MENTAL HEALTH OF ST. JOHN'S IMMIGRANTS:
CONCEPTS, DETERMINANTS AND BARRIERS

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CONCEPTS, DETERMINANTS AND BARRIERS

By

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Abstract

Canada is in one respect like the kingdom of Heaven: those who come at the eleventh hour will receive the same treatment as those who have been in the field for a long time. We want to share with them our lands, our laws, our civilization ... Let them take their share in the life of this country ... Let them be electors as well as citizens. We do not want or wish that any individual should forget the land of his origin. Let them look to the past but let them still more look to the future. Let them look to the land of their ancestors, but let them look also to the land of their children. Let them become Canadians...

Sir Wilfrid Laurier, 1905

Immigration-related difficulties and excessive social stress are the reasons for immigrants' vulnerability toward developing mental illness. In addition, immigrants experience numerous organizational, communication and financial barriers to utilizing mental health services. Very little is known about the mental health concerns of immigrants in St. John's, where both ethnospecific infrastructure and cultural diversity is very limited. For this reason, this qualitative inquiry examines, through the personal experiences and perspectives of eight St. John's immigrants, their concepts and determinants of mental health, as well as the barriers to their utilizing mental health services. In addition, this inquiry evaluates how the local mental health promotion programs and healthcare services address immigrants' mental health needs. The goal of this study is to increase the understanding of mental health providers and policy makers about the determinants of immigrants' mental health, which can then inform the development of accessible and appropriate support mechanisms tailored to the mental health needs of the St. John's immigrant population.

The findings that emerged from a thematic analysis of the semi-structured, open-ended interviews conducted show that St. John's immigrants understand mental health in broad holistic terms and do not see any clear-cut boundaries between mental health and illness. Moving to Canada challenges immigrants' stereotypes about mental illness, but also exposes them to the ideology of medicalization, according to which the reason for their mental unwellness lies in defective biological processes rather than in faulty sociopolitical structures. There are several key determinants that shape immigrants' mental well-being: the lack of social support, resources and information, financial difficulties, and unemployment. Furthermore, their cultural identities are often not appreciated or understood. These factors contribute to immigrants' stress, and their feelings of loneliness and isolation. As a result, some suffer from depression and seek professional medical attention. However, the mental health promotion programs and services only reflect immigrants' mental health needs and concerns to a very small extent and have a limited ability to address immigrants' vulnerability to developing mental illness. In addition, immigrants encounter several barriers to utilizing these services: for instance, lack of information, culture, language, waiting times, and finances.

This study supports previous research calling for major changes across different levels of healthcare, social, economic and political systems. In order to improve the mental well-being and integration of St. John's immigrants, several suggestions are proposed to health and social services providers so as to address the lack of support, information and resources for immigrants, as well as unemployment, cultural conflicts and the barriers to utilizing mental health services that immigrants experience.

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List of Abbreviations

ADHA	Attention Deficit Hyperactivity Disorder
ANC	Association for New Canadians
APA	American Psychiatric Association
CFIRC	Canada First Immigration Reform Committee
CIC	Citizenship and Immigration Canada
CMHA	Canadian Mental Health Association
CTFMHI	Canadian Task Force on Mental Health Issues
DSM	Diagnostic and Statistical Manual of Mental Disorders
ISAP	Immigration Settlement and Adaptation Program
NL	Newfoundland & Labrador
NLMA	Newfoundland & Labrador Medical Association
SC	Statistics Canada
USDHHS	U.S. Department of Health and Human Services
WHO	World Health Organization

1. Introduction

The research on immigrants' mental health conducted in the last three decades has elicited findings which support the notion that the immigrant population is vulnerable toward developing mental illness. Generally, researchers cite two main reasons to account for immigrants' vulnerability to mental illness. The first reason is the immigration process itself (often called "uprooting") when one leaves behind his/ her native land and encounters adaptation difficulties in the new environment (Liebkind, 1996; Sam and Berry, 1995). The second reason is excessive social stress caused by "social isolation, cultural conflicts, poor social integration and assimilation, role changes and identity crises, low socioeconomic status, and racial discrimination" (Kuo and Tsai, 1986, p.133).

In addition, three sets of factors are used in understanding the mental health problems of immigrants: the characteristics of the immigrant (demography, language and culture); the migration (motivation and circumstances); and the characteristics of the receiving society (public attitude, immigration policies and services, pre-existing ethnic community, and so on) (Nguyen, 1984). These factors do not influence immigrants' health in isolation, but rather interact with each other and behave either as facilitators or stressors of immigrants' mental health at the same time: "It is not immigration per se, nor even its challenges that creates mental health risk, but rather the interaction between vulnerabilities, stressors, social resources and personal strengths" (Beiser, 2005, p.38).

Since large numbers of immigrants stream into Canada every year, there is an acute need to develop mental health promotion strategies and mental health services that would respond appropriately to the needs of the immigrant population, and enable immigrants to cope with resettlement stress and maintain good mental health.

Despite the existence of a broad spectrum of mental health determinants, current research focuses mainly on identifying the barriers which prevent immigrants from utilizing mental healthcare services. These studies found that immigrants have to overcome financial, cultural, and organizational barriers (Cheung and Snowden, 1990; Woodward et al., 1992) as well as physical (Leong and Lau, 2001; Miranda and Grenn, 1999), communication (Herrick and Brown, 1998) and information barriers (Sadavoy, Meier and Ong, 2004) in order to access and use mental health services. The healthcare system proposed several models for developing and implementing strategies that would aid immigrants in utilizing healthcare services. The Model of Cultural Competence and Health Care Delivery enables diverse populations to utilize mental health services by incorporating the principles of availability, accessibility, affordability, acceptability, appropriateness and adoptability to the current healthcare system (Campina-Bacote, 1997). Further, Becker and Maiman's Health Belief Model emphasizes that "understanding cultural beliefs about health and illness is key to understanding how best to serve diverse populations" (Herrick and Brown, 1998, p.232). This model is based on the idea that health seeking behaviour is determined by people's perceptions of a threat to their health as well as their trust in the efficacy of the healthcare itself (Becker and Maiman, 1975).

Although incorporating these models into the healthcare system can ease immigrants' access and utilization of mental health services, these models do not address the sources of immigrants' vulnerability to mental illness and profound problems already mentioned by Kuo and Tsai (1986). The right key to designing and implementing mental health promotion strategies and mental health services that are appropriate and accessible to the immigrant populations is the identification of complex and interrelated factors that influence the mental health problems of Canadian immigrants. For this reason, in order to address immigrants' vulnerabilities to developing mental illness caused by social isolation, cultural conflicts, discrimination and/or low socioeconomic status, major changes need to occur at a variety of different levels of healthcare, social, economic and political systems.

1.1 Research questions and objectives

The necessary structural and functional changes to mental health promotion strategies and mental health services can be executed only when researchers, healthcare providers and policy makers will listen to the voices of immigrants. It is essential to understand what makes immigrants healthy, or, on the contrary, what prevents them from sustaining their mental health, and what support mechanisms and services could best offer the help they need.

Indeed, the Canadian government recognized the importance of understanding immigrants' health needs in the late 1990's by establishing the Canadian Metropolis Project. This group promotes and supports research on immigration and integration that

informs policy making (Kinnon, 1998). Researchers from four university-based Centres of Excellence in Montreal, Toronto, Edmonton and Vancouver conducted city-specific studies relevant to three main domains: promotion of population health, health system support and renewal, and management of risks to health. As Kinnon (1998) describes, some studies focused specifically on the mental health issues of immigrant populations. For instance, Dossa performed her research with elderly Iranian immigrants in Vancouver, Hyman and Noh worked with Ethiopians refugees in Toronto, Kirmayer et al. examined mental health issues among Vietnamese, Anglo-Carribean and Filipino immigrant communities in Montreal and Baker undertook a mental health relevant study among Vietnamese and Indian immigrants in New Brunswick.

Besides research carried out by the Metropolis Centres, other mental health researchers have worked with immigrant communities in Toronto (Ahmad et al., 2004; Sadavoy et al, 2004; Wong and Tsang; 2004) and in Vancouver (Dossa, 2002). But, to my knowledge, there has been no similar research, which focuses on determinants of immigrants' mental health carried out in Newfoundland and Labrador (NL).

Since there is no study that looks at immigrants' mental health needs in NL where ethno-cultural communities are small, and ethno-specific support networks and infrastructures are fairly limited, the purpose of this qualitative inquiry is to explore mental health issues pertinent to St. John's immigrants. The study objectives are:

1.   to examine St. John's immigrants' understanding of mental health and illness;

2.	to identify immigrants' mental health needs, in particular facilitators and barriers to maintaining their mental health as well as their perspectives of support mechanisms and services that could facilitate sustaining their mental health; and

3.	to identify immigrants' barriers to utilizing the local mental health services and scan what mental health programs and services targeting the immigrant population are in place in St. John's

1.2 Research rationale

My interest and curiosity about the mental health needs of Canada's immigrant population is born out of my experiences of being a Canadian immigrant as well as my training in medical psychiatry. As an immigrant, I often ask myself how long I can cope with prejudice, how long it will take to feel differently about my life in this new country or how long it will take for me to "end up" at the hands of mental healthcare providers. In spite of the fact that I earned my Canadian citizenship, I am still facing life situations and circumstances that have the potential to negatively impact my mental health:

- I have very limited chances of finding a job that I am qualified for due to unrecognized foreign educational credentials and no North American work experience.

- I have lost all privileges, respect and social status associated with being a medical doctor that I enjoyed in my home country.

- My birthdays and religious holidays nobody remembers.

- I had nobody to prepare a shower for my baby or celebrate my college graduation with me.

- I had nobody to visit me in the hospital and care for me after the surgery.

- I had nobody to call when my child became sick and I had to skip an important college class.

- My children are scared and shy around their grandmother who visits every other year and they can barely communicate with her in my mother tongue.

- I am a woman who cherishes family values and the privacy of her body while the society around me measures success based on one's career, achievements and attractiveness.

- Wearing my hijab (scarf and clothes that cover my body) makes me the object of unwanted stares from strangers.

- When I showed up at a pre-booked appointment to see a new apartment I wanted to move into, I was told it was not longer available. However, when my Canadian born friend called the landlord she learned that the apartment was still available – but, probably, just not for me and my family.

- When I contacted a Canadian professor with a request to supervise my graduate studies, he was pleased with my resume and invited me to see the University labs. When I met him in person, he could not hide his disappointment and told me that my English was not good enough to suit Canadian academic requirements. (Incidentally, my TOEFL score was 630 while Canadian Universities require a score between 550-580).

- Since 2001, I have been bombarded daily by media images and news associating my religious beliefs with acts of terror, violence and injustice.

- All Canadian daycare centres require a clean criminal record for anyone working with children, yet I was the only student "checked upon" by a security guard when doing my field placement.

These are just a few examples of my everyday experiences of being a female Canadian immigrant.

My professional background in psychiatry makes me sensitive to immigrants' vulnerability to mental illness. Looking through the eyes of a psychiatrist, I cannot help wondering whether immigrants exposed to experiences similar to mine feel mentally healthy and well. I am asking if they know where, when, how and why to seek help when they need it, and whether this help is appropriate and sensitive to their needs as well as their social and cultural location. I am curious as to whether the treatment of immigrant individuals considers their potentially different biological and genetic make-up as well as their different ideas about treating mental illness.

Thus, my personal experiences, stresses, and frustrations associated with being a Canadian landed immigrant led me to conducting this project in St. John's, the provincial capital, of which 3 % of the total population or about 4,885 immigrants, including me, call home (Statistics Canada, 2001).

1.3 Research significance

I expect that this study will improve the understanding of the local medical community and policy makers about the mental health needs of St. John's immigrant population, about factors that facilitate immigrants' mental health or prevent them from maintaining it. It will also provide information on how St. John's-based organizations and agencies, concerned with promoting mental health and providing mental health services, address the mental health needs of the immigrant population and identify any gaps in these services. My goal is to provide an insight that can inform the development of accessible and appropriate mental health services and support mechanisms specific to the St. John's immigrant population. Without the information that this study will provide, immigrants will remain at risk of not receiving timely help and possibly developing a variety of mental disorders.

Moreover, the Government of Newfoundland and Labrador recently announced its intention of attracting more immigrants to the province. According to Premier Williams, "increased immigration presents an excellent opportunity to stimulate and enhance the economic, social and cultural development of the province" (Government of Newfoundland & Labrador, 2005, n.p.). I believe that the plan of attracting immigrants to the province can be successful only if the healthcare, social and community services are in place so as to address properly the unique needs of immigrants. In order to develop these services, studies such as this one are essential.

1.4 Assumptions, scope of the study and limitations

Assumptions

When I approached this study I did not assume the role of the social scientist who lacks "familiarity with what is actually taking place in the sphere of life chosen for study" (Blumer, 1969, p.33). My experience of being an immigrant woman and being trained in psychiatry provides me with a partial understanding of the subject as well as the field of this study. My knowledge, personal biography and social location are reflected in developing my research questions and the underlying assumptions about the study outcomes.

In addition, my assumptions were shaped by the fact that all the participants I recruited are non-Caucasians of non-European origin (visible minority group). The term 'visible minority', in the minds of Canadians, is translated as immigrants "who don't speak English or who speak English with an accent (other than British and American), ...who have certain jobs (e.g. cleaning lady or a sewing machine operator)" (Ng, n.d., p.22). Ng demonstrates through the examples of immigration rules and employment inequalities that white European and American immigrants are considered superior to "visible minorities". While white western immigrants enjoy the advantage of the point-entry immigration system valuing their assets (education and training) more than those of visible minorities, visible minority immigrants are granted immigration only "when there are demands for particular kinds of skills...and to fill gaps in economy" (Ng, n.d., p.24). Speaking of employment, Ng (n.d., p. 28) points out that the Canadian labour market is, in fact, segregated:

Women holding managerial, administrative, and professional jobs (e.g. medicine, the social and physical sciences, the arts) are from the United Kingdom and the United States. By contrast, women from southern Europe, Asia, and other parts of the world tend to concentrate in the service, processing, fabricating and assembly sectors of industries.

Ng (n.d.) clearly shows that there are inequalities in employment and social status (and I add probably in health too) between white western and visible minority immigrants. For this reason health providers and policy makers need to understand that "immigrants and minorities are not a monolithic group. Therefore, immigrant or minority groups should be assessed separately to direct group-specific policies for improving health outcomes and patient satisfaction through the provision of equitable, effective and efficient health care" (Aroian, 2005, p.105).

Due to my medical knowledge, immigration experiences and profile of the study participants, I assumed that immigrants' mental health and illness could be influenced by a combination of many factors - not just those related to our biology and psychology. I expected that immigrants' understanding of what it means to be mentally healthy could differ from definitions supplied by medical textbooks. I also anticipated that factors such as social support, employment, income, and culture would play a greater role in maintaining their mental health than a simple presence and delivery of mental health services in their close proximity. Thus, I expected that my research findings would challenge some basic concepts of mental health and illness, as defined and applied by current mental healthcare services.

The study scope and its limitations

My research focuses on people who have been or still are Canadian landed immigrants. I excluded immigrants in refugee class, international students and those with temporary worker's permits due to the time feasibility of this project. Thus, the scope of my study becomes one of the study limitations since the health needs and perspectives of those beyond the scope may differ in some aspects from those experienced by landed immigrants.

The second point to remember is that the landed immigrants who participate in my study are all residents of St. John's, the provincial capital. The reality of immigrants in other places and/or at other points in time can be very different and reflect different social backgrounds and experiences from those captured in this study. For instance, the health needs and perspectives of immigrants residing in remote rural areas of the province where the access to services and social networks are fairly limited (Gojer, 1992) may differ from those of the research participants. Similarly, the needs and perspectives of immigrants settled in large urban areas of Ontario or Alberta where the ethnocentric support infrastructure is stronger than what is available in NL (but still falling far short of what is needed) can be different from the needs and perspectives of the immigrants residing in St. John's.

Although my research participants vary with respect to their gender, ethnicity, culture, educational background, and employment status. I was unable to recruit participants who are single, widowed, adolescent, elderly, suffering from disability or chronic disease and/or unable to speak English. All these different qualities locate

participants differently and result in diverse social experiences. Therefore, this study is limited to the health needs and perspectives of the study participants as captured in November 2005 and is not generalizable beyond this group.

The scope of this study may seem broad. The study addresses a wide range of problems related to the mental health issues of immigrants rather than exploring a single aspect pertinent to immigrants' mental health. Since there is very little known about St. John's immigrants' mental health, there is an urgent need to explore a broad spectrum of immigrants' mental health issues. Focusing in-depth on a very specific research question with no previous general knowledge of immigrants' mental health would make this study incomplete. My primary goal was to find out what accounts for immigrants' mental health and well-being. However, identifying the determinants of immigrants' mental health is not possible without a proper understanding of immigrants' conception of mental health and illness. Therefore the scope of the study is broadened to include immigrants' perspectives on mental health and illness. In addition, this study examines immigrants' barriers to utilizing mental health services since the provision of appropriate and accessible healthcare services is one of many health determinants that I describe in Chapter 2. Lastly, the study briefly looks at the provincial mental health initiatives, programs and services tailored to the immigrant population in order to see how they address the identified determinants of immigrants' mental health.

In order to conclude the section on study scope and limitations, I need to say that I believe that the role of the researcher's background and standpoint in interpreting findings and developing theory needs to be acknowledged. In Weston's (1996, p.276)

words: "no longer is it acceptable for...researchers to conceal or deny significance of their gender identity, age, class, or ethnicity. Instead, contemporary...writings tend to acknowledge these attributes as factors that shape interpretations of what they observed in the field." Similarly, the standpoint I take influences the way I interpret the findings. For instance, someone else could understand immigrants' barriers to maintaining mental health as being the consequences of their cultural "otherness". While one could blame the immigrants' different values and lifestyle for the social isolation they experience, I rather see this isolation as a consequence of social oppression and discrimination. Although one might perceive acknowledging the influence of the researcher's background on shaping the interpretation as a personal bias, it is an important feature of qualitative research without which the validity of any qualitative inquiry cannot be established.

1.5 Outline

The remainder of the thesis is organized as follows: Chapter 2 provides a literature review regarding the issues of different concepts of health and illness, health determinants and health promotion. Further, it examines the mental health issues surrounding immigration, immigrants' barriers to maintaining mental health and utilizing mental health services. Chapter 2 also pays special attention to the mental health of immigrant women. Lastly, it provides information on the Newfoundland context of immigration and immigrants' mental health.

Chapter 3 explains the methodological framework and research approaches utilized in this study. As well, it describes the methods such as interviews and

environmental consumer scan employed in collecting and analyzing data. In addition, this chapter includes the information on ethical considerations and the dissemination of the data collected.

Further, chapter 4 provides a discussion of immigrants' mental health concepts as well as mental health needs, in particular the seven factors pertinent to immigrants' mental health: social support, income, employment, culture, gender, physical environment, and coping skills.

Then, in chapter 5, the focus shifts to immigrants' perspectives on mental health promotion and healthcare services. The chapter also provides the results of the consumer environmental information scan of available mental health promotion initiatives and mental healthcare services specifically tailored to the immigrants' mental health needs.

Lastly, chapter 6 provides summary of the findings. It also describes the recommendations and implications that the findings have for immigrants, healthcare providers and policy makers.

2. Literature review

2.1 Concepts of health, illness and health promotion

I recognize that there are plenty of different definitions and concepts of mental health and illness available in the medical literature. For this reason, this section provides the reader with an overview of the main concepts of health, illness, and health promotion that I consider essential to exploring immigrants' views of mental health and illness. These concepts include the biomedical model of health and illness, and several public health models. An understanding of people's conceptions of mental health and illness is fundamental to developing and implementing strategies and mechanisms which can strengthen their mental well-being.

2.1.1 Biomedical model of health and illness

Many sociologists and social scientists argue that medicine is just a product of a particular society and its values are located in certain historical, cultural and political circumstances and that "the modern and western medical model of disease is only one possible understanding" (Clarke, 2004, p.199). However, it is the biomedical model of health and illness that has dominated western conceptions of medicine and medical practice since the 17th-century, when body and mind were separated as two independent entities (Shah, 2003).

Current medical understanding that these two elements, body and mind, do not exist in pure isolation since the brain carries out not only all mental functions but also

"somatic functions, such as movement, touch, and balance" and "physical changes in the

brain often trigger physical changes in other parts of the body" (U.S. Department of

Health and Health Services (USDHHS), 1999, p.6) is fairly limited.

The biomedical model, which is based on positivist attributes such as objectivity,

certainty, generalizability, quantification, replication, and causality, assumes that

scientific knowledge is the universal truth without paying attention to complex context in

which diseases occur and individual patients' characteristics (Clarke, 2004). The

biomedical model which reduces medicine to the physical observation, physical

categorization and physical explanation of the patients' bodies, views health mainly as

the absence of disease, and treats a human body as a machine that can be repaired when it

is broken (Clarke, 2004; Shah 2003). Further, Clarke (2004) and Shah (2004) explain

that, according to the biomedical model, the reasons for ill health lie in pathological,

biological, and chemical processes inside and outside the human body while social,

psychological, spiritual and economic factors play a very little role in people's health.

The biomedical model focuses on primary healthcare services whose task is to identify a

specific reason for the pathological processes inside the body and provide a "magic pill"

that cures disease.

The western understanding of mental health and disease, psychiatric and

psychological sciences, as well as mental health services reflect too the outlined concepts

of the biomedical model. The biomedical model of mental illness promotes the belief that

mental health is the absence of mental disease which is regarded as a biological entity

with a specific biological treatment. The widely used fourth version of Diagnostic and

Statistical Manual of Mental Disorders (DSM-IV) reviewed and published on a regular

basis by the American Psychiatric Association (APA) defines mental disease as "a

clinically significant behavioural or psychological syndrome or pattern that occurs in an

individual and that is associated with present distress or disability or with a significantly

increased risk of suffering death, pain, disability, or an important loss of freedom" (APA.

2000, p.6). According to the Surgeon General, mental disorders are "health conditions

that are characterized by alterations in thinking, mood, or behavior (or some combination

thereof) associated with distress and/or impaired functioning" (USDHHS. 1999, p.5). The

DSM-IV further classifies mental disorders into narrowly designed categories and the

causes of mental disorders are attributed to biological reasons such as impairment of

brain enzymes or neurotransmission processes while the role of social and other factors in

the etiology of mental disorders is minimized (Fernando, 2003). As Kwok (n.d., para 16)

says, "In Canada, the DSM-IV is the Bible for psychiatrists and residents. Yet, DSM-IV

very often deals with symptoms rather than causes."

In addition, Fernando (2003) adds that the biomedical model of mental health and

disease does not consider spirituality and religion as relevant to mental health since they

are not in compliance with the secular "scientific" approaches that psychiatry and

psychology developed. He says that rather than seeing people who feel, believe and

know, mental health professionals separate, measure and judge the patients' feelings,

beliefs and knowledge as separate units. In the biomedical model, there is no space for

accommodating different cultural perspectives of mental health and illness, which

prepares fruitful soil for wrong assessments and treatments of patients from other cultures

(Fernando, 2003; Kleinman, 1988). In addition, several mental disorders identified to be

disorders in non-western cultures such as koro, susto or taijin kyofusho are not

recognized by the internationally used DSM-IV.

Another feature of the biomedical model of mental health and disease is its

tendency to medicalize social problems and search for biological explanations for

different social phenomena, such as the recently introduced concepts of genetic and

biochemical causation of extremely violent behaviours, (e.g. mass killing or paedophilia)

(Halmshaw and Hillier, 2000; Fernando, 2003). Many of these concepts of medicalization

are based on the widespread use of antipsychotic drugs that have revolutionized

psychiatry. These drugs have the ability "to suppress the feelings and emotional states

that are considered to be 'symptoms' of illness" (Fernando, 2003, p.110). Clarke (2004)

provides the example of medicalized psychiatry in the case of creating the Attention

Deficit Hyperactivity Disorder (ADHD) to frame some behavioural problems of school-

age children as a disease. She believes that the creation of the ADHD category was only

based on a discovery that Ritalin (an antipsychotic drug) suppresses the disorder's

symptoms.

Lastly, some mental health professionals question the validity of diagnostic

criteria for mental disorders since these criteria are influenced by specific sociopolitical

and historic circumstances, which is precisely the argument of the sociologists and social

scientists formerly mentioned (Clarke, 2004). One of the many examples demonstrating

the controversy of what is being defined as mental illness is homosexuality. Until 1973,

APA considered homosexuality to be a mental disorder but after political pressure from

various gay rights activists, APA voted to remove this classification and regard homosexuality as an alternative sexual orientation (Lamberg, 1998). Similarly, diagnoses such as involutional melancholia of menopausal women were excluded from DSM-III due to lack of clinical evidence (Kohen, 2000).

Despite arguments that western psychiatry is embedded in the cultural and sociopolitical atmosphere of the west, despite the acknowledgement of the limitations of the biomedical approach to mental health, and despite plenty of research doubting the biological causation of mental disorders (Kiesler, 2000), the biomedical model, nonetheless, continue to dominate understandings of mental health and illness in Canada. In Fernando's words, this model of "biopsychiatry" became "the base line, or standard" in the training of mental health professionals (Fernando, 2003, p.113).

Historically, biomedically oriented mental health services underwent transformations reflecting changes in understandings of mental illness and in the sociopolitical climate in all societies (Fernando, 2003). This pattern of change can be observed in the structure of mental health services in Canada as well. The governmental report on mental health shows a great shift in the provision of mental health and addiction services from institutionalized care to deinstitutionalized care (Government of Canada, 2004). Deinstitutionalization started in the 1960's and continues to the present day. According to the report, "the preferred model of mental health service delivery currently includes a broad range of coordinated community services operating in conjunction with the psychiatric units in general hospitals and an associated regional tertiary mental health care center" (Government of Canada, 2004, p.143).

In addition, Fernando (2003) notes the language changes used in the British

mental health field; "psychiatric units" are now called "mental health services", "mental

health problem" stands for "mental illness", "psychiatric treatment" is substituted by

"mental health intervention" and "patients" become "service users." However, despite the

changes in the language and service delivery, "it is hard to find any improvement in terms

of humanity, support and understanding, care and protection of the vulnerable, and

respect for the views and wishes of service users" (Fernando, 2003, p.114).

2.1.2 Public health models and health determinants

A new perspective of health, the causes of ill health as well as the prevention and

treatment of ill health was advanced in Canada three decades ago. In addition to human

biology, three factors were determined to be important determinants of health: lifestyle,

environment and healthcare delivery (Lalonde, 1974). More recently these determinants

were expanded to include: income and social status; social support networks; education;

employment and working conditions; physical environment; biology and genetic

endowment; personal health practices and coping skills; healthy child development;

health and social services; gender; culture; and social environment (Federal, Provincial

and Territorial Advisory Committee on Population Health, 1994; Wilkinson and Marmot,

1998; Health Canada, 1996).

This new public health model, based on the mutual interaction of different health

determinants, was developed as a response to the limitations of a biomedically based

healthcare system which, in Epp's (1986, p.3) words, is not capable of addressing the

following three major challenges:

> Disadvantaged groups have significantly lower life expectancy, poorer health and
> a higher prevalence of disability than the average Canadian; various forms of
> preventable diseases and injuries continue to undermine the health and life quality
> of many Canadians; and many thousands of Canadians suffer from chronic
> disease, disability or various forms of emotional stress and lack adequate
> community support to help them cope and live meaningful, productive and
> dignified lives.

The idea that health and illness is influenced by many other factors beside biology

is reflected in other models of health, such as the World Health Organization (WHO)

model, which defines health as "a state of complete physical, mental and social well-

being" (WHO, 1978, p.2) and the wellness model, which sees health as the "strength and

ability to overcome illness" (Larson, 1999, p.129).

Similarly, WHO developed a definition of mental health that significantly differs

from the one used by the biomedical model. WHO (2001, para 1) states that "concepts of

mental health include subjective well-being, perceived self-efficacy, autonomy,

competence, intergenerational dependence, and self-actualization of one's intellectual and

emotional potential, among others. From a cross-cultural perspective, it is nearly

impossible to define mental health comprehensively."

Other authors introduced the concept of the continuum of mental health and

illness, which emphasizes that there are no clear-cut boundaries between health and

disease, just as there are different levels of health that people can achieve, based on their

values and beliefs (USDHHS, 1999). One example of the mental health and illness

continuum is the concept of "mental health problems" recently introduced by both the

U.S. and Canadian governments. "Mental health problems" are frequently experienced

difficulties whose clinical expression matches the signs and symptoms of mental

disorders, but their intensity or duration does not meet the criteria for any mental disorder

(USDHHS, 1999; Health & Welfare Canada, 1988). One of the examples of such mental

health problems are symptoms of bereavement that last less than two months and thus

cannot be considered, according to the DSM criteria, a mental disorder. However, if these

symptoms are left without proper care, they may further progress and develop into

depression. This means that an "early intervention is needed to address a mental health

problem before it becomes a potentially life-threatening disorder" (USDHHS, 1999, p.5).

In my opinion, the above WHO's definition, and the notion of disease continuum

capture more precisely the concepts of mental health and illness when compared with the

biomedical model. All identified health determinants play a significant role in people's

mental health. My intention, therefore, is to find out what determinants St. John's

immigrants consider to be the ones that help them stay mentally well and/or the ones that

contribute to their daily stress and difficulties.

2.1.3 Health promotion and illness prevention

An understanding of different concepts of mental health and illness is essential for

designing effective mental health promotion and illness prevention strategies. Within the

biomedical model, there are limited ways of promoting health, since the biomedical

model considers biology to be the main cause of ill health and regards socio-

environmental factors to be only contributing elements. For instance, biomedically oriented researchers argue that it is mental illness that leads a patient to poverty and unemployment rather than seeing poverty and unemployment as causes of mental illness (Shah, 2003). Therefore mental health promotion and illness prevention strategies derived from the biomedical model focus mainly on battling individual stress and minimizing the consequences of illness. Fernando (2003, p.98) says that in biomedically oriented mental healthcare systems, patients "are seen as suffering an acute illness followed by social handicap", which requires rehabilitation and long-term support in order to prevent relapses of acute illness and integrate patients back into society. These two strategies (rehabilitation and long-term support) are examples of a very limited kind of mental health promotion that a mental healthcare system can offer to its users.

Considering a wide range of the previously outlined health determinants, mental health promotion and illness prevention strategies have to address a broad spectrum of social, economic and political factors accountable for shaping one's mental health. Green and Kreuter (1990, p.321) define health promotion as a "combination of educational and environmental supports for actions and conditions of living conducive to health." The Ottawa Charter for Health Promotion proposed that the first step towards building effective heath promotion is to enable people "to increase control over and to improve their health" by allowing them to identify and realize their aspirations, satisfy their needs and change their environment as well as providing them with basic health resources such as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, and social justice and equity (WHO, 1986, p.425).

Health promotion information campaigns per se are not sufficient to achieve these goals. They have to be combined with a range of other activities such as education, training, research, legislation, policy coordination and community development (Epp, 1986). In addition, these health-promoting activities need to be executed at various levels represented by individuals, families, communities, and society as a whole (Hamilton and Bhatti, 1996).

Since immigrants usually establish ties within their own communities, health promotion at the community level, as developed by Labonte (1996), may be very efficient. He believes that it is communities which define their own problems and concerns. If healthcare providers and policy makers aim to empower these communities, they have to let the communities decide for themselves what is important to them. Further, Labonte (1996) talks about several important aspects of community health promotion. In order to be successful, a policy needs to be developed at the micro-level, represented by an individual health unit or agency that articulates its goal (a mission statement), action (a commitment of funds and/or staff), and permission to work with the community (a permission statement).

Labonte (1996) also mentions the importance of media promotion, which refers to the production of pamphlets and posters, the organization of health fairs, displays, special events, focus months and campaigns in order to raise general awareness levels. He shows examples of such initiatives (for instance, pamphlets on programs available to unemployed people mailed to the physicians).

Further, Labonte (1996) says that another essential aspect of community health promotion is health education provided to the community through an approach known as popular education, which utilizes less word-bound methods of education, for example teaching through art in order to reach a broader range of the population.

Moreover, Labonte (1996) sees a significant part of health promotion in health advocacy through legislation promoting health and lobbying for healthy public policies. However, in his opinion, the backbone of community health promotion lies in community development, especially economic development, which increases community control over actual economic production through the development of enterprises meeting social and material needs, generating employment, and creating wealth under community control.

Guruge, Donner and Morrison (2000, p.231) stress another important aspect of health promotion when they state that "health promotion and disease prevention activities are deeply rooted in cultural beliefs and values." Health promoting activities based on a western understanding of health (such as attending fitness classes or subscribing to a health magazine) may not be seen or understood as appropriate by women of other cultures. Furthermore, the time, money, and resources invested in health promotion activities, immigrants may regard as a privilege since they need to invest these in providing accommodation, finding jobs, and financing education, to name just a few things.

From what Labonte (1996) and Guruge et al. (2000) suggest, one can understand that effective health promotion interventions and disease prevention programs need to

address a variety of health determinants on different levels (community, healthcare, policymaking) in a culturally sensitive and appropriate manner.

2.2 Immigration and mental health

This section presents a review of some of the issues concerning immigration and mental health as well as immigrants' barriers to maintaining their mental health. Specifically, this selective literature review examines immigrants' understanding of mental health and illness, attitudes toward mental illness, access to relevant mental health services and information, and the impact of other mental health determinants. Finally, it discusses the mental health issues surrounding the lives of immigrant women.

There are plenty of original research articles, review papers, position and perspective papers, book chapters and books, which can be located through PubMed and other medical search programs. Most of the studies I chose were qualitative inquiries conducted with immigrants in Canada and the USA. I noticed that the literature focuses mostly on South Asian, Hispanic, and Chinese immigrants. While some studies examine immigrants' understanding of mental health, other studies identify their barriers to utilizing mental health services.

Dossa's (2002 & 2004) and Gastaldo et al.'s (2005) qualitative research with immigrant Iranian women in Vancouver and South Asian women in Toronto, respectively, was, in particular, very close to me, since it looks at the issues pertinent to the mental health of immigrant women in all their complexity. Further, I found Kinnon's (1998) overview of Canadian research on immigration and health extremely helpful in

familiarizing myself with dozens of research projects concerned with immigrants' mental health that took place across Canada in the last decade. Further, Kleinman's (1988) book significantly expanded my perspectives of psychiatry and challenged my preconceived notions of its universality. Books by Fernando (2003) and Kohen (2000) contributed greatly in discovering the issues of cultural and gender-based racism in psychiatry that I had not been aware of before. Lastly, Constantine and Sue's (2005) invaluable book offers a very useful practical guide, offering strategies toward developing culturally appropriate mental health services that help eliminate immigrants' barriers to the utilization of these services.

2.2.1 Mental health issues surrounding immigration

More than 200,000 immigrants come to Canada every year (Beiser, 2005). In 2001, there were 5,448,480 immigrants residing in Canada, which represents about 18% of the total population (Statistics Canada, 2001). Traditionally, most Canadian immigrants were from Europe and the USA; however, in the past decade Canada witnessed a major overturn in this trend. By 2002, 52% of immigrants to Canada were from Asia and the Pacific and 20% were of African and Middle Eastern origin (Citizenship and Immigration Canada (CIC), 2004). While European immigrants accounted for 17%, 9% of immigrants came from South and Central America and only 2% came from the USA.

In the past, immigrants, especially non-white ones, were frequently exploited for work purposes and maintaining their health was not always the country's priority (Beiser,

2005). These days, the Canadian government recognizes that healthy, educated and skilled immigrants are very important to boosting the economy of a constantly aging Canadian society. For this reason, supporting research focusing on immigrants' health issues is currently one of the government's top priorities.

Research on the health of Canadian immigrants has always been dominated by two paradigms: "sick-immigrant paradigm" and "healthy-immigrant paradigm" (Beiser, 2005). The "sick-immigrant paradigm" assumes that sickness leads people to leave their homeland and seek a new life in another country. Until nowadays, people in North American society believe that immigrants were and continue to be a source of infectious diseases threatening their health and thus, North Americans should be protected from them (Murdocca, 2003). The same discourse dominates the area of mental health. Immigrants were considered insane, weak-minded, lunatics, and incompetent by many important mental health authorities in Canada and expelled from the country due to ill health (Beiser, 2005). According to the policies that are in place today if the medical examination shows that an applicant for immigration suffers from a (mental) health condition endangering public health or safety, or placing a demand on health and social services, his or her application will be refused (Government of Canada, 2004).

In 1967 new selection and settlement policies were introduced by the Canadian immigration system, which took into consideration the human capital of potential immigrants. A mandatory part of the selection criteria is a comprehensive medical examination which ensures that immigrants entering Canada are in sound health conditions. In Sampath's (1993, p.1) words, "Immigration to Canada today involves not

only a brain drain from the donor countries, but also a drain of some of these countries' most healthy and wealthy citizens."

Research found that the health of new immigrants is better than the health of native-born Canadians upon their arrival to Canada, but then after ten years of residence this difference in health status disappears (Ali, McDermott and Gravel 2004; Newbold, 2003). This phenomenon is called the "healthy-immigrant paradigm", which researchers try to explain on the premises of convergence and stress of resettlement (Beiser, 2005).

Convergence is the process of shifting the patterns of immigrants' mortality and morbidity "to resemble the (usually worse) health norms of the resettlement country" (Beiser, 2005, p.33). Beiser (2005) explains that this change may occur either from an exposure to similar physical, social and environmental health stressors impacting the health of native-born Canadians and/or abandonment of protective health behaviours that are often associated with many immigrant groups such as, for instance, abstinence from alcohol and drugs.

Resettlement stress may be related to the conditions of unemployment, underemployment, poverty or lack of access to health and social services that are frequently related to immigrants, which is consistent with the concepts of health determinants outlined in the previous section. In addition, The Canadian Task Force on Mental Health Issues (CTFMHI) (1988) identified other factors affecting the mental health of immigrants such as negative public attitudes toward immigrants, separation from family and community, lack of language skills, being an immigrant adolescent or elder, and being an immigrant woman from a culture with different gender role beliefs.

Ahmad et al. (2004) also found that climate transition and food changes add extra stress to the daily difficulties immigrants have.

In the past decade, researchers have put more attention into exploring the mental health status of immigrants. While some studies have shown that immigrants are at a higher risk of developing mental disorders (Ali, 2002) and have higher suicide mortality rates (Strachan, Johansen, Nair and Nargundkar, 1990), others have shown that immigrants enjoy a mental health status similar (Tousignant, 1997) or even better (Beiser, 1999) to native-born Canadians. The inconsistencies of these studies need to be seen in light of the interplay of many factors related to immigrant population such as immigrants' characteristics (age, gender, education, social status, personality, and culture), their language skills along with the pre- and post-migration experiences, availability of immigrant services, the presence of a pre-existing ethnic community and finally, the culture of the host society (Nguyen, 1984), which causes some immigrants to do better than others.

Despite the numerous findings that research on immigrants' mental health issues has generated, there is no information readily available on mental health policies and programs designed specifically for landed immigrants and refugees in a systematic way to provide an overview of the situation across the nation (Government of Canada, 2004).

2.2.2 Determinants of immigrants' mental health and well-being

Identifying what barriers to maintaining mental health immigrants face is the essential prerequisite to building effective health management interventions that

minimize the risks of developing illness. Not receiving timely help can have disastrous and costly consequences in terms of developing serious mental health disorders and addictions, committing suicide, engaging in criminal activities, losing employment and/or living in social isolation. In addition, the cost of these consequences is not borne only by those who suffer from mental health problems, but also by their families, neighborhoods and society as a whole as well. Thus, well-developed mental health plans integrate strategies addressing a variety of barriers to mental health that immigrants face.

The research studies identified the following factors that influence and shape immigrants' mental health: different understanding and concepts of mental disorders (Kleinman, 1988; Nguyen, 1985; Uba, 1992); stigmatization associated with mental illness (Herrick and Brown, 1998); difficulties in accessing mental health relevant information (Sadavoy et al., 2004; Takeuchi, Leaf and Kuo, 1988; Loo, Tong and True, 1989); inadequate family and social support (Beiser, 2005; Sadavoy et al. 2004, Ahmad et al. 2004); racial discrimination (Kuo and Tsai, 1986; Stingl, 1996; Donelly, 2002; Dossa, 2002); unemployment and low socioeconomic status (Beiser, 2005; Akhavan, Bildt, Franzen and Wamala, 2004; Shams and Jackson, 1994; Beiser and Hou, 2001) as well as underutilization of mental healthcare services (Sadavoy et al., 2004; Li, 2000; Woodward et al., 1992; Leong, 2001; Miranda, 1999; Mclean, Campbell and Cornish, 2003).

2.2.2.1 Immigrants' concepts of mental health & illness

One of the factors that shapes immigrants' mental health or illness is their understanding of these issues. Several researchers have challenged the universality and international validity of mental health and illness concepts and suggest that immigrants' understanding of mental health and illness may significantly differ from the one provided by the biomedical model.

Kleinman (1988) explains that the roots of psychiatry carry fingerprints of western culture since the major figures are European and/or Americans psychiatrists and the data available are limited to mainstream western populations. In addition, since western psychiatry is derived from the biomedical model, psychiatry, too, puts the emphasis on "science rationality, objectivity, emotional distance and classifying or labeling diseases, disorders and constellations of symptoms" (Gustafson, January 15, 2006, personal communication) and relies heavily on biological explanations of mental illnesses (Kleinman, 1988; Fernando, 2003). Furthermore, western psychiatry adopted the biomedical tendencies to medicalize certain problems (for instance, new diagnoses of attention deficit hyperactivity disorder or premenstrual syndrome) (Clarke, 2004).

Kleinman (1988) notes that western psychiatry is preoccupied with three fundamental issues: distinguishing the normal from the abnormal; the perception, experience and expression of disorders; and understanding the success and/or failure of therapy. These issues, however, need to be understood and applied in the context in which they occur, because "much of ill health is but one domain of human misery and...the lion's share of that misery takes its origin from sociopolitical, socioeconomic

and sociopsychological affairs" (Kleinman, 1988, p.61). This means that what qualifies as a disease in one society, might be understood as a religious or moral problem in another (Kleinman, 1988).

Furthermore, Kleinman (1988) states that, since disease, communication, and expression of feelings cannot be separated from their cultural context, it is difficult to maintain that psychiatric disorders are universal in all societies and can be detected by using standardized diagnostic techniques. Besides challenging the universality of psychiatric disorders, Kleinman (1988) believes that psychiatrists need to acknowledge that the knowledge they apply in their practice is shaped by the ideologies and institutional structures of societal political systems.

In conclusion, one can understand that people of different cultures coming to the West can look at mental illness from different perspectives. and can communicate and express disease as well as seek help in a variety of ways. In order to understand what immigrants may regard as mental illness. it is helpful to refer to certain concepts explained by White and Marsella (1982).

First, while the West treats the body and mind as two separated entities (dualism concept). many non-western and indigenous societies regard body. mind and environment as an interrelated, interactive and dynamic whole. Hence, psychological problems are the "outcome of interaction between body and other forces" (White and Marsella, 1982, p.17), which some call the somatopsychic concept. Further. the West separates emotions from reason as two separated psychological processes. while in non-western societies

emotions and reason are integrated in somatic processes. Similarly, there are differences

between understanding personal identity and social behaviour.

Fernando's (2003) comparison between spiritual eastern and secular western

cultures, with respect to ideals of mental health and therapy, is very useful in developing

an understanding of why the western approach to mental health may fail in addressing the

needs of people from non-western cultures (Table 1). Those immigrants from eastern

cultures who value achieving harmony between the individual, others and environment,

social integration, balance in life, protection and caring, understanding, knowing, and

being, may have difficulties benefiting from the medical approaches of western culture

that emphasize self-sufficiency, personal autonomy, efficiency, self-esteem, analyzing,

gathering knowledge, and having (Fernando, 2003).

Table 1: Cultural ideals of mental health (Fernando, 2003, p.121)

Spiritual eastern cultures	Secular western cultures
Harmony	Self-sufficiency
Social integration	Personal autonomy
Balanced functioning	Efficiency
Protection and caring	Self-esteeem
Understanding	Analyzing
Knowing	Gathering knowledge
Being	Having

Table 2 shows the difference in the focus and emphasis of treatment used by eastern and western medical traditions. Spiritually influenced eastern therapeutic traditions, operating on the principle of unity between the body and mind, focus on achieving acceptance and harmony through awareness and contemplation. Secularly oriented western therapeutic traditions, based on the principle of body and mind separation, emphasize achieving control of disease and personal autonomy through analysis and problem solving.

Table 2: Goals of the eastern and western therapy (Fernando, 2003, p.122)

Spiritual eastern cultures	Secular western cultures
Acceptance	Control
Harmony	Personal autonomy
Awareness	Analysis
Contemplation	Problem solving

Concepts of mental illness

Research concerned with immigrants' mental health supports some of the previously outlined concepts of mental health and illness. Herrick and Brown quoted an Asian American college professor saying, "We have no concept of mental health or mental illness. If someone was jumping up and down and having a fit, we would say he was having a fit, not having a mental health problem" (Herrick and Brown, 1998, p.226). Similarly, Toronto's Asian seniors understood mental disorders simply as various life and

social stressors (Sadavoy et al., 2004). Moon and Tashima (1982) also found that Asian

Americans regard a disruptive and dangerous behaviour that upsets the whole social

group as a mental illness, but emotional distress and problems are not included in the

definition of mental illness. Furthermore, research with Vietnamese immigrants shows

that they associate causes of mental illness with weak nerves, loss of soul, bad wind, evil

spirits, yin-yang imbalance or immoral behaviours and desires (Nguyen, 1985; Uba,

1992).

Attitudes towards mental illness

Research also sheds some light on attitudes that immigrants may have towards

mental illness. These attitudes are either explained by general stigma associated with

mental illness (Bhugra, 1989) or by immigrants' different concepts of mental health and

disease (Herrick and Brown, 1998). Bhugra (1989) says that since the time that mental

disease had existed, people in all societies feared or joked about mental disease and

psychiatrists. They labelled the mentally ill as mad, crazy, insane, violent and regarded

them as dangerous, dirty, unpredictable and worthless (Nunnally, 1961). Due to this

stigmatization, some North American immigrants consider mental illness a shame and

secret that needs to be concealed (Leong, 1994; Sue, Nakamura, Chung and Yee-

Hradbury, 1994; Lee, 1986). Kim (1994, n.p.) states that for many Asian Americans

"problems must remain in the family, and it is a sign of weakness to ask for help."

Similarly, Iranian immigrant women refused using the term 'mental health' and

suggested, instead, the term 'emotional well-being', which made them more comfortable (Dossa, 2002).

Some authors argue, however, that what is actually hidden behind psychiatric stigma is structurally defined and sanctioned racism rather than disease stigma itself (Fernando, 2003; Crass, 2000; Sayce, 2000). Fernando (2003, p.147) states that "psychiatric stigma is essentially discrimination against people who are given a psychiatric diagnosis" when these people become excluded from social interactions and are cut off from certain rights and privileges.

Some authors, however, challenge the universality of stigma associated with mental illness. Fernando (2003) notes that in non-western societies, where understanding of mental illness differs significantly from the western biological concept, shame and stigma associated with illness comes mainly from the western influence (Fernando, 2003).

Understanding people's attitudes toward mental illness and seeking professional help is very useful for finding ways how to approach them; however. Wong and Tsang (2004, p.458) warn that generalizing about patterns of health seeking behaviour and attitudes towards illness in specific cultures "conceals the immense internal diversity …and further amplifies the differences between 'self' and 'other'". That means that when designing effective outreach strategies, one should avoid portraying immigrants as a homogenous cultural identity and regard them instead as the diverse populations that they are.

Expression of mental illness

Concepts of mental illness vary across cultures and the same is true when it comes to the expression of mental illness (Kleinman, 1988). For instance, patterns of depression vary between European and Asian cultures (Marsella, 1982). Marsella (1982) states that, while Europeans express more existential problems such as questioning the purpose of their life and negative thoughts, Asians tend to show physical symptoms of depression such as gastrointestinal problems. Indeed, a similar somatization of psychological problems was found among elderly Korean immigrant women (Pang, 1990). Understanding that cultural factors influence the symptom expression is important in order that mental health providers avoid mistakes in a diagnostic process due to over- or under-pathologizing patients' symptoms.

In addition, Fernando (2003) understands that misdiagnosis of patients from other cultures does not happen solely on the premise of a diverse expression of symptoms across cultures. He sees the reason in the racist ideology that infiltrated the Euro-American culture as well as the fields of psychiatry and psychology during the era of colonialism and the Atlantic slave trade. In fact, the roots of today's assumptions and stereotypes about patients from other cultures can be traced to the numerous works of renowned western psychiatrists and psychologists of the 20th century (Fernando, 2003). Fernando (2003) notes that Hall's, Kraepelin's, Jung's and Carothers's views, which consider eastern people to be adolescent, immature, irresponsible, and with an idle frontal lobe, resonate in contemporary stereotypes, which regard, for example, blacks as dangerous people.

In the past two decades, prejudices and discrimination based exclusively on skin colour has been transformed into cultural racism, "in which the object is no longer the physiology of the individual but the cultural style" (McCulloch, 1983, p.120). These racist stereotypes of those who are 'Other' than western often lead to inappropriate diagnoses and medical interventions (Fernando, 2003). In fact, members of minority ethnic communities experience higher rates of involuntary psychiatric detainment than members of non-ethnic communities (Littlewood, 1986). Visible minorities are less likely to be offered counseling services, but more likely to be prescribed drugs in higher dosages and transferred to the locked wards than a comparable group of whites (Callan and Littlewood, 1998; Fernando 2003). Equally disturbing are the reports of institutional stereotyping that associate a particular racialized group as being more prone to mental illness and dangerous behaviour (Mclean et al., 2003; Fernando 2003).

2.2.2.2 Family and social support

Four types of support received from family and personal networks are essential in maintaining one's health and well-being (Clarke, 2004). Emotional support offers recipient affection and acceptance. Informational support provides an individual with desired or requested information. Instrumental support assists one with practical help. Finally, cognitive support helps a person in reframing and recontextualizing his or her problems.

Family and social support are powerful factors in sustaining mental health. Lack of family and social support together with the loneliness and isolation that immigrants

often experience contributes to stress and mental health problems as well as preventing

immigrants from utilizing mental health services (Beiser, 2005; CTFMHI, 1988;

Sadavoy et al., 2004; Ahmad et al., 2004).

2.2.2.3 Unemployment and low income

Research demonstrates that immigrants often experience unemployment or

underemployment (Ng, n.d; Gastaldo, Khanlou, Massaquoi, Curling and Gooden, 2005;

Dossa, 2002: Dossa, 2004; CTFMHI, 1988). Hakim (1982) states that ethnic minorities

are, indeed, the most vulnerable group to unemployment because they are regarded as a

secondary labour force or "reserve army". Being unemployed or underemployed further

results in low income and socio-economic status, poverty, lack of social support and

social exposure (Akhavan et al., 2004). For instance, in Canada, "since 1986, statistics

show that immigrants of similar age, and family structure, are earning significantly less

than their Canadian-born counterparts, despite the fact that immigrants are twice as likely

as those born in Canada to have a university education" (Poy, 2004, p.3). In addition, Poy

(2004, p.8) provides the following examples:

> White applicants received job offers three times more than black job seekers, and
> the telephone callers with an Asian or Caribbean accent were often screened out
> when they called about a job vacancy…The very lowest income earners are visible
> minority women who are confronted by discrimination on the basis of both race
> and gender.

In general, immigrants have difficulties in finding employment due to their origin, language, skin colour and appearance, health status and undervalued foreign education and work credentials (Akhavan et al., 2004; Beiser and Hou, 2001; CTFMHI, 1988).

The impact of unemployment on mental health is enormous, as is the impact of underemployment because the underemployed (low-hour and low-wage workers along with involuntary part-time workers) suffer economic and psychosocial losses very similar to those of the unemployed (Dooley, 2003). Brenner suggests three different ways in which unemployment threatens people's health (cited in Shortt, 1996). Firstly, unemployment leads to poverty, which implies poor nutrition, low housing standards, low education and limited access to quality health care. Secondly, unemployment is a very stressful experience accompanied by low self-esteem, social isolation and family conflicts that can further lead to developing mental disorders. Lastly, an unemployed person can adopt unhealthy habits such as smoking, alcohol or drug abuse that help him/her compensate for this uneasy situation.

The unemployed report high levels of distress, unhappiness, anxiety and depression (D'Arcy and Siddique, 1985). In addition, there is a positive correlation between unemployment and first admissions to psychiatric hospitals as well as suicidal attempts (Shortt, 1996). Unemployment also accounts for poor marital adjustment and communication, separation and divorce as well as physical violence among couples (Dew et al., 1991). Children of the unemployed often deteriorate in school and social relationships, develop antisocial behaviour, attempt suicide or resort to substance abuse

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(Dew et al., 1991). Unemployment also contributes to higher rates of crime, delinquency and racial tension (Hakim, 1982).

As a matter of fact, researchers show that unemployed immigrants suffer from poorer health, low levels of psychological well-being, low self-esteem, depression, and anxiety (Akhavan et al., 2004; Shams and Jackson, 1994; Beiser and Hou, 2001; Pernice and Brook, 1996).

2.2.2.4 Social environment

Living in an environment that is welcoming, supportive, protective, non-judgmental, non-racist and that guarantees justice, freedom and equal rights for all society members is essential to everyone's mental health. Many western societies claim that this is precisely the type of environment they provide not only to their native citizens but to immigrants as well. Despite the fact that rights to live in such environments are officially warranted by law in some countries (Canadian Charter of Freedom and Righths, 1982), research has found that "immigrants seem to exercise very little control over their lives, have a minor influence in shaping society's cultural norms, and are powerless overall to affect the economic, political and social structure" of the society (Kuo and Tsai, 1986, p.147).

The following two examples show that native-born Canadians are not so welcoming after all. The national survey assessing how comfortable Canadian-born citizens feel being around members of 14 different ethnic groups found that the comfort levels expressed for many groups of non-European origin were lower than those

expressed for the groups of European origin (Angus Reid Group, 1991). In particular, the respondents reported less comfort being among members of the visible minority groups such as Indo-Pakistanis and Arabs.

Speaking from a Newfoundland context, the main St. John's newspaper, The Telegram (Mullowney, 2006), recently published a story of a local immigrant university professor of Indian origin who filed a complaint with the provincial Human Rights Commission alleging that the University had discriminated against him because of his race and age.

Researchers found that ethnic inequality and racial discrimination are barriers to maintaining mental health of Canadian immigrants (Stingl, 1996; Stephenson, 1995; Anderson, 1987). Immigrants experience this discrimination when dominant ideologies disregard and demean their culture and values through media, educational institutions, and the film industry; or when immigrants cannot get jobs due to their less valued foreign credentials (CTFMHI, 1988); or when they belong to certain race and/or ethnic groups (Donelly, 2002). Due to an unequal distribution of power and wealth, immigrants also have limited access to the resources and support they need, which further diminishes their self-esteem and self-confidence (Ramsden, 1990).

Lastly, immigrant women are even more exposed to societal discrimination than their male counterparts (Ng, n.d; Poy, 2004). For instance, Iranian immigrant women in Vancouver reported that the social sector perceives them as illiterate and stupid (Dossa, 2002). Therefore it is important to analyze findings along gender lines in order to avoid homogenizing men's and women's experiences.

2.2.2.5 Barriers to mental health services

While research yields inconsistent results about the mental health status of immigrants, studies are consistent in the conclusion that immigrants underutilize mental healthcare services (Li, 2000; Cheung, 1990; Woodward et al., 1992; Mclean. 2003). These studies found that immigrants tend to avoid seeking professional mental health services and use them only when absolutely necessary (for example, emergency services and hospital admissions). In addition, when the immigrant patients are already included in therapeutic procedures, they are likely to terminate them prematurely. These behaviour patterns put immigrants at risk of developing mental problems, often severe and chronic.

The reasons accountable for the underutilization of mental healthcare services are as follows: delivery of inadequate and culturally insensitive mental health services; limited skills to negotiate current health system; lack of information; economic and geographic constraints (lack of finances, transportation and childcare, inflexibility of low-income jobs); and finally, language barriers (Sadavoy et al., 2004; Li. 2000; Woodward et al., 1992; Leong, 2001; Miranda, 1999; Mclean, Campbell and Cornish, 2003).

Paradoxically, mental health services per se can actually represent a barrier to their utilization. Nguyen (1984) identifies the following four problems that challenge the suitability of dominant mental health services for the immigrant population: lack of culturally relevant treatment models, lack of cultural sensitivity on the part of service providers, lack of bicultural and bilingual staff, as well as, poor language and communication.

Cultural validity of treatment models

Diagnostic assessment

Any treatment process starts with a diagnostic assessment. Leong and Lau (2001)

question the validity of any therapeutic procedure due to several problems that can occur

at the stage of the diagnostic process. These problems include personal bias in clinical

judgment towards immigrant patients; inappropriate use of diagnostic tools, based on

concepts and linguistics strange to immigrants; difficulties communicating problems due

to certain cultural norms or weak language skills; and differences in symptomatic

expression of the same illness among different cultures.

Treatment

Research supports the notion that some immigrants may not benefit from the

traditional western approach to treatment of mental disorders. For instance, Leong and

Lau (2001) argue that the classic psychotherapeutic approach of talking about personal

matters in private or in a group session (Herrick and Brown, 1998) may be intimidating to

many Asian immigrants. They may prefer seeking help from traditional folk healers or

general medical practitioners instead (Nguyen, 1984).

Drug therapy should be strictly monitored since drug dosages are often adjusted to

the metabolism of white males. People from other cultures may require different dosages

in order to avoid severe drug side effects (Herrick and Brown, 1998). In addition, some

immigrants prefer using their own herbs, drugs and healing remedies (Nguyen, 1984;

Ahmad et al., 2004).

Marsella (1982, p.378) classified some other types of "traditional" therapy and healing into four useful categories: psychological (meditation, imagining, problem solving), social (family involvement, social re-integration), physiological (rest, massage, acupuncture) and supernatural (prayers, exorcism).

All mental health providers should be aware of the variety of these approaches and offer them to their clients based on their clients' beliefs and concepts. For instance, Constantino, Malgady and Rogler (1986) document the positive effects of combining folk therapy with mental health therapy in the treatment of Puerto Rican children; similarly, Cancelmo, Millan and Vazquez (1990) describe the successful treatment of a diseased Hispanic man when a traditional healer was incorporated into his treatment process.

Cultural sensitivity of mental health providers

Research has shown that lack of cultural sensitivity among mental health providers acts as another immigrants' barrier to utilizing mental health services. Health professionals fail to meet the needs of minority clients due to a "lack of understanding of cultural diversities, racism, racial stereotyping, lack of knowledge, exclusiveness, and ethnocentrism" (Chevannes, 2002, p.290).

The first one to be blamed for this situation is the health education programs, which do not prepare health professionals to work in cross-cultural settings (Gerrish 1998, Murphy and Mcleod-Clark, 1993). In his study, Chevannes (2002, p.297) states, "Health professionals acknowledged that they lacked sufficient knowledge of the culture,

health beliefs and experiences of ethnic minorities to provide quality care. They were also concerned about their lack of skills to communicate inter-culturally."

One example of such unreadiness of healthcare programs to train mental health providers caring for culturally diverse populations is the fundamental isolation of these programs from spirituality and religion. Mentally ill patients believe that spiritual health is as important as physical health and wish to include spiritual issues (King and Bushwick, 1994) and prayer (Fitchett, Burton and Sivan, 1997) in their care. However, "most Canadian programs offer minimal instruction on issues pertaining to the interface of religion, spirituality, and psychiatry" (Grabovac and Ganesan, 2003, p.171) and mental health professionals seldom include spiritual and religious aspects in their treatment plans. Recalling the fact that the eastern medical and cultural traditions value significantly the role of spirituality and religion in mental health, the disparity between the spiritual needs of culturally diverse service users and provided secular mental health services may be, in fact, enormous.

Carrillo, Green and Betancourt (1999) argue that even when the cross-cultural curricula are included in medical education they are used inappropriately because they teach students to categorize culturally diverse patients according to narrowly designed specific characteristics rather than exploring a variety of problems that occur in cross-cultural medical settings, and examining the broader context of patients' diseases.

Numerous academic writings recommend that healthcare professionals develop such behaviours, attitudes and policies that will enable them to work more effectively

with culturally diverse populations (Rorie, Paine and Barger, 1996). According to Willis (1999), developing cultural competence can be achieved in the following steps:

1. developing knowledge of one's own cultural affiliation;

2. developing knowledge of others' cultural beliefs, values and lifeways;

3. adopting non-threatening or non-fear-provoking interactions;

4. being tolerant, inclusive, and accepting; and

5. being competent.

In addition, Herrick and Brown (1998) stress the importance of developing skills to communicate with culturally diverse clients. This includes non-verbal communication as well. For instance, Latina and Asian immigrant women perceive the voice tone and body language of their health providers as signifying "discomfort, judgement, or lack of interest" (Bauer, Rodriguez, Szkupinski Quiroga, and Flores-Ortiz, 2000, p.40).

However, critical cultural theorists challenge these models of cultural competence for understanding diversity, once again, in narrowly designed categories. In Dossa's (2004, p.163) words, "Cultural sensitivity cannot be translated into merely food and dance. A genuine attempt toward reaching out and being inclusive must address the issue of unequal relations of power that determine the distribution of resources and one's status in society." Rather than merely meeting patients' needs in a manner derived from the cross-cultural "recipe" books, cultural diversity needs to be understood as "deeply interconnected social, political, and ideological categories to which positive and negative meanings are attached" (Gustafson, accepted, n.p.). This means that mental healthcare providers need to consider critically the social context of their knowledge, beliefs and

thoughts, which reflects prevalent sociopolitical discourses, when dealing with immigrant patients. In Fernando's (2003, p.30) words, "A psychiatric assessment whereby symptoms are identified involves subjective judgements based on human values of the person making the diagnosis which in turn reflect their cultural background and mindset." In the context of Canadian psychiatry, Beiser (2003, p.158-159) calls for abandoning egocentrism in order to develop "appreciation, empathy, and a sense of responsibility for people" from other cultures, which requires "a strong dose of humility to guard against Western imperialism."

<u>Bicultural and bilingual services, cultural interpreters and translators</u>

Immigrants identify the lack of bicultural, bilingual and translating services as one of the barriers to utilizing mental health services (Sadavoy et al., 2004; Ng, 1993; Stephenson, 1991). Research demonstrates that a cultural and language match between a client and his/her mental health provider has a positive outcome in terms of reducing premature termination of therapy and increasing length of treatment (Takeuchi, Mokuau and Chi-Ah, 1992; Sue, Fujino, Hu, Takeuchi and Zane, 1991). The authors note that the match in patient-provider culture and language improves rapport and understanding on both sides involved.

When culturally or ethno-specific mental health services are not available, researchers recommend using specially trained mental health translators and culture brokers who may directly assess the patients or discuss the cases with the referring clinician or organization without seeing the patients in person (Kirmayer, Groleau,

Guzder, Blake and Jarvis, 2003; Guruge et al., 2000). In Kirmayer's study (2003) the cultural consultation services helped clinicians manage their patients by increasing knowledge of the social, cultural, religious, psychiatric and psychological aspects of their cases. Clinicians also reported improved treatment and communication. increased empathy and understanding. However, some of the recommendations made by culture consultants could not be implemented due to lack of staff and resources, or due to patients' non-compliance.

Guruge et al. (2000) further recommend incorporating the knowledge and expertise of community leaders in developing and applying culturally appropriate health-promoting and therapeutic activities and materials. The authors also propose increasing the representation of immigrants on the boards of a variety of healthcare institutions and developing more programs like "Across Boundaries" or the "Hong Fook Mental Health Service" which involve immigrants in educating mental healthcare providers about relevant cultural and language issues. Moreover, Guruge et al. (2000) suggest using different types of media for disseminating health-relevant culturally- and language-appropriate information.

Research also identifies lack of communication and language skills as a barrier to the utilization of mental health promotion and care services (Woodward et al., 1992; Sadavoy et al., 2004; Nguyen, 1984). Lack of communication "compromises patient care, interferes with the diagnostic power of the interview, impairs patient education, decreases compliance and follow-up, and often results in patient dissatisfaction" (Bauer et al., 2000, p.39).

As for language, there is one more important point to consider. Medical terms can cause problems even to those immigrants who have a good knowledge of English. In the words of Kwok (n.d, para 4), a former psychiatric patient:

> Though, English Literature was my major at the University of Minnesota, my knowledge in Science and in Medicine was very poor. I did not know what was the equivalence of manic and depressive in Chinese. I did not know how to say the word syringes in English. When it came to medical terms and medications, I was tongue-tied.

Regarding the identified language barriers, Bauer et al. (2000, p.37) found that "the presence of interpreters frequently created a distance between the patient and the provider that interfered with creating trust and rapport." Therefore, hiring healthcare providers of diverse ethnic backgrounds who speak diverse languages is the optimal solution. If hiring interpreters is necessary, Sadavoy et al. (2004) suggest hiring translators who are professionals rather than realtives of patients since disclosing personal problems in front of other family members can be intimidating. Kleinman (1988) further adds that the translators should discuss the therapist's questions in detail with him or her in order to gain a proper understanding, describe fully the content of the patient's answers and display no judgments about the patient's beliefs, values or behaviours.

Access to mental health relevant information

Accessing mental-health-relevant information is an essential step toward promoting mental health and well-being. People need to know that what they go through

could be evolving symptoms of a mental illness that can be treated. Further, they need to

know where, when, why and how to prevent an illness or cure it. In addition, this

information needs to be tailored to their language skills and cultural background.

Research on the mental health of immigrants has found that immigrants cannot

access this mental-health-relevant information easily. They often do not know what

services and support are available to them and therefore do not utilize them (Takeuchi et

al., 1988; Loo et al., 1989; Sadavoy et al., 2004). In addition, Guruge et al. (2000)

emphasize the need for recognizing the sociocultural context within which immigrant

patients access healthcare, in particular the obligations and priorities they have, since

these factors can interfere with their access to healthcare and information they need.

Financial and geographic factors

Mental health services can be inaccessible to immigrants for reasons relating to

finances and geography. Some mental health services are not covered by the provincial

insurance plans. Unless a newcomer has additional coverage through an employer, he or

she may not be able to afford to access and utilize mental health services. Finances are

also needed to pay for transportation to agencies and to cover the cost of caregivers for

their children or elderly dependents during the time they utilize mental health services.

Participating in some mental health promotion initiatives such as outings, sport

activities, and art events can be costly to immigrants who are already experiencing low

income during the first years of resettlement (Beiser, 2005; Cheung and Snowden, 1990;

Ginsberg, 1991; Miranda and Green, 1999; Leong and Lau, 2001). In addition, some

immigrants, in particular those who reside in remote rural areas. usually have geographic constraints that limit their access to mental health services and choices to participate in any health promoting initiatives (Gojer, 1992)

2.2.3 Mental health and immigrant women

Although gender is considered to be one of the principal health determinants (Shah, 2003), I chose to offer an overview of the issues surrounding mental health and immigrant women in a separate section for three reasons. First, the issues surrounding the mental health of immigrant women are quite complex and deserve to be talked about in more detail. Second, most of the interviewed participants are women. Third, a gendered perspective of mental health needs among St. John's immigrants is one aspect of my thesis.

Gender, indeed, plays an important role in shaping women's mental health. For instance, Kohen (2000, p.3) states:

> With the modern understanding of epidemiology it is well established that women have a higher prevalence of depression, dysthymia, deliberate self-harm, seasonal affective disorder, generalized anxiety disorder, panic attacks. social phobias and eating disorders, including anorexia nervosa, bulimia and obesity. than men.

While some authors argue that the higher prevalence of mental disorders among women is attributable to such artifacts as the higher willingness of women to report their problems, and statistical methodological bias, others believe that women, in fact, do experience more mental health problems either due to greater vulnerability or greater stress (Holmshaw and Hillier, 2000).

Researchers agree that causes of women's mental disorders can be divided into three categories: biophysiological (genes and hormones); psychological (mind and behaviour) and social (social environment) (Kohen, 2000). However, researchers differ in their opinions of how much weight to attribute to these factors. Although the biological and psychological aspects of female bodies play some role in shaping their vulnerability to developing mental illness, the health-damaging or health-protective effect of women's social environment cannot be ignored.

Stress associated with prioritizing the needs of others, caring for children, home, partner and relatives, high work load, no time for rest and leisure, limited autonomy and opportunity for creativity, no appreciation and devaluation of female work are factors that make women more vulnerable to mental illness (Holmshaw and Hillier, 2000).

Researchers referring to the inequity and inequality that women experience see their mental illness as "the consequence of social, political, economic, psychological and physical discrimination" (Government of NL, 1994, p.45). Holmshaw and Hillier (2000) demonstrate this notion through the example of poverty and depression. They say that, according to the United Nations' 1995 report, over 70% of all people living in poverty are women, and being poor, unemployed and uneducated represents is the most common risk factor for depression. In addition, many women have limited access to education, employment, basic rights, and they experience violence and different forms of abuse (Holmshaw and Hillier, 2000). Western countries like Canada are not exceptional in this regard. For example, in 1993, 39% of Canadian women participating in the Violence

Against Women Survey reported having experienced sexual assault (Government of NL, 1994).

Discrimination in all aspects of women's lives is caused by the lack of social power that Wenegrat (1995, p.1) defines as "the ability to provide for one's needs and security and the needs and security of loved ones, to stand up for oneself in conflicts with others, and to make life decisions based on one's own desires". Because women lack social power, their discrimination was not omitted even in the field of psychiatry which historically served as "an instrument for social control of women, who, like the former Soviet dissidents, are labeled mentally ill whenever they challenge society" (Wenegrat, 1995, p.6). Many rebels and heroines of their times were diagnosed with mental illness because of the threat they posed to the norms of their societies. While psychiatrists labeled many women insane due to a variety of menstrual and sexual problems, these women claimed that it was the "lack of meaningful work, hope or companionship that led to depression" (Holmshaw and Hillier, 2000, p.42).

Holmshaw and Hillier (2000, p.48) also describe how this gender-based discrimination has continued to the present day because psychiatry is "male dominated and underpinned by stereotypes of female inferiority." While men's problems are seen as more unusual and more severe, women's problems are often overlooked. In addition, women's emotions and behaviours are also often medicalized, which results in overprescription of psychotropic drugs with severe side effects. One of the worst examples of discrimination against women in psychiatry is the one described by Showalter (1987) as referred to in Holmshaw and Hillier (2000, p.49):

From the 1930's to the 1950's in the UK the main treatments for schizophrenia were insulin shock, electroshock and lobotomy. These were used far more for women than men patients with the justification that the resulting damage to memory and cognitive ability would have less important consequences for women's lives.

Like their native-born female counterparts, immigrant women are subjected to other social stressors that play a role in the development of mental illness. Health Canada recognizes the following risk factors that threaten the mental health and well-being of immigrant women (Hyman, 2001):

- Exposure to violence

- Lack of reduced autonomy

- Lack of recognition of foreign education and work credentials and experience

- Cultural and systematic barriers to care

- Poverty

- Underemployment

- Lack of language skills

- Burden of multiple social roles

- Social isolation

- Loss of pre-existing social support systems

- Discrimination

Most often, immigrant women come to their host countries as dependents of their spouses with little decision making power regarding the family resettlement. Due to restrictive immigration processes, women lose their autonomy. In being defined as

dependents of their husbands, they do not qualify for equal access to social and educational programs and employment opportunities (CTFMHI, 1988; Ng, n.d.). Staying at home, enstranged from others, without any support, results in further and deeper isolation of immigrant women (Government of NL, 1994).

In addition, the Canadian Research Institute for the Advancement of Women identified the following stereotypes and myths held by the Canadian public that immigrant women encounter (Morris and Sinnott, n.d.):

1. immigrant women come to Canada to do the 'dirty work' that native-born Canadians will not do or they take jobs away from Canadians

2. immigrant women are coloured women who cannot speak English or French

3. immigrant women have large families

4. immigrant women are "more feminine, docile, sexually available, obedient, undemanding, and excited to do housework" than native-born Canadian women

5. immigrant women are against feminism

6. immigrant women manipulate the immigration system to get into Canada and bring with them conflicts and problems

In fact, immigrant women face discrimination due to several intersecting inequalities that immigration imposes on them (Dossa, 2004; Ng, n.d.). Besides that of gender, they battle discrimination against their race, ethnicity, religion and social class when searching for accommodations, jobs or further education. They are often forced to live in segregation in specific low-income, high-crime neighbourhoods (Novac, 1999), be

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unemployed despite having university degrees (Statistics Canada, 2000) or take manual, low-paying jobs (Mojab, 1999). Discrimination also translates into economic and social confinement, as Dossa finds (2004, p.167) in her discussion with Iranian immigrant women in Vancouver: "Their structural isolation and social invisibility deprives them of the opportunity to engage in what should be basic human rights: the right to work and to seek opportunities for social interaction."

The echo of Vancouver immigrant women's voices resonates in the stories of immigrant women in Toronto (Gastaldo et al., 2005, n.p.):

> Becoming a good immigrant requires a constant manifestation of gratitude for being accepted into the country, hard work, being self-conscious for having limited English skills, full or partial acceptance that education from other countries is not sufficient preparation to work in Canada, that volunteer work is a central element in becoming Canadian, that previous professional and experiential knowledge are very limited because 'Canada is different', and finally, that despite all these elements for hopelessness, immigrants should persevere through the hardship of their lives because 'eventually, they will succeed'.

In addition, immigrant women have limited access to healthcare services for reasons already described in the section on immigrants' barriers to utilizing healthcare services. In addition, one can question the ability of the Canadian healthcare system to address women's needs when, for instance, Canadian doctors are unable to diagnose the Post-Traumatic Stress Disorder in immigrant women and there are no programs caring for their children who have also witnessed war, rape, violence or disasters (Prairie Centre of Excellence for Women's Health, 2001).

Taking into account all previously described problems surrounding the mental health of immigrant women, I agree with Guruge and Khanlou (2004, p.33) when they

say that the issue of health needs and risks of immigrant women needs to be seen and studied "within the complex socio-economic, historical, political, and institutional structures and dynamics in the pre- and post-migration context."

2.3 Newfoundland context of immigration and mental health

This section provides an overview of immigration to the province of Newfoundland and Labrador, demographic characteristics of immigrants, and issues regarding the mental health of local immigrants.

2.3.1 Immigration

Historically, Newfoundland and Labrador did not play an active role in immigration. It is only very recently that the Government of Newfoundland and Labrador joined the other Atlantic provinces to develop new immigration strategies under the umbrella of the project entitled "Building Human Capital in Atlantic Canada: The Immigration Factor" which was created by the Atlantic Canada Opportunities Agency (Government of NL, 2005). This new initiative comes along with a greater recognition of the significance that immigration represents to the province. According to Joan Burke, Minister of Human Resources, Labour and Employment, "the Government of Newfoundland and Labrador believes that immigrants make significant contributions to the economic, social, and cultural development of the province" (Government of NL, 2005, n.p.).

According to CIC (2003), there were about 400 immigrants to Newfoundland and Labrador each year between 1998 and 2003. The retention rate was about 36%, which means that 64% of immigrants decided not to stay in the province. These numbers are the lowest in Canada. The Government of NL (2005) explains these low rates as being due to immigrants' preference to settle in large urban areas, and places where they already have support networks; high unemployment rate in the province; ignorance and misperceptions about available opportunities and services; and the lack of any incentives to settle in this province. Gilroy (2005) sees the challenges in lack of economic opportunities, low federal support for developing provincial immigration resources, insufficient level of services and supports, and lack of diversity.

The provincial government understands that providing services responsive to immigrants' needs is essential to retaining immigrants in the province when it states that "people will stay only if they are truly welcomed in their new community, can make a reasonable living to provide for their families, and build supportive networks in their workplaces and communities" (Government of NL, 2005. p.19). Gilroy (2005, p.36) further adds that the key to attracting and retaining immigrants is developing services "delivered at the grassroots level". He lists the following key elements of the welcoming community:

- Acceptable and suitable employment opportunities

- Suitable and affordable housing

- Family, ethnic connections, and/ or hospitable community

- Quality education facilities

- Competent immigrant settlement organization

- Easy networking in a non-discriminatory community

- Quality health and other services

- Appropriate cultural and religious institutions

Gilroy (2005, p.37) believes that Newfoundland offers many of the elements of a welcoming community, but he also thinks that the province "does not go far enough in building an appreciation in the broader community of the contribution of immigration and multiculturalism to the province from all perspectives – economic, social and cultural." He also notes that the multicultural organizations and leaders are not engaged in policy and program development and points out that there are no existing operation funds to these organizations with the exception of a limited support for education projects by Canadian Heritage.

There are very few programs for immigrants operating in the province. These programs include the Immigrant Settlement and Adaptation Program, the Host Programs and the Language Instruction for Newcomers. The only federally funded immigration service provider that runs these programs is the Association for New Canadians (ANC).

For these reasons, the provincial government introduced a number of initiatives that will become part of a provincial immigration strategy. To name just a few, the NL government intends to raise awareness and dispel myths about immigration; market and promote the province; develop multicultural and employment diversity policies; improve access to government services and English as a Second Language training; enhance the process for a credential assessment; and develop strategies targeting particularly the

needs of immigrant women. Unfortunately, the intention of developing appropriate and accessible health, social and community services is not listed among the proposed initiatives. Hence, I hope that studies such as this one will direct the attention of healthcare providers and policy makers to the persistent need for the development of these services.

2.3.2 Immigrants to Newfoundland and Labrador

This section provides a demographic account of St. John's immigrants. All data and figures are drawn from the Census 2001 and prepared by Statistics Canada (SC). They represent numbers of landed immigrants and exclude all other categories such as refugees, international students, and workers with a temporary work permit.

According to the last Census (Statistics Canada, 2001), there were 8,030 immigrants in the province, and 4,885 (61%) in the city of St. John's directly. 1690 women represent 35% of all St. John's immigrants. Figure 1 shows a breakdown of St. John's immigrants according to their country of origin. The majority of immigrants came from Europe (2,445), particularly from the UK. The second largest group of immigrants came from Asia (1,020). They are followed by immigrants from the USA (930) and Africa (305). The remaining 185 immigrants came from Oceania, Central and South America, and other countries.
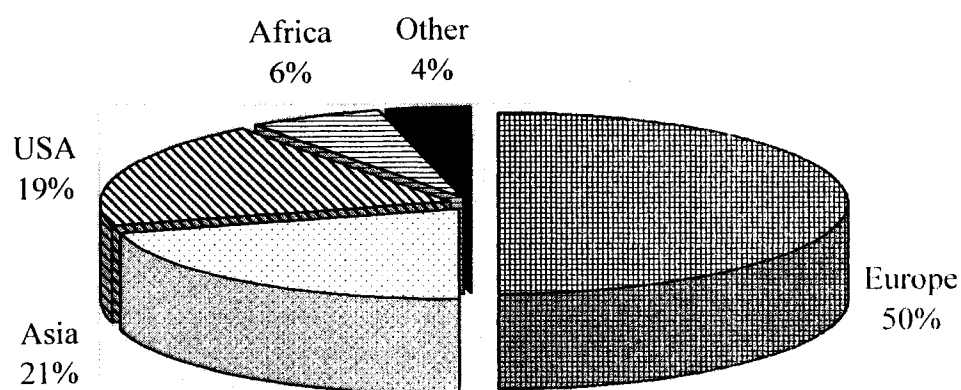
Figure 1: Country of origin of St. John's immigrants (SC, 2001)

Table 3 shows the number of St. John's immigrants holding Canadian citizenship and the number of immigrants according to the language spoken at home. While 3,365 immigrants held Canadian citizenship, the remaining 1,525 held citizenships other than Canadian. 4,090 immigrants spoke at home most often English, and 640 some non-official language. The other languages most often spoken at home were French, a combination of English and French or a combination of English and some non-official language. Only 70 immigrants could speak neither English nor French.

Table 3: Citizenship and languages spoken at home (SC, 2001)

Citizenship	Canadian	3,365 (69%)
	Other	1,525 (31%)
Language used at home	English	4,090 (84%)
	Other	640 (13%)
	No knowledge of the official languages	70 (1%)

Figure 2 offers an overview of the numbers of St. John's immigrant population according to age. Most immigrants (2,715) were in the 20-39 age category, followed by the 0-19 age category (1,625) and the 40-59 age category (485).
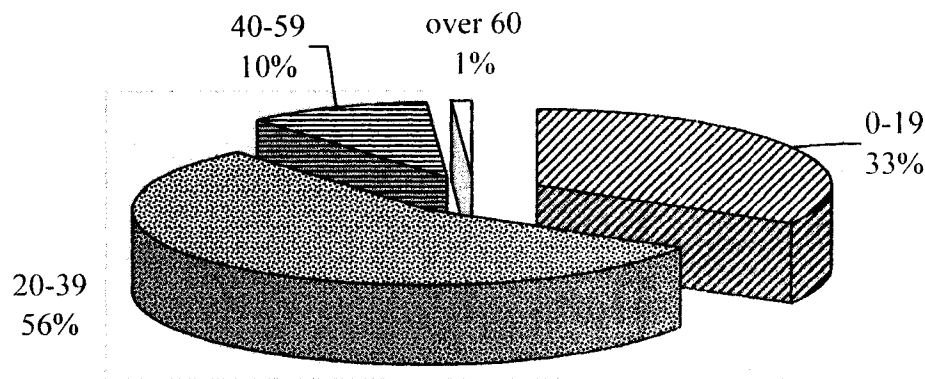
Figure 2: Age of St. John's immigrants (SC, 2001)

While the majority of immigrants (2,995) were married, 780 were single, 465 were separated or divorced and 365 were widowed. See Figure 3 for a breakdown of St. John's immigrants according to their marital status.
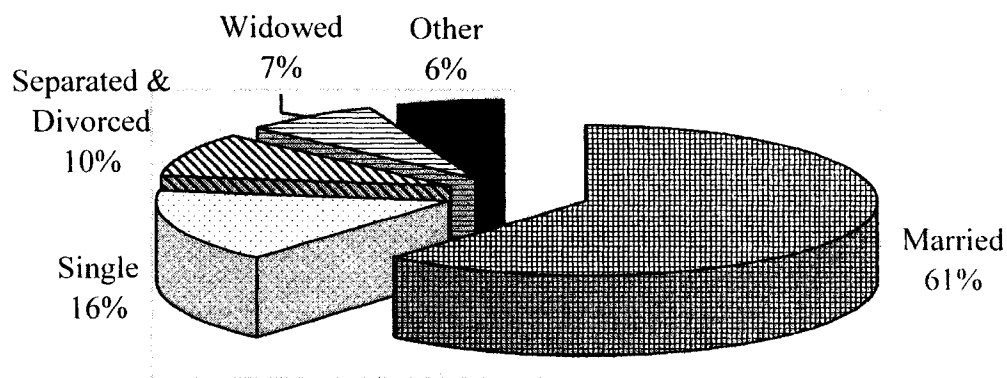
Figure 3: Family status of St. John's immigrants (SC, 2001)

Sixty-six percent of immigrants to NL are Christian (3,185). Muslims (360) and

Hindus (295) constitute (7%) and (6%) respectively of the immigrant population. Four

percent of immigrants identify themselves as Buddhist, Sikh, Jewish and other. 875 or

18% of immigrants claim no religious affiliation (see Figure 4).
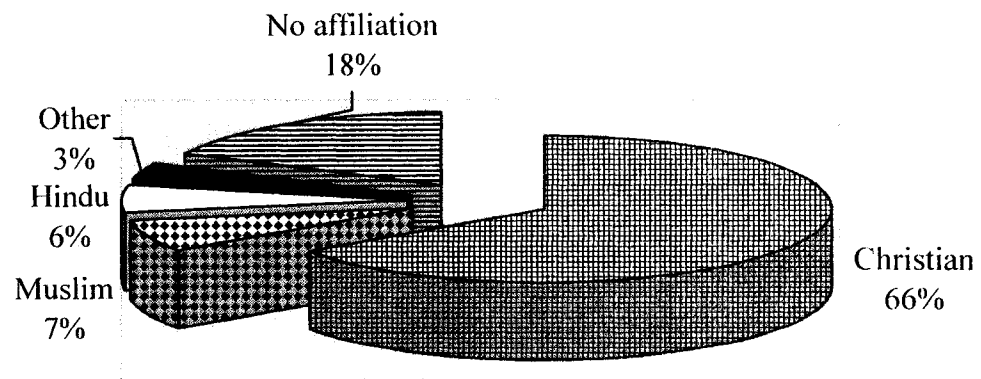
Figure 4: Religion of St. John's immigrants (SC, 2001)

The educational levels of St. John's immigrants are shown in Figure 5. The

majority of immigrants (2,180) possess some type of University degree. 350 have some

postsecondary education, 630 have a college certificate/ diploma and 420 have a trades

certificate/ diploma. Most immigrants are educated in health profession and related

technologies, in applied science technologies and trades. Other educational areas almost

evenly cover engineering, mathematics, computer and physical sciences, commerce and

management, social sciences and humanities, educational and counseling services, and

agriculture and food sciences. Some immigrants are educated in fine and applied arts.
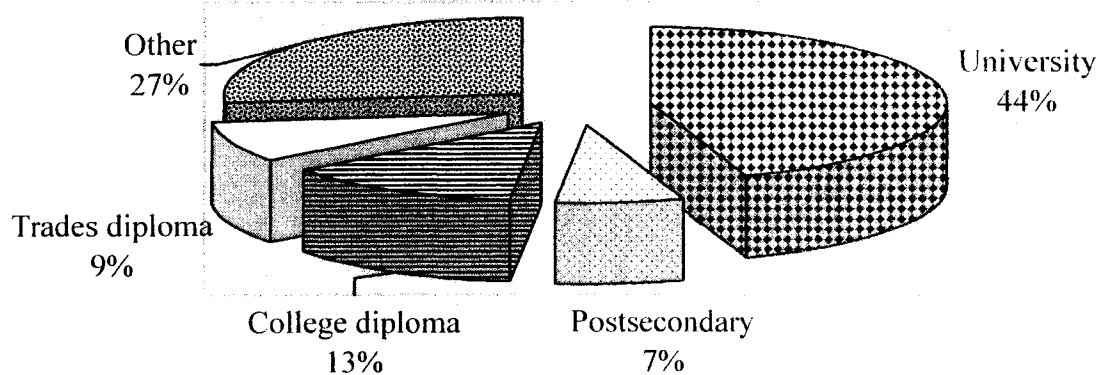
Figure 5: Education level of St. John's immigrants (SC, 2001)

Figure 6 shows the employment status of St. John's immigrants. In 2001, 1705

immigrants older than 15 years were not in labour force (this may include 740 (16%)

immigrants who were attending school) and 255 of those in labour force were

unemployed, which constitutes unemployment rate of 9%. (The definition of labour force

represents those who were actively seeking employment just before the survey was

conducted). Only 1,820 immigrants had full-time jobs, while the remaining 1,200 worked

part-time or seasonally. The majority of immigrants were employed in healthcare and

social assistance services; educational services; professional, scientific and technical

services; public administration, as well as in the retail trade and manufacturing.
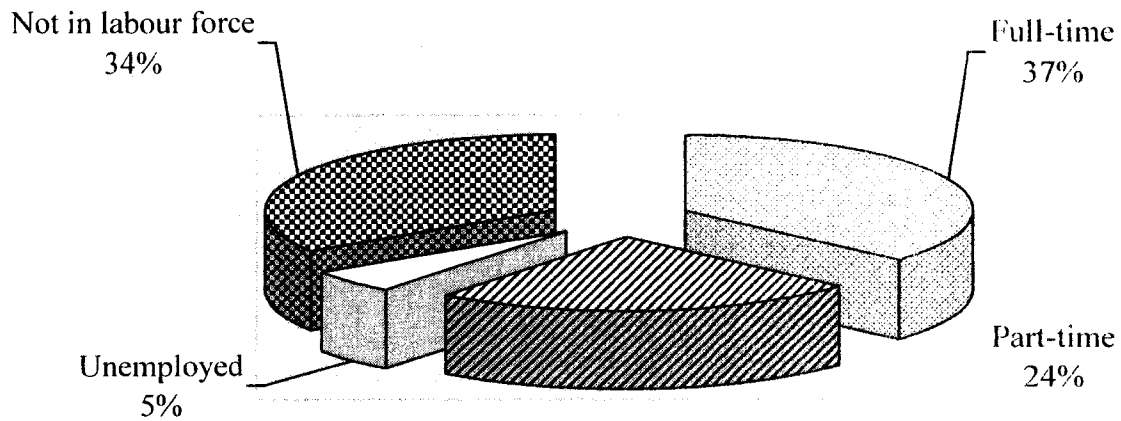
Figure 6: Employment status of St. John's immigrants (SC, 2001)

The earnings of St. John's immigrants are shown in Figure 7. The average income of immigrants was $42,745. While 1,090 (24%) immigrants had an average income of more than $60,000, 1595 (35%) earned less than $20,000 - and this includes 420 (9%) immigrants who earned less than $10,000 and 520 (11%) immigrants who earned less than $5,000. 12.8% of these immigrants fall into the category of low-income families/workers.
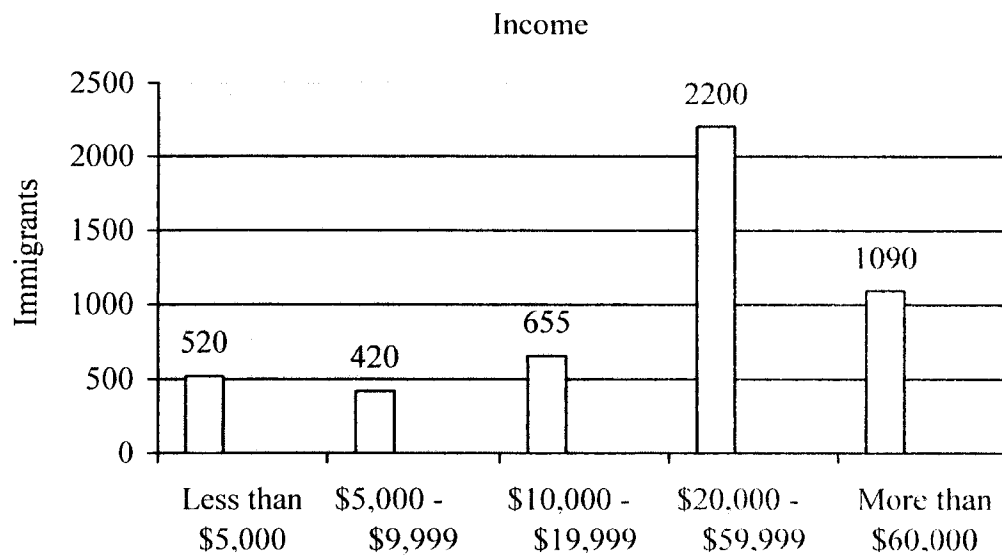
Figure 7: Income of St. John's immigrants (SC, 2001)

In conclusion, these data show that the majority of immigrants in St. John's are European and American young and middle-aged married Christian men with a postsecondary education degrees and an average income of about $43,000, which supports Ng's (n.d.) views of white immigrants having good white-collar jobs with a relatively good income. Considering these data, if the provincial government aims to increase cultural diversity in Newfoundland and Labrador (Government of NL, 2005), it has to create opportunities to attract and retain immigrants of diverse demographic characteristics. In addition, the needs of those 31% St. John's immigrants of non-European, non-white origin, as well as those who will come in the future, need to be reflected and addressed in the provision of appropriate and accessible health, social, community and other relevant services.

2.3.3 Mental health of St. John's immigrants

This section describes the mental health of St. John's immigrants as well as mental health promotion strategies and mental health services available to this immigrant population. The overview shows that there is a very little information available regarding the mental health status of St. John's immigrants. Also, the mental health programs and initiatives designed to address immigrants' needs are fairly limited.

2.3.3.1 Mental health status of St. John's immigrants

Very little is known about the mental health status of St. John's immigrants. In fact, my search yielded only two research papers written by the same author, Dr. Hugh

Sampath (1993), a local psychiatrist. He randomly selected and compared the case histories of fifty immigrants and fifty native-born patients that he diagnosed and treated during his twenty-two years of practice in the province. Sampath's sample of immigrant patients was very diverse with respect to country of origin, age, family status, employment, and length of time spent in Canada. Sampath (1993) states that 22% (11) of his immigrant patients had some mental disorder history before coming to Canada while the remaining 78% developed mental problems here. The most common disorders among his immigrant patients were depression, sleeping problems and marital/ family disharmony. Further problems included suicidal thoughts, anxiety, low concentration and ability to perform at work, as well as cardiovascular and gastrointestinal psychosomatic problems, and headaches.

Looking at gender differences, immigrant men suffered from depression, adjustment disorder, and schizophrenia more frequently than immigrant women, but women required more hospitalization than men. In general, Sampath (1993) concluded that immigrant men are more vulnerable to developing mental disorders than women. He postulated that this fact could be explained by the cultural factor. Many immigrant men come from patriarchal societies that place a great amount of responsibility for the family on the shoulders of immigrant men. Many formerly mentioned studies on the mental health issues of immigrant women, however, suggest that women are more vulnerable to mental health problems. Hence, Sampath's findings can have other explanations. It is possible that St. John's immigrant women have more barriers in utilizing mental health

services. They may be preoccupied with family responsibilities, or lack information on where to access the services, or prefer a female psychiatrist.

Furthermore, when comparing immigrants with native-born patients, Sampath (1993) found that immigrants suffer significantly more from suicidal thoughts and attempts as well as adjustment disorders, but less from psychosomatic problems, alcohol and drug abuse, or physical and sexual abuse.

The National Mental Health & Well-being Survey (Statistics Canada, 2002) provides data on mental health profiles, suicide, mental health problems, well-being and access to mental health resources according to the age and gender of the survey participants in each province. However, the publicly accessible data on immigrants' mental health in Newfoundland and Labrador are not available yet.

2.3.3.2 Mental health promotion and services targeting immigrants

This section provides an overview of the mental health promotion strategies and mental health services available in the province and considers the extent to which these services are designed to meet the health needs of NL immigrant population.

As for mental health promotion and mental healthcare services, the most important issue to consider is the new Mental Health and Addictions Services Plan for Newfoundland and Labrador (Government of NL, 2004). The plan seems to be ambitious and comprehensive. It aims "to cover the full continuum of mental health services" at all levels for all age groups and account for "regional and geographic variations as well as current and future projected demographic realities" (Government of NL, 2004, p.2). The

basis for planned mental health promotion strategies and primary mental healthcare interventions is the Community Resource Base Model, which reflects the self-expressed needs of service consumers who have been consulted across the province. Although the plan focuses on primary mental healthcare services, it also aims to address other health determinants such as employment, housing, education, and early childhood development through cooperation between different agencies and organizations at the community and provincial level.

Importantly, the plan considers a provision of special services to consumers whose circumstances or cultures require a specific approach. These special consumer populations include children, youth, elderly, Aboriginal people, prisoners, people living in remote rural areas, as well as those who suffer multiple losses and those with major diseases or disabilities (Government of NL, 2004). Unfortunately, the plan does not refer to immigrants as a unique population requiring a special structure of mental health promotion strategies and a special arrangement of mental health services. Considering all the immigrant-bound mental health needs and barriers to mental health services formerly mentioned in chapter 2, this is quite surprising. In order to become truly community-resource-based and to reflect the provincial demographic realities, the plan must acknowledge the special needs of the 8,030 immigrants living in the province (Statistics Canada, 2001) who form an integral and dynamic part of the provincial population. Doing so will result in building a much-needed environment of appreciation and inclusiveness for immigrants, which will help in attracting and retaining both present and future immigrant populations.

The mental health services available to the St. John's population include one specialized psychiatric hospital, several hospital-based psychiatry units, psychiatry outpatient clinics, psychology and counseling services run by community heath and social centres, or privately. According to the most recent information provided by the Newfoundland and Labrador Medical Association (NLMA), there are fifty seven practicing psychiatrists in the province with the highest concentration in St. John's and the other urban areas (NLMA, 2006). Out of forty three psychiatrists practicing in St. John's and surrounding areas, thirty one were educated and trained in Canada, eight earned their degrees in Europe and four in several other countries (see Table 4) (Mitchell, January 30, 2006, personal communication). Furthermore, out of those twelve who received their education abroad are four women, two of whom obtaining their degrees in Europe. Unfortunately, NLMA does not collect information on languages that psychiatrists can speak (Mitchell, January 30, 2006, personal communication).

Dr. Callanan, the president of the Newfoundland and Labrador Psychiatry Association explains that these numbers mean that "the St. John's area has fewer than sixty percent of the required number of psychiatrists" for the population of about 180,000 (Callanan, 2003). That results in a ratio of 7,200 patients per one psychiatrist. In addition, Dr. Craig, the chief of the psychiatry department at the Health Sciences Centre in St. John's, points out that many St. John's psychiatrists are older than 65 or close to retirement and many internationally trained psychiatrists leave the province after 1-2 years of practice for other places in Canada (Quinn, 2002). Because there is such a small pool of psychiatrists in the city, immigrants often seek professional help from general

practitioners who may not have the necessary training to address immigrants' unique mental health concerns. In addition, there are seventy nine practicing clinical psychologists in the province (Bazana, 1999), but their services are not publicly funded, which can be a barrier to many immigrants who cannot afford to pay for these services. Considering just these outlined facts, I think that the St. John's immigrant population is at risk of being underserved when the need for mental health services arises.

There are also several locally based agencies such as Health and Community Services St. John's Region (HCSSR), Canadian Mental Health Association (CMHA), and Consumers' Health Awareness Network Newfoundland & Labrador (CHANNAL) whose task is promoting mental health. In addition, there are several organizations such as the Association for New Canadians (ANC), Multicultural Women's Organization, Friends of India Association, and Muslim Association of Newfoundland and Labrador that help new immigrants of different cultures to integrate more easily and quickly to their new home. Since the interim report on mental health already indicated that there is no information available with respect to mental health promotion policies and strategies targeting immigrants (Government of Canada, 2004), I wondered if the agencies and organizations mentioned above develop and implement policies and strategies addressing immigrants' mental health issues. The outcome of my environmental scan is provided in the Chapter 5.

Table 4: St. John's psychiatrists by country of graduation from medical school

(Mitchell, January 30, 2006, personal communication)

Country of graduation from medical school	Number of practicing psychiatrists
Canada	31
Ireland	4
Poland	2
Czechoslovakia	1
Romania	1
Egypt	1
Sri Lanka	1
India	1
Pakistan	1

3. Methodology and Methods

This chapter provides an account of the methodological and theoretical

underpinnings of my study and the methods I employed in conducting my research. First,

it explains the background and reasons why I chose a qualitative inquiry and grounded

theory to fulfill my research objectives. Next, the chapter describes the methods, such as

semi-structured open-ended interviews and environmental information scanning, that I

used to collect the data. Further, it clarifies the way I analyzed the data and drove my

interpretation. Lastly, it addresses ethical concerns and provides information on study

dissemination.

3.1 Why a qualitative approach?

When I first identified my research questions I considered using quantitative

tools. In February and March 2005, I conducted a community survey entitled "Barriers

preventing immigrant Muslim residents of St. John's from utilizing mental health

services." The objectives of this pilot project were to explore the perspective of St John's

immigrant Muslim residents on mental health issues, develop directions for further

research, and test the suitability of the quantitative questionnaire as an appropriate tool to

conduct mental health research.

A structured anonymous mental health survey (see Appendix F) approved by the

Human Investigation Committee at Memorial University of Newfoundland was delivered

to 35 members of the immigrant Muslim community. These individuals were between

19-64 years old and resided in the St. John's area for an unrestricted number of years. While 60% of participants were women, 40% were men. All of the participants had some kind of postgraduate education. Some were single, some married or widowed. 75% had no formal or informal education in mental health issues.

In addition to demographic data, participants were asked to provide information about four main areas: knowledge about mental diseases, attitudes towards people with mental diseases, circumstances for utilizing mental health services, and feedback on the clarity of the questionnaires. The results were analyzed using EpiInfo Software as frequencies and proportions. Then the results were interpreted in an attempt to explore what demographic characteristics and factors may determine immigrants' perspectives of mental health issues. Participants' feedback on the survey instrument itself was also considered and evaluated.

The survey revealed that some participants were ignorant about mental illness, had very little experience with people suffering from mental illness and possessed stigmatizing attitudes toward seeking professional help from mental health providers. Importantly, participants displayed a great interest in mental health research and suggested the inclusion of topics such as the impact of religiosity on coping skills and mental disease prevention as well as the impact of a busy life and a nuclear family structure on mental health. They were also interested in examining the influence of ethnic background and culture on understandings of mental illness, stigmas associated with mental illness (for instance, being labelled as 'unstable', 'stupid' or 'mental'), and finally, the attitudes toward using different types of mental health services (for instance,

counselling vs. psychiatric services). These participants' suggestions shaped my research interests and the design of my research proposal.

First, I found that the issue of maintaining mental health is important to immigrants and thus worthy of further investigation. Second, the themes of ethnic and cultural understanding of mental health concepts suggested that their mental health needs may differ from those of native-born Canadians. Third, the suggestions showed that the quantitative survey with close-ended questions did not capture rich data about participants' attitudes and experiences.

For these reasons, I decided to conduct a study using comprehensive open-ended interviews. The interview questions (see Appendix D) reflect the concerns and suggestions of the pilot study participants and focus on the participants' understanding of mental health and illness, facilitators and inhibitors of their mental health and well-being, coping strategies and experiences with mental health services. Because a qualitative approach allows for exploring meanings, experiences, perspectives and "takes into account that viewpoints and practices in the field are different because of the different subjective perspectives and social backgrounds related to them" (Flick, 2002, p.6), it is a better fit to serve the purpose of my research, which is to explore the mental health determinants of the St. John's immigrant population.

In addition, since the most appropriate way of promoting mental health is engaging people in the process that gives them an opportunity to identify the important issues impacting their health and to realize their health needs (WHO, 1988), I consider qualitative inquiry to be one of the most important tools of health promotion because it is

"oriented towards analyzing concrete cases in their temporal and local particularity, and starting from people's expressions and activities in their local contexts" (Flick, 2002, p.13). Thus, the process of a qualitative inquiry gives people an opportunity to have their voices be heard, and to express their concerns and needs.

3.2 Methods

This section describes the steps and procedures I followed when collecting and analyzing the research data obtained from interviews and an environmental consumer scan.

3.2.1 Data collection

This section first explains the reasons as to why I chose interviews as a tool for collecting my data and describes the interview process. Furthermore, it clarifies steps I followed during the environmental information scanning of the availability of mental health services and mental health promotion initiatives specifically targeting the St. John's immigrant population.

3.2.1.1 Interviews

Initially, I contemplated using a focus group for data collection because of several advantages that focus groups have over one-to-one interviews. Wilkinson (2004) sees the following advantages in conducting focus groups: relatively fast data collection, a

dialogical nature, facilitation of sensitive personal disclosures, and elaboration of accounts through either participants' synergistic contributions, or, on the other hand, through their disagreements and challenges. Although I recognize the advantages of conducting focus groups, I chose to conduct one-to-one interviews for two reasons. First, the advantage of fast data collection during the focus group session is relative and "clearly reduced by the high organizational effort needed to make an appointment at which all members of a group can participate" (Flick, 2002, p.119). Indeed, two of my participants apologized just before the scheduled interview for not being able to attend and requested rescheduling. Had I organized a focus group, the problem of having to repeatedly reschedule appointments would have been arised and I would have risked discouraging some participants from continued participation.

Second, the advantage of facilitating sensitive personal disclosures while conducting a focus group does not always appear. Wilkinson (2004, p. 180) says that "there is a common misconception that people will be inhibited about revealing intimate details in the context of a group discussion," but I argue that it depends on how the topics discussed fit the nature and values of the study participants. For instance, many immigrants from non-western countries may see participating in a mixed gender discussion group and talking about sensitive and intimate issues as inappropriate. Thus, a focus group conducted in such manner could represent a barrier to their participation. Moreover, I could not conduct two separated focus groups for men and women with only two male participants. I intended to examine perspectives of both women and men, and therefore interviews offered the best basis for expressing participants' viewpoints.

knowledge, assumptions and theories about the studied topic and made this information accessible to interpretation (Flick, 2002).

Before describing the interview process itself, I will discuss the recruitment of participants. I recruited a convenience sample of eight adult immigrant men and women through poster advertising and snowball technique. The study posters (see Appendix A) were sent to some immigrant gathering places such as community centres, churches and temples as well as to the Association of New Canadians in St. John's. They were posted on several mailing lists often accessed by immigrants such as Envision Canada or University mailing lists (for instance, mailing lists belonging to the Muslim Students Association and Community Health Division). I also approached other researchers from other University departments who had worked with immigrants in the past and they provided me with lists of several research volunteers.

Despite extensive recruitment attempts, I experienced great distress over the difficulties of finding participants, which is consistent with the findings of studies on immigrants' barriers to participating in health research. Researchers examining these barriers found that two reasons for immigrants' reluctance to participate in research are lack of general knowledge about research, which Robertson (1994) calls a conceptual barrier, and lack of knowledge about specific research projects, which Killien et al. (2000) identify as a structural barrier. One of the main obstacles preventing immigrants from research participation, however, is fear of exploitation or mistrust in researchers and medicine (Arean & Gallagher-Thompson, 1996; Baker 1999). For example, Harris (1999) found that black Americans are hesitant to participate in research because they are aware

of dangerous and unethical research such as, for example, the well-known Tuskegee project, which denied necessary medical treatment for syphilis to the black Americans in the study.

Barata, Gucciardi, Ahmad and Stewart (2006, p.480) further add that "this mistrust may be compounded by consent procedures that are foreign to participants and require a signature, which may connote a legal obligation to come." They elaborate that their difficulties in recruiting Portuguese participants were caused by their fear of voicing their opinions and mistrust in governmental institutions that have historical roots when these immigrants have formerly lived under an oppressive Portuguese political dictatorship. I believe that, since many immigrants residing in St. John's come from the countries known for such oppressive political climates, this may also be one reason why I had difficulties in recruiting informants.

Furthermore, Barata et al. (2006, p.486) find that a written explanation of the study is insufficient because "written information is ignored by people" and minority participants are more receptive to a personal verbal explanation. Initially, I planned such a personal verbal explanation by visiting immigrant communities, but the Human Investigation Committee (the committee granting ethical approval to Memorial University researchers) saw this approach as inappropriate and potentially coercive. For this reason, I had to accept the printed forms of a study poster (Appendix A) and a study information letter (Appendix B).

Most importantly, Barata et al. (2006) find that recruiting research participants from immigrant communities is much more efficient when done with the help of

community leaders. They acknowledge that this may lead to losing some control over the recruitment process (for example, they found among the Portuguese participants whom they initially targeted immigrants from Brazil and Mozambique as well); however, all their participants noted that "they only come that day because someone familiar and trusted invited them" (Barata et al., 2006, p.484). Unfortunately, I did not think about approaching community leaders. I did approach, however, the Association of New Canadians with a request for assistance in recruitment, but I did not receive any response. Similarly, I approached one executive member of the Multicultural Women Organization who posted my recruitment ad on their mailing list, but this strategy too did not bring any results.

Lastly, Barata et al. (2006) also discuss the importance of understanding the research benefits to immigrants when considering what they can gain and lose from participating in research. My study information package contained information about potential benefits to participants, but in the end this did not seem to encourage the recruitment.

Despite experiencing recruitment difficulties over a period of two months, I was able to find nine interested individuals. After these individuals contacted me, I explained to them the purpose of the interview, introduced them to the interview questions, reassured them of the confidentiality of the interview, and answered all their questions. I obtained their written consent to participate. The consent form (Appendix C) clearly states the purpose of the study, the method of conducting the interviews (audiotaping) and once again reassures them of the confidentiality. After I gave the consent form to

all participants, they had at least one week before they were asked to sign it and participate. They determined a convenient place and time for conducting the interviews. All but one individual, who initially indicated an interest in participating, signed the consent form after reviewing the study information package. The participant who declined to participate in the study did not provide any reasons for this decision and I fully accepted it without questioning her reasons.

I interviewed all participants in the comfortable privacy of my or their homes at a time that was convenient for them. The length of the interviews spanned from one to two hours. All interviews were tape-recorded and then transcribed. Participants were asked questions using an interview protocol (see Appendix D). To help participants reconstruct the knowledge, assumptions and theories, I employed open-ended, theory-driven and/or confrontational questions, which "allow the researcher to deal more explicitly with the presuppositions he or she brings to the interview" (Flick, 2002, p.83).

Participants were very productive in answering my questions, but some questions needed further clarification and simplification from my side. As I will mention in the discussion of my findings, some participants had problems in defining mental health and illness. They found it easier talking about what accounts for their mental well-being, rather than providing specific definitions. Sometimes, participants could easily identify several factors that are important to maintaining their mental health and could also talk about them in detail, so I did not need to employ any guiding questions from my list. Other times, I had to facilitate the discussion by asking them about particular factors. I think participants encountered the greatest difficulties in answering questions on the

differences between men and women regarding mental health issues. Their usual answer was: "I have never thought about it before."

In general, all questions were well received and participants felt relaxed in front of the recorder. However, when it came to the issues of being accepted in society and experiencing discrimination, several participants did not feel comfortable enough to disclose everything they wanted while the recorder was on. As one participant suggested: "I will tell you something when you turn it off." They told me several stories of discrimination and prejudice they experienced during their stay in St. John's, and asked me to keep this information confidential, which I intend to do. I assume that this discomfort and fear of speaking about these issues openly is rooted in their homeland-based experiences, since most of these people come from the countries where speaking out against injustice is severely punished. Although immigrants know about the Canadian tradition of democracy and freedom of speech, the decades-long experiences of oppression and persecution cannot be easily erased.

Finally, I would like to introduce my research participants. I recruited six women and two men who were at one point in time, or still are, Canadian landed immigrants. Some of them are now Canadian citizens. Their ages vary between early thirties to middle forties. They came to Canada from four different continents and eight different countries. They speak five different languages. (Initially, I intended to recruit also participants who cannot speak an official language to conduct the interviews in their native languages. However, the Ethics Committee at Memorial University requested that I provide the official translators trained in conducting interviews. Since I am not aware of

presence of such translators in St. John's, I had to exclude this group of participants from my interviews). All of them are married and most of them have children. Also, all of them have some type of post-secondary degree obtained either from abroad or in Canada. Two are employed full-time, three are pursuing graduate degrees and three are unemployed. They have been in Canada between three to ten years; some of them moved to St. John's directly from their native countries and some came from other Canadian cities. Three participants have some kind of formal education in mental health issues. Five participants had personal experiences with mental health services and had either received treatment for mental health problems or were receiving counseling in the past or when the interviews took place. Two had been admitted to psychiatric hospitals and three were seeing their family physicians. All five participants had been prescribed medication to manage their problems. One participant was seeing a counselor and another one had used a special rehabilitation program designed for people with mental illness. I chose the participants with diverse demographic characteristics in order to "represent the field in its diversity...in order to be able to present evidence on the distribution of ways of seeing or experiencing certain things" (Flick, 2002, p.70).

3.2.1.2 Environmental information scanning

Choo (2001, n.p.) defines the method of environmental scanning as "the acquisition and use of information about events, trends, and relationships in an organization's external environment, the knowledge of which would assist management in planning the organization's future course of action." Similarly, I performed a consumer

environmental scan to acquire and use information about what mental health promotion initiatives and services targeting the St. John's immigrant population are available and develop recommendations for improving any gaps in information if necessary.

Authors writing in the area of information research often refer to Aguilar's (1967) four concepts of scanning: undirected viewing, conditioned viewing, informal searching, and formal searching. Morrison (1992) defines these four modes as follows:

- Undirected viewing – reading a variety of publications just to be informed
- Conditioned viewing – assessing relevance of the read information to the organization
- Informal searching – active but unstructured searching for specific information
- Formal searching – active structured searching for specific information

Based on these definitions, I employed a combination of undirected viewing, informal and formal searching in the environment consumer scan I performed.

There were two criteria that directed my information search. First, I searched for readily available information only. I believe that a person experiencing difficulties should be able to find information about the available help and services fast and easily. For this purpose, I turned to the two most commonly used information sources such as print sources and the Internet. Second, being concerned about potentially limited language skills, possible differences in cultural understandings of mental health and in values between immigrants and Canadian healthcare services, I searched only for information specifically targeting immigrants.

Thinking of the information that I intended to seek and adhering to my search criteria, I determined the following information sources:

Print-based information sources

I settled on two sources of information: yellow pages and take-out pamphlets available at ten medical clinics in the St. John's East area that I visited. I believe these two sources are readily available to all St. John's immigrants.

Internet-based information sources

I searched the websites of several St. John's organizations and agencies responsible for delivering mental health services and health promotion programs as well as helping with the integration of immigrants. I discovered these organizations by employing the Google search engine. I used the following key words as my search terms: "Newfoundland", "St. John's", "mental health", "immigrant", and "immigrants". At the end, I found the following organizations and agencies: St. John's Healthcare Corporation, Waterford Hospital, Health and Community Services St. John's Region, Canadian Mental Health Association Newfoundland & Labrador Branch, and Consumers' Health Awareness Network Newfoundland & Labrador, Association for New Canadians, Multicultural Women's Association, Friends of India Association, and Muslim Association of Newfoundland and Labrador. After I had determined the organization responsible for delivering mental health services, I visited their websites and searched for information targeting immigrants. If the website provided a search engine, I used the following key words as my search terms: "immigrant", "immigrants", "culture", "cultural", "culturally sensitive", "culturally competent", and "multicultural". If the

website did not have an engine, I read all available information including the website's

links to search for the pre-defined information. When searching the websites of

organizations involved with the integration of immigrants, once again, I either read all

available information or employed the search engine by using key words such as

"health", "mental health", "health service", and "health services". The results of the

information scan are discussed in Chapter 5.

3.2.2 Data analysis

In this section, I explain the process of analyzing the data collected. First, I will

describe the process of thematic analysis that I used in studying the interview data

collected and then the process I used to evaluate the information available from the

environmental consumer scan.

3.2.2.1 Interview data analysis

The technique I used in analyzing the interviews is called a content analysis,

which represents "any technique for making inferences by systematically and objectively

identifying special characteristics of messages" (Holsti, 1968, p.608). Wilkinson (2004,

p. 183) further explains that the method of "content analysis is based on examination of

the data for recurrent instances of some kind; these instances are then systematically

identified across the data set, and grouped together by means of a coding system." In

addition, the criteria that a researcher uses for developing the coding system need to be

organized in the way that "other researchers or readers, looking at the same messages, would obtain the same or comparable results" (Berg, 2001, p. 241).

The process of coding represents "operations, by which data are broken down, conceptualized, and put back together in new ways" (Flick, 2002, p.177). The coding process starts with initial or so-called open coding "concerned with identifying, naming, categorizing and describing phenomena found in the text" (Borgatti, n.d., para 8). As Borgatti (n.d., para 9) further explains that coding leads first to developing categories, "nouns and verbs of a conceptual world," and then to the properties of these categories, "adjectives and adverbs." After these categories and their properties are defined, the researcher proceeds to axial coding in which he or she, either inductively or deductively, mutually relates the categories and their properties. As Borgatti (n.d) continues, sometimes the researcher chooses a core category and relates all other categories to this core category. This process of developing "a single storyline around which everything else is draped" (Borgatti, n.d., para 19) is called selective coding. The ability to discover and label the categories and the mutual relationships between them which build the theory is called "theoretical sensitivity" which is influenced by "one's reading of literature and one's use of techniques designed to enhance sensitivity" (Borgatti, n.d., para 6).

At all stages of coding, data and the concepts of each participant are compared and cross-checked with those of all other participants. This process results in generating research-relevant concepts and relationships that form a basic network for building theoretical assumptions (Flick, 2002). It is important to understand that the developed

theoretical assumptions "are not (right or wrong) representations of given facts, but versions or perspectives through which the world is seen" (Flick, 2002, p.43).

In the case of my interviews, I organized the transcribed texts according to several main recurring themes among all participants. Rather than counting the frequency of particular themes among all participants (a quantitative content analysis), I performed a qualitative thematic analysis which focused on "discovery and description, including search for contexts, underlying meanings, patterns, and processes, rather then mere quantity or numerical relationships between two or more variables" (Altheide, 1996, para 1). I coded the recurring themes and topics into several categories. The main categories, for example, included unemployment, social support, income, culture and so on. Then I looked for the sub-themes which helped me understand the meaning of particular themes. For instance, the sub-themes of unemployment included a bad job market, unrecognized credentials, over-qualification and discrimination.

After identifying the main themes and sub-themes, I continued with a second level data analysis in order to elicit further information on attributes of the established categories and their mutual relationships. Finally, from the transcripts, I selected specific quotes best representing the substantive themes and proceeded to the interpretation. I discuss my findings in light of the information presented in Chapter 2. The interpretation of data is also influenced by my own impressions, irritations, and feelings, which often form part of the qualitative research interpretation (Flick, 2002).

3.2.2.2. Evaluation of environmental information scanning

In order to establish my evaluation criteria, I chose some of the very helpful measures that Marton (2001) developed when she evaluated women's health information resources in Ontario. Considering my research questions, I evaluated the scanned information according to the following criteria:

- Availability (Is the information available?)

- Content (What information is available?)

- Accessibility (How much time, effort and cost is involved to find the information?)

- Language sensitivity (In what language is the information provided?)

Based on the identified lack in availability, content, accessibility and language sensitivity, I developed recommendations for improving the delivery of information to immigrant populations. These are discussed in Chapter 6.

3.3 Ethical considerations

Ethical approval for this study was obtained from the Human Investigation Committee (HIC) at Memorial University of Newfoundland. (see Appendix E). All participants were provided with an information package explaining the purpose of the study, and potential harms and benefits (see Appendix B). After delivering the package, the participants were provided with sufficient time to make an informed decision about participating in the study. All participants signed written consent forms which are

currently stored in a safe locked place along with the audiotapes and interview

transcripts. As a researcher, I understand the absolute right of my participants to protect

their identity and keep all disclosed information confidential. I chose only general

statements to describe participants and deleted all information that could reveal their

identity from the audiotapes and transcripts. All study materials will be destroyed five

years from the end of the study as required by HIC and the regulations of Memorial

University of Newfoundland.

3.4 Dissemination of the results

I will offer the executive summary and recommendations reports to interested

mental healthcare providers, family physicians, mental health authorities and policy

makers. I intend to tailor these reports to various needs for communication (sources,

channels, content and formats) and knowledge transfer that the different types of

decision-makers have (Lomas, 1997; Lomas, 2000; Feldman, Nadash and Gursen, 2001).

The stakeholders interested in the study's outcomes include: NL Psychiatric Association,

Association of Newfoundland Psychologists and Mental Health & Addictions of Eastern

Health, the Association for New Canadians, and the provincial chapter of the Canadian

Association for Mental Health Promotion. Also, I will present the findings of the

environmental information scan to the authors of the scanned websites. Lastly, I intend to

deliver the findings of my study through oral presentations in immigrant communities

and at local and/or national conferences concerned with the health of minorities and the

multicultural approaches to healthcare and health promotion. I would like to also present

my research findings and recommendations through publications in community

newsletters, as well as academic and professional journals.

4. Immigrants' mental health: concepts and determinants

In this chapter, I discuss the findings that emerged from my participants' interviews. At first, I describe these participants' understandings, definitions and descriptions of mental health and illness. Then, I move on to discussing the determinants of these participants' mental health and well-being. This discussion covers the factors that help in maintaining immigrants' mental health, as well as the factors that contribute to immigrants' difficulties and put them at risk of developing mental illness.

4.1 Immigrants' understanding of mental health and illness

My first research question is to examine St. John's immigrants' understanding of mental health and illness. For this reason, I asked participants to elaborate on their ideas about mental health and illness and to describe how their perspectives changed (if at all) after moving to Canada. I found that while immigrants either have no concepts of mental health or their concepts are more consistent with a broader holistic understanding of mental health issues that they learned in their countries of birth, their understanding of mental illness is more consistent with the concepts of the biomedical model. Furthermore, moving to Canada influences immigrants' ideas and attitudes around the issues of mental health and illness in two ways: by challenging their stereotypes and exposing them to the western ideology of medicalization. I discuss these findings in more detail in the following paragraphs.

Some participants found it difficult to define mental health. For some, mental health is synonymous with mental disease, something they "see on television…someone in a padded room strapped in a jacket…" or the image of someone who "is like a lunatic." Other participants equate mental health with mental health services, or psychiatric and psychological sciences. Generally, participants found that it is easier to talk about mental disease either because they "don't have enough exposure to mental health" in their home countries or because there is no linguistic term for mental health in their mother tongue. In the words of one participant, "I don't distinguish between them [mental health and mental disease]. … Maybe if they use different terms in my language I would understand it." Herrick and Brown (1998) reported a similar finding among some Asian American immigrants who described an absence of mental health and illness concepts in their native culture.

Among those who were able to define mental health, some described it as a personal attribute. They spoke in general terms of positive and healthy thinking, feeling and acting using words such as 'well', 'happy', 'satisfied', 'comfortable', 'balanced', and 'harmonious.' Some participants were more specific, defining mental health as an "ability of the person to cope with any situation," satisfaction with one's life, work, money, and education, or having good thoughts about him/ herself. This conceptualization of mental health is consistent with Fernando's (2003) summary of ideals of mental health in eastern cultural traditions as harmony and balanced functioning (see Table 1) as well as with a definition introduced by WHO (2001, para 1) that sees mental health as culturally underpinned "subjective well-being" and by Larson (1999, p.129) who understands

health as the "strength and ability to overcome illness." Only one participant defined

mental health as having "no problem in brain, in thinking," which is consistent with the

definition of mental health as the absence of "alteration in thinking, mood, or

behavior...associated with distress and/ or with impaired functioning" (U.S. Department

of Health & Human Services, 1999, p.5).

In my understanding, immigrants' notions of mental health (the conception of

non-existing mental health and the description of mental health in terms of feelings about

life) resist the western concept of medicalization which tries to explain processes of

human life and social problems from the medical point of view (Clarke, 2004; Fernando,

2003). In medicalized society, healthcare providers developed the category 'mental

health' to define feelings of wellness, happiness and satisfaction, similarly as

psychiatrists created the nosological unit 'premenstrual syndrome' to explain changes in

female emotions, mood and behaviour before menstruation.

When describing their perspectives of mental illness, several participants stressed

the importance of differentiating between the terms 'mental problem' and 'mental illness/

disease.' In their understanding, mental illness is usually an extreme state when a sick

person needs professional help because "it has a deeper impact...it's not just temporarily,

it doesn't go by itself." A mental problem is just a deviation from normal behaviour, but

it is not a health problem. One participant gave this example: "Someone might sneeze

several times – it can be something abnormal, but it doesn't mean that he has flu."

Participants agreed that if such a problem "is not controlled, then it may progress to

mental disease." A person with a mental problem can help him or herself by relaxing in a

nice place surrounded by family and friends, which would not help someone suffering from a mental illness.

This understanding of reversible transition from 'health' to 'mental problem' and then to 'mental illness' suggests that immigrants do not see any clear-cut boundaries between health and illness. Such a conception supports the notion of a health and illness continuum that recognizes the many levels of health and illness one can develop (U.S. Department of Health & Human Services, 1999).

When participants were asked how they would recognize a person with mental illness, they listed a variety of signs such as problems with controlling body movements, switching moods, extreme happiness, extreme sadness, extreme anger, withdrawal, isolation, abnormal gestures, sleeping problems, concentration problems and abnormal performance at work…without a reasonable reason." One participant talked about her own experience of being mentally unwell and how this experience changed her perception of mental disease:

> Personality changes, you are no longer as happy as you used to be. You have no interest in doing anything. If you will be a nice person you can suddenly become a very hostile person or withdrawn, you have negative thoughts, thoughts like killing yourself. That's my personal experience. Before, I would have say that someone with a mental problem is someone who is probably walking down the street talking to himself or stuff like that.

In terms of defining mental illness, immigrants' perspectives seem to match more closely the definitions provided by the western biomedical model when they identified mental illness as a cluster of different physical and psychological symptoms. However, their understanding of the causes of mental illness shows that these causes can come from

a variety of biological (e.g. faulty brain chemistry), psychological (e.g. unresolved bad childhood experiences, trauma, prolonged stress) and social sources (e.g. social oppression). Some participants said that it is a combination of biological and psychological factors that is necessary for developing a mental illness. This notion does not support a strong preference of biological factors in the etiology of mental illness that psychiatry so keenly favours (Fernando, 2003; Kleinman, 1988).

Lastly, participants talked about the changes in thinking about mental health and illness that they encountered after moving to Canada. Some participants expressed that issues of mental health and disease are usually considered taboo in their native lands. It is not "something to talk about a lot. And usually someone who is said to be mentally ill is normally in the hospital locked away." But after coming to Canada, participants realized that the mentally ill "can be part of this society, they can be part of my [participant] everyday life and I [participant] can be one of them one day or another."

Participants further noted that "having access to mental health experts is something not abnormal or unusual here." One participant documented it with her personal experience of being diagnosed with mental disease:

> Yeah, it [the perspective of mental disease] changed after I got sick. Before it was the same stereotype that everybody has more or less, but then as I got sick and I got to seek help and met more people I began to realize that it happens to anybody. And a lot of people are still ashamed to admit, but I am at point when I'm not because if I could talk about it and help somebody to get help then I'm okay with that. I think back home society is different.

I see the act of confronting the stigma associated with mental illness that immigrants have brought with them to Canada as a positive change. Breaking down the

taboo of mental illness by talking about it more openly and understanding that seeking professional help is 'normal' are the key elements toward effective health promotion and disease prevention.

However, participants mentioned another aspect of mental illness that changed after moving to Canada. They said that, before coming to Canada, they perceived the mentally ill as mad, crazy, bad-mannered or the ones losing their minds, similar to the way in which people of their native societies perceive the ill, but in Canada participants realized that mental illness "does not need to be madness; it can be anything, depression, stress, feeling uncomfy..." One participant also suggested that in her native country mental illness is considered an issue of choice rather than having medical reasons, "I haven't been able to tell my mom because I tried to explain to her why I'm off work and she said: 'Why would you decide to get depressed?' So she didn't understand because of the culture."

Thinking about the changes in participants' perception of mental health and illness after moving to Canada, once again, I hear the echo of medicalization in immigrants' stories. In the society penetrated by the ideas of medical imperialism, immigrants learn through media and personal experiences that mental illness "can be anything." They start to label feelings of being sad and stressed with the term 'mental illness,' which, in my opinion, has dangerous consequences.

For example, after turning off my tape recorder, one participant told me that she feels very distressed and unwell because she cannot work in the field she is qualified for. When I asked her if she can develop some other goals she could work for, she started to

cry and said: "Immigrants don't have goals, they have only dreams." Feelings of stress or sadness can be caused by many difficulties that the immigration experience brings, but it is easier and more convenient to attribute immigrants' feelings to a medical illness - depression in particular. This way the focus shifts from the social causes of immigrants' feelings to blaming their brain chemistry and the notion that what immigrants need is medication. Thus, I believe that, thanks to the ideology of medicalization, the solution for immigrants' problems lies in medicine rather than in society and its faulty structures.

In addition, I noticed that participants who had a formal medical knowledge of mental illness before coming to Canada did not think that their perspective of mental illness had changed since their ideas were always consistent with those presented by the western schools of health. This fact shows that the western concepts of medicine found their ways to infiltrate health education worldwide.

All participants realized that coming to Canada brought many challenges and difficulties to their lives. One participant put it this way:

> This is a new life and change in everything, you know, culture and people. I feel very uncomfortable here because we are used to certain culture and people. And then stress. I know some people who got depression and had suicidal attempts. They are also from my country.

Prior to coming to Canada, few participants realized their vulnerability to mental illness. Indeed, five of them were forced to seek professional help and attributed their health problems to immigration related difficulties such as isolation, loneliness, unemployment, lack of social support and climate change. I discuss these issues in more detail in the following section on mental health determinants.

4.2 Determinants of mental health and well-being

My second research question is to identify immigrants' mental health needs, in particular, the facilitators and barriers to the maintenance of their mental health. Participants reported a broad spectrum of factors shaping immigrants' mental health and well-being that were consistent with the holistic eastern mental health ideals described by Fernando (2003). Participants talked about general issues such as having a balanced life between work and family, personal life and entertainment, dealing with the reasons of anxiety and worries, and understanding the purpose of life and meaning of things. As one participant expressed: "If I'm satisfied with my life, with my income, with my husband and my children, and everything that God gave me it's ok. And this is my treatment." Participants also detailed more specific factors contributing to their mental health such as being surrounded by friends and family, being physically healthy, having a positive attitude, having a personal space and time, having a meaningful career and sufficient income, being accepted in society, and having some basic understanding of mental health issues. These findings are organized around seven determinants of health and discussed in the sections that follow: social support, income, employment and working conditions, culture, physical environment, gender, and coping skills (Shah, 2003).

4.2.1 Social support: "A supportive nice circle of friends and family."

St. John's immigrants need a variety of forms of social support to sustain their mental health: affection, acceptance, information, advice and/ or practical help (Clarke 2004). The absence of such support can lead to feelings of deep loneliness, emptiness and isolation and an adequate network of information, advice and help to deal with problems when they arise. These findings support previous studies by Beiser (2005) Sadavoy et al., (2004); Ahmad et al., (2004) and Gastaldo et al. (2005).

Many participants stressed the importance of having the support of their families and friends who can help them psychologically or financially to handle stress. Besides help from family and friends, participants talked about the support their native societies offer them, which is not available in Canada:

> By nature...indirectly...even if you don't need it or you don't feel you need it...just attending ceremonies and prayers, meeting some good people in the mosques and friends, meeting senior family members, neighbours, some people with good understanding of religion and life, with good manners...such things can give help.

Almost all participants believed that after moving to Canada they did not have enough support, they "don't know to whom they can go" and they are left "alone with all these stresses." As one participant described:

> Back home the relationship between people is completely different than here. We are close to each other, we are like sisters, brothers, we have uncles, cousins, we have warm relationships back home. Even with friends - every two or three days we visit each other. But when we came here, you can say that everybody lives his own life.

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Participants thought that the reasons for being lonely and not having social support can lie in cultural differences or in expecting too much as two of them pointed out:

> There is no support. This is our sixth year in Canada. There is the only neighbour that offers to me any support and any help. She told me: 'I'm ready for anything.' All of them are with their own life, just 'hi' and that's it... There is a difference between our cultures. I think this is the point.

Another participant put it this way:

> I have never find anybody here that I could call a real friend or close friend, I have friends, ... I have acquaintances, but I don't have a very good friend. Maybe I'm expecting too much. Maybe I want to substitute the friends for the family members that I don't have. And of course, when I compare them, they won't be my mom, they can't be my aunt. So I always feel void. Like there is something empty in that and maybe I'm expecting too much.

It is important to mention, however, that not having a family around does not necessarily mean a bad thing to some immigrants. One participant saw a positive aspect of moving to Canada in terms of her personal development in a Canadian multicultural context. She noticed a big shift in her views and perspectives that are different from those she held back at home where everybody is from "the same cultural and economic box." As a result, she realized that there is a growing gap between her own ways of looking at things and those that her family has. She explained:

> For instance, if I go through certain difficulties I need someone to help me through the lenses of the person who I am now, maybe whereas my family back at home can somehow be... I don't want to use this word ...but can be somehow backwards in dealing with this particular and new issue I'm facing. So, whatever advice they may giving me does not always help me solve the problem; sometime it can make it even worse.

The feelings of being lonely, forgotten, overlooked and not supported are not experienced just in relationship with Canadians and Canadian society. One could think that the same colour of skin would make people of this colour close to each other as easily as one could think that the same difficulties and problems would make people who share these problems closer. For example, for a black non-African immigrant woman, being black is not 'enough' to feel accepted by other black African immigrants:

> There is nobody here from [country of participant's origin] that I know him. No one at all! There are a lot of Africans from Africa but ...when I see a black person, I try to say 'hi' and associate, but they never accept me. I'm more accepted by the Newfoundlanders than by the blacks, which is very sad, but this is the way it is.

In the case of other immigrants, it seems that being an immigrant is, once again, not 'enough' to find close friends and receive the support they are looking for. The immigrant communities appear to struggle with internal disparities and inequalities, since the experiences and social circumstances of their members differ significantly. This supports Ng's (n.d.) and Aroian's (2005) views that immigrants are not a monolithic group. Ng (n.d.) and Aroian (2005) see that this division occurs between immigrant communities based on the differences in race, nationality and ethnicity of their members. But, in my opinion, this separation exists on two levels: between different immigrant communities and within the same immigrant community. Besides race, nationality and ethnicity, the members of the very same immigrant community can also be divided according to religious affiliation, language, class, status and so on. These 'invisible' barriers lead to an uneven distribution of power and resources between and inside immigrant communities, which distances immigrants from each other and creates

mistrust to confide their problems and seek help. As a result, the feelings of loneliness

grow and their sense of isolation increases:

> It's really good to talk to someone and discuss these issues, cultural things. You
> are being away [from the home country] and a lot of things happened to you that
> you don't know if other people will go through. Is it only you? Should you
> change? ... People are not feeling comfortable talking about these things. So when
> we sit we don't talk about these things, we don't advertise it that we are feeling
> lonely or not good. But if the topic comes up I would sure say I'm not happy, I feel
> uncomfortable, I miss my family. But the topic never comes up and there is always
> something else that we talk about.

In addition to the mistrust and misunderstanding of their mutually different social

backgrounds and life experiences, some participants identified other reasons for not

discussing their problems and feelings of mental unwellness within the immigrant

community. Some assumed that people of other cultures don't like to talk about mental

illness because it "is like death, it's like cancer...it's a disaster," or they are simply too

busy or not interested in such issues.

One more issue emerged from the interviews: Canadian immigrants who are

constantly on the move do not have the time or opportunity to receive the support and

help they need. One participant made this observation:

> I know many families like this who move from one city to another city, they look
> like they don't live the present they live the past. They always refer to their former
> friends, former city they lived in. They always dream about going back to that
> particular city. It's very interesting; they kind of suspend adjustment, which they
> need in this city [St. John's].

Moving while searching for a job or better opportunities is not something out of the

ordinary in North America. However, many immigrants come from countries with less

dynamic lifestyles. One can find the same picture in many Asian, African and Middle-eastern countries: the same government is in power for decades, people work in the same factory or teach in the same school all their life, and several generations of offspring inherit the same apartment in succession. Adjusting to a fast-paced lifestyle in Canada (where people move from one place to another very often) can be very stressful to many immigrants. Immigrants may suspend the adjustment to the new place and building the new home because they are afraid that they may get hurt once again when leaving behind everything they had and friendships they developed when it is time to move again.

In addition, the uncertainty of being in the same place next month or next year also prevents immigrants from making new friends, buying furniture, cars and houses, developing ties and connections, committing effort and time to different activities and projects, and being intensively involved in society and politics. One can say that not being able to anchor in any place that immigrants could call home forces people to become the 'endless' immigrants. Searching for satisfying employment and a continuous income are two of the reasons immigrants move more frequently than they might want. These two determinants of mental health are discussed next.

4.2.2 Income: "Income is a big thing!"

Participants agreed that income is a very important factor contributing to mental well-being. Similar to the findings of previous studies (Beiser, 2005; Cheung and Snowden, 1990; Ginsberg, 1991; Miranda and Green, 1999; Leong and Lau, 2001), some St. John's immigrants experience a high level of stress due to insufficient income.

Inadequate income can result in a lower standard of accommodation and nourishment, and reduced ability to pay for medication and participating in social activities.

Visiting some immigrants' dwellings reminded me of Gastaldo's et al. (2005, n.p.) portrayal of immigrants in Toronto: "Through their photos we saw very modest living standards (e.g. four people living in a one-bedroom apartment), basic furniture, and homes situated in average to poor neighbourhoods."

Most participants noted that there is a direct connection between financial deprivation and mental health because a person without income can be stressed, depressed, lonely, left out from society, insecure, anxious, and worried or abused. However, one participant thought that too much money could cause problems and threaten one's health as well, especially if it is in the possession of a person without good character and/or good knowledge of financial management. Another participant expressed the idea that mental health is not a matter of money but personality, because she believed that while poor people can be satisfied, the rich cannot and may want more and more.

Some participants find their current financial situation quite stressful. They found that the income they had before moving to Canada was much higher than what they have now. Now they are unable to cover even their basic expenses because "everything is so expensive." One family with children could not afford to finance a car for a long period of time, which is very stressful especially during the province's harsh winter weather. As well, one participant expressed her concerns about paying for medication to treat her disorder.

One of the biggest stresses is finances. You do have bills to pay and if you don't have any income it will be stress for you. So income is definitely for me one of the reasons why you can get depressed. Fortunately, I have medical insurance through my work so my medications are paid for 80%, so that is one less stress that I need to think about. There many people I know they have no income, no benefits, no nothing and they have to be on three, four different meds - that is extra stress to them. Definitely, income is a big thing!

4.2.3 Employment: "Why can't I get a job?"

Having a meaningful job is a very important factor shaping the mental health of

St. John's immigrants. Six of the eight interviewed participants were unemployed

(including three graduate students looking for employment) and thought that finding a job

was very difficult for reasons discussed below. To St. John's immigrants, unemployment

is the source of stress, depression, anger, feelings of uselessness and low self-esteem,

while employment is the source of income as well as pride, satisfaction and feelings of

usefulness:

> Here we don't have friends or families that we can go to visit to chat with them, to sit with them, so I think it's important to go to work to make your life busy. Otherwise your mind will be very tired. When you achieve something, it will make you relaxed that you did something, you achieved something that made you proud or comfortable or happy.

Besides, voluntary work is valuable but it undervalues immigrants' knowledge and skills

and therefore cannot substitute appropriate employment.

In fact, the situation of St. John's immigrants endorses the findings of other

studies showing that immigrants experience problems in finding employment (Akhavan

et al., 2004; Beiser and Hou, 2001, Canadian Task Force, 1988) and that being unable to

work makes them feel powerless, depressed, useless and upset (Akhavan et al., 2004; Shams and Jackson, 1994; Beiser and Hou, 2001 and Pernice and Brook, 1996).

Participants listed several different reasons for being unable to find jobs. Two participants had foreign education credentials of high values and long-term working experiences, but these were not recognized in Canada. Not having their foreign credentials recognized made them feel upset, angry, or depressed. These feelings have to be understood in a broader context than just by the fact of not having a job. It is also about losing one's social status, privileges, and respect: things that many immigrants had and enjoyed before moving to Canada:

> ...our degree doesn't qualify. So this is the point. It's very difficult. They think that the Canadian degree is the best and every other one is not worthy. I feel upset about it. Because if we come from other country to here we suppose everything is better than in our; and it's not like that. We are here for five years and my husband still studies. It's not easy. A lot of exams and we spend a lot of money on everything... Why do they accept qualified people? They can accept any person without any qualification. Because when you come qualified you think it's easy to match the system here. But everything is difficult because he [immigrant] is 'international'.

It is also troublesome but consistent with Canadian statistics (Statistics Canada, 2000) that two unemployed participants, who received their graduate education in Canada, were also unable to find jobs. In one participant's words: "I have a degree from here, from one of the best Universities in Canada. Why can't I get a job? Why can't I contribute?"

Participants also referred to the bad labour market situation currently present in the province that contributes to their difficulties in getting a job: "The job market is

small. If you move to mainland you can find job everywhere but here the job market is very small." As a matter of fact, Gilroy (2005) says that this is one of the main reasons why immigrants leave the province. Another reason for having difficulties in finding a job was participants' overqualification for a particular job:

> I passed my resume to maybe 10-20 different locations at the University and nobody even bothered to reply to me. Even I accepted any kind of work just to have some income. But it is very difficult - to find a job...I think one of the reasons is that maybe they consider me as highly qualified. When they look at my resume, they maybe say: 'He is a PhD candidate and he wants to work at the restaurant at the University?'

The same participant considered that the roots of his difficulties to find a job could be traced also in the unfair treatment based on his ethnicity and nationality:

> Sometimes my guts say that it is my name. Maybe if they look at your name and your background, your place of birth, it could be a factor. This is my guessing; I'm not sure... Sometimes when you apply to some place and when you have a Canadian name and some other name that is not Canadian, you will pick the first one.

Indeed, Poy (2004) and Ng (n.d.) expressed similar concerns about discrimination against visible minority immigrants when they are applying for jobs.

Lastly, the employed participants found two work-related issues important to them. The participant who was diagnosed and treated for a mental disease raised the issue of the lack of an understanding of mental illness in the workplace, and the absence of an adequate system for accommodating the needs of the mentally sick.

> It's not just having a job, but having a job where the employer understands and deals with the situation. If someone is in a wheelchair, they have a wheelchair ramp, and everyone knows that it is a wheelchair, it's visible. If someone is blind they make adjustments for that. But for someone with mental problem nothing has really been done. From my personal experience, they say they understand but yet

they still have some expectations, which you can't really fulfill...We may not always be able to work a full eight-hour shift five days a week but there are times when we could work.

The other participant talked about the exclusive environment at his workplace that prevents him from making new friends and developing a sense of belonging. He wanted to participate in the social activities offered at his workplace, but when he asked the organizers to accommodate from time to time his cultural customs that prohibit him from taking part in social functions where alcohol is served, his request was not considered. At his workplace, he feels isolated, excluded and ignored. This problem opens the door to discussing the impact of culture on immigrants' mental health.

4.2.4 Culture: "You can't change the world...there is not enough of you!"

Participants identify culture as an important determinant of their mental well-being. They use the concept of culture when referring to the positive beliefs and values they hold, in particular, cherishing family ties, a non-materialistic approach to life, morality, religion and spirituality that offer them strength, support and understanding. Some immigrants also note cultural differences between living in Canada and their birth countries where they were not encouraged to express their views or ideas and therefore as a result they presently struggle with low self-esteem and low self-confidence. Indeed, these cultural differences have been noted in literature (Fernando, 2003). However, St. John's immigrants often encounter a lack of appreciation of cultural differences and lack

of institutional support for these differences. While some immigrants try to retain their cultural identity, others abandon it in order to "fit in." This lack of appreciation and support for cultural differences, as well as the tension between the preservation or abandonment of immigrants' cultural identities leads to stress, feelings of loneliness, sadness and isolation. These issues are discussed in more detail in the following passages.

Most participants described how people's misperceptions and misunderstandings of their race, customs, values, problem solving, and humour increase immigrants' pain, isolation and loneliness, and widen the gap between immigrants and society. In the words of one participant, "Sometimes I say: 'I don't care. Let them go to hell!' But sometimes I say: 'Oh, I wish they knew'...and there are times that it hurts, really hurts." Another participant talked about her feelings of exhaustion when dealing with the constant burden of being stared at (because of the colour of her skin) and being asked inappropriate questions.

> Isolation of myself is one of my biggest factors... and the fact that I'm different and I feel like I'm being investigated by everyone, looked at because I'm different... so not feeling that you fit in to a place... if I go to the mall I can look in any direction and I can see someone staring at me. And I don't think that's really polite. So normally if I have to go out I have to be: 'Okay. I'm gonna go out and decide I am gonna be strong and do what I got to do'...but five years eventually gets to you. ...and they ask questions that normal people...like in my culture we would think that's a little bit too personal and being asked those same questions for the last five years, it eventually gets to you.

Men of other cultures are also not exempted from people's judgement when they decide not to participate in certain social activities in the way Canadian-born people do. As one participant described, "They [immigrants] are always invited to dance or drink.

These are things we are offered to do and they [Canadians] will criticize us why we are not doing these things."

Another participant provided an example of cultural misunderstanding in the context of the Canadian law system which caused the father of one immigrant family his health.

> There was one case when there was a family crisis of the new immigrant family. The way they were dealing with their family issues was unacceptable to Canadian society. So now the family is falling apart because of the legal measures that were taken. And I know that the father of the family now has a miserable life because the way the things were dealt with in his home culture were not working here, were not accepted here, so now he is isolated, he is rejected, he is on his own and he has serious mental health problems.

Immigrants also feel that the misunderstanding and disrespecting of their identity and values demonstrate itself not only on the streets, and at workplaces but in schools as well. One participant thought that the school curricula are not inclusive and do not appreciate certain values that immigrant children of diverse cultures hold. In addition, they send children the message that the Canadian way is the best way. Then children feel shy and uncomfortable sticking to the culture and values of their parents and this creates intergenerational conflicts among many immigrant families. Children may start to rebel against their parents and parents may fall into depression, frustration or anger, which eventually may lead to breaking the families apart.

> Most of the time the educational approach here does not take into account properly differences existing in different cultures. So if these differences are taking into account and if the kids are also told that their culture is valuable and this is something, which they should preserve.

This finding supports Gilroy's (2005) report that Newfoundland school curricula do not reflect the needs of immigrant children.

Most participants felt that there is little they can do about the ways people perceive their culture. They felt they "can't change the world" because there is not enough of them. As one participant noted, "You just don't go there and shout: This is what I want to do, this is the way I think. " As a result, participants try to change themselves in order to fit in. One participant provided the following example:

> For example, in our culture is not good to make eye contact. What they assume is that you are hesitant, you are telling a lie or you are not confident enough [when avoiding eye contact], which you are giving the whole wrong idea. It is none of them. You are respecting them by not looking and staring at them. We say making a direct eye contact for long time and staring is impolite...It makes me feel uncomfortable. But I'm trying to work with this eye contact. I was working on it for the last ten years, I haven't been successful.

The story of an immigrant woman struggling with establishing eye contact for ten years suggests that immigrants are forced to confront and change their values after moving to Canada. In order to survive and succeed, they need to adopt the values enforced by their new society. But this inner struggle between preserving their own values and adopting the values of their adopted society either exhausts them or forces them temporarily to change their identity. In both cases, I argue that these ways are not healthy ways to achieve mental well-being.

One could think that confiding these issues to fellow Canadians can ease the immigrants' pain. But one participant reported that she feels hurt by the attitude of her

acquaintances when she describes to them the difficulties of being an immigrant in St.

John's:

> Sometimes people say some sentences that really hurt you, but they don't mean that when they say it. They don't know what they are saying and how it will affect me...like when I came new and I was talking about my profession [difficulties to find a job due to unrecognized foreign credentials] and then one person laughed very loudly, "Why did you come here then?" And everyone used to ask, " Why did you come here?"

In conclusion, one can realize that the misunderstanding of immigrants' identities

and cultures frequently resonates in immigrants' experiences. It is not important whether

it is their colour, clothes, or customs that appear to be different, unusual or maybe strange

in the eyes of Canadians: It is people's stares, curious gazes, laughs, remarks or loaded

silence that causes immigrants pain, exhaustion, and feelings of isolation. One of the

reasons why immigrants long for their birth countries despite how difficult their lives

there could be, is the feeling of being 'normal' again.

4.2.5 Physical environment: "Yet another thing we have to sacrifice!"

There were two other issues that several participants mentioned as important

factors contributing to their mental well-being: weather and food. Weather and food are

considered as part of one's physical environment, which is one of the health determinants

(Shah, 2003). The issue of having to cope with the cold and sunless climate as well as

having to find familiar food and ingredients is not new. The same findings came out from

other studies of immigrants in Newfoundland (Varghese and Moore-Orr, 2002) and

Toronto (Ahmad et al., 2004).

First, participants mentioned that they came from a climate in which the weather was mostly warm and sunny. Living in harsh windy and snowy Canadian weather is a challenge to them and, actually, two participants identified the change in climate to be the main factor that contributed to the development of their mental illness. Second, by moving to Canada, immigrants sacrifice their traditional food, which they consider healthier and cheaper than Canadian food:

> St. John's is an isolated place...So you can't find certain type of food we like. So we have to ask someone to bring it for us from other places, from the States...and this affects us. We don't know what to eat, just to repeat things. You know our food is mainly fruits and vegetables and those things are highly expensive here. We resist the change. We can't go to their diet, which is rich in saturated fat acid and transfat acids.

4.2.6 Gender: "Men will not cry!"

Prior to this study, I assumed that women would be more inclined to identify family relationships and social networks as the most significant determinants of mental health, while men would place more significance on income and employment. This assumption did not hold, as both men and women identified social support, inclusion, appreciation, employment and access to resources and information as key determinants of their mental health.

Female participants expressed a need for meaningful employment and social support. Their descriptions of feelings of loneliness and isolation indicate that employment is as significant for women as it is for men in this study. These findings contradict the two myths about immigrant women: that they are excited about doing housework and that they have large families to support them (Morris and Sinnott, n.d).

However, discriminatory societal structures that do not recognize their foreign credentials cause St. John's immigrant women to remain unemployed or underemployed; these are the problems previously identified by Statistics Canada (2000) and supported by Hyman (2001) and Dossa (2004).

In addition, the situation of immigrant women is complicated by the burden of women's multiple social roles. St. John's immigrant women put the priorities of their children and spouses first, which does not allow them to make independent decisions such as moving to a place where they can find a job. Furthermore, they have fewer opportunities to upgrade their education and skills because they lack a wide network of kin support and other financial and material resources. Restricted mobility and social networking leads to deeper feelings of isolation and loneliness on the part of immigrant women. Indeed, this stress on immigrant women which is associated with their prioritizing the needs of others as well as their limited autonomy is known from the literature (Holmshaw and Hillier, 2000; Gastaldo et al., 2005; Hyman, 2001; Ng, n.d. and Government of NL, 1994).

Considering just these outlined points, the speed with which immigrant women adjust to the new environment of the recipient country is much slower when compared to immigrant men, who focus on developing their careers and earn a living outside their homes. For this reason, immigrant men have better chances of developing the contacts they need in order to access necessary resources and information, including those relevant and needed to mental health promotion and services.

Despite the better access to resources and information that immigrant men enjoy, immigrant women find it easier to express and confide their problems. I think this may be one of the reasons why most of the recruited study participants were women. Indeed, most of the Canadian research concerned with the needs of immigrants that I found was done with women (Dossa, 2004; Ahmad et al., 2004; Gastaldo et al.. 2005; Hyman, 2001; Guruge at al., 2000, Wong and Tsang, 2004). Participants thought that expressing their needs through emotions, for example by crying or talking, provides some clues about women's stress and mental health. At the same time, participants said that men have more difficulties expressing their needs or even admitting them. They thought that this could be caused by their expected social role of being strong and independent. Male participants confirmed this notion.

Most women thought that it would be more difficult for men to seek professional help due to their difficulties admitting their problems and talking about them. From their experiences, men usually begin to seek help much later than women. In the words of one female participant: "None of the guys that I knew went to see a physician and say: 'Look, there is something wrong.' It reached the stage when it was just out of control." Male participants felt, however, that they didn't have problems looking for help in the past and they would always seek help if needed in the future.

The issue of gender surfaced one more time when participants identified their need for same-sex healthcare providers. The absence of any healthcare provider of the desired sex may prevent immigrants from seeking professional help since they may feel shy and uncomfortable confiding sensitive issues to a provider of the opposite sex. Only

one participant saw the advantage in her health provider being a male because the advice regarding her problem that he gave to her spouse as 'man-to-man' was taken more seriously. The issue of the importance of gender match between immigrant clients and their health professionals was previously described in a study by Sue et al. (1991).

4.2.7 Copings skills: "That is how I cope."

Participants identified that the way they cope with stress and difficulties is another important factor which shapes their mental health. In fact, they described a variety of methods they employ to minimize the impact of daily stress and problems. Some participants discussed the importance of having personal time and space for identifying and analyzing their problems, and finding a practical solution to them. While some participants like to be surrounded by other people, some prefer the privacy of associating with their family and very close friends. Some participants use physical activities such as walking, swimming or working out to deal with stress, while others engage in enjoyable activities such as reading books, watching movies and sports, playing with pets or shopping. Several participants identified religion as an important element that helps them deal with stress. Saying prayers or reading religious books brings them peace, strength and calm, and makes them realize that "whatever happens to me is good for me; it is from God."

In conclusion, St. John's immigrants understand mental health and illness in a broad, holistic way and identify a wide range of factors that shape their mental health and

well-being. It is mainly the lack of social support networks, low income, unemployment, and a unfriendly environment which make immigrants vulnerable to mental illness. Considering their battle for surviving and succeeding, finding a job, adjusting to new values, lifestyles, and systems, immigrants have little strength and stamina left to struggle with misunderstandings of who they are. Instead of struggling, they surrender and accept things the way they are with the justification that they "can't change the world." They slip into their quiet, invisible lives, being content with any appreciation of their being made by others because in the end things could be much worse than they are. In addition, healthcare does not have the ability to provide relief for immigrants' wounds because these problems are, as one participant said, "social problems that are not in the hands of professionals or psychologists, it seems to be in people themselves." I discuss these and other immigrants' perspectives of mental health services in the following chapter.

5. The range of St. John's mental health services and immigrants' barriers to utilizing them

My third research question is to identify immigrants' barriers to utilizing the local mental health services and scan what mental health programs and services targeting the immigrant population are in place in St. John's. The chapter begins with a description of the mental-health-related programs and services available to the immigrant population in St. John's as located through the environmental scan of consumer information in readily available sources such as the Yellow Pages, pamphlets at health clinics and the Internet. I assessed whether these services specifically address the needs of the St. John's immigrant population. Only a few services are dedicated to the specific needs of St. John's immigrants. In other cases, information about these services is not readily available. The remainder of the chapter focuses on immigrants' views of mental health services as well as their attitudes toward seeking professional help. This study found that immigrants often delay seeking professional help because they feel shy and uncomfortable seeking help or they think that mental health services have a limited potential to address the sources of their vulnerability to mental illness. In addition, immigrants experience several problems in utilizing efficiently the offered mental health services. Some of these issues are the same issues that non-immigrants face (non-availability of mental-health-relevant information, long waiting times, and fee-for-service structure), however, these problems further burden immigrants who are already disadvantaged by stress of immigration. Some

barriers that St. John's immigrants face are unique problems that reflect immigrants' difference in culture and language.

5.1. The range of mental health services specific to St. John's immigrants

This section provides information about programs and services that specifically address the mental health needs of St. John's immigrants. Communication of health information is one of the key strategies "to inform and influence individual and community decisions that enhance health" (Office of Disease Prevention and Health Promotion, n.d.). One of the goals of health communication is to provide information about care providers and the range of treatment options in order that the general public can make informed decisions about their own health. Consumers need to know that they can get the help they need when they need it, what range of services is available to them, and whether these services are sensitive to their culture and language. Having access to quality information at little or no cost is important. Information also needs to respect the range of consumers' literacy levels. The health information can be disseminated through a variety of print-based or audiovisual mass communication channels. Print-based materials such as ads in the Yellow Pages, and pamphlets and brochures at the health clinics are relatively inexpensive. Audiovisual sources such as the Internet, TV, and radio can target an even greater number of customers in more attractive ways. However, not everyone can afford to have a computer or pay for Internet access or cable TV.

I scanned the mental-health-relevant information that is readily available and relatively cheap for immigrants to access: the ads in the Yellow Pages, the pamphlets at the health clinics and the Internet. My goal was to assess the range and accessibility of mental health services specifically for immigrants. Such services would offer multicultural approaches to treatment, and access to translation and interpretation services, and would recognize the multiple determinants that influence the mental health of immigrants such as the need for social support, employment, a non-discriminatory environment and access to culturally appropriate and accessible mental health information.

5.1.1 Print-based sources

Through scanning information contained in the Yellow Pages (Aliant, 2005), I located four kinds of services relevant to the provision of mental health and one service relevant to immigration. Table 5 presents the range of services according to the number of providers, the type of services they offer (if the description was available), and availability of specific services offered to the immigrant population such as, for instance, a multilingual setting, translation or cultural interpretation.

In general, there is little information available to St. John's immigrants in the Yellow Pages except the phone numbers of the providers. Only a few providers describe their services and none mentions services specifically tailored to the immigrant population. In addition, all identified information was in English.

None of the pamphlets available at ten medical clinics located in the St. John's

East area provided information about mental health services or programs specifically for

immigrants. Indeed, only a few pamphlets were dedicated to mental health and illness

issues. These focused on depression, managing stress, dealing with addictions or abuse.

All pamphlets were written in English, except for a few that also included some French.

No other languages were available.

Table 5: Mental-health-relevant services in St. John's (Aliant, 2005)

Type of service	Number of providers	Service description	Services specific to immigrants
Mental health services	9	Assessment Consultation Treatment Marriage, family & individual counseling	No information
Psychiatrists	15	No description	No information
Psychologists	20	Assessment Psychotherapy Counselling	No information
Social & Human services	18	No description	No information
Immigration	2	No description	No information

5.1.2 Internet sources

Several St. John's organizations promote mental health and the integration of immigrants into the community. I searched the websites of these agencies to determine what mental health services and information they provide, whether any information is specifically for the immigrant population, and the language in which the information was presented. I was able to locate the websites of the following organizations that provide mental health or immigration services and ordered them alphabetically.

Canadian Mental Health Association (CMHA), with its branch in Newfoundland & Labrador, is a voluntary charitable organization aiming to promote and advocate mental health through education, media and partnership with communities and government (CMHA, n.d., a). The national website recognizes the unique approach to the mental health of immigrants when it states (CMHA n.d., b, para 1):

> As our population becomes more diverse, the services we provide have to be relevant and accessible to all the people in our community. In addition, as the population changes, the ways in which we provide services must also change. For instance, in order to provide good mental health services, the services need to become culturally sensitive and appropriate.

Based on the outlined principle, CMHA recommends that all its chapters ensure the cultural sensitivity and accessibility of their programs, cultural training of their staff, recruiting culturally diverse staff and volunteers and eradicating systemic racism. The NL website does not indicate that it operates programs implementing specific mental health approaches to immigrants' mental health. It appears that only Ontario and Quebec currently meet the national standard.

The local CMHA operates the Mental Health Resource Centre in which a vast number of books, pamphlets and videos concerned with mental health issues can be accessed. As well, the association runs community educational presentations and government-funded development projects. The available information is not specifically tailored to the needs of the immigrant population. In addition, all provided materials are in English and there is no direct link to the multilingual pamphlets presented on the website of the national CMHA (CMHA, n.d., c). In conclusion, despite the efforts of the provincial branch of CMHA to promote mental health and educate the public, the website does not provide any specific information targeting the immigrant population.

Consumers' Health Awareness Network NL is another organization serving and advocating for the needs of mental health consumers. Its goal is to "build and strengthen self-help initiatives among individuals with mental health issues/ difficulties...combat isolation, to educate the public...to provide social and emotional support...and a forum for consumers' concerns" (Consumers' Health Awareness Network NL, n.d.). Although the agency states that they welcome all consumers, once again there is no indication that the initiatives consider the specific mental health needs of immigrant consumers and information is written in English only.

Health and Community Services St. John's Region provides several mental health services such as PREP (a program helping the mentally ill return to the workforce after being absent due to their illness), ACCESS (a program helping former mentally-ill patients find appropriate housing and support), Mental Health Crisis Centre (24/7 phone intervention service) as well as addictions counselling services (Health and Community

Services St. John's Region, n.d.). The website does not refer to any special mental health services or approaches directed towards the immigrant population nor does it consider the provision of such services in the agency's future vision. All displayed information is in English only.

Health Care Corporation of St. John's offers acute, rehabilitative and continuing care comprising assessment, treatment, rehabilitation, housing and leisure programs for the mentally ill (Health Care Corporation of St. John's, n.d.). The website provides an extensive list of contacts for service providers and short services descriptions. While many immigrants may benefit from this information, there is no specific remark considering multicultural approaches to care, the provision of translators or other service features addressing immigrants' needs. All accessible information is in English.

Waterford Foundation is a non-profit organization supporting programs and services designed for mental health services users (Waterford Foundation, n.d.). It is also involved in educating the public about mental health issues in order to reduce the existing stigma surrounding mental illness. The website provides information about several mental diseases and contacts of providers of many services such as, for instance, abuse or career counselling, family/parenting therapy, financial services, housing, and self-help resources that are all relevant to mental health. There is no information, however, describing these services and no comment on whether these services are concerned with the specific mental health needs of the immigrant population. All information is written in English.

The Association for New Canadians (ANC) is an organization providing comprehensive settlement and integration services to NL immigrants (ANC, n.d.). The main programs offered at this agency are the Resettlement Assistance Program and the Immigrant Settlement and Adaptation Program (ISAP) which both offer information on a variety of issues such as law, healthcare, education, employment, and finances. The Association also offers employment assistance, translation services, free English classes and University preparation seminars as well as support groups. The goal of this wide range of services is to ease the settlement and integration of immigrants. The website also indicates that the Association provides counselling and referral in a culturally sensitive manner. The website does not provide any specific information regarding the mental health issues of their immigrant clients or links dealing with mental health in general. All displayed information is available in English only.

Although the programs offered through this Association have a potential to address immigrants' needs, there are several issues that raise the question of how many immigrants take advantage of these programs. Gilroy (2005) states that ANC serves 300 clients, of which 90 are landed immigrants. Recalling the last statistical data, there were 4,885 immigrants in the province in 2001 (Statistics Canada, 2001). That means that the services offered through ANC (that is the only St. John's organization designed to meet the needs of immigrants) are used by approximately only 2% of all St. John's immigrants.

The second problem is the eligibility criteria for ISAP. According to the agency's website, the governmentally sponsored ISAP is offered to new immigrants who come to St. John's directly from overseas and who are fortunate enough to have a special

arrangement between the agency stationed in their native country and ANC. They are provided with reception, orientation and referrals to community agencies and counseling, which are the services offered under the umbrella of ISAP. This poses a serious question: why are such programs not in place for immigrants moving to NL from other Canadian provinces? It is well known that legislature, education, healthcare and other relevant information can vary from province to province. Thus, the information that immigrants had before may be no longer valid in Newfoundland. In addition, these immigrants may have already had the experience of living in Canada; however, moving to a new place with no support networks puts them at the same vulnerable spot as those who just came from overseas. Dossa (2002), in response to "the services providers' assumption that the longer newcomers are in Canada, the greater is level of integration", included in her research immigrant women who had lived in Canada for twelve years to illustrate that their experiences are not different from those of newcomers. Canadian-born newcomers may face similar issues, however immigrants' problems are compounded by other difficulties surrounding immigration (for instance, discrimination).

According to the Citizenship and Immigration Canada website, there are several ethno-cultural organizations and groups currently operating Newfoundland: African-Canadian Association of Newfoundland, Friends of India Association, Hindu Temple Association, Multicultural Women's Organization of NL, Muslim Association of NL, Newfoundland Sikh society, Sri Lanka Association of Newfoundland, and Chinese Association of NL. Only two organizations operate their own websites: Hindu Temple Association and Muslim Association of NL. The websites provide information relating

mainly to religious celebrations and social activities of these organizations. There is no

mental-health-specific information or relevant links for immigrants to use.

Regarding the accessibility of the information relevant to the mental health needs

of immigrants in the Internet-based sources, some sources were somewhat easier to locate

than others. Many sources were not directly yielded through a Google search, but I found

them through linking with the initially found sources. It was very time-consuming to

search for all websites and for the mental-health-information specifically relevant to St.

John's immigrants. All information was available free of charge; however, for

immigrants to find this information they must pay for Internet access or gain access

through public sites such as the library. As previously mentioned, the income for some

immigrants can make Internet access prohibitive.

5.1.3 Summary of the range of mental health services in St. John's

The environmental consumer scan reveals that a limited amount of mental health

information is available to meet the specific needs of St. John's immigrants. There is no

reference to initiatives, services, or programs that address immigrants' needs for social

support, employment, a non-discriminatory environment and culturally appropriate and

accessible mental health information and services. Furthermore, there is no reference to

the consideration of multicultural approaches to treatment or the provision of translators.

With few exceptions, the information is limited to providing the service providers'

contacts.

The information concerned with mental health issues such as descriptions of diseases does not consider possible differences in cultural understandings of mental health. Accessing the Internet- based sources was more time-consuming compared to the print-based sources which I located quite easily. While some pamphlets were available in English and French, the information available on the websites of provincial organizations was in English only. This is surprising since French is also Canada's official language and Newfoundland has a small but important French history and community.

St. John's organizations and agencies may indeed provide mental-health-relevant services for immigrants, but this is not apparent from the pamphlets or web-based information I surveyed. I think that identifying this gap is essential since these may be the first resources that people in need would turn to if they wanted to access professional services. This lack of information about mental health and mental health services is one of the barriers described by research participants. These barriers are discussed in the next section.

5.2 Immigrants' barriers to utilizing mental health services

This section answers the research question that aims to examine immigrants' barriers to utilizing mental health services available in St. John's. Immigrants' experiences and expectations of mental healthcare services are discussed first, including their understanding of the treatment of mental illness. Then the discussion moves to the circumstances under which participants would seek treatment and their feelings about seeking professional help. This section concludes with a review of the barriers to utilizing

mental health services. Some barriers are shared with non-immigrants and others are specific to the immigration experience.

5.2.1 Immigrants' attitudes toward utilizing mental health services

Participants agreed that the treatment of mental illness depends on the type of a particular illness. They believed that some mental illnesses required treatment with medication and some could be treated with counselling. This belief was consistent with their belief that mental illness is a diagnosable and treatable biological entity. However, in addressing the source of their vulnerability to mental problems such as lack of support, unemployment, limited access to resources and information and an unfriendly environment, all agreed that mental health providers do not have any "magic pill" to offer them.

Participants who had some personal experiences with mental health treatment said that they decided to seek professional help when they could not cope anymore, and felt overwhelmed by their problems. Participants reported marked changes in their mood and behaviour to the extent that their relationships with other people started to deteriorate. Some said that their physical symptoms were unbearable making it impossible to perform efficiently at work.

Those with no personal experiences with mental health treatment believed that they would seek professional help if their coping mechanisms no longer helped them handle stress and problems, and if they became aware of abnormal behaviour without any particular reason that stays with them for a long time and began to affect their

relationship with their families. These accounts suggest that immigrants do not seek preventative health care but delay seeking help even when they experience persistent loneliness, lack of social support, face discrimination for their cultural differences, and feelings of discouragement related to lack of employment. Immigrants seek help when they experience a considerable burden of distress, when their relationships with others deteriorate, and they are unable to fulfill their social, family and work responsibilities.

Immigrants explain the delay in seeking treatment in two ways: First, they downplay the severity of their own situation claiming that professionals deal with "extremes" cases. In their understanding of the continuum between mental problem and mental illness, immigrants think that the 'jurisdiction' of mental health professionals starts where mental problems turn into mental illnesses.

The second reason participants give for delaying help-seeking relates to the stigma associated with mental illness. This stigma manifests itself in different ways. Only one participant believed that the experience of seeking help changed dramatically her attitude from being embarrassed to being able to talk about her illness in order to help other people. Other participants did not feel ready to talk about their treatment in public and in front of their families and friends because "it's easier to explain someone that I [participant] broke my ankle than saying: 'Well I want to kill myself'". This secrecy associated with seeking treatment and reluctance to reveal this information even to their close families and friends, is a strong indication of the stigma associated with mental illness.

Another example of such hidden stigma is the refusal of the immigrant woman who was treated by drugs for situational depression, to acknowledge that her condition was, in fact, illness: "I could not say mental illness. Because with mental illness, I believe, that is extreme. But definitely, it is a mental problem." The label 'mental problem' is much easier to carry and accept than the one of 'mental illness'. In addition, her admission that she or her family members may be vulnerable to depression from adjustment difficulties but to no other mental illnesses, indicates that to some immigrants, having a situational depression is more acceptable than having any other mental illness.

Some participants said frankly that they feel too shy and embarrassed to visit a mental health specialist. While they perceived that Canadians talk more openly about mental health and that persons with mental illness are more actively involved in society than in their homeland, participants expressed feelings of guilt and mistrust about revealing their personal confidential information to someone they did not know. Moreover, being diagnosed with mental illness and labelled as a "psych patient" represented a big threat to them and added burden to their experience of marginalization. Indeed, similar stigmatizing attitudes toward mental illness among immigrants were already described by Leong (1994), Sue et al. (1994), Kim (1994) and Dossa (2002).

Participants identified five barriers that make it more difficult for them to seek help: lack of information, waiting times, finances, culture, and language. The first three are not specific solely to the immigrant population, however they burden a population that is already disadvantaged by other immigration-related problems. The latter two are the barriers particular to the immigrant population.

5.2.2 Barriers shared with the non-immigrant population

Participants identified three barriers to utilizing mental health services such as the lack of information, long waiting times, and financial constraints. In fact, these barriers have been previously described by the provincial government in the framework for developing a new mental health policy for NL (Government of NL, 2001). The government plans to address these issues in the new provincial mental health and addiction services plan (Government of NL, 2004).

In terms of accessing mental-health-relevant information, participants identified three problems. First, there is a lack of information about mental illness; second, there is a lack of information about available mental health services; and third, there is a lack of information about the forms of support they can get. The findings support the results of the environmental consumer scan presented earlier in this chapter indicating that the mental-health-relevant information available to St. John's immigrants is fairly limited.

Participants agreed that having information about mental health and illness is important because this knowledge enables them to recognize any potential problems and seek help before their problems become too serious. Participants said that while waiting at the medical clinics, they had a hard time finding information about mental health and illness. Only one participant recalled seeing a poster about depression and family violence. They were able to recall seeing pamphlets and posters about physical diseases such as diabetes, cancer, women's problems, STD's or hepatitis. In the words of one participant:

No one is providing information like where and how and when to seek this information for immigrants or foreigners. There is a lot of job to do to provide the basic information regarding mental health where, when, how...I think there is a potential for this subject and also for mental health providers. When you ask me where I can go, I don't know except to my family doctor.

Another participant who was treated for mental illness mentioned that she did not receive any information about her illness from her family physician during her treatment, "Even my doctor didn't explain to me what is my problem. He just gave me a medication and he tried to talk to me a little bit."

Participants felt that more effort is needed to make information on mental health and illness issues as well as about the support and help available to them through pamphlets, and magazines delivered by mail, through the media such as TV and radio as well as through the clinics and community centers. They proposed having community talks and workshops where they could learn something about mental health, stress, problem solving and also develop social networks with others. In addition, participants stressed that all information should be provided in user friendly language omitting dry topics and complicated words that are beyond the understanding of regular people. In fact, the other studies also identified this lack of information about when, where, why and how to seek help (Takeuchi et al., 1988; Loo et al., 1989; Sadavoy et al., 2004).

Another issue that concerns participants are the long waiting times they experience when they want to see their mental health specialists or enroll in treatment programs. This comes as no surprise, considering the current low number of practicing

psychiatrists in St. John's (NLMA, n.d.). As one participant described, "There were days when I was really, excuse my language, screwy and I wanted to talk to someone and there is no one. I called: 'Can I see my doctor'?' No, she is booked up for next two weeks'."

This participant recounted a similar problem while waiting to attend a special therapeutic program:

> It took a month before I could see someone at the hospital. I think the waiting list is way, way too long. There is a program I did where you get into a group session and they teach you about mental health, and how to cope with it. It took three months to get into that program! What happens to you in the meantime?!

She suggested that "having someone to call" while immigrants are waiting for the appointments to take place is essential:

> I think we need to have more people trained, educated, more programs, medicine needs to be more accessible because what happens in between? You can be on medication but... then there were days I was at home in bed, nothing to do, no one to talk to, didn't know whom to call and I suffered alone and it should not be that way... It should be - pick up the phone, call the number and I can talk to someone.

It is important to note that participants varied in their preferences for a care provider. Some said that they would be satisfied with care from a family physician for their mental health needs. Only if the disease did not improve they would seek help from a mental health specialist. Other participants did not mind seeing a specialist directly since they thought he or she would better understand mental health than a regular general practitioner. While some participants expressed a preference for a psychologist over a psychiatrist, others could not identify the difference between these two specialties.

The third issue that emerged in the interviews concerned the cost of paying for

mental health care. Some could not afford to pay for the therapy they needed or only a

portion of it. Some reported that if therapy was too expensive, they would not seek

professional help. For some, paying a fee for counselling is not an option. All participants

who were prescribed medication as part of their treatment had this medication fully or

partially covered by their drug plans. They expressed concerns that without these drug

plans they could not afford to pay for medication. The financial barrier to utilizing mental

health services was described by many other researchers (Beiser, 2005; Cheung and

Snowden, 1990; Ginsberg, 1991, Miranda and Green, 1999; Leong and Lau, 2001).

5.2.3 Barriers specific to the immigrant population

The first concern that most participants expressed was related to the fact that their

cultural values and beliefs are different from those held by the mental health

professionals trained in Canada. They feared that this difference could account for

misunderstandings of their problems and lead to ineffective therapy. This supports

similar concerns expressed by Fernando (2003), Kleinman (1988) and Herrick and Brown

(1998). The following statement demonstrates these concerns:

> Someone who is trained to be a mental health provider in western country, in
> Canada in particular, uses typical approaches that are not necessarily efficient for
> the patients from different cultures. So I don't consider it a barrier [to the
> services], but I consider it maybe inefficient approaches. Lack of knowledge about
> different cultures, different concepts and lifestyles, so... maybe understanding can
> be attained between the patient and mental health provider, but after the
> understanding, there is treatment and help itself...I'm not sure if it's a single
> recipe for everyone from different cultures.

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One participant who had sought medical care expressed his concern about health care providers' lack of cultural insensitivity. As the following example illustrates, he felt his beliefs and values were misunderstood and disrespected. This problem negatively impacted on the patient-physician relationship and treatment process.

> We try with my spouse to adapt ourselves to new life here in Canada. I don't know how to say it... I am not expecting from my family doctor to ask me to go and pray. One should admit it that there is a difference...I don't expect him to ask me to recite my holy book. But I remember when I got cured from my condition and I said that: "I want to thank God and you." And he asked me: "Why do you put God in this one?" "We always thank God for everything. It's simple thing that you do." But he didn't understand why I [first] thank God and then him ...he expected maybe to thank only him.

Other studies have noted the lack of recognition and accommodation of spirituality and religion in the biomedical mental health treatment model traditionally used in Canada (Fernando 2003, King and Bushwick 1994, Fitchett et al. 1997).

The influence of culture on the diagnostic process that had been noted by Leong and Lau (2001) and Kleinman (1988) is evident in the stories of St. John's immigrants too. One participant described the difficulties he had when undergoing a psychological depression test where some of the questions seemed irrelevant to his cultural understanding of this world and family relationships. For example, he was asked whether he thought that the man should be the head of family. He replied that all men of his cultural background would answer "yes" without hesitation but he wondered how his response would be interpreted in the Canadian context of gender 'equality.' In addition, he could not understand some words and phrases such as "having fits", "blue spells", and "raw deal."

Together these findings support the assertion made by other studies about the validity of standard diagnostic testing for mental health in the immigrant population. Some immigrants questioned the suitability of some standard health promotion strategies, interventions, and therapy that promoted a western lifestyle that contradicts some immigrants' cultural norms. For example, some standard suggestions include engaging in sports and other physical activities. Such suggestions may violate some participants' ideas about physical privacy and norms of socializing which preclude them from joining in activities that are not accessible exclusively to the one gender. Similar concerns can be found in Guruge et al. (2000).

The third barrier to mental health services concerns cultural congruence between the individual and the health provider. A participant who was treated for a mental problem by a family physician of a similar cultural background felt confident talking to him about her problems.

> As soon as I opened my mouth he knew what I was going to say, he knew the cultural problems. It seems from that point that I had a problem they have at their country too. So he knew what I was talking about. He knew why I could not stand up for myself...He actually said: "There is nothing wrong with you." So I thought some of them are maybe like cultural things that I need to change a little bit, cultural beliefs... And after he talked to my husband everything changed.

She thought that Canadian-trained physicians could not possibly understand her:

> They would never understand what I was going to say... They would not understand, I know that. There are a lot of things that I would say to Canadian friends or neighbours; they just don't know what I'm talking about.

The importance of a cultural match between patient and health provider has been noted by other researchers who found increased positive outcomes in utilizing mental health services (Takeuchi et al., 1992; Sue et al. 1991).

Another important factor in receiving the appropriate medical assessment and therapy concerns language. Participants expressed concerns that they may be misunderstood either because they lack English expressions of medical terms or use English words in different ways. Some participants recommended a translator when treating people who cannot communicate in English. However, others felt that a mental health problem is too sensitive issue and would prefer a health provider who is able to communicate in their first language. As one participant said:

> I think when you have a problem it is very, very comfortable to express it in your own language because you will show a person exactly what you have. Sometimes thinking of the words will cause you some pressure that you will struggle to express these things. At the same time, you can also make mistakes. You may use unsuitable words that may be understood in a different way. It is a very good thing to have a person to whom you can talk in your own language.

Similar concerns about the barriers in communication between patients and health providers were expressed in the literature (Woodward et al., 1992; Sadavoy et al., 2004; Nguyen, 1984, Bauer et al., 2000; Kwok, n.d.). The importance of developing bi(multi) cultural and bi(multi) lingual services with providers and staff of the same gender, language ability and cultural background as the patient was suggested by the previous research as well (Sadavoy et al., 2004; Stephenson, 1991; Takeuchi et al., 1992; and Sue et al., 1991, Kirmayer et al., 2003).

5.2.4 Summary of immigrants' barriers to utilizing mental health services

In conclusion, the findings show that St. John's immigrants delay getting the professional help they need. They seek help only when they experience a considerable burden of distress, when their relationships with others deteriorate, and they are unable to fulfill their social, family and work responsibilities. Furthermore, they struggle with the stigma associated with mental illness and believe (with good reason) that mental health services cannot address all their difficulties. When immigrants do seek professional help, they experience several barriers to receiving quality care. Like the non-immigrant population in St. John's, participants reported a lack of information, long waiting times, and the high cost of care as barriers. While these obstacles are not unique to immigrants, these barriers add to the other burdens they face. Differences in culture and language, as well as lack of culturally and linguistically appropriate services, are barriers that are unique to the immigrant population.

The following chapter offers recommendations for mental health providers, policy makers, and researchers who are concerned about addressing these barriers to immigrants' mental health.

6. Summary and recommendations

The purpose of this qualitative study was to examine immigrants' understandings of mental health and illness, the factors that influence their mental well-being, and their perspectives of and barriers to utilizing local mental health programs and services. This chapter provides the answers to these questions and concludes with recommendations directed to the health providers, policy makers and researchers interested in developing and implementing strategies and services that are sensitive to St. John's immigrants' mental health needs. My knowledge of psychiatry and the unpleasant experiences of being a Canadian immigrant equipped me with the assumptions that immigrants' mental health and illness is influenced by a variety of factors besides our biology, psychology, and the provision of mental health services. However, despite these initial assumptions, I learned a great deal about how immigrants understand mental health and what accounts for their mental wellness.

First, immigrants' ideas about mental health reflect a broad holistic approach, in which their mental health closely relates to their emotions and interactions with the environment. In their understanding, being mentally healthy means being happy, satisfied, and living a balanced life in harmony with the environment. Immigrants' perspectives of mental health resemble the definitions provided by WHO (WHO 1978 and 2001), which defines mental health as culturally influenced subjective well-being, and the Wellness Model of Health (Larson, 1999), which identifies health with strength and ability.

Second, immigrants understand mental health and illness as a continuum characterized as a reversible transition from 'health' to 'mental problem' and then to 'mental illness.' This separation between 'mental problem' and 'mental illness' is critical since immigrants do not think that the healthcare services have remedies for their 'mental problems.' Healthcare services can address only immigrants' illnesses that immigrants see as the diagnosable biological entities, which is consistent with the perspectives of the biomedical model of disease.

Immigrants believe that mental illness is regarded with greater acceptance and empathy than in their home countries and are therefore able to confront their attitudes towards mental illness. While this can be an advantage, what immigrants learn from the media and their everyday social interactions is heavily influenced by the ideology of medicalization (Fernando, 2003; Clarke, 2004). Immigrants have learned to think about their sadness, frustration or anger in medical terms. So, for example, a woman's deep sadness over her inability to find employment in the society that undervalues her foreign credentials is reframed as depression caused by the imbalance of brain chemical substances. The appropriate solution lies in prescribing antidepressants rather than addressing the sociopolitical reasons underpinning the devaluation of her foreign credentials.

Moreover, immigration brings many difficulties into the lives of St. John's immigrants, which makes them more vulnerable to developing mental illness. These factors were eight of the determinants of health defined by Health Canada: support,

income, employment, culture, physical environment, coping skills, gender, and mental health services.

St. John's immigrants do not have sufficient support from their families and friends who are physically far away as well as from their neighbours and society. As a result they have only limited resources, help, and information, and experience loneliness and isolation. Moreover, immigrants do not find this support even within the immigrants' communities. Immigrants have fewer material, social and emotional resources to care for themselves and therefore they are less able to offer the support to others in similar situations. In addition, the immigrant communities struggle with internal inequalities, which leads to developing mistrust and enstrangement among immigrants. In addition, some immigrants are reluctant to seek and develop social support networks due to the uncertainty of long-term settling in St. John's.

Sufficient income is another factor important to immigrants' well-being since it relieves the stress of financial difficulties and enables immigrants to socialize and develop the networks they need. However, some St. John's immigrant families have income lower than they had before moving to Canada and can barely cover their basic expenses. Sufficient income walks hand-in-hand with having a job that reflects immigrants' skills and knowledge. Employment becomes associated with feelings of pride, satisfaction and usefulness. However, many St. John's immigrants encounter problems finding jobs. The reasons for this situation lie in a bad local job market, unrecognized foreign credentials, overqualification and discrimination. In addition, those immigrants who are employed struggle with the lack of understanding of their mental

health needs as well as the lack of accommodation of their cultural norms at their workplaces.

Another factor shaping the mental wellness of St. John's immigrants is culture. Culture affects immigrants' mental health positively due to the values such as cherishing family ties, a non-materialistic approach to life, morality, religion and spirituality, which guide immigrants' lives. However, coming to Canada creates difficulties in preserving cultural values, because in order to succeed immigrants need to adopt the values of their new society. For this reason, some St. John's immigrants try to change their cultural values and identities in order to fit in, but most often they do not succeed. In addition, due to their different cultural identities that manifest as skin colour, cultural dress, and behaviour norms, immigrants perceive that they are misunderstood, judged and excluded by the local Canadians. Being excluded and marginalized impacts negatively on how immigrants feel about their life in St. John's.

Furthermore, the school curricula do not appreciate the cultural values of children from the immigrant families as something that is worthy of being preserved and thus create tension between children and their parents. St. John's immigrants feel they do not have enough power to change the status of these matters and are aware that healthcare cannot provide the solution they need, but changes need to occur directly in the society.

St. John's immigrants also feel deprived of food they enjoyed in their native lands since there are very few ethnospecific food suppliers in the city. The food items that are available are quite expensive. Many of them consider a cold climate with a little sunshine as another factor negatively influencing their mental health.

Immigrant women experience several issues relevant to mental health differently from immigrant men. Women's situation is complicated by their multiple social roles and prioritizing the needs of other family members which both contribute to the limited autonomy of immigrant women. Lack of support and resources does not allow women leaving their households and children in order to upgrade their knowledge and skills or search for jobs. To immigrant women, meaningful employment is as important as satisfactory family life. In addition, because immigrant women do not have the access to resources and social support, the speed of adjustment to the new life in St. John's is slower than in the case of immigrant men. Speaking of expressing mental health needs, immigrant women find it easier to admit their problems and talk about them than immigrant men do.

Coping skills is another factor that plays a role in immigrants' mental health. St. John's immigrants use a variety of enjoyable activities to deal with stress and difficulties. Some immigrants find religion especially important since it provides them with strength and support.

The last factor influencing immigrant mental health is the delivery of mental health services. Indeed, five immigrants used the help of health professionals to deal with mental health problems. The reasons that immigrants seek professional help are rooted in problems associated with immigration to Canada. To St. John's immigrants, however, medication and counseling do not eliminate the sources of their vulnerability to mental illness. Typically, immigrants seek professional help when their hardship accumulates,

their relationships deteriorate, and they are experiencing serious problems performing at work or fulfilling other duties.

There are two reasons for this delayed call for help. First, immigrants believe that they are able to handle stress and problems themselves; second, they struggle with the stigma associated with mental illness. This hidden stigma of mental illness is 'visible' through keeping treatment in secrecy, reluctance to acknowledge illness, resistance to the idea of vulnerability to mental illness (except depression) and fear of being diagnosed with mental illness.

In addition, St. John's immigrants face other barriers to utilizing mental health services: lack of information, cultural misunderstandings, limited language, long waiting times and lack of finances. Immigrants do not have sufficient information about mental illness, mental health services and supporting services pertinent to their mental well-being. Further, the cultural mismatch and language limitations between immigrants and their health providers lead to difficulties in the diagnostic process and therapy, and also insensitivity toward immigrants' values. St. John's immigrants face long waiting times while waiting for their appointments or enrolling in therapy. In addition, they do not know about any professional support and help that immigrants can get between the appointments. Finally, St. John's immigrants do not have the finances to pay for counseling for fee and drugs not covered by their drug plans.

According to the environmental information consumer scan of selected print-based and Internet-based sources, there is very little information about mental health promotion programs and mental health services available to St. John's immigrants. The

programs and services in place do not indicate whether they operate in multicultural and multilingual settings and consider the mental health needs that are unique to the immigrant population. In addition, the services enhancing immigrants' integration are used by only 2% (90) of St. John's immigrants. First, these services are poorly advertised and second, only overseas newcomers qualify to use them (although immigrants already possessing Canadian citizenship are in need of these services too).

The study findings show that the main factor that reflects in all other determinants of St. John's immigrants' mental health is the social environment, since it gives or takes away immigrants' opportunities to access needed resources, information, support, help, employment, and services as well as to be accepted and valued. The St. John's environment is not ready to give immigrants these opportunities or promote the equality and acceptance of its immigrant population, which affects negatively immigrants' mental wellness. But the same applies to other places in Canada too because the experiences of discrimination against race, ethnicity, and culture were described by other Canadian researchers as well (Stingl, 1996; Stephenson, 1995; Anderson, 1987; Donelly, 2002; Canadian Task Force on Mental Health Issues, 1988; Ramsden, 1990 and Dossa, 2004). The stories of St. John's immigrants support the findings of Kuo and Tsai (1986, p.147) that "immigrants seem to exercise very little control over their lives, have minor influence in shaping society's cultural norms, and are powerless overall to affect the economic, political and social structure."

Ignorance and fear are fuelled by media representations depicting immigrants as threatening the health of Canadians with diseases such as SARS and Ebola viruses

(Murdocca, 2003) or threatening their personal safety and security with the terrorist

sleeper cells (Seper, 2003). Immigrants are also depicted as being deceitful and

manipulative (obtaining visas for supporting the election campaigns of Canadian

politicians or faking Canadian passports) and encouraging conflicts with members of

other ethnic and cultural groups (the bombing of the India Air airplane by Sikhs, and the

torching of a Jewish library by Muslims). The stereotypical images that communicate

dislike and avoidance (see Figure 1) become inscribed in the Canadian imagination. It is

a small step from dislike and avoidance to discrimination. One example of such images

spreading fear and hatred of immigrants among native-born Canadians is the racist

website run in Ontario by so called Canada First Immigration Reform Committee

(CFIRC). This website calls multiculturalism "a rotting turtle" and claims that

immigrants import to Canada diseases that may kill Canadians and also suggests that

immigrants are responsible for crime and unemployment (CFIRC, n.d.)

The stories of immigrants "who have added so much to the growth of our

country….who give generously of their time and money to Canadian society" (Poy, 2004,

p.9) are missing. In addition, rather than portraying the difficulties immigrants face after

moving to Canada and the complexity of their lives, media images show immigrants as

happy, smiling and grateful to have the opportunity to celebrate their cultural holidays

and sharing their food with Canadians (Dossa, 2004). Providing more balanced and

truthful images of immigrants in the media is one of the prerequisites for building an

inclusive environment and facilitating the mental wellness of all Canadians. The

following paragraphs offer a few other recommendations for improving immigrants'

mental health and addressing the factors that shape their mental well-being.

Figure 8: Anti-immigration propaganda (CFIRC, n.d.)

Health Canada (2002) recognizes that all factors such as social support networks,

income, employment and working conditions, gender, coping skills, healthcare services,

and physical environment do not influence health in pure isolation, but they interact with

each other. Facilitating one factor has a great potential to impact on the other factors. For

instance, providing immigrants with the opportunities to improve their social networking

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by engaging them in a variety of community-based social, sport and entertainment activities that are culturally appropriate may lead to increasing chances of accessing information, resources and help, and eventually result in finding employment.

Following Epp's (1986) guidelines for effective health promotion strategies, the changes need to cover education, training, legislation, policy and community development. This means that all government and local policy makers need to work together and across boundaries to develop healthy public policy, bridging health, social and economic policies, rather than adopting an isolated approach to health - and mental health in particular (Hancock, 1994). In order to improve the public's health, the policies have to ensure that people's needs for good health, social support networks, equal access to employment, healthy environment, affordable housing, education, economic security, and respect and dignity are met (Walker, 1992). For these reasons, local health, community, and social services providers need to develop a network with policy makers and create a partnership with immigrant communities. This network will provide an environment for creating mechanisms that allow for identifying and providing for immigrants' needs.

The recommendations (see Table 6) contain general implications for health, social and community services providers, as well as for policy makers. More detailed recommendations, which reflect the different communication and knowledge transfer needs of all targeted audiences, will be developed in the near future, as suggested in the dissemination plan.

Health and social services need to provide training of volunteers from immigrant communities who become important knowledge brokers between services and the immigrant service users. In addition, health and social services need to involve immigrants in decision-making about service and resource allocation. More support is needed for immigrant women to enable them to access the resources and assistance they need in order to enhance the speed of adjustment and equal integration into society. These immigrants' suggestions support earlier calls for a similar approach proposed by Guruge et al. (2000).

The social changes need to also reflect a transformation of education. The school curricula need to become more accepting and inclusive. In addition, immigrants need a fair evaluation of their knowledge and skills assets rather than just having their credentials ignored. More friendly immigration policies facilitating the process of immigrants' close families being able to join them in Canada are needed too.

Further, policy makers involved in creating and implementing the new provincial mental health plan must investigate options for including the immigrant population among the groups that qualify for special services. These mental health services may investigate how to adapt the guidelines proposed by the American Psychological Association. (I quote the guidelines from Constantine and Sue (2005, p. 9-12), but for better understanding, I prefer using the term 'mental health providers' for 'psychologists' and remove the adjective 'psychological'):

1. Mental health providers are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their

perceptions of and interactions with individuals who are ethnically and racially different from themselves.

2. Mental health providers are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals.

3. As educators, mental health providers are encouraged to employ the constructs of multiculturalism and diversity in education.

4. Culturally sensitive researchers are encouraged to recognize the importance of conducting culture–centered and ethical research among persons from ethnic, linguistic, and racial minority backgrounds.

5. Mental health providers strive to apply culturally–appropriate skills in clinical and other applied practices.

6. Mental health providers are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices.

These guidelines suggest that the provincial mental health authorities and policy makers should develop bi(multi)cultural and bi(multi)lingual services. The mental health providers need to be educated and trained in multicultural sensitivity. Immigrants should receive culturally and linguistically sensitive information about mental illness, mental health promotion programs and healthcare services.

Health education can reach immigrants through mail, media (newspaper, TV and radio), health providers or trained volunteers from immigrant communities, in the form of pamphlets, posters, displays, fairs, workshops, special events, or broader campaigns. The health and social services providers need to also develop websites with comprehensive information describing what services they can offer to immigrants considering special features of immigrants' mental health needs, for example, accommodating prayer in the

therapy or providing translators. The Association of New Canadians, in particular, needs to improve the advertising strategies (in ways formerly noted) to reach the immigrant audience as well as provide services available to all immigrants, not just newcomers from overseas. In addition, more mental health specialists and staff (of different cultures and languages) are needed in order to shorten the waiting times for appointments and therapy, or accessing help in crises. Counseling services and drugs need to be covered by the provincial health plan since immigrants do not have the finances to pay for these.

Lastly, more community-based participatory action research about questions pertinent to immigrants' mental health is needed; in particular, the questions about mechanisms that can address the inequalities between and within immigrant communities need to be investigated. Moreover, research needs to explore in depth how to enhance factors that determine immigrants' well-being and quality of life. In addition, researchers need to examine the barriers that restrict the Canadian-born population in St. John's from reaching out to the immigrant communities, which should include addressing the portrayal of immigrants in the media. Attention should be directed toward exploring the mental health issues important to the differences among immigrant groups, such as those who are elderly, unable to speak the language of their health providers, or living with disabilities, as well as refugees, international students and worker's permit holders, because their mental health needs may differ from those presented in this study as was demonstrated in studies conducted in other Canadian cities (Fenta, Hyman and Noh, 2004).

Table 6: The overview of recommendations

Developing networks among immigrants, providers of health, social, community services, and policy makers
Providing opportunities for social networking: community-based social, sport and entertainment activities
Training of knowledge brokers among immigrant volunteers
Involving immigrants in decision-making about services and resource allocation
Developing inclusive school curricula
Fair evaluation of immigrants' education and work credentials
Developing friendlier immigration policies regarding immigrants' close families
Developing special mental health services based on the APA guidelines
Developing bi(multi)lingual and bi(multi)cultural services
Training of mental health providers in cultural sensitivity
Providing culturally and linguistically sensitive health-relevant information
Providing health education through mail, media, Internet, health providers and immigrant volunteers
Expanding immigration services to all immigrants and improving advertising
Covering drugs and counselling services by provincial health plans
Engaging in community-based action participatory action research with diverse immigrant populations
Balancing the media portrayal of immigrants and coverage of their issues

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Appendix A

Did you come to Canada as a landed immigrant?

I'm looking for
ADULT MEN AND WOMEN
to take part in a study entitled

"Mental Health and Care Needs of St. John's Immigrants"

The study will explore the mental health needs of immigrant population and their experiences with mental health services (if any). The aim of this study is to understand the barriers preventing immigrants to maintain their mental health and develop culturally sensitive health services to insure a quality care for minority groups.

Taking part in this study will include a confidential individual interview. Your real name will be not required.

Topics of discussion will include:
1. Mental health and information needs you experience
2. Experiences (if any) with mental health services
3. Suggestions to overcome barriers to using mental health services

If you are interested in participating or have any questions please contact

Sylvia Reitmanova, MD
Community Health, Faculty of Medicine, HSC
St. John's, NL A1B 3V6
(709) 754 6852
Email: sylvinka@hotmail.com

Thank you in advance for considering to participate in this study!

This study has been approved by the Human Investigation Committee at Memorial University of Newfoundland.

Appendix B

My name is Sylvia Reitmanova and I am a graduate student at the Division of Community Health at Memorial University of Newfoundland. Starting in September 2005, I will be conducting a study entitled, "Mental Health and Care Needs of St. John's Immigrants" that has been approved by the Human Investigation Committee at MUN. The study will explore the mental health needs of Newfoundland immigrant population and their experiences with the local mental health services (if any). The aim of this study is to understand the barriers preventing immigrants to use mental health services and develop culturally sensitive health services to insure a quality care for minority groups.

If you are interested in participating in this study, I will ask you to take part in an audiotaped individual interview. We will talk about your mental health and information needs, your experiences (if any) with mental health services offered in Newfoundland and your suggestions to overcome barriers to using mental health services. Each interview will take approximately 1.5 hour and you will choose time and place convenient to you.

I will erase from the results any information that may lead to the identification of you or your family and lock the tapes and transcriptions in my supervisor's office at the University during the study. The collected data will be stored for the period of five years after the study is complete (as requested by the University) and then the tapes will be erased and transcripts shredded. Keeping the interviews strictly confidential will minimize all risks and discomforts. I will assign to all participants pseudonyms (names that differ from their own) before the interviews will be taped and transcribed. The decision to participate in this study is left completely up to you.

I will give a summary of the results to all participants. In addition, I will share the findings with interested health care professionals and agencies providing mental health services.

If you are interested in participating or if you have any questions or concerns, please feel free to contact me. You may also contact my supervisor. If you are willing to participate in this study, please read the attached consent form, sign it and return it to me. You can also talk to a person who is not involved with this study but can advise you on your rights as a study participant at the Office of the Human Investigation Committee, (709) 777-6974, hic@mun.ca.

Thank you in advance for your help in this project.

Sylvia Reitmanova, MSc Candidate
Community Health
Faculty of Medicine, HSC
St. John's, NL A1B 3V6
(709) 754 6852
Email: sylvinka@hotmail.com

Dr. Diana Gustafson, Supervisor
Assistant Professor of Social Science & Health
Community Health
Faculty of Medicine, HSC
St. John's, NL A1B 3V6
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Appendix C

**Faculty of Medicine, Schools of Nursing and Pharmacy of Memorial
University of Newfoundland; Health Care Corporation, St. John's; Newfoundland
Cancer Treatment and Research Foundation**

Consent to Take Part in Health Research

TITLE: Mental Health and Care Needs of St. John's Immigrants

RESEARCHER: Sylvia Reitmanova (MSc Candidate), Community Health, Memorial
University of Newfoundland

You have been invited to take part in a research study. It is up to you to decide whether
to be in the study or not. Before you decide, you need to understand what the study is
for, what risks you might take and what benefits you might receive. This consent form
explains the study.

The researcher will:
- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- be available during the study to deal with problems and answer questions

If you decide not to take part or to leave the study this will not affect you in any ways.

Introduction/Background:
Research has shown that mental health needs of immigrants can be different of those
experienced by people of Western culture because immigrants have special status in the
society due to their resettlement experiences. Also they may have different ideas about
mental health and disease, attitudes toward mental illness and mental health providers as
well as expression of psychiatric symptoms and response to therapy. It is important to
look at the mental health needs and barriers experienced by immigrants since ignoring
them may unnecessary cause or elevate people's suffering.

Purpose of study:
The study will explore the mental health needs of Newfoundland immigrant population
and their experiences with the local mental health services. The aim of this study is to
understand the barriers preventing immigrants to use mental health services and develop
culturally sensitive health services to insure a quality care for minority groups.

Participant Initials _____

Description of the study:
I will ask you to take part in an audiotaped individual interview at your convenience. We will talk about your mental health and information needs, your experiences (if any) with mental health services and your suggestions to overcome barriers to using mental health services.

Length of time:
Each interview will take approximately 1.5 hour.

Possible risks and discomforts:
There might be possible discomfort and inconvenience during the interviews to disclose any sensitive information about participants' mental health needs and experiences with health care system. However, all risks, discomforts and inconveniences are minimized by keeping the interviews strictly confidential. I will erase from the results any information that may lead to the identification of you or your family and lock the tapes and transcriptions in my supervisor's office at the University during the study. The collected data will be stored for the period of five years after the study is completed (as requested by the University) and then the recorded tapes will be erased and transcripts will be shredded. I will assign to you a pseudonym (a name that differ from your own) before the interview will be taped and transcribed. Participation in this study is voluntary and you can terminate it at any time. The time required to complete the interview should be the inconvenience that will be addressed by letting you to choose convenient time and place for the interviews. In addition, I will provide you with the name and contact information for a counselor if you wish to talk to a professional regarding any issue which arose during the interview.

Benefits:
There are no immediate benefits from this study.

Liability statement:
- Signing this form gives me your consent to be in this study.
- It tells me that you understand the information about my study.
- When you sign this form, you do not give up your legal rights.
- Researchers or agencies involved in this study still have their legal and professional responsibilities.

Participants Initials_____

Confidentiality:
Your privacy will be maintained and your identities will be kept confidential at all times.

Questions:
If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study or her supervisor.

Investigator: Sylvia Reitmanova (709) 754 -6852
Supervisor: Dr. Diana Gustafson (709) 777- 6720

You can also talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study at the Office of the Human Investigation Committee (HIC) at 709-777-6974, email: hic@mun.ca

Participants Initials_____

Signature Page

Study title: Mental health and care needs of St. John's immigrants
Researcher: Sylvia Reitmanova (MSc Candidate), Community Health, Memorial University of Newfoundland

Please fill out and sign: Please check as

appropriate:

I have read the consent and information letter.	Yes { } No { }
I have had the opportunity to ask questions and discuss this study.	Yes { } No { }
I have received satisfactory answers to all of my questions.	Yes { } No { }
I have received enough information about the study.	Yes { } No { }
I have spoken to Sylvia Reitmanova and she has answered my questions	Yes { } No { }
I understand that I am free to withdraw from the study	Yes { } No { }

- at any time
- without having to give a reason
- without affecting my future care

I understand that it is my choice to be in the study and that I may not benefit. Yes{ } No{ }
I agree to take part in this study.   Yes{ } No{ }
I agree to participate in an audiotaped interview.   Yes{ } No{ }

_____   _____
Signature of participant   Date

To be signed by the researcher:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____   _____
Signature of researcher   Date

Appendix D

These questions will help me understand what you think about mental health and illness. Your answers will help me understand what is important to your mental health and barriers you experience when seeking and maintaining mental health. I will ask you all introductory questions and concluding question. All other questions are only my guide to facilitate our conversation and I may use only few of them.

Introductory questions

- How do you define mental health?
- How do you define mental illness?
- What do you think that are the reasons of mental illness?
- What do you think that is an appropriate treatment for mental illness?
- Did your perspective of mental health and illness changed during your stay in Canada? If yes, can you explain how and why?
- Do you know anyone who suffers from a mental illness? What is your attitude toward this person's illness?
- What do you think that is important to you to stay mentally well?

Guiding questions

Income & social status
- Do you think that income plays some role in people's mental health? How do you understand the role that income plays in people's mental health?
- Are you concerned about your income? If yes, what impact does it leave on your daily life and mental health (e.g. worries or stress).
- Could your mental health change if your income is higher? If yes, explain how.
- How much money would you spend on mental health services (e.g. talking to a counselor) if these services were not covered by health insurance?

Social support networks
- Do you think that support from your family and friends plays some role in people's mental health? How do you understand the role that social support plays in people's mental health?
- What kind of support do you get from your family and friends? Do you think that this support is important to your mental health?
- Could your mental health change if you didn't have support from your family and friends? If yes, explain how.
- Is there any other way that this support can be provided to you if you don't have a family or friends around?

Education

- Do you think that education plays some role in people's mental health? How do you understand the role that education plays in people's mental health?
- What kind of information do you have about mental health and mental illness? Can you tell me the sources of this information? Is there any other way how this information can be delivered to you?
- Could your mental health change if you don't have this information? If yes, explain how.

Employment & working conditions

- Do you think that employment and working conditions play some role in people's mental health? How do you understand the role that employment and working conditions play in people's mental health?
- Could your mental health change if your employment and working conditions changed? If yes, explain how.

Physical environment

- Do you think that physical environment (air, water, soil) plays some role in people's mental health? How do you understand this role that physical environment plays in people's mental health?
- What role does transportation play for you in accessing health services?
- Could your mental health change if your transportation means changed? If yes, explain how.

Biology & Genes

- Do you think that one's biology and genes play some role in his/ her mental health? How do you understand the role that biology and genes play in people's mental health?

Personal health practices & Coping skills

- How are you dealing with any problems and stress you experience?

Health services

- How do you understand the role that health services play in people's mental health?
- Do you know what mental health services are available to you? Have you ever used any mental health services? If yes, can you describe your experience?
- Can you describe me your feelings about visiting a mental health specialist? Are there any barriers or challenges that you can think of?
- How would you assess your need for mental health services? What do you see as some of the problems that make it difficult for you to use mental health services?

- Can you describe circumstances that could encourage you to use mental health services when needed (e.g. delivered by your GP or in your own community)?

Gender
- Do you think that gender plays some role in people's mental health? How do you understand the role that gender plays in people's mental health?
- Do you think that your gender plays some role in your mental health? (For example, some women find it difficult to talk about their problems to a professional of the opposite gender).

Culture
- Do you think that culture plays some role in people's mental health? How do you understand the role that culture plays in people's mental health?
- How would you define your culture? What influence has your culture on your mental health?
- Do you think that your culture is a barrier between you and mental health services? If yes, can you explain why? Do you have any suggestions how this barrier can be eliminated?

Concluding question

- Is there anything else I didn't ask that you would like to tell me?

Appendix E

Memorial
University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

September 12, 2005

<u>Reference #05.151</u>

Ms. Sylvia Reitmanova
C/o Dr. Diana Gustafson
Community Health
Faculty of Medicine
2nd Floor, Health Sciences Centre

Dear Ms. Reitmanova:

This will acknowledge your correspondence dated August 30, 2005, wherein you clarify issues and provide a revised consent form and interview information sheet for your research study entitled **"Barriers preventing immigrants from utilizing mental health services: Newfoundland study"**.

At the meeting held on **August 18, 2005**, the initial review date of this study, the Human Investigation Committee (HIC) agreed that the response and revised consent form could be reviewed by the Co-Chairs and, if found acceptable, full approval of the study be granted.

The Co-Chairs of the HIC reviewed your correspondence, approved the revised consent form and interview information sheet and, under the direction of the Committee, granted *full approval* of your research study. This will be reported to the full Human Investigation Committee, for their information at the meeting scheduled for **September 15, 2005.**

Full approval has been granted for one year. You will be contacted for annual update before **August 18, 2006.**

Modifications of the protocol/consent are not permitted without prior approval from the Human Investigation Committee. Implementing changes in the protocol/consent without HIC approval may result in the approval of your research study being revoked, necessitating cessation of all related research activity. Request for modification to the protocol/consent must be outlined on an amendment form (available on the HIC website) and submitted to the HIC for review.

For a hospital-based study, it is **your responsibility to seek the necessary approval from the Health Care Corporation of St. John's and/or other hospital boards as appropriate.**

This Research Ethics Board (the HIC) has reviewed and approved the application and consent form for this study which is to be conducted by you as the qualified investigator named above at the specified study site. This approval and the view of this Research Ethics Board have been documented in writing. In addition, please be advised that the Human Investigation Committee currently operates according to the Tri-Council Policy Statement and applicable laws and regulations. The membership of this research ethics board complies with the membership requirements for research ethics boards defined in Division 5 of the Food and Drug Regulations.

Notwithstanding the approval of the HIC, the primary responsibility for the ethical conduct of the investigation remains with you.

We wish you every success with your study.

Sincerely,

John D. Harnett, MD, FRCPC   Richard Neuman, PhD
Co-Chair   Co-Chair
Human Investigation Committee   Human Investigation Committee

JDH/RSN/jd

c: Dr. C. Loomis, Vice-President (Research), MUN
        Mr. W. Miller, Director of Planning & Research, HCCSJ

Appendix F

Mental health questionnaire

This questionnaire was developed by Sylvia Reitmanova, a graduate student at Community Health Department, Faculty of Medicine at Memorial University of Newfoundland. It is designed to find out how Muslim residents in St. John's understand about mental health and diseases and about their attitudes toward these issues.

- **To help me understand what you know about mental illness please answer the following questions.**

1. Are you a certified mental health specialist (e.g. counsellor, psychologist, psychiatrist, etc...)?
Please tick the correct answer.

    ( ) Yes
    ( ) No

2. Have you ever received any education about mental health and illness issues (e.g. course, lecture, workshop, etc...)?
Please tick the correct answer.

    ( ) Yes
    ( ) No

3. What do you think that may be the reason of mental diseases?
Please tick all answer you think are correct.

    ( ) biological brain disease
    ( ) psychological reaction (e.g. after some traumatic event)
    ( ) weak personality
    ( ) stress
    ( ) genetic reason
    ( ) other reasons (e.g. curse, black magic, evil eye, etc...)
    ( ) I don't know

4. Schizophrenia is one of the most common mental illnesses. Can you tell me which of the following signs are associated with schizophrenia?

Please tick all answer you think are correct.
    ( ) epileptic convulsions
    ( ) seeing, hearing, smelling or tasting something that is not real
    ( ) very bad dreams
    ( ) intense fear of becoming fat and excessive physical exercising
    ( ) I don't know

- **To help me understand people's attitudes toward the mentally diseased and mental health specialists please answer the following questions.**

5. Has anyone from your family, relatives, friends, or people you know ever visited or talked to a mental health specialist?
Please tick the correct answer.

( ) Yes
( ) No

If no, please go directly to the question # 7.

6. Did you, yourself, talk to this person about his or her problem and/(or) disease?
Please tick the correct answer.

( ) Yes
( ) No

7. Would you be afraid live or work beside someone who has a mental disease?
Please tick the correct answer.

( ) Yes
( ) No
( ) I'm not sure

- **To help me understand under what circumstances people use mental health services please answer the following questions.**

8. Have you ever visited or talked to a mental health professional?
Please tick the correct answer.

( ) Yes
( ) No

9. Imagine that in the last month you were very sad, did not enjoy things you usually do and lost your appetite. Your friend suggests to you to see a mental health specialist. How would you feel about this suggestion?
Please tick all answers you think are correct.

( ) afraid
( ) shameful
( ) angry
( ) uncomfortable
( ) desperate
( ) encouraged
( ) I don't know

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10. Imagine that you have some serious problems that could affect your mental health (e.g. financial, marital or work problems). When would you consider going to a mental health specialist?
Please tick all answers you think are correct.

    ( ) never
    ( ) only when I would be seriously ill
    ( ) only when accompanied by a relative or friend
    ( ) only when the service would be free of charge (covered by health insurance)
    ( ) I would always seek professional health
    ( ) I don't know

- **Please tell me a little bit about yourself by answering the following questions.**

11. How old are you?
Please tick the correct answer.
    ( ) 19-34
    ( ) 35-44
    ( ) 45-64
    ( ) 65 and over
    ( ) no response

12. What is your gender?
Please tick the correct answer.
    ( ) man
    ( ) woman

13. What is your family status?
Please tick the correct answer.
    ( ) single
    ( ) married
    ( ) divorced
    ( ) separated but not divorced
    ( ) common-law relationship
    ( ) widowed

15. What is the highest level of education you received?
Please tick the correct answer.
    ( ) any grade of elementary school
    ( ) any grade of high school
    ( ) any year of college or university
    ( ) any postgraduate degree

- **These questions will help me design a better questionnaire in the future**

16. Is there something I did not ask you would like to tell me?

17. Have you understood clearly all questions?
Please tick the correct answer.

       (   ) Yes
       (   ) No
If no, can you tell me which question it was?

18. Is there something you would like to change in this questionnaire (e.g. format, length, structure, etc...)?

Thank you very much for completing this survey!

Please use the enclosed self-addressed stamped envelope to return the questionnaire to the address displayed on the envelope.