Life Experiences and Patterns of Distress in Chinese-Canadian Women with a History of Suicidal Behaviour

by

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A thesis submitted in conformity with the requirements for the degree of Master of Science
Graduate Department of Institute of Medical Science
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Abstract

Recent studies have highlighted higher rates of suicidal ideation and behaviour and associated themes of gender role stress in Chinese women residing in North America (Chung, 2004). Through qualitative interviewing and analysis, this study explores the experiences, stressors and beliefs of Chinese-born women living in Canada with a history of suicidal behaviour. They describe restricted patterns of emotional communication, feelings of lack of agency, experiences of victimization and oppression and stress related to traditional gender expectations and those related to social change. Expectations of immigration often go unmet and stress arises from financial, educational and family pressures. As the women struggle to endure this distress, they experience a negative view of self, worsening depressive symptoms and hopelessness. They come to a "breaking point" leading to suicidal behaviour that can be understood as an escape from pain, a strategy to communicate distress and a consequence of pervasive hopelessness.
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Contributions

The study research team was comprised of Dr. Paul Links, Dr. Samuel Law, Dr. Wes Shera, Dr. A Ka Tat Tsang, Dr. Alan Fung and Dr. Rahel Eynan.

This study was conceived by Juveria Zaheer. She wrote the study protocol and interview guide and was responsible for data management and open coding and memoing. The memos were reviewed every two months at a research team meeting and the team made suggestions on extant theory to review as well as feedback on the work as it progressed. Dr. Zaheer prepared manuscript in its entirety.

Catherine Cheng served as a research assistant on this study and obtained informed consent and conducted the qualitative interviews for Cantonese and Mandarin speaking subjects with my guidance. She also provided analytic memos reviewing her experiences.
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Chapter 1
Literature Review

1 Literature Review

This chapter will provide an overview of the literature pertaining to suicide and gender in Canada and China and will provide a rationale for qualitative exploration. The theoretical underpinnings of the study, including its ontological and epistemological background, social constructivist conceptions of gender, cultural and suicide, and a model of suicide-related behaviour, will be discussed.

1.1 An overview of suicide and gender in China and Canada

In almost every country in the world, women have higher rates of suicidal ideation and behaviour, but lower rates of death by suicide, than those seen in their male counterparts (Mann, 2002; Nock et al., 2008; Phillips, Li, & Zhang, 2002). Sylvia Canetto & Isaac Sakinofsky (1998) labeled this phenomenon the gender paradox of suicidal behaviour, and it is most striking in industrialized nations, specifically English-language countries such as the US, Great Britain, and Australia (Canetto, 2008). These patterns of suicidal behaviour are also seen in Canada (Canetto & Sakinofsky, 1998). Almost 4000 Canadians die by suicide each year and many more deliberately harm themselves (Langlois & Morrison, 2002). While significantly more men die by suicide than women at a rate of 3.2:1, women are at significantly greater risk than men for non-fatal suicide attempts (Langlois & Morrison, 2002). China's suicide rate is two to three times the global average; in percentages, China has 21% of the world’s population, but 44% of world’s total suicides, and 56% of world’s female suicides, which translates to close to 300,000 suicide deaths in China each year (Phillips et al., 2002). China has a unique problem with suicide as the Chinese national reports on suicide have shown a strong reversal of the international trend: in those who are under age 60, female rates exceed male rates by an average of 26%, with rural female rates exceeding rural male rates by 66% (Ji, Kleinman, & Becker, 2001; Murray & Lopez, 1996).

Researchers have proposed that cultural conceptions of gender and suicide may play a role in the patterns seen in Canada and China. In Western countries, including Canada, suicide is seen as a
masculine act and “failing at suicide” is feminine; in China, suicide is considered to be a feminine “act of the powerless” and males exhibiting suicidal behaviour are seen as effeminate or weak (Canetto, 1997, 2008, p. 259; Cleary, 2012; Range & Leach, 1998). Many researchers have suggested that Chinese women have lower social status than men, leading to restricted economic options and significant gender role conflict with kin (Aubert, Daigle, & Daigle, 2004; Meng, 2002; Nock et al., 2008; Zhang & Xu, 2007). He & Lester (1998) suggest that for some women in China, suicide is not considered a mental health issue but rather a strategy available to powerless people for influencing the behaviour of others, or for a powerless individual to exact revenge upon those who have made their lives intolerable. Pearson, Phillips, He, & Ji (2002) characterized suicidal behaviour in young rural women by high levels of impulsivity, little effort to seclude themselves and low rates of mental illness, including depression. Traditional Chinese cultural values may put women at a disadvantage because in family disputes or crisis, women are typically blamed (Zhang et al, 2007). A study of men and women admitted for suicidal behaviour to six hospital emergency departments in a rural area of Northeastern China found family and love crises occur in 61% of females compared to 40% of males; females also showed significantly higher levels of metempsychosis (a culturally bound desire to transform to the opposite gender) than males and non-suicidal female controls, perhaps indicative of this gender inequality (Zhang & Xu, 2007). Recent studies have examined the role of psychological strain related to a conflict between traditional Confucian values and modern values of gender equality in rural Chinese youth who have died by suicide. (Zhang & Zhao, 2013). This study found that those who experienced value conflicts between Confucian gender role and gender egalitarianism scored significantly higher on depression scores than those who did not experience this conflict (Zhang & Zhao, 2013).

China’s one-child policy, instituted in 1979, should also be considered in a discussion of gender, as women may also face considerable emotional and financial stress from family planning workers with respect to contraception, abortion and sterilization, and female children may be considered less desirable than male children (Hesketh, Lu, & Xing, 2005; X. Li, Zou, Liu, & Zhou, 2012). Several studies have hypothesized a link between psychological distress in women mediated by the one-child policy (J. J.-L. Chen & Liu, 2011; Gao et al., 2012; X. Li et al., 2012). Studies have also hypothesized a link between this policy and higher rates of suicide and suicidal
behaviour for Chinese women, particularly in rural areas (Ma et al., 2009; Zhang & Xu, 2007). In addition to distress associated with feeling inferior or unwanted, childlessness or failure to produce a son has been linked with abuse and eventual suicidal behaviour in Chinese women (Canetto & Lester, 1998).

Wu Fei (2005) described the relationship between cultural beliefs, family structure and suicide in anthropological fieldwork carried out in rural China. He focused on the importance of “Qi”, which was translated as “the origin and essence of the universe…a vital fluid in the human body, encompassing air, breath and vigor”; its psychological meaning implies “both dignity and anger” (Fei, 2005, p. 10). Fei theorized that suicide is often a result of power dynamics in the family and a consequence of impulsive anger, closely tied with the significance of moral capital and the concept of saving face (Fei, 2005). Impulsive suicidal behaviour is conceptualized as a “trump card”; it is an unimpeachable defense of one’s dignity in these complex power games (Fei, 2005, p. 19). These gender-related issues, among others, are thought to contribute to the high rates of female suicide in China.

Canadian researchers have also explored the possible effect of gender role stress as a risk factor for suicidal ideation and behaviour. In Canada, men die of suicide three to four times more often than women, while women are more likely to experience non-fatal suicidal ideation and behaviour (Langlois & Morrison, 2002). In the Western world, cultural and sociological explanations of this paradox have historically betrayed gender bias - Durkheim hypothesized that suicide requires a degree of energy, courage and intelligence found only in men, while women were too unsophisticated and timid to die by suicide (Canetto, 2008; Lehmann, 1995; Steen & Meyer, 2004). Researchers have hypothesized that changing gender roles for women, including education, employment, and independence would put them at higher risk for suicide, although this has not been borne out in research studies (Platt & Hawton, 2000; Steen & Meyer, 2004). More recently, the adverse impact of the traditional male gender role as well as male reluctance to seek help have been posited as factors that increase their risk of suicide (Desaulniers & Daigle, 2008; Houle, Mishara, & Chagnon, 2008). However, few studies address the role of female gender role stress in non-fatal suicidal behaviour, or the impact of immigration, ethnic and cultural diversity and differing, culturally-mediated expectations and attitudes women face in Canada.
According to the 2006 Census, approximately half of the population in the metropolitan Toronto area is foreign born, with over one million residents born in Asia and the Middle East (Canada’s Ethnocultural Mosaic, 2006 Census, 2006). In the Greater Toronto Area (GTA), 10.4% of the population identifies as ethnically Chinese (Canada’s Ethnocultural Mosaic, 2006 Census, 2006). While Statistics Canada reports immigrants are less likely than native-born Canadians to die by suicide, with an age standardized rate of 7.9 suicides per 100,000 compared with 13.3 per 100,000 for people born in Canada, they found that immigrant suicide rates more closely matched those in the immigrants' countries of birth than those of Canada (Malenfant, 2004). The gap between male and female suicide rates is narrower in immigrants; in the three-year period from 1995 to 1997, Canadian-born males were four times more likely than females to commit suicide, whereas among immigrants, males were three times more likely than females to take their own lives (Malenfant, 2004). In the United States, Asian-American women aged 15-24 have the second highest rate of suicide of any ethnic group, after American-Indian and Alaskan-Native women, and Asian-American women over 65 have the highest rate of female suicide across all racial/ethnic groups (Jacobs, Brewer, & Klein-Benheim, 1999). Asian-American women born in the United States have a higher lifetime rate of suicidal ideation than the general population (Duldulao, Takeuchi, & Hong, 2010). Asian-American college students are more likely to experience suicidal ideation and behaviour (Kisch, Leino, & Silverman, 2005). These statistics highlight the importance of cultural background and gender on rates of suicide.

Recent studies have highlighted themes of gender role stress of Asian born women and women of Asian descent residing in North America who have experienced suicidal ideation and behaviour, including conflict between traditional and Western female roles (Chung, 2004; Noh, 2002). Eliza Noh’s examination of the narratives of Asian-American women who have attempted suicide suggested that over-reliance on Western psychotherapeutic philosophy and the systematic minimization of racial and sexual subjugation result in a lack of understanding of the issues that these women face (Noh, 2007). Irene Chung posited that Asian American women resort to suicidal behaviour to express their emotional distress rather than engaging in externalizing behaviour such as substance use, and that their distress did not manifest in functional decline or seeking help from family, friends or mental health services (Chung, 2004). Several studies have suggested that Chinese immigrants and those of Chinese descent are much less likely to utilize
mental health care than the general population, suggesting that women at risk for suicidal behaviour may not present to mental health services or may present much later within their course of illness (Bansal et al., 2014; A. Chen, Kazanjian, Wong, & Goldner, 2010; A. Chen & Kazanjian, 2005; Sentell et al., 2013).

Familial obligations and stresses related to gender have been described in the accounts of women of Chinese background living in North America. In a study of Asian-American female college students with a history of suicidal behaviour, the expectation that women should take care of parents, succeed academically and sacrifice their own interests to show love was noted as a significant stressor (Chung, 2003). These pressures can be understood through the lens of filial piety. Filial piety, central to Confucian role ethics, is derived from the view that one’s life is the continuation of one’s parents’ lives (Hwang, 1999). It describes an attitude of devotion, obedience and care towards ones’ parents and ancestors (W.-W. Chen & Wong, 2014; Liu, 2013). This value system prioritizes family harmony over personal goals and stresses the importance of self-sacrifice, and the conflict between a women’s own desires and wishes and those of her parents has been identified as a stressor by Asian-American women who have a history of suicidal behaviour (Choi, Rogers, & Werth, 2008; Chung, 2004).

Several studies have described the “Model Minority” myth as potentially damaging to Chinese-Americans (Lim & Lim, 2003; Qin, Chang, Han, & Chee, 2012). This myth ascribes a female identity to Chinese and Asian-American women characterized by compliance, a strong work ethic, discipline, and leading a stable and promising life (Chung, 2004). A perceived failure of women to live up to the expectations of family and culture, as well as the ways in which they are perceived by the dominant culture, can lead to stress within the family, psychological distress, and impact help seeking behaviour, and can cause internal and external conflict in terms of the ways in which this identity is rejected or accepted (Chung, 2004). Studies have linked model minority pressure to suicidal behaviour, particularly in women (Choi et al., 2008; Chung, 2004; Noh, 2002).

Alternatively, Pascale Aubert et al. (2004) hypothesize that a narrowing in rates of suicidal ideation in male and female Chinese-Canadian students compared to their Chinese counterparts can be explained by a reduction in gender role stress, as gender equality is established by law and
more evident in daily life. They suggested that while Chinese women were clearly identified as second-class citizens, with a lower social status than men, women who immigrate to Canada enjoy better social status and greater control of lives, while Chinese men may lose some social status and control (Aubert et al., 2004).

It is important to note that several studies examine the experiences of “Asian-Americans”, which is a broad group both geographically (comprising those of Chinese, Japanese, Korean, Cambodian, Vietnamese, and Thai descent, among others) and with respect to immigration (comprising all immigrants as well as future generations born in North America). No research exists that differentiates those of Chinese descent from the larger Asian population with respect to suicidal behaviour.

1.2 Rationale for qualitative exploration

A qualitative analysis of the impact of social and cultural conceptions of gender on the meanings and experiences of suicidal behaviour in Chinese-Canadian women is needed for several reasons. While the impact of gender role stress has been postulated as a risk factor for suicide, the need for further evidence, specifically an understanding and appreciation of their experiences, has been stressed in the literature. As Noh (2007) points out, while studies of suicide in women of Asian descent in North America often recognize “psychosocial stressors” as a risk factor, empirical studies, specifically from the perspectives of the women themselves, are scarce. Pearson et al. (2002) suggest that further studies are needed to address the impact of social stress and inequality on Chinese women, specifically those in rural areas, and the lack of social and economic support to manage this stress (Pearson & Liu, 2002; Pearson et al., 2002). Joe, Canetto, & Romer (2008) have recommended qualitative ethnographic studies in order to appreciate the complex experiences of ethnic minorities who have experienced suicidal ideation and behaviour.

Qualitative methods may be more culturally congruent with the preferred modes of communication compared with more structured, Western diagnostic interviews, and can be adapted to different ethnic groups (Qin et al., 2012; Range & Leach, 1998; Scarpinati Rosso & Bäärnhielm, 2012). Integrating cross-cultural research with well-known risk and protective factors can increase the understanding of how ethnicity, culture and social factors mediate the
risk of suicide (Andermann, 2010; Range & Leach, 1998; van Bergen, van Balkom, Smit, & Saharso, 2012; Y. J. Wong, Koo, Tran, Chiu, & Mok, 2011). Prevention researchers must consider the relevance of cultural values, customs and strengths to determine the preferred way for community members to manage crisis situations. Stigma regarding mental illness and suicidal behaviour in communities can have significant clinical and prevention implications and can exert considerable influence on the perception, implementation, delivery and outcome of interventions (Joe, Canetto, & Romer, 2008). Qualitative and mixed-methods studies relating to suicide and suicidal behaviour have been undertaken to explore the experiences and inform the care of several populations, but no study has explored the experiences of women who have immigrated from China to another country with a history of suicidal behaviour (Adinkrah, 2012; Cleary, 2012; Lakeman & FitzGerald, 2008; McAndrew & Warne, 2010; Oliffe, Han, O'gradniczuk, Phillips, & Roy, 2011; van Bergen et al., 2012; Y. J. Wong et al., 2011; Zayas, Gulbas, Fedoravicius, & Cabassa, 2010). An understanding of the experiences of Chinese-Canadian women with suicidal behaviour, is crucial in the development of appropriate and effective screening, service provision, and suicide prevention (Hicks & Bhugra, 2003).

1.3 Theoretical background

1.3.1 Ontological and epistemological background

Much of the current research in mental health care presumes that science is a neutral and objective instrument designed to examine a single objective reality (Attride-Stirling, 2001; J. M. Eakin & Mykhalovskly, 2003; Nicholls, 2009; Thornhill, Clare, & May, 2004). This premise is the basis of positivism, which is the belief that illnesses have essential properties that can be located, explored and understood through objective experimentation (Nicholls, 2009; Range & Leach, 1998). A positivistic approach informs much of the research on suicide prevention, as an emphasis is made on identifying risk factors for suicide on a population level and testing interventions in an objective, reproducible fashion (Joe et al., 2008). However, this perspective does not account for the unique experiences and complexities of individuals; it cannot fully explain why two people can present with the same risk factors for suicide, for example, but can have very different experiences of suicidal ideation and behaviour. Further, research is often conducted on majority populations by researchers in positions of power, silencing minority
voices and ignoring the cultural, social, economic or spiritual aspects that may shape their experiences (J. Eakin, Robertson, Poland, Coburn, & Edwards, 1996).

Qualitative research provides a voice for the subjective experiences of individuals and populations by challenging the existence of a single, objective reality; rather, it seeks to explore and understand lived experiences and the impact of social structures, relationships and cultural frameworks on the way in which reality is perceived. A belief in a single, objective reality lends itself to quantitative research, and guides the ways in which quantitative research is critically evaluated. However, this approach is not ideal for exploring the lives of the women in this study because the “objectivity, value-neutrality, detachment and rationalism” sought in quantitative work seeks to exclude peoples’ subjectivities (Nicholls, 2009, p. 528). The subjective nature of qualitative research does not lend itself to the same kind of evaluation applied to quantitative research; rather, as suggested by Carter & Little (2007), its quality should be ascertained through the evaluation of the internal consistency between ontology (the theory of the nature of reality), epistemology (the theory of knowledge), methodology (the theory and analysis of how research should proceed), and methods (the procedures, tools and techniques of research). Many different theoretical schools exist within qualitative health research, in keeping with the idea of multiple realities, and the framework suggested by Carter & Little provides a guide for qualitative research to be evaluated for quality regardless of theoretical background (Carter & Little, 2007).

This study fits into an interpretivist paradigm (Nicholls, 2009; Ryan & Bernard, 2003). It subscribes to a relativist ontology, which assumes that reality is constructed intersubjectively through the meanings and understandings developed socially and experientially (Carter & Little, 2007; Cohen & Crabtree, 2006). The ontology informs the transactional or subjectivist epistemology, which assumes that we cannot separate ourselves from what we know – the investigator and the object of the investigation are linked such that how we understand the world is a central part of how we understand ourselves, others and the world (Cohen & Crabtree, 2006). Findings and knowledge are co-created by the investigators and informants as the investigation proceeds, and fostering a dialogue between the researchers and respondents is critical.

Social constructivism is a term that describes the construction of knowledge by groups for one another, collaboratively creating a small culture of shared artifacts with shared meanings, and is
another way of describing interpretivist epistemology (Charmaz, 2003). The methodology that follows from this understanding is constructivist grounded theory (Charmaz, 2003, 2006). The qualitative interviews and analysis in the study will be informed by constructivist grounded theory. Grounded theory is a systematic qualitative research methodology that emphasizes the generation of theory rooted in data (Glaser & Strauss, 1967). Constructivist grounded theory is a contemporary revision of grounded theory that assumes a relativist approach, acknowledges multiple standpoints and realities of both the grounded theorist and the research participants, and takes a reflexive stance towards actions, situations and participants, allowing the researchers to undertake a literature review and form hypotheses to inform the qualitative interviewing and analysis (Charmaz, 2006). Constructivist grounded theory guidelines assist in the examination of social psychological processes, direct data collection, manage data analysis and develop an abstract theoretical framework that explains the studied process (Charmaz, 2003). Qualitative interviewing can provide an in-depth exploration of an aspect of life about which the interviewee has substantial experience and can elicit views of the person’s subjective world (Charmaz, 2006).

1.3.2 Conceptualizing gender, culture and suicidal behaviour in a social constructivist framework

In this study, “sex” will be conceptualized as the physiological characteristics related to reproduction, and “gender” as the phenomena and issues related to social and cultural influences (Canetto & Lester, 1998). “Culture” will be defined as “a product of people living together and creating traditions, patterns, norms and values that manifest as a pattern in a specific group of people”, in keeping with the language used in other works stressing the importance of the advancement of culturally-focused research on suicide prevention (Joe et al., 2008).

When exploring the relationship between gender and suicide, is important to understand that gender is defined and prescribed by culture and can only be understood contextually (Canetto & Lester, 1998). Cultural diversity in gender patterns and interpretations of suicidal behaviour challenges essentialist perspectives on gender and suicidal behaviour and points to the pitfalls of theorizing about clinical phenomena as if they were culture-free, and calls for culturally grounded theory, research and practice (Canetto, 2008). Chung’s 2004 qualitative analysis of suicidal behaviour in Asian-American college students also utilized a social constructivist framework, stating that suicide should also be viewed as a cultural and gender bound
phenomenon. This methodology was chosen as cultural and social determinants may sanction behaviour among males and females, and gender a social construction plays a crucial role in the way individuals perceive their options and communicate distress (Chung, 2004). It is also important to note that gender is only one social construction of human experience and other factors including psychiatric illness, ethnicity, social class, and sexual orientation also are important to consider in suicide research (Canetto & Lester, 1998).

1.3.3 A model of suicide-related behaviour

In this study, suicide-related behaviour will be defined as a self-inflicted, potentially injurious behaviour for which there is evidence (either explicit or implicit) either that a) the person wished to use the appearance of intending to kill herself in order to attain some end; or b) the person intended at some undetermined or some known degree to kill herself (Silverman, Berman, Sanddal, O’Carroll, & Joiner, 2007). Suicide-related behaviours comprise self-harm, undetermined suicide-related behaviours, and suicide attempts (Silverman et al., 2007). While suicidal behaviour is understood as a complex interaction of biological, psychological, sociological, cultural and geographical factors, psychiatric illness has been shown to be a major contributing cause (Chan et al., 2009; Hawton, Casañas I Comabella, Haw, & Saunders, 2013; Mann, 2002). Established risk factors for suicide also include the availability of lethal means, alcohol and drug abuse, lack of access to psychiatric treatment, physical illness, marital status, age and sex (Hawton et al., 2013; Mann et al., 2005). While these risk factors for suicide have been well-studied, cultural factors have not been as well defined (Colucci & Martin, 2007). Rates of major depressive episode (MDE) in those who die by suicide in China are difficult to ascertain because of the lack of mental health resources and stigma associated with mental illness (Phillips et al., 2007). Studies often quote the rate of MDE in suicide victims at 30%; more recent, rigorous psychological autopsy studies accounting for cultural differences in reporting estimate the rate at 40%, still well below the rates quoted in Western literature (Phillips et al., 2007). This discrepancy may indicate cultural factors may be risk factors for suicide that have not yet been formally established or accepted in clinical practice.
1.4 Summary

Suicide and suicide-related behaviour are complex phenomena that can be understood from clinical, psychological, social and cultural perspectives. Suicide prevention research, particularly within the medical community, focuses on Western epidemiological patterns to understand and modify risk factors for suicide. However, a strong body of evidence suggests that cultural and social factors may play a role in suicidal behaviour. Cultural constructions of gender can impact the ways in which suicidal behaviour is understood as an option and the patterns of distress that lead to suicidal behaviour. Qualitative research, which privileges the narratives of those with lived experience with suicidal behaviour, can be an important tool to elucidate the intersections between gender, identity, social role, mental illness and suicide.
Chapter 2  
Research Aims and Methods

2  Research Aims and Methods

2.1  Research aims

This study explored the experiences, stressors and beliefs of Chinese-born women living in Canada with a history of suicidal behaviour, and the impact of gender as a social and cultural construction on their experiences, including self-image, relationships, ways of coping, and the communication of distress. Through qualitative interviewing and analysis, the study enhances the understanding of the ways in which these women construct their meanings and experiences of gender, culture and suicidal behaviour through their interactions with their families, communities and social structures.

The main research question asks, how do Chinese-born women living in Canada understand and experience suicidal behaviour, and how are these conceptions and experiences influenced by cultural and social constructions of gender? More specific questions will examine the perceived culturally-bound expectations for women, the perceived consequences for not meeting culturally-bound expectations of gender, and perceived options available to cope with these stressors.

Secondary research questions include, what are the shared life experiences of Chinese-born women living in Canada with a history of suicidal behaviour, how do they access, perceive and engage with the mental health care system, how does immigration mediate suicidal behaviour in this population, and how do Chinese-born women living in Canada recover from experiences of suicidal behaviour?

The respondents also completed questionnaires regarding depression, hopelessness, impulsivity, suicidal behaviour, alexithymia and childhood trauma, which all are known risk factors for suicidal behaviour in the general population (Beck, Brown, Berchick, Stewart, & Steer, 1990; Fink, Bernstein, Handelsman, Foote, & Lovejoy, 1995; Hintikka et al., 2004; Mann, 2002). The goal of questionnaire completion is the description of the sample in a meaningful way to clinicians who work with suicidal clients rather than to inform the qualitative data analysis.
The experiences of Chinese-Canadian women with a history of suicidal behaviour have never been studied. China is the only country in the world where women die by suicide more often than men, and Chinese women living in North America have been identified as being at risk for higher rates of suicidal ideation and behaviour. This study provided an opportunity to explore their experiences in order to understand how cultural conceptions of gender can impact suicidal behaviour as well as the role of immigration in mediating this risk.

Study collaborators at Tsinghua University have explored the same questions in a population of women living in Beijing, China who had been admitted to hospital following suicidal behaviour or where engaged in outpatient psychiatric care. Shared aims include fostering cross-cultural collaboration and reflexive research and practice, conducting a comparative analysis at the thematic level, focus on themes of acculturation and immigration stresses.

2.2 Methods

2.2.1 Study design

The qualitative interviews and analysis in the study was informed by constructivist grounded theory. Grounded theory is a systematic qualitative research methodology that emphasizes the generation of theory rooted in data (Glaser & Strauss, 1967). Constructivist grounded theory is a contemporary revision of grounded theory that assumes a relativist approach, acknowledges multiple standpoints and realities of both the grounded theorist and the research participants, and takes a reflexive stance towards actions, situations and participants, allowing the researchers to undertake a literature review and form hypotheses to inform the qualitative interviewing and analysis (Charmaz, 2006). Constructivist grounded theory guidelines assist in the examination of social psychological processes, direct data collection, manage data analysis and develop an abstract theoretical framework that explains the studied process (Charmaz, 2003). Qualitative interviewing can provide an in-depth exploration of an aspect of life about which the interviewee has substantial experience and can elicit views of the person’s subjective world (Charmaz, 2003).

2.2.1.1 Recruitment and sampling

Chinese-born women with a history of suicide-related behaviour (including self-harm and suicide attempts) within the past twelve months receiving psychiatric assessment or ongoing
psychiatric care at four study sites were invited to participate in this research study. Inclusion criteria consist of being born in China and fluent in English, Mandarin or Cantonese, 18 years of age or older, and having engaged in previous suicide-related behaviour within the past twelve months. After obtaining the individual’s informed signed consent, eligibility will be based on a brief chart review of the patient’s medical records. Individuals meeting criteria for psychotic disorders, bipolar disorder type 1 (currently manic or psychotic) and substance withdrawal were excluded from the study. Further exclusionary criteria include low levels of intellectual functioning, early-onset dementia, history of neurological impairment, and significant visual or auditory impairment. The participants completed a semi-structured qualitative interview, brief structured demographic interview, and several scales measuring known risk factors of suicidal behaviour. Recruitment ended when theoretical saturation was achieved.

Only women who were born in China were included in order to better understand the ways in which immigration mediates conceptions of suicidal behaviour and patterns of distress. While intergenerational pressures of acculturation are important factors to consider, a more homogenous sample is needed for analysis and interpretation in this study in order to focus the analysis. While several cultural differences exist between Mainland China and Hong Kong, women from both samples were recruited given the high rates of immigration to Canada from both areas. Within data analysis, particular attention was paid in order to ensure that the themes that emerged were applicable to both groups, and that significant differences did not exist between the groups.

2.2.1.1.1 Detailed recruitment procedure

2.2.1.1.1 Stage 1: Identifying potential participants

The women were recruited to this study from four mental health service sites within the Greater Toronto Area. They were receiving emergency, inpatient or outpatient services and were identified for recruitment by mental health clinical personnel, who have a level of expertise and comfort with patients presenting with major mental health issues. If the participant was comfortable communicating in English, the process below would be undertaken by Juveria Zaheer. If participants were more comfortable communicating in Mandarin or Cantonese, they would be approached by a Mandarin and Cantonese–speaking research assistant.
In the Emergency Department, potential participants were identified by clinical staff, including psychiatrists, resident physicians, registered nurses and social workers. If a patient who may be eligible for the study is seen, the identified crisis team personnel will ask this person if they are comfortable being contacted by the investigator for further information regarding the study, and provided the patient’s name and this phone number with patient consent to the investigator. The clinical staff member could then page or call the study coordinator with the information.

For potential participants who were admitted to the hospital, the investigator would approach and ask the attending physician if the patient is competent to speak with the coordinator about the study. For those who were recruited through outpatient services, the investigator would approach women in these clinics if had been identified by a psychiatrist, social worker or nurse as meeting criteria for the study. If permission was granted, the investigator would contact them over the phone, leaving a message only if the potential participant had consented to this. Any phone messages were as vague as possible in order to protect the participant’s confidentiality. Potential subjects also received the study coordinator’s phone number (available to hand out) in order to contact the study coordinator themselves.

2.2.1.1.1.2 Stage 2: Obtain informed consent

If the participant had a follow-up appointment with a clinician and had agreed to be approached to discuss the study, the investigator was contacted ahead of time and met the participant in person to obtain informed consent. If no follow-up was booked, the investigator called the patient, explained that she is recruiting for a study and asked for consent to conduct a short screening interview. The investigator explained the purpose of the study and the expectations of participants. The participants were informed that the investigator will examine their clinical records with their consent to obtain diagnostic information only. The investigator also explained the consent form and participants who agreed to be interviewed will be asked to sign the form. With respect to those recruited from the Emergency Department, women presenting in the emergency department or who are admitted to hospital are under significant distress, and as such, informed consent was not obtained during the first meeting. Rather, information was provided, questions were answered, and a phone number was given to call the investigator within one week to set up a meeting to obtain informed consent. The participant could use the week to decide on
consenting to the study and could contact the study coordinator to set up the first meeting at a
later date once the decision was made. If they were comfortable to give informed consent in this
meeting, stage 3 would occur at this time. The informed consent was obtained prior to assessing
eligibility as the patient is required to complete a questionnaire on her history of suicidal
behaviour to determine inclusion or exclusion in the study.

2.2.1.1.1.3 Stage 3: Assess eligibility and schedule interview

At the meeting where informed consent is obtained, the investigator asked the patient to identify
her ethnic background, and administered the Suicidal Behaviors Questionnaire 14 (SBQ-14). The
revised SBQ-14 is a comprehensive assessment of suicide ideation, suicide attempts and suicidal
acts (without intent to commit suicide) using a self-report format (Linehan, 1996). The SBQ-14
assesses for a lifetime history of suicide ideation and related suicide behaviours and has shown
internal consistency and concurrent validity (Brown, 2002). Asking questions related to suicidal
behaviour has not been shown to be linked with increase distress in patients with a history of
suicidal behaviour and these questionnaires are widely used in suicide prevention research, and
have been shown to be much more likely to provide relief than cause harm (Brown, 2002;
Meerwijk et al., 2010; Tatarelli, Pompili, & Lester, 2005) Further, a brief three question tool
(asking the patient if they are having suicidal thoughts, thoughts of self harm, and how in control
they felt of those thoughts) was administered before and after every contact with potential study
participants and in the course of the study in English, Mandarin and Cantonese, and resources
were available to the researcher and participant to address any increased risk (support, crisis
lines, visit to emergency department if necessary).

If the patient met eligibility criteria, she was invited to participate in the study and a time was
scheduled to conduct the structured demographic and semi-structured qualitative interviews as
well as scales. If the participant preferred to conduct the interviews in Mandarin or Cantonese, a
qualified graduate student, Catherine Cheng, conducted the interview. Ms. Cheng is currently
enrolled in the PhD program in Sociology in the University of Toronto. She is fluent in Mandarin
and English, and has experience in qualitative interviewing, having extensively interviewed
female sex workers in Hong Kong for research purposes.
2.2.1.1.4 Stage 4: Interviews

Participants were asked to complete a short interview to obtain demographic information and were asked to complete five self-report scales that measure known risk factors for suicide. A semi-structured qualitative interview was also completed. Participants were asked if they preferred to conduct the qualitative interview first rather than doing the scales; it appeared that most felt more comfortable with this approach, and completing the scales following the qualitative interview prevented content from the scales to guide the qualitative interview. Following this interview, the participant was informed that she may be contacted for a second semi-structured qualitative interview at a later time, once the initial open-coding of a selection of transcripts was completed. The goals of the second interview would be to elaborate on any additional issues, ask questions about themes emerging in the analysis, and to provide the participant with a chance to engage in a member-checking process; the interviewer will reflect on the participant’s response and ask for clarification of the interviewer’s interpretation of the response. The participant was also able to request a second interview if she would like to share more information with the interviewer.

Considering the content of the interviews and the personal nature of the questions, a possibility existed that the process could be distressing or anxiety-provoking for the participants. Several steps were taken to minimize this risk. The qualitative interview guide is semi-structured, allowing the questions to stem from the respondent’s answers. Respondents were not forced to answer difficult questions that the interviewer reads from a script; rather they guided the interview by describing their own narrative. For this reason, the interview guide was not provide to participants beforehand in order to ensure that the respondents were introducing concepts rather than having concepts be imposed by the researcher. Secondly, the participant was told that they did not have to answer any question that makes them feel uncomfortable, and that if they are feeling distress, they are able to check in with the interviewer. Thirdly, anxiety and distress has been identified as a potential ethical issue in qualitative research (Richards & Schwartz, 2002). Qualitative research aims to achieve an in-depth understanding of an issue, including an exploration of the reasons and context for participant’s beliefs and actions, so is often designed to be probing in nature (Richards & Schwartz, 2002). Further, the questions that lead to anxiety and distress cannot always be predicted, as they depend on the personal experiences of the
respondents. However, these risks can be managed by ensuring the researcher has adequate levels of expertise and supervision, as this person can be considered the “research instrument” (Richards & Schwartz, 2002, p. 137). In this study, it has been ensured that the people carrying out the interviewing have qualitative interview experience, have worked with this vulnerable population, and have the expertise to identify levels of distress and can recognize the potential need for further care. A safety screening protocol consisting of three questions (identifying level of suicidal behaviour and self-harm and feelings of control) before and after the qualitative interview also ensured that elevated risk came to the attention of the interviewer and participant.

2.2.1.2 Data collection tools

2.2.1.2.1 Brief structured interview and scales

In order to describe the samples in a clinically meaningful way, five self-report scales measuring known psychological risk factors for suicide were administered. This data will anchored our sample clinically and could also be used to facilitate cluster analysis based on scale results (Charmaz, 2006).

Impulsivity was assessed with the Barratt Impulsivity Scale (BIS-11) (Barratt, Stanford, Kent, & Alan, 1997). The BIS includes subscales assessing motor, cognitive, and non-planning aspects of impulsivity. The BIS-11 has demonstrated internal consistency (Cronbach’s alpha ranging from 0.89 to 0.92 for all the three subscales), clinical utility, and trait specificity (Barratt et al., 1997). The BIS-11 is available in Mandarin and has shown reliability and validity in populations of Chinese adolescents (Yao, Yang, & Zhu, 2007). The Chinese version of the BIS-11 (BIS-11-CH) has been used frequently as a measure of impulsivity in clinical and non-clinical populations, including subjects with a history of suicidal behaviour (Barratt et al., 1997; C. R. Li & Chen, 2007).

Depression was measured with the Revised Beck Depression Inventory (BDI-II), a 21 item self-report questionnaire that assesses different aspects of depressive symptomatology (Beck, Steer, & Carbin, 1988). The BDI-II has demonstrated internal consistency (Cronbach’s alpha for psychiatric populations’ ranges from 0.76 to 0.95), convergent validity with hopelessness and suicidal ideation, and a strong positive association with an earlier version of the measure (Beck et al., 1988). While Zheng et al. (1988) suggested that the C-BDI may not be culturally sensitive
enough to be applicable as a clinical or research tool, the C-BDI has since shown good sensitivity, specificity, positive predictive value and negative predictive value as a screening tool for MDE in Chinese–American populations (Beck et al., 1988; Yeung et al., 2002; Zheng, Wei, Goa, Zhang, & Wong, 1988). The Chinese version of the Beck Depression Inventory (C-BDI) has shown demonstrated high internal consistency and high item-total correlations for most items in Chinese populations (D. Shek, 1990).

Hopelessness was measured with the Beck Hopelessness Scale (BHS), a 20-item true or false measure pertaining to the global experience of hopelessness (Beck, Weissman, Lester, & Trexler, 1974). The BHS has demonstrated internal consistency (Cronbach’s alpha ranges from 0.82 to 0.93), and convergence with clinician ratings of hopelessness (correlation coefficients ranges from (r) 0.62 (inpatients) to 0.74 (medical patients), and with measures of depression and suicide intent (r=0.68) (Beck et al., 1990, 1974). The Beck Hopelessness Scale is available in a Chinese version (C-HOPE) that has shown good internal consistency and validity and has been used widely in suicide prevention research (Fu & Yip, 2007; Lai Kwok & Shek, 2008; D. T. Shek, 1993).

The Childhood Trauma Questionnaire (CTQ) is a widely used child maltreatment self-reported measure (Bernstein et al., 1994; Fink et al., 1995). The CTQ has subscales for emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect (Bernstein et al., 1994; Fink et al., 1995). The CTQ demonstrates strong psychometric properties in clinical and non-clinical samples. The reported internal consistency of the CTQ subscales is good with Cronbach’s alpha for adult psychiatric outpatients ranging from .66 (Physical Neglect) to .92 (Sexual Abuse). The Cronbach’s alpha for the subscales for Emotional Abuse, Physical Abuse and Emotional Neglect are also high (.82, .83, and .81, respectively) (Bernstein et al., 1994; Fink et al., 1995). A Chinese version of this measure is available and has shown good reliability and validity in keeping with the psychometric standards of the original CTQ (Zhao, Zhang, Li, & Zhou, 2005).

The Toronto Alexithymia Scale (TAS-20) is a self-report, 20 item scale of alexithymia (Taylor, Bagby, & Parker, 1992). The intent for utilization of this scale is to investigate difficulties identifying feelings (DIF), difficulties describing feelings (DDF) and externally-oriented
thinking (Taylor et al., 1992). The TAS-20 has been used in a variety of populations, including psychiatric outpatients, showing considerable evidence supporting the convergent, discriminant and concurrent validity of the TAS-20 (Taylor et al., 1992). A Chinese translation of this measure is available and has been back-translated and modified until cross-language equivalence was established (Zhu et al., 2007). The TAS-20-C has shown adequate internal and retest reliability in non-clinical and clinical populations in China, and confirmatory factor analysis supported a three factor structure of the TAS-20 in both samples (Zhu et al., 2007).

If the participant had difficulty reading the scales due to language or literacy barriers, the researcher could provide support and the scales could be completed orally.

2.2.1.2.2 Qualitative interview guide

The qualitative interviews and analysis in the study were informed by constructivist grounded theory. Grounded theory is a systematic qualitative research methodology that emphasizes the generation of theory rooted in data (Glaser & Strauss, 1967). Constructivist grounded theory is a contemporary revision of grounded theory that assumes a relativist approach, acknowledges multiple standpoints and realities of both the grounded theorist and the research participants, and takes a reflexive stance towards actions, situations and participants, allowing the researchers to undertake a literature review and form hypotheses to inform the qualitative interviewing and analysis (Charmaz, 2006). Constructivist grounded theory guidelines assist in the examination of social psychological processes, direct data collection, manage data analysis and develop an abstract theoretical framework that explains the studied process (Charmaz, 2003). Qualitative interviewing can provide an in-depth exploration of an aspect of life about which the interviewee has substantial experience and can elicit views of the person’s subjective world (Charmaz, 2003).

A semi-structured qualitative interviewing format was used, allowing the interviewer and respondent to engage in a one-on-one, formal interview. The interviewer used a semi-structured interview guide, comprised of topics and open-ended questions be covered during the conversation (Appendix 1). The initial guide closely followed the research questions; however the guide was revised throughout the data collection process in light of emergent themes. This process of adding questions as the study progresses is consistent with the qualitative research tradition (Lofland & Lofland, 1995). Interviewing was flexible and allowed for narrative space,
and the interviewers could pursue important ideas and emotions during the interview, prompting the participants to provide specific examples of the types of interactions and emotions they have experienced, specifically by asking “what” and “how” questions (Charmaz, 2003).

Semi-structured interviewing has several benefits. It provides a clear set of instructions for interviewers and can provide reliable, comparative qualitative data, but is flexible enough to allow the researchers to develop an understanding of the topics of interest in order to continually revise the semi-structured questionnaire (Cohen & Crabtree, 2006). The inclusion of open-ended questions and the ability of interviewers to follow relevant topics that may stray from the interview guide provide the opportunity for understanding the topic, and allow the respondents the freedom to introduce their own meanings, views and ideas to the interview (Cohen & Crabtree, 2006).

The patient interview began with several open-ended questions, which were asked slowly and clearly, to foster reflection but not to interrogate (Charmaz, 2003). The questions were broad enough to cover a wide range of experiences related to the stressors that led up to the participant’s suicidal behaviour, her understanding and recollections of the suicidal behaviour, and her experiences of cultural conceptions of gender. The interview was designed to place an emphasis on learning the participants’ meanings and stresses the participant’s actions and individual experiences. The interview was meant to be informal and conversational, and the interviewer concluded with positive and supportive questions in order to transition the participant out of the interview.

As the participant answers the initial framing questions, the interviewer will be cognizant of several “sensitizing concepts” related to cultural conceptions of gender and suicidal behaviour that have been described in the literature. The interviewer will be careful not to introduce these concepts in order to ensure that the participants themselves are describing the phenomena and to strengthen the data for analysis. The sensitizing concepts can be found in the interview guide and follow closely from the literature review.

If a participant identified a greater comfort level in Mandarin or Cantonese, a Mandarin and Cantonese speaking member of the research team and qualified graduate student conducted the semi-structured interview. The interview was transcribed in Mandarin or Cantonese and
translated into English. Given the importance of culture, language and expression, the translations were reviewed by three Mandarin- and Cantonese-speaking research team members to ensure proper interpretation of the concepts described in the Mandarin-language and Cantonese-language semi-structured interview.

2.2.1.3 Data management

Steps were taken to ensure that confidentiality will be protected during the data management phase of the study. All participants were asked to read and sign a consent form. These forms are stored in a locked cabinet separate from the tapes and transcribed interviews and will be destroyed following the completion of the study. Participants were identified only by a subject number on the scales and demographic interview form, and the data were kept in a locked filing cabinet. The electronic databases will identify participants by subject number only and will be kept only on password protected, encrypted computers. Participants were also informed that their identity will not be disclosed, unless the law requires disclosure.

All patient identifiers were removed from the transcripts by the interviewer. Tapes were transcribed externally but confidentiality will be ensured by working with trusted staff people who have experience in transcribing confidential medical data. Email transmission of transcripts occurred through encrypted servers and transcripts were anonymized to remove names and other identifying details. Team members were instructed to only open these files on computers with encrypted hard drives. Participants were assured that any verbatim quotes that may identify the speaker will not be used in any of the reports from this project.

The interviewer destroyed any administrative records containing names and telephone numbers following the interviews. The personal health information was retained with subject number and initials until study completion, and was then destroyed. The tapes were erased after verification of the transcripts. Electronic file destruction will be done through reformatting or rewriting regardless of whether data was encrypted. The anonymized qualitative data will be retained in order to be available for data analysis and future publications.
2.2.2 Data analysis

All variants of grounded theory included the following strategies: a) simultaneous data collection and analysis, b) pursuit of emergent themes through early data analysis, c) discovery of basic social processes within the data, d) inductive construction of abstract categories that explain and synthesize these processes, e) sampling to refine the categories through comparative processes and f) integration of categories into a theoretical framework that specifies causes, conditions and consequences of the studied processes (Charmaz, 2003). The analysis examined how participants construct meanings and actions related to a particular experience by coding for what is happening, and comparing statements, emotions, and responses within and between participants (Charmaz, 2003). Experiences of suicidal ideation and behaviour, and the related meanings and actions were of particular importance.

Qualitative interviews were taped and transcribed verbatim. The accuracy of the transcripts was verified by the interviewer as well as the research team. Mandarin and Cantonese transcripts were translated and the original and translated interviews were reviewed to ensure fidelity; in the case of uncertainty, the section of the transcript was reviewed by the research team and discussed until consensus was reached. The transcripts were open coded from both a procedural and substantive perspective. Memos were written immediately after open coding was completed and the coding and memos were reviewed and discussed by the research team. Memos were prepared that detailed the discussions of the research team meetings. Data was also entered into NVivo-8, an electronic text management and analysis software package designed to support a variety of research methods, including grounded theory. Coding was an on-going process conducted during the data collection period, and analysis conducted during the data collection procedure informed the list of “sensitizing concepts” in later interviews. As data analysis proceeded, analytic memos were written iteratively to capture the major issues relevant to each code. Each transcript was read, coded, re-read and re-coded as necessary. Each transcript was coded at least three times during the data analysis process to ensure that earlier transcripts were examined for themes that developed through the process of serial memo-writing. The team met every two months to work on data analyses and to ensure consistency in coding, compare analytic memos, explore emergent themes and finally to construct larger theories. Recruitment ended when theoretical saturation is achieved. In keeping with grounded theory conception of saturation, data collection
ended when new codes were not generated in the analysis of the data and the identified themes categorize the phenomena and explain relationships between concepts and were complex enough to capture the participants’ experiences (Charmaz, 1990; Kontos & Naglie, 2006; van Bergen et al., 2012; Y. J. Wong et al., 2011).

Demographic information and scores from self-report scales were entered and analyzed in Microsoft Excel, an electronic spreadsheet program.

2.2.3 Ethical considerations

As participants in this study are associated with mental health service providers, several steps were taken to ensure that the information provided by participants would not compromise their current and future treatment. The interviews were conducted in a location that allows for the participant to speak freely and without concern about being overheard. All participants will be ensured that anything said during interviews is 1) confidential; 2) will not influence any current or future treatment received; and 3) will not be added to their clinical record.

Participants were informed that if an acute risk of harm to self or others is assessed to be present by the interviewer and confirmed by a staff psychiatrist and member of the research team, then appropriate clinical and/or legal steps will need to be taken. The investigators recognized that the participants in this study have a history of suicidal behaviour and are at higher risk for suicidal ideation. The people conducting the interviews were trained to assess suicide risk, and if a participant feels unsafe or discloses suicidal ideation or behaviour, appropriate clinical steps would be taken (i.e. escorting the participant to the emergency department, providing information on resources or follow-up). Women may also disclose that they are victims of abuse and appropriate steps would have been taken to ensure the person’s safety.
Chapter 3
Results: Characterizing the Sample

3 Results: Characterizing the Sample

3.1 Demographic information

Ten women who have immigrated to the Greater Toronto Area from mainland China or Hong Kong and experienced suicidal behaviour within the previous year were recruited for participation in this study. These women were receiving psychiatric care at one of four mental health services providers in the Greater Toronto Area. Four other women were recruited and declined to participate in this study. Table 1 presents the demographic information of the subjects who completed the study, which was obtained through a structured demographic interview conducted before or after the qualitative interview.
Table 1: Demographic Data

<table>
<thead>
<tr>
<th></th>
<th>Average: 39.6</th>
<th>Range: 19-51</th>
<th>SD: 10.9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (in years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age of Immigration (in years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td>Married: 5</td>
<td>Divorced: 3</td>
<td>Single: 2</td>
</tr>
<tr>
<td><strong>Location of Origin</strong></td>
<td>Mainland China: 8</td>
<td>Hong Kong: 2</td>
<td></td>
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<tr>
<td><strong>Children</strong></td>
<td>&gt;1: 1</td>
<td>1: 4</td>
<td>No children: 5</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>High School: 1</td>
<td>Some College /University: 2</td>
<td>Completed College: 2</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td>Unemployed (on ODSP): 4</td>
<td>Unemployed (supported by family): 4</td>
<td>Working: 1</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td>Living in own or family-owned home: 5</td>
<td>Renting with family: 2</td>
<td>Renting alone: 2</td>
</tr>
<tr>
<td><strong>Interview Language</strong></td>
<td>Mandarin: 8</td>
<td>Cantonese: 1</td>
<td>English: 1</td>
</tr>
</tbody>
</table>

3.2 Clinical presentation

The following table presents a clinical summary focusing on diagnoses, treatment and history of suicidal behaviour. It is important to note that this sample was recruited from a clinical population and may not be representative of women with suicidal behaviour who have not accessed mental health care or who have not had ongoing mental health support. While two women have been diagnosed with major depressive disorder with psychotic features, hallucinations or delusions were prominent during their report of the episode of suicidal behaviour. Diagnostic data was obtained by using the most recent clinical diagnosis given by the
treating psychiatrist and recorded in the patient chart. Additional data was determined through both the structured demographic interview as well as the Suicidal Behaviours Questionnaire 14 (SBQ-14) (Linehan, 1996).

A history of childhood trauma has been identified as a known risk factor for suicidal behaviour (Santa Mina & Gallop, 1998). Data was obtained from both the qualitative interview as well as the administration of the Childhood Trauma Questionnaire (CTQ), which is available and validated in both English and Chinese (Bernstein et al., 1994; Zhao et al., 2005). Although both versions are validated, the items differ on the scales and the scores cannot be combined for quantitative analysis due to differences in the items. Rather, presence of trauma across the domains of emotional abuse, emotional neglect, physical abuse, physical neglect and sexual abuse will be noted. Eight of ten respondents identified some form of trauma on the CTQ and/or in the qualitative interview.
Table 2: Clinical Presentation

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Major Depressive Disorder</th>
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<tbody>
<tr>
<td>Major Depressive Disorder with Psychotic Features</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Major Depressive Disorder with Borderline Personality Disorder Traits</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Bipolar Disorder (depressed at time of suicidal behaviour)</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lifetime episodes of suicidal behaviour</th>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td>10+</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>5-9</td>
<td></td>
<td>2</td>
</tr>
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<td>2-4</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Episodes of suicidal behaviour in the last 12 months</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10+</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>5-9</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>2-4</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency of suicidal behaviour in the last 12 months by method (number of women who engaged, number of times seen)</th>
<th>Overdose/ingesting poison</th>
<th>7</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cutting/Stabbing self</td>
<td></td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Asphyxia/Smothering self</td>
<td></td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Burning self</td>
<td></td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Jumping from height</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intent of suicidal behaviour (number of women reporting, number of times seen)</th>
<th>Intent to die</th>
<th>10</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambivalent</td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>No intent to die</td>
<td></td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of hospitalizations (lifetime)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10+</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>0</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental health support</th>
<th>Care team (Psychiatrist and Case Worker)</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist and Psychotherapist</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrist only</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Past history of traumatic life events identified</th>
<th>Emotional abuse</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional neglect</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Physical abuse / Physical neglect</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>
3.3 Sample characteristics: alexithymia and impulsivity

Higher rates of alexithymia and impulsivity have both been associated with higher rates of suicidal behaviour in some studies (Hintikka et al., 2004; Maser et al., 2002). Alexithymia was assessed using the Toronto Alexithymia Scale (TAS-20), a self-report, 20 item scale of alexithymia (Taylor, Bagby, Ryan, & Parker, 1990). This scale investigates difficulties identifying feelings (DIF) and difficulties describing feelings (DDF), as well as externally-oriented thinking (EOT). A Chinese translation of this scale was also used (Zhu et al., 2007). Impulsivity was assessed in this sample with the Barratt Impulsiveness Scale (BIS-11), which includes subscales assessing motor, cognitive, and non-planning aspects and is available in English and Chinese (Barratt et al., 1997).

3.3.1 Alexithymia

Although alexithymia is a dimensional construct, TAS-20 scores are best analyzed as a continuous variable (Taylor et al., 1990). The empirically derived cutoff scores used for identifying individuals with high or low alexithymia are the following: \( \geq 61 \) = high alexithymia (“alexithymia”) and \( \leq 51 \) = low alexithymia (“non-alexithymia”). The average alexithymia score in this sample was 63.2 (minimum: 37, maximum: 92, standard deviation: 15.9). Six subjects scored \( \geq 61 \) and were classified as having high alexithymia. Two subjects scored \( \leq 51 \) and were classified as having low alexithymia. Two subjects fell between 52 and 61 and could not be classified in either category.

In Table 3, means and standard deviations are presented for the study sample, as well as for three comparison groups from other study populations (Taylor et al., 1990; Zhu et al., 2007). A two-tailed unpaired t-test was conducted comparing the study sample to the comparison group. Statistically significant p values are marked with an asterisk.

The study sample showed significantly higher rates of alexithymia (total and across all three dimensions). When compared with a sample of female students from China, the total score was significantly higher in the study sample, as were the dimensional scores for “difficulty identifying emotions” and “externally oriented thinking”.
The alexithymia score was highly correlated with number of attempts at a level of $p<0.0001$. Women with high alexithymia scores have more frequent suicide attempts, a greater number of somatic symptoms, and are less likely to self-identify as depressed or show clear functional impairment or hopelessness associated with depression. They are more likely to view suicidal behaviour as a way to communicate distress rather than as an escape from pain or a strategy to end a pointless life. This finding is discussed in greater detail in the Discussion section (Chapter 9).

**Table 3: Comparing TAS-20 score between study sample and standardized population of English-speaking women and a sample of female Chinese students**

<table>
<thead>
<tr>
<th></th>
<th>TAS-20</th>
<th>P value</th>
<th>DIF</th>
<th>P value</th>
<th>DDF</th>
<th>P value</th>
<th>EOT</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Study sample</strong> (N = 10) Mean age: 39.6</td>
<td>63.20</td>
<td>N/A</td>
<td>23.20</td>
<td>N/A</td>
<td>16.80</td>
<td>N/A</td>
<td>23.20</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Adult English speaking women</strong> (N = 1096) Mean age: 35.4</td>
<td>44.15</td>
<td>0.004*</td>
<td>14.27</td>
<td>0.005*</td>
<td>11.96</td>
<td>0.02*</td>
<td>17.93</td>
<td>0.007*</td>
</tr>
<tr>
<td><strong>Female Chinese Students</strong> (N=523) Mean age: 18.8</td>
<td>48.36</td>
<td>0.02*</td>
<td>16.29</td>
<td>0.02*</td>
<td>13.11</td>
<td>0.05</td>
<td>18.96</td>
<td>0.02*</td>
</tr>
</tbody>
</table>

**3.3.2 Impulsiveness**

While no clear cut-offs exist for the BIS-11, many studies characterize high impulsiveness as a score over the $75^{th}$ percentile, or a total score of 72 or above (Maloney, Degenhardt, Darke, & Nelson, 2009; Stanford et al., 2009). It is also important to note that no gender-based differences have been noted in factor analysis (Patton, Stanford, & Barratt, 1995; Stanford et al., 2009).

In this sample, the average score BIS-11 score was 71 (minimum 55, maximum 94, standard deviation: 13.2). Five participants scored higher than this $75^{th}$ percentile cut-off. The study sample mean was compared with that of the normative data population (Adult North American English-speaking population, N=1577, mean age: 21.6) reported by Stanford et al, 2009. The
results of two-tailed unpaired t-test were not significant (p = 0.07). Subscales assessing motor, cognitive, and non-planning aspects were also compared and were not significant, although the non-planning subscale, measuring self-control and cognitive complexity, showed higher scores in the study sample group approaching significance (p=0.05).

The sample score was also compared to normative data available from a female Chinese adolescent population (N=200, mean age = 16.2) (Yao et al., 2007). The average BIS-11 score in this group was 69.5 (SD = 9.09) and the difference between this group and the sample group was not significant (p = 0.7).

Table 4: Comparing BIS-11 score between study sample and normative English-speaking population data

<table>
<thead>
<tr>
<th></th>
<th>BIS-11</th>
<th>P value</th>
<th>ATT</th>
<th>P value</th>
<th>MOT</th>
<th>P value</th>
<th>NP</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Study sample</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(N = 10)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age: 39.6</td>
<td>71.0</td>
<td>N/A</td>
<td>19.0</td>
<td>N/A</td>
<td>24.3</td>
<td>N/A</td>
<td>27.6</td>
<td>N/A</td>
</tr>
<tr>
<td>SD=13.3</td>
<td></td>
<td></td>
<td>SD=4.19</td>
<td></td>
<td>SD=4.16</td>
<td></td>
<td>SD=5.56</td>
<td></td>
</tr>
<tr>
<td><strong>Adult English speaking population</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(N = 1577)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age: 21.6</td>
<td>62.3</td>
<td>0.07</td>
<td>16.7</td>
<td>0.1</td>
<td>22.0</td>
<td>0.1</td>
<td>23.6</td>
<td>0.05</td>
</tr>
<tr>
<td>SD=10.2</td>
<td></td>
<td></td>
<td>SD=4.1</td>
<td></td>
<td>SD=4.0</td>
<td></td>
<td>SD=4.9</td>
<td></td>
</tr>
</tbody>
</table>

3.4 Depression and hopelessness

Depression and hopelessness are both well-established risk factors for suicidal behaviour (Hawton et al., 2013). Study respondents were asked to complete a Beck Depression Inventory II (BDI II) and Beck Hopelessness Scale (BHS) (validated in both English and Chinese) in order to measure levels of depression and hopelessness within the sample (Beck et al., 1990, 1988).

Unfortunately due to an administrative error in data collection, only five participants completed these scales. Of these five respondents, three of five endorsed clinically significant levels of depressive symptoms, while two described minimal depressive symptoms. The average score on the BDI II was 28 (SD = 19.43). With respect to the Beck Hopelessness Scale, four of five
respondents had scores over the cutoff of nine, indicating an elevated risk for suicide (Beck et al., 1990). The average score on the BHS was 14.2 (SD = 6.38).

3.5 **Suicidal Behavior Questionnaire 14 (SBQ-14) - Conceptualizing past history of suicidal behaviour and attitudes toward suicide**

The Suicidal Behavior Questionnaire (SBQ-14) is a tool that assesses experiences of suicidal ideation and behaviour over the lifespan, including frequency, intensity, and past behaviours (Linehan, 1996; McKay, 2007). The SBQ-14 also evaluates the future possibility of suicidal ideation and behavior, perception of lethality, availability of means, and social supports (Linehan, 1996; McKay, 2007). Finally, the SBQ-14 evaluates attitudes toward suicide, including whether suicide is seen as a solution to problems, the relationship between suicide and quality of life, and the emotional experience associated with engaging in non-fatal suicidal behaviour (Linehan, 1996; McKay, 2007). The SBQ-14 has been validated in a North American population but has not been validated in a Chinese sample, and was not available in Chinese. The scale was translated and back-translated until equivalence was achieved, with feedback provided from study collaborators with clinical expertise. Information related to past experiences of suicidal behaviour is summarized in an earlier section.

3.5.1 **Future possibility of suicidal behaviour**

The participants were asked to assess the chances of considering the possibility of suicide, attempting suicide, and dying if attempting suicide. They were also asked whether they had a plan for suicide and access to the means to undertake that plan. Finally, they were asked if someone would want to stop them if they engaged in suicidal behaviour. Responses were scored on a five point Likert scale and assigned the following meanings: 0 = no chance at all, 1 = unlikely, 2 = some chance, 3 = likely, and 4 = very likely. Participants were asked to reflect on several time frames: lifetime, over the next year, over the next four months, over the next month, and over today or the next few days.

Table 5 demonstrates that, over the course of their lifespans, seven of ten respondents believed that there would be some chance or likely/very likely that they would consider suicide. Four respondents indicated that there would be some chance or likely/very likely that they would
attempt suicide over their lifetime, while 3 respondents felt there was some chance or likely/very likely that they would die by suicide. As the time frame becomes shorter and more proximal, the proportion of respondents who indicate there is some chance or likely/very likely that they will consider, attempt or die by suicide decreased. For example, only one respondent indicated “some chance” of considering, attempting or dying by suicide over several days or the next month. It appears that while the majority of the women in the sample are not actively experiencing significant suicidal ideation, most believe that at some point in their lifetime suicidal ideation will return.

Table 5: SBQ-14 assessment of future possibility of suicidal ideation and behaviour (score: number of respondents)

<table>
<thead>
<tr>
<th>SBQ-14 Item (score: number of respondents)</th>
<th>Likert Score</th>
<th>In your lifetime</th>
<th>Within the next year</th>
<th>Within the next four months</th>
<th>Within the next month</th>
<th>Within today or the next several days</th>
</tr>
</thead>
<tbody>
<tr>
<td>What chance is there that you will consider the possibility, no matter how remote, of killing yourself?</td>
<td>Very likely</td>
<td>0 0 0 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Likely</td>
<td>2 1 0 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Some chance</td>
<td>5 1 2 1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unlikely</td>
<td>0 2 1 2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No chance</td>
<td>3 6 7 7</td>
<td>7</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How likely is it that you will attempt suicide?</td>
<td>Very likely</td>
<td>1 0 0 0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Likely</td>
<td>2 0 0 0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Some chance</td>
<td>1 2 2 1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unlikely</td>
<td>1 2 1 2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No chance</td>
<td>5 6 7 8</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you did attempt suicide, for any reason, how likely is it that you would die as a result?</td>
<td>Very likely</td>
<td>1 0 0 0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Likely</td>
<td>1 0 0 0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Some chance</td>
<td>1 1 1 1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unlikely</td>
<td>2 3 2 1</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No chance</td>
<td>5 6 7 8</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 3.5.2 Associated factors related to engaging in suicidal behaviour

Table 6 presents the subjects’ responses to questions related to presence of suicide plan, access to means, and presence of social support. Four women described having “a vague plan”, while nine of ten women said that if they did engage in suicidal behaviour, the means would be possibly available. Eight of ten women felt that someone in their environment would want to stop them from engaging in suicidal behaviour to some degree.

**Table 6: Assessing future plans, means and social support (number of respondents)**

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes, to some degree</th>
<th>Yes, definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you currently have a plan for how you would go about killing yourself, if you decided to do it?</td>
<td>6</td>
<td>4 (“a vague plan”)</td>
<td>0</td>
</tr>
<tr>
<td>If you decided to kill yourself at this point in your life, would the means for carrying out such an action be available to you?</td>
<td>1</td>
<td>9 (“yes, possibly”)</td>
<td>0</td>
</tr>
<tr>
<td>If you decide to kill yourself at this point in your life, is there someone in your environment that would want to stop you?</td>
<td>2</td>
<td>3 (“yes, to a degree”)</td>
<td>5</td>
</tr>
</tbody>
</table>

### 3.5.3 Attitudes toward suicide and suicidal behaviour

The SBQ-14 also asks questions designed to explore participants’ attitudes toward suicide and suicidal behaviour. When asked whether they could imagine what it would be like to die by suicide, nine of ten women responded that they could somewhat or definitely imagine what it would be like. The women were also asked to assess suicidal ideation and behaviour in the context of quality of life, asking if suicide would “solve their problems” currently, in the future if their quality of life had not changed, and in the future if the quality of life had worsened. Responses were measured on a five-point Likert scale ranging from 0 “no, definitely not” to 2 “maybe” to 4 “yes, definitely”.

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Table 7: Attitudes toward suicide related to quality of life (number of respondents)

<table>
<thead>
<tr>
<th></th>
<th>0: No, definitely not</th>
<th>1</th>
<th>2: Maybe</th>
<th>3</th>
<th>4: Yes, definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would any of your problems be solved if you committed suicide?</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>If you knew the quality of your life would never change, do you feel suicide would be a good way out?</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>If the quality of your life were to get worse, do you feel that attempting suicide would solve any of your problems?</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Finally, the SBQ-14 provides a list of 66 paired adjectives (i.e. happy/sad, afraid/unafraid, alert/dull). The respondents were asked to indicate the emotional effect of intentionally injuring themselves or attempting suicide by marking how they would feel afterwards. In this study, nine of ten women were able to complete this section of the SBQ-14. The paired adjectives, located on each end of a five point Likert scale, were assigned a numerical value (0, 1.25, 2.5, 3.75, 5). The pairs were analyzed by a paired, two-tailed t-test and adjectives that showed a statistically significant (p > 0.05) over their antonym were identified (26 in total). Using the publically available web application “TagCrowd” (Steinbock, n.d.), the adjectives were compiled into a word cloud, designed to visually represent the emotional experiences of women following non-fatal suicidal behaviour (Figure 1). The adjectives are stratified by size based on the difference between its score and that of its antonym. The women described adjectives in keeping with feeling depressed (depressed, bored, less humorous, less sexual), as well as adjectives related to poor self-image (unsuccessful, weak, ashamed).
3.6 Experiences of the research interview

3.6.1 Relationship between participating in the study and intensity of suicidal ideation, self-harm ideation, and feelings of control

As discussed in the previous chapter, asking about suicidal behaviour has not been shown to be linked with increased distress in patients with a history of suicidal behaviour. In order to ensure the safety and comfort of the participants, a brief three-question tool (asking the patient if they are having suicidal thoughts, having thoughts of self-harm, and how in control they feel) was administered before and after every contact with potential study participants and in the course of the study in English and Chinese. These Likert scales ran from zero to seven. Further, resources were available to the participants in order to address any increased risk.
Table 8 shows the results of these scales. Two participants completed the assessment over two sessions and so 12 sets of scales were analyzed. The average score for self-harm and suicidal ideation both decreased post-intervention; however, these differences were not statistically significant based on a two-tailed paired t-test. The score for self-control increased, indicating the women felt greater control over their suicidal and self-harm thoughts, and this difference was statistically significant. It is important to note that two women did experience an increase by one point in suicidal ideation after the qualitative interview; however, both also reported increased feelings of control (in one case, by one point; in the other, by four points). One woman did report an increase in self-harm ideation following completion of the structured interview in scales (from 1 to 4); however, her sense of control over these thoughts also increased (From 2 to 6). All ten women felt safe after the intervention and no reports of suicidal behaviour in the days post-intervention were noted.

Table 8: Measurement of suicidal ideation, self-harm ideation and feelings of control pre- and post-study intervention (N=12)

<table>
<thead>
<tr>
<th></th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Harm Ideation</strong></td>
<td>2.5 (SD = 2.02)</td>
<td>2.08 (SD = 1.83)</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Suicidal Ideation</strong></td>
<td>2.67 (SD = 1.67)</td>
<td>2.25 (SD = 1.71)</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Self-Control</strong></td>
<td>3.75 (SD = 1.42)</td>
<td>4.83 (SD = 1.90)</td>
<td>0.02*</td>
</tr>
</tbody>
</table>

*denotes statistically significant at p < 0.05

### 3.7 Summary

The preceding chapter characterizes the study sample from a demographic and clinical perspective. The results of the quantitative scales are also reviewed. Important findings include the relationship between alexithymia score and recurrent suicidal behaviour as well as the emotional experiences of the women following non-fatal suicidal behaviour described through Likert scales on the SBQ-14 and interpreted in a word cloud format. Finally, the results demonstrate that no significant increase in self-harm or suicidal ideation was noted after
participating in this study, and feelings of self-control increased significantly following participation.
Chapter 4
Results: Shared Life Experiences

4 Life Histories of Chinese-Canadian Women who have Experienced Suicidal Behaviour: Common Themes and Stressors

This chapter presents the common life experiences and stressors elicited from the life histories shared by the women in this sample. These shared life experiences were analyzed and conceptualized into five themes: restricted patterns of emotional communication within the family, feelings of lack of agency, recurrent victimization and oppression, cultural conceptions of gender, and culturally related stressors. These themes also connect to drive a coping response focusing on endurance, duty, and powerlessness that inform patterns of distress and suicidal behaviour that will be discussed in a later chapter.

4.1 Restricted patterns of emotional communication

The ten women in the sample discussed patterns of emotional expression within their family of origin as well as within their current relationships. These patterns were characterized as limited with respect to bi-directional openness, emotional validation and warmth. These communication difficulties, seen in early life, persisted through adulthood and often led to feelings of isolation and loneliness, particularly during experiences of physical and emotional distress.

4.1.1 Lack of bi-directional openness

Six women described experiences as children and young women where they did not feel that they had the opportunity to discuss serious issues within the family. Many women described that while growing up, important information was not disclosed, leading to a feeling having to “figure things out” on one’s own. For example, one woman recounted that a half-sibling of whom she had not been aware moved into the family home with no explanation and another described the experience of moving into the home of her father and his mistress.

These stressful situations were not addressed or explored by family members. Emotions were “pushed down” and not expressed. As one woman described, “I didn’t feel my feelings. I didn’t
feel much, and it would not affect me much even it was miserable. No much. Just knew that I was upset, not happy, just like that.”

Unidirectional emotional communication was also identified as informing stressful encounters within the family. Six women described being subject to “lectures”; or one-sided communication pertaining to educational expectations, and all described these interactions as distressing or stressful. As one woman recalled, her father would be “sitting down and talking for two hours, very stressful”. These communications, often focused on school performance, were centered on treating her “as an adult”, and stressed that the role of the parent was to provide guidance with little input from the woman herself. Another woman described a similar interaction with her husband. She described feeling as though she had no say in decision making, being systematically marginalized with respect to her role in the home, and bearing the brunt of husband’s frustration as he lost his temper with her repeatedly. She is placed in a double bind: she was unhappy, and if she tried to address the situation, the situation was made worse: “I found that he always took it out on me. Whatever I did, whatever I asked him, he would be annoyed by me…. Whenever I asked him something, he would talk to me angrily, scolded me and whatnot. He looked furious, and treated me with rage.”

Although many relationships were characterized as supportive, difficulties with open communication were still identified. For example, one woman described her husband as gentle and kind, but when she began to become fixated on caring for her parents and having symptoms of depression, he did not complain or acknowledge her distress. This woman also experienced clear manic symptoms (“talking more, shopping more”; fear that “there are people are there to harm my dad and my mom so I have to protect them and protect myself”); however, her husband did not discuss this with her (“all this time my, my husband didn’t say anything and so I thought it was okay”; “we never talked about this at the time”).

4.1.2 Limited emotional validation

All ten women in the sample described experiences of feeling invalidated when they made attempts to describe emotional experiences to loved ones. One woman described a desire to be validated with respect to her suffering: “I had never been recognized. I always wanted to be
recognized. Even if it was just recognize my difficulty, even just confirming that I was in a bad state. Even if just being sympathetic to me, I would need, like that. I had never been recognized”

Recurrent invalidation serves to reinforce the lack of openness and unidirectional emotional communication described earlier, as efforts to change this pattern are seen as fruitless. For example, women are often told that they are not telling the truth or “pretending” when expressing their emotions. In one example, a woman described attempting to let her father know that she was afraid of him:

“And my dad, he refused to admit that, a few years ago he refused to admit that I was afraid of him. If I told him in a very careful manner, and he told me like ‘you do not pretend like you are scared’. But then he knew I was really afraid of him. Because my mother told him I was really afraid of him; not close to him. In fact, my mother was afraid of him.”

A second woman described suffering from distress and depressive symptoms as a child, recalling that she did not feel that she was validated or supported by her parents: “In fact, I haven’t really received much comfort from my parents…when I was upset, they never really helped me, although I know they love me, I believe this, but they never really helped me to get out of the lowest point”.

A third woman described feeling invalidated when discussing distress with her friends, and described a desire for empathic communication that acknowledges her suffering rather than being told to remain optimistic or positive. She describes telling a friend, also a recent immigrant, about work related stress, and being told that she was being ungrateful for her opportunity. Expressing distress is framed as being ungrateful or not optimistic; the woman was left feeling that expressing distress is complaining and not appreciating the opportunities that can lead to a happy life:

“Others would not understand you. Like some of the girls in our church, they came as students. It was hard to find a job after graduation. You came with a job. Some people envied you. I said my job was not an easy one. She said you didn’t appreciate the happy
life you are supposed to enjoy. She said things like that, so I. I was so upset. How to talk
to here, did not know, no one could understand how much pressure I had to bear on.”

Even in situations where women are describing physical pain, they are given the message that
they must manage their suffering on their own:

“My mom had been taking care of me for a few years, then I knew she was a little bit
tired, and was not so willing to take care of me, sometimes she would even say that find
the medicine to take when you feel the headache, not telling me…I would not tell them
that my head, or other parts are uncomfortable, because then she could be very impatient.
I would rather take care of myself.”

4.1.3 Desire for warmth

Seven women in the sample clearly identified a desire to “chat” about day-to-day activities and
interests in interpersonal relationships. Chatting was described as a way to be close to loved ones
and for loved ones to validate, support and show interest in them. This desire for warmth
manifested in several descriptions of “ideal family life”. As one woman related, “Previously I
had a fantasy that my parents would become very gentle, and very kind to me. Spending time
with me and chatting with me about a lot of my favorite topics. Now I would not have this kind
of imagination.”

In another transcript,

“My ideal life is a simple and happy life, an ordinary and happy life. For example, he
stays at home…goes out to work and then comes home to enjoy the love of family, we
would go out for a walk, go out and play with our kid, and chat with other people.”

Another woman described her ideal relationship with her husband and wanting to experience
warmth and engagement: “I prefer, hoping to chat with my husband. But he is the type of cold,
not chatty… I have the desire to chat after going home. But we rarely could chat much. Haven’t
chatted a lot. This might be, also a problem.” When asked what she wanted to talk about with
her husband, she replied:
“Anything. Nothing specific topic to chat, just talking about his day, for example, what he eat in the morning, met with who, what he did. That would be quite good. Just to have a person to chat with, not necessarily having a specific topic. Just trivial things are very warm.”

Finally, one woman described her desire to find someone to “chat with” when she began to feel overwhelmed and distressed. She viewed the opportunity to “chat” as potentially protective and beneficial to her, and was disappointed that she could not find anyone to talk to in this manner: “there was no one to chat with. Nobody for chatting. So at that time, I really hoped, I held too much to myself, to find someone to talk, talk, talk”.

### 4.1.4 Consequences of restricted patterns of emotional communication

Restricted patterns of emotional communication in the lives of Chinese-Canadian women with a history of suicidal behaviour, characterized by a lack of bi-directional openness, invalidation and limited warmth, can be linked to pressure to “endure” distress on one’s own. This focus on endurance of emotions can lead to feelings of isolation, loneliness, difficulty expressing anger and being overwhelmed.

Aloneness and isolation were named by seven women as a consequence of limited emotional communication within the family environment. These emotions often came to a head when women began experiencing anxiety and depressive symptoms secondary to life stressors, for example, the death of a parent, experience of infidelity, or financial stress. Many women stated that their partners did not ask what was going on, and described feeling distant and disconnected from family members. Restricted patterns of emotional communication are often linked with feelings of powerlessness within the relationship and are associated with growing within relationships.

Because the expression of distress is not an accepted part of emotional communication, and because attempts to describe negative feelings are met with invalidation, coping strategies for stress described by women in the sample involve “pushing down emotions” and enduring distress. As one woman recalled, behaving optimistically while denying negative feelings was identified as a way to cope: “Until my high school time, I was very optimistic superficially, and I
read about things like putting down is happiness, self-redemption approach, and in fact I was very depressed. But I did not know and I did not admit.”

The goal of this approach was to disconnect from unhappiness, and many women described an inability to admit depressed feelings. Several women used imagery referring to themselves as being vulnerable to being a dam that can burst; as one woman described, “I was so afraid of having an outburst”. Feelings like anger and resentment are seen as particularly difficult to tolerate. One woman even refused care initially for depressive symptoms, stating “if there was a breakthrough, I could be resentful. I had never been resentful towards anyone in my life.” In Chapter 6, the focus on emotional self-endurance derived from restricted patterns of emotional communication will be linked with patterns of distress leading to suicidal behaviour.

### 4.2 Feelings of lack of agency

Every woman in this study described feelings of lack of agency with respect to decision-making within their lives. This lack of agency was driven by a strong sense of familial obligation, meaning that even if the woman had the capacity to meet her goals, it would not be appropriate for her to do so. The lack of agency also resulted in poor feelings of self-efficacy and engaging in a process of self-doubt. Even if a woman had the agency or permission to make choices, she did not feel as though she could effectively solve her problems or move forward. While family support is often framed in positive terms, it can come at a cost to the woman’s sense of self and ability to make decisions in keeping with her values or interests. Over time, a recurrent feeling of lack of agency in the navigation of major life decisions can lead to feelings of powerlessness and hopelessness. In this section, lack of agency within the family of origin, within a marriage, and within the workplace, as well as the emotional impact of these experiences, will be discussed. A link between lack of agency and the privileging of duty over self-care will also be made, and this link plays a significant role in the modeling of distress and suicidal behaviour and will be elucidated in Chapter 6.

#### 4.2.1 Lack of agency within the family

In the previous section, it has been demonstrated that patterns of emotional communication are unidirectional and attempts to address this pattern are met with invalidation, leading to feelings
of isolation, powerlessness and distress. These communication difficulties can be seen through a lens of a greater lack of agency within the family system. The literature review discussed the Confucian principle of filial piety, or a respect for one’s elders and ancestors (Hwang, 1999; Lieber, Nihira, & Mink, 2004). This concept framed relationship dynamics within the family discussed by the women interviewed in this study. All ten women described a relationship dynamic within the family that privileges the parents, particularly the father, as the leader of the family. The parents make sacrifices to allow the children to succeed, and that it is the children’s job to succeed, especially within an academic and financial sphere, in order to meet the expectations of the family, and to provide care for their parents in old age. Interestingly, five women also describe a history of multiple caregivers and long periods of time away from one or both parents. While there are positives that can come from this (i.e. close relationships with grandparents, improved financial opportunities within the family), they also relate a sense of distance and estrangement. Seven women describe how love is often shown through the provision of material goods, providing advice and guidance, and instilling successful traits rather than through emotional support.

Every woman interviewed in this study described instances where they felt as though their parents’ strictness manifested itself in a lack of ability to make their own decisions or in behave in ways that were natural to them. For example, one woman recalled that her father was “very strict about, from childhood how I should walk, how to eat without making a noise, then until now, he would be very angry if I did not handle something well.” A major flashpoint with respect to lack of agency within the family pertained to stress to achieve academically and to achieve financial success in the workplace. Every woman in the sample described these pressures as a major source of distress, and described feeling as though they did not have the final say when it came to decisions pertaining to school and work. In the words of one woman, her family wanted “Just like what the majority of Chinese wants…accomplishment, go to university, go to highly recognized school, earn a lot of money.” Because of the singular focus on achievement and the hegemonic definition of accomplishment (attending prestigious school, earning a good living), many women described that they did not have a say in the subjects they studied; personal interests were not considered and parents made decisions for women. One woman described how her father selected her University major for her:
“When I was in high school… The application to university where you had to prioritize your choices, my father filled out that form for me… Because my father thought that this was good for me, and then he discussed it with my teacher, and then my teacher said that was good.”

A second woman described how even small decisions pertaining to course selection were made by her father. Here, lack of agency in academic pursuits related to parental control and authority over life decisions leads to feelings of being lost and powerless:

“You need to think that if you go to summer school, blah, blah. ‘Once the summer school is over, you need to work. You cannot stay home. Then in next September, did you select courses? Tell me the courses you chose’. I read to him. Told me about every single course. He said that Vocal was not like what you thought, needed to learn theories, blah. Economics, blah. Analyzed all courses for me. Then made me feel lost again.”

Another woman described a similar experience; although she had hoped to study art in University, she was told by her mother to study economics. She describes acquiescing to her mother’s decision, feeling that she could not say no:

“I didn’t want to go into economics but I was interested in art myself but um my mom said you can’t, you just can’t you know take art so that’s why I ended up in something that will pay me, I would have a better job… when I was in high school I did painting and some sculpture but my mom was really against it so I, I didn’t put up a fight… I, I just felt okay that this is my, this is my mom, I, I can’t say no to her.”

Five women described a clear link between affection and success. They described a belief that affection, love and respect from parents was dependent on academic performance, and also described tension in sibling groups as they were compared and ranked based on perceived academic success. If the only way to make parents happy or have value is to succeed in a very narrow frame, it followed that the women did not feel that they had the agency to follow other paths or the ability to fail:

“If you had three kids, one studied well and the other didn’t, if you liked the one who’s good at study more, then the others must have bad feelings right? The three children
would have a difficult time interacting with each other, right? My dad was like that, he likes the child with higher accomplishment, whichever child who’s not doing so well, he would sigh for that child, thinking that I have a bad life.

Nine women described a lack of agency with respect to their own decision-making due to a strong sense of familial obligation. For example, one woman described that after immigration she wanted to have a family and that work and studying would be too stressful; she was told she had to work and study and began to feel overwhelmed. The family does provide support (i.e. financial, child-care) but she felt that it came at the cost of being able to make her own life decisions. Her family interfered quite strongly in her view of self and her future, placing tremendous pressure on her:

“I wanted to be a housewife in North America, taking care of kids, managing housework, doesn’t that sound good? Especially because of my childhood, I hope that my family could be warmer, so I chose to be a housewife, because I think being a housewife is very important to a family. However, later I gave birth to my daughter, and my parents didn’t allow me to be a housewife, this gave me a lot of pressure, they took my baby away, and they asked me to study.”

All ten women described ways in which fulfilling role obligations, particularly the achievement of academic success, came at the expense of self-care. Self-care can be understood in several ways, including engaging in enjoyable or rewarding activities, spending time with friends or family, cultivating relationships, and taking a break from stressful situations. Taking time out for oneself rather than exhibiting complete dedication to success, or failing to succeed in spite of complete dedication, were characterized as signs of moral weakness. The outcome of success was more important than the process by which it was achieved; in the words of one woman: “in China particularly…if you didn’t have good marks, then your moral was bad. Whatever you did was not good”. Another woman described the emotional distress associated with listening to her father enumerate the expectations of her:

“In general, my father sat there for two hours, he talked to me, he talked for two hours, I listened for two hours, I could not interrupt during the time. Then he said a lot and let me go. Then for a lot of times I was scared to talk to my father. He would tell me, ‘you’d
better make sure your next goal, well, if you are not good in the future’ then blah, blah, blah, then said how great achievement you should have, then just said a lot of this and that. …Just about my life. My life must be managed well, must manage self well.”

The high pressure placed on the outcome of educational experience was seen to have primacy over other needs. The stressor of familial expectations leads to a double bind regarding self-care and achievement, as parents stress self-control, duty and persistence in academic pursuits, and the women feel as though they must abide by these pressures. Self-care, as conceptualized as “taking a rest”, exploring other interests, or cultivating relationships both inside and outside the family are seen as failure, weakness or as a lack of persistence. The double bind exists because these women cannot choose self-care over working toward academic achievement, and academic achievement cannot exist without self-care, as the women become too overwhelmed and distressed to function. As one woman describes:

“I sometimes needed to take a rest during my study time. Then I went to my dad’s study room. I said that I came out to take a break. My dad said that ‘it’s ok to take a rest; but before you went back you must think about your future, such as you had not choose the right direction so how to choose, if you have the confidence to be persistent once you chose your direction’, and said I was not good at self-control, so I should do this and that. And he could talk about two to three hours; I stood inside for two to three hours, and then went back.”

In the following passage, a woman describes taking time to repair her relationship with father, only to be criticized for not focusing on her studies:

“I had once wanted to restore the close relationship, then on holidays I made him some gifts and sent to him, sent him e-mail greetings when he was in business trips, and then tried to spend time with him. But later I discovered that if I made gifts for him, he would say you should spend the time on study; then sometimes when I sent e-mails to him, he would say ‘you are playing on computer again’; then no matter how much I tried to restore the relationship it did not seem to be successful. Later, I thought, ‘forget about it’.”
Another woman described an interest in taking time to read books and her mother’s reaction to finding out that she was reading a book in class. Her expression of agency, choosing to read a book, was met with punishment:

“I liked to read extracurricular books after school, at that time at our age, parents didn’t like that very much, because they wanted us to focus on our study….The most remarkable incident was… I remember I was reading a novel, I was reading it in class, and then my teacher found out, and then s/he confiscated the novel and gave it to my parents. ..Then my mother… gave me a basin and a packet of matches and said “you tear it yourself, tear the novel page by page and burn it page by page.”

A third woman described the priority on educational performance over enjoying life and having fun from a young age:

“In our generation we always had to study, hm…at that time that’s a “hard education” (yinshi jiaoyu 硬式教育), usually…everyday…like my mom and dad they are all highly educated people, their expectation for me was to enter university, to enter a highly recognized university, highly recognized secondary school something like that, now thinking about it, life was pretty stressful, there was nothing fun. That’s my childhood, I wasn’t particularly happy about it (laugh). My parents were very strict with us. That was how it’s like in general; we were required to study hard to go to high ranking school, so our lives were quite tiring.”

Rigid expectations from parental figures lead to very strict expectations on behaviour within the family environment. One woman described a desire for freedom to be “not so obedient”, and felt that she would never have that choice within her own family environment: “When I was little, I saw in my classmates’ home, [their] mom and dad together, playing together, and then children sometimes also were not so obedient. I was especially envious to them. After growing up I know that, my family is my family, no choice.”

Finally, experiences of childhood physical or sexual abuse were described by five women. Three of the five women described a lack of agency in navigating experiences of abuse within the family context. Physical abuse in particular was described as something to be endured and within
the rights of the parents to enforce discipline; in the words of one: “Those who were naughty would get beaten up, those who were good would not be beaten”. The women did not describe any strategies except for enduring and “letting something pass”. Self-sacrifice was another factor that was explored; one woman described feeling forced to submit to sexual assault by a family member in order to protect the interests of its others members. The value of “sacrifice” for family was prized over one’s own bodily autonomy or independence:

“(If he were) arrested, then there was no income. Then my little brother and sister could not grow, would die. So should be aggrieved, you could only sacrifice and bear with it. Said nothing. Then he could at least have income for your brother and sister’s development. Then I could only sacrifice for my brother and sister. Well, just sacrificed.”

4.2.2 Lack of agency within marriage

Seven women in the sample referred to the traditional Chinese role of husband as leader of the family. Five described “following” their husband and acquiescing to their viewpoints and decisions at the expense of their own desires, and felt that they did not have a choice to act otherwise. In the words of one woman,

“According to the original perspective, like the Chinese traditional one, everyone was telling me to follow the man I married to (嫁雞隨鴨 jiaji suiji). Now when I think about it, it’s actually not very nice, because I have my own life, and if I had to follow someone else, then I would lead a very sad life.”

Another woman described how major life decisions with respect to employment, immigration and family decision making became the purview of her husband:” I realized that my whole life, not my whole life, but my life after getting married is all arranged by my husband”.

A third woman described difficulty in engaging in self-care as her husband felt that she was not entitled to do so. She described that she “just followed her husband” and was unable to spend time to herself or with friends:

“He wouldn’t let me go out… or to have my own time, or my own space outside of home. He also… because he thought that he didn’t have those either. Contributed… he
contributed immensely to our family. He didn’t have much time or space to himself, how could I … I have any? It was like this. It would be unfair. So I rarely had time to myself, or for my friends, or to go shopping or whatnot. Not at all. I was always at home, at our home. I just completely… just… I just followed my husband.”

A fourth woman described the relationship dynamic she observed between her parents; although both were highly educated, she described her mother as being subservient to her father: “I think their relationship is more like a master-servant relationship…Master and servant in general are, when dad asked mom to do something, she had to follow it one hundred percent.”

4.2.3 Lack of agency in the educational system and the workplace

In addition to experiences of lack of agency within interpersonal relationships, seven women described feelings of lack of agency in larger spheres, including within the educational system and the workplace. One woman describes having very little say in her employment decision-making:

“In my generation, basically you got a job after you graduated from university. Your job was allocated when you were still in school. It was done by a management team. You got a job while you were still studying in the university. But the job allocated to you might not be the kind of job that you liked. Regardless of the match, people took up the job.”

Feelings of lack of agency within the workplace also led to feelings of powerlessness, marginalization, victimization and oppression and will be discussed in the next section of this chapter.

4.2.4 Duty over happiness: Lack of agency throughout the life script

The experiences of the women in the sample were characterized by a feeling of lack of agency, stemming from a parental view that only one right way exists to succeed and the experience of women trying to meet parental expectations by subsuming their own needs. Further, these women went on to experience similar feelings of lack of agency within their marriage and within the workplace. They describe recurrent experiences of lacking the power to make decisions to guide their futures, and these experiences are built in to their life script. A woman expects to
have decisions made for her by her parents, and then to follow her husband, and to have little say in decisions pertaining to education and employment.

In many situations, duty and obligation trump women’s own desires and interests. This is made clear in the value placed on self-sacrifice and endurance in the face of physical and sexual abuse; the women could not describe any other strategy available to them other than simply suffering silently. With respect to behavioural expectations from family and in the workplace, saying no, or refusing to meet role obligations, does not feel like an option to these women; in the words of one respondent: “I am the kind of person that wouldn’t say “No” easily, I wouldn’t say “No” easily when I do anything, I do whatever other people asked me to do, just like that.” These experiences can lead to cognitive inflexibility. Parents frame their daughters’ choices as black or white, right or wrong, and this can impact the way the women see themselves and the world: “my mom said my thinking model was like either black or white mode. I think she was right. It is, either one hundred percent right, or one hundred percent wrong. Not in the middle.” These beliefs can make it difficult for women to navigate stressful situations and find alternate strategies of coping with distress, which will be discussed in Chapter 6.

4.3 Recurrent victimization and oppression

Eight women in this sample described recurrent experiences of victimization and oppression in several spheres, including education, employment, law enforcement, and mental health care. Eight of ten women in the sample characterized themselves as “good”, “hard-working”, “simple” or “fragile” and described multiple events in which they felt as though people in positions of authority take advantage of their kindness or vulnerability. Several described a difficult time expressing anger and blame themselves for allowing themselves to be taken advantage of, while others were able to express anger but felt as though they were powerless compared to the people and institutions that oppress them.

Six transcripts feature women as identifying as “simple” related specifically to the navigation of complex group politics at school or work. Their experiences of stress related to hierarchy and feelings of arbitrary marginalization by people of power echo experiences of feeling powerless and in some cases victimized within family and romantic relationships. Lack of agency within the family dynamic as described earlier in this chapter creates a feeling of powerlessness for
women, and their experiences of oppression by larger institutions can be seen to reproduce this powerlessness.

The women see themselves as good and kind but fragile people whose plans are thwarted by abuse of more powerful people or structures. This experience often leads to feelings of hopelessness, powerlessness and confusion, and can trigger depressive symptoms and suicidal behaviour, as well as forming a core belief about oneself and the world. Theme of victimization and hopelessness are derived from the contrast between personal integrity (hard work, struggle, achievement) and recurrent experiences of oppression. Although the cultural values of simplicity and kindness seem to reflect a gendered view of what is appropriate for a woman to be, the women in the sample did not make this link explicitly. Rather, they described themselves using these adjectives but did not attribute them to larger gender and cultural pressures.

4.3.1 Experiences of victimization and oppression within the workplace

Several women within the sample described complex power dynamics at work. A view of self as “simple” and those in people of authority as powerful were seen repeatedly and were very distressing for the women within the sample. These patterns reinforced women’s view of self as incapable of achieving success; one woman describes losing her job secondary to her inability to navigate internal politics: “I was really naïve at that time, my logic was really simple and I wouldn’t think too much, so I am not suitable…especially when it comes to communicate with officials, I am not suitable for that, because I am too simple…I am too simple”.

Another woman described in detail her experience of feeling vulnerable to victimization by authority figures at work. She described a situation where she was repeatedly denied promotion and removed from a respected portfolio for no clear reason, focusing on her experience of being marginalized, trapped and without value. She also spoke to complex politics which reward status over hard work and competence, echoing the experience of other women who felt that they are barred from achievement by complex power structures (in the Chinese context, “leader” refers to a boss, supervisor or superior):

“The leader is the one who is good at social networking but doesn’t really have actual ability. The leader is very often the useless one, but those who are under him/her are the
ones that have the ability, but very often they get marginalized by the leader. They have to do what the leader asked them to do. It’s a very complicated feeling…But in mainland China, what happened was that the power was concentrated by a particular group or a particular person, and then the rest of the group had to work (and get no recognition). The last 10 years I was tortured by my work, and everything else related to it. I felt bad, but I’m not the kind of person who would speak up for myself... I’m not that kind of person, and I felt stuck…the reasons they gave you were upsetting too, it made you feel that you were cornered in a room, like you worth nothing, it made you feel uncomfortable.”

One woman described conflict between a desire to achieve and the competitive values that guided their academic histories with a fear of standing out as “aggressive” which can lead to targeting by an authority figure. One woman described a sense that if she was “too aggressive” she would be seen as someone who would be punished: “they wanted to torture you”. Balancing competitiveness and interpersonal relationships predicated on a view of self as simple and kind as well as collectivist pressures to put the team’s needs in front of one’s own with little recognition was a source of stress.

4.3.2 Experiences of victimization and oppression by government institutions

Five women described stressors and experiences of victimization secondary to cultural and governmental pressures in Mainland China and Hong Kong prior to immigration. China has had several rapid social changes over the last fifty years, and these changes are reflected in the types of struggles these women faced. One woman described her experience of the Chinese Cultural Revolution. Her family was restricted, stripped of their status and financial security, and subject to victimization: “people threw stones at you, or other things, there were no human rights in China, others discriminated against you and called you counter revolutionist, called you son of a bitch.” She describes significant trauma and life changes in this time period:

“At that time my family was in a particularly good shape, because my family, that is, in the city was basically ranked the top ten rich, ranked high before raided. So my family was that from when I was little to I grew up, the situation, including the time we were decentralized, sent to countryside… The Communists set it up, the goal was to torture
you. Torture. Because you made mistakes, was counter revolutionist, you were against the Communist Party. Your whole family was sent to the countryside, so that you accepted the labour reform, I went with them, the family must go together.”

She also experienced physical trauma from military guards:

“Once I went to visit my dad, the guard like a rogue, just like a bandit, they were guard for criminals. He touched me once. My dad saw it from the window, my dad loved me so much, he said ‘you do not touch my daughter’. I scolded the man once, ‘I will kill you’. I scolded him. He pushed me and I rolled down on stairs.”

Another woman described the arrest of her mother for practicing Falun Gong: “I learned that she got four years of sentence. She did not do much, but it was like that anyway. Because they belonged to the kind of political prisoners, yes. She did not do anything. As long as you practiced it, you got that.” This experience was very difficult as her house was searched, certain belongings were confiscated, and she was not informed of her mother’s sentence for several months and was not allowed to contact her by phone or in person.

For other women, patterns of victimization and oppression form government institutions were less dramatic but also distressing. One woman described having to bribe government officials in order to ensure the safety of her father-in-law, who suffered from dementia and had been arrested. Another described difficulty in getting a position in a state-run company in China: “The stress was huge in China… In China, if you have no network, no money, you could do nothing. You spent tens of thousands, got a position in a so-called state-owned enterprises. Two or three thousand Chinese dollars a month.”

Four women described political oppression in China as a push factor for emigration, as will be discussed in Chapter 5, which explores experiences of immigration. One described making the decision to leave following the Tiananmen Square protests for fear of negative consequences; another described her father’s dissatisfaction with the Chinese government policies as the rationale for immigration, stating that he felt that China was growing particularly dangerous. However, it must be noted that three women in the sample described experiences with Canadian law enforcement that were experienced as traumatic. One woman describes a very stressful
interaction with the police in Canada, noting feelings of abuse of power and describing feeling taken advantage of by governmental structures:

“Then in the interrogation room, you know that the police somewhat forced me, forced me to speak. Because I did not know, he forced me. As I was forced I could only cry, but still forced me. I think these things, government gave someone the power, you should not force confession. It’s not that if you are the police, then you're superior. You can do whatever you want, shouldn’t be like that. Once like, once that, like for example the last time, on the highway, the police, he was among the highest level of violence, right? The highest level in the government. He took advantage of his authority, he arrested me when he didn’t have the arrest warrant. I couldn’t do much. I went to the police station; we went to, he, he, searched, and arrested. The detention in fact was a very big insult myself….All clothes had to be taken off. For person in sub-health like me, was overwhelming. You asked me to take everything off. Men and women, everyone could see me… I really did not know what law I broke. In this situation, I feel very bad.”

4.3.3 Experiences of hopelessness in the context of recurrent patterns of victimization and oppression

Six women described frustration, hopelessness and powerlessness when reflecting on experiences of victimization and oppression. The view of themselves as fragile and kind and the world as powerful and malevolent results in an unsolvable conflict: hard work and dedication is met with negative consequences, and if this is the case, many women feel as though there is no reason to continue to strive or to be hopeful for the future. One woman expressed this feeling poignantly:

“I work hard. I have also tried hard to accept the reality. Then tried to work hard and strive to learn. I was supposed to be a very motivated person, but each time, as if every time I planned something, there was always bad people interrupted. In fact, we are kind, people are kind by nature, like I am very fragile and kind. I am a person with integrity. But people like me are often being taken advantage of by others. And I am very sensitive when I am being taken advantage of. It happened easily that people used me like that. So I thought that, I struggled for what. I could easily get good marks in the school; in my
career and job I could easily make achievements. But my achievements were being taken advantages of by the bad instead of generating a positive energy to the society for better influence, but used by bad guys to extend their evilness. So my life, or my efforts, didn’t generate positive energy, greater energy.”

4.4 Cultural constructions of gender: The double-edged sword of opportunity

The women in this study described with some variability their beliefs on the roles of gender, and it is clear that age, socioeconomic class, geographic area of origin and family background status influenced their views. However, throughout the interviews, all ten women described a conflict between conforming to traditional, culturally mediated gender roles and meeting new expectations deriving from rapid social change and immigration. While pressures to achieve academically and financially have climbed for Chinese women, men are still seen as being more capable and having greater freedom and opportunity. This conflict between traditional gender roles and rapid social change led to women feeling under pressure to meet two sets of expectations, without the power and status provided to men. This section will discuss the respondents’ conceptualization of traditional female gender roles, the double-edged sword of greater opportunity and higher expectations that come with rapid social change, and the ways in which the two sets of pressures manifest in these women’s lives.

4.4.1 Traditional female gender roles: expectations and stressors

4.4.1.1 “Boys are valued and girls are belittled”

Five women described a feeling that males hold more value than females do within the family structure, although this was by no means consistent throughout the sample, and several women described that there was no preference for a son over a daughter within their family. However, for one woman, she described that people within her family, particularly in the older generation, felt that females are inferior to male: “my grandparents both treated woman as inferior to men, did not love me. Although I was the only child, she did not love me. My mom said my grandmother didn’t want me”.

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Seven women also described a belief that men have more options available to them than women do, and have the freedom to move on regardless of what has happened in the past, while women are powerless and bound by duty. As one woman stated, “Women usually lose out, really, and men they…they don’t lose out, because it’s women who get pregnant, so you have to take care of the consequence…it’s always women who take care of the consequence.” As discussed previously in this chapter, many women described feeling bound by a traditional gender-based relationship pattern that was focused on the role of husband as leader and the role of women to follow their husbands in major life decisions.

Interestingly, four women described a belief that men were under more pressure to achieve, as the expectations are lower for women. One woman described her view that women are under less pressure than men:

“I think a woman has less pressure than a man has. After all, after all, at least for Chinese culture, a man should, the requirements for men are higher. After all, the requirements to a woman are less. Usually someone talks about a man, for example, he is competent or not, something like that. But rarely we evaluate a woman, expecting her to be very competent. So I think a woman would have less pressure.. I think the pressure is all from life.”

Another patient describes differences between urban and rural areas in China and how she felt as though she was under less academic pressure as girls were valued less than boys were:

“Because I grew up in a rural village, unlike from the urban areas who feel pressured at school… at school…in rural villages the practice that “boys are valued and girls are belittled” (重男轻女) is more serious. If you are a girl, it’s okay to be so-so at school, but I did really well, so I was quite happy. Not that serious, but…it’s just that there was not much pressure [for girls], because in our place, in our village there was no girl who went to university before me, so they…it’s not that they valued boys and belittled girls, it’s just that they didn’t put much expectation on me, so it’s not that harsh.”
4.4.1.2 Aging and beauty

Women are also bound by tremendous pressure with respect to aging and beauty. Six women described a fear of aging, and linked getting older to an inability to find new relationships or start a new job. One woman described a wish to die after age 50, stating that women are worthless when they are old. These fears are compounded as she describes feeling as though she did not meet traditional gender role expectations, like getting married and having a child: “Because taking myself as an example, first after I become old, I don’t have my own child, right? No relatives. No, I would be very lonely, will be very lonely, a very lonely person.”

Five women discussed the value of beauty and the stressors they experienced for not meeting prescribed standards of beauty. The focus on beauty is hegemonic, as women describe very clear goals for women to achieve; not meeting these goals is source of ridicule with respect to height and weight, skin texture or colour and symmetry of features. Women described comparing and ranking one’s beauty with others, and that ranking was felt to determine whether one would be worthy of romantic love. In the section below, one woman describes significant stress as young woman for not being tall enough – fear that not meeting attractiveness standards could have negative consequences and spoke to her value as a person, and appeared to trigger a depressive episode:

“My sister was actually quite mean sometimes, for example, sometimes she would say something that really upset me, for example, there was a “soul mate magazine (zhizhi zazhi 知音雜誌)... they talked about the requirements that men wanted in women, and one of them was about height, you have to be 160cm tall, in China men always want their wives to be 160cm tall, especially during that time... they said men had to be 170cm and women had to be 160cm, I was furious, and she said, “look at you, you are so short, no one would want you in the future.”

These five women talked at length about beauty standards, and described feeling worried about being unattractive. Other women described seeing physical beauty as important trait with respect to relating to other people. There is a tight link for women between physical attractiveness and being cared for and about by others:
“Because when I was little, my personality was like a boy when I was little. I did not look pretty when I was little. I looked different until I was 18-year-old started. Becoming more lovely like that. There was a period of time that, I was cared about by others. But all of a sudden it seemed going back to my childhood, felt ugly and never recovered.”

Finally, as discussed earlier in this chapter, cultural values prioritizing gentleness, kindness and simplicity in women may reflect a gendered view of feminine gender role expectations. It is important, however, to point out that the women in the sample appeared to describe themselves similarly but did not explicitly attribute them to larger gender and cultural pressures.

4.4.2 Rapid social change: increased opportunity, increased pressure

Rapid social change in China has resulted in an education system where both boys and girls have the opportunity to attend school and join the workforce (Yip, Liu, Hu, & Song, 2005). However, this opportunity has led to significant pressure on young women to succeed academically and financially. While men and women are educated in the same system, and have the same expectations placed on them, men continue to be seen as more competent and have more opportunities available to them. As described earlier, women may feel that they have fewer expectations put on them, due to the fact that they are seen as less capable than their male counterparts. However, in this new system, women are expected to work and succeed just as men do, while simultaneously being seen as having less value and ability.

Cultural expectations of behaviour can put women at a disadvantage in the workplace. Typically feminine traits (being kind, good, not expressing anger) can put them in a position where they feel vulnerable to be taken advantage of by co-workers and those in positions of authority.

Although rapid social change brings on increased pressures, it is also very important to note that there are more opportunities as well, particularly for women who are highly educated and of high socioeconomic status. For example, a woman who is working professional in mainland China felt that she was able to get divorced easily and take care of self and son alone. This woman’s financial independence was a source of agency and power for her:

“In mainland China I had nothing to worry really, so when I divorced I even gave him the house. I don’t need it. I moved out and I got myself a house and I worked. I took care of
my son alone. I had a lot of confidence. I had confidence in everything…May be I have too much pride in myself, after I came here I felt like it’s pride, but at the time I came here I felt very confident. A lot of people…I came with my son alone, I wanted to do it and I did it, even though all my relatives opposed to it.”

4.4.3 Navigating two sets of gender-based expectations

For seven women, particularly post-immigration, navigating these two sets of gender-based expectations is a cause of tremendous stress. While the immigration experience in general will be discussed in Chapter 5, gender role upheaval often follows immigration, as women described balancing a desire to have children, “make a home” as well as financial pressure to work and pressure to use education to have high-status job. These women commonly describe stress post-immigration with respect to managing family life and motherhood:

“When I came here I didn’t know if I would be able to adapt to the new job, and I was also afraid that I wouldn’t have enough time to take care of my son. I was concerned about the commute to my work too. If I worked and neglected my son, then my son might get into trouble and that would cause problems for the society, and this emigration plan would go to waste.”

In the words of another woman, describing expectations on Chinese immigrant women:

“She will have a very good family, and a very good job, and at work she will…I think it’s very difficult, because for a women, and we are talking about Chinese new immigrant here, it’s not easy for them in North American society, they have to overcome language barrier…like those Chinese women immigrants, they have to overcome barrier related to gender as well these are all the barriers they face, and I think we shouldn’t expect them to…ai…it’s not easy to have a regular job, and on top of that they have to go home and take care of the kids.”

This woman described her struggle: she wanted to stay at home to care for child, but with that comes feelings of being overwhelmed. She also described facing pressures to achieve in academic and work spheres, leading to a sense of losing control. Pressures from parents and
partner to work lead to a feeling of powerlessness, and a feeling that they have a lack of access to narratives available to North American women:

“I had never thought about…at least after coming to Canada…although I had received very good education in China, but if you asked me to study again, not that I couldn’t study, but even if I could, my logic at that time was that I chose not to study, I wanted to be a housewife in North America, taking care of kids, managing housework, doesn’t that sound good?”

She related her concerns stemming from growing up with two working parents and a feeling that household work was not addressed in the changing dynamic of the family:

“When I was young, I always thought…Well there was another thing that my parents always fought over, I think it’s the fact that my mom’s not always attending to housework, she basically didn’t do any housework. At that time I think, not doing housework is something…not that women don’t do housework, but I think family and work, family is a very important element, no matter if men or women do it, or if you hire a help, or if you ask the elderly to help, I should say it’s something about lifestyle, it’s not about right or wrong.”

For six women within the sample, one way to navigate the two conflicting sets of expectations was to reprioritize what it meant for them to be “a good woman”. For example, one woman reflected, “when I was younger I felt that…a career role was very important and it’s important to be independent… but now I think…the family comes first”. Another woman described being drawn to more traditional gender roles, seen in religious texts, a way of reinstating order within the family:

The bible said men are the heads, men are the heads of women, we are all educated under modern Chinese education system, it’s very hard for men to be our head, so that’s why I said the position was not put right, it’s very difficult. Now I’m trying to learn this lesson, I need to put men first, I have to look up to him and that will change things.
For two women within the sample, the view of self as weak and vulnerable felt too powerful to overcome, however they are both able to see potential for other women to be independent and they view this as having some value. These women reflected on changing roles for women and the view of themselves and viewed independence as an option to aspire to for women. As one woman explained:

I think, I think that I am, I do not know, I think I am weak internally. I cannot live alone. I think I cannot survive. I myself, I feel very fearful, if no one with me. Not independent, nor strong, nor independent. Then in my heart, from the heart, I think that independence can have two meanings. One is you can live completely independently; another one is being psychologically independent. I think I firstly, basically, I am not able to be independent in my heart. I always feel that I cannot really live as a single person. Cannot survive. I think some women can be very strong and can raise children and handle things well. I feel that I cannot handle.

Five women described some positive and nuanced views of gender when describing future opportunities for other generations of women. One woman described a desire for her daughter to achieve some form of work-life balance, stressing both independence and success in the family sphere. Interestingly, success is measured not by financial or academic achievement but by living with integrity:

“[A good woman] has to educate her kid well, not necessarily about her academic work, I don’t ask too much of her, I’m happy if she can continue with her study, I don’t ask her to do a PhD, I only hope that she can be independent, to live with integrity, to take good care of housework, to create a worry free environment for her husband, that’s all.”

4.5 Cultural stressors: Understanding the context

Three stressors came up repeatedly within the interviews and are important to note given the cultural context. They include the loss of a parent, managing relationship with in-laws, and navigating parenthood. These stressors can be understood within a frame of filial piety, a Confucian respect for one’s elders and ancestors (Hwang, 1999). While filial piety was a sensitizing concept in the interview guide, it was not introduced directly by the interviewer.
4.5.1 Loss of parent

Parental illness or loss and the subsequent questioning of ones’ own filial piety leading to distress is a theme that was noted in six transcripts. The death of parent or grandparent in particular was a proximal stressor leading to depressive symptoms in three interviews. These women are responsible for caring for ill parents, and for arranging funeral arrangements, which often involves returning to China to manage these issues.

The death of a parent often brings up thoughts of filial piety and feelings of guilt; by immigrating, the women described feeling like they may have not done enough for parents. These feelings are exacerbated by communication focused on blame. One woman described being made to feel guilty by a member of her extended family:

“But at that moment, she scolded me, yelled, ‘What pain, you're damned. Are you a dutiful daughter? A dutiful daughter would not go abroad without bringing your mother.’ Ah, well, I was mostly afraid to listen to these words, because I already felt very guilty.”

The woman continued:

“I think my mom would have definitely blamed me, I felt my mother blamed me, blamed me definitely. This thought has been lingering. I feel, it didn’t matter how good my mom wrote about me on the will, I did live up to it. I was just not filial. People said I was filial, which was useless. I know how much I did. I could have stayed; I was not like other people who had a job, right? I could have stayed for one more month. If I had done that way, when my mother fought with her over the phone, maybe I could have saved my mother's life you know. Was it because, because I did not accompany her. I found it out when I went up. If I were there, my mother quarreled with her, I could have helped her to release her anger, right? I could certainly have resolved it. My mother probably would not have died. If she had not been dead, and have come over to live with me. Because my mom liked the life here. It’s all ruined.”

Another woman described depressive symptoms as starting “a few months after my mom passed away…I felt a sense of um or maybe a lack of purpose”. She described that “at the time I was very obsessed with taking care of them, trying to make them, their last, their last period of time
um a little better”. She stated that she moved in with her parents but felt guilty for “ignor(ing) her own family. She described being preoccupied with showing her parents that she had the strength to care for them: “I didn’t want to show them that I couldn’t handle it and I’m…so I, I, I would tell myself I have to be strong, I have to stay calm”.

4.5.2 Managing relationship with in-laws

Three women described problems navigating husband’s filial piety and spending money and time on family of origin rather than on their own wife and children. They described anger and powerlessness as their husbands would spend significant amounts of money to support their parents and siblings:

“His siblings were like…many people are poor but some of them have ambitions and they study hard, but they were not like that. They didn’t study. Okay, it’s fine that they didn’t study, but perhaps they could work hard and appreciate the jobs that we introduced to them? They were like, “Oh he’s the eldest brother, so he should take up all the responsibilities from our father.”

Extended family involvement can have both positive and negative effects. One woman described benefits and stresses associated with this – for example she had positive relationships with her mother and father-in-law who were both helpful around the house and who she cared for; however she describes her husband’s sibling relationships as quite stressful.

4.5.3 Managing relationships with children

While the women in the sample described the importance of respecting and caring for their parents, they also held expectations for their own children based on the value of filial piety. Stress arose for four women in the study when they felt that their children were not meeting the expectations they had set for them. One woman related her experience with her son talking back and the emotional consequences she felt: “He learnt “what?” “Who cares?” at school. He learnt this when he just got here. The first time I heard it, my blood pressure raised. I felt like I was on fire. I have never felt like this in the last 45 years?”
Four women described distress relating to their children getting older. While in China, the expectation for children was that they would provide care for parents as they aged; as one woman described, “raising a son or a daughter for what, it is for elderly care and end of life care”. Another woman felt distressed about her son getting older and moving out: “My son will leave me eventually and I’ll be all by myself, can you imagine that loneliness? Now I’m afraid of that”. A third woman described having difficulty transitioning from caring for young children to older children who were more independent:

“When they were young, it was better. I would go to different places with them on weekends. Went for a walk with them or whatnot. Drove around to see things or whatnot. I think it was better then, because weekends were family days, and I played with my children….When they were older, especially when they were in high school, they started to have their own activities. So we spent less, less time together.”

4.6 Summary

The ten women in this study provided rich narratives of their life histories prior to their experiences of suicidal behaviour. These narratives were coded and analyzed in order to construct five shared themes that characterized these life experiences: restricted patterns of emotional communication within the family, feelings of lack of agency, recurrent victimization and oppression, cultural conceptions of gender, and culturally related stressors. These five themes describe the ways in which these women see themselves and understand their roles within family and society, privileging endurance and duty to others over ones’ own interests and happiness. They also influence the ways these women are able to understand and cope with life stressors following immigration and the patterns of distress that lead to suicidal behaviour, which will be discussed in Chapter 6.
Chapter 5
Results: Immigration Experiences

5 Experiences of Immigration: Stressors and Protective Factors

“There is no point of returning, and I feel embarrassed of going back. I have this kind of feeling. We went out to explore, gained nothing but illness.”

Every woman in this sample described her and her family’s hopes for immigration, and each described the ways in which these expectations were challenged by the immigration process. In this section, the ways in which Canada is portrayed with respect to opportunity will be discussed and contrasted with the lived experiences of the women post-immigration. Nine of ten women in the sample described a view prior to immigration that Canada would provide greater opportunities with respect to finances, security and quality of life for themselves and for their family members. Unfortunately, almost all of the women struggled with disappointment with respect to a perceived lack of governmental support, fall in social status, and social isolation. Further, while many women expected the Greater Toronto Area in particular to be “good for our Chinese”, several faced acculturation pressures including experiences of interpersonal and institutional racism. Institutional racism can be defined as the systematic domination of people of colour through embedded and operating in social institutions, while interpersonal racism refers to overt and covert racial domination seen in everyday social interactions (Desmond & Emirbayer, 2009).

In spite of these disappointments and struggles, every woman in the sample planned to stay in Canada and was able to describe ways in which immigration had been a positive experience. Protective factors included increased social welfare, better opportunities for future generations, greater agency to make life decisions and a desire to contribute to Canadian society.

5.1 Immigration expectations: Opportunity, security, belonging

When describing their expectations for immigration to Toronto, the women in the sample described both their own views and what had been described to them by others. One woman stated that she knew very little about Canada, but said that reports from family members who
have immigrated to Canada previously described life as “so good, also very easy”. The women and their families were drawn by three key factors 1) Greater opportunity for financial stability and achievement, 2) Improved social welfare as characterized by political stability and access to government support and health care, and 3) The view that Canada, and Toronto in particular, had a network of Chinese immigrants that would allow for success post-immigration, providing access to support while allowing for opportunities to escape rigid cultural expectations.

5.1.1 Financial expectations

With respect to financial expectations, many women were told and believed that they would have greater opportunity to succeed, to earn money, and to be free from bureaucratic or government pressures in comparison with Mainland China or Hong Kong. Many parents believed that moving to Canada was a way for their own daughters to circumvent the stresses they endured within the Chinese system:

“My dad worked hard, very hard. They, my dad, because he worked too hard, so he did not want me to work hard as well. He wanted me to come to Canada so I could be settled, with less pressure. The stress was huge in China…In China, if you have no network, no money, you could do nothing.”

Another woman described her father as having similar beliefs. Her family immigrated to Canada with the goal of greater educational and financial opportunities: “the benefit is good in the foreign country, good education, everything is good. Getting a job in the future would not be so unmanageable in China.”

A third woman described a belief that moving to Canada would allow for the achievement of success and recognition in the absence of complex power dynamics seen in the typical Chinese workplace. She felt that emigration from China as being fuelled by skilled workers who were unhappy with their work situation:

“If I worked and got recognition at the same time, if everyone’s psychologically comfortable, then there wouldn’t be so many emigrat(ing) from mainland China. It is exactly because of that, because some people worked very hard but got very little or even no recognition, like even after twenty years of work.”
5.1.2 Social welfare expectations

Concerns over political unrest were mentioned in four transcripts, and women were drawn to the relative stability of the Canadian political landscape. One woman described her father’s desire to immigrate in the context of China’s political climate: “Dad was like a cynical youth. A cynical youth is like not satisfied with China’s politics. And thinks that in China it is particularly dangerous. So brought us abroad.” In keeping with concerns over political unrest, one woman described making the decision to immigrate following the Tiananmen Square protests in order to provide a better life for children in the context of political upheaval in China: “the reason for migrating to Canada was “Six Four”. Actually we had never thought of migrating…we both agreed on this. But because of “Six Four”, we changed our mind. So we immigrated to Canada for our kids.”

Three women in the sample described a pull to Canada based on its social welfare system. In the words of one woman, “many Chinese families came here under the impression that the government would take care of them…all of us want to get out of the predicament so we came here. And it’s advertised really well here”. Two other women named Canada’s health care system as a key factor in immigration. One woman described stressors related to health care in China in contrast with Canada’s system as a reason for immigration:

“I had been supporting the whole family, and the welfare system in China isn’t that good. My mother had already retired, and thank God she’s quite healthy, although she had to take medication from time to time. And every time she needed medication I had to pay. She has high blood pressure and heart disease, those old people diseases. And she was always in pain, and needed to go to the doctor from time to time, even if she didn’t need to go to the doctor she needed to have Chinese herbal medicine. So what could I do? And my son’s health was not good neither, so we went to the doctor all the time. And if we went to the western doctor, it cost me more than RMB 200. And I had to pay for this. I had to pay several hundred here and several hundred there, and I used up my salary very quickly.”
5.1.3 Cultural expectations

Four women in the sample described an attraction to Canada, and Toronto in particular, due to the strong Chinese community in the Greater Toronto Area. Some had family who had immigrated previously who praised Toronto highly. One woman recalls speaking to a family member prior to immigration, who strongly suggested settling in the area, stating “You should buy the house in Toronto, as my home is in Toronto. Toronto is good for our Chinese, in Ontario, right?”

Further, four women described being drawn to coming to Canada in order to escape traditional Chinese expectations in order to have greater agency in their lives. In the words of one woman, “I came here to avoid family burdens, I came here to breathe”. Two other women described a belief that immigration would allow them to engage in “Western” gender roles, specifically taking care of home and family, rather than being pressured to work at a high stress job.

5.2 Facing the reality of immigration: Common stressors

5.2.1 Financial stressors

In the post-immigration period, financial pressures mounted for all eight women in the sample who immigrated as adults, and this was considered by all to be a very high stress time. The women began to question their belief that financial opportunities were greater in Canada, and that they would not be beholden to bureaucratic pressures in order to succeed. They found that in Canada, social connections remained important to find work.

“I was troubled by money before, and I thought by moving here things would get better, but then now I’m still facing financial problems. Now it’s like what they said, it’s really quiet here. It’s quiet but it’s also realistic, it’s not much different from China. No matter where you go, people ask you where did you get your degree from?”

In the words of another woman, “I think new Chinese immigrant women face tremendous pressure, it’s not like…their social network is not like those who grew up here, who have lots of social network, for them, it’s really difficult to get a job, really.”
Four women believed that because they were highly educated, and had professional backgrounds, it would not be difficult to find work in Canada. However, most women in the sample described difficulty finding and keeping work post-immigration. One woman described the difficulty in achieving the same amount of employment success as her parents post-immigration:

“I think it’s not easy for new immigrants, they…especially new immigrants that are women…and some of them are very traditional, and they come from families that are professionals, they received high education and they think that their parents…because their parents have jobs in mainland China, I mean both husband and wife have jobs in mainland China, but I think for both husband and wife to have jobs in North America, it’s really, really a kind of luck.”

As higher quality jobs within their own professional field were difficult to obtain, many women described feeling forced to take “bad jobs” that are not commensurate with their training or skills. In addition to the financial and emotional stress that comes with taking these positions, several women describe feeling as though they have disappointed their parents:

“I know a lot of girls, they are either jobless or working bad jobs, like cashier, not that those…not like jobs that they (referring to her parents) say…like “why are you working as cashier?” , and asked you to go to school to get a decent job. That’s what they want from me, it’s not like I can just get a job in the factory.”

Five of the eight women in the sample who immigrated as adults felt that they were forced to take on work that was not appropriate to their training or below their or their families’ expectations, and experienced significant distress related to a fall in social status. It is very important to note that within the current immigration framework, skilled and educated workers as well as those with family connections in Canada are much more likely to qualify for immigration, and as such, most of the women in the sample come from educated and upper middle-class families in China. One woman described the feelings of inferiority that came with working in a job in which she would have not expected to find herself:
“I was not mentally balanced. I thought that my life was so good in my own country, why should I come and do this. This indecent job…maybe I didn’t think that way. I thought, telling myself, I was making money, in a normal way, earning money through a normal approach, nothing low. But, it seemed as if there was a subconscious mind it, subconsciously there was a feeling of inferiority.”

She began to compare her social status to that of her friends in China, which lead to feelings of hopelessness: “all of them had a good living. So enviable. It was an entirely different world. I thought that I had no future. I thought my whole life would be like this.”

In addition to describing distress associated with a fall in social status, all five women who took on lower-status jobs described stress related to the work itself. One woman describes her situation: “I did a very unsuitable job- being a cashier in a Chinese supermarket, and I was new to Canada at that time, you know how hard it is to be a cashier, so I was bullied by a Western customer.” Another woman reflected how the demands of her new job affected her mental state:

“After coming here, I felt, I suddenly felt a lot of pressure in life. Then I was very anxious. And then I started working, worked in any kind of factories. Then work was relatively heavy, and I never did that in China. So I felt that my life was completely different, facing high pressure. So I think I suffered a lot.”

Even when work is eventually obtained within their field, stresses still exist. Four women within the sample described a hope that work experience in Canada would not be fraught with complex power dynamics. For some women, however, this was not the case. One woman described being told that work relationships would be much simpler and more straightforward in Canada, which was not her experience. Her goal was to immigrate to a place where she would have more opportunities and fewer complications, but she was tremendously disappointed by the actual outcome.

“I’m a very simple person. I don’t think of too many things, there are a lot of complicated things that I won’t think of. So I came here. When I was in mainland China, people told me that it’s much more simpler here, the interpersonal relation is not as complicated.
Now I fell into a hole, I feel like now I’m in a hole, and I don’t know where to go, and I don’t know how much longer and deeper I would fall. It’s that simple.”

For other women who had arranged employment prior to immigration, reality did not match the description of the job they had received. In one case, a woman thought she would be working as a tutor, in fact she was a nanny and had to care for two small children, with which she had no previous experience. This situation also caused tension within her extended family, as they had arranged the position for her. In another case, a woman described feeling overwhelmed she was expected to learn the English terms for the machinery she had been using previously in China:

“I have to report a lot of numbers, and I have to read a lot, and I have to familiarize with all the terms, and then he would give me some small tasks, tasks like correcting something, correcting some designs and knowing the equipment and so on, the flowchart, I felt dizzy just by looking at those….and I got really tired after one week, I couldn’t do it anymore.”

5.2.2 Limited governmental support

In comparison with Mainland China and Hong Kong, half the women in the sample felt that the Canadian government would provide greater political stability and almost every woman described a view that the government would provide greater social services, specifically financial support in resettlement and improved health care. Unfortunately, in many cases, they were disappointed by what they found, which led to feelings of distress. It is important to note, however, that the women did have positive experiences with respect to governmental support, which will be discussed later in the chapter.

Three women described difficult interactions with police and within the Canadian legal system that led to feelings of victimization and oppression, as described in Chapter 4. In the words of one of these women, “I am neither able to trust this society, nor able to trust any government. I hope that I could trust the Government of Canada, or the Chinese government. But I really cannot trust.”

With respect to the provision of social services, five women were disappointed with the gap between what was expected and what was received. One woman described her belief that the
government would provide financial support to struggling families, but that support was limited and these limitations had serious consequences:

“The people who make policies need to consider the transition so that people’s standard of life wouldn’t be so different. That would make things a lot easier…many Chinese families came here under the impression that the government would take care of them. They came here and they earned about CAD 1000 a month, but a big portion of that money goes to the rent. The main problem is that we don’t get a house, so we have to rent. What about food? And what about other expenses? So that’s why many of them have no other ways but to do illegal work or to work in a factory, even though those are not their professions.”

Of the eight women who had completed their education prior to immigrating to Canada, five enrolled in some form of education (job training, college programs) in order to improve their chances of obtaining work, and all did so with some form of government support (formalized job training programs or student loans). Of these five, two had very positive experiences, which will be discussed later in this chapter. For the other three, however, navigating both the educational responsibilities and the structural issues around choosing and paying for a program were very stressful, and two in particular felt unsupported by the government. One woman described her experience:

“Although I got some supports from the government…Oh it all sounded so nice, the government’s supporting the new immigrants, but it’s a trap. It deceived you so now you finished your school, got your diploma, and you kept going around in circle. There seems to be no other way. Should you continue to study? What should you study? How do you study? If you decide to study, perhaps you should study now because when you get older your memory is not as good.”

The two women who named the Canadian health care system as a draw for immigration in particular expressed some disappointment with what they found. One woman described her views:
“There’s something about medical care as well. Although it’s said it’s free but in actuality it’s not free, it’s only free when you are really sick and have to go to the hospital. If you don’t have a job, and if you are not affiliated with a big company, then you are not entitled to those benefits. For these people, if they caught a cold or had a headache, they didn’t have the benefits and they had to pay for themselves. But usually, these people are very stressed. They don’t have high income and they are under lots of stress, so they get sick easily. Those who are in big corporation they have benefits like massage or physiotherapy. Many people don’t have that, but usually it’s these people whom get sick the most. When people go to hospital, they’ve already become a source of burden to the society and to the nation. So if there is a system...everyone’s saying it’s different here from China because they think (the policy) here is more for prevention rather than cure. But then it’s actually not like that. It’s preventive only when big things occur. Where’s the prevention? There are only regular physical check-ups, blood test, X-rays, and weight measuring. I can do than in China for less than RMB 100. The government doesn’t provide anything for illness prevention.”

Finally, within this sample, four of ten women relied on the Ontario Disability Support Program (ODSP) or Employment Insurance (EI) after they found themselves unable to work secondary to mental health issues. This program had its challenges:

“The biggest problem is economic source, so I feel very light even though I am stepping on the ground. Although I have subsidy from the government, it’s very basic, and I feel very empty. I don’t know which day it (the subsidy) would end, and I know that I get more when my child is under the age of 18. After he turns 18, I will get less.”

5.2.3 Cultural stressors

Although four women within the sample were drawn to a large Chinese community in Toronto, in reality, most continued to experience feelings of social isolation. Although many immigrants face similar pressures, lack of community connectivity was particularly salient for the Chinese community. Six women described the cultural importance of a network – friends, elders and peers – and described that post-immigration, they struggled to rebuild that network. One woman described her experience:
“After coming here you need to establish your new network of friends, meet with a lot of people. Those networks set up in China for more than ten years, whether with elders or peers, it’s different in the future. Everything else is fine but it’s hard to build up new relationships.”

Elaborating on difficulties that exist in rebuilding this network, another woman described difficulties in connecting with colleagues at work. Although they were superficially positive relationships, they did not have the depth that she experienced prior to immigration: “I started to have co-workers, but it was different in Canada from in Hong Kong. In Canada, people all went back to their own home after work, because everyone was an immigrant.”

A third woman described the emotional impact of being a way from close family, particularly as closeness with family is a cultural priority, comparing her previous life in China to new life post-immigration: “That was okay because there were a lot of relatives. No such kind of feeling. After all, it was a familiar environment. But I just came here, in a strange environment.” Several women in the sample described difficulties connecting with new friends, as they did not have the history of friends back home. One woman describes friends made post immigration as “not so close”:

“I think probably we are not so close. As we are not friends who have known each other since we were little, like those childhood friends. In my heart they are very very close. Friends made here, after all, we had limited time and frequency of interaction. I do not think we are close enough that I can entirely tell them what I think.”

Six women described difficulties navigating the work-life balance in Canada. Child-care in particular was a stressor. In China, women had access to family members who could care for children, in keeping with cultural values, and had access to state-sponsored kindergarten beginning at age two as well. One woman recalls her experience in China:

“The school there provided three meals for the kids, it’s pretty nice, then I sent her to the kindergarten, and when I came back from work my mother would be home and lunch would be ready, then I went back to work again, we got off work at 12 noon and went
back to work at 2pm. I would work until 6pm and then I would go pick up my kid. By that time, she was already fed.”

For comparison, another woman describes the experience of some of her immigrant co-workers who are working in factories in Canada:

“Those working in the factory leave home earlier than me, and they come home at around 7-8pm. How would they know where their kids go? That’s why many of their kids become delinquent. I’ve heard many stories like that, and a lot of families broke up because of financial problems.”

Acculturation stress was commonly seen in the sample on several levels. Almost every woman in the sample reported that she felt more comfortable having relationships within the Chinese community, which can be understood as a desire for affiliation, comfort communicating in one’s first language, and through shared physical and cultural spaces (i.e. churches, community organizations, workplaces). Language difficulty can make it difficult to integrate; interestingly, while only two women identified language difficulties as a stressor, five reported that their husbands lost job opportunities because of difficulties communicating in English.

Five of ten women described stresses directly related to navigating relationships with, as they described, “Westerners”. One woman described being teased after immigrating in high school: “it was not as bad because I knew some English at the time, but I would still get teasing sometimes…it’s also like because I’m Chinese and tease you about go home or something like that”. Another described the experience of being bullied by a Western customer at her place of employment. A third described a difficult situation with neighbours that escalated to police involvement and reflected on the cultural differences that she believed led to this situation:

“The front yard lawn close to garage was not trimmed. I was out of Canada…for more than a month, the grass grew fast in summer. Then I said, how come these people were so non-friendly, if you helped me trimming, I could I give you money, you did not have to get me a ticket. Gave me a fine of 400 dollars. Then I felt that it didn’t make sense to live around Westerners. You ate the large cherries for nothing. Really, ate a lot, and so heartless. Reported me to police for this. I moved later. Then I moved. I did not share
cherries with them. I called a friend and invited him to go to my home to pick cherries. I'd rather throw it away and not gave to neighbours. I thought you were so heartless, you reported the police. Just reported. Then I sold the house. Started to look for a place with more Chinese people.”

Another woman described acculturation stress that comes from “parachute” husbands as well as changing cultures:

“But after I came here, I met many women that are single. Some of them are not truly single, their husbands are like parachutes, many Chinese families are like that, their husbands are away doing business, and because they have business in China so they are able to commute often. But after all, everyone has needs, and especially with weather in here, the food is also different, so people have desires. A lot of foreigners look down on Chinese women, because they have husbands, and they are not able to stay alone, so they go out to look for other men. So here it’s like…it’s very messy if we look at it from the traditional Chinese perspective.”

5.3 Positive experiences of immigration

5.3.1 Improved social welfare

Although the expectation of improved social welfare and government programs held by all women in the sample was challenged in several ways post-immigration leading to stress, on balance, almost every woman identified that Canada provided a higher level of Government support than what was seen in China. Although the Canadian system was challenging to navigate and disappointing at times, in general, women held a positive view. In one woman’s words,

“I could analyze myself future in Canada. I need to decide whether I should stay in Canada or go back to China. I believe that Canada, the possibility of staying in Canada. If possible, I still want to stay in Canada. Because Canada, it has some things, especially those on immigration, humanity, in the humanitarian aspects…all good.”
As discussed earlier in this chapter, several women felt victimized by governmental institutions, specifically police, but on balance, as one woman described, social welfare programs were generally very good:

“I think it is better than China. But the government, the police are not friendly. However, in terms of welfare, and services are excellent. If you are not involved, not deal with the police, you would not encounter these things. If you occasionally run into this, if you have positive things that can replace it; you can resist it, that's OK.”

The Ontario Disability Support Program, or ODSP was seen as particularly valuable government programs. Four of ten women received financial support from ODSP, and while the support was certainly not perfect, it was seen as very helpful. Two women described having more freedom to not rely on their husbands for money. Another described how financial assistance helped her ease the financial burden of divorce. A fourth woman described the ways in which ODSP helped her feel happier and stabilized her life:

“Now I have ODSP, I am on welfare benefits, so my life is quite nice, but I’m not sure what I’ll be like without ODSP, I have to go out to get a job, and I don’t know if I’ll get involved in something or if I’ll experience any stress, or if I’ll get into something bad, I’m not sure, but at the moment I’m happy, I think I have made things clear, and I’m able to… I think I can, I think one thing that is good for me is that I am entitled to welfare, I used to think that it’s not good to be on welfare benefits, and I didn’t really care about it, but now I realized that it’s a very important thing.”

Government support, specifically ODSP benefits, held emotional meaning for one woman in the sample. She felt that the government saw her as valuable enough to help, leading to a more hopeful orientation and participation in the recovery process:

“I think that that was a consolation for me personally, as if the government were helping me. I should live, to survive. I should not give up on myself. I should actively cooperate with the treatment; I should actively cooperate with social workers. I should have good attitude.”
Employment Insurance (EI) was identified by one woman as being valuable in her recovery. She felt that by having the benefit of EI, she would not be forced into going back to a job that could potentially be destabilizing for her: “my EI will be almost ended, at that time I will find one…find a good one, I pick, I can be a little bit picky.”

Job retraining programs were identified by two women as being very helpful. It can be seen as a way to learn to navigate new culture when one does not have similar patterns, connections, contacts as in country of origin. One woman described a positive experience:

“At that time the government offered some training, helped you with any need you have. So I went to some workshops, and they taught us what to do in interviews, taught us how to write a resume, which did help me. I began to receive some responses, some responses for what I had sent out. I have been to two interviews.”

5.3.2  Greater agency to make life decisions

Eight of the ten women in this sample described ways in which immigration has led to greater choice in their lives. Although three women had poor experiences obtaining education and job retraining, four had very positive experiences in this field, and linked these experiences directly to feelings of having more choice in the workforce. One woman described her experiences with the Canadian education system compared to the one in China:

“I prefer the education here. Because in China, Liberal Arts and Science, it doesn’t matter you are good at it or not, you have to take. But here, you can choose your favorite program, and get high scores. In this way, you can determine your future major earlier, which is helpful in the long-term. In China usually you don’t know what you are good at even after you graduate from the university.”

She went on to link the ability to pursue a career of one’s choosing with a lack of adherence to the Chinese cultural value of “saving face”, allowing her to attend a college rather than a university:

“If talking about schooling, whether college, or university, I want to choose (redacted) because I want to work in this field in the future. Um, and then a senior student told me
that in Toronto, Toronto’s cultural environment, if not focusing on ‘saving face’, and going to a university, try to choose a college; because in that way, you can focus on your major. It’s easy to find a job in the future.”

Another woman described a future plan that involved changing careers by getting an education that will allow her to work in a field that she prefers over her current one:

Even a little less payment, at least I can handle these things. Then, just live like that. Upholding for a year and a half, accumulated to two years, then I’ll apply for the Permanent Resident Card. Then at that time I may not have to do this type of work. With the Open permit, I can do something else. Get the green card and go to a college, gradually it’ll be better

In addition to having greater agency with respect to education and career, five women described feeling that they have opportunities to take care of themselves rather than relying on romantic partners or family. In one woman’s words, “I believe that simple tasks, just my own, through my own work, I can live on my own, pay my own bills, I can get my own food and clothing. I have the extra things to help others.”

5.3.3 Better opportunities for future generations

Although nine of ten women faced many challenges in immigration process, five women noted that immigration provided greater opportunities for the next generation. One woman described that although she has suffered, her niece has done very well, which provides meaning to her:

“The little girl. my only, our sacrifice, it is the only good thing that my sister’s little girl has made achievement…The child is now in the elite school and has very good marks, outstanding. Canada, now is a child who was particularly educated by the Canadian government… So overall, overall, my contribution, my sister's contribution, suffering in Canada are for this child. We might not take any credit, but I didn’t want to leave them.”

In another poignant example, a mother who was unable to pursue her passion for art in order to study in a field determined by her parents discusses her own son’s love of art:
“He loves art ever since he was a young child um he always says he wants to become an artist um and ah in Grade 10 there was like a career choice um counselling and ah it turned out he wants to become an illustrator…um and he’s quite good in um in art itself so um yeah that’s, that’s what he’s taking”

5.4 Absence of immigration stress

Within the sample, it is important to note that one woman did not describe immigration as a particularly stressful experience. Although she did not have the youngest age of immigration within the sample, her family had few financial concerns and she felt as though she assimilated quite well in Canada. She described herself by saying, “I think I am a person who can quickly adapt to the environment, so the relocation didn’t bring any bad effects on me.” She was also able to attend school and build a social network of many friends who shared her cultural background, which she noted was beneficial to her. Interestingly, despite varying ages of immigration within the sample, this woman was the only one not to identify themes of difficulty with respect to immigration expectations and reality or other types of acculturation stress.
Chapter 6
Patterns of Distress and Experiences of Suicidal Behaviour

6 Patterns of Distress and Experiences of Suicidal Behaviour

This chapter will discuss the patterns of distress leading to suicidal behaviour described by the women in this sample. The focus will be on 1) precipitating factors; 2) characterizing the distress and its worsening over time; and 3) the ways in which the women make sense of their symptoms. The second part of the chapter will focus on the development of suicidal behaviour, focusing on 1) patterns of suicidal behaviour; and 2) the way suicide is constructed.

This pathway of distress leading to suicidal behaviour can be conceptualized as a model (Figure 2). Stressors lead to a build-up of "stress" and "pressure". Restricted patterns of emotional communication, lack of agency, recurrent patterns of victimization and oppression and gendered expectations contribute to a coping style focused on "endurance" of distress. However, enduring on one's own can lead to a negative view of self, physical manifestations of distress, worsening depressive symptoms and feelings of hopelessness. Eventually, the women come to a "breaking point" where they can no longer endure in this way, leading to suicidal behaviour that can be understood in three ways 1) as an escape from pain and distress 2) as a way to communicate distress and 3) as a consequence of pervasive hopelessness.
Figure 2: Model of Distress and Suicidal Behaviour

6.1 Conceptualizing “endurance”

The primacy of “endurance” as a coping strategy described by all ten women in this study forms the conceptual lynchpin in the model of distress and suicidal behaviour described in Figure 2. While Western interpretations of endurance focus on the ability to do something difficult or manage suffering over a long period of time, the women within this sample described endurance as well-established coping strategy that prioritizes suffering through difficulties on one’s own without showing distress. Their conception of endurance can be better understood as “ren”, the Confucian cultural value defined as enduring stress through civility, self-restraint and self-control (Yue, 1994).

The value and reliance on “endurance” can be linked with the five major themes discussed in Chapter 2, and comprises the main coping strategy used by these women in the face of stress and
pressure. The pressure to endure distress on one’s own was linked with restricted patterns of emotional communication. As emotional distress is not validated and met with limited warmth, the women attempt to endure or “push down” without asking for support, leading to feelings of isolation, loneliness, difficulty expressing anger and being overwhelmed. A perceived lack of agency in the family and social environment paired with experiences of victimization and oppression inform the conception of endurance. As women do not feel as though they have options to assert themselves or to overcome victimization, the only strategy left is to “let something pass”. Filial piety, which stresses the importance of the family over individual desires, prioritizes self-sacrifice and endurance over actively changing or challenging others.

In many situations, duty and obligation trump women’s’ own desires and interests. As described in Chapter 4, saying no, or refusing to meet role obligations, does not feel like an option to these women. This belief can make it difficult for women to navigate stressful situations and find alternate strategies of coping with distress. Finally, with respect to gender role pressures, traditional expectations for women are focused on a view of self as simple, fragile or weak. A perceived inability to cope with distress or to meet role obligations when distress leads to worsening feelings of inferiority and poor self-efficacy, making it difficult to do anything except suffer on one’s own.

In the next two sections of this chapter, focusing on patterns of distress and conceptions of suicidal behaviour, the role of “endurance” will be discussed in detail.

6.2 Pattern of distress

6.2.1 Precipitating factors

All ten women in the sample clearly identified a precipitating incident that they viewed as causally linked to the development of their distress. It is important to note that five of ten women describe a prior history of depressive symptoms and all five endorsed ongoing mild depressive symptoms; however all ten framed the episode of distress leading to suicidal behaviour as being triggered by a particular event or series of events. The events included work, financial or educational stress linked to immigration (seven cases), marital or romantic conflict, including infidelity, increasing conflict or emotional distance, and divorce or breakup (six cases), conflict
with family member other than romantic partner (five cases), medical issues (three cases) and illness and death of a parent (two cases). In all ten cases, more than one stressor was identified.

6.2.2 Characterizing the distress and its pattern over time

6.2.2.1 “I was living under extreme high level of stress”

Every woman in the sample described feeling as though they were under some type of stress in the context of the precipitating factors. Seven out of ten women used the word “stress” or “pressure” in describing their experiences during the precipitating factor or factors. One woman, describing managing her mother’s end of life care, stated “I must have a lot stress built up but I didn’t know it”. Another described several difficult incidents leading to feelings of stress: “two persons from my family died the second year I discovered that I got cancer. I was really stressed that year, then I found out my husband had an affair”. A third described going through a divorce and having financial and legal difficulties, stating “I was living under extreme high level of stress”. A fourth woman stated that even post-immigration, she could not escape family relationship conflict and work-related stress: “No matter where I go I can’t get rid of the pressure. At that time, our family and our work were a mess. There were so many things happening at the same time. A lot of pressure.” A fifth woman described feeling parental pressure about her academic performance: “Then my father wanted to give lectures. He wanted me to be great, great, great. Then gave me a lot of pressure; there were lots of pressure at school as well. Then a variety of pressure”. Finally, one woman described work-related stress post-immigration:

“Then I thought, after coming here, I felt, I suddenly felt a lot of pressure in life. Then I was very anxious. And then I started working, worked in any kind of factories. Then work was relatively heavy, and I never did that in China. So I felt that my life was completely different, facing high pressure.”

Each woman in this study described strategies that she would undertake to manage her distress. Thematically, the women focused on the value of self-endurance, and the belief that they were responsible for managing their difficulties on their own. As one woman related when discussing her relationship with her dying mother’s medical team: “I didn’t want to show them that I couldn’t handle it and I’m…so I, I, I would tell myself I have to be strong, I have to stay calm”.

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Another described feeling as though she could not discuss her issues with her parents or ask for help to manage the pressure: “my mother's idea is self-endurance, endure it by yourself”. As described in Chapter 4, the women describe histories of victimization and oppression and feelings of lack of agency, which contribute to a feeling that they are powerless and do not have options to manage their distress. A failure to “endure” the stress led to feelings of pain and second-guessing oneself; as one woman described, “I am now also very anxious, sometimes I also very painful. I do not understand how come I could not handle.” Attempts that were made to express distress to loved ones were often seen as unsuccessful, in keeping with patterns of restricted communication described in Chapter 4. One woman described feeling uncomfortable when she was told that she should not cry by her father:

“I was very uncomfortable while listening to him. Very sad. Wanted to cry. My tears would come up to here, and then I had to swallow it back like this. Because sometimes when he heard me crying he would rebuke me, and would not allow me to cry. ‘What are you crying about? If you cry again, why do you cry’. Then just cannot cry. Then I had to suppress the emotions. Very uncomfortable.”

6.2.3 The cycle of distress: Consequences and perpetuating factors

6.2.3.1 “Because I always couldn’t sleep, I was a mess”

As the women continued to manage building feelings of stress and pressure, they began to experience the development or worsening of symptoms associated with depression. Five women in the sample described an inability to fall asleep as a major early manifestation of stress and pressure. They described their difficulty sleeping in vivid terms and linked worsening of sleep with the onset or worsening of other depressive symptoms, hopelessness and functional impairment. The inability to fall asleep was linked by the women in the sample with feelings of being overwhelmed, anxiety, somatic symptoms, and feelings of despair and hopelessness. In one example, a woman described sleeplessness as an early manifestation of stress:

“I just thought that if my husband and I couldn’t get on well, we wouldn’t be happy living together. I am not sure if it was for that reason, and then my age was also… er… relatively… I was ageing… er… and I was transitioning into menopause. Maybe my
physical and psychological conditions had affected me, and then… er… gradually, somehow I started to have problem sleeping… I couldn’t fall asleep.”

She detailed the process by which the sleeplessness led to other forms of psychological and physical distress:

“I was really sleepless, I couldn’t sleep. They just started… Because I couldn’t sleep, I… my emotions and moods and whatnot all began to… to be different. Then I was… very scared. My thought was… at that time I always felt that I… I was dying. I couldn’t sleep. I felt terrible. I… I felt that every part of my body was sick. My entire body didn’t feel right…because I always couldn’t sleep, I was a mess. I couldn’t do anything, anything. I was just constantly…screaming, crying, or whatnot, or whatnot.”

Another woman described sleeplessness as early manifestation of her distress. After she took on a demanding work position, she noticed that she began to have difficulty falling asleep:

“I found that I could not sleep at all. Sleepless so I went to see the doctor, the doctor prescribed me some pills for sleep, and then I couldn’t stop it. Could not stop. Could not sleep. Sometimes I laid in bed for 2-3 hours and could not fall asleep. Even four hours and could not sleep. Because I had to work during the daytime, it was very, very hard.”

6.2.3.2 Experiences of depression: “I didn’t want to go out, didn’t want to see anyone, didn’t want to eat, didn’t want anything.”

When describing the events and emotional experiences leading up to engaging in suicidal behaviour, all ten women in the study described clear mood changes and depressive symptoms. Although mood symptoms were not directly elicited in the study, every woman interviewed described at least three symptoms associated with major depressive disorder (average 5.6, SD 1.6), and six of ten women self-identified as having experienced depression or having been “depressed”. Two women in the sample described themselves as being in a state of “sub-health” (Chinese translation); defined by one as “being in a mental state between clear and unclear” and described by the other as being “sick, was in the state of sub-health. Not defined by western medicine”.

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Five women described experiencing anhedonia, and were able to describe this symptom with great clarity. One woman described that she “completely lost the sense of fun. Was not able to, ordinary people may be able to feel that there are still lots of positive stuff in everyday life. But depression made you lose interests in anything.” Another reported that she “had no interest... I had no interest in anything. No interest. So I just felt like I didn’t know what to do.”

Feelings of guilt and shame were described by five women, and these feelings were related to not meeting role obligations in work and family as well as feeling guilty for being ill. One woman experienced great distress after being criticized by a family member for leaving her mother in China post-immigration. As the woman recalled, the family member stated, “Are you a dutiful daughter? A dutiful daughter would not go abroad without bringing your mother.” She related her emotional response: “Ah, well, I was mostly afraid to listen to these words, because I already felt very guilty”. Another woman was overwhelmed by feelings of guilt while depressed, reacting with self-blame when faced with even minor criticism: “Because at that time I was already belonged to a high-risk sensitive population. Then their action caused my feeling of guilt. I blamed myself. I was kind of person I would blame myself if anything happened. Even obviously I did not do much bad things”.

Difficulties with concentration were identified in five transcripts. One woman described that as pressure built up, she “couldn’t even concentrate, I couldn’t concentrate on neither studying nor working”. For another woman, “during that period of time I wouldn’t think of anything, wouldn’t think of anything. It was like nothing could go into my mind. I couldn’t concentrate on one thing. I couldn’t do anything.” Four women also described having low energy in the context of enduring stress.

Change in appetite was described in five cases. Two women described gastrointestinal distress when having to eat. Two others described losing their appetites, while a fifth noted that she felt very hungry but “didn’t have the energy to eat”.

6.2.3.3 Somatic symptoms

In addition to clear depressive symptoms, eight women described experiencing somatic manifestations that worsened as they continued to endure pressure and stress. One woman
described the physical manifestations of stress, stating, “I could feel that my blood was rising, and it’s like those described in the novels, it’s like there’s a source of heat inside of my body and it kept rising.” In the words of another woman, attempts to endure her distress over a long period of time led to feeling completely overwhelmed and physical shut down:

“I could not handle it anymore. I found that I couldn’t handle the workload. To be honest from the first day I felt that I could not cope. But I endured, and put up for more than nine months. In the end I really felt, I couldn’t get out of bed already with my willpower. I couldn’t get up.”

Another woman described feeling as though her entire body was in pain: “My whole body was in pain. Lying in bed with a headache, ache all over the body, as if I was it trapped”. A second woman also described debilitating headache and backaches.

Somatic symptoms of distress can also be understood in the context of anxiety or panic. One woman described classic symptoms of panic when faced with a stressor: “I was really stressed out that year, I couldn’t say I was stressed out…I should say I had too much attacks (打撃), it’s that kind of feeling”; I feel scared when I is agitated, I can’t breathe, I feel like my heart is jumping out, and it’s very upsetting.”

6.2.3.4 Functional impairment

Seven women within the sample described clear functional impairment attributed to build up of stress or pressure. As attempts are made to endure the stress and the symptoms that follow, they describe decline in function. As one woman related:

Later, gradually I became very lazy. I didn’t want to do anything or to think about anything. Always, sometimes, actually I couldn’t sleep, but I just sprawled on the bed not doing anything. I hoped that I could sleep, but I always couldn’t. I just stayed in bed …So later I felt that I had no… I just locked myself at home all the time. I just lay on my bed and did nothing. I just locked myself inside and lay on the bed all the time, every day. I remember that I did nothing.
6.2.3.5 Increased interpersonal sensitivity and social isolation

As stress and pressure built up, every woman in the sample described greater interpersonal sensitivity. As described in Chapter 2, eight of the women in the sample described themselves as simple, fragile, or weak, and nine women described a desire to avoid conflict in interpersonal relationships. One woman described her relationship with her husband as having stability because she would not say “no” to him: “I am the kind of person that wouldn’t say “No” easily” - It’s like there is no turbulence”. As discussed, women cited the importance of traditional cultural values with respect to “following” their husbands rather than creating conflict; in one woman’s words: “according to the original perspective, like the Chinese traditional one, everyone was telling me to follow the man I married to (嫁雞隨鴨 jiaji suiji).” Interestingly, the only woman in the sample who felt comfortable expressing anger in interpersonal relationships often described herself in male terms: “Not a girl, I was a boy. In my impression a boy could support the home. So I took care of my brother. My brother. In particular, he, my brother was spineless.”

As they continued to experience stress and pressure and increasing depressive symptoms, all ten women described increased interpersonal sensitivity within relationships. One woman described feeling extremely sensitive to the comments of others, which she attributed to depression:

“Because of depression, I had depression and could not control myself was at high risk and very sensitive, extremely sensitive. I couldn’t bear with it even if they just said one caring phrase. I thought that you did not understand me. It was easier said than done for all of you. You’ve gone too far. Also hurt me. Like that. I couldn’t handle it. They were concerned, but I think to people with depression, you really cannot treat them like treating average people, because people with depression are so sensitive, more sensitive than children, like little babies; if you don’t protect them with that kind of mind, they can easily get hurt.”

In six cases, increased interpersonal sensitivity in the context of enduring stressors and depressive symptoms was identified as causing greater interpersonal conflict. One woman described how in, the past, she would never dare to offend her friends, but as she became more depressed, she felt frustrated with the sacrifices she had made to make them happy:
“I did not want to talk to people. I felt that they were terrible. So gruesome. Then I think, maybe now I am better, but I would be mad at minor things. I could be so angry. And now I hate, I rarely hated people before. I have been, my feeling was that I had never dared to offend my friend. never dared to offend people around. Why? I made compromises, sacrificed a lot to make them all happy, but I actually felt frustrated.”

Another woman described how she began to alienate her friends and family by expressing anger towards them and linked these experiences to her ongoing distress:

“I feel besieged, it is possible because of my bad state of mind. Offended them all. In fact, I think people might unintentionally hurt me. but I may just feel that she hurt me on purpose. I may became clear afterwards, but at the moment I was not able to control. How could you become someone like this. How could you hate people so much?”

A third woman described feelings of anger leading to conflict with her husband that felt out of character for her, which she linked to mood changes:

“Soon my mood changed a lot…and also I became angry easily, it was easy to be angry, often throwing things, not normal, I didn’t feel normal. For example, once, I originally bought a new cell phone, applied for a new phone. I forgot my phone at school; left it in the washroom when I washed hands, then forgot to take it, someone stole it. After losing it, it was not a smart phone, just a regular phone, then my husband bought me a smart phone. Actually it was better. But I was not satisfied, I said why bought a phone like this, I wanted one exactly the same as the previous one. I said that this was not easy to use, I did not want it. Then, in fact, it was entirely unreasonable. Then he bought another one, because I quarreled with him all the time at home; he bought the same one, bought a similar phone, I began to feel bad, and I said that others used iPhone, Why should I use this phone? He said you did not want to use a smart one, and wanted this. Then I, do not know, every day fought with him regarding the phone, saying that this phone was not good, I did not want to use this phone. Then he bought me an iPhone. Maybe saying this way, it seems, I did not answer your question…but I really lost temper for that phone often, because I was not like that before. Because I would never insist on possessing on something.”
Five women within the sample described isolating themselves socially. One woman compared herself prior to symptom onset with her experience during the time of distress:

“Someone like me, I was very fond of making friends, having dinner with friends or having a party, I would say it’s my treat, we had fun together. But I just stayed at home, not even sitting upstairs, but sitting in the basement. Lights off, I could sit there since morning till my husband came back from workplace….I rarely went out with friends this year, before I went out several times every week. Went here to eat, went there to drink, had fun every day…now I am very reluctant to go out”.

In some cases, this isolation was linked to greater interpersonal sensitivity; one woman described feeling “more cynical” toward others and how this feeling created distance in her relationships with friends and family. In another case, a woman described being unable to enjoy social interaction and fearing that people would see her as sick or abnormal:

“I didn’t want to go out, didn’t want to see anyone, didn’t want to eat, didn’t want anything. Even when friends came to visit me, I didn’t want to… I didn’t see them. I almost… er… I just… er… when I… er… during the time when I was sick, I hadn’t gone out. I just locked myself at home, refused to go out. I was afraid to see people. I thought that I was sick, I was abnormal and whatnot.”

6.2.3.6 Poor sense of self-efficacy

As described earlier, eight women in the sample described themselves as being “simple”, “fragile” or “weak”. This self-image is informed by cultural conceptions of gender as well as lack of agency in life decisions and patterns of victimization and oppression. As the women attempt to endure distress and become increasingly symptomatic, seven out of ten experienced worsening self-image, particularly related to their perceived ability to cope with distress and feelings of inferiority.

Four women in the sample described feeling as though they were weak for being unable to endure their distress. This self-view of weakness led to poor self-image and fear that they would be unable to manage. One woman, dealing with the illness and death of her parents, focused on staying strong: “I would tell myself I have to be strong. I have to stay calm”. As she struggled to
cope, she began to feel increasingly incapable and hopeless. Another woman described being disappointed in herself for managing her depression by listening to music, and how this disappointment led to negative feelings about herself: “I immediately asked myself why I was so weak and then I felt disappointed with myself… and I was feeling a bit depressed, and I remember listening to songs for the entire night…and I think I was weak”. A third woman described developing feelings that she could not survive on her own as she was “very weak, very, very weak”:

“And then you became a very, very weak person; very fearful of this society, thinking that the people around, so many people, but no one was very close to me…At that time I felt that I was so lonely in this world; the world was so big and I was so small. How to survive in the future? I felt that I was very weak, very, very weak. Then I was not able, no way to survive on my own.”

Three women described worsening feelings of inferiority in the context of distress. One woman described that she had feelings of “extreme inferiority” and how they felt overwhelming: “I feel inferior that not only the appearance was gone, but also age is getting older; the youth age was gone; Got nothing. I had never succeeded on anything. It seemed that I am not slightly falling behind others. Seems too much.”

Another woman described how her world-view changed while depressed: “I just felt that life was meaningless; and probably I would not have a happy life anyways. I felt inferior to other people”. A third woman described the ways that her feelings of inferiority led to interpersonal difficulties and a negative view of the future after her boyfriend told her about a successful life event:

“One thing I did wrong was that he told me that he transferred to another university…and I thought that a normal girl should be happy for him. I was, I was all of a sudden started to cry, feeling inferior. I told him. Told him that if you are so great, then I could not be good enough for in my whole life.”
6.3 Models of suicidal behaviour: reaching a breaking point

6.3.1 Patterns of suicidal behaviour: “I took things too seriously and gave myself too much pressure. How could that not lead to something bad?”

In the earlier part of this chapter, a pattern of development of distress is described. Chinese women who have immigrated to Canada share life experiences of restricted patterns of emotional communication, lack of agency in decision making, patterns of victimization and oppression, and cultural and gender-based expectations. They identify one or more serious life stressors, including work/financial/educational stress related to immigration, marital and family stress, and medical issues, as causing a build-up of pressure and stress. The life experiences described above lead to a value of “endurance” which informs how these women attempt to manage the pressure and stress. As women attempt to endure their symptoms, they begin to experience difficulty sleeping, worsening depressive symptoms, and physical manifestations of distress. These difficulties make it increasingly difficult for women to endure, leading to functional impairment, increased interpersonal sensitivity and social isolation, and poor self-image. This section of the chapter will discuss how this cycle of greater difficulty to endure stress, worsening symptoms and increasing impairment leads to a “breaking point”. As it becomes impossible to endure any longer, the women begin to view suicidal behaviour as a strategy to break the cycle of distress.

It is important to note that the women described experiences of both impulsive and planned suicidal behaviour, with clear, ambivalent or no intent to die. Some women felt directly triggered by an external event; others could not identify a proximal trigger. However, thematically, all women described reaching a breaking point – an emotional state that required action to stop the cycle of distress. Prior to engaging in suicidal behaviour, the women describe four features: 1) worsening hopelessness; 2) increased frequency and intensity of suicidal ideation; 3) increasing emotional lability; and 4) experiences of worsening insomnia, psychomotor agitation or confusion.

6.3.1.1 Worsening hopelessness

Eight out of ten women described increasing feelings of hopelessness prior to suicidal behaviour, on a scale of minutes to days. Hopelessness manifested in several ways, and six women
described feeling hopeless in more than one of the domains described. Six women described a belief they would never feel better: as one woman described, “I thought… I … no one could save me, I was incurable.” In the words of another, “perhaps my life is too messed up, perhaps it’s at a point where things couldn’t be worse, so that’s really close to…close to those who contemplate suicide. Nothing can be worse than this”. A third woman described, “It was like that every day and I didn’t know what to do. So… I just really wanted to die. I just had that thought. I thought that nobody could help me”.

For four women, hopelessness manifested itself in a feeling that life was meaningless and there was no point in living: “I thought that life was boring and did not want to live anymore. Just like that, nothing else to say. Nothing really happened. Then asking me why I committed suicide. I really felt that it’s pointless to stay alive.”

Finally, six women described feeling hopeless in the context of disappointment with interpersonal relationships. One woman described worsening hopelessness after she discovered her husband had cheated on her while she had been physically ill and struggling with depression: “I should say that was the lowest point in my life, my husband did that to me, I felt there was no point, and because of that I thought about committing suicide”. Another woman described increasing hopelessness and suicidal ideation after her partner broke up with her because of her depressive symptoms: “I was particularly sad. All of a sudden became emotional. At that time I thought so if you did not value me, you thought this disease could not be cured, then why should I get treatment, then I treated myself very bad at that time”.

6.3.1.2 Increasing frequency and intensity of suicidal thoughts

Eight of ten women in the sample described having a past history of suicidal ideation, either in a previous time of stress or during their current episode. However, prior to engaging in suicidal behaviour, six described a clear intensification of suicidal thoughts at least several days prior to the act. Five women described having suicidal thoughts at several points throughout their lives, while two experienced these thoughts for the first time during their current episode of distress. For the other three women, the suicidal ideation was chronic and peaked acutely in the context of increasing hopelessness, emotional lability and agitation.
6.3.1.3 Increasing emotional lability

Eight women described feeling increasingly emotionally labile proximal to the episode of suicidal behaviour. In the words of one woman, increasing emotional instability preceded the development of worsening suicidal ideation: “soon my mood changed a lot, and then the suicide, very strong suicidal thoughts had emerged, then, and also I became angry easily, it was easy to be angry, often throwing things, not normal, I didn’t feel normal.” She also described rapidly shifting emotions that caused her to fear that she would harm herself: “Just, just I thought I might have the kind of impulse to, and I got moody, became very angry easily, very likely to be angry, and then sad, and in rotation, so I went there by myself.” Another woman linked increasing emotionality to suicidal behaviour: “I was, that morning…all of a sudden became somewhat emotional. Then I really wanted to cry. So much. Then, while my mom dropping the garbage downstairs, I cut on my wrist.” Another woman described how feeling emotionally unstable led to increasing thoughts of suicide: “Because you didn’t know my state of mind at the beginning. I was in tears all the time in front of my doctor. I simply could not control myself. I was simply unable to control my emotions”.

6.3.1.4 Insomnia, agitation and confusion

The final proximal sign prior to the onset of suicidal behaviour identified in this study is the worsening of insomnia and development of feelings of agitation and confusion. These feelings were identified in eight transcripts and were related specifically in five cases to an inability to fall asleep causing distress, leading to agitation and suicidal behaviour. While the suicidal behaviour appears impulsive, it is important to note that six women had described preexisting suicidal ideation over the several days or weeks that had been intensifying. Clear psychomotor agitation was described in four cases proximal to onset of suicidal behaviour. Feelings of confusion, identified as feelings of not knowing what to do or being unable to understand or control behaviour, were identified in four transcripts.

Five women described feeling increasingly disturbed by an inability to fall asleep. Difficulties in falling asleep were described as a clear proximal trigger to overdosing on sleeping medication. One woman described her experience of suicidal behaviour that occurred after the sleeping pills prescribed to her stopped working:
“I couldn’t sleep again after four or five days. Once I couldn’t sleep, I was more panic. I thought that I couldn’t sleep even if I had taken medicines. I was more….So I felt more hopeless. Suddenly on one morning, suddenly, it was on the morning of the fifth or the sixth day when I couldn’t fall asleep, I got up at around 4 o’clock in the morning. Then… then somehow I just really wanted to die. So I took a knife and walked out into the street, walked out into the street, walked to the street and thought that I… cut myself, I could cut myself to death, cut myself to death. However, I cut cut cut cut for a long time, I cut both of my hands/arms, but it didn’t work. Then I rushed onto the road, I wanted to run onto the road, rushed onto the road. But I didn’t dare to really walk onto it. I rushed to the road, but I didn’t hop onto it. I wanted to hop onto it, but I couldn’t. I just stayed there. I just couldn’t sleep, couldn’t sleep every night. I felt very painful. Very painful. The worst… in the worst moment I just kept thinking… I really wanted to commit suicide. I felt very painful, because suicide… because I couldn’t sleep.”

Other women described similar experiences. One woman described impulsively overdosing on sleeping pills as she could not fall asleep:

“Then at that time, it was just I had taken sleeping pills for two months, I could not sleep. I have to take sleeping pills to sleep. I took for about two months. Then the doctor just got me a new prescription, thirty tablets, for a month. I took three, there were 27 left. In fact I didn’t think much when I took that 27 tablets. I just thought, try it. Took it, after taking the, I felt good. Right. Hey, finally took, and finally did it. Very cool.”

A third woman provided an account of the way the stressor of her husband’s infidelity led to feelings of “emotional breakdown”. She attempted to endure, or “bear with” the distress over several months, but as her distress worsened she found herself at a breaking point, compounded by an inability to sleep. She also overdosed impulsively on sleeping pills:

“But I began to have an emotional break-down. Then I started to cry. But I did not commit suicide that day. I committed suicide probably in a few months. Then, because it was a very painful process. I could not bear with it any more after a few months, so just did it. I think that it was, at the beginning I felt that I could bear with it, although it was very painful and very, later on, the feeling was heavier and heavier every day. Then I
couldn’t withstand it. Then out of impulse. Just, um, because I had insomnia, then in Wujia… there is the ingredient of sleeping pills. I took all the pills. I feel very painful, very sad.”

The development and intensification of psychomotor agitation prior to the onset of suicidal behaviour was seen in four cases, on a scale of days to weeks. One woman described feeling agitation, which she linked to medication treatment, directly leading to suicidal behaviour: “the suicidal thoughts came back again and ah like I was very agitated, yeah. I, I don’t know if it’s the medication um and at that time I, I wanted to, to jump off the second floor um inside the house, yeah so this time I, I had a lot of injuries.”

Another woman describes increasing psychomotor agitation in the weeks prior to her experience of suicidal behaviour. She links this psychomotor agitation with a feeling of confusion, stating, “I didn’t know what to do…later I felt that I didn’t know what I could do at home. I just walked back and forth, walked back and forth, just walked back and forth. I didn’t know what to do, and just walked back and forth.”

A third woman described feeling increasingly restless prior to suicidal behaviour, stating “I could not sit still”. She also linked feelings of agitation with feeling confused and overwhelmed. As her attempts to endure become too much to handle, in the context of agitation and confusion, she engaged in suicidal behaviour:

“It's not what I can control. If in that state of mind, I could not hear anything…I think I suddenly got too much to handle… Yes, this time, just stabbed myself, stabbed myself. Then froze myself, in cold weather, wearing pyjama standing outside, I stayed cold”.

6.3.2 How is suicide constructed?

“I just couldn’t step out of the circle. I was trapped.”

The next section will discuss the ways in which the women in this study construct suicide. All three themes can be understood as an attempt to break the cycle of endurance and distress. Women reach a breaking point when the continuing to endure worsening symptoms become untenable, and suicide is constructed as a way to escape the pattern. Two women conceptualized
suicide using one of the three themes; three women used two, and three described aspects of all three. It is important to note that five women in the sample had more than one episode of suicidal behaviour; conceptualizations may differ based on the experiences of each within the same woman.

6.3.2.1 Suicide as escape from suffering

Seven women conceptualized suicide as providing a way to escape the suffering and pain that they had been enduring. These women described feeling emotionally overwhelmed proximal to suicidal behaviour and understood the behavior as a way to end suffering in the moment. With respect to their thoughts prior to suicidal behaviour, women used descriptors in keeping with feeling overwhelmed and unable to cope, or under the influence of escalating distress. One woman described feeling as though she “couldn’t handle things”. Another described feeling “under the influence of bad emotion”. A third stated that she felt “out of control, couldn’t handle that”. A fourth described feeling that she could not “bear with” the pain any longer; she stated: “Because there were a lot of emotions, and then I thought I had to do it. It could not wait, just wanted, just, just wanted to end my life. That really could not wait, just wanted immediate relief.” She described being overtaken by her pain and harming herself impulsively: “Then I couldn’t withstand it. Then out of impulse.”

Although six of the seven women described having suicidal thoughts prior to the suicidal behaviour, they described a rapid escalation of suicidal thoughts in the context of sleeplessness or worsening emotional distress. The behaviour was impulsive in the sense that the women had not planned to engage in this behaviour prior to the escalation of distress. As one woman describes, “I felt very helpless. I couldn’t handle things, I um and I couldn’t sleep well so I, I had things um sleeping pills just sitting in the drawer so I decided to ah just take the whole bottle”. Another woman described how sleeplessness led to “the worst moment”: “I just couldn’t sleep, couldn’t sleep every night. I felt very painful. Very painful. The worst… in the worst moment I just kept thinking… I really wanted to commit suicide. I felt very painful, because suicide… because I couldn’t sleep.”

Another described feeling overwhelmed by emotion that was too painful to endure, leading to behaviour that was not “normal”:
“I stabbed myself, because it was too painful so I stabbed yourself. But it's not what I can control. If in that state of mind, I could not hear anything. Now you talk to me, I think right right right, yes yes yes. In these circumstances, it would not be alright. But after the emotional moment is over, I become normal again.”

One woman described the Chinese singer Chen Lin, who died by suicide after jumping from a building in 2009, and relates the experience to her own:

“I understood why Chen Lin chose this way. This way is the best relief. Nothing to worry. No bother, right? All the troubles, right. It is definitely gone. Why should I suffer so much, so painful, so much pain. I took a look of the ground, cement. Cement. It would be nice if I could drop on the ground. It would be over. As during those days, I liked to go to the balcony and looked down. I felt stimulated. There was terrace windows, French windows, sealed, and I thought that, breaking it by kicking, sitting on the swivel chair and bumping it and breaking out. Thinking about the excitement. I felt, what a relief. Big relief. I was excited when I was in the balcony. Oh really easy. Just went down, happy, that could be happy…the feeling was uncontrollable, kept thinking, uncontrollable just wanted to move forward. I felt that that would be thoroughly happy. There would be no pain. Or, I was too painful. Painful every day. Was a kind of impulse. I also thought that, because the hotel’s balcony was closed. I tried to open, this and that. I thought if I could open it, then I would be so happy. Like there was something pulling me, and I wanted to move forward.”

6.3.2.2 Suicide as a strategy to communicate interpersonal distress

Eight women described suicidal behaviour as a strategy to communicate interpersonal distress. In five of eight cases, the women described that they did not have a clear intent to die; however, all women felt under stress and pressure and had depressive symptoms prior to the event, and all but one had been experiencing ongoing suicidal ideation. In five cases, the women described conflict within romantic relationships, and in all five cases, the women described the ways in which they attempted to be supportive partners and feelings of being unappreciated or being treated without respect, and all five women described significant difficulties in emotional communication with their partners. One of the women described suicidal behaviour in the context of conflict with her
son, and she also described themes of feeling undervalued and described at length the sacrifices she had made for him. Two others described conflict with parents and feelings of powerlessness and anger associated with this. The last woman in the sample described ongoing conflict with her family of origin and anger specifically related to feeling undervalued and disrespected. One woman described conflicts in two domains. It is important to note that every woman within the sample described greater interpersonal sensitivity as a consequence of ongoing distress, which may relate to greater interpersonal conflict within their relationships.

Two women described the desire to show her husbands, who had extramarital affairs, the extent of their distress related to the behaviour. In both cases, the behaviour came several months after the stressor, as the women had attempted to endure the distress and had both stated that there was very little communication or validation of their distress about the affairs. As one woman described:

“I actually didn’t think about taking my life that day, I only wanted to hurt myself. I told my doctor about this as well. I researched online, the amount of pills I took wouldn’t kill me, no not that the pills wouldn’t kill me but the dose that I took wouldn’t take my life, people from the ER could save me for sure, it like…I think…I can’t say if I’m punishing him or punishing myself, but I guess both of us were punished. I punished myself, and he got punished, it’s this kind of feeling. It’s from that moment on, he felt like this is something big.”

The other woman described a similar experience:

“My first hospitalization (following an episode of suicidal behaviour) was because my husband had an affair. It was a big blow to me; I thought that the relationship cannot be trusted. There is no real love in the world. I did a lot for him. So for me, it was not acceptable.”

Three women in the sample described engaging in suicidal behaviour after their partners ended the relationships. One woman described her experience:

“My boyfriend wanted to break up with me. Because he said I had depression; he said, ‘because depression is incurable’. I thought that he was not respectful to me. Then I was
particularly sad. All of a sudden became emotional. At that time I thought so if you did not value me, you thought this disease could not be cured, then why should I get treatment, then I treated myself very bad at that time.”

One woman in the sample described her increasing distress related to her son’s poor school performance. She described how intolerable this was to her, and how in spite of her best efforts the situation was getting worse rather than improving. She harmed herself in front of him after finding out he had not attended class for one week:

“So I asked him about that, and the only positive thing was he didn’t get into troubles with other people. He’s just playing computer games at home. But that’s a big issue for me and I couldn’t take it. After all, I was a teacher in China, for me, it’s big already to miss a class, not to say missing school for the entire week. That had never happened to him before. I couldn’t take it at that time. I said if I could fly I would fly away, or if I could hide under the ground I would hide myself. I really couldn’t take it. So that’s why at that time I cried and I repeatedly banged my head against ground until I felt dizzy. He was scared and he screamed loud. But what could I do? He held me and he shook me.”

Finally, two women in the sample described suicidal behaviour as directly related to feeling oppressed in their relationships with their fathers. One woman described her wish to punish her father through her death:

“Why did I want to die so much? Why did I want to get a cancer? During that time I cursed myself every day, every day, especially wanted to get a cancer. I thought that if I got a cancer, then you would know how much you owed me. You see, I actually wanted to have a cancer or die, so that they could feel a little guilty for me. So them would know they were wrong. It’s ridiculous, but really I thought that way. It was a bit abnormal. I wanted to die because, in order to giving him a sense of guilt. For a while totally no guilt to me. Simply did not really care. Because if I were dead, I just died.”

6.3.2.3 Suicide as a strategy to end a hopeless life

Six women in the sample described suicide as a way to end a “pointless”, “meaningless”, “hopeless” or “boring” life. As they continued to endure distress, they became increasingly
hopeless about the future and conceptualized suicide as a strategy to end their lives. Interestingly, the behaviour described in these situations was planned in four of six cases rather than as the result of impulsivity.

One woman described her experience of having chronic suicidal thoughts, and getting to a point where she “didn’t care”, in spite of support from friends and family and reconciliation with her husband:

“I felt there was no point, and because of that I thought about committing suicide. Before that I felt that life was boring (没意思), I thought about ending my own life, but I have never... I just thought about it, I felt that life was boring, “what is the meaning of life” I always question the meaning of life, I did not have an answer. That didn’t last very long, because...he kept apologizing, I rented a room in an apartment, and then he quickly rented another place near me, his attitude was pretty good, and then my housemate he is a Christian and he kept persuading me, my friends were also persuading me, and then I felt like...I didn’t know what to do, it was at that point that I thought of killing myself I didn’t care.”

Another woman used similar language to describe her own experience of suicidal behaviour, and her husband’s reaction:

“I already had depression by then. I just felt that life was meaningless; and probably I would not have a happy life anyways. I felt inferior to other people, and there was pointless of living. I just did not want to live anymore. Then he, he felt it was very strange why there is this idea, he felt as if, nothing happened and why you got this idea. There were not huge sudden changes in life. Everyone had a calm life, why you suddenly did so...I thought that life was boring and did not want to live anymore. Just like that, nothing else to say. Nothing really happened. Then asking me why I committed suicide. I really felt that it’s pointless to stay alive.”

Another woman described a belief that “freedom comes in many dimensions”. She felt that it was “useless” to study, to try to find a romantic partner, or to move forward in her life. She
described a view that death by suicide can be a “sophisticated” choice, referring to Sanmao, a popular Chinese writer who died by suicide:

“Sanmao’s writings have a great impact on my life, look at her, she committed suicide at the end, and she was really upset after her husband died, but her work really influenced me a lot, I still read her work from time to time. She lived well in Sahara Desert…not that she was rich, but she lived well and lived romantically in the desert. I think only those who are sophisticated can do that. I think I can do that too.”

One woman’s hopelessness was not only related to her depressive symptoms. She described distress in the context of feeling powerless and vulnerable to those in power:

“Everyone, all people think that, oh you're more stupid than me, I can exploit you…It did not make sense to work hard. You cannot make the society better; you cannot let yourself get better; so what’s the meaning of your life? meaningless. I would rather die early. I often think in this way…I also earnestly try to overcome various difficulties, a variety of problems from all aspects. I strive to make a normal, had a normal life, but so far, I indeed had not had a normal life. I do not even have basic human rights, or the basic female power. I do not know who can help me, so I chose to commit suicide many times.”

6.4 Summary

Pathways of distress and suicidal behaviour can be understood as a model focusing on precipitating stressors, failed attempts to “endure” these stressors, and the consequences of an inability to cope, including feelings of inferiority, physical manifestations of distress, worsening depressive symptoms and feelings of hopelessness. Eventually, the women come to a “breaking point” where they can no longer endure, associated with increasing hopelessness, worsening suicidal ideation, increasing emotional lability and confusion, insomnia or agitation. Suicidal behaviour that can be conceptualized as an attempt to break the cycle in one of three ways 1) an escape from pain and distress 2) a way to communicate distress and 3) as a consequence of pervasive hopelessness.
Chapter 7:
Experiences of Mental Health Care

7 Experiences of Mental Health Care

A key role for this study is to examine the experiences of Chinese-Canadian women with a history of suicidal behaviour in order to determine 1) pathways of access to care and 2) experiences of the care received. It is important to note that this sample was recruited from patients who have accessed mental health services through the emergency department and / or have access to regular psychiatric care. As such, the sample may not be representative of all Chinese-Canadian women with a history of suicidal behaviour.

7.1 Access to care

Two major pathways of care were described by the women in this study: 1) visiting family physician for evaluation of physical symptoms related to distress and 2) accessing psychiatric care through the emergency department post-suicidal behaviour.

7.1.1 The key role of primary care in accessing mental health services

7.1.1.1 Presenting to primary care with physical manifestations of distress

Six of the ten women in the sample presented to their family physician for assessment of physical symptoms, including insomnia, chronic pain and exhaustion. For five of the six, they did not appreciate that these symptoms were related to mental health and were seeking evaluation and treatment of the physical issues. Although insomnia can be considered a psychiatric symptom, the women conceptualized it in a physical framework and were seeking a medical work-up. In the words of one woman who struggled with insomnia and exhaustion, “I thought maybe I was sick. Then I went to see the doctor. I saw a doctor in a walk-in clinic, 7-8 tubes of blood were withdrawn, and the result was no problem with indicators.” Another woman described being taken to a physician by her mother, who was seeking an explanation for her physical symptoms: “I was always a little tired, with some headache and backache like that. But there was no physiological symptoms. Then my mom went to see the doctor, and said why this child had no physical illness, but kept having some minor problems”. 
In three cases, the family physician was able to pick up on potential mood and anxiety symptoms. In one case, the doctor asked about life stressors; in another, the family doctor provided an explanatory model for the patient: “the doctor checked me and said that might be too much stress. If it was stress you would be referred to psychiatry. Might be mental problems reflected in the physical way”. Family physicians in two cases made referrals to a psychiatrist.

7.1.1.2 Shortcomings in the care provided by family physicians

In four cases, women were given sedatives to treat insomnia without being asked about other mood symptoms. In a fifth, a woman was asked about mood symptoms but denied these for fear of appearing as though she had a “psychological problem”. Another woman had the experience of being told that her insomnia was her own difficulty and must be managed on her own. Her family physician told her that she must depend on herself to solve this problem. He indicated that it was her responsibility to improve sleep, and provided her with “mild” sedatives without screening her for depression or anxiety.

“The doctor said he wasn’t able to help me… uh… he said that this depended on yourself. The only thing he could help me was to give me a physical examination, to see if I had any problem physically. After the physical examination the doctor found that I was fine. The doctor said, when I slept, I should relax myself, or think of my own ways to sleep. After that I had been unable to… had been unable to sleep, yeah, really unable to sleep. I stayed awake throughout the nights. I was like that for a while. I asked the doctor to give me medicines, and he… er… he could only give me some mild ones.”

All six of these women were prescribed medication for sleep, and four described distress that these medications did not work or stopped working after a few days. None described returning to their family physician or walk-in clinic, and none described being scheduled for a follow-up appointment to monitor the effects of the medication. Chapter 6 described how insomnia, and specifically distress related to ineffectiveness of using sleeping pills as prescribed, was a direct precipitant to suicidal behaviour. Further, prescribed sleeping pills were used as a method for suicidal behaviour in half the cases in the sample.
7.1.1.3 Patient and family factors impacting family physicians’ ability to provide mental health care

Four women described ambivalent feelings in disclosing symptoms of depression, anxiety or “stress” to their health care provider. This ambivalence can be because of personal concern about being identified as ill, or concern about being identified as having a psychological problem. As one woman stated, “when I heard the doctor told me that it might be psychological reasons, I thought I was in big trouble…I’d rather to get sick; I’d rather to have a cancer in the body and I would be fine with it”. Family attitudes are also very important; in previous experiences, family might have stated that they did not believe or validate the woman’s experience. One woman describes an interaction with her father: “he did not believe me. He didn’t believe my words no matter what. He assumed that it was for attention seeking. I was obviously sick, but he said you were not”. Another woman described a relationship ending due to stigma as her partner stopped speaking to her after she disclosed she has a history of depression; this experience made her feel hopeless and less likely to get care. After her boyfriend’s mother told him that depression was not treatable, he ended the relationship, in the words of the woman, “Because he said I had depression; he said, ‘because depression is incurable’. I thought that he was not respectful to me. Then I was particularly sad. All of a sudden became emotional. At that time I thought so if you did not value me, you thought this disease could not be cured, then why should I get treatment, then I treated myself very bad at that time.”

The interplay between stigma and invalidating emotional communication can make a woman less likely to believe that she is ill or believe that treatment will be effective. It can also prevent her from following through on medication recommendations. One woman described how her husband did not want her to use medication for sleep: “But my husband… I told him, but he didn’t… he didn’t think… he didn’t believe it. He didn’t approve of me taking medicines, so I didn’t take the meds.”

Finally, one woman described a worry that seeking treatment for her mental health issues could result in resentment and anger towards others in her life, which could potentially compromise her
view of herself, stating, “as if there was a breakthrough, I could be resentful. I had never been resentful towards anyone in my life”.

7.1.1.4 Health system factors that interfere in access to mental health care through family physicians

Four women within the sample described significant delays in obtaining mental health care after symptoms of depression or anxiety were identified by a primary care provider. The family physician is presented as a gatekeeper for care, and women described distress specifically related to not being able to see a psychiatrist in a timely fashion in the health care system. As one woman stated,

“I haven’t completely, because I have not fully understood the system in Canada; not yet fully understood the government. So currently that is, you see, I used to have a doctor, a family doctor, I wanted to make an appointment with a psychiatrist, for about three or four years, already. Let me see, 2006, 2008, started to ask for a psychiatrist in 2008 or 2009, and didn’t get one.”

Another woman described having much easier access to care when she returned to China, underscoring her difficulties in obtaining timely services in Canada. In China, she reflected, “you can go to see the specialists right away, as soon as you book for them. But it isn’t the case here. You have to wait. There you can see them right away as long as you pay.” In contrast, she described her experience in Canada as she and her husband attempted to secure mental health care:

“(We) often went to our family doctor and asked if they could recommend some specialists…our family doctor said that if we wanted to see a specialist, we couldn’t go there directly. We had to make an appointment and wait in the queue. Then we said please made an appointment for us. But at that time we had to wait in the queue for at least a few months.”
7.1.2 Accessing mental health care through the emergency department post-suicidal behaviour

Nine out of ten women in the sample were hospitalized for risk of suicide or post-suicidal behaviour at some point during their lives, and seven of the ten were connected with specialized mental health care services for the first time following an episode of suicidal behaviour that resulted in hospitalization. Seven of ten required some form of medical treatment and were admitted for a psychiatric inpatient hospitalization thereafter; in one case, she presented to the ED after disclosing suicidal behaviour to her mother and guidance counsellor and did not require medical intervention and was admitted directly to the psychiatric unit. None of the women had presented to the emergency department for mental health support prior to engaging in suicidal behaviour in their initial presentation. However, of the six women with more than one mental health hospitalization, four had brought themselves to the emergency department prior to engaging in suicidal behaviour following the index presentation.

7.2 Experiences of mental health care

7.2.1 Experiences of hospitalization

As stated earlier, nine of ten women in this sample had at least one experience of mental health hospitalization. When reflecting on these experiences, the women described ambivalent feelings towards hospitalization – on one hand, six women held a view that hospitalization was a stressful experience whose only goal was to prevent imminent suicide risk and held very little benefit otherwise, and on the other hand, five women held a belief that hospitalization can be a way to keep oneself safe from self-harm when in crisis. Taking both together, it was clear that hospitalization was conceptualized as a strategy to prevent suicide in the short term, but was not seen as a beneficial strategy to reduce symptoms or facilitate recovery. Women also described the ways in which hospitalization engendered feelings of victimization and oppression. In this way, hospitalization can be conceptualized as an event that has the potential to reproduce previous stressful life experiences in this population.

7.2.1.1 Goal of hospitalization: suicide prevention rather than recovery
"I think they just wanted to make sure that I did not have suicidal thoughts, not die there, then that’s it."

The previous quote describes one woman’s experience of hospitalization, and encapsulates feelings held by six women in the study. Several women described feeling as though the prevention of suicide was paramount for those treating them, and expressed frustration and several other aspects of hospitalization that they felt were unhelpful and even distressing. Several women described feeling like “nothing happened” during their admissions, and once the team felt they would not harm themselves, they were discharged: as one woman described her experience post-overdose: “I was taken to the hospital but they didn’t really do anything and then I was released (after two days).” Another, when asked to describe her experience, replied: “Nothing happened; just was kept there 11 days. Nothing happened”. No woman described a demonstrable benefit to her mood following her first discharge from hospital; as one described, “finally, after one week, I went out. But after I was discharged, I didn’t feel well during that period of time.”

While every woman in the sample described her first hospitalization as a negative experience, it is important to note that it was also seen as a way to keep people who are risk safe from suicidal behaviour. For one woman, a desire to avoid re-hospitalization also served a protective function:

“I couldn’t live in the hospital. It was too uncomfortable, I didn’t want, sometimes I was a little afraid to commit suicide, just because I did not want to be sent to that place again. That place was too bored. I was almost sick before of that.”

Five women in the sample described returning to hospital when they were feeling distressed or unsafe in the moment. They described the hospital as a place they could go when they are, in the words of one woman, in “really bad shape”. In another woman’s words, she used the emergency department and subsequent admission to hospital as a strategy to keep herself safe until the feelings passed:

“The first two times needed emergency. The third was that I felt that I might be in danger, and I went to hospital in a normal and healthy state. Just, just I thought I might
have the kind of impulse to, and I got moody, became very angry easily, very likely to be angry, and then sad, and in rotation, so I went there by myself.”

Similarly, a third woman described the utility of going to the emergency department and short-term hospitalization as a strategy to manage unstable emotions and feeling “out of control”:

“Out of control. Cannot handle it. Who wants this. I stabbed myself, because it was too painful so I stabbed yourself. But it's not what I can control. If in that state of mind, I could not hear anything…but after the emotional moment is over, I become normal again. Playing, having fun.”

### 7.2.1.2 Re-experiencing victimization and oppression during hospitalization

Many of the stressors described by the women in the sample are difficulties that are common to almost all people experiencing a psychiatric hospitalization. For example, one woman described anxiety related to her co-clients on the inpatient unit: “just looking at the other patients, I felt even more anxious.” Several women described the unit itself as uncomfortable, unclean, and generally stressful. It is important to note, however, that several of the examples of stress provided were consistent with previous life experiences of victimization and oppression. It is important to note that a description of these experiences is not an indictment of the care provided; rather, it serves to highlight the ways in which past experiences of victimization and oppression can inform emotional experiences related to hospitalization.

Six women described feeling trapped or stuck during the inpatient hospitalization. One woman described that she spend her days being “kept in a small room”, unable to use the internet or keep in touch with family members. A second woman described her distress as a nurse with whom she was working did not allow her access to her mp3 player: “the hospital didn’t allow anything, telephone, cell phone and mp3, all not allowed. Did not allowed us to listen to songs. No, no electronics. Unbearable…later, she saw my mp3, and took it. I was not happy. I said I wanted mp3. I wanted to listen to music, I felt bad. I was a little demanding. She did not give me. She would not give me.”
One woman described stress in navigating relationships with health care providers in hospital. She described doctors as holding the unilateral power to discharge, and was troubled by a difficult experience with a nurse that led to negative feelings. In this section, she noted that she felt mistreated and punished by not being allowed to be discharged:

“Most nurses were nice, but there was a nurse who treated me bad. Once they, for the medicine I took every day, I heard from somewhere, and I asked the nurse, did the medicine have side effects? She said, ‘so you do not want to take it?’ In English, the meaning was, you didn’t want to take it, right? I said that if this medicine had side effects, I would not want to take it. I said I did not want to take it. She said Okay, you don’t take it. I would talk to your doctor. You could ask her about the side effects; you can also google, to search. Then she take away the medicine. She said you did not take it. I said that I would not take it. Took it away. Then she told my doctor, and she told my doctor that. After telling my doctor then it seemed that I would not be discharged.”

Later, this same woman had difficulties with a nurse, who reported them back to a doctor. In this encounter, the woman described feeling like she was not a citizen: “Then she told the doctor, said that my manner was not good. The doctor talked to me, said ‘you wanted to go home, I can discharge you’. Because after all, I was not, what is that, a citizen, right? I was just a general labour.”

7.2.2 Experiences of outpatient mental health care

All ten women in this study were or had been engaged in long-term mental health care with a psychiatrist in the community. Six had interdisciplinary support while four were seen only by a psychiatrist. Their experiences highlighted several key aspects to quality mental health care: 1) the development of an explanatory model that validates emotional experience and instills hope 2) medication treatment as an evolving process 3) social support and engagement 4) instrumental support 5) awareness and sensitivity to cultural issues and support in the navigation of family relationships.
7.2.2.1 Development of an explanatory model that validates emotional experience and instills hope

By the time all ten women in the sample were able to access mental health care, they were experiencing significant depressive symptoms and feelings of hopelessness. These feelings of hopelessness led to difficulty engaging in mental health care. As one woman described her first meeting with her psychiatrist: “When I first met that doctor, I just told him frankly that I wanted to commit suicide, and I didn’t want this, didn’t want that. I thought… I … no one could save me, I was incurable.” For this woman, her symptoms made it difficult to engage with her psychiatrist: “I didn’t understand anything, didn’t want to listen to anyone, and didn’t want to accept anything. I didn’t want to… go to see the doctor at all.”

The development of an explanatory model to understand their experiences was described as a benefit to engaging in mental health care and important factor in recovery. The development of the explanatory model happens in two ways: 1, by providing education about mental health diagnoses and how it applies to the patient’s life and 2, to validate the patient’s emotions over their life history to help them understand how their experiences contributed to their current distress.

Mental health care providers, and in this case, especially physicians, who are charged with making diagnoses, validated distress by acknowledging the severity of symptoms, and used diagnosis to create a model for which the women could better understand their experiences. One woman described her physician’s conception of her as having a “serious condition”: “At the beginning he also thought my condition was very serious, because at that time I was… I was… a mess.” Another woman described how her doctor was able to reframe the last ten years of her life as having been suffering from depression: “The doctor said it seemed that I had 10 years of depression, so my body was like this. The doctor said it has been a long time, 10 years, at least 10 years. Then I looked back, yes, I felt depressed during adolescent years. Depressed everyday.”

Mental health care providers also supported women in constructing an explanatory model that allowed them to understand their distress by reflecting on their life histories. This validation through a life history approach can be understood as co-constructing a new narrative that shifts
the woman from the role of victim to the role of a strong person who has agency in her life. For example, one woman described her psychiatrist’s reflection on the difficulties she has faced in her life, which led her to feel that she could try to change her own status:

“Dr. X said, wow, ‘I have seen so many cases, but I have never heard such a tragic story. How could everything (have) happened to you?’ I said I did not know. I now wonder, I just think, I also try to change my own status; I also try to think that I should have a better life; I tried not to commit suicide.”

By working with mental health care providers, women discussed that they were better able to understand their experiences by engaging in self-reflection, or, in the words of one woman, “analyzing myself as a doctor would”. Another woman described that through the process of reflecting on her life history with her psychiatrist, she was able to understand her symptoms in the context of her past experiences: “maybe this was a cumulative result of many problems over the years. It could be. My counselor has also analyzed this with me.” She also described a meeting with a physician who helped frame her physical symptoms in the context of psychological distress and life stressors. She also reflected on the need to “let go and relax” rather than enduring the stress:

“S/he also thought that there had been something… some stress that I endured, bore and didn’t release. After a long time, this kind of… this kind of issue would occur. S/he said this, and I am not sure if this was what happened in my case. Because every time when something happened, I always stayed quiet and … er… endured it and whatnot. It was always like this. Because I didn’t want… arguments, a home full of fights and arguments, so when I was unhappy, I always bore it by myself. I don’t know whether it was because of this, and plus I was ageing. I couldn’t stand it anymore. In addition, at home… er… my husband and I had some problems. I couldn’t find a job. There were so many things to worry about. So gradually I had this kind of issue. After all these, I told myself that I needed to let go and relax. I need to let go. Don’t think about these things… don’t think about the unhappy things”

As one woman described, her psychiatrist “always encourages me, he said you can change the way of thinking.” Through the encouragement of self-reflection and the validation of suffering,
mental health care supported the women to change their way of thinking about themselves and to consider other options, thus encouraging a sense of agency.

7.2.2.2 “When I could sleep again, I just felt that I had hope again”: Medication treatment as an evolving process

All ten women in the sample were currently taking psychiatric medication or had done so in the past. Seven of the ten indicated that the medications were eventually helpful in improving their symptoms, but that medication treatment on its own was not sufficient to manage their distress completely or to return them to their previous level of functioning. Rather than a fast-acting cure for distress, medication management was seen as an ongoing process between the woman and her physician in order to balance improvement of symptoms with introduction of side effects. Medication management was seen as an important piece in the recovery process, but not sufficient on its own.

The first step described in the medication treatment process involves creating a supportive relationship between the physician and patient. Medication treatment can be difficult to initiate for several identified reasons, including feelings that medication treatment would not be helpful, negative family attitudes toward medication, previous negative experiences with medication, and hopelessness. A positive supportive, longitudinal therapeutic relationship between the physician and the patient can help manage these issues. In one striking case, a woman was admitted three times for suicidal ideation and behaviour but did not take medication following discharge. She noted that her psychiatrist met with her regularly in order to convince her to take medication, which led to stabilization:

“After being hospitalized, my depression was very severe already, but I did not want to take medicine. The doctor prescribed me medicine, but I did not take on time. Soon my mood changed a lot, and then the suicide, very strong suicidal thoughts had emerged, then, and also I became angry easily, it was easy to be angry, often throwing things, not normal, I didn’t feel normal. So immediately I went to the hospital, the third time. After the third time discharge, I did not take medicine. By then I was severe, cried every day, very desperate, then, and also trying to lie on rails… Later, I started to see (her
psychiatrist). He spent a long time to persuade me to take medicine, and then I started to take medicine every day. Now it’s stabilized.”

The second important step in medication management involves frequent reassessment of symptoms in order to optimize benefits and minimize side-effects. While seven women identified a benefit to taking medication, five described that this benefit took time and required adjusting to find the right treatment. This speaks to the need for longitudinal follow up and adjustment of medications to find the right combination. As one woman related,

“Then after taking the medicines for several months, gradually I felt like I was… I was more peaceful. I had the feeling of peace. My thoughts were less messy. My conditions of not willing to do anything and of not willing to listen to anyone were relieved. So I took (the medicines) for a number of months, for a few months, then I … actually I started to… uh… Dr Y modified his prescriptions. He let me try the medicines, and then he modified the prescriptions according to my conditions. He then modified it until they fit. I started to feel more peaceful.”

Six women within the sample paid particular attention to the difficulties in finding a balance between insomnia and over-sedation. Sleep difficulties were seen as a major contributor to distress, and the management of insomnia was linked with overall symptom improvement. As one woman described,

“When I first started to take the medicines, I felt it still didn’t work. I still couldn’t sleep. I kept taking the medicines and later I started to feel that I could sleep again. I could sleep again. I felt that I had been unable to sleep for a long long time, but suddenly I could sleep, and I felt that I was completely different. I started… started to feel that I was much better. I used to feel that I had a lot of health problems. I always thought that I had a lot of problems, and there was no way to fix them. When I started to be able to sleep, I felt so comfortable. I started to feel much better…because most importantly I could sleep. When I could sleep again, I just felt that I had hope again”.

While sleep improvement was identified as a major factor in symptom improvement, over-sedation and over-reliance on sedative medication was also identified by four women as a major
difficulty. In one woman’s words, her mood remained low as she traded insomnia for over-sedation:

“I took medicine at that time, I was so uncomfortable, I was sleepy every day. I went there and began to sleep, slept until the end. Sleeping like that. Then I felt sleepy. I still felt depressed”.

For another woman, she initially had some benefit from sleeping pills, but this benefit wore off, leading to medication overuse and feeling that there is nothing else she can do to alleviate these symptoms:

“Now I'm basically, sleepless at least two or three days per week. Relying on sleeping pills, sleeping pills in fact sometimes do not work. Not good. It’s said get milk before going to sleep. I drink milk and take the sleeping pills, which should have double effects. The prescription was two tablets each time, I ate three. No, I needed to think of something, could not sleep. Sleeping pills are useless. Really, what else I can do if sleeping pills are useless… So I cannot. I just take sleeping pills. I now take, and sometimes, if usually I was supposed to take one to one and a half tablets, I would have to eat three or four. I felt dizzy, and nausea. Not working.”

Over-sedation was also identified as a factor that created difficulties in achieving goals associated with recovery. As one woman described, “So I think later when I can sleep less I can take some classes, I can learn something or I can go to the community…but lately I have been sleeping too much so I can’t do that.”

During the initial management of insomnia, the experience of sedative medication “not working” or having “stopped working” was identified by six women in the sample as a precipitant for suicidal behaviour. This phenomenon will be discussed in greater detail in Chapter 4 and in the discussion section.

Only one woman described particular difficulty with anti-depressant side-effects other than over-sedation, particularly “trembling hands”. The women were not asked directly about specific medication side-effects, but rather their experiences with medication in general.
Finally, eight of ten women in the sample described that while medication was helpful, it was only one piece of their recovery. As the woman explained, “medication is only one aspect, I’ve never thought of medication as the most important cure”. In the words of another, “Doctor gives me medication, but we can’t just rely on medications”.

7.2.2.3 Social support and engagement

Six women in the sample described a benefit from the social aspect provided by their mental health care team. Having social workers engage in home visits or meeting in the community was identified as a way to stay integrated and feel less isolated. As one woman described,

“Although I don’t have a husband now, I have social workers who often come to see me. Like B. and E., girls from (mental health care team), they are all nice to me and I really like them. I rely on myself most of the time as for the people around me, for example…like B. actually I think B. is really nice to me, and she has a great impact on me, I really like her, it’s not like you have to…comfort me or something, sometimes you just need to listen to me, listen to what I want to say, or you can say a few words, I don’t need you to teach me a lesson or whatever, you only have to listen to what I have to say. B. sometimes comes over and we go out for coffee, so things get better and I’m able to get over it now.”

Another woman described how the long-term interactions with her social workers helped her to feel calmer and more stable: “In the recent six months, six months to a year, there were a lot of friends; also some people, there were some social workers helping me, helping me, to calm down and live a normal life”.

7.2.2.4 Instrumental support

Four women in this sample required support from their mental health care team to gain access to the Ontario Disability Support Program (ODSP). This program will be discussed further in the recovery chapter, but it is important to point out here that physicians played a key role in advocating for this support. All four women indicated that help in obtaining financial support, such as ODSP, has a tangible effect on improving their health. One woman in particular
identified the important role her psychiatrist played, not only in filling out the necessary forms, but providing her with validation that she was entitled to the benefits:

“I said I felt very guilty now, because I stayed here…and fed on other people, it’s like I am doing nothing. My body is doing okay but the government gives me money each month, he said that you needed to get rid of this idea, the government…Dr X said…I think I should get government’s subsidy and government agrees to subsidize so I shouldn’t worry to receive those money.”

7.2.2.5 Awareness and sensitivity to cultural issues and support in the navigation of family relationships

Clinician awareness and sensitivity to cultural issues can be beneficial to women engaged in treatment in several ways. For example, certain modalities of care may create difficulties for women that may not be seen for other patients. One woman described her experience of day hospital as being unhelpful for her secondary to a language barrier:

“After I was discharged I needed to go to the day hospital every day, but I did not like there. Because my English was not very good. Basic communication was not a problem, but it was hard for me to listen to various accents, I really did not understand the accents”.

Another woman described difficulties with the group therapy, as she felt uncomfortable expressing herself emotionally in this setting: “I’m not very good in a, in the group sessions….these groups are very big”. She was able to discuss this issue with her care team who were able to understand her concerns and modify her treatment approach.

Mental health professionals can also provide support to women in the improvement of family relationships. One woman identified that the counselor’s work with her husband helped to improve his anxiety as well as her own:

“I am not sure if it was because I was lucky, the counselor and me… it was like fate brought him/her to me. I had met him/her once before. When my problem was very
serious, I didn’t go to him/her, but he/she helped my husband, helped to ease my husband’s anxiety and whatnot.”

7.3 Summary
The women in this sample accessed mental health services through their family physician or the emergency department following suicidal behaviour. This chapter reviews the physician, patient and system related challenges faced in accessing mental health care from the family physician, and reviews experiences of mental health care in hospital and as an outpatient. Finally, a list of factors identified as important in the provision of quality mental health care was described, including the development of an explanatory model that validates emotional experience and instills hope, medication treatment as an evolving process, social support and engagement, instrumental support, and awareness of and sensitivity to cultural issues and support in the navigation of family relationships.
Chapter 8: Experiences of Recovery

8 Experiences of Recovery

In Chapter 7, the elements of mental health care that the women identified as integral to their recovery process were discussed, including 1) the development of an explanatory model that validates emotional experience and instills hope 2) medication treatment as an evolving process 3) social support and engagement 4) instrumental support 5) awareness of and sensitivity to cultural issues and support in the navigation of family relationships. In reviewing these elements it is evident that high quality mental health care is one component of the journey of recovery for these women.

Recovery can be conceptualized through a multimodal approach. The first focus the women describe is on “surviving”, which includes accessing mental health care and obtaining social and instrumental support in order to gain support in ensuring safety, managing stress and treating psychiatric symptoms as described in the previous chapter. The second focus is on “thriving”, or building a life with meaning. It is important to note that the recovery process is not always a linear one; only one woman described a straight path from suicidal behaviour to recovery. For the other nine women, their recovery journey involved setbacks, recurrence of symptoms and sometimes recurrent suicidal behaviour and/or hospitalization.

The components of “thriving” described by the women in the sample include 1) undertaking a process of narrative reflection and prioritizing self-care 2) engaging family support 3) exploring spiritual, psychological, cultural and social supports, and 4) creating goals for the future and a sense of mastery. Through these four avenues, the women began to experience a sense of self-efficacy and agency which improved their ability to cope with stress and pressure.

8.1 Narrative reflection and prioritizing self-care

Every woman described a new ability to see themselves in the context of their family, relationship and immigration histories, to better understand the pressures that led up to their distress. By framing their distress in a life history model, the women are better able to understand
the antecedents of their suicidal behaviour and re-frame themselves from being weak women who cannot endure to women who have endured a great number of things in their lives. This re-framing can result in a view of the self as stronger and better able to cope, as well as providing a rationale to ensure proper self-care in the recovery process. One woman described gaining understanding of her symptoms in the context of her life history:

“You see, maybe with one blow, one big blow, the person could get healed slowly. Everyone knew that your father died, and they would give you some comfort. But me, since I was little, I never got continuous hurt. But I was not even aware of the hurt. In fact, subconsciously it already became a damage, but I never thought about it, I got hurt, hurt was hurt, I did spend time to fix it, or deal with it, just like, so like, all the bitterness in my heart, all complaint, rancor, too deep, all at once outburst.”

Eight of the ten women in the sample described their recovery using a now versus then approach. Self-reflection as part of recovery was seen as women found ways to reflect on their journeys, specifically how far they had come. Rather than feeling overwhelmed and unable to communicate, they describe gaining a capacity to reflect on and manage their emotions. By reflecting on the differences between their previous and current emotional state, the women were able to give voice to and make sense of their previous experiences, and focus on the improvements they have made. One woman described her experience:

”You didn’t know my state of mind at the beginning. I was in tears all the time in front of my doctor. I simply could not control myself. I was simply unable to control my emotions. Now I think if I did not spend this period of time to adjust, I would not be able to talk to you like this. I might cry, badly, and might not be able to talk in a clear way. Clueless. Now, more clearly. Maybe not in the exact sequence. But at least I can talk to you clearly. At that time, it was an state of unclear mind. Especially when I mentioned my mom it was impossible for me to talk like right now, I would just cry uncontrollably.”

One woman compared her previous and current emotional state by focusing on function. Every day activities were seen as an indication that she was “normal”, and provide touchstones for her to understand the difference between now and then:
“Whenever I think the situation, in fact, I was already, really, was abnormal mentally. Cannot say, already crazy I think. Now I am really afraid that I might go back to that kind of state. Basically I am normal. I can go to work, every day, doing chores every day at home.”

By reflecting on how distressed they were at the worst stages of their illness, the women were able to identify self-care as a priority in order to improve their abilities to cope. The self-reflection allowed them to validate their own distress and led to a greater focus on self-care. One woman explained her focus on moving away from being overwhelmed by stressful experiences and focusing on what she can control:

“I feel I think the most practical thing to do…is not to be engulfed by what seemed to be happened, that’s to say to live regularly every day, to live healthily every day, that’s to say to use a healthy living style to replace the unhealthy living style, in fact I think I’m doing a pretty good job lately, for example, I eat healthily, I cook for myself and I eat healthily, and I often watch TV and browse the internet, to look for some news. I think the only way to go it to live more practically, say for example live healthy, eat healthy, get up early and sleep early, I think these are the things that I can do, and I did it. And doing those things makes me feel happy, these are my real feelings.”

Another woman described a recovery process in which she focuses on both her physical and mental health. She began to feel more capable and began to instill routine and schedule into her daily life; contrasted with her experience of depression, where she described lying in bed all day and feeling unsure of what to do.

“So, for my health… so I have been telling myself that I need to exercise. Now I have a schedule. In the morning, I would definitely go exercise, go exercise, and with the dog… and walk the dog, because my daughter has a dog, and I would help her walk the dog. At noon, I would cook, cook something for the children, or dine out with the children, go out and have lunch. In the afternoon I would do something that I like to do, such as watch… watch some movies that I like after I clean the house, when I finish cleaning. Something like that. In the evening, after dinner I would get the cleaning done. When I have got everything done, I would watch TV. I feel that my current schedule is… very good.”
8.2 Engaging support of family and friends

When the women were having thoughts of suicide they often described their family as being very protective in surviving in the short term and thriving in the long term. This support could come in several ways 1) emotional support (describing how important the woman was to the family, validating her emotions, improved patterns of communication) and 2) promoting safety through practical strategies. It is also important to note that a focus on intergenerational achievement can also provide a sense of meaning during recovery for these women; all seven women with children in the sample identified hope for the future of their children. Please see chapter three, focusing on immigration experiences, for more details.

8.2.1 Emotional support

In Chapter 6, seven women described how communicating interpersonal distress provided one explanatory model for suicidal behaviour. Many of the women in the sample described how their illness and suicidal behaviour allowed their families to better understand their distress, validate her emotions, and communicate her value within the family. Improved communication within family relationships was identified in several transcripts and seen as extraordinarily helpful.

One woman described her son’s response to her suicidal ideation and behaviour. By understanding the value she held in her life, she felt that she was able to “survive”:

“My son said, 'Mom, you should not leave me alone. If anything happens to you, I cannot live anymore. Do you care about me?' . I said I cared about you. My son’s words actually worked. I just cried. Son said you told me ‘if you felt uncomfortable, just call me anytime. I don’t want to go to school, I’ll take several days off. I’ll catch up with my study. I assure you. Just talk to me. Or I fly over to here’. I said no, no. I survived in such a mental state.”

A second woman described a similar experience with her own son:

“My son was very sweet, he… er… he wiped my tears for me, and he told me, “you can do something that you like to do”, “be happy, just do something that makes you happy,
you can do whatever you like”, “we are grown-ups now, you don’t have to take care of us any more”. So I felt, oh my son was really good to me, and very sweet.”

She also described the way her husband was able to show greater appreciation for her as a consequence of fearing that he would lose her:

“When I got sick this time, I think he has changed considerably. After I got ill this time, he finally realized it. He said he just felt that it turned out… if he lost me, he would be very sad. So he started to cherish. He cherishes more now.”

Another woman described how her romantic partner’s support allowed her to feel encouraged and his kindness helped her through a period of intense suicidal ideation, allowing her to feel more hopeful: “My current boyfriend is very strong. He encouraged me; and I thought, well, it didn’t matter what he did, what he had done, but his kindness to me was helpful.”

A fourth woman described feeling touched that a friend made a strong effort to support her during her illness. She linked her desire to recover with the care and effort made by her friend:

“A good friend of mine, took a plane…specially to see me. S/he came to see me, came to see me… er… came to keep me company for a month. I just thought that it was so nice of my friend to come and keep me company. When s/he was with me, s/he took me out. I think… why… er… maybe…. Firstly, it could be because of that friend of mine. S/he specially… s/he took some time off work specially for me, flew in here to visit me. So I felt… er… I felt that this was rare and precious. My friend did this, did this for me, came to help me, so I really really wanted to recover, gradually started to want to recover very much.”

Five women described improved emotional communication with family members as a key part of their recovery. One woman described finally confiding in her mother about her distress, which she had not done previously. She stated that the process of “venting” her emotions with her mother was helpful to her, contrasted with a lack of emotional communication in the past. “Venting” and “chatting” can be contrasted with the experience of enduring on one’s own and holding emotions in. She described, “The reason why I'm not so desperate like before, probably
because meeting my mother had somewhat impact. Seeing her, chatting, chatting finally crying. At that moment, crying was a type of venting out.”

Four women described improved emotional communication within their marital relationship. Four women who had difficulty communicating with their husbands prior to the period of distress identified clear improvements, which aided in recovery. One woman described a closeness that she had not experienced previously:

“Every day, eating together, living together every day, and then sometimes making phone calls after work; making phone calls before going to work. Chatting everyday together. Even two strangers, how to say, would have a very close feeling, like a family member.”

One woman poignantly described how the process of managing her illness has brought she and her husband closer together, and improved the communication between them. This improved communication and closeness provides a source support for this woman, in contrast with enduring her distress on her own:

“So because of my issues this time, he has been by my side for almost an entire year. He has been with me, to face it together with me, to care about me. It is like this. I feel that he has done a lot for me this time. Now I have recovered, and we still had some quarrels at the beginning. Now when he looked back to the past, he noticed that he had changed. He started… started to get along better with me. I feel that we are better now. At least he would…er…would chat with me, would talk to me, and whatnot. He tries not to lose his temper over me. He has changed those things. He goes out with me more often. As both of our two children are grown-ups now, they rarely spend time with us. They aren’t with us very often. So the time that the two of us spend together increased. Now he spends more time… on a walk with me, or to do some shopping, or to have a meal or have a drink.”

8.2.2 Promoting safety through practical strategies

Family support can help the women survive during periods of high distress and worsening suicidal ideation. Nine of ten women identified ways in which family and friends promoted
safety, including calling 911 or taking patient to hospital prior to and after suicidal behaviour, and providing intensive supervision in high risk periods. As one woman describes, a cousin stayed with her 24 hours a day when she was having intense suicidal ideation. She reflected on how this support led to her staying safe: “Maybe that time, I think back, was my most dangerous days. If my cousin had not stayed with me, just myself, I would have been gone.” A second woman felt so unsafe that she would go to work with her husband every day in order to keep herself from engaging in suicidal behaviour. Another woman reported that at the peak of her hopelessness and distress, her husband stopped working and kept her safe at home.

“I didn’t want to go to the doctor. I thought that nobody could save me, nobody could cure me. My thoughts at that time were like that. Uh… so later my husband just looked after me constantly, constantly.”

Providing support in arranging and attending mental health care appointments was seen as valuable in the recovery process by six women. One woman described the way in which her husband provided her with support to attend doctors’ appointments: “my husband, he was by my side. He constantly… when I came to see the doctor, he came with me. We came together, together.”

Another woman identified her friend’s interest in helping with her concerns as moving her towards recovery. Her friend’s suggestion of a particular doctor was seen as helpful:

“We went out and walked. Later when we were chatting casually, s/he mentioned that a friend of hers/his knew a doctor of traditional Chinese medicine, so s/he recommended that doctor to me. I am not sure if it was because of my psychological conditions, or because that doctor of traditional Chinese medicine fit me, I just felt I was very … at that time I really wanted to recover, really wanted to recover.”

8.3 Exploring spiritual supports

“Doctor gives me medication, but we can’t just rely on medications, when we get emotional, we need God to release…to release us…to help us, medications are not enough.”
Three women described finding religion as a key component of their recovery, providing a sense of meaning as well as a sense of community. Two women identified the church as the primary factor in their recoveries; as one woman stated “If there is no God I think my life is over a long time ago”. She described the church as “happy, peaceful and supportive”. She describes going on a spiritual path, and feeling stability provided by the church in the face of confusion and the unknown. Importantly, the church provides a sense of identity, family and community to the patient. She identified the “Lord as father”, stated the “church is my home” and had access to a community of people who validate her emotions and suffering. As she described, “we will meet and chat and talk, we discuss and exchange thoughts, just like a family.”

The church also provided support for this woman and her family, encouraging open and validating communication. The church provided a framework for a journey into recovery: a way of achieving peace and mental health, and providing hope for future. It also helped to solidify relationship with her husband and improve communication. She described her experience of the church as accepting, open and de-stigmatizing.

A second woman also described the support of the religious community as instrumental in her recovery. She described feelings of emotional validation from the Bible:

“I was so so upset. I was kind of funny when I think back, I suddenly saw a sentence, in the Bible, it said, could exactly described my state. It said singing to a broken soul, just like add the frost on snow. I couldn’t remember the whole sentence, but the first part was correct, I forgot the rest. Ah so right. How could it be so right? I also showed it to my pastor. I said, look. She said oh ‘Do you think that the person was singing to you. I said exactly. It’s like, perhaps, patients with depression firstly, need reorganization. To be recognized; if you accept her, then I think it maybe, it would be helpful to her.”

She also described receiving instrumental support from the church community: “People in the church were also very concerned about me. Sometimes they checked if I had enough money, giving me some money. All very nice to me.”

It is important to note, however, that in some cases, some interpretations of the church’s teachings can also encourage the value of endurance and restricted agency for women. One
woman described that she did not choose to divorce her husband because “God said one couldn’t leave a marriage”. It appears that for this woman, the church’s teachings created a way to reconcile the double bind of increasing academic expectations and traditional gender roles. However, her reconciliation appears to endorse a view that women should submit to men within a marriage, and that this will “change things”:

“The bible said men are the heads, men are the heads of women, we are all educated under modern Chinese education system, it’s very hard for men to be our head, so that’s why I said the position was not put right, it’s very difficult. Now I’m trying to learn this lesson, I need to put men first, I have to look up to him and that will change things.”

Spiritual support, for one woman, came through important pieces of fiction. She described changing her view on restrictive standards of beauty, previously a source of tremendous distress for her, by referencing the author Sanmao. By shifting her understanding of herself and the world, she began to feel an increased sense of agency and self-efficacy:

“So later I came to read some novels and I read all novels written by Sanmao. After that I realized that I had become more mature. My attention gradually shifted away from women’s appearance, look, height, and beauty…which means I have gradually developed a more mature ideology, and gradually I walked out (of the past). I walked out of it by myself…I like her care-free personality, then I slowly walked out, I walked out then…it’s a real maturity…but later…later I became more mature, I realize that a woman’s attractiveness entails many different dimensions, and the maturity…mental and psychological maturity will continue to develop, so after I realize this I feel better.”

8.4 Creating goals for the future and a sense of mastery

Six women in the study described a process by which they were able to gain a sense of mastery or self-efficacy during their period of recovery, allowing them to become more hopeful for the future. One woman described her recovery process as gaining support to “overcome”. She identified the ways in which self-reflection and support from others allowed her to feel more capable and create goals for the future:
“If I can from this process, overcome myself, through social help to me, through you guys, can get a proper evaluation, a proper judgment from the society, I think, I am worth it. I can give up committing suicide; I can do a lot of things; I’m not unable to work; and I am not lack of life skills. I do not know I live for what and work hard for who. I am not a person without work ability. I have the skills; I also have the capability.”

Another woman focused on cooking and how a mastery of cooking and caring for her home led to positive emotions and self-image:

“When I go online I learn some recipe, I learn how to cook, I think it’s really nice to cultivate some interests, and to make my home clean, comfy and cozy, I think it’s to make life. I think now what I need to do is to make my home comfortable, to watch more TV, and then to learn how to cook. I’m already a good cook, but there are so many recipes in this world. I think this can be a very good life. Now I want to learn how to make buns and bread, as long as I get the yeast I’ll be able to make it…For example, cooking, trying our new recipe, sometimes I go to English class and I go online, I think this is quite nice, finding something that I enjoy doing to reduce my negative emotions I think this is really nice and I think this is a good strategy, and I think this strategy is working for me”.

With respect to pursuing work and educational opportunities as a way to build mastery and increase a sense of agency, it is important to note that while it is seen as protective for six women, two women described how returning to work or school could be a source of stress. The type of work is clearly important; women who work in higher status or higher paying professions tended to see return to work as more beneficial than those working in positions with less power (i.e. in a factory, in sales or in childcare). It is key that the women see work or school opportunities as positive and feel that they can incorporate them into their lives without compromising self-care or putting themselves back in a position to endure stress or pressure without feeling well enough or having the strategies to do so.

For one woman, working led to a sense of purpose that helped her feel less “useless” and allowed her to put less pressure on herself to do household work:
“I felt I was happier when I started working. I thought that at least I had a job. When I had a job, I felt that even if I came home and didn't cook or whatnot, I felt that er… I wasn’t that bad, I wasn’t that useless. At least I went to work. I could help our family. I could help our family financially and whatnot. So I felt a little better, a little better.”

8.5 Summary

Recovery from depression and suicidal behaviour is seen by the women in this study as a multimodal process with several aspects, including recovery from psychiatric symptoms through formal mental health care, personal recovery through the development of self-care, self-efficacy and rebuilding identity, and reconnecting with one’s family and community.
Chapter 9
Discussion and Future Directions

9 Discussion and Future Directions

The goal of this study was to better understand the experiences, stressors and beliefs of Chinese-born women living in Canada with a history of suicidal behaviour, and the impact of gender as a social and cultural construction on their experiences, including self-image, relationships, ways of coping, and the communication of distress. Through ten qualitative interviews with women who have emigrated from Mainland China and Hong Kong, this study was able to characterize the sample from clinical and sociodemographic perspectives through structured interviewing, scales measuring known risk factors for suicide and chart review. Themes pertaining to shared emotional and cultural experiences that led to feelings of distress and difficulty coping, including restricted patterns of emotional communication, lack of agency in personal decision making, and experiences of victimization and oppression. The women also discussed the double bind of gender-based expectations in the face of rapid social change, as well as culturally-bound stress relating to meeting familial expectations derived from the value of filial piety (Hwang, 1999).

These shared emotional and cultural experiences have a profound impact on the women’s experiences of immigration and access to mental health care. They also mediate the ways in which women understand and react to stressful life events, promoting a coping style focused on enduring stress rather than engaging in self-care, asking for support, or making positive changes. As women attempted to endure the stress and pressure on their own, they began to experience worsening depressive and somatic symptoms, interpersonal sensitivity, poorer sense of self-efficacy and functional impairment. These factors made it more difficult to endure, causing a cycle of stress and pressure that led to worsening hopelessness, increasing suicidal ideation, greater emotional lability, and agitation, worsening insomnia or confusion. Suicidal behaviour was conceptualized as a way to break this cycle, by providing an escape from pain, communicating distress to loved ones, and as a strategy to end a hopeless existence.

This study also examines the factors required for recovery: access to and engagement in mental health services, family support, and instrumental support. These factors can be understood as part
of an overall explanatory narrative of stress, illness and recovery, which can lead to an improved sense of self-efficacy and agency and hope for the future.

This chapter will focus on the following topics: 1) how can we conceptualize the study population by integrating clinical and social characteristics with the qualitative findings? 2) How does this study contribute to the conceptualization of suicide in Chinese-Canadian women? 3) How does this study help us better understand access to mental health care in this population? 4) What are the strengths and limitations of this study? and 5) How can this work impact future research and care?

9.1 Understanding the sample in a clinical and social context

The study sample in this population was recruited from four mental health services in the Greater Toronto Area. These women, who were obtaining psychiatric care at the time of the study, all met criteria for major depressive disorder or were experiencing a depressive phase of bipolar disorder. During the qualitative interviews, eight of ten women self-identified as “depressed” or in “sub-health” at the time of suicide-related behaviour, and every woman in the study described at least three symptoms associated with a major depressive episode (average 5.6, SD 1.2; cutoff for diagnosis of MDD is 5) (American Psychiatric Association, 2000). Epidemiological studies from China have indicated that those who die by suicide are less likely than those from North America to meet criteria for a psychiatric diagnosis at the time of death, even when culturally expanded probes are used (Pearson et al., 2002; Phillips et al., 2007; Zhang et al., 2010; Zhang, Conwell, Zhou, & Jiang, 2004). However, several studies also suggest that as the number and severity of depressive symptoms increases, so does the risk for suicide (Phillips et al., 2007; Zhang et al., 2010, 2004).

Because the participants were recruited from a clinical sample, they are not representative of all Chinese-Canadian women who have experienced suicidal behaviour. Chinese immigrants in Canada have been shown to use less overall health care than the general population, and that this gap is particularly significant with respect to mental health care, including visits to family physicians for mental health reasons, visits to psychiatrists and inpatient hospitalization (A. Chen & Kazanjian, 2005). Even those Chinese immigrants with severe and persistent mental illness received less treatment overall and were more likely to be treated by psychiatrists than general
practitioners (A. Chen et al., 2010). This data is in keeping with lower mental health care service utilization by those of Chinese and Asian (including Chinese) ethnicities in Scotland and the United States (Bansal et al., 2014; Sentell et al., 2013).

Considering many Chinese immigrants access mental health services at a lower rate, female Chinese who have experienced suicide-related behaviour may not come to the attention of the health care system. Further, those women who were identified as having a history of suicidal behaviour through family physicians or psychiatrists but did not receive follow up for any reason would not have been eligible for this study. Four women without prior mental health care were approached in an emergency department setting after disclosing suicide-related behaviour, but none consented to participate in the study. The women in the study who were recruited were all receiving ongoing mental health care for a psychiatric disorder, and therefore may describe greater psychiatric symptoms than women who are not receiving ongoing care.

With respect to recruitment, only women who had immigrated from Mainland China and Hong Kong to the Greater Toronto Area were included. Several cultural differences exist between women of these two groups, a full discussion of which are beyond the scope of this report. However, a review of the literature provides several examples: one study examining experiences of parenting, Hong Kong adults perceived both parents as less warm and more controlling than did women from Mainland China (Berndt, Cheung, Lau, Hau, & Lew, 1993). Another study examining anger responses found that younger versus older Hong Kong Chinese were more likely to report direct aggression toward family members, while older Mainland Chinese were more likely to do so (H. Fung & You, 2011). The same study found that Hong Kong Chinese were less likely to report malevolent or fractious motives in interpersonal relationships than those from Mainland China (H. Fung & You, 2011). With respect to suicide and suicide-related behaviour, studies have shown high rates of death by carbon monoxide related to charcoal burning in Hong Kong, as well as a greater percentage of suicides related to a diagnosis of schizophrenia (Chan et al., 2009; P. W. C. Wong, Yeung, Chan, Yip, & Tang, 2009).

Although several important cultural differences exist between Mainland China and Hong Kong (and of course, within urban and rural areas of Mainland China), both were included given the large number of immigrants from both areas. Women who have emigrated from Taiwan and
Macau were also eligible for this study but none were recruited. In data analysis by the primary coder as well as in coding and analysis by the study team, no new codes were generated that pertained only to the participants from Hong Kong. While the women from Hong Kong were on the higher end of the socioeconomic scale pre- and post-immigration, they did experience financial and other stressors related to immigration in keeping with the rest of the sample. They also described restricted patterns of communication, feelings of lack of agency, history of victimization and oppression, and both experienced suicide-related behaviour in keeping with the model.

Women who are of Chinese-Canadian descent who were not born in China or Hong Kong were not included in the sample, in order to examine the experience of immigration in the context of suicidal behaviour, and to homogenize the sample. In the future, it would be very valuable to examine this population, specifically the role of acculturation stress and conflict between family values.

Impulsivity has been identified as a risk factor for suicide-related behaviour across cultures (Bhugra & Desai, 2002; Kim, Kim, Kawachi, & Cho, 2011; Manoranjitham, Jayakaran, & Jacob, 2006; Maser et al., 2002; Nock et al., 2008). In the Chinese population, impulsivity has been identified as a risk factor in psychological autopsy studies of suicides and case-control studies of those who have engaged in non-fatal suicide-related behaviour (Pearson et al., 2002; Phillips et al., 2007; Zhang et al., 2010, 2004). In our study sample, half the women had impulsiveness scores higher than the 75th percentile on the Barratt Impulsivity Scale, but as a whole, the population was not significantly more impulsive than normative data from an adult North American population or a female Chinese adolescent population (Barratt et al., 1997; Zhu et al., 2007). It must be noted that the sample size of this study is small and this finding of non-significance may be related to a lack of power.

The participants in this study also completed the Toronto Alexithymia Scale (TAS-20) (Taylor et al., 1992). Six women were classified in the “high alexithymia” group, and the scores were significantly higher than the normative population data (English speaking women and Chinese speaking women) (Taylor et al., 1992; Zhu et al., 2007) The alexithymia score was highly correlated with number of attempts at a level >0.0001. In the results section, the differences in
presentation between the high alexithymia and low-moderate alexithymia group were noted. Women with high alexithymia scores have more frequent suicide attempts, a greater number of somatic symptoms, and are less likely to self-identify as depressed or show clear functional impairment or hopelessness associated with depression. They are more likely to view suicidal behaviour as a way to communicate distress rather than as an escape from pain or a strategy to end a pointless life. These factors illustrate how alexithymia can mediate patterns of distress and suicidal behaviour. Although both groups can be understood by the model of suicidal behaviour presented in this study, the alexithymia score may influence the intensity of symptoms, frequency of suicidal behaviour and conceptions of suicide.

9.2 Reviewing the life experiences in women with a history of suicidal behaviour

9.2.1 Perceived lack of agency in decision making

The women in the sample also described a lack of agency with respect to personal decision-making within the family environment. This lack of agency was driven by a strong sense of familial obligation and a sense of poor self-efficacy. Poor self-efficacy can be understood as a subjective sense of being inadequate or unable to succeed, while lack of agency pertains to a feeling that choices are not objectively accessible within a woman’s family or social environment. While family support is often framed in positive terms, it can come at a cost to the woman’s sense of self and ability to make decisions in keeping with her values or interests. Over time, a recurrent feeling of lack of agency in the navigation of major life decisions can lead to feelings of powerlessness and hopelessness.

Perceived lack of agency characterizing life experiences for Chinese-Canadian women who have experienced suicidal behaviour can be understood in the context of Confucianism, a philosophy and value system that informs the relationship between the self and the family and community (Qin et al., 2012; Wei-Ming, 1976). Confucian values stress importance of the self not as its own entity but in relation to family, community and society, focusing on living “for the sake of others” rather than in the service of one’s own interests or achievements (Qin et al. 2012; Wei-Ming 1976, p. 114). In the relationship between parents and children, Confucian values stress a vertical hierarchy (Hwang, 1999; Qin et al., 2012). Filial piety, central to Confucian role ethics,
is derived from the view that one’s life is the continuation of one’s parents’ lives (Hwang, 1999). It describes an attitude of devotion, obedience and care towards ones’ parents and ancestors (W.-W. Chen & Wong, 2014; Liu, 2013). Hwang (1999) described how Confucians conceptualize family members as one body by quoting Confucian Rites: Chapter on Morning Dress: “Father and son are one body; husband and wife, brothers, are all one body. The relationship between father and son is like that between head and feet.”

With respect to feeling of agency within parent-child interactions, cultures that subscribe to the notion of filial piety privilege the expression of love, respect and loyalty to parents, at the expense of their own wishes and desires (Liu, 2013). The expectation exits that children and adolescents should conform to parental expectations and serve community and society’s goals rather than their own (Liu, 2013). While the concept of filial piety, which stresses devotion to family over one’s own self-interest, is often framed as a negative counterpoint to the focus on individualism in Western culture, a body of literature exists which describes the ways in which filial piety can be beneficial (W.-W. Chen & Wong, 2014). For example, filial piety has been linked with strong academic performance, as students try to honour and repay their parents’ sacrifice and investment in them (W.-W. Chen & Wong, 2014). Filial piety has also been associated with a decrease in caregiver burnout, which can mediate the risk of depression in those caring for elderly parents (Khalaila & Litwin, 2011). As Liu (2013) describes, those with a stronger belief in filial piety may respect their parents’ teaching and guidance, and believe their parents’ actions are performed for their children for their own good; therefore, strictness and control, which are perceived as domination or hostility in Western countries, may be perceived as concern and caring by Chinese adolescents.

In order to better understand why, for the women in this study, obligation to family was seen as distressing and fostered a sense of lack of self-efficacy, while in other cases filial piety is a protective factor, we can conceptualize filial piety as a dualistic concept: authoritarian vs. reciprocal filial piety (W.-W. Chen & Wong, 2014; Liu, 2013; Yeh & Bedford, 2003). Reciprocal filial piety is defined as affection-based gratitude and respect for parents’ efforts, while authoritarian filial piety describes adherence to relationship hierarchies and role obligation that demand children’s compliance with parents (Liu, 2013; Yeh & Bedford, 2003). In a two-year study of Taiwanese high school students, only those with higher authoritarian filial piety
were more likely to feel obligated to obey parental rules and commands, even if they disagree, while adolescents with high levels of reciprocal filial piety were able to love, respect and appreciate parental efforts without displaying complete obedience (Liu, 2013). Reciprocal filial piety was also shown to be associated with an incremental view of intelligence, or a belief that intelligence can be increased through effort, that contributes to academic achievement among high school students in Hong Kong (W.-W. Chen & Wong, 2014) Conversely, authoritarian filial piety has been associated with depression, anxiety and aggression in children and adolescents and an entity view of intelligence, or a belief that intelligence is a fixed or unchangeable trait, which deteriorates academic performance (W.-W. Chen & Wong, 2014; Yeh, 2006).

The theme of lack of agency within familial relationships described by the women in the sample can best be understood through a frame of authoritarian filial piety. The women feel as though they must adhere to role and relationship obligation and have no freedom or choice to act differently. This lack of choice manifests in poor self-efficacy, powerlessness and hopelessness. The link between high levels of authoritarian filial piety and suicidal behaviour has not been studied and may be a future area for investigation.

Five women within the sample described feelings of lack of agency within their own romantic relationships. They described feeling as though they had to “follow” their husbands’ decision making on important issues and that they did not have the ability to assert themselves or meet their own needs. In a qualitative study examining factors impacting marital satisfaction among urban Mainland Chinese women, a feeling of “freedom of choice” and a sense of power were identified as a key factors in marital satisfaction, echoing the importance of feelings of agency in decision making (J. Y.-Y. Chen & Lim, 2012).

9.2.2 Restricted patterns of emotional communication

The women in the sample described a long history of engaging in restricted patterns of emotional communication with parents and romantic partners. These patterns were characterized as limited with respect to bi-directional openness, emotional validation and warmth. These communication difficulties, seen in early life, persisted through adulthood and often led to feelings of isolation and loneliness, particularly during experiences of physical and emotional distress. These feelings of isolation, loneliness, and lack of validation make it increasingly difficult to engage support or
cope with pressure. Suicidal behaviour can be conceptualized as a way to communicate interpersonal distress and to elicit acknowledgement and support from loved ones, as indicated by seven women in the sample. Importantly, women with high alexithymia scores, meaning they are less likely to be able to identify and describe their emotions, were more likely to engage in suicidal behaviour to communicate distress.

These findings are consistent with other research focusing on the emotional experiences of Chinese, Chinese-American and Asian-American women with a history of suicidal behaviour. A qualitative study focusing on the experiences of female Asian-American college students with a history of suicidal behaviour described feelings of emotional deprivation and invalidation during their childhood years (Chung, 2004). The women also described difficulty communicating interpersonal distress and poor coping mechanisms as they did not feel they deserved to be validated or supported by loved ones (Chung, 2004). The study also described how the most common mode of communication in Asian cultures discourages direct expression of emotions, especially negative feelings (Chung, 2004).

The impact of parental practices, defined as strategies used in the rearing of a child such as warmth and discipline, have been shown to impact the offspring’s psychological well-being in childhood and as an adult (J. J.-L. Chen & Liu, 2011). Negative parenting practices (punishment, neglect, hostility) have been linked with internalizing and externalizing mental health disorders, and responsive and warm parenting has been linked with social and emotional well-being and academic success (J. J.-L. Chen & Liu, 2011). From a cultural perspective, Chinese children are expected to follow the principles of filial piety, while Chinese parents are expected to train and socialize their children in order to ensure that they are responsible, successful and obedient adults (J. J.-L. Chen & Liu, 2011). Rather than being conceptualized as a negative trait, parental punishment is associated with ensuring a child’s success in the future (J. J.-L. Chen & Liu, 2011). However, parental warmth is associated with higher adaptive functioning and psychological well-being in Chinese children in both urban and rural areas of Mainland China (J. J.-L. Chen & Liu, 2011).

Lack of parental warmth and validation, as well as an inability to engage parents in emotional communication, were described by seven of the ten women in this sample, and were seen as a
particularly distressing combination. Interestingly, a body of evidence suggests that female children may experience less warmth from their parents as a function of cultural expectations in the context of China’s One-Child policy (Aubert et al., 2004; J. J.-L. Chen & Liu, 2011; Hesketh et al., 2005). Male children are seen as more likely to care for parents in old age, and one study suggests that 60% of fathers responded coldly to the birth of a daughter (Aubert et al., 2004; J. J.-L. Chen & Liu, 2011).

With respect to communication within romantic relationships, eight of ten women described similar restricted patterns of emotional communication, which was a source of distress. Many women in our sample described communication difficulties with their partners, seeking a desire to “chat” in a warm way. In another study, women described having difficulty communicating with their partners about their emotions as their parents were never able to do so (J. Y.-Y. Chen & Lim, 2012). In this study, several women described improved communication with loved ones as a key part of their recovery, and marital counselling and support has been described in the literature as an excellent way to improve emotional communication within the couple (J. Y.-Y. Chen & Lim, 2012).

9.3 Understanding suicide-related behaviour in a social and cultural context

In the literature review, suicide-related behaviour is conceptualized as complex and multifactorial, and culture, social and sociopolitical stress and stigma must be considered. These factors can shape the ways in which suicide-related behaviour is understood in the context of gender role and help shape cultural scripts of suicidal behaviour. This study aimed to explore narratives of suicide-related behaviour presented by the informants, with respect to the chosen course of action, the impressions of suicide-related behaviour within the family and community, and the emotions preceding and following suicide-related behaviour. This study also examined the impact of gender as a social and cultural construction on self-image, relationships, coping strategies and the communication of distress. In the following section, the study findings pertaining to suicide related behaviour will be situated in the literature.
9.3.1 Suicide-related behaviour: A consequence of mental illness or response to social stress?

As discussed in the literature review, suicide-related behaviour is not commonly conceptualized as secondary to a mental health issue in China. Suicide and suicide-related behaviour are rarely described in Chinese medical or psychiatric textbooks; rather, they are conceptualized as a response to social stress and act of free will rather than as part of a mental illness (Fei, 2005; Ji et al., 2001). Further, studies in China indicated that those who die by suicide are less likely than those from North America to meet criteria for a psychiatric diagnosis at the time of death, even when culturally expanded probes are used (Mann, 2002; Phillips et al., 2007).

The women interviewed in this study integrate these two conceptions. All ten women understood their experiences of suicide-related behaviour as a consequence of live stress and pressure. However, they also describe the ways in which stress and pressure lead to clear symptoms associated with depression, and eight of ten women self-identified as depressed within the sample. Rather than understanding suicide-related behaviour as independent of mental illness, the women describe the ways in which attempts to endure stress and pressure lead to worsening depressive symptoms and feelings of hopelessness, as illustrated in the model presented in the results section.

“Diu manzi”, or loss of face, is a powerful cultural construct that has relevance in the conception of suicide-related behaviour; the fear of shame is very powerful and suicide may be an escape from the unbearable experience of living in shame, a culturally sanctioned means for resolving interpersonal conflict, or a morally sanctioned act (Pritchard, 1996). Zhang & Xu (2007) hypothesized that suicide may be seen as morally acceptable under particular circumstances as Confucian doctrine allows suicide as an expression of high moral or emotional protest. Fei (2005) theorized that suicide is often a result of power dynamics in the family and as a result of impulsive anger, closely tied with the significance of moral capital and the concept of saving face.

Although women in this study endorsed feeling ashamed post-suicidal behaviour on a quantitative measure of emotional states contained in the Suicidal Behaviours Questionnaire 14 (SBQ-14), fear of shame or desire to save face was not directly identified by any woman in the
sample as providing a rationale for suicide-related behaviour. However, similar to the theories described above, suicide was conceptualized as a strategy to communicate anger or distress to family members who have been unable to meet the women’s emotional needs, either by behaving inappropriately or disrespectfully (husbands having extramarital affairs, children behaving in a non-filial manner) or by being emotionally unavailable or withholding. However, these women were all clearly experiencing depressive symptoms and functional behaviour prior to the onset of suicide-related behaviour. It is also important to note that the women who were more likely to engage in suicide-related behaviour to communicate distress had higher rates of alexithymia.

9.3.2 The impact of social change, including immigration, on suicidal behaviour

Several articles have hypothesized about the ways in which rapid social change in China have impacted rates of suicidal behaviour. For example, Zhang et al in 2004 hypothesize that suicide, particularly in rural areas, can be affected by disintegration of traditional supports for the elderly as well as economic stress coming from reforms. Aubert et al’s 2004 study focusing on suicidal ideation in Chinese-Canadian students compared with their Chinese counterparts showed narrowing of rates of suicidal ideation between male and female students in Canada, which they suggested was related to reduced gender role stress in the Chinese-Canadian female population, as gender equality is established by law and evident in daily life. They suggested that while Chinese women were clearly identified as second-class citizens, with a lower social status than men, women who immigrate to Canada enjoy better social status and greater control of their lives.

The findings of this study can deepen the understanding about the ways in which social change resulting in greater opportunities for women and immigration mediate suicidal behaviour. One interesting finding in this study was how rapid social change in China has led to a double-bind of gendered expectations. Traditionally, Confucian values prioritize harmony within family and society while downplaying the role of women (Zhang & Zhao, 2013). In contemporary Chinese society, while women are expected to act in a traditionally feminine way and are seen as less capable than men, they are also expected to perform at an equally high level from an educational and employment perspective with fewer structural opportunities to succeed. These conflicting
sets of expectations were explicitly identified as a major source of stress and pressure in six of ten transcripts, with the conflict observed in the narratives but not explicitly defined in two of the remaining four. This finding is in keeping with recent work examining the role of psychological strain related to a conflict between traditional Confucian values and modern values of gender equality in rural Chinese youth who have died by suicide. (Zhang & Zhao, 2013). This study found that those who experienced value conflicts between Confucian gender role and gender egalitarianism scored significantly higher on depression scores than those who did not experience this conflict (Zhang & Zhao, 2013). The conflict between traditional values and gender equality has also been identified as a source of marital stress in the literature. Qualitative studies interviewing women from Mainland China about their marital satisfaction have found that even as women achieve higher levels of education and income, they experience unhappiness if their husbands do not uphold the traditional male role of earning more money (J. Y.-Y. Chen & Lim, 2012; Lu & Wen, 1999). As one woman who earned more than her husband described, “I’m not happy, because I felt that I am playing both the female and male roles…I’m bearing double toil” (J. Y.-Y. Chen & Lim, 2012)

With respect to immigration, nine of ten women identified a belief that more options would be available to them than are available in China with respect to education, employment, home ownership and health care. Four women referred explicitly to beliefs that they would have greater freedom in Canada in navigating the double-bind of gendered expectations. While many positive factors related to increased agency for women were identified, nine of ten women faced significant distress as their expectations were not met by the reality of immigration. While supports available through the Canadian government including financial support, mental health care and educational opportunities were identified as part of the recovery process for all the women interviewed, seven identified stressors associated with immigration, including an inability to find appropriate work, unexpected financial stress, feeling targeted by police or subject to racism, and fall in social status as clearly contributing to suicide-related behaviour.

9.3.3 Cultural conceptions of gender and suicidal behaviour

In the literature review, we discussed the gender paradox of suicidal behaviour (Canetto, 2008), which posits that in Western countries, suicide is seen as a masculine act and “failing at suicide”
is considered to be a feminine “act of the powerless”. A significant body of literature from China focuses on the characteristics of rural women who die by suicide. Several studies characterize this population with higher levels of impulsivity and lower levels of depression, and identify interpersonal stressors that are often related with suicide, including unhappy marriage, financial problems, spousal abuse, changed routines, and conflict with mother-in-law (Pearson et al., 2002). It is important to note, however, that rural women in China have higher rates of death by suicide than urban women, and that the characteristics of urban women who die by suicide in China are not well understood. For rural women, it was the fourth leading cause of death; for urban women, the rate of suicide is still the eighth leading cause of death, compared with 14th for urban men.

Irene Chung (2004) posited that Asian American women resort to suicide-related behaviour to express their emotional distress rather than engaging in externalizing behaviour such as substance use, and that their distress may not manifest in functional impairment or seeking help from family, friends and mental health services. The women in that study also described feeling as though they must take care of parents, succeed academically and sacrifice their own interests to show love for family (Chung, 2004). This study echoed the stresses described in the literature. A focus on family pressure, as described in both the Chinese literature and the literature around Asian-American women, was seen. Feelings of lack of agency can lead to lack of choice and feelings of poor self-efficacy, which make it more difficult to endure stress and pressure and to seek support. The expectation to privilege duty to family over one’s own happiness or self-care was seen in all ten transcripts, and led to feelings of guilt for not meeting expectations as well as a feeling that life was “boring”, unhappy and could not be improved. These emotions were tied to the constructions of suicide observed in this study, including understanding suicide as an escape from pain or as a strategy to end a pointless, unhappy life.

No woman in this study described model minority pressures, or reflected on the way she is seen by “Western” society. As these women had immigrated to Canada and lived in a city with a large Chinese population, they were more concerned about their own family and community expectations rather than those of the dominant society. Every woman in the study described her predominant social circle as being of Chinese descent. In a more diverse group, including women
of Chinese descent who have been born in Canada, these pressures, resulting in navigating traditional and Western pressures, may be seen.

9.4 Modelling suicidal behaviour

9.4.1 Understanding the concept of endurance in Chinese culture and how it relates to the model of suicidal behaviour

While “endurance” in English is used to signify an ability to do something difficult or manage pain and suffering over a long period of time, it tends to be used in scientific literature to represent the ability to successfully undertake physical activity. “Endurance” is a concept that is used less often in mental health literature, and when it is used, it is often framed as a positive strategy related to resilience (Edward, 2005). In this conceptualization, endurance is defined as “behaviour that causes one to face the stressor and accept its consequences”, and has been associated with positive mental health, improved quality of life and reduction of problematic behaviours (Cederblad & Dahlin, 1995; Ryan-Wenger, 1992; Stewart et al., 1995). In a qualitative analysis of individuals recovering from psychosis, “endurance” is conceptualized as a key strategy to accept life’s struggles while acknowledging the need to contend with ongoing stressors in order to move forward (Thornhill et al., 2004). It is also conceptualized in the context of enduring with faith, or the belief that God will provide support and that faith is strengthened by suffering, which studies have suggested is positively associated with recovery from severe mental illness (Webb, Charbonneau, McCann, & Gayle, 2011). In cross-cultural research, “endurance” has been associated with resilience in survivors of genocide in an elderly Armenian sample (Kalayjian & Shahinian, 1998). Qualitative studies focusing on the experiences of African immigrant women and Kenyan women of low socioeconomic status who have experienced intimate partner violence, and Egyptian women navigating work and home stress have described “endurance” as a strategy to cope with ongoing conflict informed by gender inequality (Hattar-Pollara, Meleis, & Nagib, 2003; Swart, 2013; L. Ting, 2010).

One of the most striking findings in this study was primacy of the coping strategy labeled as “endurance” by the women in the sample, and the differences between their experience and the western conception of this concept. The women described endurance as well-established coping strategy that prioritizes suffering through difficulties on one’s own without becoming distressed;
as one woman described, “my mother’s idea is self-endurance, endure it by yourself”. This coping strategy informs how women manage pressure and stress. As women attempt to endure their symptoms, they begin to experience difficulty sleeping, worsening depressive symptoms, and physical manifestations of distress. These difficulties make it increasingly difficult for women to endure, leading to functional impairment, increased interpersonal sensitivity and social isolation, and poor self-image. As the cycle of distress and endurance continues, women reach a breaking point where suicidal behaviour is conceptualized as a way to break the cycle. While “enduring” may be an effective coping strategy for these women in the short term or in less stressful situations, in the face of serious life stressors, it can lead to feelings of low self-efficacy, hopelessness and, ultimately, suicidal behaviour.

The Confucian cultural conception of “ren” must be discussed in order to understand the experiences described by the women in this study. “Ren” can be defined as “endurance”, or putting up with sustained stress through civility and self-restraint (Yue, 1994). It has also been translated as benevolence, compassion, magnanimity, goodness, love, and charity (Lieber et al., 2004). From a psychological perspective, “ren” refers to both the capacity for self-control when suffering from emotional agitation and the ability to endure long-term suffering (Yue, 1994). The concept of “ren” has been used as to better understand the experiences of Chinese women who have experienced intimate partner violence. It was identified as a coping mechanism while remaining in an abusive relationship, and involves actions used to please the partner and ignore the abuse (Tiwari, Wong, & Ip, 2001)

Studies have explored the role of “ren” in the suicidal behaviour of Chinese women. One case-control psychological study in rural China, a belief in Confucianism was found to be protective for men but not for women with respect to suicide (Zhang, 2013). The study describes how the Confucian principle of “harmony” consists of being harmonious, self-discipline, and endurance (defined as restraining oneself in the service of long term goals) (Zhang, 2013). The value of endurance of one’s problems has been hypothesized to lead to a delay in contact with mental health services in those experiencing psychological distress (Ng, 1997). This delay can lead to a protracted pre-diagnosis stage for those suffering from serious mental illness, and mental health services are only sought in the context of despair when symptoms are too profound to manage at home (Ng, 1997).
The concept of enduring emotional pain and difficulty disclosing pain as a consequence of masculine role-expectation has been linked to suicidal behaviour in a qualitative studies of the experiences of Irish and Ghanaian males with a history of suicidal behaviour (Adinkrah, 2012; Cleary, 2012). Cultural norms of female endurance and self-sacrifice have also been elicited in a qualitative study focusing on the experience of South Asian, Surinamese and Moroccan women in the Netherlands with a history of suicidal behaviour (van Bergen et al., 2012).

Several studies have suggested that within the Chinese culture, less willingness exists to acknowledge the psychological components of stressful experiences; rather, distress is more likely to manifest in somatic symptoms (Ng, 1997; Ngai, Bozza, Zhang, Chen, & Bennett, 2014; Phillips et al., 2007; Sentell et al., 2013; Yue, 1994). As women continued to endure psychological distress, the majority began to experience somatic manifestations, resulting in increasing difficulty to endure distress.

9.5 Improving mental health care for Chinese-Canadian women

9.5.1 How do Chinese-Canadian women with a history of suicidal behaviour access mental health care?

As discussed earlier in this chapter, Chinese immigrants in Canada have been shown to use less overall health care than the general population, and that this gap is particularly significant with respect to mental health care, including visits to family physicians for mental health reasons, visits to psychiatrists and inpatient hospitalization (A. Chen & Kazanjian, 2005). Even those Chinese immigrants with severe and persistent mental illness received less treatment overall (A. Chen et al., 2010). This data is in keeping with lower mental health care service utilization by those of Chinese and Asian (including Chinese) ethnicities in Scotland and the United States (Bansal et al., 2014; Sentell et al., 2013).

Although most women interviewed in the study conceptualized themselves as depressed, they did not often present to family physicians complaining of mental health concerns. They were more likely to present with physical complaints (fatigue, insomnia, pain). Many women were finally able to access psychiatric care through the emergency department following an episode of suicidal behaviour.
A greater understanding of the cultural and mental health issues affecting Chinese-Canadian women can be helpful for family physicians and mental health clinicians to provide culturally competent care. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR and DSM-V) stress the importance of cultural formulation, but a lack of knowledge, awareness and comfort asking about cultural issues can make it difficult to use the cultural formulation in practice (Aggarwal, 2012; American Psychiatric Association, 2000; Mezzich, Caracci, Fabrega, & Kirmayer, 2009). Greater knowledge of the common life experiences, stressors, patterns of distress and barriers to care can result in a better understanding of the patient as well as a greater ability to meet her needs (Aggarwal, 2012; Laurence J Kirmayer, Thombs, Jurcik, Jarvis, & Guzder, 2008). As Canadian society becomes increasingly multicultural, multiethnic and pluralistic, greater expertise and sensitivity is needed to assess and meet the needs of the population (Alarcón et al., 2009; L. J. Kirmayer, 2006). Qualitative research, focusing on the lived experiences of those accessing care, can help reduce the perpetuation of cultural stereotypes and raise awareness of the disparities resulting from socioeconomic and sociocultural factors (Alarcón et al., 2009; Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Further, an examination of women’s experiences is necessary to better understand the social construction of gender and the ways in which gender inequality can lead to disparities in mental health (Andermann, 2010; Canetto, 1994).

In terms of screening for risk for these women, Chung (2004) had some recommendations that were validated by this study 1) exploring the relationship with family 2) understanding the impact of romantic relationships as a potential trigger for distress and 3) examining reaction to anger, low self-esteem and other strong emotions (Chung, 2004). This study was able to add some important pieces to help support family physicians, psychiatrists and mental health workers in understanding and working with Chinese-Canadian women with a history of suicidal behaviour.

9.5.2 Screening for mental health issues in Chinese-Canadian women

Somatic complaints, particularly insomnia, pain and fatigue, are an extremely common presentation for women at risk for suicide in this population (Ji et al., 2001; Phillips et al., 2007). Culturally, depression can manifest in a somatic and psychological picture known as
neurasthenia, described as an depletion of qi (“vital energy”) and a reduction of functioning of internal organs, described by Arthur Kleinman as “biculturally patterned illness experience (a special form of somatization), related to depression or other diseases or to culturally sanctioned idioms of distress and psychosocial coping.” (Kleinman, 1986). The women in this study were much more likely to present to their family physicians with somatic complaints than emotional symptoms, and insomnia in particular was a distressing symptom conceptualized as a physical problem. This finding is meaningful given its longitudinal consistency across geopolitical and historical contexts.

Given the strong association between insomnia and psychological distress in this population, Chinese-Canadian women presenting with insomnia should be screened for depression, anxiety and suicidal ideation. Common stressors seen in this population include feelings of lack of agency or victimization within the family, work, or school environment, difficulties communicating emotional distress with loved ones, and financial and employment stress related to immigration. Common psychosocial stressors also include caring for a sick parent, managing relationships with in-laws, feeling pressure pertaining to academic performance, and concerns related to behaviour of children or role as mother. Knowledge of these issues can assist health care providers in identifying and discussing these them in the context of overall mental health.

Worsening insomnia, agitation, hopelessness or significant functional decline are key indications to refer to psychiatry and should be done as urgently as possible in this population. These symptoms combined with increasing suicidal ideation, can also indicate the necessity for an urgent care psychiatric consultation through an emergency department.

9.5.3 Strategies for culturally-competent care

The women in this study described ways in which their families’ attitudes toward mental health impacted their help-seeking behaviour and adherence with treatment. If health care providers are more familiar with cultural issues in this population, they are better able to provide support and psychoeducation to the women and their families. In one study exploring the experiences of mental illness disclosure in Chinese immigrants in the United States, the importance of culturally sensitive support by health care providers to facilitate this process was seen as a critical factor to prevent stigma and enhance support (F. Chen, Lai, & Yang, 2013).
Several women described the crucial role that health care providers play in co-creating an explanatory model that validates emotional experience and instills hope. Rather than feeling as though they are weak or incapable, the women are able to understand that they are experiencing symptoms of mental illness and tremendous psychological suffering that impact their ability to function. While many women described somatic symptoms and functional impairment, fewer were initially able to describe themselves as experiencing mental illness prior to engagement with mental health care. By working with health care providers, they were able to feel validated and overcome the stigma that depression was, in the words of one woman, “incurable”. This finding is in keeping with studies measuring self-stigma of mental illness and its implications for recovery in a Chinese population (K. M. T. Fung, Tsang, Corrigan, Lam, & Cheng, 2007). Stigma was associated with lower self-esteem, self-efficacy and psychosocial treatment compliance and by creating an validating explanatory model, clinicians are able to reduce the negative view of self driven by stigma, allowing the for engagement in the recovery process (K. M. T. Fung et al., 2007).

9.6 Understanding patterns of recovery

Although the focus of this study was the experience of suicidal behaviour rather than recovery from depression, the women in this study were able to provide data that can help conceptualize the recovery process in this population, and provide support to mental health care providers to act as facilitators and advocates.

In 2011, the Substance Abuse and Mental Health Service Administration (SAMHSA) defined recovery as “A process of change through which individuals improve their health and wellness, life a self-directed life, and strive to reach their full potential” (“SAMHSA’s Working Definition of Recovery,” 2011). This document also stresses as one of its ten guiding principles that recovery is culturally-based and influenced, and that culture, including values, traditions, and beliefs, are crucial (“SAMHSA’s Working Definition of Recovery,” 2011). This document, and several others stress the importance of culturally congruent and competent services to meet the unique needs of individuals and communities (Kwok, 2014; “SAMHSA’s Working Definition of Recovery,” 2011).
The clinical model of recovery from serious mental illness and suicidal behaviour, focused on a reduction in suicidal ideation, symptom remission and functional improvement, is only one method of conceptualizing the recovery process (K. Ting, 2014; Trainor, Pomeroy, & Pape, 2004; Whitley & Drake, 2010). Within this study, every woman stressed the importance of other, more holistic models of recovery.

From a clinical perspective, validation of emotional experience by health care providers was identified as a key strategy. The women in this study also described the development of an explanatory model that places their symptoms in the context of their life histories as well as within a medical framework as extremely helpful. Medication management should be seen as a process rather than as a one-time event. Important pieces include assessment of patient and family attitudes, psycho-education and support, safe prescribing patterns, and regular follow-up. Awareness of culturally significant issues can help the clinician better identify and understand stressors in the patient’s life, and many women described a benefit from discussing these issues with their care team. Clinicians can also provide support by liaising with family members to provide psycho-education and support. Many women found this to be very helpful and benefited from family inclusion in the recovery process. Although the women stressed the importance of the clinical model of recovery, all agreed that symptom improvement through medication management was only one piece of the recovery process.

A dimensional approach to recovery, which encompasses not only clinical recovery, but functional, existential, physical and social recovery, has been described in the literature (Whitley & Drake, 2010). The women’s experiences were consistent with this model, as they described each of these pathways in their own personal recovery stories. Existential recovery, encompassing religion and spirituality, agency and self-efficacy and personal empowerment, was a key factor in the recovery narratives of all ten women in this study. They focused particularly on building a stronger sense of identity and agency as they moved forward through the recovery process. Functional recovery, focusing on employment, education and housing, was discussed at length by all ten women as well. In this population, functional recovery is tied closely with resources available to women post-immigration and they describe the difficulties they have navigating this new system. Physical recovery, describing improved diet and exercise and other lifestyle factors, maps on nicely to the theme of improved self-care that the women described.
Culturally, they are focused on enduring or “pushing forward” rather than stopping to take time to care for themselves, and several described the importance of self-care in their healing process. Finally, social recovery encompasses engagement with family, friends, peers, community and social activities. These factors, specifically the importance of engaging family support, were noted by almost every woman in this study as being key factors in recovery.

### 9.7 Limitations

This study aimed to explore the experiences of Chinese-Canadian women with a history of suicidal behaviour, in order to understand their shared life experiences, their patterns of distress and model of suicide-related behaviour, and the ways in which immigration mediates this risk.

Although thematic saturation was achieved in this sample, it is important to note that they are not representative of Chinese-Canadian women with a history of suicidal behaviour as a whole. They were all engaged in mental health care with a psychiatrist and in several cases, an interdisciplinary mental health team. They were born in Mainland China or Hong Kong, and their experiences cannot be generalized to all women of Chinese-Canadian descent. The sample size makes it difficult to interpret quantitative data beyond a clinical characterization of the sample. The identification and treatment of depression was a clear important factor in this population, but may not be for those women who have not been in psychiatric care. It is also important to note that themes of “Model Minority” stress (described in the Literature Review) and one’s own self-image as it relates to two cultures may be more prominent in second generation women who have been born in Canada and may have greater stress that comes with greater integration into the dominant culture.

Finally, this study aimed to describe the experiences of Chinese-Canadian women and focused on their cultural context. It is important to note that patriarchal structures exist in many other cultures and are not unique to Chinese culture. A review of patriarchal pressures cross-culturally and their impact on suicidal behaviour for both men and women was beyond the scope of this report.
9.8 Future directions

This study is the first study to explore the lived experiences of female Chinese immigrants with a history of suicidal behaviour. The major contributions of this study include exploring the ways that cultural conceptions of gender influence patterns of suicidal behaviour in this population, describing the ways in which immigration is both a stressor and a protective factor for women at risk for suicidal behaviour, and presenting a culturally-informed model of distress and suicidal behaviour in Chinese-Canadian women.

Several findings in this study merit further investigation, including the role of alexithymia in mediating suicidal behaviour in this group, the role of reciprocal versus authoritarian filial piety in Chinese and Chinese-Canadian women at risk for suicidal behaviour, and the impact of perceptions of parental warmth and relationship satisfaction on the risk for suicidal behaviour. As discussed in the limitations section, women who are of Chinese-Canadian descent who were not born in China or Hong Kong were not included in the sample, and it would be very valuable to examine this population, specifically the role of acculturation stress and conflict between family values. Further, this research methodology can be applied to other groups at risk for suicide in Canada, including Aboriginal peoples and men over the age of 65, in order to better understand their experiences and conceptions of suicide. Finally, a cross-cultural comparison is underway between this group and a group of women from Beijing with a history of suicidal behaviour, and this comparison will be valuable to understand the ways in which cultural scripts about suicidal behaviour are transmitted.

In the future, findings from this study can inform the development and evaluation of culturally competent strategies to promote recovery, including marital counselling, life history and narrative psychotherapeutic interventions, and a rapid access assessment and management clinic for women who are at risk. Strategies can also include including stakeholders within the community to build strategies to improve access to care for these women.

In this study, we have suggested that Chinese-Canadian women may have anxiety about seeking mental health care, for several reasons 1) suicidal thoughts is not framed as mental health issue – focus on stress and pressure, insomnia and somatic symptoms rather than mood 2) stigma associated with help-seeking – rather a focus on endurance and getting through rather than self-
care 3) feelings of lack of agency, victimization and oppression that can prevent access to care. If this is the case, there can be a role for intervening with primary health care providers to provide education, support to help manage mental health issues – referral to psychiatry, family engagement for medication management, crisis services, familiarity with cultural stresses. Provider education may also be a potential role in urgent care settings, to better understand and appreciate risk for suicide and cultural formulation in this group.

The women in this study identified medication management as a key factor in recovery. Through their experiences, several potential recommendations can be generated. In the future, these suggestions can be examined for effectiveness.

If the patient is presenting with insomnia, the practitioner should screen carefully for mood disorders, life stressors and suicidal ideation before providing sedative medication. In this study, insomnia was most often the presenting to complaint to family physicians. In prescribing sedative or psychiatric medications, it is important to build alliance with patient by providing an explanatory model for symptoms and using validation to decrease their distress. Contextual factors that can impact medication management (i.e. patient and family attitudes toward medication and mental illness, a belief that medication will not be helpful grounded in hopelessness, previous poor experiences with psychiatric medications). When prescribing medication, psycho-education is very important, particularly that medication may not work right away and that it may take some time to find the right combination. Hopelessness related to sedative medication “not working” has been identified as a major proximal risk factor for suicidal behaviour. Safe prescribing patterns, including prescribing a safe amount of medication, and following up within a week are key factors in medication management. Medication management is a process; frequent follow up and adjustment of medication, particularly with respect to over-sedation, should be the standard of care.

Stigma related to having “psychological problems” was identified as a major barrier to care for these women. This stigma can manifest in fear about disclosing illness to family or friends, being told not to take medication by family or friends, and feelings of shame and self-blame. Discussing the patient’s attitudes related to mental health and treatment and the attitudes within
the patient’s family can be an important part of providing care. Culturally appropriate client and family psychoeducation may be an important intervention based on the findings of this study.

Appendices

Appendix 1: Qualitative Interview Guide

This interview guide was adapted from a template created by Dr. A. Ka Tat Tsang (Tsang, 2008).

1. **Venue:** Wherever it is convenient for the participant, and allows sufficient privacy. Interviews will be conducted in private offices at St. Michael’s Hospital, North York General Hospital, Centre for Addiction and Mental Health or Hong Fook Mental Health Association, or at a location of the client’s choosing. The location and time will be discussed prior to the meeting.

2. **Duration:** As long as it takes for the participants to complete their stories, although we try not to go over an hour and a half. If the participant is tired, let him or her take a break. Use your discretion if it is better to go back a second time to continue the interview.

3. **Procedures:**
   - **SET UP**
i. Introduce yourself and the purpose of the interview, e.g., “I am a researcher working on a study the life experiences of women born in China who have harmed themselves in the past conducted by St. Michael’s Hospital, North York General Hospital, The Asian Clinic at the Hong Fook Mental Health Association, the Centre for Addiction and Mental Health, the University of Toronto and Tsinghua University in Beijing. The purpose of our research study is to explore the experience of women born in China who have had suicidal thoughts and actions in the past.”

ii. Explain the key content in the consent form (e.g., confidentiality and anonymity, the participant’s right to withdraw and to delete data).

iii. Explain the need for audio-recording and obtain approval from the participant.
[Remember to bring your recorder and to check it for proper functioning, including sufficient battery life, memory space for recording]

iv. Obtain written consent. If the participant can't read or write, seek the participant's approval to start recording, read out the consent form and provide explanation if necessary, then obtain the participant's verbal consent, make sure that you record the whole process

B. OPEN EXPLORATION

i. Start the conversation with a brief prompt, e.g., you may repeat the purpose of the research and invite the participant to share his/her experience, the following are examples of what you may want to say to the participant:

Thank you for giving us the time to do this interview with you. The main purpose of this interview is to understand the experience of women who have had suicidal thoughts and actions. We are most interested in your personal experience.

You can start with whatever you want to talk about first (if participants asked what they should start with).

ii. the main purpose of this part of the interview is to allow the participants to express themselves as freely as possible, this can be achieved by keeping in mind that:
The participant decides what is important to him/her, so let them talk about whatever they want to as much as possible. That means we DO NOT control the agenda rigidly, but try to allow maximum narrative space. You may also want to make sure that you do not interrupt the participant or cut her/him off.

Each individual has his/her own idea of what is relevant to the research question. You should let them talk even though you may find what he/she says is irrelevant, unless the speech is obviously cyclical or incoherent. You may, however, repeat the research question at times to remind.

Respect the participant’s language by using their expression and their wordings as closely as possible, this will avoid unnecessary (mis)interpretation and narrative conditioning on our part.

Use more prompts and invitations, and use less questions; e.g. invite them to elaborate on or explain about, or give examples for a topic or an experience that they have mentioned. A question-and-answer format tends to put the participant in a passive mode, and severely compromises the opportunity for the participant to volunteer information which is not on your list of questions, therefore defeating the very purpose of ethnographic or discovery-oriented interviewing. If you need to ask questions, ask open-ended and not close-ended questions. Ask specific questions only when you have collected enough information from a topic and need to know the specific details.

Summarize what the participant has said would let him/her know that you've been listening, and help to build a good rapport. This is also helpful when you want to shift the conversation to another topic - make a summary first and smoothly change the topic. Try to be brief with summaries, for long summaries might turn people off.
(6) The purpose of this interview is to explore and discover, **NOT** to solve problems, provide therapy/counseling, or offer help. If you think the participant is not receiving the service he/she needs, you can make necessary referrals after the completion of the interview.

(7) Pay attention to “free information” (content not requires by your question or request, given to you freely): The participant offers as he/she responds to your prompts and questions, these are often things that the participant want to talk more about

iii. Please try to jot detail notes during the interview, this will help you to keep track of what has been said and to make summary. Please also note down your impressions, and the participant’s non-verbal behaviors whenever possible. These notes can be especially valuable in the unlikely event of recording failure.

iv. When you think the open exploration part has been completed, try to summarize the main points of the conversation and ask the participant if he/she has any thing more to add. If not, thank him/her for the sharing. Then prepare them for the structured exploration part by saying something like, “In the remaining time, I am going to ask you some further questions.”

C. STRUCTURED INQUIRY

i. The purpose of structured inquiry is to focus on specific areas or issues we are interested in, but have not been addressed by the participant in the Open Exploration section. These areas may include those that are potentially sensitive or embarrassing for the participant (e.g. elder abuse, sexuality, family conflicts, stigmatized conditions such as disability, cancer, mental illness, etc.). It is hoped that by this time, you would have established a good relationship with the participant and he/she might be more ready to talk about these topics
Before we ask the questions, note if any of them had already been answered during the Open Exploration. Ask only those that have not been addressed. Asking the question again will make the participant feel that we have not been paying attention and listening carefully.

**Topics for exploration**

1. Tell me a few things about you and your life
2. Tell me about the people who are most important to you
3. How did you come to be receiving care at ______?
4. Tell me what life was like for you before you needed this care
5. When did you first experience thoughts of harming yourself? What was that experience like for you? What were your thoughts at that time? Who if anyone influenced your thoughts? How did they influence your thoughts?
6. Could you describe the events that led up to you harming yourself? What circumstances contributed to this? What was going on in your life then?
7. How would you describe how you viewed yourself before it happened? How, if at all has your view of yourself changed since that time?
8. How do you see your life now?
9. How has the fact that you are a woman influenced your life?
10. How has your culture influenced your life?

*If the participant introduces the following concepts, the interviewer will ask open-ended clarifying and exploratory questions pertaining to that topic.*

1. Cultural scripts of suicidal behaviour – “allowable” behaviour for men and women
2. “Model Minority”: perceptions and stressors
3. Familial obligations and expectations related to gender – support, stressors
4. Romantic relationship support and stressors
5. Friendship support and stressors
6. Self-image and identity
7. Changes in relationships, identity, emotions in times of transition (immigration, education, employment) – “now and then”
8. Ways of communicating distress – role of cultural conceptions of gender
9. Experiences of racism and/or sexism
10. Ways of coping – the ways in which culture and gender can shape options
11. Impact of culture or gender on experiences of help-seeking
12. Experiences of religious or spiritual supports
13. Stigma – within family, within family culture, within Canadian culture

Ways in which to ask follow up questions about sensitizing topics (probes and clarification)

1. Can you tell me more about that (person, event)?
2. Can you give me a specific example?
3. Can you explain your answer?
4. In what way?
5. How did you understand that?
6. What does that mean to you?

Wrap up questions

1. Do you have anything to add?
2. Is there anything I should have asked?
3. How did the interview feel for you?
4. Is there anything that surprised you?
5. How are you feeling now?
References


Richards, H., & Schwartz, L. (2002). Ethics of qualitative research: are there special issues for health services research? *Family Practice, 19*(2), 135–139.


