belief that mental illness was ‘God’s will’ could explain why South Asian women did not engage formally with mental health services. So, here, religion was a deterrent to help-seeking. This study was qualitative in design and involved interviews with depressed women from an ethnoracial community but was unable to make gender comparisons.

The literature on the intersection of culture and gender in mental health is sparse. There is little qualitative work that addresses how socialization processes and experiences in the home country shapes the culture and gender dimensions of an individual and how this impacts health and health behaviour, especially in the context of immigration. Such
studies as exist are largely focused on women, thus precluding gender comparisons between men and women.

2.6. Issues related to service provision:

2.6. i. Conceptual Challenges

Kirmayer (2007) notes that cultural concepts of the person vary between cultures, and this ranges from egocentric and individualistic concepts to more socio-centric, eco-centric and cosmo-centric views. Service providers need to understand how these varying world views impact notions of health and well-being, as well as being predictors of health and well-being.

Challenges to identifying distress, understanding cultural expressions of distress, and making appropriate diagnoses have been well documented (Bilu, 1995; Giel, 1995; Green et al., 2002). As Kirmayer (2006) elaborates, expressions of distress differ in different cultures; however, the diagnostic scales that are used have been developed in the Western world and this may lead to misdiagnosis. Hitchcock et al. (2006) call for the development of culturally-sound assessment tools that pay due attention to cultural variations in psychological constructs.

For example, in the traditional Euro-American model of depression, the focus is on the individual’s symptoms (Iyer, 2007) or ‘depression as a disease’ model (Karasz, 2005), whereas studies with ethnic minority populations suggest that it is the social factors that are seen as important in depression, thereby leading to a suggestion that social dimensions of depression be focused on while working with visible minority populations (Sellers et al., 2006).
2.6. ii. Service Provider – Service User Interactions

Studies reveal considerable challenges in service provider–service user interactions. In a study in U.K. where Chinese immigrants were found to underutilize services in comparison to other ethnic minority groups, communication with health care professionals was hindered by language and lack of shared concepts pertaining to health and illness. These delayed diagnosis and deterred access (Green et al., 2002). This qualitative study utilized a purposive sample of 42 Chinese women, all of whom had visited a family doctor. These women were recruited through primary care and secondary mental health service providers. In depth interviews found that these Chinese women were extremely hesitant to communicate with White service providers as they could not express themselves due to language barriers. They also felt that White service providers would not understand the issues of Asian women. However, this study does not focus on the barriers faced by men nor does it reflect the views of service providers.

A study of Somali immigrants in Minnesota found that Somalis identified family needs as important while service organizations did not (Robillos, 2001). These differences could arise because of differing world views: individualistic vs. collectivistic/ego-centric vs. socio-centric. Such disparity can translate into differences in determining goals and needs during the help-seeking process (Hussain, 2006; Robillos, 2001). In a qualitative study undertaken in the U.K. (Hussain, 2006), Pakistani–Punjabi immigrants who had sought mental health services, primary care physicians and traditional healers were interviewed, using focused narrative questioning. Data analysis was undertaken using the constant comparative method (Silverman, 2000). Findings revealed differing expectations in terms of treatment outcomes between the immigrants and the physicians due to cultural differences. Communication difficulties were also recorded. Thus, this simultaneous exploration of service providers and service users yielded important insights.
However, there are studies that indicate that belonging to a similar culture does not automatically translate into better service provision. Bhui et al., (2002) notes that family physicians may not be adept at diagnosing mental health problems within their own cultures. Cultural stereotypes and cultural filters of service providers may lead to the overlooking of symptoms of depression in their own communities (Burr, 2002).

2.6. iii. The Notion of Cultural Competence

The most used definition of cultural competence is that proposed by Cross et al., (1989), which defines cultural competence as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or professionals to work effectively in cross cultural situations.

A more recent definition from the United States Department of Health and Human Services (Office of Minority Health, 2005) defines cultural competence as the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviours, and needs presented by consumers and their communities.

The notion of cultural literacy is embedded in these definitions. The cultural literacy approach focuses on the need for service providers to develop knowledge and understanding of the cultures and culturally determined health beliefs and behaviours of their patients, which help the health care provider and client to work together effectively (Leininger, 2002, Alaggia & Marzialli, 2003). Williams (2006) has noted that the cultural content used to educate service providers is often a static representation of a culture that serves to reinforce stereotypes. Cultures are dynamic and need to be understood as they change — gender roles being a prime example of a rapidly changing phenomenon.
Culturally Competent Interventions

An evaluation of a Cultural Consultation Service in Montreal (Kirmayer et al., 2003), which documented the service process using a participant observation method, found that cultural consultants and cultural brokers with in depth knowledge of immigrant and refugee communities were particularly effective in facilitating assessment, service utilization and efficacy. It was found that issues that were commonly raised were related to variations in family systems, gender role variations, impact of war and torture, health care system of home countries, use of traditional medicine and the importance of religious practices. The study noted with surprise that explanatory models of illness that were central to the literature in medical anthropology did not warrant much attention. The authors thought that this could be explained by the pluralistic models of illness that many communities possess. This study reflects the importance of cultural knowledge and literacy in service delivery. This is corroborated by a report of the characteristics sought after in interactions with service providers: the ability to bond with the client, competence and knowledge, especially of cultural and religious background. These characteristics contributed to client satisfaction in community mental health services (Mason et al., 2004). In a study of the Filipino community, it was found that service provider characteristics such as compassion superseded gender preferences. Filipinos expected service providers to actively engage with them and expected familiarity and close affiliation with the service provider (Plummer, 1995, Sanchez & Gaw, 2007). A commentary on Asian American health focusing on South East Asians (Kramer et al., 2002) points to the fact that Asian Americans do not view the physician-patient relationship as a partnership; rather, the physician is considered the authority. The commentary notes that Asian patients will answer questions but are not likely to raise issues, and they will tell the physician what they think he or she wants to hear. These issues have not been explored in the Sri Lankan community.
Many researchers believe that visible minority communities benefit most from approaches that address the need for mutual support and the sharing and processing of common experiences (Dossa, 2002; Simich et al., 2003). This supports the use of group therapy. The incorporation of traditional cultural practices into mental health services and the validation of religious practices and culturally relevant altruistic practices are recommended as they have been found to support recovery and resilience (Rothe et al., 2002; Helsel & Mochel, 2002; Mollica et al., 2002).

A number of stressors that immigrants deal with are social, and these tend to be exacerbated whenever there is a collectivistic orientation, with a focus on the family and community. Hence, case management services as part of mental health services have been shown to be beneficial to ethnoracial communities (Andres, et al., 2005; Guarnaccia & Lopez, 1998; Kim et al., 1996).

Many visible minority communities, like the Latino community and the African American community, access primary health care and family physicians more than they do mental health services. The importance of developing capacity amongst primary health care has therefore been highlighted (Dupree et al., 2005; Vega et al., 2001; Wells et al., 2001; Gravel & Legault, 1996).

In a qualitative study of family physicians working with diverse communities, three common strategies were found: insistence on patient adaptation, physician adaptation, and negotiation of a mutually acceptable plan. These strategies were not mutually exclusive. The authors suggest the development of a framework to help general practitioners work with diverse populations (Rosenberg et al., 2007).
Recommendations found in many studies include employing bilingual staff, creating and translating culturally relevant health education material, utilizing culturally-relevant assessment tools and protocols, and training staff (Wilson, 2006; Chigier & Nudelman, 1994; Kirmayer et al., 2003). The need to go beyond the notion of culture located at the level of ethnicity, and understand and address cultural and operational frameworks of organizations, carers and clients has been highlighted as an affirmative step towards culturally competent service provision (Mallet & Cole, 2002; Wilson, 2006).

2.7 Tamil mental health:

There have been very few studies in Canada regarding the mental health of the immigrant Sri Lankan Tamil community. This subsection explores findings from studies in Canada and elsewhere to understand culture and gender in the context of the mental health of Sri Lankan Tamil immigrants. Due to the paucity of research in the area, this section will not attempt to delineate literature into specific headings, but will explore concepts and findings from studies that appear relevant.

The Tamil refugee experience has been marked by loss, including death of family members, loss of livelihood and property, and displacement (Mills, 1993, Beiser et al., 2003). Among Tamil refugees, one study found that the experience of torture was the most powerful predictor of chronic post traumatic stress disorder (Silove, 2003). A salient factor that predicts anxiety is the apprehension of leaving family members in danger zones in Sri Lanka (Beiser, 1991; Mills, 1993).

Alluding to the protective dimensions of cultural factors, Mills (1993) states that "Tamils are blessed with the identity and a cohesion of a millennia-old classical culture, understood better by some than others, but which is part of the awareness of all." She
postulates that Tamils abroad continue to live within extended families, share reciprocal relationships and have longstanding social or group connections, all of which are protective of mental health. While the assumption is logical that close family and community ties are present and provide the required support, actual findings might run contradictory to expectation. Hence the role of the family and the larger Tamil community warrants further exploration.

A qualitative participatory research study of ethnoracial seniors in the Sri Lankan Tamil and Chinese communities in Toronto used a grounded theory approach and derived data from 17 focus groups, including ethnoracial seniors, families, and service providers (Sadavoy et al., 2004). This study found barriers related to the mental health service system in terms of inadequate numbers of trained and acceptable mental health workers in the Tamil and Chinese communities, inadequate capacity in ethnoracial organizations and lack of readily available information regarding services. Additional barriers to access included limited awareness of mental disorders, limited capacity to negotiate the current system, disturbance in family structures, decline in individual self-worth and fear of rejection and stigma from the community. In another quantitative study of mental health in the Tamil community, the findings also indicated that the elderly worked more than they would have preferred, as they felt obliged to aid their children. This invariably became a source of stress (Beiser et al., 2006). These first studies support the premise that the role of the family and community needs to be further explored.

The large scale quantitative study on mental health of Sri Lankan Tamils and barriers to care (Beiser et al., 2006) in which this researcher worked as a research coordinator involved a survey of a random sample of 1600 adult Tamils from the general population in the Greater Toronto Area. This was a participatory research project and enlisted active participation of a Project Advisory Committee comprising service providers working with the Tamil community. The survey involved the administration of a standardized questionnaire, which included the Composite International Diagnostic Interview along with other tools, and questions specifically tailored to the Tamil community. The tool
was administered in face-to-face interviews conducted by trained bilingual (Tamil and English) interviewers from the Sri Lankan Tamil community. With regards to depression, it was found that Tamil women had significantly higher rates of depression than Tamil men. Men’s employment and marital status helped to predict the occurrence of depression but these factors were less predictive in women. The study also found that specific health beliefs such as the “problem will go away by itself” or “I want to solve the problem on my own” impacted the decision to seek help for health related problems. Regression analysis revealed that female gender and duration of stay in Canada of less than 10 years were significantly related to a preference for a Tamil speaking service provider. The study also found a much higher propensity for seeking help for physical as opposed to psychological problems (however, this was only based on a hypothetical question), regular contact with the family physician, and underutilization of mental health services.

Working on this study helped to formulate questions that the researcher has sought to explore in this dissertation.

Gender dimensions in the Sri Lankan Tamil community have been examined predominantly with reference to domestic violence (Mason et al., 2008; Guruge et al., 2008). A qualitative study (Guruge et al., 2008) that used focus groups and interviews with Sri Lankan Tamil women, where data was analyzed used inductive thematic analysis (Bryman, 2001), found significant cultural factors in the experience of women in the context of resettlement. The study found that older Tamil women in Canada were subject to various forms of threat and control coming from the community. These pressures influenced decisions such as leaving (or not) the perpetrator of domestic abuse, living alone, engaging in paid employment, or refusing to engage in unpaid work (Guruge, 2008). Such decisions loom large in a patriarchal society where the dominant belief is that women must sacrifice their lives for the benefit of children and grandchildren.
2.8. Summary:

A review of the current literature identifies 4 major gaps that the study described in this dissertation hopes to fill:

- There are few studies that address the intersection of culture and gender in the field of mental health in ethnocultural visible minority populations.
- There is a dearth of literature that simultaneously addresses the viewpoints and experiences of both service users and service providers in the mental health sector.
- There are very few Canadian studies on the Sri Lankan Tamil immigrant population despite the fact that the largest Tamil Diaspora resides in Toronto.
- While there is an evolving literature base that is qualitative, the majority of studies that inform the field are quantitative. Specifically, qualitative work from Canada which looks at mental health in ethnocultural, visible minority populations is very limited.

The review also shows us that some cultural groups - South East Asians, Hispanics and African-Americans, have been more studied than others. In the United States, studies on the South Asian population have focused on the East Indian population, which shares some commonalities in terms of orientation and values with the Sri Lankan population, but is very different in terms of reasons for immigration, immigration processes, and life experiences. There has been very little research on the mental health of the refugee Sri Lankan Tamil population, which has a presence of around 250,000 in Canada. There has been only one large-scale quantitative survey of mental health needs of the Sri Lankan Tamil population in Toronto (Beiser et al., 2003). Other studies have focused on senior mental health, care giving, and domestic violence (Sadavoy et al., 2004; Guruge et al., 2008). While there is research related to mental health that might include Tamils as part
of a larger visible minority population group, studies exclusive to the Tamil community are sparse.

While help-seeking and pathways to care have been the focus of many studies, little has been explored in terms of ongoing help-seeking and continued engagement in care and the interface between the multiple dimensions of help-seeking. Similarly, expectations from treatment have not been an integral aspect of research on ethnoracial populations.

While underutilization is reported widely amongst ethnoracial populations, gender research shows greater rates of utilization, and more favourable attitudes towards mental health services by women in comparison to men. However, many studies are restricted to women and studies that look at men and women simultaneously usually use quantitative methodology. The combined effect of gender and culture in ethnoracial communities on the experience of mental illness and help-seeking needs to be further explored. Hence, this study will undertake a closer examination of the intersection of culture and gender.

The literature on service provision speaks to the challenges faced by both service providers and service users in a multicultural context and alerts one to the importance of cultural competence. System gaps have been explored but there are few studies that simultaneously look at both client and service provider perspectives. These studies demonstrate that a simultaneous analysis is crucial to understand the influence of culture and gender in an immigrant population, and to check whether this reality is reflected in service providers’ perspectives and practices. Such a view will provide a real time analysis of the situation, and strengthen clinical and policy recommendations as it will factor in the experience of two stakeholder groups crucial to health care. There are no previous studies that have examined this in the Sri Lankan Tamil population.

Finally, it is the premise of this thesis that qualitative research, provides better opportunities to describe cultures and characterize their needs than do quantitative studies (Hong, 2001).
Chapter 3

Research Design and Methods

“The idea that multiple realities exist and create meaning for the individuals studied is a fundamental belief of qualitative research.”

This chapter elaborates on the research design and methods employed to address the overarching question that the study explores:

How do cultural and gender factors influence mental health, health beliefs, health behaviour, help-seeking and treatment expectations for mental health problems in newcomers who are members of an ethno-cultural, visible minority population?

This qualitative study employed a comparative design with two points of comparisons pertinent to the Sri Lankan Tamil population — gender and a comparison of service provider perspectives versus the perspectives of community respondents who self-identified as having a diagnosis of depression.

The constructivist paradigm (Mertens, 2005) based on the belief that reality is socially constructed was used in this exploration and, true to constructivism (Creswell, 2003), the exploration began without a firm theoretical framework in mind.

The Long Interview Method, set within the constructivist paradigm, was employed as the choice tool for data collection and analysis based on the fact that this research method does not position the exploration "on a clean slate" (McCacken, 1988) with respect to the researcher. Rather, it encourages the researcher to embody previous learning and
experience, as well as the results from previous studies into the context of the current study to enhance conceptualization of the study and encourage expansion into areas that are yet to be explored, while also providing a substantive backdrop and support for such an expansion. The researcher’s previous knowledge and experience are incorporated into the study, not as a "bias", but as an enrichment, which can, of course, be challenged.

3.1. Rationale for the study design and method:

Prior to this study, the investigator had the opportunity to work as a research coordinator on a large scale research project funded by CIHR on mental health issues in the Sri Lankan Tamil community in the Greater Toronto Area (Beiser et al., 2003). This was a quantitative survey of 1600 adult Tamils. Data analysis showed clear gender differences with regards to help seeking, but did not answer the question "why" or "how"? This warranted a qualitative exploration.

Also, as a student, the investigator had the opportunity to conduct a "mini study" (Leininger, 2002) as part of her course in qualitative research methodology using the grounded theory approach (Corbin and Strauss, 1990). This study looked at the experiences of mental health professionals working with cultural groups other than their own. While the study yielded rich insights, they were all being viewed from the service provider perspective. A simultaneous inquiry on culture and gender influences, with both community respondents and service providers, using a qualitative method was, for the purposes of health promotion and service planning, considered more appropriate.

The grounded theory approach requires "bracketing", that is, the conscious suspension of one's knowledge or bias. It involves temporarily relinquishing one's own perspective so as to enter the participant's world (Bowers, 1988; Hutchinson, 1993). It is also
recommended that an extensive review of literature be avoided before beginning the study (Lincon and Guba, 1985; Hickey, 1997). The investigator sought a method that would allow her to maintain the rigour that the grounded theory approach afforded in terms of coding and data analysis but would also utilize to advantage her prior knowledge, learning and expertise. Hence the decision to employ the Long Interview method. Many qualitative researchers have highlighted the role of the investigator as instrument (Cassell, 1977, Miles, 1979, Graham et al., 2002). The Long Interview method clearly articulates how this can be achieved.

3.2. The Long Interview Method:

The long interview method is an intensive qualitative approach that can uncover and describe complex realities and situate them in larger social processes (Alaggia, 2004). It requires an intensive questioning of respondents selected for their special knowledge, experiences and insights (or ignorance) of the topic under study, including an understanding of the respondent's world view in his or her own language (Woodside & Wilson, 2006).

The long interview method enables the researcher to accomplish many ethnographic objectives without committing the investigator to intimate, repeated and prolonged involvement in the life and community of the respondent, as would the method of participant observation (McCracken, 1988). While ethnographic researchers strive to study cultures from an emic approach (Williamson, 2009), the long interview method helps the researcher study a cultural group from the close outside, using a sharply focused, rapid, and highly intensive interview process. As stated by McCracken (1988), the long interview is designed to give the investigator a highly efficient, productive, stream-lined instrument of inquiry, while allowing the flexibility of an open-ended questionnaire.
3.2. i. The Long Interview Four Step Method of Inquiry

1. Review of analytic categories: The method involves a detailed and focused review of literature that sharpens the researcher’s capacity for surprise (Lazarsfeld, 1972), when the data conflicts with expectations. The review of literature informed the development of the interview guide as it helped establish an inventory of categories and relationships that the interview needed to investigate.

2. Review of cultural categories: This was a challenging phase for the investigator as it involved using the self as an instrument of inquiry. While not being of Sri Lankan Tamil origin, I am of South Asian origin, from the Southern part of the Indian peninsula, thereby sharing a partial historical, cultural and linguistic background with the respondents. In addition, I have worked closely with the Sri Lankan Tamil community in Toronto, both in the capacity of researcher and mental health professional. From 2006, I was also involved in direct mental health capacity building, post-tsunami in Sri Lanka. This gave me a very good understanding of the context from which immigrants and refugees from Sri Lanka had come. Fluency in Tamil facilitated communication. In addition to my work with the Sri Lankan Tamil community, I am viewed as a credible resource in the fields of cultural competence and diversity, and have been called upon on many occasions to make presentations, conduct workshops or consult with organizations on these issues. The cultural categories phase of the research process gave me an opportunity to take advantage of my knowledge and acquaintance with the Tamil community and the topic of the thesis and position my knowledge as objectively as possible within the research process. I examined my assumptions and associations with regard to the topic (Merton et al., 1956). I recalled instances when, in the past, my expectations and assumptions about what I would find had been violated (Agar, 1983), thus preparing myself for surprise and learning.
Example:

One of my assumptions in working with ethnocultural visible minority populations is that culturally sensitive outreach will aid help-seeking and service access. While this has been affirmed in many instances of my professional experience, there was one instance that threw this assumption totally off balance. It was when a potential respondent was contacted (for an earlier study that I was involved in as research coordinator) by telephone by one of the interviewers to seek consent for study participation. It was found that this Tamil speaking individual was living alone and was highly delusional, with delusions of persecution. All effort was made to stay connected with the person and offer help. After various options were offered, the individual wanted to see a non-Tamil psychiatrist with the interviewer acting as interpreter. The services of a cultural psychiatrist were sought and confirmed. However, on the day of the appointment, the person declined to attend, as she was leaving for Sri Lanka to meet with a god-man to deal with this issue. Friends had encouraged her to do this. So while my initial assumption was challenged, the event brought up a new line of inquiry — what is the role of significant others in help-seeking? What are some traditional conceptions about mental health issues? Besides modern medicine, what else needs to be factored in for effective outreach? This helped in the construction of the interview guide.

Reviewing cultural categories helps establish distance. In other words, the investigator begins to understand the cultural categories and assumptions he or she uses to understand the world, thereby becoming capable of moving away and developing a long range view, when warranted. McCracken (1988) states that, while certain qualitative research methods encourage investigators to treat their experience as bias and set them aside, the long interview uses the experience to understand and explicate and views it as essential intellectual capital without which analysis is not complete.
3. Discovery of cultural categories: This is the phase where the interview guides are formalized and interviews begin. The interview guide is set out so that it captures biographical details that help situate simple descriptive details of a person’s life. Thereafter the interview guide is shaped to aid respondents tell their story in their own language. There are “grand-tour” questions (Werner and Schoepfle, 1987) which are opening, non-directive questions, which can be followed up with “floating prompts” (Churchill, 1973). The method identifies different prompts ranging from non-verbal to verbal prompts. However, one may need to use “planned prompts” to elicit certain information that one is looking for. For example, in trying to understand roles and responsibilities in childhood and adolescence, one of the focal points is to look for gender differences. So in addition to the “grand tour” question, a prompt such as “were there differences in the responsibilities between brothers and sisters in your family” might be used. This is a contrast prompt, but was used only if such material failed to surface spontaneously. So, in the final interview guide, there is a set of biographical questions, followed by a series of question areas. Each has a grand-tour question and floating prompts to be used readily and planned prompts that are banked, to be used only if the need arises. Appendices B and C shows how the interview guide was designed in this framework.

The guide was then translated into Tamil and back translated into English. The Tamil version was then further refined.

This is followed by the interviews. This phase involves selection of the interview participants, and is not governed by any sampling rules. The one criterion in the long interview method that could not be accommodated was that the respondents should all be perfect strangers to the interviewer. While this was not a problem with the community respondents, who all turned out to be perfect strangers, my close contact with the service providing community did not allow for the same
anonymity. While I had no previous contact with two service providers, the remaining six were known to me. This proved to be unavoidable and my identity as a mental health professional known to other service providers might have enriched the interviewing process (Graham et al., 2002). Details of study recruitment and participation will be addressed in the following sections. The interviews ranged between two and two and a half hours for most interviews and were conducted in the language of choice of the respondents – Tamil or English.

4. Discovery of analytic categories: The long interview method presents a rigorous approach to analysis, which allows both for consistency, reliability (Kirk and Miller, 1986) and flexibility. A verbatim transcript of each interview was created. The Tamil interviews were translated and transcribed into English. Reliability of translation was ensured by having a certified translator translate sections of audio tapes already transcribed by the investigator. This followed a five stage analytic process where, at the first stage, observations were created from utterances; these observations were then developed according to the evidence in the transcript and previous literature and cultural review. Then the connections between observations were analyzed, and then these observations were subject to collective scrutiny. From this, inter theme consistency and contradictions emerged. The patterns and themes, as they appeared in all of the interviews were subjected to a final process of analysis. Through this process, the investigator moved from data to observations to meta observations, finally leading to higher level conclusions. This is presented in detail in the findings and discussion sections of the thesis.

The long interview method thus ensured that the richness of the qualitative data was captured in a manageable manner, and offered a platform that allowed rigorous analysis, leading to the emergence of themes and higher level conclusions.
Figure 1: Long Interview Method: Four Part Method of Inquiry

Stage 1
Review of analytic categories & interview design

Stage 2
Review of cultural categories & interview design

Stage 3
Discovery of cultural categories & interview

Stage 4
Discovery of analytic categories and write up

Review Processes

Analytic Data

Discovery Processes

Cultural Data

(Source: McCracken, 1988)
3.3. The Process of Data Collection:

Twenty-four interviews were conducted, at one interview per respondent. The sample was comprised of 8 men and 8 women from the Tamil community who have experienced depression, and 8 service providers who serve the Tamil community.

3.3. i. The Tool

As stated in the previous section, the Long Interview was the tool of data collection. The interviews with community respondents explore the experiential continuum of problem identification, help seeking, and treatment for depression, in order to identify cultural factors and the gendered experience of culture in the process. It also looked at childhood experiences, socialization and the conceptualization of health to understand the influence of culture and gender on mental health and related help-seeking. A semi-structured interview guide was created for this purpose, one for community respondents and one for service providers (Appendices B and C).

The interviews with service providers also used the Long Interview as the tool of data collection. The semi-structured interview guide enabled the exploration of culturally informed service providers’ perspectives of mental health problems in the Sri Lankan Tamil population and their optimal treatment, as well as cultural factors influencing the client-provider relationship, and the treatment process through the service providers’ lens.
3.3. ii. Sample size justification

According to the long interview method, a sample size of 8 in each category is sufficient to reach the data saturation point (McCracken, 1988). This is because the long interview method requires both extensive and exhaustive in-depth interviewing. So in all, 24 interviews were conducted, with 8 in each subcategory.

3.3. iii. Criteria for participant selection

Community Respondents:

For the individual interviews with community members, the sample was comprised of 16 adult respondents from the Tamil population (8 men and 8 women). All the respondents were individuals who self-identified as having suffered from depression.

Inclusion Criteria:

1. Adult Tamils over 18 years of age who provided written consent to participate in the study
2. Length of stay in Canada between 2 and 10 years
3. Self-identified individuals with a diagnosis of depression
4. Tamil or English speaking

People who were experiencing symptoms of depression at the time of the study were not excluded. The study was explained to them in detail, the nature of questions and their purpose was highlighted so that the individuals could make an informed decision regarding participation. Irrespective of whether they were experiencing symptoms of depression...
depression or not, the focus was on their cognitive capability to understand the nature of the study and provide informed consent. Participation in the study was through a process of self-selection. The diagnosis of depression could have been made either in their country of origin or in Canada. The important factor was that the diagnosis has been made. However, it was ascertained with the participants about where the diagnosis had been made. Indigenous beliefs about what constitutes depression did not affect selection of study participants as all participants had been medically diagnosed with depression.

*Service Providers:*

Interviews were conducted with eight service providers working with the Tamil community. *Service Provider* here refers to those providing frontline mental health services to the Tamil population. An attempt was made to interview both service providers belonging to the Tamil community and those who did not belong to the Tamil community.

3.3. iv. Recruitment

*Community Respondents:*

The respondents were recruited from the larger community through posting flyers in doctors’ offices, settlement centres, accident claim centres and community health centres (Appendix A). The flyers were translated into Tamil. The investigator also sent flyers to service providers and their networks, so that they could post it in their specific organizations. The flyer had the name of the investigator and contact information so that the respondents could contact the investigator directly. On first telephone contact, the investigator confirmed the inclusion and exclusion criteria, explained the study, and sought consent. This was followed by arranging a convenient time and place for interview.
Both Tamil and English speaking members of the Tamil community were recruited as the investigator is fluent in both languages. This permitted insights that interviews in the respondent’s native language brought to the data collection.

To ensure equal numbers for men and women, concerted outreach was undertaken. As respondents volunteered for the study, a count was kept on the number of male and female respondents. When 8 female respondents were interviewed, then a couple of others who contacted the interviewer were informed that the interviewing process in the study had concluded for female participants. At this point, participation for two male respondents were required. So the service providers were contacted again and asked to let community members specifically know that participation of male members was required. This helped recruit the male participants required.

Insights into the actual process:

Very few potential participants called the investigator directly. When recruiting from ethnocultural, newcomer communities, participants usually feel more comfortable being contacted rather than making the contact. The calls most often came from service providers who were approached by the community respondents about the flyer information. Once the service provider explained the study to them and told them that they knew the investigator as a professional, then, there was a request that the service provider pass on their contact information to the investigator, so that she could call them. Sometimes, would-be participants would call her directly after having checked her out with the service provider. So the investigator received calls from doctors’ offices, family health centres and settlement service organizations. It was interesting to note that, while many of the women accessed her through these multiple sources, half the men who were either referred or called her directly came through the accident claim sector in one form or the other. There was also a snowball sample of sorts that occurred with the
recruitment. One service provider had told a group she was conducting about the study and distributed the flyer to them. One woman participant called the investigator and offered to participate. She also encouraged another acquaintance of hers to participate in the study. As the flyer was widely distributed, participants were from different neighbourhoods in Toronto – Markham, Scarborough and St. Jamestown were where the majority of participants came from as these neighbourhoods have a significant Tamil population.

Two women who had initially agreed to participate later contacted the investigator to refuse participation as their husbands had not given them "permission." It was difficult to verify whether this was a fact or whether it was a "culturally sanctioned" excuse to refuse participation. Also, a youth who was living with his parents confirmed his participation through a service provider. Then the investigator called and confirmed the date and time. Subsequently the mother of the young man called to say that she was not giving him permission to participate, as he was getting better and she did not want him to be reminded of his illness. Though efforts were made to explain the nature of the study and the minimal risks involved, she was adamant in her refusal.

Another interesting factor was that many of the community members who initially offered to participate were living in Canada for over 10 years. Hence they needed to be excluded from the study. Service providers also said that recruiting people who were new to Canada was a challenge as most people who were availing themselves of services had been in Canada over 10 years.

_Service Providers:_

Recruitment of service providers was through a process of purposive sampling. They were all involved in mental health and related services. They were from health centres,
community mental health organizations, hospitals and private practice (three psychiatrists, one community development worker, one case manager, one mental health clinician, one family physician and one manager of domestic violence services). As expected, service providers initially identified and interviewed connected the researcher to other mental health service providers thus providing a snowball sample. Five male and three female service providers were interviewed. Four belonged to the Sri Lankan Tamil community and two belonged to the Indian Tamil community while 2 were non-Tamil speaking. As Tamil service providers are limited in number, special effort has been taken to protect their privacy. Hence, in Table 4 describing service provider characteristics, the distinction between Indian Tamil and Sri Lankan Tamil has not been made. The ages have also been changed.

3.3. v. The Actual Interview:

Community Respondents:

The interviews with the community respondents took around two to two and a half hours on average. With the exception of one interview, all community respondent interviews were conducted in Tamil. Most of the interviews with women were at their homes, doctor’s offices or health centres. Men preferred to be interviewed in their homes or in the home office of the interviewer. They all asked that they be picked up and dropped off if interviewed in the home office of the interviewer. Before commencement of the interview, written consent was sought. A consent letter elaborating the nature and purpose of the research was used for obtaining written consent of the respondents (Appendix D). There was no withdrawal of any participant from the study. However two participants did not wish to divulge their income details. All interviews were audio taped. An honorarium of $30/- was offered to the respondents at the end of the interview.

Service Provider Interviews:

The service provider interviews lasted for one and a half to two hours on average. They were mostly conducted in the offices of the service providers. The interviews were all
conducted in English by choice of the respondents. Written consent was sought prior to the commencement of the interview. A consent letter was used for obtaining their consent as well (Appendix E) Service providers who were fluent in Tamil sometimes switched between Tamil and English although English was the predominant language through the course of the interview. The interviews were very animated and open as they were relating to the investigator, both as a researcher and a mental health professional. The investigator tried to maintain a “distance” and sought clarification when understanding was assumed on the part of the respondent. For example if a service provider said “You know how it is”, the investigator would respond by “Please could you elaborate?” There was no honorarium offered. The service providers were thanked for their time and participation.

3.4. Data analysis:

As explained in Step 4 of the Long Interview Method, the analysis of interview data involved careful examination of interview transcripts in order to identify common themes and trends and lead to the next stage of coding and analysis. In addition, the field notes maintained by the researcher also informed the analysis. Field notes were made either during the interview in the form of jottings of certain phrases or observations, and/or recorded as soon as possible after the interview. No editing was undertaken during the recording of the field notes (Crabtree & Miller, 1992). The field notes were used to record data that would not be expected to emerge out of the transcribed interviews.

Verification of data:

The accuracy and reliability of translated transcripts was verified by having a certified translator translate sections of audio tapes from different interviews and verifying them against the original transcription and translation by the investigator. Data triangulation
was possible as the comparative design enabled comparison of results from three different data sources (Mays and Pope, 2000), namely community respondents and service users, and men and women amongst community respondents. This encourages comprehensiveness and encourages a more reflexive analysis of data. Also the very nature of the Long Interview method, which allows for the positioning of the researcher's knowledge and experience in a manner that objectively enhances the analytical process, also adds to the validity of the study. Deviant case analysis which is a process of validation in qualitative research is an intrinsic element of the Long Interview method.

3.5. Ethical Considerations:

Ethics Approval:

The study received REB approval from the University of Toronto in 2005, with subsequent annual renewal approvals.

Risks and Benefits:

The only anticipated risk was that the community respondent might get emotionally overwhelmed during the interview while talking about their experiences of depression. However, every attempt was made to minimize this risk by: a) ensuring no pressure on the respondent to participate in the research project. b) availability of a list of mental health services for the Tamil community if needed.

The researcher is a trained mental health professional with both clinical and research experience. She is a Registered Social Worker with the Ontario College of Social
Workers and Social Service Workers, hence able to determine whether mental health resources were needed. In case of an emergency, it was planned that the researcher would accompany the person to a hospital emergency department in the hospital or call 911, as seen appropriate. The expertise of supervisor Dr. Mary V Seeman, psychiatrist, was to be utilized to decide on appropriate intervention and follow-up.

While risks were minimized through participant self selection into the study, and having an interviewer who is a trained mental health professional who can respond to crisis if it arises, benefits to participants were the opportunity to speak about their experiences and making an important contribution to their community in terms of increasing need awareness and helping create culture and gender sensitive mental health services.

*Privacy and Confidentiality:*

The interviews were conducted in settings that the respondents were comfortable with to ensure privacy.

The audiotapes were destroyed as soon as transcription of the interviews and verification had been completed. Data will be kept for 6 years after completion of the research in accordance with U of T policy. The data is password protected. Data is assigned identification numbers instead of names or initials. The list of people interviewed with their names and contact information is kept under lock and key, in a separate location offsite, known only to the researcher. The researcher, Nalini Pandalangat and the supervisor Dr. Mary Seeman are responsible for the data. Only the investigator and the supervisor have access to the data. In terms of verbatim quotes, all identifying information (place, name, initials, affiliations and certain idiosyncrasies or phrases that might typically identify an individual) have been removed. Lengthy quotes which might have inadvertent identifiers are avoided. Thus special effort has been taken to protect the identity of the participants.
Conflicts of Interest:

The investigator has no conflicts of interest. While service providers were known to the investigator, there was no working relationship or line hierarchy that would have resulted in a conflict of interest at the time of the interview.

3.6. Summary:

This is a qualitative study which employs a comparative research design with gender and respondent groups (service provider vs. community respondents) being the two points of comparison. The study employs the Long Interview method, which is a highly refined and intensive tool that has the capability to elicit and manage extensive qualitative data in an efficient manner. It also allows for the objective application of the knowledge and experience of the investigator to the study. It has inherent data validation qualities which makes it a method of choice.
Chapter 4

Results and Findings

“We shall not cease from exploration, and the end of all our exploring will be to arrive where we started and know the place for the first time”

T.S.Eliot (n.d)

This chapter presents the findings from interview data and field notes obtained from interviewing male and female Sri Lankan Tamil respondents who self-identify as having been diagnosed with depression well as service providers who work with the Sri Lankan Tamil Community.

A brief description of participants is followed by the presentation of findings under the following major themes:

- Situating the Tamil Community — A contextual understanding
- Resettlement and its challenges
- Social Dimensions of health and illness
- Social Dimensions of help seeking, engaging in treatment and support
- Service systems and Service delivery

The sections will be informed by findings from the community respondent interviews and service provider interviews. Verbatim quotes will be used to illustrate the findings. Each theme will have sub-themes.

Culture and gender and their interactions are common factors that weave through all the themes and will be the common thread running across the entire section.
Participant Profile – Community Respondents:

8 men and 8 women who self-identified with depression were interviewed. All of them were recent immigrants to Canada, with a length of stay ranging from two to ten years. Except for one male, who had his post-secondary education here, all others had limited fluency in spoken English. Most men and women had limited education. The respondents were from Scarborough, Markham, and the St. Jamestown area. These neighbourhoods have a high density of immigrant visible minority population, with a significant proportion of Sri Lankan Tamils living here.

Male Community Respondents:

As seen in Table 1, the age of male respondents ranges from 26 to 63 years of age. Most of the respondents fall into the low to middle income range with income details not available for two respondents. Of the eight respondents, five are unemployed and three are partially employed. Three of the eight respondents are unemployed following an accident. Five men are single and three are married with children. The age of children range from 4 to 30. Five of them are on some form of social support while the support details for one respondent are not known. One man was sponsored to Canada by his wife.

Female Community Respondents:

As seen in Table 2, the age of female respondents ranged from 31-49. Most of the respondents fall into the low to middle income range. Of the 8, three are divorced. One of the divorced women sponsored her husband to Canada. All other women are married. The age of children range from 4 - 21. Seven of the eight women are on some form of social support.
Table 2 – Socio – Demographic Characteristics of Male Community Respondents:

<table>
<thead>
<tr>
<th>S. No:</th>
<th>Age</th>
<th>Education</th>
<th>Family Income</th>
<th>Support Source</th>
<th>Year of Entry</th>
<th>Type of Entry</th>
<th>Family Type</th>
<th>Employment</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>27</td>
<td>Technical College S.L. (incomplete)</td>
<td>31,000-50,000</td>
<td>WSIB</td>
<td>2006</td>
<td>Independent Immigrant Family Class</td>
<td>Joint</td>
<td>Unemployed since major accident</td>
<td>Single</td>
</tr>
<tr>
<td>2</td>
<td>35</td>
<td>College education- S.L.</td>
<td>31,000-50,000</td>
<td>E.I and odd jobs</td>
<td>2000</td>
<td>Refugee Claimant</td>
<td>Single-living alone</td>
<td>Laid off 10 months. Odd jobs</td>
<td>Single</td>
</tr>
<tr>
<td>3</td>
<td>40</td>
<td>Grade 11 A Level in S.L. ESL Canada</td>
<td>11,000-30,000</td>
<td>ODSP</td>
<td>2000</td>
<td>Refugee Claimant</td>
<td>Living alone - Restraining order</td>
<td>Unemployed</td>
<td>Married with a child</td>
</tr>
<tr>
<td>4</td>
<td>49</td>
<td>Grade 8</td>
<td>-------</td>
<td>-------</td>
<td>2001</td>
<td>Sponsored by wife</td>
<td>Nuclear</td>
<td>Unemployed since accident</td>
<td>Married with two children</td>
</tr>
<tr>
<td>5</td>
<td>63</td>
<td>Grade 11 A Level in S.L.</td>
<td>-------</td>
<td>E.I</td>
<td>2003</td>
<td>Refugee Claimant</td>
<td>Nuclear</td>
<td>Unemployed since accident</td>
<td>Married with 4 children</td>
</tr>
<tr>
<td>6</td>
<td>56</td>
<td>Grade 12 - O Level i SL</td>
<td>11,000-30,000</td>
<td>ODSP</td>
<td>2002</td>
<td>Brother brought him here</td>
<td>Single living alone</td>
<td>Unemployed</td>
<td>Single</td>
</tr>
<tr>
<td>7</td>
<td>26</td>
<td>Graduate Degree Canada</td>
<td>51,000-70,000</td>
<td>Salary of self and relative</td>
<td>2001</td>
<td>Relative sponsored him through agency</td>
<td>Living with single male relative</td>
<td>Two part-time jobs</td>
<td>Single</td>
</tr>
<tr>
<td>8</td>
<td>30</td>
<td>O Level</td>
<td>31,000-50,000</td>
<td>Salary of Self</td>
<td>2002</td>
<td>Refugee Claimant</td>
<td>Single living alone</td>
<td>Part time employment in retail store. Odd job</td>
<td>Single</td>
</tr>
<tr>
<td>S. No</td>
<td>Age</td>
<td>Education</td>
<td>Family Income</td>
<td>Support Source</td>
<td>Year of Entry</td>
<td>Type of Entry</td>
<td>Family Type</td>
<td>Employment</td>
<td>Marital Status</td>
</tr>
<tr>
<td>-------</td>
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<td>----------------</td>
</tr>
<tr>
<td>1</td>
<td>43</td>
<td>Grade 12 S.L</td>
<td>11,000-30,000</td>
<td>O.W</td>
<td>2000</td>
<td>Refugee Claimant</td>
<td>Single Parent Family</td>
<td>Unemployed</td>
<td>Divorced with 2 children</td>
</tr>
<tr>
<td>2</td>
<td>49</td>
<td>Grade 12 ṭ S.L</td>
<td>31,000-50,000</td>
<td>Husband’s salary</td>
<td>2007</td>
<td>Sponsored by husband</td>
<td>Nuclear</td>
<td>Home maker</td>
<td>Married with 4 children</td>
</tr>
<tr>
<td>3</td>
<td>47</td>
<td>Grade 11 A Level ṭ S.L, Grade 12 diploma in Canada</td>
<td>31,000-50,000</td>
<td>ODSP and husband’s part-time job</td>
<td>2001</td>
<td>Refugee Claimant</td>
<td>Nuclear</td>
<td>Home maker</td>
<td>Married with one child</td>
</tr>
<tr>
<td>4</td>
<td>39</td>
<td>Grade 12 -O Level ṭ S.L</td>
<td>11,000-30,000</td>
<td>ODSP</td>
<td>2001</td>
<td>Sponsored by husband</td>
<td>Nuclear</td>
<td>Unemployed</td>
<td>Married with 3 children</td>
</tr>
<tr>
<td>5</td>
<td>44</td>
<td>Grade 11- A level ṭ S.L</td>
<td>11,000-30,000</td>
<td>ODSP</td>
<td>2002</td>
<td>Sponsored by husband</td>
<td>Nuclear</td>
<td>Home maker</td>
<td>Married with one son</td>
</tr>
<tr>
<td>6</td>
<td>33</td>
<td>Grade 11 S.L, ESL Canada</td>
<td>11,000-30,000</td>
<td>ODSP</td>
<td>2004</td>
<td>Sponsored by husband</td>
<td>Living with mother</td>
<td>Unemployed</td>
<td>Divorced</td>
</tr>
<tr>
<td>7</td>
<td>31</td>
<td>Grade12incomplete ṭ S.L</td>
<td>11,000-30,000</td>
<td>ODSP</td>
<td>2004</td>
<td>Sponsored by first husband</td>
<td>Living alone</td>
<td>Unemployed</td>
<td>Divorced and Remarried</td>
</tr>
<tr>
<td>8</td>
<td>37</td>
<td>Grade 11 ṭ S.L</td>
<td>11,000-30,000</td>
<td>O.W</td>
<td>2007</td>
<td>Refugee Claimant</td>
<td>Living with infant daughter</td>
<td>Unemployed</td>
<td>Married with one child. Husband in detention centre elsewhere</td>
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</tbody>
</table>
**Participant Profile – Service Providers:**

8 service providers were interviewed. All service providers were involved in providing front line mental health or related services to the Sri Lankan Tamil community. While all providers served diverse populations some served a very significant number of clients from the Tamil community. They had all received some level of professional training in mental health, either in Canada or elsewhere.

**Table 4 – Service Provider Characteristics:**

<table>
<thead>
<tr>
<th>S. No</th>
<th>Age</th>
<th>Gender</th>
<th>Background</th>
<th>Field</th>
<th>Organization</th>
<th>Population Served</th>
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<tbody>
<tr>
<td>1</td>
<td>45</td>
<td>Female</td>
<td>Non Tamil</td>
<td>Domestic Violence</td>
<td>Hospital</td>
<td>Diverse</td>
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<tr>
<td>2</td>
<td>56</td>
<td>Female</td>
<td>Tamil-Indian or Sri Lankan</td>
<td>Domestic Violence &amp; Mental Health</td>
<td>Health Centre</td>
<td>Diverse ì significant Tamil population</td>
</tr>
<tr>
<td>3</td>
<td>46</td>
<td>Female</td>
<td>Tamil-Indian or Sri Lankan</td>
<td>Mental Health</td>
<td>Health Centre</td>
<td>Diverse ì significant Tamil population</td>
</tr>
<tr>
<td>4</td>
<td>50</td>
<td>Male</td>
<td>Tamil-Indian or Sri Lankan</td>
<td>Psychiatry</td>
<td>Hospital/P. Practice</td>
<td>Diverse</td>
</tr>
<tr>
<td>5</td>
<td>38</td>
<td>Male</td>
<td>Tamil ì as above</td>
<td>General Medicine</td>
<td>Private practice</td>
<td>Diverse ì significant Tamil population</td>
</tr>
<tr>
<td>6</td>
<td>50</td>
<td>Male</td>
<td>Tamil ì as above</td>
<td>Mental Health</td>
<td>Community Mental Health Org.</td>
<td>As above</td>
</tr>
<tr>
<td>7</td>
<td>55</td>
<td>Male</td>
<td>Tamil ì as above</td>
<td>Psychiatry</td>
<td>Hospital</td>
<td>As above</td>
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<tr>
<td>8</td>
<td>60</td>
<td>Male</td>
<td>Non-Tamil</td>
<td>Psychiatry</td>
<td>Hospital</td>
<td>Diverse</td>
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</tbody>
</table>
MAJOR THEMES AND SUBTHEMES:

4.1. Situating the Tamil Community – A Contextual understanding:

Findings lent strong support to the fact that understanding the background of the respondents’ place of origin, their childhood experiences, socialization, experiences of war and displacement lend important insights into the culture of the Tamil people and the gendered expressions of cultural values and norms.

This theme of situating the Tamil Community flows largely from findings from the community respondent interviews as they illustrate the context and the dynamics of the community from the “inside”.

4.1. i. Life in Sri Lanka

*The Farms, Temples and Cattle*

Most of the respondents with the exception of two grew up in small rural communities or small towns in Sri Lanka. The vegetable gardens that they lovingly tended to, the temples that they frequented and the cattle that they raised are part of the fond memories of childhood that they cherish. It was interesting to note that some respondents who looked dull and depressed lit up considerably when speaking of their childhood in Sri Lanka.
Farming was an integral part of daily life. While the produce from the farm and the cattle were a source of income, and part of their livelihoods, the respondents did not consider it work, but a labour of love.

“My father was a farmer in Jaffna. We were very well off. In the North, in Jaffna district. We were very happy. We had a lot of land and agriculture was good. We were comfortable...... We had a cow farm, we had agriculture – onions, kovakkai, paddy......... I liked farming ......Even when I was 14 years, before I left for school, I would wake up in the morning, go to the farm, come back in the evening, go to the farm.......”

#002 Male Respondent

“Yes, those things were there, normally everyday in the house there were cows and goats. My father was a teacher, but we had our farms as well – so sometimes I used to go to help in the farms.......even in the home, I had like a little garden, also growing chicken – that was a hobby.”

#009 Male Respondent

“Farms, animals, house – life like that...... There were animals in the field. We all took care of it with our brothers. Those were happy days.”

#015 Female Respondent

Temples were a centre of social activity, spirituality and very much part of the daily lives of the Tamil community. It was also considered auspicious to seek blessings at important points in one’s life which included lives of one’s family members.

“He (father) came back from work and then went to the temple as he had gone to get blessing from God for his son’s first month salary.”

# 010 Female Respondent
“….we used to go (to the temple) early in the morning everyday, for festivals we used to go in the evening, if it was Tuesday we would definitely go. In the temples, they used to have competitions like the IQ test, while there – there would be a temple committee which would conduct competitions, exams and give prizes, like that. It will be happening, every Friday – regularly like that.”

#016 Male Respondent

We have a lot of belief in God – we used to go to temples, perform rituals, hear “arul vakku” (prophecies)…………. When I go to the temple I perform “archanai” (an offering to God that the person makes and which is offered to God by the priest in the form of a ritual). I pray to Lord Krishna more. I am not sure whether it is true or not – I believe it is true - a lady got possessed by God there, when praying to Lord Krishna and there was a “namam” (white ash like powder)… that came out of her mouth. I saw it with my own eyes. In Koplan. Namam means something out white – I believe in that. If human being is true, then supernatural beings like God would also be true. That’s my belief. So it came like powder. And we have even adorned it like ashes on our foreheads with it. It was fragrant…..sometime she would give us double roses”

#001 Female Respondent

Focus on Education

It is a historical and awe-inspiring fact that Jaffna University, which is situated in Northern Sri Lanka, literally in the ņeye of the stormô in terms of the ethnic conflict, held a record for the very limited time period that it was closed. This is a testament to the importance the community gives to education. This historical fact was corroborated by the findings from the respondent interviews. However the demographic data of the Tamil community respondents shows limited education. This reflects a significant loss (due to external factors such as the ethnic conflict) of something deemed important and a symbol of status.

The following verbatim account shows how the major part of a childô daily life in Sri Lanka is dedicated to studies
“...from young, we will get up early in the morning – at around 4 o clock. All of us (girls and boys), we would get up in the morning and study. Then we would go to school and return at 2p.m. from school, then we would go for tuition from 3p.m to around 6 p.m...... Usually until Grade X we have 10 subjects, tuition mainly we would go for Math, English and Science. That’s what we would go for.”

#014 Male Respondent

The following account is that of a woman who had an abusive father addicted to alcohol. Her disappointment at having failed to reach a level of education that would accord her and her family with a status is evident here. Another theme that this speaks to is the family centrism which is elaborated in the section which highlights findings related to the family.

“...everybody thought I will study well and come to a good status. But I didn’t study. I had a lot of expectations (of myself) that I would study well and come to a status. But I didn’t have anybody to help, or guide me with studies, there was no peace at home”

“When you say status, what do you mean?”

“That I should study, get into a good job and take care of my family”

#007 Female Respondent

The verbatim account of #016 in the section on Life in Sri Lanka shows how the society values education in that the temple held I.Q tests and competitions regularly on their premises to promote education.

A service provider talks about this focus on education and the unrealistic expectations around the performance of their children after parents immigrate to Canada
“.....you will have to talk to them. Then you will have to talk to them about expectations – about wanting their children to come first in class”

# 003 Tamil Service Provider

Education was deemed important for both males and females. However, it is interesting that in the case of a few female respondents, education was seen as an end rather than as a means, whereas it was seen both as an end and a means for the all of the male respondents. It is interesting that a woman who had lost the opportunity to work because of parental refusal, educates her daughters, but again denies the daughters permission to work. Here one sees the interface of cultural and gender related norms and values.

“Mom is smart and has studied well. My mom got jobs in the government – as a teacher. But my mother’s father wouldn’t let her. He said that you don’t need to work for a small salary. Our agricultural land would do for income. So she was not allowed. My mother used to say. In the same way, my mother educated us – though she didn’t let us pursue jobs.....”

#015 Female Respondent

While there were narratives where the girls received education and subsequently became employed, for females, getting a job was not considered the priority that marriage was.

“.....After dad died he (brother) got scholarship and he studied in XX (high school), then with that he got into XX (A prestigious college). I just had to take my A level exam, so I studied in a school in my village and passed the A level exam. I did well in Math (laughs) I got an A in Math, in everything else I got only an ordinary pass. Then mother was thinking of getting me married. But I got married only when I was 26.”

#010 Female Respondent
The following is an account of a male respondent who grew up in Southern Sri Lanka with his grandparents. Irrespective of geographic location, the focus on education and the gendered differences are apparent here as well.

“Growing up and responsibilities, I would say – other than studying – that was my only responsibility – getting a good mark and getting a good name for my parents and my grandparents, because every time we had a program or meeting, my grandma and grandpa would come - and then they hear ‘he is doing good, he is doing this, he is doing that ‘. They always get a good response from teachers…………. They didn’t even pressure them (girl cousins) to study as well. They are girls or whatever, but they did lot of other things, like going out, buying different, different things for them, those type of things. For me, I have to earn it by getting a good mark. That’s the thing. If I ask for a big thing they will say “get a good mark on this, I will get you”

#012 Male Respondent

4.1.ii. The Family

Family Centric Dynamics

The family was the pivotal point of the lives of the Tamil respondents. All memories were linked to family and happiness - a central theme of most childhood experiences that were reported. This was despite the fact that the respondents were living their lives amidst bombshells and continuous displacement. Only in three families, where the fathers were dependent on alcohol, was unhappiness reported. So a cohesive family trumped other considerations as key to happiness in childhood. The central role that grandparents played came out front and centre, especially in narratives where the family faced challenges due to the negligence and alcohol dependence of the male parent.
a) Happiness

One of the respondents came from especially excruciating circumstances where the family was working in tea estates of Central Sri Lanka. The people who worked in tea plantations were further disadvantaged because they were of more recent Indian origin in comparison to other Sri Lankan Tamils and led a life of almost bonded labour in the tea plantations which are referred to as “estates”. However even in the face of such adversity, happiness is reported.

“...then gathering firewood, that is very difficult, even when I was 10 or 11, I used to go into the forest, we used to carry the heavy wood. We did not get money. We used to help our parents get the money by helping carry the firewood. That is how our family earned. There was no financial stability. That was how life was.....Estate life. It was hard life. But even so, we were happy – we would do everything, we used to cultivate gardens; if we need to buy something from a store we need to walk three four miles, upcountry, hillside, so we will travel 5 mile, buy stuff for a month and bear that on our shoulders and return. It was difficult, but it was a happy life also. Because there was happiness in the family, we were doing it together”

#006 Male Respondent

The family centrism is evident in that even as a ten year old this respondent feels the necessity to earn to contribute to the family.

Another narrative of a respondent from a highly influential family belonging to an upper socio-economic status also revealed the happiness in being together.

“Back home, in Sri Lanka, my family was a BIG (in status) family, we were a rich family, I have 6 siblings – 5 sisters and a brother...... Yes, we were all together
initially, it was like one big happy joint family. If there was a lack of food (due to the ethnic conflict) we would share it between all. If I have a problem my siblings will not be able to bear it”

#008 Male Respondent

b) “Being Taken Care of” – A gendered perspective of happiness influenced by birth order

While narratives of males and females spoke about the happiness in the family, women took pride in talking about how they were taken care of by their families. This was a consistent theme in many narratives. Also, this was reported largely by women who were youngest amongst their siblings in rank order. Older female siblings also took care of their younger female siblings.

This language was not used by men, even when they were latter born, in any of the narratives. This indicates a gendered expectation that Tamil women have.

“When I was a child itself, my brothers came this side, so I grew up alone. My parents were with me. They looked after me well. It was good there – I was studying well.”

#005 Female Respondent

“After a long time, children were born to my mom’s parents and she was taken good care of and grew up in a very loving environment (“chellamai valanthava”), after marrying him (respondents father), she really suffered………."

#007 Female Respondent

The term ‘Chellama’ used as a verb is found in many of the narratives of female Tamil respondents. Translating this term into English is difficult as there is no parallel. In very general terms it means ‘with love’. It derives from the noun ‘Chellam’ which means
“Since I was the last kid, I was brought up being showered with affection (“chellamai valarnthen”) Till my eldest sister got married, she did everything; even giving me a bath”

#011 Female Respondent

“I grew up in my town. Since I was the youngest ......Then I grew up and was given all the love and affection as I was the youngest. If my father bought a sofa set, he would buy a small chair for me as well. I was brought up with so much affection. I was the “chellam”. As there was no electricity, everybody studied using lamps. I would get a small lamp specially bought for me. Even my dresses – they would take care to get very good dresses for me from Point Pedro...... My sisters also took similar care of me (after the loss of her parents)........”

#001 Female Respondent

c) Gendered Roles and Responsibilities influenced by birth order

The onus of taking care of the family was on parents and the older siblings, with the eldest male and female siblings taking on the instrumental and care giving role of their father and mother respectively as the situation warranted. This meant sacrifices and giving up studies for the sake of the family and younger siblings.

A day in the life of an older male sibling is highlighted here. This person is from a small town in Sri Lanka. His father was working in another district and would visit them only once in six months. So at a young age, as the eldest son, he took on the instrumental role in the family even though older women including his mother and elder sister were present. The women had specific responsibilities aligned to gender roles and contributed to work which aided their care giving role; in this narrative the respondent talks about the women picking up wood that fell from trees to use for lighting the fire to cook.
“After returning (from a long day of school and tuition), I would water the vegetable garden, there used to be banana plants and other vegetables. So I would water them. I used to go and sell the vegetables, my neighbor’s too and would maintain the accounts. I used to take the motorcycle…… and at that age, load it with vegetables on both sides, and leave early in the morning if I was going to the market –I will leave for the market by 4.30a.m., so that I give the produce by 5a.m. at the market. 

So you just drop it at the market and come?

Yes, then I will collect the money.

What about the girls in the family. Would they do such work?

No, they didn’t, but in the farm, things like plucking grass my mom and grandmother used to do themselves. Those things and then picking the wood falling from the Palmyra tree, because you needed it to light the fire to cook, as there was no gas there. So those things the women used to do. Me, even if I needed to transfer bags of rice – I used to do that. Because of all this, I was very strong. I was the elder boy and my younger brother was much younger than me when I was doing all this – so he wouldn’t do much. Also as I was the eldest son, I had the responsibility for looking after the household. That was my role – for example to pay the school fees, even though my mom and older sister were there, I was the one who would pay the fees”

# 014 Male Respondent

Older female siblings took care of the other siblings and nurtured them. There are narratives in which older female siblings gave up their studies to take care of the younger siblings. This also points to internalized gender roles driving behaviour even when there is no evident external pressure

“Oh yes, I stopped my studies (starts crying) just because I wanted my younger siblings to study. I realized that if I study they will not be able to study, my mother was mentally affected after fathers death, kept thinking of him, started feeling very tired, even if she cooked a curry, she would lie down. Then I thought, if I also continue studying – my brother used to study better than me, he was very smart, so I thought that it would be worthwhile if he continues. So I told my mom “my elder brother is working, enough of studies for me, I will look after the house, let my younger siblings study” They studied and came up well.
….. I would get up in the morning and do the needful and cook for them, because they had to go to Jaffna, in the bus – my elder brother, younger brother and younger sister – so I would get up with my mother, cook and pack their lunches for them”

#010 Female Respondent

Male siblings who exited the country early carried their instrumental responsibilities towards the family of origin with them and were primarily responsible for the financial needs of the family back home. Here is an interesting account by a sister about her brother’s contribution to the family.

“My brother left (to Canada) when I was 11 years old. So I didn’t know much. Just talking over the phone – he wouldn’t reveal anything (any problems he was facing). My brother was the one who got us all married ….. from my eldest sister to everyone. ….. Yes, he was the one who did everything for us, father was not responsible, you know

After sisters got married did they help the family?

Oh, they would buy us clothes for festivals and give a little bit of money now and then. But it was my brother who took the entire responsibility. When my sister started going to work, that took care of the money for food, the rest was all my brother”.

#011 Female Respondent

The younger male and female siblings were treated with a lot of affection and there was not much expectation of them except to do well in studies. While they helped with household work, their contribution was minimal in comparison to their older male and female siblings. This has been highlighted under the theme of being taken care of for younger female siblings.
“…No brothers did not have much responsibilities, nor did my sisters. None of my (younger) siblings knew what problems were. They were happy. They went from school to home – that was it”

#002 Male Respondent

“…so before going to school we (the two older sisters in the family) would do all the work – sweep the front lawn, sweep the house, wash vessels, do laundry, scrape coconut, we had to do everything and go. We used to do all this, (younger) brother would also help, if we sweep the lawn, he would collect the garbage (what we had swept) and throw it out. He will do all that. It was only one brother right. So we took care (of him). We wanted him to focus on his studies and do well”

#007 Female Respondent

d) Gendered expectation of men pertaining to women in the family

The expectations that men have of women was clearly articulated in many of the narratives. This was reflective of their experiences growing up in Sri Lanka. The implications of such gendered expectations during the resettlement process are looked at in detail in later findings under the theme of Resettlement.

The following is an account of a male sibling who is used to being waited on by his female siblings.

“……my sisters used to wash and iron my clothes and keep them ready for me. They would match my clothes – this jeans for this shirt and keep them ready for me. I expected the same after seeing the life that my parents lived – for dad – my mom used to do everything for him – all service (“panividai” – in Tamil) she would do for my father. My sisters also do the same for their husbands. In my life, it is all very different…….”

# 008 Male Respondent
This account reflects the expectation of men that wives should stay at home and take care of the family. This finding is particularly relevant when there are long separations due to the war and displacement, during which the wife takes on the instrumental role, and the challenges because the man is not able to reconcile to changed roles. These are reflected in the findings on resettlement.

“During that time, I did not think of going for a job. But after marriage, I came to Colombo with him, 1988 I got married. At that time I wanted to go for a job. However he did not want me to. He said “I am in a good job, our income is okay, so you stay at home and take care of me and the work at home”. So I said okay to that. Yes, I really wanted to work, I used to speak Sinhala fluently, when I was studying O level, Sinhala was a subject, in Colombo, so I used to speak well. But you know, during those times (1988), back home women going to work was very rare, only if they have studied for Doctor or Engineer, only those people (women) will work. He also said that. (laughs) I always give in to everything.”

#010 Female Respondent

However it should be made clear that this did not mean women did not seek employment while in Sri Lanka. One female respondent was employed while in Sri Lanka and in many narratives of male and female respondents, references to female siblings working at jobs was found. However the primary focus of women remained taking care of the family.

These gendered expectations come as no surprise considering the gendered roles which boys and girls are socialized into from childhood.
Grandparents play a crucial role in the lives of families supporting them in general, but specifically in times of crisis. In many families, grandparents played a role in contributing to family income in times of need and taking care of grandchildren when the need arose. In two accounts of families where the father was addicted to alcohol, grandparents played a major role in supporting the family.

“I was born and 6 months later, my uncle took me to my grandparents. I lived with my grandparents. During childhood I never lived with my mom, no, until I was 17 years old. My mom went to XX country to work and came back every 10 year, 6 years, 10 years like that. She will come to visit me for 2-3 days and then she will go back. Every time I see my mom it is like seeing a neighbour or somebody who is a far relative. I don’t call my mom “mom”. I will call her mom, but I call her first name and then mom. Like “XXXmom”. Dad, I used to do the same thing. Because he never lived with us. My dad had alcohol problem. He drinks a lot, in that case – I DON’T like him. He drinks and stuff. I don’t like it since I was a kid. I see him and I say hi, that’s it. So pretty much lived with my grandfather, and grandmother – my dad’s side”

#012 Male Respondent

In the above narrative there was no sense of loss or feeling of strangeness reported about living away from parents and with grandparents.

“….we don’t remember our dad ever feeding us, bathing us or buying us clothes, that was how we grew up. Our mother’s father only brought us up. This was in Jaffna. My mother’s father was with us”

#007 Female Respondent
Another narrative also talks about the care taking role of the grandparents, wherein, each spouse lives with different children so that they are able to take care of their grandchildren from different offspring.

“…they went to take care of my sisters’ children in Wanni. My sister was a teacher. One son. My father was with the other sister – as when my brother in law goes to work, he would take the children to school”

#016 Male Respondent

4.1. iii. The War

The civil war or internal conflict in Sri Lanka as some describe it raged for decades. At present the Sinhalese government has attained a military success by defeating the rebel Tamil group, the Liberation Tigers of Tamil Eelam in May 2009.

While all of the country was affected by the civil war, the Tamils of the North and the East bore the brunt of the war and the associated losses and trauma. The findings illustrate how the war impacted all aspects of a rural, integrated, family centric community, focused on education and agriculture and damaged its very core. The impact of such trauma on mental health and well-being is not difficult to fathom. The multiple facets of dispersion, loss and trauma are at the crux of the war related experiences of the community.

Dispersion, Loss and Trauma

With the exception of two respondents all others spoke about scattering and dispersion of the family of origin due to war. Internal displacement and exodus to foreign countries
was present in the majority of narratives. There was forced and lengthy separation from spouse, early exit of young males to foreign lands for safety and to provide for their families, physical harassment of young Tamil males, detention and jailing in foreign lands and loss of loved ones, property and loss of education. Service provider interviews also spoke to these factors.

While family dispersion and separations were characteristic of the experiences of most respondents, some experiences were gender specific with males reporting a greater incidence being captured by the army, being held in detention centres and fleeing the country due to safety concerns and to provide for their families back home.

Biographical information shows that members of the families of origin of the respondents are scattered world over as a result of fleeing from the war. India, Germany, Canada, Switzerland, and the U.K. figure prominently as countries in which Sri Lankan Tamils have resettled. The family of origin was central to a person’s existence in the Tamil community. The scattering of such families lead to immense stress and a sense of loss.

The following account relates multiple aspects of the theme of dispersion, loss, trauma and gender specific challenges.

“…..catching us, beating us, leaving us (male siblings in the family), as there was threat from the army, just like that we… (separated) We had three houses. Due to helicopter bombing our houses were destroyed, then we were separated in different directions. Lost our studies……

You mean while in Sri Lanka?

Yes, while there – when some of us had to flee, we just fled and that was it. Then we went – and then I married, my brother connected with an agent and he went to India,
no Italy…. Earlier, when the Indian army came, they killed my cousin – in his house, they rounded up the house, then he was with the mother, so they came and shot him in his head. After that we (the boys) did not stay at home. We would move from place to place. We would return home secretly from time to time. Another brother we sent to London.

#002 Male Respondent

The account of a service provider speaks of the personal experience of trauma and its impact on mental health

“Then the riots in 83 happened and that changed everything. It was in xxx, Sri Lanka. So I refused to live in xxx following that and it also happened that time during the riots (talks about a significant life event that took place under the most difficult circumstances) So it was life changing…… I refused to be back in xxx and we left, after a few months, left to XX (country), because a lot of our friends had been to XX, because it was close to go, but going to XX was a temporary thing. Because I thought within a few months things will settle back and I will come back, but it never happened. Before going to XX, we tried living in Jaffna and the tension was too much, I thought that I might lose my mind, because the tension was so intense, to live in this……not knowing what will happen next…..”

#007 Tamil Service Provider

Another non-Tamil service provider also speaks to the collective trauma that they have been exposed to.

I mean the population has been extensively exposed to trauma, so, because the war going on so long, it is very difficult to find even one person who has not been exposed to trauma.

#001 Non-Tamil Service Provider

Trauma and its impact on education and mental health is very evident in the following account
“…at that time, my parents expected me to become a doctor. But for me, going to study was sometimes – when I saw my country’s situation…… we were not able to go to school properly. Sometimes while going to school, the flights used to bomb and we used to lie down for cover. So because of all that, I couldn’t study as well. One day… they were neighbors. I was standing in their house and was talking. Then when a flight started hovering around, me and another boy in that house came running out to see the flight. At that time, the flight was dropping a bomb and we lay down on the ground – everything was too dark. When we looked back at that house, we were the only two people who survived. Otherwise his entire family was wiped out – a small kid – everybody…..all that – for a long time I had nightmares and all that. Even if I studied during that time, in such a situation, I kind of resented studying. Even when we go to the hospital, mostly it was wounded people that we went to see. This had an impact on me mentally”

#009 Male Respondent

The following is a very telling account of a woman separated from her husband, the impact on mental health, and some unforeseen repercussions like the impact of the political conflict on medication compliance. While the researcher considered this a wild card initially, it was surprising to find a similar occurrence in the context of resettlement.

“….as the army was after him, he went and stayed in a different place, in hiding away from me. As they were constantly coming and taking him away. So I was isolated, with the child, then it was very difficult. So I tried to commit suicide.”

“Oh, yes, I think I started taking medication when I was 18 or 19 years. I would buy the medicine, but not take it. Sometimes I will put it, then I will feel sleepy. Then I will not be able to run if the army comes. So I didn’t take the medication”.

#007 Female Respondent

Family dispersion and the sense of isolation it brings with it is evident in this account

“I have 6 siblings – 5 sisters and a brother. My father died last month in Colombo. He was 89. Mother died last year when she was 64 years. She was in Colombo as well. I have two elder sisters – now in England. Third is my brother – was in Canada, now in India, then me. Of my three younger sisters one is in England, and one sister is studying in Australia. The other sister is in Italy. Yes, we were all together initially, when I was in Europe, I had my siblings, my relatives, I never used to be alone, I don’t
like being alone. After coming to Canada …..Away from family, I hated it, I started drinking”

#008 Male Respondent

This is an account of a single male and his experience in detention in the U.S. before coming to Canada. There are other accounts of husbands being detained while wives carried their onward journey to Canada. One respondent’s husband is still in detention in another country and her struggle to get him here continues.

“As……before that in the night I had said ‘instead of sending me to Sri Lanka, better shoot me and kill me here.’ I had given such a statement – then they understood that it was a problem if I was sent back. My saying that turned to my advantage – plus point to my case. Then they sent me to Seattle….the cops came into the flight and took me to another jail. Two months I was in a jail – there were only Mexican people there. Then the next three months I was sent to the Federal Detention Centre. As soon as I went there, I sought asylum, Then the case succeeded and they ruled that I could stay in America itself. For five months I was in. They asked me to go, gave me my bag and opened the door. No family, no education, no nothing….. I didn’t have any phone numbers. One path led to the highway, the other……”

#016 Male Respondent

4.1. iv. Summary

The section on “Situating the Tamil community” reveals the cultural context of a rural/small town community defined by farms, cattle and the temples, priding itself on its family centric dynamics and focus on education. Roles and responsibilities are influenced by birth order and gender. The male is very clearly the provider while the female is the caregiver. Sacrifices by older males and females for the well-being of the family are common place. Gendered roles and expectations defined by cultural norms are internalized to a large extent. The war and the resulting dispersion, loss and trauma shook the very core of the Tamil community, disfigured the family as a unit, placed further burdens on gendered roles and affected the mental health of the community.
4.2. Resettlement and its Challenges:

"Fleeing" not "moving" represents the migration experience of the respondents. Even in cases where the respondent was sponsored by a family member, it was not a smooth process. Internal displacement, going underground, detention centre experiences and hurried exits preceded the migration process. In addition, being unprepared for settling in a foreign land, which was very different from one’s home country brought its own challenges. These resettlement challenges are presented as sub themes. It is important to note how being uprooted from a culture and context familiar to you and replanting yourself in a strange culture and context brings its fair share of challenges and dilemmas. The theme and sub themes are informed by findings from both community respondent interviews and service provider interviews.

4.2. i. Coping with the Unfamiliar

This was a theme that resonated in almost all of the service provider and community respondent interviews. Moving from a small, rural, warm, Tamil speaking, largely Hindu context into a large, urban, cold, English speaking/multi-lingual, largely Christian/multi-religious context can be quite a challenge even in the most planned migrations. Add to this the fact that gender roles are challenged and in many cases reversed in the resettlement process. As there is family dispersion, it is not always easy to reach out to families of origin for support.

Isolation of women, seniors and single males were highlighted in a number of narratives. Growing up in a small rural community, within a family centric environment, isolation is an unfamiliar state that people struggle to cope with.
Here is an account by a young Tamil male about his isolation. It is very interesting how the sense of isolation is expressed. There is a denial of feeling isolated, but the narrative points to the contrary.

“Then in xxxx, in the detention centres, I was alone, there were no other Tamil people, only other people, I was with Mexican people, then for three months, I was in a room with one other person. So when I came here and am alone, it does not bother me that much. After the accident, though, now I feel like I am alone at times. But I go on the computer – chatting or yahoo messenger, sometimes my brother in Colombo will come online, then the feeling that I am alone will not hit me. Also if I don’t feel sleepy, I go to my computer – it would be day time for them and they would be at the computer, so we would speak. Like that. So when I see them on webcam and talk to them, there is a feeling like I am there with them, back home”

#009 Male Respondent

The isolation faced by a Tamil woman who was forcefully separated from her husband and is now living alone in Canada is highlighted here. Though she has supports from family members for meeting some of her instrumental support needs, she lives alone in the basement of another Tamil family. The isolation has led to poignant consequences which affects medication compliance and thereby her well-being.

“When I was taking the medication, I was okay then. I will sleep. But after my child was born, she was born here isn’t it. Then I got the disease/problem again of not getting sleep– it came in 10 days of childbirth, no it came right away, because I did not sleep. Then I was taken to the doctor and he gave medication. I used it for around 2 months. Then for the child, because I would not hear the child even when she cried, so though he had asked me to take it for six months, I discontinued in two months”

#011 Female Respondent

This respondent talks about the isolation of seniors and its impact on mental health
“...Yes, I think they (the elderly) have a lot of problems. Whether it be their children or their daughter in law or son in law, they are always out of the house. Too busy. We cannot refute that. So there is no chance to take them out or anything. So they are always within the house. And they start thinking and worrying – their mind is affected. They compare how they were back home and how they are here. Thinking of that itself has a severe impact. They are pushed to that condition.”

#005 Female Respondent

Females being forced into unfamiliar circumstances is another challenging aspect in resettlement. Women who arrive before their husbands are forced into the unfamiliar situation of taking on the instrumental role. Families become single parent or female headed families due to separation, disappearances or detention of male spouses. Life events and responsibilities that were jointly undertaken by the family like childbirth and caring for off spring, fall completely on the women.

Here is an account of a woman who arrived from Sri Lanka with an infant and a toddler in tow. Her struggles here are well documented and are contrasted against the support in her home country.

“.....Presently I am not working, but since I came here I have been working doing factory work, lots and lots of work – right from when I came I have been working. If one job gets over, I immediately find something else – I needed to sponsor my husband isn’t it? So the time I was on welfare was very less – less than a year. As soon as I came, within a short while – for me, my English standard was not enough to get a desk job here, so as I needed to join some job – so I studied tailoring and joined in a tailoring company, then I worked in a steel factory – it was very HARD work there, very hard, I used to get overtime there. I did not see the sun at all during that time. I have to go from here to Dufferin and Steeles for the job

So you had to start early?

Oh, yes, also I had to take the children to day care. I had got subsidy day care. But that would open only at 7.30a.m. So I arranged another day care – home day care. So I had to leave them there and go. So I had to get up at 2.30a.m. – bathe my children and get them ready. So it was really a “pressure”, as I had to take small children right
in the morning – leaving children with unknown people for daycare – as a mother, that is very very difficult. So to forget that I will work very hard.

Were you working in Sri Lanka?

Yes, I had been working as a Tamil typist in Jaffna. That was a job that was not physically hard. When I come from work, it was a joint family, so I will do one job – like cooking or something and my work will be done. Here when I do ALL the work myself…..”

#013 Female Respondent

A male respondent spoke of his wife’s struggle coming here alone as he was held in a detention centre in a foreign country during the immigration while his pregnant wife continued her onward journey here.

“I married and both of us (wife and him) started out. She was pregnant within a year of marriage. She is from Jaffna. We got hold of an agency and started off to any (just wanted to flee the country) foreign land. I got caught. She came to Canada

Where did you get caught?

Me? In the Mala islands. I was in jail there for three years. My wife reached Canada. She was pregnant – had a baby in her womb Only after coming here she delivered. Yes, she suffered a lot. She had a cousin. They had three daughters. So they also….. Don’t you know when you are in another’s house (there are problems). So after she delivered, she moved in a month to a separate house. It was difficult. When ever I contacted her she would tell me about her worries. I also could not do nothing but worry. I tried coming from there. But all my money was spent.”

#002 Male Respondent

Systemic factors like discrimination and underemployment which force men into subordination in roles that are unfamiliar to them are also evident in the narratives. This respondent talks about her husband who was working as an accountant in Sri Lanka, and his distress at having to do janitorial work in Canada.
“He used to say, ‘I was like that back home, here he asked me to take the broom and clean the place’; it upset him terribly. But we need to do it. We have to start from the bottom and go up here. We can’t just come up like that”

#013 Female Respondent

4.2. ii. Marital Issues

Changed roles, role strain, challenges to gendered expectations, prolonged separations, acculturation to gender roles of a new culture by one spouse as opposed to another, and expectations of women from Sri Lanka when they marry somebody who has resettled in Canada impact marital relationships significantly.

Here is an account of a married male who expected that his wife would do things for him. He had been doing tasks incongruent to his perceived gender role when he was alone in his resettlement. He expected the situation to change when his wife came here. However, when his wife rejoined him after many years of being separated, he was disappointed.

“….because my wife had a good job there – there my wife was the one who was maintaining her family (of origin) ……I am the one who does the cooking at home. I DO the cooking …. For 10 years I have been cooking, cooking even after my wife came. I only do the laundry as well.

I feel bad because (eyes cloud and voice breaks) when I was home (in SL), I used to change clothes at least two times a day. In keeping with that, my sisters used to wash and iron my clothes and keep them ready for me….. My sisters also do the same for their husbands. In my life, it is all very different. Also, this problem with this (restraining order as he beat his wife)”

#008 Male Respondent
Here is another account from a female's perspective. Coming here, living independently, bringing up two children, working hard, paying the bills and sponsoring her husband, she is devastated by the turn in the relationship when her husband arrives. Gendered role expectation has a lot to do with this narrative as well.

“.....I had really worked hard here and since I had lived alone, I had become a little independent and had started voicing my views a bit. In general, there will be a difference between woman there (in Sri Lanka) and woman here. It is not that I would answer back. Sometimes I would have said certain things, but I would think twice before I speak.

......But this was how the problems started. He went on doing this (finding fault). But my going to work for him was...... at the same time, I couldn’t give up my job, we need an income, isn’t it? So he would do the cooking, so when I come back home he would say, ‘the queen has come. I have cooked for her.’ Then he would put the kitchen towel on his shoulder (like a waiter in Sri Lanka) and ask me ‘‘Maharani (queen in Tamil), what do you want, was it nice?’ It was such a torture. Now since he was there, I would be happy that there was cooked food at home when I got home. Before there was nobody, and so it was okay, I would know there was no food, I would just eat whatever was available. Now I was excited that there was food, but everyday when I would eat, there would be tears in my eyes. But if I cry he would shout. He also started drinking a lot here”

#013 Female Respondent

The Views of Service Providers

The views of service providers on the resettlement process in terms of coping with the unfamiliar stresses the impact on mental health. There is also the understanding that unfamiliar circumstances also create opportunities, hitherto unavailable to the community.

Negotiating the resettlement process is one of the ways people have learned to cope with the unfamiliar. The struggle has resulted in an ongoing process of understanding changes
and reframing priorities in the resettlement process. This has been very eloquently described by a Tamil service provider

“The understanding that there is a probability of contracting mental health issues (during resettlement). Because if you see, the West has given us a way of life, which is much more challenging than our general lifestyle. It has created a life which is constricted in a lot of ways in terms of dimensions, and values. Just as it created opportunities, it has also created stresses and challenges. The way our society faced this earlier, was different, now it sees it with more maturity. Now if you see the TV shows there are dialogues such as “Why do you want to buy a big house and struggle with your mortgage? Why don’t you choose something that suits your pocket?” Before things like this wouldn’t be highlighted......... Yes, people ran, got tired............ If you look at the first generation of Tamils here, it was a very challenging situation, they had to learn a lot of things through their own experiences, it was not that they could learn from others. They had to go through it first hand. Now we have progressed reasonably; at least in acknowledging mental health as an issue.

# 003 Tamil Service Provider

The above reference to buying houses beyond one’s means directly alludes to owning your own home which was of great importance in the Tamil culture. The pride of having your own home and farms is a prominent aspect of Tamil culture. Another Tamil service provider also talks to this. The attempt to move towards the familiar and the culturally valued in unfamiliar, challenging environments pose further challenges.

“......psycho social stressors - People – comparison, that is cultural, always people compare, what do I have achievement wise, so that is there. So that is one of the things. Also in our culture, having your own home, not in a rented or leased property, its one of the very important things. So it – everyone trying very hard. It is a very cultural thing”

# 004 Tamil Service Provider

That the community has gone through its challenges in resettlement with very severe repercussions, and is now trying to move along is also evident in this narrative by a Tamil service provider.
“.....as you know the largest percentage of people outside Sri Lanka, Toronto is the largest diaspora. And most of the people who came here, not on the higher social level, well educated and higher – they went to America or England or Australia. These are people who have lived in villages, never seen even Jaffna town or Colombo, within 24 hours they are here in Toronto, ultra modern, North American living, but because of their educational level and their social level, we expected and we did have a lot of problems initially, during the early 90s, every other day you would hear a suicide – a woman jumping from the balcony, from the Parliament street, or somebody hanging, burning themselves, jumping in front of the subway, very common condition. The women were committing suicide because they got depressed because of the husbands alcohol problem, men were committing because they couldn’t help anyone there (in SL). Things have lessened now.”

#002 Tamil Service Provider

It is important to understand sources of stress in the resettlement context that are culturally informed. For example if you are a Sri Lankan Tamil male with a family who has been living in a rented or subsidized apartment for some time since immigration to Canada because of factors such as unemployment, underemployment, limited opportunities due to language inadequacy, financial obligations to family back home and a myriad of such factors, it can place a tremendous amount of stress as the man sees himself as failing in his responsibilities as a provider because he cannot even acquire a home that he owns for his family.

As many of the service providers work with diverse communities, the findings provide additional insights with regards to challenges that other communities face as well.

Here is a Tamil service provider's account of what people are faced with when they come to Canada. This is relevant in understanding how resettlement poses greater challenges for communities that are farther removed from the culture and the context of the host communities that they resettle into. Also identified here, is the positive impact of having a like ethnic community in the country or city of resettlement. However this notion of
community as a source of social support is challenged by narratives from community respondents who perceive the presence of like community as unsupportive at times. The two sides of the coin in terms of community as social support will be explored in latter themes on social dimensions of help-seeking, support and treatment. The support of having like community here is in the context of the familiar within an unfamiliar context.

“…..I think it (stress) is common for all first generation immigrants, it affects everyone, but then, it affects more the refugee population among all, because these refugees are as I said unprepared immigrants, that is one of the things, then come to their social support, language proficiency, cultural adaptation, other things, some of the cultures when they come, even though they are refugees, they are very closer to the western culture or religion, so their assimilation is easy, it is less stressful, some of the cultures for example Chinese, Sri Lankan, or some part of Indian culture, they come with, what do you call, very low level of English, then it is very hard, harder for them. Then again in the host community, there is their own socio cultural community there, that is a strength. Chinese community has that strength, Sri Lankan Tamil community has the strength too”

#004 Tamil Service Provider

Another non-Tamil service provider spoke to the challenges of resettlement that women face in particular as the service provider’s experiences were with women who face domestic violence.

“And, when you don’t speak the language, that’s a problem, when you come from India, China, Sri Lanka, you come to a foreign country, the weather is cold at this time of the year, you don’t speak the language, and now your husband has assaulted you, it is a horrible myriad of problems, challenges for them, you can’t begin to imagine what they must be going through…..”

#008 Non-Tamil Service Provider

Older citizens also face specific challenges. In the section on Family centric dynamics where the role of grandparents is elaborated one finds that grandparents are in a position
of power and play a key role in supporting their offspring and their families. However, when they immigrate here, sponsored by the children, the tables are turned. They are forced into the unfamiliar circumstance of being dependent on their children. This poses challenges as evidenced in this account from a Tamil service provider.

*I have some of the senior citizens, they feel very isolated, they don’t fit in, their heart is back in Sri Lanka and they always want to go back. And the children want them to stay here, so there is a constant struggle between the children or the adults here and the parents who feel they are locked in here and they want to go back.*

005 Tamil Service Provider

While the above account speaks of the challenges, this account by a Tamil Service provider contextualizes the challenge faced by the elders in the community:

*The other thing is that elders play a very important role back home, not only do they continue to impart their values and discipline even when their children become adults, and other things …. while we are enjoying our freedom, they also took a great pride in looking after our grand kids and other things too. Because they had their own roof, they had their own economic base, they are not fully dependant on their kids, but here it is different, for the first generation immigrants, their parents like their kids are also dependant. So for the elderly population it is like a lost kingdom for them, they are never going to regain that kingdom again – meaning building up their own home, living in their own home, entertaining their kids and grandkids is their pattern there. Here it is different. They are living in their kids home. Their kids came first and established themselves, got married even before the parents comes and other things – so when they come here it is like they are living and entering somebody else’s home, so that is a big mental health stress for the elderly population. It is also limiting their potential*

# 004 Tamil Service Provider
Service providers also talk about **marital issues and relationship issues** in resettlement.

Systemic barriers to employment and underemployment find men and women working long hours in their country of resettlement. They earn less and struggle with life. According to a Tamil service provider, this leads to extra-marital affairs. The culturally informed views of the service provider are also evident here.

“There is a shift there. The extramarital issue is a very sad thing again, because we come from Tamil culture, we have “Karppu” (chastity) and all that, okay, one man and one woman. I am not saying everyone is having extra-marital, but unfortunately the circumstances are to be blamed….., I would say, because the woman goes to work – this is just an example – she goes for factory work – there the supervisor is a Sri Lankan male, and he finds this woman attractive, how does he get his way?.. by saying okay “if you do this, this, this for me, I will give you overtime” Overtime or whatever. Another thing is the man works long hours, he comes home and sleeps, woman goes odd hours for work, so the exposure to man and woman in strange places at strange hours are not ….. there (in Sri Lanka), most of the women stayed at home, looked after their family, they moved with their friends and relatives, that’s it.

*Here you are exposed to all kinds, It is happening in both sexes, I see them, I talk to them, … very very sad”*

*# 002 Tamil Service Provider*

Another Tamil service provider talks about marital issues and draws parallels to similar issues in people migrating from other rural communities in other parts of the world. Such generalities in rural, collective cultures are important to understand from the perspective of service provision.

“…..yes there are marital issues, Actually (in SLT community) most of them come from small town, and villages, where the concept of relationship or expectation from a relationship (cultural) is very different, but they are not very different from even an Italian couple who come from a small town (urban vs rural cultures)”

*005 Tamil Service Provider*
Role reversals and its impact on marriage is discussed by this service provider.

“What the women come first and the man has an issue. Now all the expectations they have and will feel that everything will be okay. But here she will be established, be able to drive a car, will be able to do everything. Husband can’t do anything. His status will go down. Everything. I think we have so many things, but there are not channels of respite.”

#007 Tamil Service Provider

4.2. iii. Summary:

The community faces significant resettlement challenges and in some ways has learned from the struggles and is coping better. There is an interplay of gender and cultural factors that compounds the problems in the resettlement process. Examples are gendered expectations informed by cultural norms which results in marital issues. Coping with the unfamiliar that is marked by cultural differences between the home country and the receiving country, isolation, and role changes; and marital issues, also informed by role reversals and gendered role expectations are the main themes here. The findings from service providers focus more on the mental health impact of resettlement and serves to draw comparisons with other population groups. Parallels between rural, collective cultures from across the world and the Sri Lankan Tamil community are drawn here. Findings from community respondents talk to personal struggles in resettlement as well as struggles faced by the community. Findings reflect similar themes and sub themes. While the impact on mental health is articulated by service providers as such, the impact of resettlement on mental health is clearly evident in the narratives of the community respondent. This section focuses on findings related to gender and culture, however, it should also be mentioned that systemic barriers to resettlement like unemployment and underemployment are significant stressors and have echoed in the narratives.
4.3. Social Dimensions of Health and Illness:

The community’s perception of health and illness is predominantly through a social lens, which is informed by culture and gender. Though there was an array of responses some of which points to other dimensions as well, what stood out in almost all the interviews was this social dimension. Hence it has found its place as a major theme in the findings.

This section is informed by interview data from both community respondents and service providers.

4.3. i. Concept of Health

*Health as defined by social functioning*

The emphasis on social functioning as defining health was prominent in the interviews with community respondents. It almost gave the impression to the interviewer that the question about health was not properly understood. However on closer scrutiny findings indicated that the respondents were directly relating health to aspects of their social functioning that were important to them from a cultural and gender perspective, but which were impacted because of their illness. Functioning that enables *family centricism* and the *focus on education* — two aspects that are identified as hallmarks in situating the Tamil community are markers of health. It also indicates a level of distress, because all of these conceptualizations of health very distinctly relate to their personal experiences and what they have lost.
The following account is from a woman who lost her son to gang violence.

“When I think about health, children should be healthy and good, I should be good, as much as possible we should help others.”

#015 Female Respondent

This was a man’s response to how he viewed health. He was diagnosed with depression after an accident, which resulted in the loss of his job and compromised his functioning as an instrumental provider. His account points to his notion that being healthy is something that will help one achieve his goal of enabling children’s educational and other successes.

“I am asking your opinion of health in general”

Oh, right, I think of children. We should bring up our children well, make them study well. I didn’t study - now we need to know what they are interested in and channel them. We have suffered – now if we get them in the right path, that is enough. That is my desire – but this happened (the accident)”

#002 Male Respondent

As his health was compromised he was not able to carry out his social roles. Worrying about this further aggravated his mental health problems.

“Initially I thought I would be like this – I will work well, taking care of them. Then, I didn’t expect the accident. So thinking about all this, I worry and I have developed a lot of problems”

#002 Male Respondent
“Health means that one should be happy. There should be progress in life through education, through living, mental health means dreams and relationships should thrive”

#004 Male Respondent

Women spoke more of relationships as being integral to health. Again, it was noteworthy that these women who had been diagnosed with depression had significant stresses in their relationship with their spouses or have been estranged from their spouses.

“For mental health you should get a good husband. I think that is what is life. Otherwise whatever happens, there wont be happiness in the heart.”

#001 Female Respondent

“When you say health - it encompasses everything – troubles and diseases. I feel healthy when people care for me and come and visit me.

#003 Female Respondent

The one man who is estranged from his wife relates to health in terms that identify with his loss. He also does not have a steady source of income.

“When I think of health, I feel that you should be peaceful in your mind and happy with your wife and children. Other than that be happy with the income you receive. I think that is the basis of health. Other than that for keeping the body healthy it is diet and your mind”

#008 Male Respondent

Factors seen as crucial to staying healthy had a significant social functioning dimension. Respondents spoke about relating to friends, a healthy marital relationship, ensuring good education for children and a job as most important factors in keeping a person healthy.
The Views of Service Providers:

The social dimension of health and illness, though not articulated as such by service providers is evident in their understanding of when and how the Tamil community engages in help seeking. This will be highlighted in the theme around social dimensions of help seeking and service engagement.

**Normalcy as health**

A state of normalcy was noted by many respondents as denoting health.

There is an implication in the following narrative that normalcy is being free from disease and medication is needed to be free of disease along with other factors.

*I think health is being normal. For example, if you have diabetes, you should control your sugar and your diet, take medication in a timely fashion, do the work that you need to do.*

  # 001 Female Respondent

Normal functioning, absence of illness and the importance of both physical and mental health is highlighted here

“……with age you will get diabetes and ulcers – you can’t help that. According to me if a man is up and about and well I would say he is healthy. Diabetes – now about 80% have it. Apart from that if a person is able to do his work, walk, go shopping, have his bath….. when you think of younger people, they should have good physical health. They should also have a good mental status. These two are essential”

  # 014 Male Respondent
“I think it is (health), memorizing, ability to take in things, not using medication – these things…. It’s like, if today, I think that I should do this- I should be able to do it. If I think I should go shopping today, I should be able to do it. I should be able to memorize things well. Forgetting is a sign of being unwell.

# 009 Male Respondent

It is interesting that male respondents alluded specifically to functioning as sign of normalcy and health in comparison to women.

The Views of Service Providers:

Service providers also reflect this understanding of how the community views health as a state of normalcy, an absence of illness. They stress that the community lacks an understanding of preventative measures as being in the realm of health. Service providers spoke about fatalistic attitudes as something that might be informing this lack of focus on preventative measures. The sense of ‘If it is meant to happen it will happen, nothing can stop it’ (thereby seeking help is of no use).

“….I feel it is more like an absence of illness is physical health, as far as I’m feeling okay, then its fine, it doesn’t seem to be in terms of ‘what do I need to do to better my way of living, relating to people’…."

#006 Tamil Service Provider

“I think health, maybe this is common to others, I have seen it – the prevention component in not a big thing, only when you fall ill then you think of – okay, what do I
have to do, the prevention I would say is only an overall general thing, like okay “do eat properly” or those kinds of – very broad, nothing specific, the other thing that goes hand in hand – I think with Tamil community more, is almost like a fatalistic attitude – you know “my parents died of cancer, might be that’s what I will die of” that’s one kind of fatalism” (laughs).

007 Tamil Service Provider

Mental and Physical Health as Interrelated

There is evidence of a holistic view of health, with a significant social dimension and an understanding of the interconnectedness between the physical and psychological dimensions of health. Many respondents spoke about health as encompassing physical and mental health. This has been alluded to in the earlier section on Health as Normalcy. Here are some further examples.

What do you think is health?

Being without illnesses, a healthy body.

What kind of illnesses?

One is definitely depression, it should not affect anybody at all – even if it comes – as we are in Canada, we are still able to be with everybody, even so, when we think of what happened back home (to people with mental illness), we feel bad, the other thing is diabetes, whatever it is, it should not come (illness), if it comes it is a problem. Depression, or diabetes – things like that, of course it is different getting a cold or fever, these things one should not get.”

#007 Female Respondent

“....Real health is when the mind (“manam”) is good, if the mind is good, then automatically the body will be good (starts crying) that’s what I am thinking of. Now
“after I got cancer, my mind has been affected. I have depression….”

#010 Female Respondent

A farther refinement of this concept is seen in the following account.

“*Health is physical health. After studying, I feel that it is both physical and mental well-being. Only if there is mental health, there will be physical health. What I mean is you can achieve anything even if you don’t have a hand or a leg if you have a healthy mind. So I think mentally – I think 90% is mental health when you talk of health*”

#006 Male Respondent

“*Mental health, thinking positive things, have a good eating habit, sleeping habit, sleeping is very important for your health, I know, those are the things very important. Because mentally when you think healthy stuff you tend to do healthy things*…”

#012 Male Respondent

The Views of Service Providers:

Service providers interviews, for most part did not reflect this understanding that the community viewed mental health and physical health as interrelated. Some service providers did speak about a movement towards better understanding of mental health issues in the community, but not about the relatedness of mental and physical health.

The only wild card was the interview with a family physician, whose experiences with clients reflected this understanding. This might be because the integrated concept of
health might prompt people to talk to a family physician about mental stress and issues, rather than seeking out the exclusive services of a mental health service provider.

“People are very open to open up about their family problems and their underlying stress, depression, family problem, relationship issues, financial problem, work stress and their other stress which was affecting their physical health and thereby their mental health too. So sometimes they come and talk to us openly.”

#004 Tamil Service Provider

_Taking medication and visiting doctors as indicative of ill health_

In many narratives it was found that taking medication was equated to "being sick" and hence there was an expressed need to reduce medication. Perceptions of the negative effects of medication also led to non-compliance. As medication was associated with ill-health, there was a tendency to stop medication when improvement was perceived. This led to a long history of non-compliance for many respondents in their struggle with depression. Society places an emphasis on health as a movement away from medication, and this influences health behaviour. There did not seem to be any gender differences in this regard. However, it must be said that some respondents have become medically compliant after having felt the impact of non-compliance first hand. Some accounts highlight not visiting doctors or not having had to take medication as a very positive attribute.

When social functioning is one of the primary indicators of health, then preventive measures are undervalued and only an evident breakdown of function or presence of an overt illness prompts seeking medication and the services of the health system.
“...But now see how many pills I have (shows me the stack). Taking it I feel frustrated”

#006 Male Respondent

Why did you not go to the specialist?

I did not think it was necessary. I don’t like taking medication. I was in Europe for 13 years. Even there I will not go to the doctor or take medication.

#008 Male Respondent

Only now I have started going to doctors after this (accident). Before that I did not like to go to doctors.

Why is that?

I don’t like to take medication. In the 10 years (that I have been in Canada), it is only now that I am going to a doctor. If I am really very unwell, then only will I take a Tylenol. If it does not get better with that...as I remember, I have gone to a doctor only 3 or 4 times.

So the yearly check ups?

I have done it only three times – full medical check ups. But for blood donation – I go every six months.

#016 Male Respondent

When I landed in Canada with my five children I had no ailments or complaints (health wise) whatsoever. When I came here and saw the doctor, she checked me and said ‘since you need a family doctor in Canada, you should register with some family doctor’. I said that I don’t need a family doctor as I was keeping my body and health under good control. I don’t need a doctor. But then I was advised that I definitely need a doctor, because if I was going somewhere for something, they would require a report from the family doctor. Only because of that I registered myself and my children with the family doctor. When my doctor saw me she asked me, ‘did you use any medication in Sri Lanka, did you have any ailments?’, I said ‘only when I was pregnant did I take tablets. Otherwise I have not taken any medicines. Till 46 years, I
have had such good control over my body and health.’ I had kept my body disease free. Sometimes for cold or fever, I would just take a Panadol. She then tested me and said ‘you are a smart woman, she said here even young people get ill, but you are good – so maintain your health as such’. Apart from that, I wouldn’t come to her, but she advised me to come and get a check up done intermittently. But I wouldn’t since I had no issues….

# 015 Female Respondent

She also has depression, but she does not take medication, she feels that she will become lazy if she takes the medication.

…..So when I went to the clinic the next time, I told the doctor and they gave ECT treatment (in Sri Lanka). I felt better, but the mistake is with me – discontinuing medication…..Now I take medication, but I would like lesser medication.

#001 Female Respondent

The availability of services, referrals, or reminders to do regular check-ups are not sufficient to ensure visiting the doctor or taking medication for most of the respondents.

Views of Service Providers:

On the surface, one hears a very different reality from the perspective of service providers. Many of them say that the clients prefer to have medication and would not want to avail themselves of psychotherapy or counselling without medication. In a way, this might be in consonance with the views of community respondents. If medication and going to the doctor is indicative of illness, then the doctor is approached only when there is an illness and the expectation is that the illness will be cured by medication.

“…..Yeah, and they do want a prescription or medication – very few of them would like to engage in ONLY psychotherapy, without medication”

# 005 Tamil Service Provider
It is also indicative of the fact that counselling and psychotherapy are largely alien concepts to the Sri Lankan Tamil community, and are usually not seen as a stand alone treatment.

This is in contrast to how medication and other therapies are viewed by mainstream society when it comes to mental health issues. In the words of the same service provider

“...Suppose I am seeing a Bank Manager - a Canadian for three generations, when they say they are depressed, they know it is a mind-related issue, their awareness of what sort of therapy is available, the down side of taking medication, the possibility of getting hooked on to medication, withdrawal – all these things are there”

# 005 Tamil Service Provider

“... of using medication as against psychotherapy to deal with the issues, it is ‘give me the medicine, I will sleep better’. There does not seem to be the resistance, that I am seeing with the general population, it is ... ‘I don’t want medicine...’ so they are very different things... so the kind of respect and belief in the family doctor and psychiatrist is very high (in the Tamil community) very different from what you would see with the general population, that seems to be the pathway, through the doctor and the psychiatrist and then counselling”

#006 Tamil Service Provider

4.3. ii. Contributors to mental health issues

Social attributions to the personal experience of depression

When asked about their specific experience with depression, many respondents spoke about social causes as playing a significant role in their condition. Death of loved ones,
failure in love, marital problems, problems with the spousal family, problems with children, unemployment, inability to support the family and resettlement challenges were the factors cited. Relationship-related factors play a major role as contributors to risk.

There were significant gender differences in attribution, which were in keeping with the gendered social roles that culture dictated. Men referred to their inability to provide for the family and being unemployed as either causing or aggravating their depression. Only one man talked specifically about his relationship with his spouse as causative. Women pointed to marital discord, problems with spousal family and issues relating to their children and related factors as contributing to depression. Alcoholism in men and the resulting domestic violence also featured as significant contributors in the narratives of women. In the case of the one man who had talked about marital discord as causing his depression, there was both alcoholism and domestic violence involved.

“We got registered there. It was okay, then. Then after I came here it was okay. Then after marriage in a short while, there were problems and I became unwell”

#005 Female Respondent

In the following narrative, marital discord is linked directly to the development of symptoms. Another interesting finding is that the expectation of “being taken care of” which is a gendered cultural expectation that women have due to their socialization process, as highlighted in the findings on Family centric dynamics, leads to disappointment in the marital relationship when this care is not forthcoming from the spouse or spousal family. This was found in many other interviews with women.

“Then I thought that he will protect me. He just kept looking (when her mother-in-law assaulted her). I thought he will show affection towards me, take care of me. He did not. Then even I cook – he will not eat it. So I stopped cooking, stopped eating, every once in a while I developed a throbbing in my head and I would fall down without my knowledge. Then after a while I would get up to find myself on the floor”.

#003 Female Respondent
This respondent speaks about her disillusionment on reuniting with her husband and the distress of leaving her children in the care of others as significant stressors that contributed to depression. This is directly related to resettlement-related stressors.

“I was building up an expectation about what would happen when my husband came here. I thought I would get some rest, when that hope broke, I thought I was affected physically, but I did not even imagine that I would be affected mentally,..... at the same time – leaving children with unknown people for daycare – as a mother, that is very very difficult”

#013 Female Respondent

The following account is that of a male respondent who prides himself on his role as provider. Losing his job after an accident and the subsequent inability to provide for his family and larger society (as he used to) were seen as the major cause of his depression

“Only after the accident did I start staying at home. After the accident I couldn’t go to work.”

Where were you working prior to your accident?

“I was working in a restaurant and a laundry, I sometimes used to do three jobs in a day. I would go wherever – whatever job was given to me, I am okay. If they ask me to clean it, okay, if they ask me to write it – okay. My mentality is like that – I have been habituated like that. After coming here I was working well, for my house, others, I have helped many others as well. Before the accident I have sent so much money – to orphanages etc. But now everything has stopped, I cant do anything. Wife is not working. She has problems in the leg because of the cold weather. So she does not work. Children are at home. I could not support my daughter and her husband who are in India. This threw my life completely on the other side and I was severely depressed.”

#006 Male Respondent
Another male respondent talks about a multiplicity of social factors, including resettlement challenges, with a specific emphasis on unemployment.

“For my studies I could get a good job in Sri Lanka, here the only problem is the language problem. I had 35 people working under me in Sri Lanka. I was the manager of a shop. For almost a year I was in Colombo. In life, some of the reasons why I got depressed was – I was happy as soon as I got married. In Canada, weather is a big problem. Then after that, when I came, I did not have a job, I was not well, no welfare either……”

#008 Male respondent

Service Providers also spoke about the social causes of depression in the Sri Lankan Tamil community. Two service providers specifically spoke about the fact that the community was able to relate to social factors as the reason for their depression.

Cultural beliefs regarding causation of depression

It was interesting that only women subscribed to cultural beliefs as playing a role in causing their illness. This could be because, of the 8 men interviewed, 5 men attributed their illness to the aftermath of an accident. Also, some of the women traced their depression back to Sri Lanka, where cultural beliefs regarding illness might have been stronger, while all the men reported that their depression occurred only after migration.

“Catching a chill” was cited in a few narratives as a possible contributing factor. Female respondents said that the community members had said that having a bath in cold water at odd hours might have led to the condition, and that they themselves thought that this could be a reason for developing the illness. Women also said that community members had suggested that their condition could be the result of “possession by spirits”, or because of “black magic” (Ṇsei vinaiō in Tamil) though they themselves were unsure of
it. A related concept was being punished by the Gods because of inappropriate behaviour.

“I used to pour buckets and buckets of water on my head. That also could have caused my illness. People say that if you pour water like that you could develop mental illness. Is that true?”

#001 Female Respondent

“They told me that I was constantly fainting, our relatives suggested that I be taken to the temple. ‘If you apply the holy ash she will be okay’. Then they would take me to the temple and holy ash was applied. Even they said that it was black magic. When they said “sei vinai” (black magic) – they gave me some liquid extract (“charu” in Tamil), they made me drink it and vomit – then they said that there was hair in it. I didn’t see it properly, but they said so.”

#007 Female Respondent

“Well, they thought that this was happening due to some wrong doing (kurai), when I went to my mother’s place in Parithurai, I became unwell, when I went to attend my cousin brother’s wedding - they said that since I was wandering during my periods (menstrual cycle), and there was the Vairava temple, they said that the spirits had caught me”

#011 Female Respondent

It must be stated that in not one of the interviews were these beliefs cited as an exclusive reason for having contracted the illness. At best they can be seen as factors contributing to a multiple causation theory of illness, which is quite normal in many cultures.
Views of Service Providers:

There is a very good understanding on the part of the service providers and there is no longer stress on cultural beliefs and beliefs around supernatural causation as dominating the Tamil psyche when it comes to mental illness. Service providers attribute an increased understanding around mental illness to education and awareness in their country of resettlement, initiated largely by Tamil Service providers.

“…..now (as compared to earlier) 99.9% of my patients are Sri Lankan Tamil. That shows their shift about their views about illness, about psychiatry as such. I’m not saying that the Tamils accept psychiatric illness as a normal condition like Canadian White, still we have taboos and beliefs and all that. In spite of that most Tamils do understand the concept of depression, Change occurred over a period of time, by many of us who have been involved in the community, educating them…..”

#002 Tamil Service Provider

“That kind of beliefs mainly, in paranoid illnesses, some of them – it has lessened now – like they have done something “ sooniyam” (black magic) exactly - so they go to the poojari, the temple and do all these things, - that is still there, but I don’t see them as often, because one person might believe it, but the spouse might say “no, no no, this is something, this is an illness, we have to take treatment”.

#004 Tamil Service Provider

Psycho-social stressors as a significant factor in mental health

Community respondents and service providers stressed psycho-social stressors as significant factors that affect mental health adversely in the Tamil community. Stress and loss related to the war, displacement and resettlement play a prominent role here. Gender and gender role expectations also impose further stresses, as found in many narratives. Some psychosocial stresses have their basis in cultural factors. For example in many Sri
Lankan families, the wife is expected to stay home and take care of the children. To make up for the adverse economic impact this causes, the husband works two or more shifts. Some respondents draw parallels to other similar cultures with regards to the stressors that impact mental health.

“Today, if you ask me, the reason that my accident happened was because of that (stress). Not only my accident – even road accidents. Everybody wanders around “stress”ed. If you are late by 5 minutes to work, your salary gets cut for half an hour. There is stress at home when you work two jobs. Stress for our people – if it is older people, they are stressed because of their children. Here children grow up “free”. So that is a problem for our people – I mean Asians as we are all family related. What is the child studying, where is the child going, why is he/she not informing us about where they are going, all that. So that is the reason that older Asians are stressed out. The other thing – you know the war going on in Sri Lanka is another reason for the stress. It has affected everybody. For older people it is for their kith and kin, their relatives (lost, back home), like that money is another stressor – today mostly the reason for fights within families is money. In Asian families both husband and wife working is less, around 50-50, it is less among Pakistanis. In Indians it could be slightly more. But in Sri Lankans it is very very less. Only in around 30% of the families do both work, Otherwise it is only the men. So money is a big stressor. Men are out most of the time working

#014 Male Respondent

“With regards to men, it is more related to jobs, if somebody is driving a better car and things like that. Sometimes there might be younger people, who work hard, buy a car and house and all that. So that creates jealousy. Also many have family responsibilities – that also causes stress for a lot of people. Mostly for women, it is women who have married and come from there to be with their husbands or it is women living with their parents. As far as men are concerned, they are sent here by their family and then the family members back home have expectations of them. For every small thing they will keep asking him to send money. Sometimes here the man might not have enough money to pay his rent. At that time, if there is a demand for money from home, that will create a pressure”

#016 Male Respondent

Findings indicate that some of the stressors and the circumstances cited as leading to mental health problems are informed by cultural values with specific gender overtones
“I am not talking about myself now. If you see Sri Lankans here in comparison to back home, more girls than boys have mental health issues – they go for that treatment – for treatment and such issues to Dr. XX

Why do you think that is?

Many people – there is divorce, normally girls going out with boys, girls drinking – such things, when boys cheat girls, when married men go to other women, such things …. There (in Sri Lanka) such things do not exist at all. Normally those things are not there.”

#009 Male Respondent

“To tell the truth, the mental health problems occur more back home. To tell you the truth, my sleeplessness was largely due to the shelling. Me and my sisters children would always be scared of what would happen. Here we do not have that problem. Here there is not such sound or anything. People can be happy here. Beyond that something is happening to the children, it is the parents’ responsibility to take care of the children. In our towns, till we (girls) get married, our parents will take care of us and watch over us – keep an eye on what we do, where we go and come, my mother used to do all that. There we are under the control of our parents till we marry. Here parents watching out for children is a little less. After they grow up…. This leads to mental health problems here”

#011 Female Respondent

Views of Service Providers:

Service providers also point to the role of specific psychosocial stressors in mental health. This reflects an understanding of issues that are relevant in the context of immigrant and refugee communities. Domestic violence, problems with spousal family, isolation of women, seniors, single men, and challenges in resettlement are cited as important stressors.

“….the Tamil group…. a lot of people came with nothing, as refugees, they couldn’t come with a lot – that is a bit different from some other cultural groups, I am thinking
of the Chinese, for a certain period, Chinese came to the country with a fair bit of money. So that makes a difference – the Tamil group would be the issue of poverty, the language is an issue, even though in some of the more educated people it is less of an issue, than for example the Chinese community, so there are these differences – So language is one, the poverty, employment – creates, stress, mental health issues, then of course they also somehow get into different problems, I can't tell you the exact reason because I do not know how – for example alcoholism, it is a common problem.”

#001 Non-Tamil Service Provider

“One thing I notice, those Sri Lankan Tamil people that I see, they have lots of social problems as well – either employment problems, financial problems, relationship problems, alcohol and physical abuse issues, a wide spectrum of social issues – some of them suffer from schizophrenia, whereas their family background everything is stable, so probably that is genetic contribution. But with mood disorders, especially depression alone, there are lot of ongoing stressors that come into it”.

#005 Tamil Service Provider

Many service providers talk about relationship issues as major stressors that lead to mental health issues. Strains in relationships lead to domestic violence. The issue is compounded by alcohol abuse in men. In all instances of domestic violence told by the respondents, the abusers had a history of alcohol abuse. Service providers also reflect this in their interviews and talk about domestic violence instigated by alcohol abuse.

“Now in the families that we see alcohol is a problem. Alcohol or there is an affair, most reasons are those – which people come with…… Depression …. Yeah, because, I’m, because of the work and the population that I’m seeing, its as if when you work you see it everywhere. And so, I feel in a way that the relationships in many many families are not working”

# 007 Tamil Service Provider

4.3. iii. Identified mental health issues and related problems in the community

The factor most readily identified by community respondents as a mental health issue that their community suffers from is depression. They also relate this to psychosocial factors
that have been highlighted earlier as well as the war trauma in their home country. Verbatim accounts in the earlier sections on psychosocial factors also lend support to this finding.

“...the problems of some people can be seen, those of others are hidden. Mostly, as far is the Tamil community is concerned it is clear that around 60% is depressed.

Why do you think that it is so?

Depends on husband or wife or families, then when you think – the husband being always out at work and the wife being always home alone, that could also be an issue, being alone. It can be caused because of that also. I think those are some reasons”

#005 Female Respondent

While the community has developed the capacity to articulate depression using the term depression, it is not so with other disorders. When people are out of touch with reality, the term “mental” is used. None of the respondents interviewed were able to identify other illnesses, though they referred to behaviour that they considered out of place like talking to self and laughing inappropriately. There was one respondent who used the term “autism” to refer to mental illness. In this narrative, the respondent talks about mental illness in the community and the role of psychosocial factors.

“Here I have seen a lot of people, who have been here less than 10 years, they are fully “mental”. They are all – many people think that they are abroad, so they give dowry and marry their daughters off here. The wives come with a lot of expectations to Canada. When wife comes here, they will immediately buy a house, taking bank credit, then they take a car – for one or two years, they will be really happy. Then the problems come full force. The wife will start pressuring that you bring her siblings to Canada. To do that it takes around $40,000/- (illegally, because legal ways are closed)”

#008 Male Respondent
Almost all respondents talked about alcoholism as a growing problem in the Tamil community. While some respondents spoke about women drinking, personal experiences were always related to alcohol abuse in the male spouse or oneself (when the respondent was male). The social dimension to this drinking problem is highlighted in the following section on views of service providers.

**Views of Service Providers:**

Service providers were unanimous in their view that **depression** was a major problem in the community and attributed it to psychosocial stressors. Trauma due to the war and pre-migration experiences was also cited as significant factors in the community. There were also significant **gender differences** in the presentation of mental health issues when the community reached the service provider. In general service providers reported that they saw more depression in females and more schizophrenia and alcoholism in males.

*“Depression is a big thing, psychosis, issues related to war trauma that have an impact now, alcoholism, and family related issues, men have been more related to psychiatric diagnosis and counselling, alcoholism, things like that……………….*

*And what is the psychiatric Diagnosis*

*Maybe it is schizophrenia, schizophrenia is what I am seeing more, and paranoia, and depression, of course. and I’m seeing, in terms of men and women, interestingly I don’t think that I have seen any women with a psychiatric diagnosis, of course there are psychosomatic presentations, but not a diagnosis, men it is always a diagnosis, they have depression, psychotic depression, and things like that, and in terms of factors, I think it is the resettlement and the stress of settling here, just going back….. what I’m also seeing is alcoholism, in men, you don’t see that in women at all. Also, factors contributing to mental health…. seems to be related to settlement, that’s a huge stressor…..”*

*#006 Tamil Service Provider*
The same service provider spoke about trauma and personality disorders as being major issues that she deals with in the general population.

The gender differences mentioned above is also reflected in another account.

“Among the men we have more alcoholics and schizophrenics. Women schizophrenics are less. Most of the women are depressed with various factors. Unfortunately it is not the textbook type of depression where you can say “okay, take this pill, go and come for counselling”

#002 Tamil Service Provider

Similarly, alcoholism was seen as a growing problem in the community and most service providers spoke of the specific impact of alcohol on men and how men use it as a coping mechanism. It is to be noted that all service providers including non-Tamil service providers spoke about alcoholism as a significant problem in the community.

Psychosocial stressors, the stress that men in a family-centric community are faced with when there are no supports in the country of resettlement, the challenges of resettlement and the norms of the host country, all play a role, bringing a significant social dimension to the issue of alcoholism.

“However slowly, because we faced practical issues – we would have taken a loan to pay the agency, we would have to send money back home or might have to send money for a sister’s wedding. So I might be working two or three jobs. So my relaxation would be that in the little free time I get, I (does not mean him, but youth who have come like this) will drink or have fun with my friends. So when I get more time in the process, I will start drinking more. This is how many youth start drinking. When they find time, they get together in somebody’s house and drink. For people working in restaurants at the end of the day you will get one or two free beers, if you are a chef, the alcohol is unlimited, then you get habituated and you want it at home. In our home country, if we want to have fun, the issue will always be how to overcome or break
taboos. One of the taboos there was drinking – you should not drink, so when this became probable, we started breaking the taboo and drinking, also getting together and creating a racket which you were not allowed to there either.

Also there was no social control mechanism, who is there to ask us, no elder brother or anybody…. So this created another social problem.”

# 003 Tamil Service Provider

Coming from a culture where social drinking was a taboo to a culture where it was acceptable makes access easier, and the chances of unregulated drinking behaviour higher in the face of stressors and the lack of social control mechanisms.

“Ok, in the Tamil community I can say that they are depressed and drink and drink and depress, both.…

Yeah, and you know, the drinking is a fashion, drinking in the Sri Lankan community like it is accepted culture, like birthday party to funeral home, every, it is a must…. 

I have a question, is that here, after people have come to Canada or is it like that with the Tamil community in Sri Lanka?

No, here, In Sri Lanka, they take it like a medicine, like after a baby is born (mother given some alcohol for health reasons) But here it has become acceptable and also access to the drink. And also because of their financial…. ”

004 Tamil Service Provider

This service provider also talks about depression and alcoholism as being major issues amongst Sri Lankan Tamil men. S/he talks about socialization and gendered roles as important factors.

“….Again I would say depression and for them(men), maybe the factors are slightly different, could be the whole adaptation would be there of immi….racism, and all that, also loss of status in the sense that – again going back to the whole socialization – man’s primary success or role is the provider, but HERE, they might be providing,
maybe they are working in a job – their qualification is much much higher, but they are working in a menial job, so they do not see a sense of fulfillment and the loss of status contributes to that….. but, addictions, alcohol is a major issue in the Tamil community and gambling. I think we don’t talk about gambling so much, but gambling and addictions are major.”

# 007 Tamil Service Provider

Very few service providers spoke about alcohol abuse amongst Tamil women. In fact, one female service provider stated that she had not heard of a single case of alcoholism in Tamil women. However two male service providers did speak to the fact that more and more women were getting addicted to alcohol. Changes in cultural norms, and expectations are seen responsible as are stressors that are based on relationships.

“…number 2 in SL, rarely have I seen any women drinking, now a lot of women are drinking here, you know, from girls underage girls to elderly mothers. Sometimes some of them have had cirrhosis of the liver and everything because of the alcohol – I ask them when they come to me for alcohol treatment, I ask them “Amma, when did you start drinking” You know what one woman said, she is in her 50s and she said, doctor when I came to Canada my daughter said, “we are going for a party and there they will serve you wine and you SHOULD drink” why – if you don’t drink you are not in the social class. This is the mentality – okay, see the mentality. In Tamil they say “the calf which has joined the pig also……, the same attitude. I have heard men telling me “when I go to parties, my wife tells me to drink because otherwise I am not a man.” See the way, these are all kind of – uneducated kinds of thinking, but it is happening…”

#002 Tamil Service Provider

Lack of understanding of what a drink constitutes because of unfamiliarity also leads to addiction, according to this service provider. This was an interesting observation that was not brought up by other service providers.
“...Yeah, yeah, more men (are drinking), and women are also becoming addicted – those who are being separated, have problems with children, they think that it is the medicine for them........ Yeah, and they experience sleep problems, they drink, they think it will... (help them sleep). That is the addiction concern, I can say, and you know standard drink – standard drink is 13.6 grams, so they don’t know, they think one glass is the standard drink. So they don’t...”

#003 Tamil Service Provider

4.3. iv. Summary

This section on the social dimensions of health and illness highlights social functioning as an important factor in how the Sri Lankan community defines health and illness. Concepts of health are directly related to social functioning which is informed by cultural and gender expectations. For men, health is equated to the ability to work and provide for the family; for women, it is directly related to relationships and their success. The respondents point to social factors, with specific gender overtones as causing or aggravating their personal experiences of depression. There is a movement away from supernatural beliefs as being causative. A holistic view of health encompassing social, physical and psychological dimensions is in evidence. However this understanding of the community’s notion of health is not reflected in service provider narratives.

Taking medication and visiting the doctor are seen as indications of ill-health rather than as mechanisms to promote health. Psycho social factors related to immigration and resettlement are considered to play a major role in impacting mental health adversely. Family-centric dynamics and the stresses that derive from resettlement are also seen here. Again, this is informed by gender role expectations.

With regards to mental health and related problems; depression, trauma, alcoholism and domestic violence were major concerns. Service providers spoke about gender differences in the manifestation of mental health issues, with more women being
depressed and more men suffering from schizophrenia or alcohol dependence. While many service providers did not recognize alcohol dependence in women as an issue, there is a definite need to consider this as an emerging issue in the Tamil community. Alcoholism and depression are largely influenced by social factors in the Tamil community.
4.4. Social Dimensions of Help-Seeking, Engaging in Treatment and Support:

Help-seeking, engaging in treatment and expectations thereof, and support needs are largely influenced by factors such as socialization, assigned roles, role expectations, and social functioning. Culture and gender play a very significant part in help-seeking, treatment and support.

Findings from community respondents directly reflect their personal experiences with regard to depression. They also mirror cultural and gender realities in the larger Tamil community. Findings from service providers focus on aspects of help-seeking and engagement in treatment within the Tamil community. They also serve to highlight commonalities and differences between the Tamil community and other populations.

Help-Seeking

Pathways to Care

There are distinct differences in pathways to care depending on whether the help-seeking was initiated in Sri Lanka as opposed to Canada. There are also gender differences in pathways. Contact with the health system does not automatically lead to facilitating the referral process.

Four of the respondents revealed that the help-seeking process began in Sri Lanka. Of these, three were women. In all of the four narratives, the help-seeking began at the temple. Hindu priests at the temple were approached. They conducted certain rituals for the well-being of the person, such as making certain offerings to appease the Gods and
ask pardon for any misdemeanors, bathing the person in milk to cleanse them, and the like. The male reported that he was taken to the astrologer as he was not able to focus and was not performing well academically, and maintained that his depression started after migration. Two of the female respondents reported that the priests practised Shamanism to drive away the evil spirits and counter the effects of black magic that had resulted in the illness. Some of these procedures were experienced as distressing and painful.

“Then I was taken to the temple – kalamari – that priest put a “Ullakkai” (*a cylindrical wooden device around 6 feet long with iron on both ends used for pounding rice*) on my leg and that hurt me terribly. Nothing worked….Only after this they took me to the hospital. Tellipillai hospital – Dr.XXX. He is a very smart guy (laughs)”

#001 Female Respondent

“But everyday (exasperated sigh), they used to take me to the temple and cut something or the other

Cut something?

Yes, like lime and pumpkins (*there is a distinct religious and cultural connotation here as these are auspicious vegetables in Hinduism and are used for good luck and/or to ward off evil*) Doing something with ‘kumkum’ (*the red powder which is again a cultural symbol, worn by women on their forehead and offered to men and women at temples*), bathing me in milk – like this they did many things”

#011 Female Respondent

“My father used to take me to the astrologer and they looked at the planetary positions and the ‘lagnas’”.

#004 Male Respondent

The subsequent point of access was the psychiatric hospital in Jaffna or the Psychiatric Division in a General Hospital. This was when there was a very overt problem or a break down of function. Some individuals continued to be seen by a private psychiatrist. On
arrival to Canada, in two of the four cases, a Tamil service provider who was not a physician played a role in facilitating a connection to a psychiatrist. In the other two cases the family physicians referred the respondents to a psychiatrist. Family physicians also play a role in the care for mental health problems. In three of the four cases, psychiatrists and family physicians caring for these respondents belong to the Sri Lankan Tamil community.

When help-seeking or the occurrence of depression reportedly began in Canada there were distinct gender differences in the pathways to care.

Five of the men got engaged with the mental health system only after an accident. Pain specialists or lawyers usually referred them onwards to a psychologist or a psychiatrist. In this process, they were referred to non-Tamil mental health professionals as well. However at some point in the pathway, there was a Tamil family physician or Tamil-speaking counsellor involved. Some men indicated that they did not have a choice with regards to the service provider that they were referred to. With two of the other men, where the point of entry was not an accident, referrals by physicians did not proceed to active help-seeking. In one instance, engagement with the mental health system finally occurred when a friend attending the community health centre brought the person to an Indian Tamil mental health worker.

This account shows how family physicians dropped the ball in failing to perceive the depression of the client, leading to a delay in accessing treatment for depression. Also, engagement with the family physician was facilitated by another Tamil friend, showing that informal supports play an important role in setting pathways to care.
“I kept worrying all the time (after the accident). Could not sleep, felt like dying…. I went to the family doctor…. a Tamil doctor. For one year he did not help me in any way. Now I go to a white Jew doctor……I went to this doctor after 1 year. He was my friend’s family doctor. It took me 3 months to get an appointment from him…… I got the appointment through the telephone. The very day I went to him he arranged for a pain specialist appointment……..The specialist sensed something and sent me to xxx (psychologist) and then xxx asked me to get a referral from the family doctor to the psychiatrist. Then I was referred to Dr. XXX. I am being treated by him.”

#002 Male Respondent

With women, the narrative was different. The onset of depression and help-seeking started with significant life events like death of a son, a stigmatizing physical illness (as viewed by the Tamil community), an overt breakdown following a significant event involving husband or husband’s family, domestic violence or divorce. In most of the cases, referrals to the mental health system were initiated by family doctors, most of whom were Tamil. In one case, the respondent was hospitalized, seen by non-Tamil physicians and later referred to a Tamil-speaking counsellor who referred her to a Tamil psychiatrist. Tamil-speaking settlement service workers also facilitated referrals to the mental health system.

Though engaged in the health and the mental health system at some level, delay in accessing care, and delay in the identification of depression by professionals was also present in some of these narratives.

Female Respondent #010 had been diagnosed with cancer which, in her own words, is associated with a high level of stigma in the Tamil community. The family doctor referred her to a specialist who made the diagnosis. She developed depression following her diagnosis and continued to be seen by the specialist and the family doctor. However, her depression went undetected. In the meantime she also attended general group session for mental health provided by a community health
centre in her neighbourhood. Her depression still went unidentified. More than a year later she was involved in a community development activity facilitated by a settlement service provider with no mental health background. This provider suspected that she was suffering from depression and referred her to the Tamil-speaking counsellor in a community health centre. She was then referred by the counsellor to the non-Tamil female psychiatrist. At this point, she was referred by her Tamil family physician to a Tamil psychiatrist. However, she continues to access care at the health centre.

For women it is not uncommon that they continue to access more than one service for mental health simultaneously after the initial pathway to care has been established. Many of them were seeing a psychologist or a counsellor in addition to a psychiatrist. Some of them were also attending groups run by the social worker or counsellor, in addition to attending individual sessions.

Pathways to care were more direct for women than for men. For women, referrals by family physicians or other workers resulted in directly accessing mental health care, whereas for men the access occurred following an accident, domestic violence, or some other event which necessitated a referral. Failed referrals were more common in men than in women.

Views of Service Providers:

Service providers specifically point to the role of family physicians and instances where the “ball is dropped” in initiating the pathway to care. The psychiatrist is also an important service provider identified in this pathway to care.
“...but when they go to our doctors they don’t realize that they are experiencing depressive symptoms”

You mean family physicians?

Yeah, family physicians, they just give the medication for ‘Okay, you don’t have sleep, okay, put aspirin, or do it’ These are the things happening, they don’t talk to them more deeply about the problem they are experiencing, so it also misdiagnosed and are given medication.

.....Yes, as I said, psychiatrists, they (service providers) refer to them, even Tamil psychiatrists we refer to them, we have few of them”

#003 Tamil Service Provider

As in the interviews with community respondents, the fact that an imminent crisis or life event sets the help-seeking in motion is also clear in some service provider narratives. This also decides the pathways with regards to points of entry.

“.....it is a specific need that they have, it is a crisis, maybe it is a psychiatric diagnosis, it is, you know, probably something that has happened, I mean it is very situational based.....”

“.....and there is more case mgmt needs, with the Tamil community, like I need support with my ODSP application, my employment, so it is that, so the point of entry is different, so once you do that, they have some kind of a trust and then they reveal something”

#006 Tamil Service Provider

Sometimes service provider biases may impact the help-seeking pathway. This was clearly articulated by one psychiatrist. Service providers turn away from events or needs that set the help-seeking in motion, thus creating barriers and deviations in the pathways to care
“So again it makes you question how the help-seeking pathway goes. Sometimes there is a psychiatrist having a selection bias, like some of the psychiatrists who I work with say very clearly, “I do not want to work with the legal issue, WSIB issue, any insurance issue and other things” because they are troublesome, you have to fill forms and legal – they might have to go to court and psychiatrists do not want to do it, it is messy. Why not I deal with a clean case – I get paid the same, dealing with a clean case and a messy case, right, so that is one part that I see, the Dr. having selection bias, but I don’t think that is everything, the system is set up so that a lot of people do not get to the …… (right services)”

# 001 Non-Tamil Service Provider

A provider suggests that regardless of background, gender has an influence on pathways because of how the system is set up.

“So in a way definitely they use it differently, so for help seeking it has also implications of where they would end up, so the men would end up in the criminal justice system. For any altercation that happens between the man and wife, the men would go the legal route, whereas women would go to the shelter and the psych…mental health route which is just how the system is. But is that the best way of responding to the system, I am not sure.”

#001 Non-Tamil Service Provider

Problem Identification and Initiation of Help-Seeking

None of the respondents or their families had been able to identify the issue as depression at the onset, even though some of them sought help. It was usually other service providers like settlement and social service providers, case managers, psychiatrists, pain specialists or family physicians who identified the issue as depression. In most of the narratives, the initiation of help-seeking is delayed because the depression was not identified by the sufferer or the family. Retroactive problem identification after engagement with the system was present in many narratives. As seen earlier in the pathways to care, some family physicians were unable to identify depression in their
clients and thereby failed to initiate psychiatric help-seeking. There was no pattern that was noticed in who initiated help. Surprisingly in quite a few cases, help-seeking was initiated by the depressed person. There were **gender differences** in how help-seeking was initiated for men and women. Narratives of women showed that an overt breakdown resulted in their husbands rushing them to care as they could not deal with the issue. For married men, the women detected at an earlier stage that their husbands were suffering and initiated help-seeking. This role of women in help-seeking will be explored in the sub-theme of “Women as enablers of care”.

Direction from a service provider plays an important role in initiating help-seeking specific to mental health issues. In this narrative it is interesting that, though the respondent attributes her lack of sleep and headaches to her marital breakdown, she is not able to see these symptoms as manifestations of a mental health problem until she is guided by the family physician. The initiative to seek help for her symptoms came from the client. In several narratives where help-seeking was initiated by the person him-or her-self, it was because of troubling symptoms rather than because of an understanding that the symptoms arose from a mental health disturbance.

“Who initially realized that there was a change in you?

*The family doctor. He only found out and asked me to go.*

*Why did you go to the family doctor?*

*For lack of sleep…..I really expected that life would be good here with my husband. But when everything turns out to be opposite, it is an unbearable disappointment for us. I couldn’t bear it. From then, I went directly to the family doctor and spoke. I did not have sleep at all. I would just go and lie down but sleep would not come. Then terrible headache, he said “go see the specialist”, that is how I went”

#005 Female Respondent
This female respondent has a very supportive family who is very engaged with her care presently. However they were unable to identify the problem initially. Though the respondent felt that something was wrong with her, she was unable to express this. This led to a substantial delay in help-seeking, which was initiated when a Tamil-speaking settlement service worker identified her depression.

“I did not.....nobody really thought about that (despite the symptoms being quite significant). Nobody thought about it. My daughter said that I was crying because I was worried. He (husband) also does not seem to have thought much about it – but I am crying always, he says “don’t cry, watch TV”. My sister is also there. Everybody .... But nobody thought about this. I don’t know whether it was there was no such problem (depression) in the family or .....nobody thought like that. But I knew something was wrong, but I did not know how to express it overtly”

#010 Female Respondent

Even in the only respondent who had completed most of his high school and university years in Canada (as he immigrated when he was around 15 years of age), there was little awareness regarding his condition, which delayed problem identification and help-seeking. A friend played a crucial role in directing him to help. He brushed aside extreme weight loss, lack of appetite and inactivity saying, “its okay, Im just feeling sad”

“.....What should I do. And that kind of ..... and at that time, I was looking like I was a sick person. Skeleton person......

When was the first time you realized that there was something wrong in terms of mental health?

I would say that one of my friends (a white Canadian), XXX, she is my closest friend, she lives in xxx (a small town north of Toronto), we became friends after going to University. She was like “come to school” after graduating, she was like “lets’ go to school”. I was like “ok’ sitting at home doing nothing, okay, let me drive. I had no energy to drive, but I’m like okay, lets’ go. Driving took me like THREE hours, trust me, I took like - I don’t know, I used to take the highway, but I took the normal road, I thought somehow in the highway, I cant drive, so I took the normal road, went very
slowly, people behind me, I’m like ignoring people, going very slow, ignoring people, met up with her, she – as soon as she saw me she started to cry “what is wrong with you, why do you look so sad and “ dark spots under my eye, as I couldn’t sleep. We had a doctor in my University, so she took me there. She said, “Sit down, you need to talk to the doctor”. I’m like “no, I don’t want to talk, I’m okay, just feeling sad, that’s it, I’m not...” you know. And the doctor looked at me and asked some questions

Had you lost weight by then?

Yeah (laughs) I was close to 100 pounds. From 300-100 pounds, I had to double belt, my belt was going around me twice.

But even then you hadn’t realized?

No, I didn’t, I didn’t, till then I was like – “oh, I’m just losing weight”. This is helping me”. Back in my mind I am saying “ I didn’t eat – of course I am going to lose weight”.

#012 Male Respondent

In terms of the initial decision with regards to help seeking, for women there is a dependence on spouse and other family members to access care. While men were more prone to report that they made the initial decision regarding help-seeking, the spouse’s nuanced role was apparent in decision making in the case of males.

“Who made the first decision that you need to seek treatment for this depression?

I only decide. I decided. I am the head of the house, isn’t it?

Can you explain how you made the decision?

My wife will always ask me before she does anything. She will come and give me certain suggestions, but if I say no, she will not do it. So I take the decisions. For helping in decision making, she will cooperate, she will come, she will come forward, but the decision is mine. She will come and say – “you have to go to the doctor definitely”, then I take the decision and go – so I think the decision was made by both of us. I make the decision based on the points that she brings forward – she will say “Today I am going to call the doctor, you need to definitely go, if you are like this it does not work for me”. Then I might say that I will not go. Then we talk and I go. That is how I went for the first time.”

#006 Male Respondent
Also for women it was noticed that, when unidentified depression affected aspects of their gender role functioning, it raised a red flag that caused concern or criticism from the family.

“.....then nobody used to help me out. I would cook for them and do the work… When my husband was beaten up and taken by the army, I would worry and not be able to do any work. I won’t work, won’t cook, I won’t even be able to take a bath.

Who was with you at that time?

My mom and others were there, but what they used to think is that I am deliberately not working, not cooking.....”

#007 Female Respondent

Views of Service Providers:

Service providers were quick to point out that the family did not play a prominent role in initiating help seeking though this did not mean that they were not engaged in care. They also spoke to the fact that problem identification was not a strength of the community in comparison to the mainstream population. The role of other Tamil service providers in initiating help-seeking was underscored. However, service providers also spoke about a movement towards increased problem identification and help-seeking.

The role of primary care in initiating help-seeking is evident here in comparison to the role of the family.

“....I would say the providers play a stronger role than the family, doctors, a Tamil speaking nurse refers a number of clients....again through primary care.... because
there is still this thing if you need counselling, there is something wrong with you, you have a mental health problem, that seems to be more of the ---unless there have been situation where there was a death in the family, a person could have been shot, and the family is undergoing a really bad time, the family recognizes that one or two people in the family require more support than the others, that’s how the family recognizes, those kind of situations, yes, .....but mostly, its been individuals who come in.

Once they come in, once the doctor tells them and they come (to the counsellor), then they feel that there is something helpful”

#006 Tamil Service Provider

This service provider contrasts the problem identification of the Tamil community to that of the Jewish community, where the problem is readily identified and targeted help is sought. This is attributed to being born and raised in Canada as opposed to being recent immigrants, which is the case with the Tamil community.

“I don’t think any one of them even had asked or requested their family doctor, “can I go see a psychiatrist”, just referred. “Go and see this specialist, he will try to help you out with some problems” so they just come. because as I mentioned most of my patients are Jewish and quite a lot of them are born and raised here, I somehow feel Jewish population in Canada, they are very aware of psychiatrists because there is someone in the family an uncle, a distant relative who was a psychiatrist, or someone of their family was seeking help from a psychiatrist. So they are more familiar with the workings of psychiatrist, they realize when they have a problem – they seek out (the psychiatrist).”

#005 Tamil Service Provider
Women as enablers of care

Findings from the earlier sub-themes on help-seeking speak to this partially in that women play a significant role in initiating help-seeking in relation to their male spouses. They share the issues of problem identification with their male counterparts, and are initially dependant on others to make the decision regarding seeking help. However after the initial difficulty, it seems that women play an active role in their mental health care, as well as in enabling the mental health care of others.

Once Tamil women get engaged in care, there is gradual increase in active help-seeking by women. They also play a vital role in the continued help seeking of their spouses, especially in terms of ensuring that they keep their appointments. Of the three men that were married, the decision to seek help in the case of two of the men was initiated by their wives. Women also facilitate help seeking for others.

“She also has depression….. But she is more a friend than a relative. I met her first in Colombo. She met my mom and then I met her through my mom. She had a lot of problems and her mother used to tell me that and worry, I only took her to the doctor here. Now she helps me and I help her…”

#007 Female Respondent

“Another lady here, in this building developed the illness. When I met her I encouraged her to go to Dr.XX. Now I take her there. Now she is much better and keeping well”

#001 Female Respondent

In this narrative, a male respondent talks about his female friend, who was depressed herself, who helped him access services.
“I came for treatment through my friend. She is still depressed. I am better now after taking medication. But she still has symptoms. She only brought me here. I did not know that there was treatment”

#008 Male Respondent

This male respondent’s wife helps him keep track of his multiple appointments for both his physical and mental health issues following an accident

“My wife will make note of all the dates and remind me”

#002 Male Respondent

This female respondent talks to the role of her sister in initiating care.

“....So initially, within two weeks of my sons death, I have gone out and knocked on the doors of different houses – thinking it was my house. They left me home. Only after that my sister consulted the doctors. She took me....”

#015 Female Respondent

Service providers also allude to the more active role that women take, especially in their own care after initial engagement with the system. This will be highlighted in the section on engagement in treatment and care. However, the facilitating role that the women play in the mental health care of others did not come through in the service provider interviews.
While stigma persisted in the community, the narratives spoke to an increasing openness to mental health issues, and an increase in sensitivity post migration. Stigma was identified as an issue that the community needs to deal with. However gender differences were evident in that more women spoke about an increased stigma for women with mental health issues.

This narrative indicates the respondent’s movement away from stigma, while highlighting that stigma persists in the community. It also indicates that family centric attitudes can play a role in accentuating stigma. It shows how stigma impacts help-seeking.

“One thing I would say – people don’t like to disclose. If it is me, I would say, I don’t have a problem with that. But the Tamil people here don’t like to talk about it – they don’t want to admit that they have depression, they don’t talk to the doctor about it, so they don’t get better. I have talked to others about my depression, read about it, come for counselling, I have opened my heart and spoken to XX (counsellor) about it. But the wrong opinion that our Tamil folk have about it is that “if we talk about it, they will say we are mad, it is bad for our children if we disclose” there is such a wrong notion in the Tamil community.”

#010 Female Respondent

The narrative below indicates that sensitivity has increased, thereby reducing stigma, but this does not necessarily correlate with an accurate understanding of mental health issues. This increased sensitivity, albeit with inaccurate understanding, have been reflected in a couple of other narratives of young male respondents.
“Oh, earlier I used to think that people will be talking by themselves, then will be laughing, will come to hit others. When we see such people back home, we will run away from them. You know people who come to hit us, or throw stones at us – when we see them, we will run away. That’s what I thought… After coming here, going to school and seeing how people are treated, now you realize that people can be cured. Such people, early on itself, through some modes like education, can be brought to the right path”

#016 Male Respondent

The following narrative also indicates a slight movement away from stigma in the Tamil community.

“I don’t know. Our people think that – some people I mean – people who have come here a long time, they have some kind of understanding, but some of them hold on to how they reacted to this back home, even now……. Here now they say “don’t stay shut in the house, go out, go to programs”, only if you go out you will be relaxed and happy even for some time. Those things people know”

#007 Female Respondent

This married respondent is open about her illness and says that the community accepts it.

“It is okay if they know. A number of people know about my condition. I tell them. I don’t mind telling them

How do they react?

They don’t make a big deal about it. Its okay. They will sympathise”

#001 Female Respondent

The impact of stigma is evident for women especially when they are unmarried or single because of a divorce or separation. This informs their help-seeking behaviour and patterns. There is a clear interaction of culture and gender factors that exacerbate the
stigma of mental illness in women. The first account is from a female respondent whose help-seeking began in Sri Lanka.

*When talking about being a girl and illness, it was only the first time that I was taken to the hospital and given medication. After that, my mom was concerned that being a girl, if others get to know this, nobody will come forward to marry me. So since then, without letting anybody know, I was taken to a private doctor for treatment (means paying money as opposed to free health and medication). But at the same time, if a man were to have the problem, the women will know, but still come forward to marry them, but if a woman is ill, no man comes forward to marry her. So my mother hid it and did it for me.*

#011 Female Respondent

This account is by a female respondent who is divorced from her husband. She does not attend groups though she is aware that there are groups for Tamil men and women who have been diagnosed with depression.

“As far as I am concerned I don’t talk about my issue to others nor do I discuss anything with them. Just with my family doctor. Otherwise I talk to one or two people like me. I don’t talk to anybody else. Whatever it is, I will talk to my family doctor. Specifically, we are women, people will try to speculate in many different ways as to why I developed depression (which was following the divorce), there are chances that people will think bad things about me. So I don’t want to talk about my problems”

#005 Female Respondent

There is also an indication that stigma tends to become internalized. However this was evident only in one narrative and can be treated as a *wild card* at this juncture. This also demonstrates this man’s fear that stigma will compromise his gender role as a male who makes the decisions and lays the ground rules. It also will impact seeking services if there is fear of disclosure by service providers.
“….If they (Tamil community) know, tomorrow when they look at me, they will look at me differently. They will think that I am “mentally upset”… For eg, if I tell my brother to sleep as he has been studying and my brother tells my mother that, she might say “he is “mad”, don’t listen to him, you study”. Sometimes my mother would have said it very normally, without thinking of anything but it will nonetheless affect me. Nobody will view you normally. Even, if I am going somewhere tomorrow and my Tamil psychologist sees me, she is coming with a friend, what would she tell the friend “this fellow is my client”. That’s how you will say it. Not that she would do it, but that is how it is…..

............... Lifelong this will stay with me. Even by chance, if I get married and I have children, the children will take their mother more seriously than me. That’s how I will be viewed”

#014 Male Respondent

Views of Service Providers:

While service providers talk about stigma in the community, they assert that there is an improvement and that there is a definite movement away from stigma. This was reflected in many service provider interviews. However, a heightened stigma in comparison to the mainstream North American community was also highlighted in a number of interviews.

This narrative is interesting in that the psychiatrist emphasizes the increased openness of the community to seeking help. At the same time, he also highlights that stigma operates at a significant level, specifically when it relates to social dimensions of life. The role of family-centrism in accentuating the stigma is also highlighted here.

The increased openness to help-seeking is attributed by many service providers to the psycho education provided by Tamil service providers over the years.

“…..I first started, at XX Hospital, my fellow colleague told me “XX, don’t tell your patients that you are a Tamil, if you tell them, they wont come to you”........ Initially
most of the patients were Caucasians of different nationalities – from Italy, to Portuguese, to Canada to everything, now 99.9% of my patients are Sri Lankan Tamil. That shows their shift about their views about illness, about psychiatry as such. I’m not saying that the Tamils have accepted psychiatric illness as a normal condition like the Canadian White community; still we have taboos and all that. In spite of that most Tamils do understand the concept of depression, when somebody has a depression they are able to recognize it, they ask for help, they come for help….. I am talking over the years – 1990 and now it is 2009…. Things have changed, things are changing, still. ……, but still the taboo is there, which you cannot eradicate in one generation, I suppose. Because I hear stories like this, when my name is on the bottle, they erase it off. Also when I go to the mall, when I see a Tamil patient who had been coming here, they will ignore me and go. I avoid going to the weddings of my patients, although some of them get upset that I don’t come, if it is a funeral or something I will go, but if it is a wedding, I don’t because they will say, “how come Dr. XX came for this wedding. Oh, oh, so the bride or the groom must have been the patient”. So that situation is still there. So there are people who don’t want to take treatment, because they when they have to get their sons or daughters married, “Oh, so and so had Dr. XX, therefore there is psychiatric issues in the family….therefore..” those issues are still there, it will take some time”

#002 Tamil Service Provider

The service provider contrasts this to the Canadian White community who do not have any problems acknowledging the provider.

“Oh yeah, oh yeah, oh yes, that is – they don’t have any problem, as I said they think this is a chemical imbalance – as it is with having a diabetes, blood sugar or cholesterol, it is a chemical – so they don’t feel that kind of a stigma”

#002 Tamil Service Provider

While talking about the decreased stigma in the community, this service provider challenges the prevalent notion about heightened stigma in the community and even critiques himself/herself and preconceived notions with regards to one’s own community. Again from this narrative, one finds an increased openness to approaching the family physician with social stressors and mental health problems. While other service
providers did speak about increased openness and help-seeking, they still made it a point to state that stigma was operating at a significant level.

“When I moved to Toronto, I knew that my main clientele going to be mainly the Sri Lankan Tamil community. I do have my so called, certain what do you call, preformed concepts - it is there for any of us, because this is coming to my community after, from my graduation years, probably after 10-12 years gap. So one thing is, our community, what do you call, this taboo or stigma about the mental illness, they don’t come openly, they feel taboo or stigmatized, afraid by the psychiatric illnesses, depression, anxiety or schizophrenia, they are afraid to take the medication, they would be what do you call, hiding those information and other things, this is one of the concepts. Second thing I thought, Okay, going to the doctor with the medical problem is okay, but going to the doctor with your underlying worry, depression, family problem is NOT USUAL among our community, back home – So I thought it is hard to see those, get those type of clients or patients, coming to the family physician. Because going to the physician is for the sickness, not for the sadness, the community – so I thought that – So in both of these things, I came to know it was wrong – our community people-I’m really surprised, still even though people not working within our community, they say that mental illness is a taboo or stigma, but I see most of our patients are very comfortable, coming openly, being referred to a psychiatrist or psychologist for help, taking their medication, and they not afraid or ashamed about taking their medications or anything else, that’s one of the things I found”

#004 Tamil Service Provider

4.4. ii. Engagement in Treatment and Care

The “One of Us” factor in engagement

The findings indicate that belonging to the same or similar culture had a specific impact on engagement in care, specifically in terms of comfort in relating to the service provider. Language and the ability of the service provider to understand the client were seen as specific advantages. While men tended to underplay the role of culture, as they spoke more in depth about service engagement, it was revealed that they felt more comfortable in engaging with service providers from their own culture. There were exceptions and
this related to other service provider characteristics that were seen as important, apart from culture. Women were very vocal in their preference for Tamil Service Providers. With the exception of two respondents, all of the other respondents had family physicians who were Sri Lankan Tamil.

Very simply put, cultural oneness or cultural identification and its function was expressed as below

“A Tamil person is our person, so they will know”

#003 Female Respondent

Understanding the issue in depth is seen as challenging for non-Tamil service providers even though they ask ‘everything’ because of a lack of understanding of one’s culture.

“They (non-Tamil) ask everything, but somehow they don’t go deep and look into things. The white doctor. But these (Tamil) people go really deep and catch the right point

Why do you think that is so?

I think it is because they understand my background”

#005 Female Respondent

The ability of Tamil service providers to read between the lines as opposed to having to say ‘everything’ to a non-Tamil provider is an important factor that impacts engagement.

“I think if there is a Tamil psychologist, I would prefer to go to a Tamil psychologist. What are the reasons. Mostly, if it is a Tamil psychologist, he will understand about us
well – about our culture, our background, they know our ways isn’t it. Even if I say it in a simple way, they will be able to understand what I’m talking about. If I am talking to a white service provider….. if I explain it to them they will not understand”

#006 Male Respondent

This lone account spoke about how a Caucasian psychiatrist helped the engagement process by adopting simple cultural gestures.

“Like our people he said “Vanakkam” (welcome) and “Nandri” (thank you). So I felt like I was talking to one of my people”

#011 Female Respondent

Respondents talk about how Tamil service providers understand the meaning of “family” (as they relate to it). They also talk about how this is not the case with non-Tamil service providers.

“Yes, he is – Dr. XX …..Family doctors see 1000s of patients. But they understand the meaning of “family”……because he is Tamil, at the same time, the experience might be a factor. Also, the maturity might be another factor. He tells me “Thambi” (younger brother), this is the problem, this is how it is – therefore do this. Try it out.”

#014 Male Respondent

This male respondent had been directed to see a female psychologist of Caucasian origin. His accident has compromised his gender role as the instrumental provider and he is distressed that he cannot sufficiently provide for his children, including his married daughter in India. There is indication that the meaning of “family” as it relates to the Sri
Lankan Tamil community is not understood by the Caucasian service provider. Conceptions around other cultures are also evident here.

“...She does not know my culture isn’t it. For example, we keep our parents with ourselves, isn’t it how we do it. We will not like our family members going away from us. But they are not like that. Their culture is different. They separate them. Now with the children – even if there is something, they don’t care. They think they have come of age. They are 18 no? So they separate them. Now it is not like that for us. We always want our children with us (laughs). So in that, with the psychologist.... She does not understand our culture right? So that is there. So I think there has been difficulty in her understanding that.”

#006 Male Respondent

Women, more than men spoke about difficulties in communicating to a service provider in English. The importance of communicating in one’s own language is effectively captured here.

“They (non Tamil physicians) would test me frequently, give me medication, water – took good care of me. I wanted to talk a lot to them in Tamil – about all that is happening within me. But at that time I wouldn’t be able to say it. Sometimes when I was not able to communicate my heart would pain.”

#003 Female Respondent

“Oh, going to a Tamil counsellor was very good, that was a great – because however much we speak in English, specially with the (limited) knowledge of English that we have, for example when we say pain, there can be many types of pain right? There will be pain that pricks you like needles, then there could be something pain like pressure, when we say that to the doctor we will explain it well in Tamil, but when we say it in English, we only say “it is paining” we don’t have the capacity to elaborate on it. Especially for me, I don’t have it. So it is very helpful to have services like this for people like us.”

#010 Female Respondent

“Going to her helped me because as she was a Tamil person, while expressing myself in “our” language, we feel a release. Whatever it is, when we express ourselves in another language, it is like another person expressing my feelings. In this all my
feelings can be expressed completely. At the same time, when the counsellor is comforting me when she says “it’s okay, don’t worry, things are like this”, then our language touches me and embeds itself deep in my heart. It makes me feel safe and secure”

# 013 Female Respondent

The comforting role of language is also highlighted in this narrative. The problem with using an interpreter is underscored.

“Oh, I can understand – that difference is there – now I talk about my problems directly with you – you also talk directly. Now when I go to someone else (non Tamil speaking), then I have to talk to a third person (interpreter), then they communicate to the doctor – so I am not sure what is conveyed, whether something is left out, is what I am saying out of my heart being communicated as such to him. So I have those worries. When I talk to you, I feel happy – I can talk directly”

#015 Female Respondent

Informality in Engagement

When the ḍone of us ḍ factor is present it is also reflected in the interaction, which assumes a certain personal dimension where clients use relational terms like ḍAnna (elder brother) and ḍAkka (elder sister) to address the service provider. This is especially for service providers who are not physicians; physicians tend to get addressed as ḍDr. Service providers also use the term ḍThambi (younger brother) to address males younger than themselves. The terms ḍAyya (which is a term for father and used in respect for men who are much older than oneself) and ḍAmma (which is a term for mother and used in respect for women much older than oneself) are used by Sri Lankan Tamil Service Providers.
There are specific gender differences. The female respondents find it very comforting that they are able to tell the service providers ‘everything’ even when they don’t see it as related to their depression. They talk to them about their families, their children’s aspects that are of great importance in their lives. Some of them also speak to their ability to immediately access the service provider suggesting a degree of informality and the expectation thereof. This was not reflected in the findings from male respondent interviews.

This narrative speaks about the doctor going beyond the appointed time to listen to a female client. It also speaks to a sense of bonding that is created because both the client and the service provider followed a particular religious leader who was also a cult figure.

“I felt that it was really good that there was a Tamil doctor. If not, I would have gone to another doctor, but a Tamil doctor being there was good, and Dr. XX was VERY good. When I went to him, first, it was just like this, I would tell him all my stories and cry. And he would listen to all of it. Even if it took more time than the appointment, he would listen to it and then he would say, he was also a Sai devotee, I am also a Sai devotee, then he would say, “let us do what we need to do, you have passed through all that and got here, now let us focus on what needs to happen”

#013 Female Respondent

“Here I got culturally sensitive and supportive help. I used to tell her everything. Not only about my depression, I have spoken to her about a number of things, when I come I talk to her about all that happens at home, what my daughter says, everything. There was no problem. It was good”

#010 Female Respondent

This respondent looks to her case manager more as a family member, somebody she confides in and seeks immediate access to.

“….. I am able to open up completely to XX. Sometimes, if there is a crisis or there is some urgency, I will immediately call XX and request him to do something about it. I
will tell him when I am unwell and unable to do things.... In the absence of my aunt and uncle, I call XX and tell him everything”

#003 Female Respondent

Views of Service Providers:

Service providers spoke about both sides of the coin when it came to clients preferring service providers from their own culture. Language and understanding clients’ culture and background were cited as primary reasons for clients preferring Tamil Service providers while stigma was the reason identified as a factor for some clients preferring non-Tamil providers. With regards to the informal nature of the engagement, service providers did speak to clients wanting to be seen immediately and the dependence on the service providers based on a perceived personal relationship.

While community respondent interviews only indicated a higher level of expectation of informality in female clients, service provider interviews suggested that it was found in both sexes.

“....not only bonding, he asks me for advice, he wants me to be everything for him. He doesn’t have people here, even if he does, he does not trust them…”

# 003 Tamil Service Provider

A service provider who works in the domestic violence sector also speaks to this expectation and also backs it up with reasons. The client tries to replace the informal social support network available in her home country through service providers. The service provider displays a certain degree of flexibility
“.....they will get the number and they will call and say – ‘akka (elder sister), can you talk to my husband?’ ‘can you help us get together again?’ and ‘can you scare him’.....

......and usually back home, they solve these things by involving other people – elderly people, respectable people and so they feel like that something could be done like that here. But if we do something like that, we are going over our boundaries, and it cannot be done, but I have to explain it to them..... One day, a guy called, his wife called, and they had a friend who was very interested in helping them out, so I got permission from them, contacted the friend. So in a way you feel like, you are doing something that you shouldn’t be doing, but then...Ø

# 007 Tamil Service Provider

The service provider also throws light on another important aspect of the řone of usØ dimension. While talking of the Tamil community, the provider also relates this to other visible minority communities. They hesitate to talk to a white service provider about issues of racism and discrimination and its impact on mental health. But they are open with a service provider of colour. Culture and the sense of shared experiences contribute to this.

“....plus it is also they have a very good relationship with a white person. They think that “they are so good in helping us. How can I say these negative things”. So they’d rather not talk about that. But with the person of color they say “ you know, you understand”

#007 Tamil Service Provider

The following narrative by a service provider highlights řthe one of usØ factor, the language issue and the informality in engagement. It is interesting that he also engages in this informal dimension of engagement. At least four other Tamil service provider interviews (including the one above) revealed that, at some level, service providers engage in a certain level of informality or řcross the boundaries.Ø
“When they come to me, I feel that they are relieved that I talk Tamil. So they are able to converse properly, easily and when they know that I am from the same part of the world, the country that they come from, they are able to feel more relieved, because they can feel that I feel their sufferings, compared to say, I am not saying that others cannot understand the suffering of Sri Lankan Tamils, but they can’t identify a hundred percent, alright, so they are more relieved – no 1. And No: 2, they are more relieved that I believe in God and they see all these things here (religious pictures from multiple faiths),….. Some of them I am carrying as patients for even 20 years, they don’t want to stop – kind of a social visit…..”

“.….I am unable to sever them and say “go back to your family doctor” that is the way I should be doing because this is a hospital practice, I can’t gather more patients and I can’t provide the proper service to the acute patients. At the same time I am having difficulties, so for your patients these are the expectations and they are very happy that…”

# 002 Tamil Service Provider

This non-Tamil service provider talks about the difficulty when one is not familiar with the language. It mirrors what the community respondents had said about working through an interpreter.

“You know what, from the few Tamil clients I see, I would say that, it’s been very hard to assess, because I’m working through an interpreter and a lot of these things, when you are talking to people and if you can’t talk to them (directly) it is difficult to pick things up.”

#008 Non-Tamil Service Provider

The same service provider also challenges assumptions that are made regarding the choice of service provider.

“.….And the other assumption is that if it is somebody who comes here from Sri Lanka, they would automatically want to see our Tamil counsellor and we are shocked that they don’t want to because it is such a small community. Again you should check out all those things before you put them on. ‘ Oh you know, we have a Tamil counsellor’ ‘Oh no, I don’t want a Tamil counsellor, I can speak English well and I want to see one of the other counsellors’. And I think that is one of the other assets of the program is that we can allow for that kind of choice…because we have both”

#008 Non-Tamil Service Provider
There were gender differences in the kind of issues that men and women focused on while engaging in treatment, their proneness to stay engaged in treatment, and their expectations of treatment. In terms of the preference for service provider, gender-related factors influenced the choice.

Women were more prone to bring up issues related to relationships and marital discord while engaging with their service provider, and this would be the primary focus of their engagement. For men, they spoke more about issues related to employment, functioning and providing for the family while engaging with the service provider. While the majority of men did not specifically talk to the interviewer about raising these issues with the service provider, women spoke about men raising these issues in group sessions. However, men spoke at length to the interviewer about their difficulties related to not having a job and being unable to provide for their families as they would like to. Though issues were different, engagement was issue-based in both genders, i.e. relationship difficulties, problems with children, or unemployment.

In this narrative, the man talks about his inability to move out of subsidized housing into his own home and the impact it might have on his children.

“Now I don’t have a job, I worry about my children. I don’t like living here. This is metro housing. Here there is smoking, blacks smoking marijuana, the biggest problem is that my son is getting older, high school....”

#002 Male Respondent
Parenting-related issues were common to both genders and concerns centered around bringing up children in a good manner and fear that children might get into the wrong groups.

This respondent attends a weekly group. She calls it "XX's (name of service provider) group. Eight women and 5 men attend the group. Women are more forthcoming with their issues than men in mixed group environments.

“All people exchange their experiences. XX tells us what to do. I take his guidance. Many people have in-law problems like me”. Everybody opens up, women are more open. Men don’t open up as much – there is hesitation.

#003 Female Respondent

This respondent also attends weekly groups and she talks about the differences in issues brought up by men and women. Also reflected here are the differences in the level of openness and engagement in a group environment.

*We (women) talk more about the children and look for matters pertaining to them, they (men) look more for their family, issues at work. For example, if my illness is because of my daughter – every one has a different reason for getting ill right, they (men) have issue related to jobs – men are depressed because they are unemployed. Then because they are separated from their families and living alone. They talk about that. Women talk more about their problems in general. It is not that men don’t talk about their problems. But women talk more, around 60-70% women only talk.*

#007 Female Respondent

In this narrative, the male respondent identifies the issues that he raises with the service provider. In an earlier verbatim account in the section on "one of us" he talks about this
same service provider having difficulty in relating to the concept of "family" as it is experienced in the Tamil culture.

“There is a white lady therapist – she will take me inside and talk to me – so she will bring out everything that is within me. Now I don’t have a job. Not having a job is very difficult. If we continue sitting at home, you feel mentally down. That is very difficult, so I will talk about it - I will tell her most of things.”

#006 Male Respondent

The ease of opening up and relating to a service provider of the same gender was found to a higher degree in males. For females the nature of the service provider and the culture which promotes the "one of us" effect takes precedence over gender.

This male respondent attributes the curtailed socialization between genders in Sri Lanka as informing the preference for a male service provider.

“I would prefer to go to a male”

Can you explain why?

Because I can explain most things freely to a male. For us from the beginning, we have grown up like that, we will feel shy. Rather than to you, if I need to say something to a male, I would say it very easily. When I am talking to you, there will be a small guard, a channel while talking. So it is up to you to understand what I am saying. So we prefer going to males”

#006 Male Respondent

The field experience of the interviewer also confirmed this. Of the two married men who were living with their families, both men preferred to be interviewed in the presence of their wives (at their homes with the wife present though she was not sitting in on the interview)
However, with this male, whose socialization was different because he moved to Canada while in high school, there is a preference for a female service provider. This relates to characteristics ascribed to the gender of the service provider.

“I will go to a female.

Why so?

Simply, females understand more and they are more open.”

#012 Male Respondent

Irrespective of culture, female respondents also spoke about interactions of female service providers that facilitated engagement.

“No, he (non-Tamil) wasn’t able to understand what I was saying. Then he directed me to a lady doctor (non-Tamil). When she came and spoke to me, I was able to comprehend a little. I liked going to her because she would explain everything well and with affection, she touched me and asked me with concern. Also, she listened to me patiently. The male doctor would just ask me quickly and move away quickly. He would not do these things. She would hear everything and explain everything with the help of a Tamil person (interpreter)”

#003 Female Respondent

“If there was something I did not understand, the doctor (non-Tamil) had it in her nature to be patient and say it in a way that I would understand. If I did not understand certain words she would give me the definition and make me understand. She would explain….”

#010 Female Respondent
This female respondent talks about a greater openness to the female Tamil family physician in comparison with her husband who is also a family physician, because the female family physician would ask her about the personal aspects of her life.

“I told Dr. Mrs. XX about the boy I loved. She asks. I did not tell him – Dr. XX, anything – he doesn’t ask, so I don’t say, I just felt like telling her about it.”

#001 Female Respondent

Female respondents revealed that they were very comfortable talking to male service providers belonging to the Tamil community, especially when they were mental health service providers who related in a certain manner.

“Yesterday the doctor spoke with me for 40 minutes. He said that I was thinking a lot about the situation in my country. I am really affected by it. So he will speak about that, my family my children. He will ask me to pray to God, to have faith in God, take the medication properly, be courageous, don’t worry.”

#007 Female Respondent

“I also keep going to YY (Tamil male case manager) and talking about my issue. It is a great consolation to me…..Just as I talk to Dr. XX (Tamil male psychiatrist), I am able to completely open up to YY”

#003 Female Respondent

Men were more resistant to continued engagement than women. While women visit their service providers with more regularity, they tend to keep their doctors appointments more diligently than appointments with their counsellors. Findings indicate that resistance to treatment is greatest for younger males and they indulge in self-moderating attempts more than older males and females. While family physicians are accessed for physical health issues, there is a resistance to opening up regarding mental health issues.
This is the verbatim account of an unmarried male who immigrated to Canada when he was in high school:

“He (family physician) is like ‘do you need any help’ and I’m like ‘I will come to you if I need help’. I never really went and talked to him about depression or anything else, he checked my body, everything, every month – you are okay – that is it, I’m good, because every month I have to go after surgery. I don’t really share anything.”

# 012 Male Respondent

The same respondent resorts to the following self-moderating attempts:

“I whatever, hobbies whatever, everytime I go out with my friends, I will take my camera, click pictures, and I have like scrap book. That just kind of helped me after depression, to do, to look back my memories, because sometimes you can’t remember them. Though you wanted to – but when you have something captured, you can relate to that. So I do like scrap books. Every time I go – even a small dinner – I take my camera, click pictures, that memory, that happiness, I keep them…”

#012 Male Respondent

Another male respondent whose family is back in Sri Lanka says that he ‘chats’ with his family back home when he feels lonely. Though on medication for depression, he does not talk about this even to his service provider.

“…..Actually, I have not discussed this (depression) in great detail with anybody. I didn’t discuss it.

……I feel that I have improved from what I was earlier……. When I feel really bad and unable to do anything, then I do meditation. Doing things like that….. doing things like that……. I feel better”

#009 Male Respondent
This female respondent spoke about a male relative whose referral she had facilitated. However, he is inconsistent in engaging in treatment.

“I told him to go for counselling, to take medication for addictions – if I tell him that, he will go once and then not go the next time.”

#010 Female Respondent

Views of Service Providers:

Service providers identified gender differences in engaging in services that was in consonance with what the respondents said. They spoke about differences in issues that were brought up during the course of engagement, more women staying engaged in treatment and a greater resistance to treatment by men.

This service provider speaks about gender differences in the Sri Lankan Tamil community and refers to the similarity to the larger South Asian community. The provider also highlights that help-seeking is greater amongst women in most communities.

“…..Again the gender difference, even though in any community the females tend to seek help more readily than males, I see it in all communities. But proportionately in our community it is more. Yes, I feel so, in our community as well as other South Asian communities. Sri Lankan Tamil males, even though they are coming forward compared to other south Asian brethren, bit more difficult to make them accept the diagnosis, the treatment and accept the help when compared to Tamil women”

#004 Tamil Service Provider

This service provider talks about more Tamil women engaging in treatment than men.
“I think women more women come for help and they continue with treatment. The men maybe the ego, (laughs), maybe they still don’t believe that there is such thing he is suffering from it. So it is a very different situation for man. Unless it is related to some work related problem or something, then they will come to you, whereas a woman if she is depressed, some or other she will go to the family physician and the family physician will refer her to us. And they will come. Here the men, even if we get the referral, they don’t come. Even if they come, they are not regular…….”

#002 Tamil Service Provider

This service provider speaks about gender differences in the issues and the propensity to engage in treatment with a greater resistance on the part of men.

“Yes, yes, Tamil women have more of family related issues, related to children, future of children, relationship, violence, domestic violence, kind of issues, men have been more related to psychiatric diagnosis and counselling, alcoholism , things like that.......... I think women are more willing to get into treatment, men are more reserved, resort to alcohol or other avoidance techniques to deal with it, issues, and unless push comes to shove and unless they are mandated to do it…….”

#006 Tamil Service Provider

Only two service providers overtly identified the gender-related characteristics of the service provider as impacting engagement.

“….but some lady doctors sometimes have a little bit of empathy, they leave medicines and look at other things talk to the clients, some of them do it”

#007 Tamil Service Provider

This is an interesting observation from a family physician who speaks about clients opening up more to his wife who is also a physician.
“People are very open to open up to their family problems and their underlying stress, depression, family problem, relationship issues, financial problem, work stress and their other stress which was affecting their physical health and thereby their mental health too. So sometimes they come and talk to us openly. My wife is also a family physician, I found that, either because she is more skilled, or because she is a female, people are more comfortable opening up to her than to me regarding the family issues, but I DO see my patients too opening up to me…….. I found women tend to open up more to her, but I have women patients opening up to me as well. But I found that even male patients open up more to her”

# 004 Tamil Service Provider

Expectations of Treatment

The major expectations of treatment for respondents who were being treated for depression were related to functioning and normalcy, to return to how I was before the illness. There were specific references to achieving a state where one was able to take less medication. Expectations were also related to social factors that were impacting health. One respondent spoke about being at peace without any loan issues, another spoke about being treated with kindness as it was the neglect and abuse from her spouse and his family that had triggered her illness. Relief from symptoms was also an expectation in many of the narratives. The somatic symptoms identified as distressing and for which relief was sought were: multiple aches and pains in the body, headaches and numbing sensation in body parts, especially the arms and head. Other significant symptoms were lack of sleep, forgetfulness, and anger. There were no major gender differences in the symptoms except that anger was reported more by men than women.

Two of the young males said that their only expectation of treatment for depression was to have prescription refills to deal with symptoms like sleeplessness and headaches.
This male respondent’s expectation of treatment and services goes beyond medication. Support, in terms of employment, was a need echoed by many male respondents.

“What were your expectations of treatment?

“I thought I needed to be relieved completely of the depression. I knew why I had become depressed - now I am taking medication for depression and I am staying home. But that alone is not enough. You have to make other things available

What do you mean by “other things?

I need a job – I need to go to a job, but I am unable to work (where I previously worked) because of my pains. However if I am able to work in some job that is compatible, then I think that I will feel better.”

#006 Male Respondent

This respondent talks about how counselling and medication helped her realize her expectation of treatment which was recovery from depression.

“I thought I should recover from depression, back to what I was. And that was very helpful. When I was sitting and crying at home, I would then come and talk to XX (counsellor), then when I go from here there is a renewed energy in my mind. I used to come frequently then. I used to come once in a week, then once in two weeks, then once a month, that was how I was coming. When I started the medication I was able to sleep, then just this routine of getting out of the house and coming for counselling, the actual counselling as well – she will say “you don’t need to worry. There is treatment” That helped.....”

#010 Female Respondent

This was another female respondent’s expectation of treatment, which shows that there are multiple expectations covering social, psychological and physical factors.
“I should not have anything (wrong with me). I should be able to forget everything, I should be able to sleep, my leg should not pain and that everybody should treat me with kindness”

#003 Female Respondent

Views of Service Providers:

Expectations of treatment - Fixing the immediate problem

Service providers spoke about the “here and now” aspect of engaging in services and expectations of treatment. “Fixing the immediate problem” was a major expectation. Hence one service provider referred to the Tamil community as “case management” clients rather than “counselling” clients. The expectation had a significant social dimension. Service providers said that this expectation accounted for the more short term nature of engagement in treatment, in comparison to treatment provided to the mainstream community.

“the major concern is not to feel better – in their kind of – ‘I need to talk to somebody to be able to…..you know to be able to take care of myself and my mental health, I need to talk to somebody’ there’s nobody coming like that. They come to find a solution to their problem……..

………..Today a client called, I had closed her file last year as she stopped coming, there were lot of issues, the husband, it turned out that he came back and reconciled, she called now because there was something, she called the police, they are separated and so now she wants help. It is mostly like, in most of the cases, nothings changed, because the woman mostly wants to keep the family together and most of the time, whatever happens, and at that time they might be very angry, they want some help, they want to get some housing and something like that…….”

#007 Tamil Service Provider
Another non-Tamil Service provider, who sees a number of women who are depressed because of domestic violence, also echoed this, as follows:

“I think that the majority of women who come here for domestic violence, have a lot of, have young children at home, they are just trying to make ends meet, if their husband has been taken away, has been incarcerated, it throws a whole different circumstances their way and seems as though they want to have other things fixed, they don’t necessarily, I don’t think they see themselves as needing more help for themselves, for their depression its more like ‘help me get a job so that I can get money so I can provide for the family’.

# 008 Non-Tamil Service Provider

There were gender-specific expectations that men have regarding the services.

“If you think of men, they will always gravitate towards employment related issues – employment, welfare, money, legal issues, problems related to immigration – we have to focus on these for men.”

#003 Tamil Service Provider

The difference between the Tamil community and the mainstream community is highlighted here. Cultural and social factors were explored by this service provider as reasons for differing expectations.

“……probably something that has happened, I mean it is very situational based…..you try and do some kind of connection between trauma, but it is very short term, people say…..oh I do not have to come any more, I have nothing to talk about… so I see some kind of difference, I feel it is more supportive counselling within the TC as opposed to in depth psychotherapy so that’s the difference that I see and it could be very cultural too… the supports, the family supports and kind of reasoning it out as a here and now as opposed to childhood issues and the war trauma, even though you can see very clear connections between those two,........................ and there is more case mgmt needs, with the Tamil Community, like I need support with my ODSP application, my employment, so it is that, so the point of entry is different, so once you do that…..I don’t know whether people in the general population, who come to me for counselling
and have been in therapy since they were children, they then know how the system works, this is what they have done for years, so they know that, what to expect, even the people who haven’t had counselling, somehow they come in with the notion of “I have this issue, I have to come in and explore, and kind of right?..... and connect the dots and look at what I have to change,” which is what I am not seeing with the Tamil community”

#006 Tamil Service Provider

Many service providers highlighted that, as expectations centered on fixing the immediate problem, Tamil clients were not very prone to engage in counselling and psychotherapy. They were regular in keeping doctors’ appointments, but not as diligent about counselling appointments. Even those respondents in the study who were attending counselling, though positive about the benefits of counselling, were not very regular in attending counselling sessions.

“....they have a psychiatric diagnosis, somebody else is referring them, it would be like “Oh, I am coming here, I would rather see the doctor, there would never be, they would never ever miss the doctors appointment, but its okay to miss the counsellors... it would be ‘give me the medicine’, ‘what is there to talk to you about’. That kind of tells me what they think “if my symptoms are okay now I do not need counselling anymore. I am eating better, I am sleeping better” Then there is whole piece of trauma that they have not worked on....torture and things like that, and its like that’s okay, it is not bothering me...so it is like....”

#006 Tamil Service Provider

Orientations – Fatalism and Externalization

Few respondents were fatalistic in their approach to depression and implied that Ŧt was meant to be.Ō In male narratives, this was shown by a resistance to engaging in treatment and a judgment about the futility of intervention.
“I will tell you what is in my heart. Another truth is nothing is going to happen because I open up and communicate. Nothing will happen. But even so, I will feel like I need to talk to someone about this thing of mine. But I would not like to talk to other – my friends, my elder sister about this. Nothing is going to happen. Whatever will happen will happen – let that happen”

#014 Male Respondent

This female respondent talks about the general belief that everything is in the hands of God, but says that it should not hold one back from doing what is necessary. This is an interesting twist to the concept of fatalism.

“…..otherwise it is of no use if we just pray and lie down. That is the truth. We cannot refute that. God is there – but we need to make the necessary efforts to get better. When I say effort, it means going for counselling, treatment, following medication, taking your medicines regularly, watching our diet. Everything should be done……. I also tell my daughter – she also prays a lot like my husband. I tell her, you have to pray to God, but you need to study to do well in the test”

#010 Female Respondent

Views of Service Providers:

Service providers spoke of fatalistic attitudes as deterrents to help-seeking and engagement in treatment.

“I think with Tamil community – it is almost like a fatalistic attitude – you know ‘my parents died of cancer, might be that’s what I will die of’” that’s one kind of fatalism ….the other kind of fatalistic thinking is that you know ‘I’m in this relationship and this is not working for me, but then what can I do. In my culture you know, once you get married you are supposed to stay with this man. So what is the point in talking about it? ….we have to get back together right”, that’s kind of another fatalistic kind of thing.”

#007 Tamil Service Provider
Acceptance of the situation, ascribing it to fate or Karma, is highlighted here:

“Mostly our women also, they don’t realize they are experiencing this (depression) and they think this is a part of their life, fate or karma – that is why this is happening to them, so they think ‘this is our life’“

#003 Tamil Service Provider

This service provider talks about the value of externalization; at the same time the provider highlights the resistance that comes about due to this orientation.

“there is a lot of thing about fate, “I must have done something wrong before, in my previous birth.. that’s why I landed in this…… culturally there is a difference between, I being responsible, as against externalizing things, that has a value, serves a purpose, so that helps them, so you either say its fate or whatever they have done in the previous birth or his fault or how could he do this. So it is the externalizing factor serving the purpose, then its more like, then the next steps in terms of me and how do I change the situation and even, if you introduce that a little bit, people hear, but there is either a lack of interest or they do not do anything about it.

#006 Tamil Service Provider

**Cultural misunderstandings impacting treatment**

In the sub-theme related to belonging to a similar culture as facilitating engagement, the respondents spoke about ease of engagement and some difficulties experienced while engaging with non-Tamil service providers. However, none of the respondents spoke about major misunderstandings that impacted treatment. This should be seen in the light of the fact that fifteen of the sixteen Tamil respondents had Tamil Service providers involved at some point in their treatment. This sub-theme is largely informed by the views of service providers and their experiences.
Views of Service Providers:

It was interesting to see that service providers spoke about the multiple impacts of cultural misunderstanding.

*Misdiagnosis and delay in diagnosis* was cited as a common outcome of cultural misunderstanding.

This service provider speaks about how symptoms of depression are manifested differently in the Tamil population in comparison to the mainstream population and how this leads to a delay in diagnosis, as mainstream service providers are not able to identify the underlying issue.

“…..because in the Canadian society, if a person calls with pain, they (service providers in the mainstream) focus mainly on the bodily side of it, not the mental side mainly, the bodily side – they do the test, everything. Then, most of the patients, if, they are not given the adequate prompt or….. they end up in a pain clinic. The reason for their pain is underlying psychological stress, depression, family relationship issues, family issues and psychological health

So when the other patients come in, is there a difference, in terms of how they express themselves?

Yes, I do work with other communities. Lot of the Canadian community when they come, with mental health issues, they already identify the mental health issue as a mental health issue, they come with “Dr., I am depressed” “I am stressed out”. “I have this panic attack”. That is the way they present mostly. They say it. In the Tamil community it is not so

#004 Tamil Service Provider
This Tamil service talks about misdiagnosis due to lack of cultural understanding:

“Now about the bipolar affective disorder, in bipolar affective disorder during the manic phase, we know that there is overactivity, agitation and things like that, the overactivity in a Caucasian, might be just doing some over active work or something. In my clinical experience I have come across many ladies when they are overactive, you know what they do (Tamil ladies), they run around on the streets. Their over activity – understand, night or day they just run – it doesn’t matter. When the police bring them – so and so Asian woman running on the street, they think it is psychosis. Get it? When we talk you and I will know, that the over activity makes her – she will say, Dr. I don’t want to stay in the home. I want to run – that is the physical impulsivity. Like that they make lots of mistakes, even the other – in depressed patients – most of our – when I say our – the Sri Lankan Tamil patients, they have paranoia also connected, but the major condition is depression, they are depressed but because of the depression, they feel insecure and paranoid. So for a Caucasian doctor it is a paranoid schizophrenia, for me it is major depression with paranoia. So the treatment is different.”

#002 Tamil Service Provider

From a social dimensions of health and illness perspective, lack of cultural understanding leads to improper assessment of a familial or social situation, creating a crisis, thereby contributing to depression. This counsellor talks about the experience of a woman who was referred to her for depression. A number of other service providers also spoke about cultural misunderstanding with regards to parenting issues as triggering a crisis and subsequently leading to mental health issues.

“….culturally there is a lot of difference, especially with the children’s aid, I am having two of my clients who are involved with the CAS now, and I mean it is ridiculous, ridiculous, that the woman has to go through so much, finally she has gotten a good lawyer and a worker who is working with the domestic violence program and that’s how the client got referred. She is a relatively new client of mine, but you know an absolute lack of awareness regarding the cultural interpretation into things has made people suffer….. the person who is doing the assessment should have an understanding of what does it mean to discipline the child…."

#006 Tamil Service Provider
The other factor cited was the resistance to using services like the shelter services and the police as there were misconceptions based on how these services are viewed in the Tamil culture and society. This was brought up by two service providers—a non-Tamil and a Tamil service provider. A similar view in other Asian communities was also noted.

“The only one which comes to the top of my head, which is a well known one, is for example, somebody you know has to leave a house and they have to go into shelters, and we have shelters in Toronto, for abused women, there is quite a lot of resistance to that, and that is because back home shelter might be considered as somewhere where prostitutes had gone, that I think is a big cultural misunderstanding and the other thing is of course, in other countries we know that police aren’t as helpful and supportive and we do have some police here who are trained specifically for sexual assault, domestic violence, I think that is something that people from the Tamil community might be very fearful, of the police, from what they witnessed at home, so those could only be the two things that I can think of, off the top of my head, which is quite understandable when you are from a country where there is a lot of violence, so you presume, so you don’t call the police and I think the Chinese may have similar attitude, because they come from a similar…. So those are the only two”

#008 Non-Tamil Service Provider

This Tamil provider talks about misdiagnosis because of cultural factors with reference to the South Asian community in general.

“One the, the, South Asian, we have some kind of shyness, and this you know, hesitate to socialize with this kind of, so they are being diagnosed with phobia ……because you know that is cultural, but you know they (mainstream doctors) think it is phobia – social phobia, this is also happening…..”

#003 Tamil Service Provider
4.4. iii. Supports

*Family Support: The two sides of a coin*

A very interesting finding was about family-centricism functioning as a deterrent to help-seeking and support. Many of the respondents revealed that they did not want to cause worry to their families and hence kept their condition from their family, especially their families of origin. The other factor was that the focus on family and the well-being of the family took away from the focus on self and taking care of self.

This single male has his family of origin in Sri Lanka and chooses not to tell his parents about his depression.

“About my problems, my parents know that I have a problem with my legs. But neither my mom or dad or anyone know that I am taking treatment (for depression) and taking medication. Some things I tell, some I don’t, because they will think more about it. They will think/worry however they know to think about it. I don’t want them to worry”

#016 Male Respondent

This respondent talks about the loss of her parents as leading to the depression. She was brought up by her brothers and sisters. She did not communicate her distress, and also put up a happy façade, as she did not want them to be worried about her.

“For me it was worries – losing my parents, it has grown within me without my knowledge. But I didn’t know it then, I could also not open up to anyone that I was suffering mentally……. No, I would always seem happy. So my brothers and sisters could not make out. I did not want them to worry”

#001 Female Respondent
This young male, who is presently living with a male relative, also refrained from disclosing because he did not want his uncle to worry.

“No, I didn’t want to tell my uncle. Simply because it will make him worried. Because only me and him living here, he is going to work and he has to look after my parents (who live in Sri Lanka), I didn’t want to get him worried, didn’t say anything…..“

#012 Male Respondent

This respondent talks about how people refrain from seeking help because they think it will impact the children. This is related to stigma as well.

“But the wrong opinion that our Tamil folk have about it is that ‘if we talk about it, they will say we are mad, it is bad for our children if we disclose’ ”

#010 Female Respondent

The supportive role of the families is also evident in many narratives. While some female respondents spoke about lack of support from their husbands, especially in the initial phases of their illness, many male and female respondents spoke about the support from their families. In the case of married male respondents, findings elaborated in earlier subsections reveal that their spouses took an active role in enabling care. In the accounts of clients #001 and #012 (highlighted above) where family-centric attitudes were a barrier to seeking support from their families, after the family realized that the person was suffering from depression, there was active support. Earlier subsections also reveal that males sought to deal with depression by connecting to families of origin back home or elsewhere and chatting with them through the internet though they don’t necessarily talk to them about their illness.
This is an account of a female respondent and the long distance support from her family of origin who live in other countries.

“They were worried, they would blame it on my husband. They would encourage me to take my medication. To date, when I call my sister everyday she will remind me to take the medication regularly”

#001 Female Respondent

This respondent’s family did not pick up on the fact that she was depressed for quite a while. However, once she was diagnosed and they understood the nature of illness, support was instantaneous, both from her immediate family and her family of origin.

“If you say supports, financially my brother supported us. My sister will make food for the family. She will visit me everyday. She will call everyday. On Saturday and Sunday she will cook in her house and bring the food to my house. She was a great help. If I needed to go somewhere and my husband had work, my sister’s husband used to take me if I needed to go by a vehicle. Also, my husband would take me when he was there, he did all the shopping that 6-7months, he did laundry. But he couldn’t do kitchen work. So that my sister used to do. My daughter also did not ask me anything. She managed everything. So everybody was a help to me, not a hindrance. Then all my relations used to come and see me. That felt good when I was not well”

#010 Female Respondent

Service providers also spoke about concern for the family affecting disclosure adversely. However their view was that it was largely related to stigma and not wanting their families to be impacted by their illness.
Community Support – Two sides of a coin

While friends were seen by most respondents as a source of support, the larger Tamil community was seen as unsupportive by some respondents because of personal experiences.

For men and women, friends and contacts from back home who were now in Canada proved to be significant sources of support. Friends provided instrumental support like driving the respondents to appointments, helping with grocery shopping, cooking and occasional financial support. Emotional support in terms of talking and sharing problems was also reported. Contacts from back home initiated referrals to service providers.

“A girl I knew back home lives nearby. She comes often. We go shopping. We go walking…. I don’t have a car, she takes me grocery shopping…..”

#001 Female Respondent

“I have a friend. She is really nice. I am able to share everything with her. Since it helps me not to bottle things within myself, sharing with her is extremely helpful. That support is there. She is still very helpful…..”

#005 Female Respondent

“I have my friends …. they will support me if I have an urgent need

What kind of support?

If I have some financial problem, they will help me. In their free time, they will take me for appointments”

#002 Male Respondent

Some respondents spoke specifically of the larger Tamil community as being unsupportive and a source of their stress.
This Tamil male who identified that his friends were a great source of support says he keeps away from the larger Tamil community as they aggravate his problems. This respondent also talks about the great support he receives from his friends.

“I did not go to jail because I killed someone, I went to jail because of my family problem. It is okay if the men ask me, but the women ask me. Also I know this neighbourhood, there around 2000 families from Sri Lanka. For them it was like news in the paper. Almost like Barack Obama had won the elections; ‘what happened, how was jail, the food, did they beat you?’ only if you are in that situation, you will know it. They don’t look at their problems, the look at the problems of the neighbors. When I am with my people (the Tamil community), that is when my condition worsens”

#008 Male Respondent

This is also reflected in the narrative of another respondent where the community’s judgment about his sexual orientation creates a very unsupportive environment and he actively avoids any contact with his community.

“…… because after getting rejected from Tamil people, I don’t like to share ANYTHING with them, I stopped talking to them, completely cut off from Tamil people, because I found that they are very judgmental, very judgmental, and if you don’t do things that they do, its like ‘oh, you’re different, oh you’re gay, this that’. Simply when there is a conversation, they would say, ‘Oh, that is gay’, that just pushed me away from them”

#012 Male Respondent

Some respondents spoke about being cheated by other members of their community early in their migration; this caused significant psychosocial stressors that impacted their mental health.
Views of Service Providers:

Though a few service providers spoke about the advantages of having a large ethnic community in terms of creating a familiarity within an unfamiliar setting, no one spoke specifically to the negative dimensions of community support, apart from underscoring a certain level of stigma in the community.

Cultural Sources of Support

The respondents sought many sources of support that were distinctly cultural. Many of them spoke about the help received from visiting the temple and the church. Meditation and yoga were also mentioned as supports. The social function of the temple, the church and other such groups are very evident in these narratives.

This male respondent is unable to go to the temple as his father died. In some communities in the Tamil culture, there is a year of grieving following the death of a family member during which time visiting the temple or attending events like a marriage or something auspicious is not allowed.

“I used to go to the temple and meditate for half an hour. Now I can’t because of my dad’s death. Now with me feeling like this, I feel like going to the temple, but because I can’t go for a year, I am not going.”

#009 Male Respondent
Respondents talk about simple rituals at the temple, which are standard offerings to God asking for well-being and prosperity. This could be an offering of flowers and coconut or the lighting of lamps.

“Even now I go to the temple. I love going to the temple. When I go to the temple I perform “archanai” (offering to God)”

#001 Female Respondent

Sri Lankan Tamil respondents who are Christian speak about the social networks through their Tamil church groups as extremely supportive

“What, once my aunts took me to the Church. Then after that I continued going to Church and that made me feel a lot better – people were nice to me...”

#003 Female Respondent

“...yesterday a Pastor came and took us out – we are stuck at home, our Pastor took us to Niagara, it was a very happy day – one thing is that he sacrificed himself and took us that far – drove us, then he spent until the night, spent time with our children as well – we took our home cooked food and ate there. It was really a happy occasion. All that are good things. But we cannot go to a place like that ourselves. We need support. Church is a support. That is why I am not so depressed. Though they cannot help me monetarily, they give me advice. Now when I told him that I don’t have a job, the Pastor discussed this with me in detail and they are making some attempts. So mentally I am just okay. Otherwise I don’t know how I would be. Church is the best for us.”

#006 Male Respondent

Another very important source of support was attending “Bhajans”. Bhajans are part of the Hindu culture, and in the Sri Lankan Tamil context, pertain to a certain cult followers of the spiritual leader, Sai Baba. There are many Sai Baba devotees in the Sri Lankan Tamil community. Different groups of these devotees meet on a regular basis all across Toronto for Bhajans which are basically recitals of spiritual songs praising the Gods. It creates a social network of support. Many of the female respondents have
identified that attending these Bhajan groups has been extremely helpful in their fight against depression. Though it was mostly women who identified Bhajans as a source of support, suggesting that it might be gender-specific, there was one male who also spoke of Bhajans as a source of support.

“My brothers are a big support. They come to see me. I go to Bhajans. It is a good support”

#004 Male Respondent

This female respondent talks about how the Bhajan group serves as a significant source of social support. The emotional impact on the client and the positive impact on the children are highlighted here.

“Then I went for Bhajans – a Sai group. I really liked Bhajans. They were a really nice group, they would take me out. I will feel happy. More than for me, my children, they had not enjoyed anything in life. It was good for them. They have never enjoyed anything and I always felt bad because of that. So this was good. They used to arrange for outings, and stay in the hotel at very reasonable rates. They would never charge a penny more. That felt very good to the heart. When we return from these trips, they would sing songs, I would sit in the van and cover my face with a shawl and cry – that was because – it was a wonderful group, a really nice group”

#013 Female Respondent

“…..then going for Bhajans, meditation.

What kind of supports do Bhajans and meditation give you?

Whatever worries, I might have, when I go there and return I feel very much at peace. I can make out a big difference when I go for meditation”

#005 Female Respondent
This respondent talks about multiple sources of support that she sought, many of them cultural, when she was unwell.

“I go to the temple, I go to Church, I go to Bhajans – there is one led by Amma Baghavan devotees in Scarborough. I went three times for it. Someone has to have the time to take me for it, isn’t it. So I don’t go now. At that time (when she was unwell) everyone helped a lot. I went for everything. I was really impacted for 6-7 months. That time I did everything, counselling, psychiatric doctor, took treatment, took medication, went to the temple, went for Bhajans, did everything. I did everything”

#010 Female Respondent

Another very interesting finding was how common threads between cultures created access to supports from other cultures in a meaningful manner. Prayer and spirituality seemed to be the common factors.

For Hindus, the temple is a place of worship that they can access anytime. Here, some Hindus find solace in the Church:

“Oh, yes, every Sunday I go to Church.

Are you a Christian?

No I am Saivam (A Hindu sect that follows Lord Siva), but I am fond of Bible study and all.

Did you like it back home or after you came here?

After I came here. Back home itself I will go to Sai Baba Bhajans and everything. …I usually pray and I go to temples frequently – I will go for all Bhajans –from Sai Baba Bhajans to Church, I go for everything.”

#011 Female Respondent

This Hindu male respondent also goes to Church when there are no sermons.
“My neighbour is a Christian. So I have gone to the Church with him. But I felt uncomfortable, because they are shouting their things from the bible. I didn’t understand anything. I will go to Church when there is no service. I will pray quietly and come away. Otherwise I will not go to Church”

#008 Male Respondent

This devout Christian used channels offered by Islam when he was working in Saudi Arabia.

“In the beginning, when I was in Saudi and there used to be fasting (during the month of Ramadan), I used to fast as well, 40 days of fasting”

#006 Male Respondent

4.4. iv. Summary

Help-seeking, engagement in treatment and supports sought are largely influenced by social factors that are informed by culture and gender. There are specific gender differences in pathways to care and engagement in treatment. Women have more direct pathways and are less resistant to engaging in treatment than men. Women also play a significant role as enablers of care. The care-giving role into which they have been socialized enables women to play this part. Both men and women expect treatment to lead to symptom relief. The social factors that inform the engagement of men in treatment are directly related to their role as instrumental provider, while women engage in treatment to address relationship issues. Issues related to children and parenting are common to both genders. In comparison to the Caucasian population and some other second generation immigrants, service providers opine that the Tamil community focuses on fixing the immediate problem. So there is no long term engagement in care, which makes it a challenge for counselling and psychotherapy. However there are distinct case management needs in terms of housing, employment, income assistance that people seek help for. A fatalistic orientation was noted in few respondent narratives and was highlighted by service providers as a deterrent to engaging in care. Tamil service providers play a significant role in initiating help-seeking specific to mental health issues
as the community seeks direction from these service providers. Informal supports like friends and spouses also play a significant role in initiating help-seeking. Family physicians are the “go to” people, but in many instances drop the ball in terms of identifying the mental health issue and facilitating engagement in care. Cultural misunderstandings lead to misdiagnosis and delay in diagnosis. The “one of us” factor makes the Tamil community gravitate towards service providers who speak the language and are from a similar culture. This facilitates communication and the feeling of being understood, as well as encouraging openness when talking about issues. There is a preference for males to go to male service providers and this can be attributed to the curtailed socialization between genders. The fact that this does not impact women as much, could be because there are more male doctors and service providers in Sri Lanka than female service providers, and hence women are used to accessing a provider from a different gender. There are certain gender-specific traits highlighted that make female service providers more appealing to a client in some cases.

While stigma is present in the community, both service providers and respondents reveal that there is a definite movement away from stigma. It is interesting that family-centric attitudes create an impediment in the family’s ability to act as a source of support as respondents do not reveal problems to their families. This aspect was overlooked by service providers. It was revealed that while friends were seen as a significant source of support, the larger community was seen as unsupportive. Hence, the presence of a peer ethnic community does not automatically translate into support. Specific cultural sources of support were accessed. Significant among these were Bhajan groups. Common threads between cultures converted churches, for instance, into sources of support for not only Christians but also Hindus in the Tamil community.
4.5. Service Systems and Service Delivery:

This brief subsection is largely informed by data from service provider interviews, though community respondent data are also used when it serves to underscore certain findings. This section serves to highlight culture and gender implications on service delivery as it impacts the Sri Lankan Tamil community. Gaps and challenges in service systems and in service delivery are also highlighted.

4.5. i. Culturally Informed Services

*Using cultural knowledge and understanding in intervention*

Service providers use their understanding of the Tamil culture in intervention in many ways. This service provider who sees a majority of Tamil clients talks about how he employs spirituality with the Tamil community that has experienced trauma in the form of losses, torture and death of loved ones. A number of community respondents interviewed had been seeing this service provider. With the exception of one, all others said that the provider’s approach to engaging with them and counselling them was helpful.

“*what I do is grief therapy through spiritual ways – because whatever I do is not very conventional, in the sense, I talk more in the spiritual level, about the souls, departure, reincarnation, I show them with proof – “you have lost so and so, but that so and so, only the body is gone, the soul is with god”. Things like that. So that calms them down*”.

# 002 Tamil Service Provider
This community respondent had tried to commit suicide. She says that the counselling by the service provider helped put things into perspective.

“XX (service provider) used to tell me that people who die like that roam as spirits, we are Hindu” ...So he would tell me that if we ended our lives before we completed what we were supposed to do (as destined or prewritten by God), I would only roam around as a spirit. He said that I have all facilities here and that I should therefore be peaceful. He said that you have a house, some money, so take care of the kids and live peacefully.”

#013 Female Respondent

This service provider talks about how Tamil poetry is used to talk about holistic health to the Tamil clients. He says that though he attempts this with his other South Asian clients, he is not as successful because he does not know the poetry and folklore that they readily relate to. The emphasis on the psychosocial determinants of health is evident here.

“...Yeah, Tamil community, the way I educate them from one of the ancient Tamil poems which is 2400 years ago, it was in “Purunaru” (an epic in Tamil) Kanian Poongundranaar (the poet) – (He recites the poem in Tamil) - It’s a story like a poet in the king’s court, he was looking very healthy, not even a gray hair in his head, and so others were amazed about his good health and just asking for the reason. He said the reason was ‘I got a good wife, I was blessed with good kids, I have good workers working for me – they do the work, the way I want it, my king my good, he is protecting us and not harassing us and above all I have in my village, well-educated, experienced people with humility living around me. That is the reason (for my health)’ he said. So it sort of expands more than WHO’s concept of health – it includes the social health, family health, occupational health and also political health, everything included there, so I just used the concept there, the concept that health is much wider and broader”

#004 Tamil Service Provider

This service provider talks about Hindu mythology as a tool for psycho-education.
“But when we talk about depression as an illness, we are not talking about sadness, sadness is unhappiness – this is more than unhappiness for which we haven’t found a Tamil word, but I tell them, the depression had been there for so many years – even Dasaratha, who died of depression when Rama left (part of Hindu mythology Ramayana). So this is nothing new, this has been there in the centuries and million years”

#002 Tamil Service Provider

Validation of the cultural and religious supports resorted to by the community respondents are highlighted by this service provider. The provider talks about similar beliefs being prevalent in many communities and religions

“They (the Sri Lankan Tamil community) do still have the beliefs, but they don’t go extra on it, sort of a secondary thing. Usually our people, they don’t do the traditional Shaman ceremonies or spending big money or anything like that. But they do go looking for the astrological consultation, horoscope, doing some simple poojas (offering to God) or something like that, they do that. That is secondary. They don’t totally depend on that, another thing – it gives them hope. It is a coping mechanism. I hear from other communities, not only the South Asian, I do have other people 2-3 generations living in Guyana and other places, they do the Shaman ceremony, and other things, but not among our community. But people go for their faith - kind of thing, I know Christians go for their healing prayers kind of thing. As long as it is not an escapism from the reality, if it helps them, gives them a hope and other things, that is okay for us, that is even helpful, positively we can use it – they ask us these questions whether it is okay – So we say, if it gives you the hope, reduces the stress level and if you are not overspending, there is no harm doing that. That’s what we say. So taking the positive aspect of that…..”

#004 Tamil Service Provider

This service provider provides a bird’s eye view of what is important from a cultural perspective while working with Tamil clients.
“It is very important to understand the history of the Tamil community (TC) and the struggle, also importance of family as an unit should be understood, the TC gives a lot of reverence to certain service providers – doctors physicians – reverence .... so they are not as challenging or demanding – so benevolence – in general, sense of entitlement is far less (in comparison to the mainstream community). Starting from the reception, as service providers we need to be aware of the community. The TC does not perceive discrimination like the other communities – there is a lot of gratitude – I don’t know, might be I am making my assumptions here – there would be specific things that the client will not tell. So the service provider should ask, should be sensitive to the nature of the community, should reach out. That’s it I guess”

#006 Tamil Service Provider

Informal aspects as facilitators

There is an expectation of a certain degree of informality in engagement that has been underscored in earlier findings. Service providers talk about how they employ this to facilitate engagement. The role of informality as a facilitator has also been mentioned in the subsection on expectations while engaging in treatment.

This service provider talks about how the knowledge of a person’s background helps in creating a certain degree of rapport and a sense of closeness to the service provider. The provider stresses that such an approach is required with different communities that we serve, though our knowledge of different communities is limited.

“I generally ask them about – because of my awareness of what is going on in Sri Lanka, in order to connect with them, while taking history I always ask them which part of Sri Lanka are they coming from, I know the names of the small towns and they feel good when the provider knows those things, they ask questions – where are you from, they feel closer and that helps them to open up about some of the difficulties they went through before they left their country and how some of the relatives are still staying there and they are worried about what is going on there. Suppose somebody comes from Croatia, I don’t know much about the ethnic issues there, I cannot explore that, but I know more about what is happening in Sri Lanka, I’m able to connect with them better.”

#005 Tamil Service Provider
This service provider talked about the lack of extended family support, which was available in their home country, making people gravitate towards counselling here in Canada. Hence their needs were different in that they seek more direction and guidance and hence one has to work differently than with other communities

“They come for counselling.....because in Sri Lanka they are not familiar with counselling because of the extended family support. Here it is different. Also in terms of counselling they think we can give – we cannot you know – we can only provide options, but they think which one is right, we will have to give them that. But even though we explain it to them, they think, they depend on us, and ..... … there is a difference, other communities don’t expect that, but these people from the Tamil community, the expect more from us, they get more comfortable and ask ...., and also more problems, they will bring it to us... so we have to do a little more....beyond our usual role”

#003 Tamil Service Provider

This service provider talks about training volunteers in the community so that they form a informal support base that can be used to engage people in treatment. The provider talks about an initiative specifically focused on South Asian women. Informal supports can be used as bridges between the community member and the service provider

“Then I have also done training for organizations where they have wanted to train people, almost as volunteers who would be like the, the first person who would be able to contact them and say – if I have gone through the training, and I am talking to a group of friends and then somebody says or some signs are picked up, I can talk to her and say “ you know what, there are these things available, there is this training course that you can do or you can talk to so and so who works in this organization who can help you more” and, or befriend in such a way so that the you are like the bridging between the person, the community member seeking the services and the service provider. So it’s kind of like of a bridging”

#007 Tamil Service Provider
This service provider talks about the informal aspects of the group process as the most important outcome of the groups provided. Again these groups are focused on women.

“In terms of the women, the reason why – when I have groups, I think one of the biggest purpose that is being served more than the dissemination of information, psycho ed that we are providing, it is the space that women get together and get to see each other, and that gives them a whole sense of connectedness with the community and it is amazing how it comes across, because they are all in silos, right? all of them – couple of them go to the temple, but here you have 20 of them on a weekly basis, for 12 weeks when they come, the sense of connection that they get, they often relate that to how they were connected as a community back home. So this needs to be the meeting point, and they kind of – so whatever else we are doing in the group is only secondary, so there seems to be that seems to be what is met and from that point onwards, in terms of health promotion….”

#006 Tamil Service Provider

Supporting the “here and now”

The Sri Lankan community expects support for their immediate problems. There are a number of real time problems and psychosocial stressors that they face. Expanding health roles to address the social dimensions of health and illness and addressing immediate concerns were highlighted as definite considerations while working with the Sri Lankan Tamil community.

This service provider talks about the social factors that need to be addressed in many ethnoracial communities including the Tamil community. The integration of the bio-psycho-social factors is highlighted as being different from mainstream cultures.

“I think it is similar (to other ethnoracial communities), they are not familiar with the use of psychiatry, the way of dividing the mind and the body, and the way of dividing the mind from the social problems, that is how, the western way, but they are not
familiar with that, I think that is why they have difficulty sorting it out, to get to the psychiatric service and... Right, so if the people get what they need at the beginning of the problem, with housing, sense of belonging, employment, income and they get supported, by these other resources and the community which is strengthened, then it would not always need to go to the psychiatrist....”

#001 Non-Tamil Service Provider

This provider talks about how s/he addresses the immediate needs as an engagement strategy.

“I think it is more to deal with the here and the now, whatever crisis there is happening then, it could be a crisis, something that is bothering them, a family relation, something, a way to deal with that immediately, that’s why I never put them on the wait list, whereas to get a counselling appointment is a four month wait list, except for Tamil speaking clients, because I see that if you are going to make them wait you are going to lose the client. so it has to be here and now”

#006 Tamil Service Provider

This counsellor talks about addressing immediate needs and case management as the first step in engagement

“So that’s what I was saying – they need to figure out what they need to do now, to find a solution, and so when the case management part is in a way going okay, about 90% of the women talk about other issues, at least to some extent.....”

#007 Tamil Service Provider
4.5.ii. Gaps and Challenges in Services

*Authoritarianism and the perceived hierarchy of services as a deterrent*

A very interesting finding was that the authoritarianism that was attributed to many Tamil family physicians and specialists proved to be a deterrent in successfully engaging clients with mental health issues. Many respondents spoke to the fact that the doctors in Sri Lanka, while treating them, did not necessarily explain to them about what their condition was. Hence some respondents knew that they were depressed only after coming to Canada. Even in Canada, community respondents talked about how the communication of some physicians and specialists was not respectful and how this impacted treatment and open communication. Another factor was that some physicians and specialists were not collaborative in their care. So there were tensions between other mental health service providers like case managers and counsellors and physicians and specialists.

This community respondent was being treated for depression in Sri Lanka, though the nature of her illness was not communicated to her.

> “I think, when I was there in Jaffna, I knew to some extent, but the doctors there will not say, “you have depression” they will not tell you. They said medication would relax me and help me sleep better. That was all… I realized that I had depression, only after coming here, after the doctors here told me”

*#007 Female Respondent*

The same respondent also talks about how her physician in Canada does not want to communicate with her case manager. She feels caught between two sides.
“But the last time, I had gone to see him, XX ‘akka’ (refers to the case manager as elder sister) came isn’t it, when she came he said he doesn’t accept workers. And if they have to come, they need to get prior permission. So he asked her to leave the room. I felt bad because of that. Also, when she left the room, I was unable to leave with her as he has been my doctor for a long while. I didn’t know what to do at that point. So when she left, I told him who she was, he also knows who she is, but said that HE doesn’t accept workers and that they should come only after getting prior permission”

#007 Female Respondent

This respondent refers to the unwillingness of the family physician to pay heed to their clients.

“The doctor is Tamil and the clients are also Tamil. However they don’t accept our concerns, they think they are above us. I have gone to my family doctor many times for medication and have returned, being refused the prescription”

#006 Male Respondent

This service provider talks about the authoritarian nature of some service providers as hindering engagement. The experience with regards to the tension and hierarchy between professions reflects the community respondent #007’s experience.

“…..and also the professionals, they are still practicing the authoritarian, whatever they practice in SL, but here no, we cannot do that, people are very comfortable with rapport, talking friendly and co-operatively, so they open up…..
…..even Tamil psychiatrists when we refer to them, we have few of them, even that I have to say that two of them are very friendly and co-operative, but others are still very authoritative, kind of things, even they don’t like to talk to the client, they spend only three or five minutes with the client and then, and only that, and they don’t guide in that manner, or they don’t spend in psychotherapy or something like that – even referring them to case management, and even some of the psychiatrists, they don’t like case managers to come or counsellors to come with the client”

#003 Tamil Service Provider

This is echoed by other service providers who are counsellors and case managers.
Service Provider conceptualization of Tamil Clients

a) Problem Clients

Service provider respondents talk about other service providers who perceive ethnoracial clients as problem clients as they have a number of social problems and needs. This requires that the physicians spend extra time and effort with them. Three of the eight service providers interviewed brought this up as a specific issue. Some community respondent interviews also suggested this where physicians refused to give them letters to support their ODSP applications or E.I. claims.

This service provider talks about how some ethno-racial providers themselves turn down legitimate request of clients. The service provider's approach to working with Tamil and other ethno-cultural clients and the extra commitment required is highlighted here.

“But they come for anything and everything which I provide as long as it is within legal limits and whatever I can give by letters to the probation, to the lawyers, to immigration, the work is manifold compared to an ordinary psychiatrist here. The immigration lawyer will need all kinds of documents for the refugee status. Then probation officers are involved because of the child abuse plus alcohol abuse, all kinds of problems, so those letters, then of course there are so many other legal involvement – who are deported, they need last minute letter before they are sent out to the States for deportation, So the lawyer will need a letter ASAP to give a report so that they can save him. Like that several aspects of it. But I feel sorry for them, so I don’t think it is a big thing. Because we are here to serve and these are real issues, I cant behave like a non-Sri Lankan and say, “no no, I cant do it, this is not in my...” I can remember – this has nothing to do with SL, but I was recently referred a Chinese patient who had been going to XX hospital to another Chinese doctor, but that doctor wouldn’t give a letter so that he can get leave from work - so his insurance was stopped. The patient said that the doctor had said that according to their laws, they are not supposed to do those kind of letters – they can only treat you and send you home. Yeah, so I am flexible on that and I provided the letter.”

#002 Tamil Service Provider
This service provider provides anecdotal evidence to prove the point about clients from ethno-racial communities being seen as problem patients. The provider says that one finds this to be true in the Tamil community as well. The training of the service provider, lack of cultural understanding, competence and increased investment are cited as factors that lead service providers to shun ethnic clients.

“One story I can tell you, again, using the Chinese experience, there is one big city in Canada which had only one Chinese psychiatrist and he told everybody in the city ‘I do not want to see Chinese patients’ (laughs). So you see this is a really funny scenario, but I could understand his rationale. Now for one thing he is trained in the Canadian mainstream, he will feel quite incompetent (emphasis) dealing with our ethnic patients – because they bring in their family, they bring in all sorts of social problems that psychiatrists are ill equipped to deal with – SO it is a PROBLEM PATIENT. It is much easier to get a nice lady who is educated and do psychotherapy for depression. So that’s one reason.

.....Sometimes there is a psychiatrist having a selection bias, like some of the psychiatrists who I work with say very clearly, “I do not want to work with the legal issue, WSIB issue, any insurance issue and other things” because they are troublesome, you have to fill forms and legal – they might have to go to court and psychiatrists do not want to do it, it is messy. Why not I deal with a clean case – I get paid the same, dealing with a clean case and a messy case, right.....”

#001 Non-Tamil Service Provider

b) Not being able to move beyond here and now

While service providers talk about the strategies in supporting the here and now, they also express frustration at the community not being able to move beyond the “here and now” in many cases. They express uncertainty regarding how this issue can be resolved.

“....My guess is if a bone is being broken, they want to fix it, a laceration – a stitch – and then they want to get OUT. Counselling, I don’t think they would consider a priority in terms of supporting them. Maybe just fix what’s wrong and then I will go home, and that’s it – end of story... what do you think...”

#008 Non-Tamil Service Provider
The sporadic nature of engagement is highlighted here because of the focus on the ‘here and now’.

“How are they going to take care of the kids, court procedure, what is the economy, financial, housing, what are they going to do about the income, can they get together again, family, you know, can they reconcile, all this stuff, sometimes it goes on for a while, sometimes if I get to see them for many sessions, then they still have the anxiety, overwhelmed with all the challenges, all the things that they have to solve, then we work with them, they get housing, they get to a stage where they are so happy and relaxed when they get the housing, and then they drop out...........till the next problem”

#007 Tamil Service Provider

Another service provider talks about the inability of clients to connect the dots unlike the mainstream clients who are able to connect the dots. Hence these clients are seen as short term clients or case management clients.

*Services for men*

Almost all service providers were unanimous in their acceptance of the fact that they have not been able to reach out effectively to men. Sometimes male attributes linked to culture, gender roles and socialization were seen as causative. They also talk to the lack of services geared towards the needs of men.

This service provider talks about the difficulty in reaching out to men and emphasizes the role of family physicians and mental health workers in helping with the engagement.
“....because it is the male ego in them – ‘they don’t have to tell me how to run the family – they don’t know, they don’t have to know what I am doing’. Even the other day the wife came because the husband is not taking pills and not coming for treatment, this is a problem – I think through education only it will come. But I think the family physicians are able to convince them to come to us and other community workers can do that. We have a lot of access to many community workers and mental health associations – they do a good job. I can talk about only in Scarborough – they do an excellent job…”

# 002 Tamil Service Provider

This service provider talks about services not being set up to address the needs of Tamil men, who are single, who have fled their countries, faced a number of resettlement challenges and are still trying to provide for their families in Sri Lanka. S/he also talks about service provider roles as confining

“Then, when I was providing services, then when you wanted to leave a Tamil homeless man in a shelter, he was not game for that. For him, going to a shelter was demeaning himself.... As a service provider there are some limitations, you have to respect the professional and ethical boundaries – that is called ethical no? the relationship between the client and myself? Boundaries – which is quite understandable. But the system is limited in providing services. If the person needs support beyond this, we do not have the answer of how to provide this service over and beyond our limited role”

#003 Tamil Service Provider

The fact that there are no culture-sensitive services to deal with addictions in mainstream organizations was brought up by a number of service providers. Sometimes court mandated programs for aggression are not culturally sensitive and fail to pick up the mental health issues of the Tamil males. Though services are accessed, albeit forcibly there is no onward referral or engagement. This community respondent’s narrative speaks to this.
“I used to take alcohol. I will get very angry, and I won’t know why I am angry. I went to XX and did this program (court mandated program conducted by a mainstream community organization for partner abuse). No, she did not refer me to counselling. I had just gone for the program. If she sees me normally she wouldn’t know that I had the problem”

#008 Male Respondent

This service provider talks about the fact that services for Tamil males are sparse. Also, the system does not promote awareness regarding services and this leads to less than optimal pathways to care.

“…for Tamil men, I don’t think so, I think men are a totally neglected group in the community, I would definitely think so….

……men, and even the court diversion program, what right they have, they are entitled to because of their mental health needs, the family is not aware of it, the person gets arrested and unless the provider knows, “okay there is the court diversion program” and you will be tried in a totally different light, but that’s not there, he is homeless, he is alcoholic, he is in conflict with the law and constantly getting arrested because he is not able to follow through with the probation order, he has a mental illness right, he will not be able to, but the thing is ….. is, is the person aware, is the system aware, is the person given all the opportunity, so those kind of challenges in terms of awareness is there”

#006 Tamil Service Provider

This service provider also talks about system gaps in terms of services for Tamil males

“….so for help seeking it has also implications of where they would end up, so the men would end up in the criminal justice system. For any altercation that happens between the man and wife, the men would go the legal route, whereas women would go to the shelter and the psych…mental health route which is just how the system is. But is that the best way of responding to the system, I am not sure.”

#001 Non-Tamil Service Provider
4.5. iii. Service and System Recommendations

Providing **culturally sensitive and linguistically accessible services** was a strong recommendation that came up in both service provider and respondent interviewers. Findings from the help-seeking and treatment engagement subsections speak to this. Service providers also spoke about options regarding services being made available to the clients i.e. whether they wanted to see a Tamil service provider or not. Expanding or modifying roles of mental health workers to address the psychosocial determinants of health and an increased role for the general practitioners in dealing with mental health issues was highlighted in the interviews. Groups and regular programs in the ethnic media, both television and radio was another strong recommendation.

This service provider talks about access to a wider specialist base if GPs from ethnocultural communities work collaboratively with specialists when dealing with mental health issues in the communities that they serve.

“So the point is there are some opportunities, but I am no sure if the ethnocultural GPs would participate in that. Because if they participate they may have a formal liaison with a psychiatrist, and actually that psychiatrist does not even need to be from the same group, because if they provide consultation and backing and support to the GP, the GP will be empowered to do much more. So I see that as one way to determine the help seeking pathway – that the GP role can be expanded by shared care”

#001 Non-Tamil Service Provider

Focused training for physicians is recommended by this service provider
“...the concept of opening up, the counselling concept, sort of a what do you call it, looking at the patients holistic or integrated health, that concept is sort of not widespread amongst the physicians. It needs to be included in the physician training. I have seen even the Canadian trained physicians, even the younger graduates still struggling to grasp those concepts”

#004 Tamil Service Provider

This service provider also talks about educating and promoting awareness amongst informal community leaders who can play a role in identification, support and referral. This reflects the findings regarding using informal supports in the engagement process

“we need more of the counsellors in the community, and what to do you call, empowering the traditional counsellors, traditional counsellors, say, in a community like immigrant community, you see certain people like retired teachers in the community, grandparents or elderly people, priest, even the astrologers, they need to be educated, what do you call educated about the counselling, the pattern, and identifying the mental illnesses, directing them for the help and other things. So those would help more to address rather than creating a physician dependant system”

#004 Tamil Service Provider

Renegotiating standard roles in organizations to reach out more effectively to the community is discussed. Working with groups, and outreach through media are dimensions of such roles.

“Maybe by doing community related activities, a group format, or making use of the media, or maybe just giving up this position (counsellor) and having another position and saying...
....Yes, if they have the resources only for one position right, and they do not have the possibility of hiring somebody else in the program who can also work with the Tamil community, then I think it is more important to support a role that goes into the community, creating awareness, working with the media, writing articles, creating some debate.....“

# 007 Tamil Service Provider
This provider also talks about a need to expand roles.

“I can do case management, I can do stuff in the community, I kind of tailor make my programs to meet the needs of the community, but I cannot say every health centre or is willing to do this or willing to work with that model…. so that could be because people are so gunho about what their roles are – if it is mental health, they don’t want to do case management, it is like go here, go there….”

#006 Tamil Service Provider

While service providers spoke about challenges with regards to services for men and the need for services to be gender sensitive, recommendations did not address the question regarding how this could be operationalised.

The media was seen as a powerful tool for outreach and promoting awareness.

“Okay, okay, this one, I will have to say that the mass media, the Tamil media is very good for promoting the mental health ideas, but we will have to have regular programs I think that a general program will help it, with specifics and then we will have to encourage the men to come and participate and come out to help-seeking. The media is the best”

#003 Tamil Service Provider

Sensitizing health professionals and the community through seminars, conferences and the media was a recommendation made by this service provider.

“Well, you can have seminars and conferences sometimes, you can organize to communities – it can be in downtown or Scarborough centre or somewhere. You can have a Saturday seminar on such a thing. That is another way of doing it. Lot of people do come nowadays. One can write articles on papers or monthly journals which are in Tamil or one can come in the 24 hour radio and talk about it, or in the TVI (a Tamil television channel) – through media, family physician offices, and seminars every
6 months or year, you can do it through your organization or your University or whatever, so that will keep on spreading – it has gained the momentum – it is not what we did 20 years ago – it has come a long way, long way, so everybody knows about the facilities, the treatment available, the illnesses, the symptoms, the people are able to recognize it, so if you keep on with it…”

# 002 Tamil Service Provider

4.5. iv. Summary

The importance of culturally informed services geared towards addressing the social factors that impact mental health is highlighted. Service providers employ different techniques that reflect this cultural understanding to respond to the needs of the Tamil community. However certain biases and expectations of the service provider pose challenges in the engagement and treatment process. Services for Tamil men are severely lacking and, though there is a recognition of need, there is no clear cut understanding of how to respond to this need. Service recommendations include expanding the current role of mental health service providers, using ethnic media to advantage and actively engaging family physicians in the mental health care of the communities that they serve.
Chapter 5

Discussion and Conclusion

“A curious mind looks at the frame and beyond the frame………
Thus continues the journey of exploration and enhancement…..”

5.1. Summarizing the context:

The exploration of cultural and gender factors and their influence on mental health, help-seeking and treatment for mental health problems in newcomers who are members of an ethnocultural, visible minority population was rooted in the avid interest created in me during my work as research coordinator of a large scale quantitative research study on the mental health of the Toronto Sri Lankan Tamil community (Beiser et al., 2003). Further exploration of culture and gender factors, suggested by the findings of the original study, seemed to demand a qualitative inquiry. While the quantitative study yielded many important insights, it did not shed light on the process or reasons behind the facts i.e. why is there a preference to seek help from service providers belonging to the Tamil community, especially amongst women and those who have been in Canada for fewer than ten years? While data indicate that the rate of help-seeking for mental health problems is relatively low in the community, what are some of the factors that promote engagement in care; does gender play a role in engagement, and, if so, how? These preliminary questions sparked my interest both as a researcher and a service provider of South Asian origin, and led to the genesis of the current research. The study utilized Leininger’s (1985) and the Canadian Nurses’ Association’s (2004) concept of culture, underpinned by the application of an intersecting gender lens. The need for such a study was supported by the fact that information on the Sri Lankan Tamil population in Canada was sparse, despite the fact that the largest Sri Lankan Tamil Diaspora resides in Canada, with a majority of the settlement in Toronto.
5.2. Summarizing the findings:

The exploration of cultural and gender factors in health and illness through interviews with male and female respondents with a prior diagnosis of depression, as well as with service providers working with the Tamil community, resulted in many significant findings. Analysis, using the long interview method, led to the evolution of distinct categories of results, which were subsumed into five main themes:

- Situating the Tamil community – A contextual understanding
- Resettlement and its challenges
- Social dimensions of health and illness
- Social dimensions of help-seeking, engaging in treatment, and support
- Service systems and service delivery

As each of the themes was informed by substantial data, findings from each of these themes have been summarized in the chapter on results and findings.

I had identified four major gaps in the literature I reviewed in Chapter 2 prior to starting the study. My findings on the importance of culture and gender in the Canadian Tamil approach to health and illness helps to fill two of the gaps (the Sri Lankan Tamil experience and the gender/culture intersection). My juxtaposition of the perspectives of both service provider and service user provides unique insights into consonance and dissonance of views that have implications for service delivery. Lastly, the qualitative nature of the inquiry has provided opportunities to describe culture, family, gender, immigration, and resettlement issues in depth, and to show how they impact mental health and help-seeking.
5.3. The Discussion:

Besides filling some existing lacunae, my findings, as they apply to Sri Lankan Tamils in Toronto, sometimes affirm and sometimes appear to contradict what has previously been written. I will speak to this in my discussion of the findings. To strengthen the contribution of my findings to practice, I will focus separately on gender implications and critically analyze the service provider perspective. A discussion of my findings with regards to the present state of services and systems that are pertinent to service provision in the cultural context of the Tamil community will follow. I will then discuss the limitations of my study and implications for future research. I conclude by underscoring how my findings lead to recommendations for service delivery.

A major contribution of this study is that it looks at an expanded concept of culture, e.g. a concept based on the Canadian Nurses’ Association (2004) definition, which encompasses group history, upbringing, gender, and life experiences, in order to try to better understand the impact of cultural and gender factors in a newcomer community on mental health, help-seeking and treatment engagement. Group history and socialisation experiences have not been adequately explored in the context of health and help-seeking. Studies looking at group history have usually looked only at experiences of pre-migration trauma and its impact on mental health (Beiser et al., 2006; Fenta et al., 2004).

The present study is unique in that it does not rely on secondary data to understand the factors inherent in this broader conceptualization of culture, but derives first hand evidence from interviews with members of the Sri Lankan Tamil community. Findings of this study underscore the importance of understanding the different dimensions of culture from this expanded perspective. For example this study found that happiness in the family and family centric orientations figured prominently in the lives of the respondents while growing up in Sri Lanka. Hence there was extreme distress when
there were losses in the family and family dispersion due to the war. This context helped make sense of the finding that functioning that enabled family centricism was a marker of health. Examples such as these help to situate the person in the context of his or her community, and to provide rich insights into the differential impact of losses and life events, pre-migration trauma and resettlement. They show how notions of health and help-seeking and distress are influenced by cultural factors that are deeply embedded in the group history, upbringing and life experiences of a person.

5.3. i. The culture of the Sri Lankan Tamil community - marked by pre-migration trauma and resettlement challenges

The cultural background of the Sri Lankan Tamil community reveals a rural, collectivist community, family-centric in orientation, where home, farms and cattle were cherished possessions; religion and spirituality were part of everyday life, and education was valued and pursued. Family-centric values were reflected in gendered roles and responsibilities, with older siblings making sacrifices for their family and younger siblings, grandparents functioning as surrogate parents with considerable power and authority, and happiness in the family being a significant part of childhood amidst the ethnic conflict.

The impact of pre-migration trauma resonates with findings in other studies (Beiser et al., 2004; Fenta et al., 2004). Internal displacement, forced migration to foreign lands, losses, dispersion of the family and detention camp experiences marked the pre-migration experiences of this community.

An appreciation of the impact of the losses suffered in the light of what was culturally valued was possible in this study due to the detailed study of the cultural context. There were significant losses that stripped the community of what it cherished — a cohesive
family, education, their homes, their farms and their cattle. Changes to roles, forced separation in families, dependant grandparents, inability to fulfill role expectations and gender role conflicts between spouses in the context of resettlement in an individualistic, egalitarian society added further stress. Similar stressors have been brought to light in previous studies (McKenzie, 2008; Beiser et al., 2006).

While not a specific focus of this study, my findings also pointed to systemic barriers in resettlement such as language barriers and unemployment. This corroborated evidence found in other studies (Noh et al., 2007; Karlsen & Nazroo, 2002; Fenta et al., 2004)

_The gender interaction_

The Tamil culture dictates stringent gender roles and expectations, with man playing the instrumental role of provider and woman playing the nurturing role of caregiver. So it is common for older male siblings to emigrate and continue to provide for their families _back home_ while older female siblings give up education to care for their siblings. The youngest female siblings are taken care of by their families of origin and retain this expectation of their spouses when they marry and immigrate to a new country. Men have many specific expectations of their spouses that synchronize with the care-giving role of women. However, in the context of resettlement and prolonged separations, men and women are forced into unfamiliar circumstances. This demands a renegotiation of roles and responsibilities. Gendered role expectations dictated by culture are not met. Women develop an independence which is seen as a threat by men. Men are not able to fulfill their responsibilities as provider. So the status accorded by a traditional role understood since childhood is challenged. This leads to marital problems, domestic violence, alcoholism and mental health problems. Findings from this study indicate that stress in the marital relationship is related to depression in female respondents. Findings
from the Beiser et al., (2006) large scale quantitative study showed that marital status is predictive of well-being and reduced depression risk in the Sri Lankan Tamil population; however, it is less predictive of reduced risk of depression in women than in men. Other studies have also found that marriage, while being a protective factor for men, puts women's mental health at risk (Williams, 2003).

This study has added to the literature by highlighting the impact of prolonged marital separations, women assuming the instrumental role, and the difficulty in renegotiating roles on marital relationships. The findings point to marital issues as a significant factor in depression in this population. While role reversals and gender role expectations have previously been discussed in literature (Sellers et al., 2006; Conrad & Pacquio, 2005), their profound impact, leading to the breakdown of families and undermining the health of men and women, has not been adequately explored. Another important addition is to the culture/gender literature. Not only is gender itself important in this culture and contributory to depression, but the birth order of women is critical. For example, this study suggests that female younger siblings may have particular difficulties with their spouses in the context of resettlement, leading to depression when their traditional expectations of being taken care of are not met. This is the first time that this relationship has been noticed, an important finding because it can translate into therapeutic interventions.

**Critical analysis of the service provider perspective**

Service providers in this study vary in their understanding of their clients' loss of cherished possessions, supports, and dreams. While all service providers speak about losses and challenges to resettlement, only a few relate this to what was once culturally valued and how such losses might have impacted the well-being of their clients. The providers related more easily to the stresses of coping with unfamiliar situations. This
was reflected in their emphasis on the need for case management in clients with mental health problems. This emphasis on case management echoed the extant literature (Andres et al., 2005). Service provider participants were unanimous in their opinion that marital issues and relationship stressors, as well as domestic violence and addictions, exist in the Sri Lankan Tamil Community. The issue of domestic violence is emphasized by most providers. Service providers also speak of similarities in challenges that immigrants to Canada from rural settings from across the world face, especially in terms of relationship stressors in the context of resettlement. One factor that two service providers brought up was addiction to alcohol in the female population in the context of resettlement, not mentioned by the other service providers; in fact, some service providers specifically stressed that alcohol was not an issue in the Tamil female population. Alcohol dependence in females was, however, mentioned by some community respondents in the context of issues they saw in the larger community. The findings suggest that alcohol dependence in women in the Sri Lankan Tamil community may be an emerging issue of concern, yet to be identified by most service providers.

5.3. ii. Conceptualization of Health and Illness in the Tamil Community

A very important finding of the study is that members of the Tamil community see health and illness as social phenomena. Prior studies of health and help-seeking in ethnocultural communities have noted similar differences relative to Western concepts of health (Papadopoulos et al., 2003; Sellers et al., 2006).

It is not surprising that, in a collectivistic community that cherishes a family-centric orientation and takes pride in fulfilling traditional social roles, health is viewed along social dimensions. The ability to function in the traditional way is what defines health in the Tamil community. That is why losses experienced because of immigration are, for Tamils, synonymous with poor health. Irrespective of gender, functioning that enables
family-centrism and achievement in education is a particularly important marker of health in the Tamil population. Respondents invariably attributed their own depression to social and interpersonal causes and, in general, stated that psychosocial stressors cause mental health problems. This has been previously noted in studies on other visible minority communities. Hispanic culture also attributes depression to interpersonal and social causes (Cabassa et al., 2007). Ethiopian immigrants in the U.K. express the cultural belief that happiness and good social relations are a prerequisite to and a reflection of good health (Papadopoulos et al., 2003; Papadopoulos et al., 2004).

The Tamil community sees health as encompassing social, physical, and mental health. The interrelatedness of physical and mental health is underscored by the community. This, again, reflects the thinking in many non-Western cultures (Jambunathan, 2003; Pandalangat, 2006; Weerasinghe & Mitchell, 2006) where there is a holistic understanding of health that lacks a division between mind and body.

A very important finding of this study, important because it went against the majority of the literature in the field (Ramisetty-Mikier, 1993; Jambunathan, 1998; Castro, 1997) was a clear movement away from beliefs regarding the supernatural causation of ill health and the efficacy of supernatural intervention. When supernatural causation was brought up by respondents, it was at best stated in a speculative way, and was restricted to respondents whose illness experience began in Sri Lanka. This is a good example of the dynamism of culture. Moving to Canada seems to partly explain this movement away from supernatural causation. Sri Lankan culture (its beliefs and traditions) has evolved, as happens in all cultures, and cannot be viewed as static (Williams, 2006), necessitating a heightened sensitivity to cultural shifts among service providers in order to keep interventions in line with changing realities.
Depression is the most identified mental health issue in this community, probably because of its close ties to the social dimensions of health. While the respondents acknowledge that other mental health problems exist, they are not aware of the nature or names of other illnesses except for alcoholism, which is readily identified. Again, this problem, too, has a significant social dimension. Other studies have not explored this dimension of differential understanding of different mental health issues.

The respondents speak to the distress associated with taking medication and there is a history of non-compliance to medication in most of the respondents in this study. In some cases, compliance finally took effect only after recurrent relapses. Taking medication is equated to being “sick.” Medication is sought for overt symptoms and is discontinued when symptoms improve or when social functioning is regained. Where social functioning is one of the primary indicators of health, preventive measures (taking medication so as not to get ill) in the realm of traditional health care are undervalued and only an evident breakdown of function or presence of an overt illness prompts medication-seeking and/or the services of the health system.

**The Gender Interaction**

Social functioning has a highly gendered connotation in the Sri Lankan Tamil community. For men, it denotes the ability to provide for their families, ensure the education of their children, and be gainfully employed. Lack of employment was a very evident stressor in most of the narratives of men. While both genders alluded to health as a state of “normalcy” it is interesting that male respondents referred specifically to functioning as a sign of normalcy and health, in comparison to women. This is related to gendered male roles where “ability” to do things is important to a male, who is responsible for the instrumental role in the family. Women focused more on relationship stressors and cited them as causes for their depression. They stressed the importance of a
happy family and good relationships with their spouse as prerequisites to good health. This supports findings in the literature that familial factors predict distress in women (Masood, 2009; Hiott et al., 2006). It adds to the literature on the social aspects of health and illness in Tamil men by underscoring that family factors are important for men as well as women. For men, they relate to the ability to meet internalized gender role expectations as instrumental providers in a family-centric context. Employment related-challenges have been found to be a significant source of distress for men in ethnocultural communities (Fenta et al., 2004; McKenzie, 2008).

Supernatural causation has been described as part of a multiple-causation theory common to many cultures (Kleinman, 1980). With respect to supernatural causation of illness, only women, and specifically those whose illness experience began in Sri Lanka, endorsed this possibility. None of the men mentioned it.

**Critical Analysis of the Service Provider Perspective**

Service providers underscore the important role played by psychosocial stressors in adversely impacting mental health in the Tamil community but the holistic view of health held by the community is not well understood by most service providers. They express frustration at the community for seeking help only when there is a specific issue to be resolved or an evident breakdown. There is some evidence that family physicians might have a greater appreciation than other providers of the view of health held by the community, as family physicians are the go to people that the community gravitates towards for both mental health and physical health issues. The one family physician interviewed had an extremely good understanding of the community’s perspective. However, he was the only family physician, so this generalization may not hold. This has not been explored in other studies as well. The community’s view of health is equated with an absence of illness; service providers stress that preventive dimensions are not in
the forefront of the community psyche. On the other hand, service providers insist that the community views medication as the treatment of choice for depression, in comparison to psychotherapy or counselling. They highlight that this is different from what is found in Western populations, where there is a relatively greater demand for counselling and psychotherapy in comparison to medication. On the surface, this runs contrary to what was said in the community respondent interviews. However, closer scrutiny reveals that, if medication is equated to illness, and services are sought from the formal health care system only when there is a breakdown/overt illness, then it is possible that medication is seen as the treatment of choice. This is contrary to evidence regarding service providers views which speaks of the resistance to medication amongst Asian Indians (Conrad & Pacquio, 2005) even when there is a mental health issue.

It is interesting that while the literature constantly points to the holistic view of health in non-Western populations (Jambunathan, 2003; Shin, 1999), service providers, even those who themselves originally come from non-Western cultures, still tend to judge a community’s view of and response to health and illness by the parameters of Western medicine. This has not been previously noted in literature. A holistic view of health lends itself to opportunities for mental health promotion and illness prevention which the service providers interviewed for this study have not taken advantage of.

5.3. iii. Help-Seeking, Engaging in Treatment and Supports

In consonance with the emphasis on the social dimensions of health and illness in the Tamil community, social and cultural dimensions play a very important role in help-seeking, treatment and supports sought by members of the Sri Lankan Tamil community when there is a mental health problem.
Pathways to care for community respondents with depression were dependent on the cultural and geographic context of where help-seeking began. When the onset was in Sri Lanka, many years prior to immigration, the initial journey began at temples and included astrology, prophecies of god-men, and shaman ceremonies to drive away evil spirits or to undo an evil. However when respondents spoke about this, most of them emphasised that their families or communities believed in supernatural causation at that point in time; however retrospectively the respondents questioned the validity of these beliefs. Help-seeking subsequently moved on to hospital admissions upon overt breakdown. This confirms findings in the literature that pathways to care involve traditional healing in many cultures (Beiser et al., 2003; Dyck; 2004; Farooqui, 2006). However, when the pathway was initiated in Canada, it began with multiple formal and informal sources that included family physicians, friends, family members, and most importantly Tamil-speaking service providers in the health and social service sectors. Cultural shifts occurring upon immigration are evident here. Such shifts have not been highlighted in other studies.

Previous studies in ethnocultural communities have highlighted the pivotal role of family physicians in pathways to care (Beiser et al., 2003; Steel et al., 2006; Shin, 1999). The community’s holistic view of health makes the family physician the first point of access for depression and family physicians continue to play a role in the care of mental health problems even after specialist mental health services have been sought. This study is the first to highlight the fact that Tamil-speaking service providers other than family physicians, both in the health and social service sectors, also play a very important role in the pathways to health care. Since social functioning is integral to the conceptualization of health and illness, Tamil service providers who supported respondents in issues related to social functioning were very often key to initiating care for depression.

Problem identification with regards to depression was delayed in the respondents. Opportunities for referral were often dropped by family physicians and other service providers, even by those who belonged to the same community. This finding confirms
the literature, with suggests that family physicians may not be adept at diagnosing mental health problems within their own community (Bhui et al., 2002; Burr, 2002). Even supportive families fail to identify the problem when it is depression. Seldom is depression identified by the afflicted person himself or herself. Retrospective identification (a realization after the fact) is a common experience in this community.

The comfort of and openness in relating to a service provider from one’s own culture, the informal nature of engagement, and the ease of communicating in one’s own language were highlighted as highly positive factors that promote engagement. This adds to literature by elaborating on the findings from the large scale quantitative study (Beiser et al., 2003), which found that Sri Lankan Tamils who had been in Canada for less than ten years preferred Tamil-speaking service providers. When the concept of health and mental health in the population is based on social functioning, this defines the relationship with service providers and the expectation from service provision. In the home environment, help with regards to social functioning is sought primarily from family and other informal sources. This could be the reason why professional boundaries as set by Western standards are not understood by the Tamil community; a certain degree of informality in the client-service provider relationship is expected. This is supported by findings in the Filipino community where clients expected familiarity and close affiliation with the service provider (Plummer, 1995; Sanchez & Gaw, 2007). Treatment expectations relate to both relief from symptoms and the renewed ability to function in a socially sanctioned gender-congruent manner. The perception that a service provider from the Tamil community is “one of us” creates rapport and a comfort zone, enhancing the client-service provider relationship. This finding confirms results of another study that found that the ability to bond with the client, competence and knowledge, especially of cultural and religious background, contributed to client satisfaction in community mental health services (Mason et al., 2004). The current study makes very significant contributions in understanding how exactly culture and language similarities between service provider and service user contribute to an enhanced client-service provider relationship.
Despite an evident preference for a service provider from one’s own culture, when rapport was not felt with a Tamil service provider, someone who was respectful of the client was preferred. Certain characteristics of female service providers were also identified as facilitating engagement. General service provider characteristics preferred by ethnocultural communities, apart from culture and language have not been explored in other studies.

While working with visible minority populations, the stigma of mental illness is often viewed as a beast, a static entity that remains in place despite all efforts. Many studies have pointed to stigma and a culture of silence around mental health problems (Aghanwa, 2004; Sanchez & Gaw, 2007) However, findings from the current study reveal progress in terms of a definite movement away from stigma. Community respondents show an increased openness to talking about their condition, an increased acceptance from friends and relatives and an increased sensitivity towards mental health problems although this reduction in stigma has not yet been translated into an increased and accurate awareness with regards to mental illnesses other than depression. The importance of understanding the fact that culture changes and that, with time, stigma toward mental illnesses also changes is evident in this finding. This is a unique contribution that this study has made towards literature in the field.

Findings on helpful supports for persons experiencing depression reveal many previously unexplored dimensions. The importance of family support in protecting mental health has been recorded in cultures that are collectivistic (Francis, 2000; Stanhope, 2002). However, the current study finds that the family-centric orientation of respondents who have experienced depression have led them to hide their suffering from their family, lest family members worry and are negatively impacted by the knowledge of the respondent’s condition. This is true for both genders. Hence, a family-centric orientation might well
impede disclosure to family and lead to a situation where a normally supportive family is not able to offer the necessary support to its ill member. This has not been noted in other studies. The context of war, loss and resettlement also needs to be taken into account here. For example, depressed single males do not reveal their condition to their families back home as they do not want to cause anxiety in an already challenging environment created by the forced separation. The other factor is that lack of awareness regarding mental health problems has led families to neglect depressive symptoms; this leads to an increased duration of untreated illness. Family support is, however, forthcoming once the family is aware and informed about the condition. Another important finding of my study was that the geographic closeness of a large ethnic community does not automatically translate into support. While friends are perceived as extremely supportive, the wider Tamil community is not, according to many respondents. This is contrary to literature, which suggests that the presence of an ethnic community is supportive and exerts beneficial influences on mental health of all its members (Beiser, 1990; Fenta et al., 2004; Inman et al., 2007).

Several studies speak to the role of religion in diverting help-seeking away from the mental health system (Whitley et al., 2000; Jambunathan, 1998). Others speak of the positive effect of religious beliefs on depressive symptoms (Jang et al., 2006; Bennedsen et al., 2006). The present study finds clear cut evidence of the social support function of religion. Cultural sources of support include the church, the temple and spiritual groups, specifically भजन groups where devotees of a specific spiritual leader convene regularly and sing devotional songs. Social interaction opportunities, the help provided by members of the Church and the clergy, and the recreational opportunities and emotional support provided by the भजन groups were highlighted by many respondents as helping them in their journey through depression. It was the social function that was underscored, rather than the religious function of these institutions.

Other studies in ethnocultural populations have not highlighted this social support function of religion.
The Gender Interaction

Study results are consistent with findings in the relevant literature that men seek help less often and utilize medical and mental health services less, in comparison to women (Mansfield et al., 2003). Pathways to care are more direct for women than for men. Men are usually forced into the system because of an accident that demands an assessment or referral, or because of domestic violence that leads to a referral. In a sense, it can be said that men’s entry into the system is largely involuntary. This does not seem to have been explored in other studies. There is also a greater tendency for Tamil men, compared to women, to disengage from care. Masculine gender socialization could explain underutilization and decreased help-seeking in men (Addis & Mahalik, 2003; Bennett & Rosalind, 2006). Younger, single males were more prone to disengage from care than married men. For women, pathways are more direct and initiated by referrals from family physicians or other Tamil service providers. Women tended to stay engaged in care for longer periods than men, though they showed a greater tendency to keep doctors’ appointments than appointments with counsellors or case managers.

An important role that women play is as enablers of care for their relatives. Male respondents report that spouses help them keep appointments. This might explain the lesser degree of disengagement from care for married male respondents in comparison to unmarried male respondents. Most female respondents had at some level enabled friends and family to access care. While putting family before self was found in the socialization pattern of both genders, in males it described an instrumental dimension, whereas in women, it took on a care-giving dimension; this might explain the role of women as the main enablers of care. This finding could possibly indicate a cultural shift in terms of women becoming more informed and independent during the resettlement process, which enables them to engage with the health care system in an active manner. The prominence
of the role of women in enabling mental health care is a very specific new contribution of this study, as such a dimension that has not been noted in other studies.

Women are more vocal in their preference for a Tamil service provider than men. However, this seems to be a superficial difference as men, when prompted also talk about their relatively greater comfort when dealing with Tamil service providers. With the exception of one respondent, all others had at least one Tamil service provider in their care network.

Another important gender dimension was the characteristics of female service providers seen as promoting positive relationships and encouraging clients to open up. Men expressed a greater comfort with service providers of the same gender, but this was not the case with females. This could be because the health care system in Sri Lanka had more male service providers; thereby females might have been socialised into seeking help from male health care providers. With respect to perceived stigma, although it was not pronounced among the respondents, single females and their families were more prone to perceive stigma than were men, and they were less prone to disclose their illness to the community. This was because of the gender disadvantage that women perceived; that they were prone to be judged harsher than men if their mental illness was revealed and that it would impact marriage prospects to a greater degree than for men.

**Critical Analysis of the Service Provider Perspective**

Service providers were quick to point out gender differences in accessing help and staying engaged in care. They also reported a reduction in stigma within the community although they noted that stigma was still at a higher level than in the general population. The biggest challenge faced by service providers was the contextual nature of help-
seeking by their clients and the disengagement from treatment once the immediate situation or problem was resolved. This challenge can be attributed to service providers having adopted a Western view of mental health interventions that did not sit well with their clients. There was concern regarding a lack of synchrony with regard to the services that were required for the Tamil community and the mandate of the provider organizations, which curtailed the scope of service provision.

Tamil Service providers tended to accommodate their clients and introduced a certain degree of informality into their practice. This involved extending appointment times and becoming readily available for Tamil clients in some cases, as well as carrying clients beyond what was required in order to serve the social function of staying connected. This flexibility on the part of service providers is a new finding as studies that have focussed on expectations of service users have not explored whether these expectations were met by service providers.

It must be mentioned here that Non-Tamil service providers were able to talk of the Tamil community only in very general terms, as they saw few Tamil clients. The Tamil-speaking service providers of Indian origin and of Sri Lankan origin were able to speak in depth to cultural and gender issues specific to the Tamil community. The culture and language of the service provider could have been instrumental for this enhanced understanding, which facilitates in depth engagement. Most service providers did not have deep insight into the different dimensions of family and community support. The social function of religious institutions and Bhajan groups, which were so prominent in the narratives of the community respondents, did not find place in service provider narratives.

While community respondents pointed to a definite preference for service providers from the same culture, service providers went a step further and spoke at length about
misdiagnosis and inappropriate interventions as a result of cultural misunderstanding. This is in keeping with findings with regards to challenges in identifying distress, understanding cultural expressions of distress, and making an appropriate diagnosis when client and clinician come from different cultural backgrounds (Bilu, 1995; Gill et al., 2002).

Service providers also spoke to challenges of reaching out to men in comparison to women, and the greater resistance to treatment they found in men. There was also indication that the service system was so set up that, on many occasions, a distressed Tamil male’s contact with the system was through the court or the police.

5.3. iv. Are the service systems responsive?

*Cultural literacy as a valuable tool*

This study found that individual service providers use their cultural knowledge to advantage while working with the Tamil community. This is more the case for Tamil-speaking service providers of both Sri Lankan Tamil and Indian origin because of cultural roots and language shared with the Sri Lankan Tamil population. While non-Tamil service providers reflect sensitivity to needs and are responsive, they lack the advantage that cultural knowledge and language proficiency brings into the service providing relationship. Culturally-informed services include using cultural knowledge and understanding in intervention, for example, a service provider encouraging preventive health strategies in his clients by talking to them of depictions in ancient Tamil poetry. Validation of cultural and religious supports also occurs. Based on an understanding that the loss of family and other informal support systems makes the community gravitate towards service providers, there is an attempt to expand the scope of service. The value of the informal aspects of groups and group processes are stressed by the service providers. This supports the argument that cultural literacy can help the
health care provider to work effectively with the client (Leininger, 2002; Alaggia & Marzialli, 2003). Service providers also make use of the ethnic media which is accessed by a majority of the Tamil population for purposes of health education and awareness promotion.

**Challenges and gaps**

There is also evidence that some Tamil service providers, especially physicians and psychiatrists, are still hierarchical in their approach to clients, and this could be a reflection of the health system of the home country in which physicians were socialized. Tamil clients in Canada, seem to resist this authoritarian approach. This could reflect a changed cultural environment. Clients are being acculturated into an environment where the health care system expects clients to take an active role in their health care; hence there is a change in clients’ expectations from the service provider. This finding is contrary to literature on Asian Americans that notes that the physician is considered an authority and clients do not argue with the physician (Kramer et al., 2007). It may speak to the empowerment of North American patients in general vis a vis their health care providers. The modern concept of collaborative care still meets with resistance from some service providers, especially physicians, who serve the Tamil community.

It is clear that the service systems do not have a planned or targeted intervention strategy while working with ethnocultural newcomer communities. Service providers stress that organizational mandates are confining. At best, a few organizations offer a certain level of flexibility while working with newcomer populations — for example; allowing service providers to see Tamil clients without delay, despite a waiting list for the general population. Services geared to Tamil men (help with employment; aggression counselling; addiction counselling) are severely lacking. While there are more services for Tamil women these services are not based on a culture and gender-based analysis of
needs, as is evident from service providers who speak to confining scope of practice as mandated by the organization which does not take into account the needs of the population.

**Table 5:**

<table>
<thead>
<tr>
<th>New Findings That May Only Apply to the Sri Lankan Tamil Community</th>
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<tr>
<td>• The social support function of religious practices, especially Bhajan groups</td>
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<tr>
<td>• Ancient Tamil literature is used to convey concepts of mental health and holistic health</td>
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<tr>
<td>• Tamil service providers in the social service sector as key players in the pathways to mental health care, more so for Tamil women</td>
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<tr>
<td>• Mental health stigma appears to be lessening over time</td>
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<td>• The relative unimportance of the supernatural in concepts of mental health, noted after immigration to Canada.</td>
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<td>• Family-centric orientation is an impediment to disclosure of mental distress to one's family, thereby compromising the role of family as a source of support</td>
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<tr>
<td>• The extraordinarily high value placed on education and its loss impacts mental health</td>
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<td>• Men's engagement in care predominantly indirect and/or involuntary</td>
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Table 6:

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<tr>
<th>Findings that Also Apply to Other Ethnocultural Visible Minority Immigrants</th>
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<tr>
<td>• A holistic view of health</td>
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<tr>
<td>• Health viewed as adequate gender-appropriate social functioning</td>
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<tr>
<td>• Preference for informality in service provision</td>
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<tr>
<td>• Preference for service providers who speak one’s language and understand one’s history, culture and traditions</td>
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<tr>
<td>• Important role of family physicians in pathways to care</td>
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<td>• Women as enablers of care for the family and larger community</td>
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<tr>
<td>• Unmet gender role expectations and role reversals in the context of resettlement lead to upheaval in marital relations and impact mental health</td>
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<tr>
<td>• Domestic violence and rising rates of alcohol abuse in the context of resettlement</td>
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5.4. Limitations of the Study:

This study is a qualitative study and relied on voluntary participation of respondents who self-identified as having had a diagnosis of depression. Hence, the study captured only the experiences of those who have had some contact with the health system, and who chose to participate. The experiences of those who chose not to participate might have been very different. It should also be borne in mind that this a small sample reflecting the experiences of men and women, largely from rural backgrounds with a length of stay in Canada of 10 years or less. Hence generalization to the larger Tamil community should be undertaken with caution.

Also, the recruitment of service providers was through a process of purposive sampling. Service providers initially identified connected the researcher to other service providers, thus providing a snowball sample. So, while there were service providers who
represented a range, in terms of cultural background and roles that they played within the health care system, there is a possibility that the service providers who participated had a greater understanding of issues in ethnocultural communities and a greater awareness of cultural and gender considerations than the average service provider. While the sample may not be representative of the larger community of service providers, the method used brought out the experiences of providers who were working with the Tamil community. Generalizations that could be applied to all service providers serving the Tamil community cannot be expected from this study.

This study does not explore in depth gender role differences between main stream communities and the Sri Lankan Tamil community. What it achieves is an understanding of how gender roles are defined through socialization processes and childhood experiences in a particular cultural context and how this impacts health and health behaviour. Further study is needed to establish how this might differ from other communities.

The study was focused on cultural and gender factors, it did not look in depth into systemic barriers to the resettlement process, though findings do indicate the presence of systemic barriers such as unemployment and underemployment.

5.5. Implications for Future Research:

This exploration clearly points to the need of expanding research in several directions. The role of family physicians in problem identification, referral and treatment has been clearly identified — the responsiveness of family physicians to working with the Sri Lankan Tamil community needs to be researched. Results would help to design an improved intervention strategy. The finding that women are the ones who identify problems within the family, and larger community and encourage help-seeking (women as enablers of care) is important to build upon. An outreach and health promotion strategy involving women from the Tamil community can be developed and tested.
preference for collaborative care can be disseminated and employed in practice settings, as is already being done. Studies focusing on the particular needs of Sri Lankan Tamil men are required to inform the development of targeted services for this sub-population. Finally, an important lesson is that cultures are not static. Research into culture change and its impact on service delivery is indicated.

5.6. Findings that Lead to Service Recommendations:

Cultural competence has been identified as a set of integrated behaviours, attitudes and policies that enable a system, agency and professionals to work effectively in cross-cultural situations (Cross et al., 1989). However, as Williams (2010) points out, there is a struggle to translate this understanding into hands-on strategies that would make mental health services more effective for ethnic populations. The analysis of cultural and gender factors in the Sri Lankan Tamil population seeks to build on the knowledge acquired and look at its practical applicability in the field of mental health. This section will explore some possibilities with regards to services and strategies based on the lessons learned. It is important to note here that my knowledge of currently available services comes from my role as a mental health professional with specific expertise in working with the Sri Lankan Tamil community. This knowledge has been employed to link lessons learned in a meaningful manner to service implications.

5.6. i. Health promotion and prevention needs to move beyond the traditional realm of health

The emphasis in the Tamil community on the social dimension of health is an important finding from a population health perspective. Study results show that, in this community, health is viewed as a resource that helps to achieve social functioning and the fulfillment
of appropriate social roles. The disjunction between the formal mental health system and the Tamil community could be partially based on the fact that Tamils do not see the formal health care system as the avenue to resolving social issues that define their health. Findings also reveal that concepts of counselling and psychotherapy are only partially understood, probably because they were not part of the health care system into which Tamils have been socialized. This does not mean that Tamils do not value prevention of ill health; rather, it means that prevention should also take place outside of traditional health care. Health-promoting interventions are more effectively focused on social dimensions of well-being such as employment, income support, and enhancement of positive communication in relationships.

Current services do not reflect a proactive stance to the marital issues and relationship stressors in the Sri Lankan Tamil community, linked, though they are known to be, to depression. Interventions are currently reactive and tend to be gender-specific. For example, when there is domestic violence, support is offered to the woman. For men, only court-mandated services (anger management and counselling) are available and they are limited. There are almost no services that address the marital couple as a unit in order to provide support in terms of renegotiating roles and supporting joint transition into redefined roles. As this is a significant problem in the newcomer Tamil population, early intervention can result in successful prevention of subsequent mental illness. Current services to the Tamil community focus on parenting and a number of providers offer parenting workshops to women. Such existing parenting workshops can be a launch pad through which couples and families can be engaged.

Knowledge of what is culturally valued can be an important indicator in assessing the impact of specific losses and can help to target health promotion interventions. For example, if maintaining farms and vegetable gardens were part of the cherished lifestyle of the Sri Lankan Tamil community, a focused intervention which looks at developing community gardens for this population would be helpful in decreasing social isolation
and increasing opportunities for interaction. The concept of community gardens is present in services for the mainstream population and can find application with this population group. Another important health promotion intervention will be to look at improving the self-esteem of Tamil seniors, and create opportunities where their inputs are respected and sought. Current services targeted towards Tamil seniors are already moving in this direction.

Finally, the role of women as enablers of care can be used to advantage in health promotion as highlighted in the section on implications for future research.

5.6. ii. Targeted culture and gender-informed interventions

Adequate and appropriate social functioning is the indicator of good health in the Sri Lankan Tamil community. Social appropriateness differs for men and women. It is important that service providers and service systems work with this understanding of the social dimensions of health, illness, help-seeking and treatment expectations and tailor their services accordingly. For example, it is now recognized that employment plays an important role in recovery from mental illness. In the mainstream, there are programs that focus specifically on employment issues and facilitate employment opportunities for individuals with mental illness. In the context of the Sri Lankan Tamil culture, where there is great emphasis on job and income as role-defining for males, unemployment or the loss of a job is extremely distressing. One of the key findings in this study was that unemployment was related to the experience of depression in males. This culture/gender-specific understanding of the importance of jobs should lead to the development of a practice framework that incorporates vocational counselling and reintegration into the workforce.
Services need to be linguistically and culturally accessible. Expanding the service base through cultural consultation services (Kirmayer et al., 2003) needs to be considered.

The integration of cultural sources of support such as ÑBhajanÑ groups into the care plan should ideally be part of any support strategy. The first step would be to understand the cultural sources of individual support and validate their function so that service users find it easier to talk about their various sources of support. Such validation can also lead to a sense of being understood and accepted and provide for greater rapport and trust in service provision. Understanding and utilizing the social support function of culture-specific resources will lead to better health outcomes. The ethnic media can and should be used to advantage by mainstream organizations for purposes of health promotion and outreach.

The dynamism of the concept of culture should always be taken into consideration. For example, while working on mental health stigma reduction efforts in the community, it is important to know where the community stands, so that relative shifts can be acknowledged and built upon.

5.6. iii. Collaboration with and capacity-building in multiple sectors

The populationÑs clear emphasis on the social dimensions of health, help-seeking, treatment engagement and supports provides clear direction that the mental health system needs to work in conjunction with settlement services and other social service systems. Case management services were endorsed by all service providers in the study.
It is important to strengthen the identification, treatment and/or referral capabilities of family physicians and Tamil service providers in the social services sector, as they have a strong role in initiating help-seeking. Early intervention would be made possible by strengthening the capacity of these sectors. This recommendation has been made before (Dupree et al., 2005; Vega et al., 2001; Wells et al., 2001). It is especially pertinent as findings of the current study indicate that family physicians may not always identify depression. An extension of capacity-building to other service provider categories is required, as the community tends to first seek services outside of the traditional health system. With regards to Tamil males, the focus should be on gender-specific outreach and access to health and social services through more direct pathways, not through the law or police. Working with law enforcement might help to bring this about.

**Table 7:**

**Service Implications in a Nutshell**

- Case management is recommended as an integral part of mental health intervention
- Employment supports and reintegration into workforce are needed as part of health promotion and health intervention strategies, especially for Tamil men
- Services geared towards working with newcomer couples and supporting them through the process of renegotiating gender role transitions in the context of resettlement are required
- Increasing the capacity of family physicians and service providers in the social services sector
- Multi-sectoral collaboration
- The expertise of women as enablers of care can be utilised for health promotion and outreach
- Cultural knowledge can be effectively used by service providers to modify their practice
- The social support function of religion, for example bhajan groups should be integrated into care plans
5.7. Towards a Comprehensive Model of Care:

This study clearly identifies that while working with ethnocultural populations, it is important to embrace a holistic view of health which forefronts the social dimensions of health and illness. This calls for interventions beyond the traditional realms of health and medical care. While not negating the need for medical interventions when illness does occur, this approach calls for culture and gender-informed health promotion and prevention strategies in health care. At the level of interventions, when dealing with mental distress, it calls for comprehensive approaches that will adequately address culture and gender-informed social factors and stressors in addition to symptomatology. In addition to mental health services, this comprehensive model will involve primary health care providers, informal networks, cultural and religious sources of support, law enforcement, and the employment and the social services sector.

5.8. Concluding Note:

The study verified the assumptions that were made on the basis of the initial literature review that culture and gender factors probably play a significant role in impacting mental health, help-seeking and engagement in treatment in the Sri Lankan Tamil community of Toronto. The study has added to the literature by beginning to fill important gaps e.g. working qualitatively, focusing on the Sri Lankan Tamil population, exploring the intersection between culture and gender, and analyzing both service user and service provider perspectives. Service implications of this study are strong. It is evidence of the fact that cultural formulations that integrate gender considerations are crucial to the discourse on culturally-responsive service delivery for ethnocultural populations.
References


Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988). *After The Door Has Been Opened*. Ottawa, Ministry of Supplies and Services


Feminist Majority Foundation (1999). Stop Gender Apartheid: Fact Sheet


Mallett, R., & Cole, E. (2002). From Theory to Practice: Operationalising cultural competence into a working model for community mental health services in the U.K. *International Sociological Association*, Brisbane Australia, W1:0


Appendix A

Flyer to advertise study and recruit participants in the Tamil community

Your participation in a research study is needed!

Are you a member of the Tamil community who:

- is 18 years of age or above
- has been in Canada for 2-10 years
- has been diagnosed as having depression

If so, we would love to hear from YOU!

Learning about your experiences will help others to understand the needs of your community and to develop more culturally sensitive mental health services.

For more information and/to to participate in the study, please contact:

Nalini Pandalangat
PhD Candidate – Institute of Medical Science
University of Toronto
Tel: 416-670-9577
APPENDIX B

Interview Guide – Interviews with Respondents from the Tamil Community

As an interview guide, this is a flexible tool designed to guide the interviewer and ensure that all sub-terrains within the terrains are covered during the interview. The prompts would be used as and when required to gain further clarity. Prompts related to identifying gender differences will be used whenever warranted.

1. **Biographical information:**
   a. Age
   b. Gender
   c. Educational level
   d. Family Income: a. $10,000 and less  b. $11,000-$30,000  c. $31,000-$50,000  d. $51,000-$70,000  e. $71,000 and above
   e. Employment
   f. Information on family of origin – Parents and siblings – age, sex, where they live currently
   g. Marital Status - Age of spouse, age and sex of children
   h. Family type
   i. Year of entry into Canada
   j. Type of entry into Canada – independent immigrant, refugee, refugee claimant or other

2. **Background history:**
   a. Can you tell me about your experience of growing up in Sri Lanka *(potential grand tour question)*
   b. Did you have specific roles and responsibilities in childhood *(prompt) pertaining to being a boy/girl*
   c. What expectations did others have of you in childhood and adolescence
   d. Were these expectations different from what they had of your brother/sister *(if there were other siblings in the family)*
   e. What were your expectations of yourself *(prompt) what did you want to be when you became an adult*

   *Special incident prompt if warranted – Ask for narrating any specific incident that would explain a statement made.*

3. **Perceptions regarding Health, Mental Health and Mental Illness:**
   a. What does the term health mean to you
b. How is health viewed in your community

c. What is your perception of mental health and mental illness — what do you think causes mental illness and what kind of help needs to be sought
(Note to interviewer — look for attributions, commonly held beliefs, help-seeking, remedies, recognition of psychosocial determinants of health)

d. What is the community’s perception about mental health and mental illness
(prompt) — are there differences between how men and women are perceived or treated when they have a mental health issue
(Note to interviewer — look for attributions, commonly held beliefs, help-seeking remedies, recognition of psychosocial determinants of health)

e. Have there been changes in your perception about mental health over the years

Use contrast prompt if warranted — what was it ten years ago, what is it now?

4. Person’s own experience with Depression:
   a. Could you talk about your experience with depression?
      (potential grand tour question)
      (Note to interviewer — Touch upon items below if not covered)

b. When did you first notice that there was a problem

c. What did you think was the cause of the problem

d. What was the reaction and observation of people important to you/family members

e. When was the need to seek help identified, who made the decision regarding help-seeking, what kind of help was sought
   (prompts) any rituals, prayers or ceremonies that was part of the help-seeking, dealing with crisis

f. What was your reaction when you were diagnosed as having depression

g. What was the reaction of your family/people important to you when your were diagnosed as having depression

h. Can you tell me about what the treatment process was like — types of treatment, duration of treatment, support and follow-up
i. Can you talk about your experiences with and opinion of service provider(s) involved in the treatment
(Note to interviewer – look for information on culture and background of the service provider, gender of the service provider, service provider’s understanding of the client’s culture and language, ease of communication with service provider)

j. What were your expectations of treatment - was this understood and addressed by the service provider(s)

k. Did you have any difficulties in relationship or communication with the service provider(s)

l. What were the positive factors that enhanced relationship or communication with service provider(s)

(Note to interviewer – use contrast prompts, and other to look for gender related issues in all the above)

5. Supports and Barriers:
   a. What were some of the challenge and supports at home, workplace and community when dealing with depression
      (potential grand tour question)

   b. What aspects of your life were affected the most; what kind of supports did you receive in dealing with these aspects of life
      (prompt) who provided the most support, who provided the least support

   c. What aspects of life were affected the least
      (prompt) – is it because existing supports ensured that these aspects were not affected.
APPENDIX C

Interview Guide – Interviews with Service Providers serving the Tamil Community

As an interview guide, this is a flexible tool designed to guide the interviewer and ensure that all sub-terrains within the terrains are covered during the interview. The prompts would be used as and when required to gain further clarity.

6. **Biographical information:**
   a. Age
   b. Gender
   c. Educational level
   d. Country of origin
   e. Length of stay in Canada
   f. Organization employed in
   g. Job title
   h. Clients served

7. **Training and employment**
   a. Can you describe the kind of training you have received in mental health
   b. Can you describe your current job and role

   *(Note to interviewer – look for information on setting, types of services, nature and diversity of clients served, whether it gender specific services, the ratio of men and women served)*

8. **Perceptions regarding populations being served**
   *(Note to interviewer – in c and d probe for gender specific information as well)*
   a. How does the Tamil population view health and mental health *(potential grand tour question)*
   b. What are the common beliefs that they hold regarding health in general and mental health in particular
   c. What are their expectations regarding treatment and intervention *(prompt) are their expectations very different from expectations of other clients seeking treatment*
   d. What is the most pressing mental health issue in the Tamil population
   e. What are the psycho-social factors that impinge on the mental health of the Tamil community *(prompt) differences between men and women with regard to the nature of factors that affect them*
9. Help-seeking and engagement in treatment

(Note to interviewer – probe for gender specific information as well)

a. Can you comment on the help seeking and engagement in treatment of the Tamil community for mental health issues
   (potential grand tour question)

b. At what stage do clients from the Tamil community seek help for mental health issues

c. What are the alternate sources of help that are sought
   (prompt) Clarify whether these are sought exclusively, whether they precede formal help seeking or are a parallel process

d. What is the level of involvement of family and significant others in help seeking and decisions around treatment and intervention

e. As a service provider what are the challenges you face in working with clients from the Tamil community

f. Were there instances of cultural misunderstanding. Why do you think it occurred
   (special incident prompt can be effectively utilized here) Any incident that highlights this cultural misunderstanding during actual engagement with clients

g. Are there any issues relating to language in working with clients from the Tamil community

h. Is there something very distinct or particular in terms of cultural factors that you think should be kept in mind when working with the Tamil community

i. What are the barriers clients face in navigating the system

j. What are the barriers service providers face in providing adequate care

(Note to interviewer - use prompts to identify differences between men and women with regard to seeking help, compliance with treatment, the service provider client relationship and treatment expectations)

10. Health Promotion and Intervention:

a. What health promotion and intervention strategies would be effective in the Tamil community
   (potential grand tour question)
   (prompt) Would strategies have to be different for men and women. Elaborate with examples
b. Do you perceive a need/lack of need to involve significant others in health promotion
   *(prompt) would there be a difference for men and women*

c. What kind of strategies would facilitate early identification and promote help seeking

d. What other help and supports are required to maintain mental health

e. What are the gaps in service delivery and nature of services that needs to be addressed
APPENDIX D

Consent Form for Community Respondents
(On Letterhead)

You are being invited to participate in a research study. Please note that participation is completely voluntary and that declining to participate or withdrawing from the study early is possible with no adverse consequences.

What is the name of the Study?
The Research Project for which consent is requested is titled, ÒCultural Influences on Help Seeking, Treatment and Support for Mental Health Problems Ñ A Comparative Study using a Gender Perspective.Ó

Who is doing the Study?
The investigator of the study is Nalini Pandalangat, who is a PhD Candidate at the Institute of Medical Science, University of Toronto. For information on the project and for answering any questions or concerns, she can be contacted at 416-670-9577.

Dr. Mary V Seeman is Nalini Pandalangat’s supervisor. She is a member of the Institute of Medical Sciences and is also Professor Emerita, Psychiatry, Faculty of Medicine, University of Toronto.

Funding Source: The Helen Marion Walker Soroptomist Scholarship awarded through the Centre for Research in Women’s Health.

What is the study about?
This project is for the completion of a PhD program. It will look at how culture and gender influences problem identification, help seeking, treatment and supports for mental health problems in the Tamil community. Members of the community that self-identify as having depression will be interviewed. Interviews will also be conducted with mental health service providers who are serving the community as well. In total, 24 people will be interviewed.

Your Participation
Your participation in this study will be very helpful in understanding the needs of the community. To participate in this study you must meet all the following conditions:

1. You must be a member of the Tamil community who is over 18 years of age
2. You must have had a diagnosis of depression sometime in your life
3. You must have been in Canada between two and ten years.

Please note that you waive no legal rights by participating in this study
What will happen at the interview?
The interviews will last for around two to two and a half hours. They will take place in a location that is convenient to you. You will be asked questions regarding your background, your experience with depression, when and where you sought help and the nature of the help that was provided to you. Questions will also relate to your expectations regarding wellness and treatment. Participation in the interview is completely voluntary. If at any time during the interview, you wish to withdraw from the interview, you are free to do so. You may also choose not to answer certain questions. There are no known risks in participating in this study. If you feel emotional during the study and want to refuse further participation, you are free to do so. The interviewer will provide you with a list of mental health services if you require them. Though there are no direct benefits to you by participating in the study, the findings from this study may lead to better mental health service provision for members of your community in the future.

Who will know about what you said or did in the study?
Your participation in the study will be kept confidential. Except for the investigator who is also the interviewer, and the supervisor, no one will know your personal identity. The interviews will be tape-recorded. After the recording, the interviewer will go over the tape and erase portions where your name is mentioned. If you do not want the interview audio taped, but would like to participate in the interview, that is possible too. The notes taken at the interview will not have your name in it. Instead it will have a code number. After the audiotapes have been transferred to notes, they will be destroyed. Data will be kept for 6 years after completion of the research in accordance with U of T policy. When data is presented, it will be made sure that there is no information through which you can be identified. When quoting what you have said, identifying information such as your name or names of others that you mention will be removed.

You will be compensated for the time spent participating in the interview. You will be paid an honorarium of $30.00 at the completion of the interview.

A summary of the research report will be made available at the following three community centres:
   a. Wellesley Community Centre
   b. Regent Park Community Centre
   c. Mid Scarborough Community Centre

If you have questions about your rights as a research participant, please contact:
Jill Parsons, Health Sciences Ethics Review Officer, Ethics Review Office, University of Toronto, at telephone 416-946-5806 or by e-mail: jc.parsons@utoronto.ca

Thank you for your consent. You are being given a copy of this informed consent to keep for your own records. Please sign below:

I have read the consent form and am willing to participate in the research project
Signature: _____________________ Name: _____________________ Date: __________

I give permission for the interview to be audio taped   Yes   No
Signature: _____________________ Name: _____________________ Date: __________
APPENDIX E

Consent Form for Service Providers
(On Letterhead)

You are being invited to participate in a research study. Please note that participation is completely voluntary and that declining to participate or withdrawing from the study early is possible with no adverse consequences.

What is the name of the Study?

The Research Project for which consent is requested is titled, Cultural Influences on Help Seeking, Treatment and Support for Mental Health Problems – A Comparative Study using a Gender Perspective.

Who is doing the Study?

The investigator of the study is Nalini Pandalangat who is a PhD Candidate at the Institute of Medical Science, University of Toronto. For information on the project and for answering any questions or concerns, she can be contacted at 416-670-9577.

Dr. Mary Seeman is Nalini Pandalangat’s supervisor. She is a member of the Institute of Medical Sciences and is also Professor Emerita, Psychiatry, Faculty of Medicine, University of Toronto.

Funding Source: The Helen Marion Walker Soroptomist Scholarship awarded through the Centre for Research in Women’s Health.

What is the study about?

This project is for the completion of a PhD Thesis. It will look at how culture and gender influences problem identification, help seeking, treatment and supports for mental health problems in the Tamil community. Members of the community that self-identify as having depression will be interviewed. Interviews will also be conducted with mental health service providers who are serving the community. In total, 24 people will be interviewed.

Your Participation

Your participation in this study will be very helpful in understanding the needs of the community. To participate in this study you must meet all the following conditions:

1. You must be a service provider working with the Tamil community
2. You must be working in an area related to mental health services
Please note that you waive no legal rights by participating in this study.

**What will happen at the interview?**
The interviews with service providers are expected to last between one and a half to two hours on an average. They will take place in a location that is convenient to you. You will be asked questions regarding your background, your experience working with the Tamil community, your perspectives of mental health problems in this newcomer visible minority population and what the optimal treatment plan would look like. Participation in the interview is completely voluntary. If at any time during the interview, you wish to withdraw from the interview, you are free to do so. You may also choose not to answer certain questions. There are no known risks in participating in this study. Though there are no direct benefits to you by participating in the study, the findings from this study might lead to better mental service provision for members of newcomer communities that you serve.

**Who will know about what you said or did in the interview?**
Your participation in the study will be kept confidential. Except for the investigator who is also the interviewer, and the supervisor, no one will know your personal identity. The interviews will be tape-recorded. After the recording, the interviewer will go over the tape and erase portions where your name is mentioned. If you do not want the interview audio taped, but would like to participate in the interview, that is possible too. The notes taken at the interview will not have your name in it. Instead it will have a code number. After the audiotapes have been transferred to notes, they will be destroyed. Data will be kept for 6 years after completion of the research in accordance to the U of T policy. When data is presented, it will be made sure that there is no information through which you can be identified. When quoting what you have said, identifying information such as your name or names of others that you mention will be removed.

A summary of the research report will be made available at the following three community centres:
- Wellesley Community Centre
- Regent Park Community Centre
- Mid Scarborough Community Centre

If you have questions about your rights as a research participant, please contact:
Jill Parsons, Health Sciences Ethics Review Officer, Ethics Review Office, University of Toronto, at telephone 416-946-5806 or by e-mail: jc.parsons@utoronto.ca

Thank you for your consent. You are being given a copy of this informed consent to keep for your own records. Please sign below:

I have read the consent form and am willing to participate in the research project
Signature: __________________________ Name: __________________________ Date: __________________________

I give permission for the interview to be audio taped
Yes / No
Signature: __________________________ Name: __________________________ Date: __________________________

I wish to receive a copy of the summary report: Yes / No
(please circle yes or no)
APPENDIX F

Summary Report of Research Findings to the Community and Service Providers

Cultural Influences on Help Seeking, Treatment and Support for Mental Health Problems – A Comparative Study Using a Gender Perspective

This study was conducted by Nalini Pandalangat, under the supervision of Dr. Mary V. Seeman to fulfill requirements for a PhD degree at the University of Toronto. The focus of this study was to understand cultural and gender influences on mental health, health beliefs, health behaviour, help-seeking and treatment expectations for mental health problems in the Sri Lankan Tamil community in Toronto. In depth interviews were conducted with 8 Tamil women and 8 Tamil men who identified themselves as having had a diagnosis of depression, and who had been in Canada for ten years or less, as well as 8 practitioners who provided mental health or related services to the Tamil community.

This summary report identifies findings that were identified as potentially unique to the Tamil community, as well as those that apply to other population groups.

Findings That May Only Apply to the Sri Lankan Tamil Community

- The "Bhajan" groups serve as important sources of social support
- Ancient Tamil literature is used to convey concepts of mental health and holistic health
- Tamil service providers in the social service sector are key players in the pathways to mental health care, more so for Tamil women
- Mental health stigma appears to be lessening over time in the Tamil community
- After immigration, the supernatural no longer looms large in Tamil concepts of mental health
- Family-centric orientation can be a barrier to disclosure of mental distress to one's family, thereby compromising the role of family as a source of support
- The extraordinarily high value placed on education and its loss impacts mental health. This is also reflected in high expectations of children regarding academic performance
Men’s engagement in mental health care is predominantly indirect and/or involuntary

Findings that May Also Apply to Other Ethnocultural Visible Minority Immigrants

- Health seen as holistic, e.g. physical and mental health as one
- Health viewed as adequate gender-appropriate social functioning
- Preference for informality in service provision
- Preference for service providers who speak one’s language and understand one’s history, culture and traditions
- Important role of family physicians in pathways to care
- Women as enablers of care for the family and larger community
- Unmet gender role expectations and role reversals in the context of resettlement lead to upheaval in marital relations and negatively impact mental health
- Domestic violence and rising rates of alcohol abuse in the context of resettlement

Implications for Service Delivery

- Case management is recommended as an integral part of mental health intervention
- Employment supports and reintegration into workforce are needed as part of health promotion and health intervention strategies, especially for Tamil men
- Services geared towards working with newcomer couples and supporting them through the process of renegotiating gender role transitions in the context of resettlement are required
- Increasing mental health capacity of family physicians and service providers in the social services sector
- Multi sectoral service collaboration
- The expertise of women as enablers of care can be utilized for health promotion and outreach
- Cultural knowledge can be effectively used by service providers to modify their practice
• The social support function of religion, for example, Bhajan groups should be integrated into the care plans