Mental health of South Asian women: 
Dialogues with recent immigrants on post-migration, help-seeking and coping strategies

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Abstract

As Canada, and particularly metropolitan cities like Montreal, becomes increasingly diverse, it is important to explore and understand the culture and needs of immigrant communities. This Masters thesis focuses on the mental health of South Asian immigrant women in Montreal, Quebec. This original research is a qualitative descriptive study based on in-depth interviews with nine women from India and Pakistan. The interviews focus on the intersection of gender and culture with post-migration experiences, help-seeking patterns and coping strategies for distress in South Asian women. The women’s narratives provide pertinent information for researchers and practitioners that could be applicable to the design of future research, outreach, health promotion, and models of care on mental health. The following four chapters provide a thorough discussion of the methodology, findings and conclusions.
Resume

Comme le Canada, en particulier les villes métropolitaines comme Montréal, devient de plus en plus multiethnique, il est primordial d'explorer et de comprendre la culture et les besoins des communautés. Cette thèse de maîtrise se concentre sur la santé mentale des immigrantes d'Asie du Sud à Montréal au Québec. Cette recherche originale est une étude descriptive qualitative basée sur des entrevues approfondies avec neuf femmes qui proviennent de l'Inde et du Pakistan. Ces entrevues se concentrent sur le rapport entre le genre et la culture avec des expériences après l'immigration, les modèles de recherche d'aide et de soutien pour les femmes d'Asie du Sud. Les récits de ces femmes fournissent de l'information pertinente pour les chercheurs et praticiens qui pourraient l'utiliser comme fondation pour des recherches futures, outreach, information sur le bien-être et comme modèles de soins de la santé mentale. Les prochains quatre chapitres fournissent une discussion approfondies sur la méthodologie, les découvertes et les conclusions.
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Chapter 1: Introduction

In recent years, Canada has become increasingly diverse and every year, it attracts immigrants from various countries around the world. In 2003, a total of 221,340 immigrants and refugees entered Canada (Citizenship and Immigration Canada [CIC], 2005). India and Pakistan were the first and second source countries, respectively. Almost 32% of all immigrants were from these two source countries, which supports literature that reports that South Asians are among the fastest growing groups in Canada (Choudhry, 2001). With recent immigration trends from South Asia, it is important for research to address the needs, concerns and unique experiences of this population.

Recently mental health research has addressed culture because of the increasing immigration trends. Culture is important to include in our research with immigrant populations because it often informs their perceptions of mental health and help-seeking (Lee, Rodin, Devins, & Weiss, 2001). Although there has been a particular focus on immigrant populations in recent literature, it is also important to focus on the needs of immigrant women (Reid, 2002). Research has suggested that women, in general, face higher rates of depression and anxiety than men do (Griffin, Fuhrer, Stansfeld, & Marmot, 2002). Therefore, with the increasing influx of South Asian immigrants to Canada, I felt it was important to design a research study that would help to understand the migration experiences of women in particular.

My interest in the topic of mental health of South Asian immigrant women stems from past academic activities and my personal background. Having immigrant parents from India, I have heard many accounts of the challenges that immigrants encounter in a new country and also experienced the duality of living in two cultures, having immigrant parents who want you to maintain their cultural traditions but also integrate into Canadian life. Hence, I am aware of the difficulties that immigrants, and also their children, experience. During my undergraduate degree in Women’s Studies at the University of Toronto, I worked on an individual thesis project that focused on the mental health promotion of South Asian women living in Toronto. I had read an article on health promotion
in immigrant women which sparked my interest in exploring if there was 
literature available on health promotion in South Asian women. Although there 
was, I felt it was limited and did not focus on South Asians.

After my undergraduate degree, I, along with Professor Nazilla Khanlou, 
also a committee member for this Master of Science thesis, conducted a literature 
search on South Asian women and mental health. Together, we wrote a review of 
the literature that was available about South Asian women, post-migration, 
perceptions, and help-seeking (Agarwal & Khanlou, 2003). We felt that there 
was a need to summarize the information that was available. This past research 
led me to the graduate program in the Division of Social and Transcultural 
Psychiatry at McGill University. This program is particularly relevant to my 
interests because it emphasizes a need for research on the effectiveness of services 
and intervention models for immigrants, refugees and ethnic communities. In 
subsequent sections, I describe the objectives, questions and literature that was 
available for this thesis.

*Research Objectives*

Although there is growing literature on the experiences of Asian 
Americans in general, there is still a lack of research and literature that address 
the needs of South Asians (Das & Kemp, 1997) and that of women from ethnic 
groups (Reid, 2002) in particular. Therefore, one of the objectives of this thesis 
was to contribute to the limited academic research in mental health and South 
Asian women from India and Pakistan. I also decided to focus on the experiences 
of women who have been in Canada less than five years, to capture their concerns 
and changes closer to migration.

This thesis study, using a qualitative descriptive design, focused on 
working in-depth with South Asian immigrant women at a community centre in 
Montreal, because ethnic minorities tend to seek help in the non-private mental 
health sector (Kirmayer, Galbaud du Fort, Young, Weinfeld, & Lasry, 1996). 
Montreal was an appropriate location for this research study due to the increasing 
number of South Asians that come to Montreal. In 2003, almost 15% of the total 
immigrant population settled in Montreal (CIC, 2005).
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Although South Asian women comprise a large and heterogeneous group, varying by language, geographical location, religion, class, caste, etc. (Choudhry, 2001), I hoped to highlight patterns or similarities in these women’s post-migration experiences and how these affected their mental or emotional health. Also, since researchers have recently stressed the importance for research to address help-seeking and pathways to care (Kirmayer et al., 1996), another goal of this thesis was to gain a thorough understanding of the help-seeking patterns of South Asian women. I also wanted to understand the barriers that women encountered in accessing appropriate services, as well as what they found made services useful to them. Below, I have outlined the four research questions that were designed to fulfill the objectives of this study.

Research Questions

The research questions that guided this original qualitative descriptive study were 1) what are the salient post-migration stresses that shape their experiences as Indian immigrant women living in Montreal? In what way is adjustment in gender roles a significant stressor? 2) in what ways and where do they prefer to seek help? 3) what barriers do they encounter in accessing appropriate services? How are these linked to culture and gender?, and 4) in what ways and under what circumstances do they feel services are useful?

Literature

This chapter introduces previous literature concerning South Asian women and mental health. It should be noted that for the literature review, I have drawn on some of the literature that was used for the manuscript review (Agarwal & Khanlou, 2003). However, it has been updated with other current literature. There are several parts here that will address concepts that are important to understand prior to reading methodology, results and discussion chapters of this thesis. These concepts include: gender roles and beliefs of South Asian women and family life, perceptions of mental health in South Asia, common help seeking patterns, post-migration factors for immigrants that could potentially be a source of stress in Canada, and barriers to accessing mental health services.
Roles of South Asian Women and Family

Females in South Asian cultures generally have a different upbringing than male children. They are taught to be good wives, daughter-in-laws, and mothers. Women and men believe that each person carries out a valued role in the smooth functioning of the family (Das & Kemp, 1997; Ibrahim, Ohnishi, & Sandhu, 1997; Prathikanti, 1997). For South Asian women, marriage is considered to be a second birth, where she now lives with her husband and his family, forever. It is said that her real life now begins (Choudhry, 2001). Marriage is also supposed to be forever. Divorced women are considered outcasts and widows have a hard time re-marrying. When married, a woman’s primary role is to uphold traditions, preserve culture and ensure the smooth functioning of their family (Choudhry, 1998). They are responsible for household duties such as cooking and cleaning, but also for raising the children (Choudhry, 2001; Khanlou & Hajdukowski-Ahmed, 1999).

Although it may seem like South Asian women do not have much power in the household, women are still respected and valued. The roles of Indian women, for example, are compared to goddesses such as Parvati, the beneficent mother, and Kaali, the dark divine force, who are respected by both women and men in Indian culture. These goddesses embody power and enforce the devotion and respect that a mother should receive (Choudhry, 2001). These women respectfully conform to their roles as wives, mothers and daughter-in-laws, because they strive to emulate Indian goddesses (Choudhry, 2001; Naidoo & Davis, 1988).

Family life is also very important to South Asians. Families in South Asia generally consist of a large and flexible household, where it is common to live with extended family (Choudhry, 1998). Unlike Western societies, cultures in the East give importance to collectivism (Das & Kemp, 1997; Jayakar, 1994; Murthy, 2000; Pettys & Balgopal, 1998). Family needs and traditions are more of a priority than one’s personal needs, and when one does put their personal needs ahead of the family, it is considered selfish and “westernized” (Choudhry, 1998).
Although I have highlighted some of the important characteristics of family life and gender roles in South Asian culture, it is also important to acknowledge what Western views are of South Asian women, so that one can understand why there is still a need to understand South Asian culture. Western views suggest that women from South Asian cultures are still oppressed because of their gender roles and the patriarchal structure of the family (True, 1990). Razack (1998) explains that images of Indian women that come to mind are usually of a passive, suppressed, and miserable woman. In contrast, Western countries and their people are described as those who welcome these women to their country. Green (1990) suggests that Eastern cultures and gender roles can not be criticized from a Western perspective. Rather, one must learn and understand the context of a culture. This is why it is important to outline and understand family life and gender roles of South Asian women.

Culture and gender play an important role in the arrangement of family life for South Asians. Female gender roles are also shaped by centuries of tradition. The different, yet valued, structure of family and female roles in South Asian culture, are important to understand because women strive to maintain these values after migration. Their roles and beliefs of family life also will help to understand their perceptions on mental health and appropriate care.

Perceptions of Mental Health and Symptomology

Like in many other cultures and societies, stigma and shame are still associated with suffering from any kind of mental problem. In addition, there is a lack of knowledge and terminology used to describe mental health and illness in the general South Asian population (Kakar, 1991). For South Asians, health and well-being are viewed as a balance between the mind, body and spirit (Ahmad, Shik, Vanzo, Cheung, George, & Stewart, 2004; Choudhry, 1998; Hilton, Grewal, Popatia, Botterof, Johnson, Clarke, Venables, Bilkhu, & Sumel, 2001; Hussain & Cochrane, 2002). Choudhry (1998) reported that South Asian women described health as good relationships with family, a good diet, and engaging in spiritual activities like attending their place of worship.
Kakar (1991), a Western trained psychoanalyst, reports that the patients he sees in India have a different understanding of the mind and body than in the West. In India, and usually other South Asian countries, symptoms for mental illness are described in somatic or physical terms. While people from Eastern cultures are considered to 'somatize' symptoms of mental illness (Ito & Maramba, 2002; Kirmayer, 2001), expression of symptoms is usually psychological in Western countries and described in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition-text revision, or DSM-IV (American Psychiatric Association, 2000). Therefore, many of the symptoms that South Asians will describe are not listed in the DSM-IV and sometimes considered ineffective expressions of emotions (Ito & Maramba, 2002).

Therefore, culture not only influences how South Asians view mental health, but it also influences the way symptoms are expressed (Fernando, 1990). It is important for service providers to understand the culture of a client so that they can understand the context of the illness and symptoms. Not understanding cultural expressions of symptoms and their meanings may lead to misdiagnosis (Hussain & Cochrane, 2002).

Post-migration Factors

Although immigration can bring increased opportunities, researchers have found that post-immigration circumstances can influence one’s mental and physical health (Choudhry, 2001; Pernice & Brook, 1996; Suarez-Orozco, 2000). Psychological adjustment to a new culture and the acculturation process can be a great source of stress. Learning a new language, new social mores and cultural patterns, are some of the things an immigrant must learn in a new country (Furnham & Shiekh, 1993). Separation from extended family, friends, and their community can also be a source of emotional distress (Beiser & Hyman, 1997; Das & Kemp, 1997; Furnham & Shiekh, 1993). Previous studies have reported that recent immigrants have higher rates of depression than people born in the host country due to acculturative stress (Miller & Chandler, 2002). Additionally, immigrant women have higher rates of depression than immigrant men (Hussain & Cochrane, 2002).
Economic hardship, employment barriers, and discrimination are among the post-migration experiences migrants face during resettlement. Although South Asian families immigrate for various reasons that predominantly include increased educational and occupational opportunities and a better standard of life in general, they are faced with difficulties they do not anticipate. Like many new immigrants, South Asians encounter economic and financial stress when coming to a new country. Because the cost and standard of living is higher in North America than in India and Pakistan, they can find themselves struggling to support and provide for their families. The economic hardships are compounded by occupational and educational discrimination. Following immigration to Canada, employment barriers result in immigrants being unemployed or underemployed in menial and low-paying jobs (Mojab, 1999; Porter, 2000). This can be a great cause for frustration and stress among some Indian women who worked as educated professionals with degrees in India. Some of the occupational barriers they face are a result of discrimination (Mojab, 1999). Discrimination is also a reported to be a post-migration factor that can cause a decline in mental health for immigrants (Chew-Graham, Bashir, Chantler, Burman, & Batsleer, 2002; Hussain & Cochrane, 2002; Moghaddam, Taylor, Ditto, Jacobs, & Bianchi, 2002; Mojab, 1999).

Help-seeking in South Asian Women

In general, when there is a problem, including mental illness, South Asian families collectively discuss and resolve problems (Das & Kemp, 1997). To protect family honour, most private matters are discussed with family, and sometimes friends, rather than publicly.

Tradition healing practices are also common in South Asians (Choudhry, 1998; Hilton et al., 2001). For example, ayurveda, a traditional Indian approach (Choudhry, 1998), is used to treating mental and social problems in a holistic and humanistic manner, by dealing with the mental, physical and spiritual (Ganju, 2000; Kakar, 1991). It is the dominant system of medicine and is widely accepted. In addition to ayurveda, traditional practices such as meditation, yoga
and faith healing have been common approaches to reducing stress and keeping “sane”.

Hilton et al. (2001) reported that South Asian immigrant women in Canada use traditional healing practices that they refer to as “desi ways”. These include home remedies, prayers, and consultations with traditional healers such as vedas, hakims, babajis, pundits, and homeopaths. The use of traditional healers is also reported to be a common way of dealing with problems in some cultures (Hussain & Cochrane, 2002). Such healers incorporate spirituality, religious texts and herbal remedies in their treatment. However, the use of traditional healers and herbal remedies is not fully understood in Western societies (Hilton et al., 2001; Hussain & Cochrane, 2002). This research study hoped to capture information pertaining to traditional healers and home remedies to better understand South Asian women’s help-seeking patterns.

**Barriers in Accessing Mental Health Services**

With the increased diversity of Canada and the increasing influx of immigrants, mental health providers must acknowledge and address barriers that South Asians encounter in trying to access services. This can help to improve outreach and prevention programs for this community. There have been some common barriers in access to mental health services that have been identified in the literature. These barriers can lead to decreased utilization of services. Two of the predominant barriers that were uncovered through my literature search were associated with language communication and culture of a service provider.

Citizenship and Immigration Canada (2005) reported that among the immigrants that entered Canada in 2003, almost 44% of them did not speak English or French. Lack of proficiency in these languages can prevent immigrants from becoming aware of services, their rights and learning health promotion practices (Chew-Graham et al., 2002). Choudhry (1998) reported that South Asian women who could not speak English felt they did not benefit from printed or audiovisual materials that informed them of health issues. Language barriers have also been reported to complicate communication and prevent accurate diagnosis in South Asian women (Hussain & Cochrane, 2002).
Studies have shown that verbal communication between the patient and service provider is central to effective treatment (Lee, 1997; Moffic, 1983; Porter, 2000). Although, the ideal situation would be to have linguistically diverse staff that would be able to converse with patients in their own language (Dutt & Ferns, 1998), it is not a practical suggestion due to many limitations. Such limitations include funding available to hire staff and space in organizations. In addition, the increasing number of ethnic populations in Canada and the heterogeneity within ethnic groups makes it nearly unfeasible to hire a service provider of each language.

Even with the presence of an interpreter, there are challenges. For example, translations could be biased or misinterpreted. Although a client and interpreter may speak the same language, they may have different dialects, accents, or linguistic styles (Lee, 1997). In addition, service providers may hesitate to use interpreters because of the shift in power from the provider to the interpreter (Blake, 2003; Lee, 1997). Therefore, language is an important access issue that needs to be explored further and this thesis hoped to uncover what South Asian in Montreal felt about it and what their experiences have been.

Although an underutilization of mental health services by South Asians exists, it can be worse for immigrants who encounter additional barriers in treatment such as language and cultural differences (Kirmayer et al., 1996). Cultural differences are not only a barrier with respect to language and the expression of symptoms, as mentioned in this chapter, but also through differences in ethnic backgrounds of a client and provider. There is much controversy and conflicting literature on whether ethnic-match, where client and provider are of the same cultural background, is a benefit for accessing services. Although one of the obvious benefits of this match would be that a provider would be able to provide culturally sensitive and linguistically appropriate treatment (Ito & Maramba, 2002), it is difficult to have a clinician for every ethnic group (Wong, Kim, Zane, Kim, & Huang, 2003). However, fear of being stereotyped by a provider of a different ethnicity can affect the client’s willingness to disclose information (Hertzberg, 1990). While many ethnic
minority clients may prefer a provider with the same ethnicity as them, Maramba and Hall (2002) propose that increasing the cultural competency of providers of different ethnicities can lead to decreased dropout rates and increased utilization of services. Their findings suggest that ethnic match alone cannot indicate a positive therapeutic intervention. Therapists of all ethnicities must be able to provide culturally competent care.

This research study hoped to explore whether these two factors, language and ethnic-match, really are barriers for South Asian immigrant women in Montreal and whether they felt they would be able to better express themselves. It is important for providers to know what would make services more useful for the community.

Limitations to Present State of Knowledge

Although there is access to literature in the area of mental health and Asian immigrants, there are still a limited number of qualitative research studies that focus on and explore the unique experiences of South Asian immigrants. Although there are some, they are predominantly with South Asian communities in the U.S.A. and the UK. Therefore, I found there was a limited number of studies with South Asian immigrants in Montreal, Canada. I found that it was important to focus on the experiences of immigrants in Montreal, since language may be a major barrier to services, as many immigrants do not speak English or French. Language proficiency may be one of the reasons that there is a lack of research on the South Asian community in Montreal. A researcher may not be able to capture important information that a participant is trying to express because they do not speak the same language. This thesis study hopes to eliminate such limitations by interviewing in the participant’s language.

Finally, with respect to gender, presentation of past research can pose a challenge in understanding the unique experiences of South Asian immigrant women. When studying immigrant populations and post-migration, there is generally a lack of focus on gender and how the experiences of men and women might differ. However, as outlined in this chapter, gender differences in South Asian culture are relevant and it is important to explore if gender influences post-
mental health experiences and help-seeking. Addressing gender differences is relevant to mental health education in multicultural settings, since gender intersects with many stages of the migration experience (Khanlou, 2003; Khanlou, Beiser, Cole, Freire, Hyman, & Kilbride, 2002) and can add strength to research with immigrants (Dion & Dion, 2001).
Chapter 2: Methodology

Paradigm

The paradigm that was used for this research study was a qualitative approach. By designing a qualitative study, I hoped to explore participant's feelings and experiences in-depth, rather than through survey style inquiry that quantitative studies usually employ. As well, qualitative inquiry has become increasingly popular in health services research (Mays & Pope, 2000) and can produce a substantial amount of data (Pope, Ziebland & Mays, 2000). Qualitative data focuses on the natural world, people's lived experiences (Polit & Beck, 2006) and the meanings that they give to these experiences in their own words (Denzin & Lincoln, 2000; Miles & Huberman, 1994). Denzin and Lincoln (2000) state, “qualitative research involves the studied use and collection of a variety of empirical materials…that describe routine and problematic moments and meanings in individuals’ lives” (p.3). There is an emphasis on reality as socially constructed, and a close relationship between the researcher and the participant is what is being studied (Denzin & Lincoln, 2000). The qualitative interview is rich and includes “thick descriptions that are vivid, nested in a real context, and have a ring of truth that has a strong impact on the reader” (Miles & Huberman, 1994, p.10). This method of research also keeps investigators close to their data (Sandelowski, 2000).

This study used a qualitative descriptive approach. Unlike other traditional qualitative research methods, qualitative description does not stem from any particular discipline (Sandelowski, 2000). Yet, it can have elements of other methods, such as phenomenology, ethnography, narrative or grounded theory. This study, although it was predominantly descriptive, has overtones of phenomenology. For example, the data was collected through in-depth conversations with participants and the sample was relatively small, or less than ten, which is characteristic of phenomenological inquiry (Polit & Beck, 2006; Russell, 2004). Therefore, qualitative description was used because it is the most naturalistic approach to inquiry and helped to capture vivid descriptions of the participants’ experiences without having to follow any mandates on how to
collect data as other qualitative methods do. This chapter describes the data collection and analysis process of the research study using qualitative description.

Data Collection Process

Ethics Review

Before proceeding with any data collection, ethics approval (see Appendix A) was obtained from the Montreal Children's Hospital research ethics board (REB), a McGill University Health Centre. The REB provided approval for both the research protocol and the English and French versions of the consent form.

Key Informants

Collection of data for this study was done in various ways and stages. The first stage consisted of interviews with four key informants, or experts that worked in health-related settings where they interacted with South Asian immigrant women. The service providers recounted their experiences in working with immigrant women and what they saw as the major categories or themes that would form from the study. The key informants interviewed for this study were a psychiatrist, the Executive Director of a community organization, and two translators, all four of whom worked with South Asian women. Their perspectives also helped shape the research study, validate the research questions that were formed, and design the interview guide by focusing on the issues that they thought were important to investigate.

Participants

The final sample consisted of nine women between the ages of 25-44. This small sample allowed for time for more in-depth interviewing and for a focus on the experiences of these individuals (Miles & Huberman, 1994). Gliner and Morgan (2000) state, a “better quality control can be obtained if one has a reasonable amount of time to devote to the assessment of each participant rather than trying to spread oneself too thin over a larger group” (p.145).

Since the sample was small, women who would be able to inform the research questions were selected (Miles & Huberman, 1994). Some of the characteristics about women that made them good candidates for the study included having immigrated to Montreal in the last five years, which helped to
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capture the experiences of these women related to settlement in Canada in the earlier stages and informed research question 1, and all of the women should speak either Hindi or English, as those were the languages used to interview. However, other than these characteristics, there were no other conditions so that the study could account for the complexity of the participants and respect for varied experiences related to marital status, religion, education, class, or ability. The sample was actually quite varied and the demographics are listed later in this chapter.

Recruitment

Recruitment of participants was initially through a community centre in Montreal, Quebec. It is one of the only centres that provides extensive programs and services serving the South Asian community and is a safe haven for many immigrant women in particular, although men and non-immigrants are also given access to programs. The name of this organization will not be revealed in this thesis to protect the identities of the participants and ensure their anonymity. This graduate level study was introduced to the Executive Director and front-line staff at the centre, who then passed the word on to clients that they thought, matched the inclusion criteria. The women were assured that if they decided not to participate or withdrew their participation at any stage, their access to services at the centre would not be jeopardized. After women gave verbal consent to staff to participate in the study, they were given the interviewer’s contact information or vice versa to set up an interview time.

Another recruitment strategy that was used was a snowballing process where women who participated in the study referred friends of theirs. Therefore, five women were recruited directly from a community organization and four women were referred through the snowballing process.

Consent

The next stage consisted of interviews with the nine participants. Each participant was asked to provide consent by filling out of a consent form (see Appendix B). In qualitative research and in-depth interviewing, gaining the participant’s trust and understanding their concerns is important. Before any data
was collected, Gliner and Morgan’s (2000) three steps for informed consent were followed. First, the study’s objectives, procedures, and any anticipated risks or benefits were explained to the participant. The second step was to ensure that the participants were in a legal and able position to understand what they are consenting to. The women interviewed were all between the ages of 25-44, and able to consent for themselves, and also able to read the consent form in their preferred language (Hindi or English). Lastly, the participants agreed to participate without any threat, force or pressure (Gliner & Morgan, 2000; Miles & Huberman, 1994). Participants were also assured that they could decide to not participate at all, as well as withdraw their participation at any point during the course of the research study. This would not affect their access to any other services or research studies. Participants were then asked to read and sign the consent form, before proceeding with the collection of data.

Audio Taping

It was also explained that all interviews will be audio taped and the purpose of this. The participants were assured that the tape would only be listened to by the research team and used for the purposes of this research only. The advantage of audio taping an in-depth interview of this length was to help to recall details and important information that could possibly be lost if we were to rely on memory (Kvale, 1996; Silverman, 2000). Also, audio taping the interview allowed for the interviewer to focus on the interview and what was being said rather than taking notes (Kvale, 1996). Therefore, after explaining this advantage, the participant was asked to also sign an audio consent form (see Appendix C), again in their preferred language. Although the interview would be recorded, the participants were assured that neither the tape nor the transcript would identify them in any way, and they would retain complete anonymity.

Data Collection Methods

There were three methods of collecting data. There was a demographic questionnaire, an in-depth interview, and notes, also referred to as field notes (Streubert & Carpenter, 1999), taken by myself following the interview on any
impressions of the interview. These three methods are described in further detail in this chapter.

*Demographic questionnaire.*

After consent had been given to proceed with the data collection, a one-page questionnaire requesting basic demographic information was administered verbally (see Appendix D). The purpose of this short questionnaire was to collect background information on the participants with respect to age, country of birth, length of stay in Canada, and preferred language of communication. The sample is described in detail below.

*Age* – Three women were between the ages of 25 and 29, two women were between the ages of 35-39, and four women were between the ages of 40-44.

*Country of Birth* – Three women were born in India and the remaining six women were from Pakistan.

*Length of stay in Canada* – Six women had been in Canada 1-2 years and three women had been in Canada longer than 3 years, but no more than 4 ½ years. Therefore, all the women had been in Canada for less than 5 years and could talk about many recent post-migration experiences, but had also been in Canada a minimum of 1 year so that they had experienced some of the difficulties of settlement.

*First language* – Three women said that they had first learned Punjabi at home and it was their first language, five women said that Urdu was their first language, and one woman said that Telagu was her first language.

*Preferred language in Canada* – Two women said that they still preferred to communicate in Punjabi, two women said they preferred Urdu, one woman said either Punjabi or Urdu, and four women said that they were comfortable and preferred at times to communicate in English. However, six women said that they could, if needed, communicate in English and fluently, in their opinion. Only three of these women did the interview for this study in English though, since they said they would be able to express themselves better in Hindi.
Interviews.

Next, in-depth, face-to-face, semi-structured interviews lasting from 60-120 minutes were conducted. This interviewing technique is most commonly used for qualitative data collection (Fontana & Frey, 2000), and in qualitative descriptive studies either individually or in focus group settings. The in-depth and open-ended nature of the interview was chosen because it can provide a larger range of useful information in comparison to other types of collection methods (Fontana & Frey, 2000) and more detailed responses (Gliner & Morgan, 2000; Sandelowski, 2000).

The semi-structured nature of the interview questions allowed for there to be a focus on the content and direction of the interview, to ensure that the data collected will inform the research questions guiding this thesis. It also allowed for some similarity in the discussion of participant’s experiences and comparison, so that trends and themes could be identified during the analysis of the data. Yet, the interview questions were also open-ended enough, to allow for the participants to answer the questions in their own words and the way they wanted (Fain, 2004; Gliner & Morgan, 2000).

The interview and protocol were designed in collaboration with the research supervisors. The appropriateness of the interview guide was assessed by conducting it with the first two research participants of the study. The objectives of this were to determine if there were any questions that the participants found confusing or redundant, whether the questions were really structured to inform the research inquiry, and also to review the total duration of the interview. After the first two interviews, the guide was not changed since the participants did not voice any concerns and the questions were generating narratives that did inform the research questions under inquiry.

The research setting was chosen by the participant so that she would feel comfortable. It is common to collect qualitative data in ordinary, real-world settings (Polit & Beck, 2006). The interviews were conducted in either Hindi or English, the preferred language of the participant and the languages that the interviewer had a fluent command of. This helped to capture important
information that the women may have had difficulty relaying in English, if it was their second language. Five women had reported that Urdu was their first language and two women even preferred to do the interview in Urdu, and it was possible since the Urdu and Hindi languages are very orally similar. The other women could all communicate in Hindi. Six interviews (P1, P2, P3, P4, P5, P6) were done in Hindi and three (P7, P8, P9) were done in English.

The interview guide (see Appendix E) consisted of key questions (in bold) which addressed the research questions of the study and were asked to all participants. There were also sub-questions that were used as prompts that may or may not have been asked, depending on the participant’s experience and the need to probe.

Fontana and Frey (2000) explain that the gender of an interviewer and participant impact the research interaction. There are complex issues, such as understanding the language and culture of the participant, deciding on how to present oneself, situating oneself and the participant, gaining the trust of the participant and establishing rapport with the participant, that the interviewer needs to address and acknowledge when interviewing (Fontana & Frey, 2000). For this research study, I completed all the interviews myself because I am fluent in both English and Hindi. I felt it was also appropriate that I do the interviews since I am a second generation Indian woman whose parents immigrated in the 70s. Thus, I felt that I would be able to relate to the post-migration experiences of the women and understand some of the hardships that immigrants encounter because of the many stories my parents have told me throughout the years. I have also experienced first hand the difficulties and issues with being raised in two cultures and feel that it will help to relate to the immigrant women with children. My ability to relate to these women’s experiences, and being a South Asian woman who could understand the language and culture of a participant, perhaps helped to build a rapport with the participants. This may have helped to collect valuable information that the participants may have hesitated to share had it been a male interviewer and someone who could not communicate in the preferred language of the participant, if it was not English. Therefore, the gender and culture of the
interviewer were important in this study. Conducting the interviews myself also kept me close to the data, which made the analysis process simpler since I knew the context of the interviews and was familiar with the narratives.

Notes.

Lastly, I made notes following the interviews regarding important observations on the interview experience (Streubert & Carpenter, 1999) and the participant's feelings. This included notes on facial expressions and body language of the participant, which can be lost if we rely solely on the tape-recorded data (Kvale, 1996; Miles & Huberman, 1994). I also took note of other visual information such as crying that might not have been clear on tape. These notes were important to explain the emotional content of interviews.

Analysis Process

Transcription

Qualitative data is usually not readily available for analysis until it first undergoes some processing (Miles & Huberman, 1994). In this case, all interview tapes were first transcribed into English. This process transformed the oral conversation into a written discourse (Kvale, 1996) and helped to analyze data in an accessible and less time consuming fashion. Also, it is more difficult to locate information or certain parts of a conversation on a tape. A professional transcriber was used to transcribe three of the participant interviews that were in English. However, the transcripts that were produced by the professional transcriber were reviewed by the interviewer to ensure accuracy.

Evaluation

In evaluating the data, software for qualitative analysis was not used due to some of the disadvantages of the software. Although it can facilitate the analysis process by cutting down on the time that a researcher would spend on manually cutting and pasting (Polit & Beck, 2006), it can also create hierarchical relationships between codes and may be unable to code complex accounts (Weitzman, 2000). As well, the software may be able to organize and manage the data, but it can not make links between theory and data (Pope, Ziebland & Mays, 2000). Therefore, the data was sorted and analyzed by the interviewer. This was
Mental health of South Asian women

advantageous because the interviewer was familiar with the narratives and the context of the interviews, hopefully avoiding any misunderstandings of narratives. As well, this strategy was chosen because as qualitative descriptive studies strive to do, it kept the researcher close to the data (Sandelowski, 2000).

Although there are several methods for qualitative data analysis, the essential goal of all methods of analysis is to organize the data in a way that would elicit meaning (Polit & Beck, 2006). However, analysis of qualitative description is less interpretive than other qualitative methods, because it attempts to present data as a summary of the interviews, not to re-present the data in other terms (Sandelowski, 2000). The evaluation of data for this study was performed using three steps outlined by Miles and Huberman (1994): data reduction, data display, and conclusion drawing and verification. The first two stages are tools for analysis. Data reduction includes coding paragraphs or segments of text with a keyword or theme, identifying patterns, summarizing, etc. Miles and Huberman (1994) state, “data reduction is a form of analysis that sharpens, sorts, focuses, discards, and organizes data in such a way that “final” conclusions can be drawn and verified” (p. 11). This transforms data into smaller units that can be reviewed easily (Polit & Beck, 2006). Qualitative descriptive studies utilize a form of analysis called qualitative content analysis (Sandelowski, 2000). This focuses on summarizing the data, and hence, is less interpretive than other methods, as mentioned earlier. Content analysis is done by reading the interviews and generating codes that are coming from the text. Unlike other methods, codes are not pre-conceived, rather data-derived (Sandelowski, 2000). This process required that I first read each transcript at least two times so that I was familiar with the data (Polit & Beck, 2006) even though I had conducted the interviews. However, this was important because some interviews were done six months prior to this stage. Then, segments of the interview were coded directly on the computer in Microsoft Word by assigning a theme that came to mind when reading the excerpt. Although the codes are data-derived, they are still applied systematically and are consistent.
The data display stage helps to organize and display information in such a way that aids analysis and making conclusions. Since an interview can produce over twenty pages of verbatim text (Kvale, 1996; Pope, Ziebland & Mays, 2000), this stage helped make information more compact and organized (Miles and Huberman, 1994). This step was performed by highlighting narratives that displayed similar themes in similar colours on the computer. This helped to identify accounts pertaining to certain themes and find the accounts when talking about the categories in chapter three.

The third step, drawing and verifying conclusions, included identifying patterns and themes, exploring what they mean, clustering things into categories, and making sure conclusions are plausible and make sense (Miles and Huberman, 1994). This was done by reading through each narrative several times. If a theme or pattern was recognized in more than two of the transcripts, it was noted down on the transcript next to the specific excerpt that referred to it, as well as on a separate blank document. This blank document would eventually have a list of all the themes that were identified. The themes and sub-themes were then categorized and organized. This process involved many revisions and feedback from my supervisors. Finally, the themes were organized by major themes and sub-themes, keeping the initial research questions in mind.

This step helped to guide chapter three, which displays the results and discusses these categories in detail. It also helped to link the themes to the research questions, which is discussed in chapter four. The themes and sub-themes are summarized in Table 1, but are described in further detail in the next chapter.
### Final Research Categories and Sub-themes Derived From Data

<table>
<thead>
<tr>
<th>Final category</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migration Patterns</td>
<td>reasons for migrating to Canada</td>
</tr>
<tr>
<td></td>
<td>pre-migration perspectives on Canada</td>
</tr>
<tr>
<td>Post-migration stresses in Canada: Downward mobility</td>
<td>financial struggle</td>
</tr>
<tr>
<td></td>
<td>occupational challenges</td>
</tr>
<tr>
<td></td>
<td>educational challenges</td>
</tr>
<tr>
<td></td>
<td>post-migration effects on health and well-being</td>
</tr>
<tr>
<td>Other experiences and views rearing</td>
<td>perspectives on female roles and child</td>
</tr>
<tr>
<td>associated with migration</td>
<td>discrimination</td>
</tr>
<tr>
<td></td>
<td>changes in lifestyle</td>
</tr>
<tr>
<td></td>
<td>climate change</td>
</tr>
<tr>
<td>Coping strategies for stress and negative settlement experiences</td>
<td>personal / religious strategies</td>
</tr>
<tr>
<td></td>
<td>accessing family or community networks</td>
</tr>
<tr>
<td></td>
<td>avoidance</td>
</tr>
<tr>
<td></td>
<td>mental health services (limited)</td>
</tr>
<tr>
<td>Barriers in accessing health care services</td>
<td>lack of knowledge</td>
</tr>
<tr>
<td></td>
<td>stigma</td>
</tr>
<tr>
<td></td>
<td>ethnicity of provider</td>
</tr>
<tr>
<td></td>
<td>fee for service</td>
</tr>
<tr>
<td></td>
<td>economic marginalization</td>
</tr>
<tr>
<td></td>
<td>long waiting times</td>
</tr>
<tr>
<td></td>
<td>racism</td>
</tr>
</tbody>
</table>
Chapter 3: Results

This chapter provides a detailed report of the major themes, or categories, and sub-themes that emerged from the data that was collected in this study. Since it is a qualitative descriptive study, I focus on presenting various excerpts from the participant’s narratives to explain the themes. The next chapter will focus on an in-depth discussion of some of the major categories in relation to the research questions of this thesis.

Although the previous chapter provided details to the demographics of the nine women that were interviewed for this thesis, Table 2 displays a summary of the demographics of the sample. I will not provide a summary of the demographics of each of the nine participants separately, since it may risk their anonymity.
### Table 2

*Summary of Demographics of Participants in This Study*

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>25-29 years of age</td>
<td>3</td>
</tr>
<tr>
<td>35-39 years of age</td>
<td>2</td>
</tr>
<tr>
<td>40-44 years of age</td>
<td>4</td>
</tr>
<tr>
<td><strong>Country of birth</strong></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>3</td>
</tr>
<tr>
<td>Pakistan</td>
<td>6</td>
</tr>
<tr>
<td><strong>Length of time in Canada</strong></td>
<td></td>
</tr>
<tr>
<td>1-2 years</td>
<td>6</td>
</tr>
<tr>
<td>3-5 years</td>
<td>3</td>
</tr>
<tr>
<td><strong>First Language</strong></td>
<td></td>
</tr>
<tr>
<td>Punjabi</td>
<td>3</td>
</tr>
<tr>
<td>Urdu</td>
<td>5</td>
</tr>
<tr>
<td>Telagu</td>
<td>1</td>
</tr>
<tr>
<td><strong>Preferred language in Canada</strong></td>
<td></td>
</tr>
<tr>
<td>Punjabi</td>
<td>2</td>
</tr>
<tr>
<td>Urdu</td>
<td>2</td>
</tr>
<tr>
<td>Punjabi or Urdu</td>
<td>1</td>
</tr>
<tr>
<td>English (but may not be fluent)</td>
<td>4</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
</tr>
<tr>
<td>Married (living with husband)</td>
<td>5</td>
</tr>
<tr>
<td>Married (living alone)</td>
<td>2</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
</tr>
<tr>
<td>Never married</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note.* Marital status was not asked in the demographic questionnaire, rather, was uncovered in the interviews. All women had children, except one participant who was never married. This information is important to understand the context of women’s family life and their lived experiences.
Although all nine women who participated in this qualitative research came from different lived experiences in terms of class, education, ability and age, there were similarities in their pre and post migration stories that bonded them together. They had similar reasons for migrating to Canada and hopes for their future. They endured similar experiences that they found stressful, as well as aspects of migration that they found positive. In this chapter, these aspects will be addressed through the rich narratives that were collected in the interviews. This chapter is particularly important because it reports the unique experiences and documents the voices of immigrant South Asian women. Since very little has been documented, these first hand accounts can help to further our understanding of pre and post migratory experiences.

This chapter is divided into five sections that will report the findings. Section I will address the reasons women discussed for migrating and their pre-migration perspectives on Canada. Section II will define the salient post-migration stresses in detail. Major stressors included financial struggle, occupational challenges, educational challenges, and post-migration effects on health and well-being. Other negative experiences included perspectives on female roles and child rearing, discrimination, changes in lifestyle and climate change. However, women did not focus on these experiences as much. Section III discusses some of the positive aspects or benefits of migration and what the women, although having reported predominantly negative experiences, think they have gained in coming to Canada. These benefits included financial support from government, educational opportunities, gender issues including safety, freedom, and independence for females, and integration into Canadian society. Section IV will talk about the different coping strategies that they women discussed in order to deal with the negative stresses and settlement experiences in Canada. The major coping strategies that they reported were: personal and religious strategies, accessing family and community networks, avoidance of their problems, and accessing mental health services. However, the last was very limited. Finally, section V discusses the barriers that women reported in accessing primary and mental health care. These barriers included lack of knowledge, stigma, ethnicity
of provider, fee for service, economic marginalization, long waiting times, and racism. Please note that Table 1, in the previous chapter, also provides a summary of the final categories and sub-themes that are discussed in this chapter.

1: Migration Patterns

Reasons for Migrating to Canada

The nine women that were interviewed for this research study talked about their reasons for migrating to Montreal, Canada. They had similar negative experiences in their home countries of India or Pakistan, or in some cases, like for participants 3, 6, and 7, in the United States of America. Eight women said that their reason was to escape political, police or family related problems in their home country. Four of these women came directly to Montreal, while three women (P3, P6, P7) went to the United States first, and one woman (P8) went to Toronto, before coming to Montreal.

The problems in their home country were posing, or were beginning to, a threat to their safety and the life of their children, if they had any. In this excerpt below, one woman described her terrifying experience with the police in India, which was a similar experience for participant 2 as well, although she did not wish to discuss it in such detail as participant 1. In this excerpt, she described feeling severely threatened and knowing that her safety and the safety of her two young children were at risk:

My brother-in-law and my husband, police used to say to them that you both are involved with terrorists and so the police and other officers here want to kill you for no reason. That’s why they wanted to kill my husband and brother-in-law. So the two of them used to run and hide, and the police would look for them. That’s why the police used to find me and my kids and say, tell us where they are, so they used to beat my kids badly and me too….. I knew that my husband and my brother-in-law were innocent. Police was after them for no reason, just for money. You know, the Punjab police can do anything for money. They can catch each other even, make false accusations at anyone, to get 10,000 rupees for someone,
Participant 1 also explained that her living in India had become very difficult because there was nowhere that she could hide from the police. Her relatives and friends also refused to house her because of the fear that they might also be caught. Therefore, her relatives, including her mother-in-law and father-in-law, all advised her that it would be best if she left the country for her safety and the safety of her children. They were willing to support her financially and help her to get to Canada.

Another six women also reported fleeing their home country in the midst of threatening or negative situations, due to either family or political tension. Participant 4 reported that political problems between religious groups in Pakistan had made it very difficult for her family to live peacefully. Although they were very well settled in Pakistan, they were forced to leave their business and extended family to come to Canada.

People who wanted to kill Shias, and because of the attacks, we left our house and the country. Because they also started bugging my husband. Threatening that they would kill him too...They said we will not leave you alone too (P4)

Three women (P3, P6, P7), who also fled from problems in their home country, reported trying to settle in the United States of America first. Shortly after they migrated there, they were impacted by the bombing of the World Trade Centre on September 11, 2001, an event that is frequently referred to as 9/11. Again, they reported that they felt unsafe and threatened staying in the United States and decided to come to Canada. All three women left the United States within seven months following 9/11. Participant 6, below, talked about her experience in the aftermath of 9/11. She described the impacts as very stressful for South Asians, but in particular Pakistanis. She talked about the lack of safety and peace she felt living in the United States, which made it pressing to leave.

It happened in 2001. We got scared....we thought we should go, but it was so hard. We were so scared to even go out of the house, scared of our
appearances, our clothes... Even if we had to go get vegetables or milk, I would leave my daughter with my neighbors. Because if something ever happened to me, at least the girl will be safe and sound. Life was getting more miserable there... Also, they would come to your house in search of someone, because of the 9/11 thing. So, we couldn't live peacefully... I didn't even go out, or go on the train at all. I went nowhere. I did all my shopping downstairs. We were stuck inside for 3 months... Pakistanis all stayed in. People who had a business would disguise themselves to go out. They would wear T-shirts and pants. I used to stay away from that area where it was bad. I was in Historia, but people who were in Brooklyn, they had changed their appearances to look Jewish. They put a scarf around their necks and put on a tie, so that no one could attack them if they went out to pick up the kids or anything. (P6)

Participant 7, one of the three women to migrate to the United States temporarily, also described the aftermath of 9/11 and the effects it had on her and her daughter.

I was so scared at that time maybe they caught me and send me to Pakistan. Maybe they deport me... so I wear trousers, and shirts, not in my culture dress. Never I speak Urdu. And never go out more than ... more than one hour, or maybe in the car or anywhere. Because I was scared. Maybe they caught me and they send me back (P7)

For this participant, living in the United States had also become unsafe and restrictive, but she also feared being sent back to her home country of Pakistan. Therefore, both participant 6 and 7 talked about the threat they felt being Pakistani women living in a post-9/11 situation. They both reported having to change their way of dressing from a cultural to a more Western style, not being able to speak their native language, and having limited freedom to go out. Both women also mentioned that many Pakistanis were being questioned after 9/11 and being sent back to Pakistan. They feared having to return to their home countries. The third woman, who also temporarily resided in the United States (P3), did not talk about her experiences or feelings after 9/11, but also said that it was necessary for her to leave since she also had 2 young children.
One woman (P9) reported coming to Canada by choice and had not experienced any traumatic or threatening experiences in her home country of Pakistan. She talked about coming to Canada purely in search for a better life with her husband. They believed that they would be able to have a better future for their family in Canada, rather than Pakistan, as qualified professionals. Although the other eight participants had migrated to Canada less willingly, they also shared similar pre-migration perspectives on Canada as participant 9.

**Pre-migration Perspectives on Canada**

All nine women talked about their hopes and expectations in coming to Canada, regardless of their reasons for leaving India or Pakistan. They conveyed that they anticipated a better lifestyle and standard of living, in a more developed country like Canada. Many of these views or expectations of Canada were formed from what they had heard from friends or seen in movies. They admitted that their expectations included living a better life as a result of better facilities, able to find a job easily, better occupational opportunities, increased salaries, saving for the future, improved educational opportunities for their children, etc.

One woman (P9), although she migrated to Canada by choice, discussed the improved environment she dreamt of when coming to Canada. She reported that this is typical of many South Asians who come from India and Pakistan. For her, this improved environment is related to cleanliness of food, health services, and the general atmosphere.

We Asian people, when we come here we have a lot of dreams. We, we think that there are a lot of good facilities there. Obviously the facilities in Pakistan, and the facilities here, they are much better, because emergency there in Pakistan is not clean. The beds are not clean. Here they try to keep everything so much clean. The atmosphere is clean. The food is clean. And these are the main things which make us ... - that, that make a good dream in our mind, that when we will go there we will enjoy these things. We will enjoy the good atmosphere, we will enjoy the good food. Because in Pakistan the food is not good. So we people think that these things we will get from abroad (P9)
Although all of the women shared the same pre-migration perspectives as participant 9 in terms of life in Canada, they all also expressed concern and uncertainty for their future and what they could really expect in Canada. One woman (P6) recounted her feelings of uncertainty in coming to Canada, and particularly the fear she felt in losing a part of her culture and not being able to pass it onto her daughter.

Before we came, we were scared about what we would do, how we would live, how will we find a home and a job. These normal problems...I feared that to what extent will we be able to save our culture. When people come here, they adopt the Western culture. Maybe with the first child, maybe even with the second child, I will be able to maintain it, but when she meets people and her in-laws, they might not enforce it. We have to struggle a bit more to maintain it. It's like we have jumped into a body of water, and we have to decide whether we want to drown or keep swimming (P6)

In this excerpt above, the participant stated a very interesting metaphor that relates to the integration process. For her, culture is integral to who she is and she wishes to maintain certain parts of it to pass on to her daughter. She described drowning as a complete assimilation process, where she would be adopting all aspects of Western culture, and being able to swim as an integration process, where she would adopt parts of both Western and Pakistani culture.

Summary

Section 1 reported the migration patterns of the nine women that were interviewed for this thesis. This section is important because it helps us to understand the circumstances which perpetuate migration. For eight of the nine women, coming to Canada might not have ever been a consideration had it not been for the threatening or unpleasant situations in their home country. Those eight women had experienced negative situations in India, Pakistan or the United States of America, which provoked them to migrate and now settle in Canada. Their negative situations were related to problems they were having with family, the police or political tensions. Only one woman had migrated to Canada by
choice, in search of a better life. It is important to highlight that women came to Canada involuntarily due to circumstances in the U.S.A. or their home country. Being forced to leave your home may alone be a source of stress, and add to the negative experiences that immigrant women have.

All nine women discussed their pre-migratory perspectives on Canada and what they expected and feared. They talked about their dreams and what they hoped they could gain in Canada, as well as the uncertainties they felt, which seemed only natural. However, the actual benefits that they gained in coming to Canada are discussed in this chapter in section III, since the actual results of their migration to Canada were reported to be primarily occupied by negative and stressful experiences related to daily living and the settlement process.

II: Post-migration Stresses in Canada: Downward Mobility

All of the women interviewed talked about the difficulties and challenges that they encountered as new immigrants to Canada, and still encounter. All of them, having been in Canada from one to five years expressed current and ongoing struggles related to their finances, employment, and education. These particular difficulties seemed to be prevalent in all of the narratives and were reported to have a negative impact of health and well-being. This was referred to as downward mobility. There were also other challenges that they faced, or are facing, in the settlement process, such as change in lifestyle, change in climate, and perspectives on female roles in Canada, but these factors were reported to be less negative or influential on their health. All of these difficulties were compounded by the shock of arriving in Canada, where their experiences were nothing like they expected.

All of the women reported that the idealized view of Canada that they had before migration, was in fact a false view in most respects, and not at all reality for any of them, at least during the time of the interview (early 2004). Below, participant 8 and 9 expressed their views of their initial reactions of Canada, or how they have come to feel now.

What is revealed there, in other countries, about Canada ... is totally different, a different picture is given than what exists in reality here ...
people are not prepared for the shocks they receive here......nobody knows the difficulties of managing, especially the first few years, in Canada. And they think I'm lying. .....But ... not much is being done to integrate or make life easier for the immigrants, especially the women. It's very difficult. And especially for women who come alone and are here managing alone. It's really hard.... And as time passed I realized the magnitude of what I have gotten into (P8)

In her interview, participant 8 described the difficulties she has had in Canada and how she, like many immigrants, was not prepared for them. She said that the picture that is painted of Canada is not a reality, and that there should be information centres or some way of getting more information on what life would really be like for a new immigrant. She also felt that the settlement process was particularly difficult for her, not only as a woman, but also as a single woman in Canada. Although none of the women interviewed had pre-existing networks or relatives in Canada, participant 8 said that women who come with families perhaps have the support of their husbands, however, she did not have that kind of support. There were three other women (P1, P2, P7) who had also come to Canada alone. Participant 7 is a divorced woman with a daughter, and both P1 and P2 had come to Canada with their children, not knowing where their husbands are. Therefore, the settlement process for a woman living alone, without any male support or additional adult in the house, was reported by these four women to be even more difficult.

Participant 9 compared the view she and her husband had of Canada before migration, as a result of the idealized picture that the media paints, and what they have learned after migration. In her interview, much of her worry centred around the future of their baby, because she realized that Canada has not given them the opportunities that they migrated for. For this participant, since migration was by choice, it was even more disappointing for her because she did not have to leave Pakistan. She truly thought that Canada would bring her family increased opportunities and a better standard of living.
We think we are going to the place that is MUCH better than our country. It's much better than our homeland. But when we come here, it creates a lot of depression because when you see other people they're in good condition, it really depress you...It was just like a dream... when we saw the movies, we saw very beautiful places, very beautiful houses and I was thinking that everything will be so much nice, and I will spend a very good time there. But believe me when I came here and I saw different type of problems...I was just I will think that I will die. I will die soon. (P9)

All of the women, like participants 8 and 9, expressed the same reactions related to coming to Canada and not expecting the circumstances that they were subject to. Life in Canada was not like the pretty picture that was portrayed to them. The women reported that certain difficulties, particularly financial struggles, occupational and educational challenges, have all had a negative impact on their health in Canada.

Financial Struggle

Financial difficulty was a major concern for all of the women interviewed, whether they were living here alone, as a single mother or with their family. Below are two accounts of women (P6, P9) who talk about their daily financial troubles, and the effects this has had on their immediate and extended families. Participant 6 talked about her familial and cultural obligations to her younger siblings back home and not being able to fulfill them by sending money to them since she herself did not have enough financial support to live here. Another concern for her was the concept of loans and not owning your own property in Canada, which was common in Pakistan. In Canada, she reported that they had no assets, but rather, just enough to live day by day.

Here, you live hand to mouth, we can’t send money back home for our family, we’re so poor we can’t even give some money to the homeless. I want to explain that you have so many duties, but we can’t fulfill them. I have younger sisters back home, I want to help them, but I can’t support them. If I even want to visit them, I can’t, there are too many expenses.
Here, you spend most of your day working hard, but still you live hand to mouth. You can’t do anything for your wife, invest in property or save for the future. Everything is about taking loans. Nothing is yours (P6).

Participant 9 also talked about the financial struggles she has encountered since coming to Canada with her husband. This participant talked in more detail about these struggles and how they have impacted her needs and her newborn’s needs.

He (my husband) is without money. When I came here he has nothing, and now we have a baby so we have nothing. That’s why I was in severe tension...Because if I am cutting down my – all the expenses, I can’t cut down my baby’s needs. Because my baby’s needs are the priority... (but) it’s so difficult to buy the diapers. And so difficult to buy the milk for the baby. That’s why I try my best to keep my baby on breast feeding...I do not spend a lot of money on the milk, on the other milk. And as regarding me here, you know the milk is so expensive, then the other needs, all the ... eating stuff, they are so expensive...believe me, I didn’t buy even one clothes for my baby from here. My parents, they send the clothes from Pakistan to me....I was even not able to buy things from here. And how – you know, if I am in tension, obviously my baby will be in the tension because she is getting my milk. All the time I can’t leave her crying. All the time I can’t leave her ... like this. She had nothing in her stomach. I can’t leave her like this. It’s so difficult to spend the time here...(P9)

In this excerpt above, the participant reported that their worries centre around their newborn. Their financial condition does not permit them to provide their baby with the essentials, including diapers, milk and clothing. So, although this participant migrated by choice with her husband, she reported that Canada is not at all what she expected it to be. She talked about other areas of their life that have also been impacted by these financial struggles. Not only is she finding it hard to provide for her baby, she said that they can not pay the rent for their apartment, for health services that she needs, or essentials such as food and clothing.
These accounts demonstrate that immigrant women and their families have a difficult time settling in Canada, due to their financial struggles. All the women that were interviewed described economic hardships, partly due to their employment situations and not being able to earn money.

**Occupational Challenges**

All of the participants talked about financial struggles, as noted about, however, they also reported that most of it stemmed from not being able to find appropriate or paid work in Canada. Table 3 lists the occupations of women in their home country and their current occupational situations in Canada. Each participant’s occupational status is listed independently, since I felt this information is not sufficient to reveal any of the women’s identities.
Table 3

*Occupational Positions of Women in Home Country and in Canada*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Home country</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Homemaker</td>
<td>Under-employed</td>
</tr>
<tr>
<td>P2</td>
<td>Homemaker</td>
<td>Un-employed</td>
</tr>
<tr>
<td>P3</td>
<td>Homemaker</td>
<td>Homemaker</td>
</tr>
<tr>
<td>P4</td>
<td>Homemaker</td>
<td>Homemaker</td>
</tr>
<tr>
<td>P5</td>
<td>Homemaker</td>
<td>Under-employed</td>
</tr>
<tr>
<td>P6</td>
<td>Teacher</td>
<td>Un-employed</td>
</tr>
<tr>
<td>P7</td>
<td>Teacher</td>
<td>Under-employed</td>
</tr>
<tr>
<td>P8</td>
<td>Engineer</td>
<td>Under-employed</td>
</tr>
<tr>
<td>P9</td>
<td>Medical doctor (candidate)</td>
<td>Homemaker</td>
</tr>
</tbody>
</table>

*Note.* Under-employed meant that women had had contract jobs involving manual labour in factories in the past, and were searching for work. However, only P5 was employed at the time of the interview. Un-employed referred to women who were searching for a job, but had never been employed in Canada.
As listed in Table 3, all of the participants who expressed a desire to work in Canada were either unemployed or underemployed. Three women were homemakers in Canada, two of whom (P3, P4) did not wish to work in Canada and another (P9) who could not work because she was at home caring for a newborn. All of the women expressed unhappiness in the occupational challenges that they themselves, or their husbands, faced. The barriers that they expressed were primarily related to not knowing about accreditation of foreign degrees and lack of fluency in the French language.

*Foreign professionals.*

Four of the women (P6, P7, P8, P9) held professional designations from their home countries: two were teachers with teaching certificates from outside of their home country and outside of Canada, one was completing medicine in Pakistan, and one was an engineer with two Masters' degrees. Three of these women (P6, P7, P8) had also held respectable paid positions in their home country. So, these women were very dissatisfied with their occupational positions in Canada. Participant 6 explained that she felt there was no respect for the teaching profession in Canada, as there was back home, and that she had a very difficult time finding a teaching position although she was fluent in English. She reported that she was sewing at home for some money, since neither her husband nor her were employed at the time of the interview. Participant 7, also a teacher in Pakistan, reported that she too could not get a teaching job in Montreal, and that it was even difficult for her to get any other kind of job because of her lack of French fluency. This participant explained that she was considering moving to Toronto because of the language situation. Although she would be able to communicate with people in English in Toronto, she is aware that she might not get a teaching job, but expressed hope that she would be able to get some kind of paid work.

Even I can't do work at McDonalds or Tim Hortons or anywhere, because I'm not bilingual. And just to learn a language is not the deal of few days. It will take time. (P7)
Participant 8 also reported that she was troubled by the fact that she could not find appropriate work as a qualified engineer and wished that she had known about how and which degrees are recognized in Canada before migration. She described that it was very important for foreign trained professionals to get this information, since it is a shocking reality when they come here and are either unemployed or doing menial low paying jobs.

Participant 9 talked about difficult it is to get a job without knowing French and again, how it would help to know which degrees or skills are accepted in Canada before coming here.

Everybody say that we want bilingual. And I do not know French. It’s not my fault. From the first day I was saying that I, I will do any type of job. And I also told them that I will do a job of salesman, and I was doing MD in Pakistan.... so when anybody takes immigration, the government SHOULD say then that before coming here, you should learn French. The government didn’t tell me that if you do not know the French, you should not come here (P9)

*Non-professionals seeking employment.*

Three other women (P1, P2, P5), who did not have neither paid jobs back home nor formal educations past the elementary level, expressed that they desired to get jobs in Canada to make ends meet. However, they also talked about the difficulties they encountered in finding any kind of stable work, due to their lack of French language proficiency and because the jobs offered were always short-term contracts. Not only was it hard for them, but five women (P3, P4, P5, P6, P9) also reported that their spouses also encountered the same difficulty and could not find suitable work that complemented their qualifications. Most of their spouses participated in family-owned businesses in their home country, such as clothing companies and grocery stores. Some of the women reported that they have resorted to manual labour in factories, organizing shelves in toy stores, and babysitting jobs.

Participant 9 talked extensively about the difficulty her husband, a qualified and practicing dentist in Pakistan, has had in finding employment. She
described the different jobs her husband has even considered as a qualified dentist, but explained how shameful it was for them when he had put so much time and effort into his education in Pakistan. At the time of the interview, she reported that he had not considered what they thought of as more menial positions such as delivering pizza and janitorial jobs, since it would be too offensive to their education.

He (my husband) was doing different jobs. Sometimes he went to … telemarketing companies…sometimes he was on welfare also…(but) he can’t wash the floor. He can’t go out to deliver the pizza. He can’t … do this type of job because in Pakistan he … he spent a lot of years for the education, and here he is even have problem of one dollar, sometimes two dollars, so it’s so impossible for him to go out and to do a lay job because when he, when he goes out to in search of the lay job, in his mind he is … in severe thought that “What I am doing? My education, it’s nothing.”

(P9)

All nine women, regardless of age, education, length of stay in Canada, or language proficiency, reported that neither themselves nor their husbands had found appropriate or paid work. They talked about how underemployment and unemployment has affected their financial positions, living conditions, and psychological well-being in Canada.

Some of the women talked about wanting to go back to school or enrolling in language classes so that they could find employment. However, enrolling in educational programs in Canada was also reported to be a challenge, increasing post-migration adversity.

*Educational Challenges*

Five women (P1, P2, P3, P4, P5) reported that either they or their spouses were enrolled in French or English language classes, in order to be considered for a job in Montreal. Therefore, their experiences with educational programs was limited to instruction in community centres. Two women (P8, P9) reported barriers to educational programs offered at the post-secondary level. In their interviews, they discussed the difficulties of having foreign degrees accredited in
Canada, and therefore, wanted to go back to school to get it accredited or retrain in their respective fields, so that they could work in Montreal. Two other participants (P6, P7) also had foreign certificates, in the teaching profession, but did not wish to return to school.

Participant 8 explained that she has made many efforts to get accepted into any educational program in Canada, but has only had acceptances from institutions in the United States. She said that she feared that the degree she may get in the U.S. may also not be accredited in Canada. In Canada, she reported that she has been declined acceptance for the past two years. So, she expressed discontentment with not being accepted to any program in Canada, but also reported dissatisfaction with the application process. She described the process of applying to an educational program as being a barrier in itself and not very relevant for immigrants with no job experience in Canada. In particular, she talked about the requirement of having reference letters, and she was only able to get them from her employers in India, having no work experience in Canada.

You know, one university said simply every time you apply we xxx, because I have to get references from the companies I worked with. I applied every year to the same universities. They said I have to get reference letters dated few months before application every year. One of the employers wrote back saying “Why do you ask the same kind of letter every year? Why can’t use one letter we sent?” Every time. This is right, that’s what we have to do. We have to give name xxx blah blah blah, anyway. But the employer won’t write every year you want to apply. Suppose it takes five years. He won’t - it’s a waste of time, and I work with big … companies where 6,000 people work. They won’t bother with such things (P8)

Another woman (P9) talked about her husband’s experiences with the education system in Canada. As a qualified dentist from Pakistan, he has been trying to get into a Masters program but has found it to be a difficult application process. He worked as a volunteer for over a year just to secure a supervisor, as many graduate programs require applicants to do before applying to the program. She
reported that he has been treated unfairly, and was not accepted because he could not secure a supervisor, although the supervisor had at one time said that they could work together. However, she said that she is still very disheartened by the fact that his qualifications from Pakistan are not accepted here in the first place.

My husband, he was a dentist and he was doing practice there. And he had a lot – he had a very good career. But they’re not accepting his degree. He ... tried to continue his study. And he tried ... many places, and the xxx also, the X Hospital because he wanted to start his MSc....he was not able to take admission in the MSc, because everybody was saying that there is no vacancy. So till now he is trying for the MSc ..... Yeah, he has been here, and he was trying for his MSc, but till now he’s not successful to take the admission. Because every time he went to the X Hospital, and he said to his supervisor that I want admission, and he did work there as a volunteer for at least one and a half years without ... without any pay. And now she said ‘they’re sorry. I can’t do anything because I, I found some other guy. ... Yeah, he was crying a lot when he came to me. He said that from the last one and a half years I was continue- continuously went to her, and but now after one and a half years she’s saying that I can’t do anything. It’s not justice. (P9)

These two participants talked about their struggles with the education system and the difficulties that they have experienced in being accepted into a program in Canada. They, along with other women, reported that the effects of these experiences, along with other negative stresses of migration that have been talked about in this section, have impacted their health.

Post-migration Effects on Health and Well-being

Financial struggles, occupational challenges and educational challenges have all been connected in many of the women’s narratives to reports of a decline in their mental health. For example, when describing a negative experience around finances, they mentioned key words or phrases that might imply that this was affecting them psychologically. The following narrative is a clear display of the interconnectedness of these negative experiences. In this narrative, participant
8 talked about how her occupational difficulties have affected her finances, and how her finances have led her to be underemployed in positions that are not to her standard because of her need to have some financial support.

After coming to Canada it’s been really difficult to find a job. And this has caused a lot of emotional, financial and all kinds of stress, and it affects every day life... And I was working there for a year and a half. It was really good but it was ... it was ... physically very demanding, but because ... it’s like a sub-level job I had (to take it). ... need for finance, money, people take it, but after a few months, say after six months or a year, people – You get the feeling ... you can’t go on with this kind of job for say six years or ten years. It really affects one’s psychological thinking. (P8)

Another woman reported that her financial struggles and lack of money has really affected her health and her access to health services. She explained that she could not afford to pay the bill from 911 emergency services because of her financial situation and makes several references to death.

When I was fainted, I told my husband that no need to call 911. It’s better to die, to go to 911. I do not want – let me die. If I have any problem, please do whatever else by yourself. No need to call them. I do not want to go to hospital because if ... if they will bring me to the hospital, it – obviously he needs some ... support, some transport, so I said no need to call them... (P9)

This participant also described how her financial situation has affected her mental health by referring to the words “tension” and “depression” repeatedly in the interview.

He (my husband) is without money...... That’s why I was in severe tension...... when we come here, it creates a lot of depression (P9)

Five participants (P2, P6, P7, P8, P9) talked about how the effects of these post-migration difficulties have had an impact on their health or mental state. This can be an indication that many immigrant women who come to Canada, either alone,
Mental health of South Asian women

with children or with entire families, experience many barriers and stressful situations that can have an impact on their mental health.

Other Experiences and Views Associated with Migration

The nine women interviewed also reported other experiences and views they have developed following migration. The participants described their perspectives on female gender roles and child rearing, experiences which were a result of discrimination and changes in lifestyle and climate in Canada. The women explained that these changes were not as stressful as the other experiences that they described in this section. However, they felt that these experiences have made them reminisce about their home country and make comparisons between the two countries during the interview.

Perspectives on female roles and child rearing.

All of the women interviewed reported some negative views on how they saw women in Canada and their roles. As is described in chapter one, Indian and Pakistani women uphold strong feminine characteristics and feel that their role in the family is of a nurturer. Although, they reported it to be a benefit that women were more independent and safe in Canada, there were some attributes that they did not like about women raised in a Western society.

Below are excerpts from the interviews of three women who expressed their views on women in Canada. One woman (P2) explained that women in Canada are too open in their interactions with the opposite sex and that their behaviours are different from that of Indian and Pakistani women.

Us Indian women don’t talk to just any man, they don’t care at all. They talk, they drink, they smoke. We don’t do all this (P2)

Another woman (P5) talked about her views on the role of women with respect to the dynamics between a husband and wife in Canada, and why she thinks the divorce rate might be higher in Canada than in her home country. However, she reported that she realized that some of her views on women as caregivers were false. She explained that women are not as neglectful of their children as people in Pakistan and India had thought they were.
I don’t know that much about them, because I’ve never really talked to them because of the language problem... But how a husband and wife interact, I don’t know, because I’ve never talked to them that much. I have heard though that they don’t give time to each other, or their kids don’t turn out good, or there is a divorce at least once a year with them, and that’s what we think in our country about them. But after coming there, I don’t feel that way about their children, because I’ve seen their mothers on parent’s day, they attend meetings and they know everything about their children. So, I don’t think that they don’t, but why they have divorces, maybe because the women are too independent. Men and women are seen as equals. So, maybe that’s why they have some problems. But for sure, in comparison to our country, there is more divorce here (P5).

In contrast to participant 5, participant 6 reported that she still feels children in Canada are not given enough attention. She talked about the outcomes of not knowing where your children are and how this can lead to dangerous situations. As a mother of a young girl, she explained that it was even more critical for women to know where their daughters were and what they were doing, so that they would not be harmed.

I don’t feel that peace here. Kids go out and parents don’t even know where or when. Especially when the kids are older, parents don’t know anything about where they are and with whom. They show it in the movies, that on first dates they go for coffee, ice cream and she brings him home and they start to be together. She then learns that he doesn’t know how to treat her, uses violence with her. But why did she have to bring him over in the first place? If she didn’t bring him over in the first place, she wouldn’t have been the target of his violence and been stuck in this situation (P6).

Although all nine women expressed some negative views on women in Canada and their roles and interactions with the opposite sex and their children, five women in particular (P1, P3, P5, P6, P7) reported that they did not want their daughters to develop these interactions with the opposite sex or learn the values
that women in Canada are raised with. Also, the views that the women expressed were based on their own perceptions because none of the women had developed a relationship with Canadian women or talked to them about these views to verify them, since there was a language barrier for some of the women, and others already had friendships within their own community.

**Discrimination.**

Some of the participants described experiences where they were a target of discrimination or felt they would be. Three Pakistani women (P3, P6, P7) described their experiences in the United States of America after 9/11. They reported fear in going out of the house, not knowing what would happen to them or if they would even return home. One woman (P6) felt so scared that she would leave her baby girl with neighbours when she went out to run an errand, so that nothing would happen to her daughter.

We were so scared to even go out of the house, scared of our appearances, our clothes...Even if we had to go get vegetables or milk, I would leave [my daughter] with my neighbors....Because if something ever happened to me, at least the girl will be safe and sound....Life was getting more miserable there... they would come to your house in search of someone, because of the 9/11 thing. So, we couldn’t live peacefully (P6)

The other two women also reported fear when leaving the house, especially with the way they dressed. One of the three participants (P7) has changed her attire to Western clothes entirely, even in Canada. She reported that she no longer wears traditional Pakistani clothing because she does not want to be stereotyped. Another participant (P9) talked about an incident outside her apartment building in Montreal, where she was walking on the sidewalk and people from above on a balcony threw an egg at her. She was also pregnant at this time.

At that time I was seven and a half months pregnant....I don’t know which floor, there was an egg they threw on me....Then I stepped forward again, another egg they threw on me. And I saw up – it was dark, because it was night, I saw a person, he was throwing eggs again and again....I started
running because I thought that today is 11th September, maybe they do anything. I was so much scared (P9)

This participant also felt that her experience was linked to the aftermath of 9/11. Therefore, although none of these participants identified their experiences using the words discrimination or racism, they felt they were linked to 9/11 and were attitudes towards all Pakistanis or South Asians.

Changes in lifestyle.

All of the women talked about how there has been a shift in their lifestyle. Many reported their lifestyle in India or Pakistan being much easier, and wished they could return to their home country, but would not, given the problems that forced them to migrate in the first place. This woman talked about the change in her lifestyle and how she frequently reminisces about her native country.

Of course there were problems that caused us to come here. Who leaves their home? We had everything in Pakistan, a car, everything. We had our own home. I still think about our home a lot, I wish in my head that I could just fly back home, amongst ours. Brothers and sisters are all there. I miss them a lot. There everything is easier. Here there is no one to clean the toilets for you! (P4)

All of the participants, except for participant 9 for whom migration was a choice, were forced to leave their home countries, since there was a situation that was making it difficult to continue living there. They reported that they were comfortable in their home countries, with respect to their financial, occupational and educational positions. Therefore, this change in lifestyle, particularly not having cooks and servants, has been an adjustment for them. They reported that it was difficult for them the first time to go out and buy groceries by themselves, where as in India or Pakistan, they have people deliver it to their door or selling fresh vegetables and fruits on the street in front of their house. This was especially difficult for the women who had first arrived to Canada in the colder months and their first experience of going out was very different.
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Climate change.

All the women who were interviewed talked about the climatic change, comparing it to their home country, usually in a humourous way. They talked about it being very cold, seeing snow for the first time, and having to wear layers of clothes to go out. This was a dramatic change for these women, since they were used to warmer temperatures in India and Pakistan. However, this change, although difficult for them, was not reported as a negative experience for them and it did not affect them psychologically. Many of the women have not become used to the colder weather, and some reported enjoying the snow.

Summary

The nine women interviewed reported their most negative post-migration experiences in Canada as being the lack of occupational opportunities, financial struggle and barriers in the education system. These three issues were all interconnected, since not being able to get a job could be a result of not being able to get a recognized degree and also affected a participant’s financial condition. Although the women talked about other negative experiences that they have had during the settlement process, such as, perspectives on females and childrearing, changes in lifestyle, and change in climate, they were not as stressful for the women and were not reported to impact their health and how they felt about Canada.

All of the women identified at least one of the negative experiences of financial struggle, occupational and educational challenges, as a post-migration difficulty. For many, the three factors were interconnected. However, regardless of how many of these they experienced, five women (P2, P6, P7, P8, P9) reported that it has affected them psychologically. Participant 9 also said that it has affected her spouse emotionally.

The four remaining women did not talk about their feelings and how the negative experiences of migration have affected their health, but articulated that they had experienced these difficulties. Perhaps, it could be due to their hesitance in revealing personal feelings to a stranger or a coping strategy, as will be discussed in a later section of this chapter.
III: Benefits / Positive Experiences of Migration in Canada

The interviews were structured to focus on the research questions being examined and discussed the immigrant women’s experiences after migration, the stresses and issues that caused a decline in their mental and physical health, and the coping strategies they use. However, the women also talked about the positive and important aspects of migration for them. These positive aspects included financial benefits or advantages that they would not get in their home country, improved educational opportunities for their children, and the integration process. The integration process was described by these women as having two parts: adapting and maintaining. Adaptation was important so that the women could benefit from gender related issues that gave the women increased safety, freedom and independence in Canada. Yet, maintaining their own culture and raising their children to respect certain aspects of their culture was also important.

Financial Support From Government

Although all of the nine women expressed difficult financial situations, and talked about it being a major stress in their lives, five women (P1, P2, P3, P4, P5) expressed gratitude to the government of Canada for helping them cope with this difficulty. Below is an excerpt from the interview of one woman who reported that she is grateful for all the help her family is receiving from welfare, but still hopes that the occupational challenges her family is facing will get better.

They (the government) are helping us till now even. They are giving us welfare. If we didn’t have that, that it would have been very difficult, because we wouldn’t have even had a job. How would we have run the house? We are grateful to them that they are helping us and doing lots of things for us. We are hoping we get a good job and end welfare (P4)

Other participants also said they were thankful for financial support, such as welfare, during their settlement period in Canada, but did not feel it was enough. Participant 9, for example, felt that there were too many rules and conditions under which someone would receive help. She explained that her husband could not receive welfare for her, for a certain number of months, and also that when they had a baby, the baby bonuses that the government provided were also for
only a certain number of months. She explained that this was extremely difficult because when the payments stopped, they could not afford the necessities to care for their baby, due to their poor financial situation.

*Educational Opportunities*

Six of the eight women who had children talked about the educational benefits for children. They reported that this was one of the main benefits that they anticipated even before migrating. Educational benefits for these women were in different shapes and forms. One woman (P2) stressed the importance and benefits of having educational facilities for special needs children, which is not common in India. She explained that special needs children are not given a chance to develop in India and that they are shunned by society. Another woman (P7) explained that she was happy that her daughter had the opportunity to learn other languages other than Urdu, like English and French. Another woman (P5) described the advantages of these educational opportunities for women. She explained that raising a daughter in Pakistan is very difficult, since girl children are not given the same opportunities as their male counterparts. In Canada, she can raise her daughter with the same education as her sons.

*Integration Into Canadian Society*

Integration into Canadian society is an important process. Eight women (P1, P2, P3, P4, P5, P6, P7, P8) talked about the benefits of the integration process. They explained that this process allowed them to adapt to certain aspects of Western culture, yet retain integral parts of their own cultural and gender values. In this way, they could have the best of both cultures. Parts of Canadian society that they felt comfortable adapting to were related to issues that were particularly beneficial to them as women: safety, freedom and independence.

*Adaptation: gender issues.*

Benefits related to gender issues were reported by seven (P1, P2, P4, P5, P6, P7, P8) of the eight women. They made comparisons between the freedom, safety and independence of women in their home country and here in Canada. They reported being pleased with the status of women in Canada and felt a sense of freedom and safety, something they did not feel in India or Pakistan. One
woman discussed the safety she feels when walking outside alone at night. She explained that, in her home country, women are often accompanied by a male member of the family if they want to go out, especially after dark.

I would be at my friend's until midnight talking, so I would be walking around in my area alone very late at night. So, I'm doing this because there is no fear, right? It's not like that there, only if my husband is with me will I go out at night, or I won't go alone. (P4)

One woman, a survivor of an abusive marriage, discussed the experience of having an abusive partner in Canada as much different than in Pakistan. She explained that she suffered emotional trauma as a result of her marriage and the divorce process in Pakistan. She reported that it was very difficult for a woman to end a marriage unless the husband asked for the divorce. Pakistani society, as she explained, was very much in favour of the male gender. When she left her husband in Pakistan, she said that her family would not report it to the police in the fear that they would be endangering their lives because her estranged husband might hurt her. In Canada, she felt that women would be able to report abuse to the police and be able to get a divorce much easier. She considered it a benefit for women to have equal status and the freedom that they have here.

They can choose life for themselves. And even if they don't like any decision, they can oppose. That's like they can help, they can have help from the police, from authorities. Even when ... when my husband - my husband beat me, other ... I came to my mom's house. My mom doesn't ... doesn't told anybody. No, they didn't call the police. They didn't call anybody. But now if somebody beat me, or beaten by anybody, or maybe have some kind of accident, they can call the police and report (P7)

The women also described a change in their roles as women. This change was mainly related to their feelings of independence. This compounded with the safety and freedom that they also described, resulted in more self-confidence.

One woman described the change she has noticed in herself. She compared her agency in India and Canada. She explained that as a woman in India, she was
raised by her parents to listen to her elders and not question them when they make a decision. Now being in Canada, she has felt a surge of independence since she makes her own decisions.

When I lived in my country, I was homely woman, whatever someone told me, I listened, they told me to sit, I sat there, but now whatever I like, I do. Before I did only what others liked, ok, it’s good, if someone asked me if it was ok, I said it was ok. But now whatever my heart desires, I eat, I wear, whatever I like (P1)

Another woman reported a similar change in her role, as a result of increased independence and confidence in Canada. She explained that in India she could not go out alone, or would always be accompanied by a male, not because of fear, but because she was a woman. Her role in India was limited to the home otherwise.

After coming here, I feel more confidence. I go out now, I learned something, I did something myself, learned to do stuff outside, so I feel confident. Before, in India, we used to think that I couldn’t do anything alone. I didn’t like to go out alone, but it’s not like that here (P2)

These women reported feeling more safe, free, and independent as Indian and Pakistani women living in Canada. They reported that they could not receive these benefits in their home country.

Adaptation: culture.

Seven (P1, P2, P3, P4, P5, P6, P7) of the eight women also reported that the integration process allowed them to adapt to certain aspects of Western culture and that this was particularly beneficial for raising their children since they could learn about both worlds. One woman explained that she teaches both her sons and daughter to embrace the good values of both cultures.

Because my kids are grown up now too, so they understand our culture.... Although they have their own thinking, own style, there are also lots of good things about people in Montreal and Canada. We like some of our own things too. So, we try that whatever is good, whether it’s from us or Canadians, that the children learn those (P5)
Another woman also talked about the importance of raising her daughter in both cultures and being able to assimilate. Although they are Pakistani, she explained that she does not feel that they should only form friendships within their ethnic community. Also because of the trauma that she experienced in her home country, around abuse and divorce, she discussed that there were aspects of her own culture that she felt were primitive and especially unfavorable to women.

I'm a different kind of person. I like to absorb the BOTH cultures. Both cultures. Because I have to raise my daughter in both way. Good points for my society, and the good points from the western society, from Canadian society. ....You have to live here, so be friendly with everybody. Don't make a circle around you just to be a Pakistani. No, no, no. You have to interact with all other cultures, all other religions, and share your food, share your ideas. Be friendly with them (P7)

Another woman, with a young daughter, agreed that there are aspects of each culture that she hopes to instill in her daughter. She also agreed that there are parts in her own culture that she hopes her daughter does not learn. However, for her it is equally important to raise her daughter to respect their own culture and not assimilate completely to Western ways. For example, freedom of women in Canada is important, since her daughter would not be able to live this way in Pakistan, but there are limits to the freedom she wants her daughter to have, as well as understand the meaning of freedom. She explained that the way women dress in Canada is not a path to freedom.

So, we have come, but I want that we adopt the good values from both cultures. She should know about our culture, and she does, she knows about our religion...we want her to blend in with society, but keep her close to our values too. I don't want her to be distant from our family or think that our ways are backwards. I want her to understand. But at the same time, she has to get more educated, but not go against her values. We want to raise her like that......I was saying that if I go to Pakistan, it doesn't mean that I will accept everything in that culture, no. You have your own thought, your own home, your own culture in that home that you
think is validated. If I live here, I will accept the good things. I will educate my daughter, give her the freedom to that limit that no one will treat her as a slave, or so that she develops bad values... Not to consider that if we are free from wearing clothes, we are free. This is no liberty. So it is not necessary that we accept everything here (P6)

Although the women interviewed talked about adapting to certain aspects of Western society, related to gender and culture, they still expressed that they wanted to retain parts of their own culture and gender values that they felt were important.

*Maintaining culture and gender.*

Maintaining culture and gender roles was expressed to be an important part of the integration process into Canadian society. Women reported that they were willing to adapt to many aspects and open to the benefits that Western society offered, however they were still very attached to their own culture and gender values. Although they were now raising their children in Canada, they articulated that it was equally important for them to raise their children to recognize the importance of their heritage. For example, participant 5 said that she was pleased that her daughter could get equal access to education as men and had equal gender status in Canada, yet she said that she still taught her the ideals of womanhood according to Pakistani culture. According to her, there are certain gender roles that are important for women to uphold, even in Canada, because they are still Pakistani women.

Another woman agreed that women should maintain certain parts of their culture, particularly the way women dress. As a Muslim woman, she explained that it is important to her that women cover themselves, which she referred to as “purdah” in her interview. She said that she did not understand why some women change their beliefs around doing “purdah” following migration. She felt that women should continue it, and also have their daughters do it.

What I don’t understand is, women who do “purdah” and then not to their children. When they come to this country they do purdah, and if it’s for adults, then it’s also for children, girls in particular. Then you should have
them do it too. This is definitely think, purdah should be for everyone. If you are not doing it then your daughter doesn’t have to do it, then ok. If you’re doing it, then your daughters (should) (P4)

Other women also shared similar beliefs about how women should dress. So, although they are able to assimilate to and adopt certain values of the West, the way a woman should dress was an important aspect of their culture that they wished to maintain.

Other aspects of their culture that they wished to retain were affiliated to their religious views. Five women (P1, P2, P4, P5, P6) talked about the importance of religion and maintaining it for their children. One participant reported that she still visits her religious place of worship everyday in Canada and said that it is an important aspect of her life.

Whatever I believed, or who I prayed to, whatever I teach the kids, that this is our god, we should pray to him, that is all the same (P1)

In general, all nine women reported that they maintained parts of their culture that were important to them.

Whatever we ate there, we eat here. Whatever our beliefs, our culture were there, we think the same here. Like, our culture, I keep it with me here” (P2)

Summary

Regardless of having negative experiences following migration, women reported having some positive experiences and views of Canadian life. In particular, several women spoke of welfare state benefits, better educational opportunities for their children, and the integration process which allowed them to adapt to parts of Western culture and gender values, while maintaining their own. It was discussed that adopting certain culture and gender values of Western society was important for the women, but only to a certain extent and in certain areas. They wished to adapt to issues surrounding gender that offered them more safety, freedom and independence. As well, they wanted their children to grow and benefit from both cultures. However, they did not specifically mention which parts of Western culture they would be okay with their children adapting to.
Despite adapting to many aspects of Western society, eight women talked about the importance of maintaining their own culture and gender roles. The women discussed maintaining traditional ways of dressing, religion, food, and gender roles. All of the women said that they maintained their roles as Indian and Pakistani women.

Although they talked about the various benefits of living in Canada, this should not undermine the fact that the women predominantly talked about their experiences in Canada following migration as negative and how they have impacted them psychologically. It is important to address how, what and when the women preferred to cope with these stressful experiences.

IV: Coping Strategies for Stress and Negative Settlement Experiences

The women that were interviewed discussed many negative experiences that they have encountered in Canada. They were then asked about how they coped with these stresses and about access to mental health care. In this part, I discovered the various coping strategies or approaches that they preferred using to maintain their health. In brief, the most important strategies for dealing with life stresses were: personal or religious self-care, accessing family or community networks, avoidance through normalizing and denying problems, or accessing mental health care services. Most of these strategies involved resilience by the women. Resilience is discussed further in the next chapter. In this part, all of these predominant strategies are discussed.

Personal / Religious Strategies

All nine women said that they would first try to resolve their stresses on their own. They felt that what they were experiencing would gradually get better and they should be strong about it. One woman (P2) reported that women needed to be strong because they were caregivers and should be able to endure stresses they encountered in daily life. In a way, I felt she had trivialized her post-migration experiences, but also understood that she was raised with this idea of women being resilient. This woman, along with participant 4, also relied on her faith in God and religion to get her through her problems. They believed that,
sometimes it is not up to them on what happens in life, but rather, there is a God that controls their experiences.

Maybe this is what Allah has decided is better for us. Nothing can be said......We have hopes still, but ahead, it's up to 'Khudha’ (P4)

Participant 2 also talked about her daily visits to her place of worship and prayer in helping her cope with the difficulties in her life.

I just left it up to God, what he will do, he will do good... So if they have depression, some people stay in a depressed state, some people can decrease their depression themselves, they pray. Like me (P2)

Another participant explained her own methods for self-care. She uses other strategies involving extra-curricular activities and spending time with others, as a way to relax herself and take her mind off her problems.

I don’t like medication. Because see also there's therapy, how to move my shoulders, how to be relaxed. How to study newspapers, books. Go outside and watch movies. I go with my daughter, we both watch movies on Saturday and Sunday when there is a discount on ticket (P7)

Another woman talked about ways of coping with stress in her life and to keep herself from feeling depressed. She explained her troubles in Canada were compounded with the trauma that she experienced in India in the form of ridicule by people because she was a single, unmarried woman, now in her early 40s. Even then, she did not discuss her problems with people considered to be 'outsiders’. She explained that whatever the case, South Asian women did not discuss their problems with others, unless they were family or friends. However, she also agreed that prayer was an integral coping strategy.

I'm ... proud of my background and the country I come from, because value systems are different. It's really ... helped me to cope and be really strong. To cope so much stress......I can focus on so many beautiful things that I can do in life....What else can I do? That's the way I can be healthy.... But I'm a very prayerful person, I'm very spiritually oriented. Most of my time I spend reading some scriptures and all that, so that does really help me to cope with xxx, but it's very difficult...Instead of going to
somebody, I write. The scripture has really got some … what to say, soothing affect, the whole being. That’s an easy and beautiful way to … to relieve you also from, from stress (P8)

Accessing Family or Community Networks

Six women (P1, P2, P3, P4, P5, P6) also talked about how common it was to talk to friends and family about your problems, in India or Pakistan. The women reported that they prefer to talk to family or friends, if they had a network of friends from their ethnic community, after they have tried to resolve the issue themselves. One woman talked about how people pull together to resolve a problem in the community.

If sometimes things go wrong in somebody’s life, people pull together and just xxx and try to help and the person to come out of it, or xxx solutions … to come out of it, or make things easier …. That’s how things work to this day (P8)

Another woman (P4) agreed that people should discuss their problems with family or friends in the community, but explained that most immigrants that she knows do not have family in Canada. Also, she reported that it is difficult because of the cost of phone calls and internet charges to have frequent contact with family in Pakistan, so she said that she discusses her problems with friends living in her apartment building who are also Pakistani. She explained that many of the immigrant women that she is friends with have also experienced the same difficulties after migrating to Canada and feels that they understand her. She said that her friends in Canada have become like family members. Another woman (P2) also reported that she talks to her friends about her difficulties and stress, since she does not have any family in Canada. She reported that she went to her place of worship everyday, where she has met friends from her ethnic and religious community. She also mentioned the importance of being able to talk to someone in your native language and to be able to express yourself.

I used to go to our Gurudwara [place of worship for Sikhs], there I would meet lots of people, there were lots of ladies there to pray……They also had some troubles such that they understood each other’s troubles. If
we’ve been through it ourselves, we understand other’s pain. We talked, they gave me support, encouragement. They helped me quite a bit (P2)

In this next excerpt, a woman talked about the importance of family in dealing with stress and difficulty. During her divorce process in Pakistan, a very depressing time for her, she allowed her family to make decisions for her. However, she also discussed her situation with friends. This experience is important to mention since it shows how important family is to women and that family can make decisions about your health and care.

Even in home country, family is the one that makes decisions about your well-being. …. Everybody knew I was in stress. I talked to my friends also, which are my colleagues, my friends. They always said you are in stress. You are in stress. Do something for yourself …. The doctor said – even here the doctor said adopt hobbies, make friends, go out, relax, and do something which ever you like. Just do exercise, move outside, walk. (P7)

Avoidance

The women discussed two other strategies for avoiding problems related to post-migration stresses in their lives: normalization and denial. By normalizing their problems or situations, the women assumed that most people, or immigrant women, suffered from the same problems or worse. They also talked about denial, or not recognizing that there is a problem or difficulty in their life, to help them cope. One woman explained that this was the best strategy for her, since worrying only made her feel worse and did not help solve the problem.

You know, even if we worry, nothing will happen. Whatever will happen, will happen. We shouldn’t take tension. But before……whatever would happen, I would feel tension, think this, think that. I would sit alone and think about it. But now I have some knowledge since I came here, women would come here together, so then I would know that I’m not alone, there are so many women in the world that are troubled. I shouldn’t take any tension, it will only ruin your health, right? Just stay happy and enjoy, whatever happens (P1)
Another participant talked about how women in particular have to be strong to cope with problems in their lifetime, since many people have problems and they will always be there. She also explained that some people do not even deal with their problems, but instead think about something else.

In India, each home depending on its atmosphere has its own problems, some more, some less...thinking was that I keep going with strength. I think that a woman should be strong. So, my thinking was that when you work hard, there will be results and you will get something good...there are some people who may have many problems, and they don’t even care about them...there are people like that. If they have depression, they don’t even care about it. They think about something else (P2)

Mental Health Services (Limited)

Although some women used words such as “tension” and “severe stress” to describe their feelings, while other women (P7, P8, P9) openly stated that they felt depressed and made references to death, only one woman (P7) talked about her experiences in accessing a mental health counselor and taking medications to help her cope with the stress of negative settlement experiences, as well as with some of the trauma she felt as a result of her experiences in Pakistan. Although it was not her first preference, she admitted that she could no longer cope with the stresses on her own and she could not sleep anymore. Also, she reported that she lacked the family and community support that she had in her home country, since she was not accepted by many Pakistani women in Canada because she was divorced and a single mother. She admitted that after taking the medication for a number of months, she felt much better.

I don’t like to take medicine actually. But ... but depression – this time, stage, I need medication. I just xxx night because I can’t sleep properly. I can’t digest my food properly. So then I go back and it was ok. It’s helped me a lot. (P7)

The other eight women had never accessed mental health care services in Canada or considered it as an option for coping with stress in their life, but reported that they might in the future if their stress or emotional difficulties reached a certain
stage. Most women did not discuss this coping strategy because of their lack of contact with mental health care services. However, one woman described the stage at which she would consider seeing a psychiatrist. She reported that reasons for getting depressed would be associated with her family. This is an example of how integral family life is in Indian and Pakistani culture. She also described the type of care and service provider she would want to consult. She reported that it is important for her to consult someone who can understand her values and culture, be willing to understand her context and have an overall cultural sensitivity. She did not wish to consult someone who would make her completely integrate into Canadian society. Although she preferred someone from her ethnic community, she mentioned that it was not necessary, as long as they possessed the qualities that she described.

If I was ever depressed, or feeling helpless to the point where something wasn’t in my control, God forbid it ever happens. I can see myself getting depressed either if my husband started meeting other women, or if my children were in bad company, then parents get depressed. Of course I would think that I need to consult someone, but I would prefer that I talk to someone from my community who would be able to guide me in what our people should do in such a situation. I don’t want an opinion that clashes with my values and my culture, because then I won’t be able to absorb it or follow that advice. I wouldn’t like it if the psychiatrist were to force me to live in this society and accept what happens here, and say that my husband or my children are right and I have to accept it. I want someone who can solve my problem, understand and respect my values, and then give me a solution keeping in mind my values (P6).

Most women said that they would consider going to see a family physician if they felt they needed help in dealing with psychological issues. However, they did not discuss how they would know they reached that stage. Most of the women reported that they do currently access primary health care services, mostly either private general practitioners or their CLSC (centre local de services communautaires), a network of community clinics in Quebec. However, their
reasons for accessing primary health care services were mostly for regular check-ups for their children. The women talked about the qualities of a service provider that would make them feel comfortable, particularly a doctor who could communicate with them in their first language and a doctor who could understand their culture. Six (P1, P2, P3, P4, P5, P6) of the nine women reported that these qualities in a family doctor made them feel comfortable and they all had access to a family doctor that was of Indian or Pakistani origin.

Summary

The interview explored many of the coping strategies that women use to deal with the daily and on-going stresses in their life, resulting from migration to Canada. Although the women discussed a range of coping strategies, only one woman (P7) had accessed a mental health service provider to resolve mental health issues that she experienced. However, many women had discussed feeling depressed or experiencing poor mental health.

These coping strategies, aside from mental health services, have been a tremendous source of support for immigrant South Asian women in Montreal in dealing with the negative migration experiences. Accessing primary health care, like mental health care, is very limited for coping with these negative experiences. However, accessing primary health care for their children’s needs is common, as well as accessing a service provider that speaks their native language. To understand their limited use of mental health services, and sometimes even primary health care services, the women discussed some of the barriers that they have encountered or fears that they have in accessing primary and mental health care in Canada, which has made it difficult for them to seek help when they want it or need it.

V: Barriers in Accessing Health Care Services

Many factors can prevent immigrant women from seeking help for stresses they encounter during the settlement process. In the interviews, women talked about barriers that they perceived in accessing both primary and mental health care services. Barriers that were perceived to prevent access to mental health care services were lack of awareness of services in mental health and stigma associated
with accessing a mental health service provider. Barriers in accessing primary health care services were defined as: ethnicity of provider, cost of services, economic marginalization, long waiting times to see a doctor, and racism. Barriers Preventing Access to Mental Health Care Services

Only one woman (P7) reported accessing mental health care services in Montreal. However, participant 8 talked about the perceived barriers for South Asian women in accessing care, if they were to seek mental health care, although she also explained that most South Asian women had other strategies that they used to cope with post-migration stress. She suggested that underutilization of available mental health services in Canada was due to the lack of knowledge or awareness that these services exist and the stigma associated with seeing a mental health care provider.

This participant explained that women did not seek out mental health services in their home countries as well, due the lack of such services and also the unawareness of services that might exist. The coping strategies that they women discussed in their interviews, were also common coping strategies for any problems in their respective home countries.

She also explained that there is a great deal of stigma associated with accessing a mental health service or provider. Women and men in India and Pakistan would not consider going to a counselor because if others in the community were to find out, it might bring shame to the family or others would think that they were crazy. This woman admitted that she had once gone to see a psychologist in India, who was also a friend of the family, for some emotional problems. She reported that she was suffering from emotional distress because she was constantly being ridiculed by family members and people in the community for not getting married. She explained that her contact with this psychologist turned out to be even more damaging, since there was a breech of confidentiality. The service provider had told someone else in the community everything that she had confided to the her about.

She (the counselor)… when I discussed a few things with her … she said some of the things which I told her in confidence, she related to somebody
Mental health of South Asian women

else ... the person who recommended doctor, something, and they told everything to the family xxx. Who are not supposed to know what they told. It created complex problems. To this day what she did is the ... affecting their behaviour towards me. See? This has caused really mental trauma. Really trauma, it's a big traumatic .... My own kin and - close relatives, because of what she said, what I told her and what she said to x and y, to which my family must came to know about it, because of it they are reacting very, very badly towards me. Because of it I have been refused help in so many ways, and I xxx xxx. It's very bad (P8)

Although all of the women interviewed had reported a negative post-migration experience that has affected their mental health, only one woman (P7) reported seeking help in Montreal. Lack of awareness of services and stigma can be a hindrance for South Asian women in accessing mental health care services. As described in an earlier part of this chapter, women also felt that they did not need mental health services at this stage of their migration. Most women accessed primary health services for their children.

Barriers to Accessing Primary Health Care Services

One woman (P9) talked extensively about her negative experiences with accessing health care services and the lack of quality in the care that she received in Montreal. Her frequent access to and need for services stemmed from suffering from regular migraines and having given birth six months prior to the interview. In particular, she discussed the cost of services, long waiting times to see a doctor, and racism. Another woman (P8) talked about the ethnicity of a provider as a barrier. The other six women had limited contact with the health care system, other than for routine check-ups for themselves or their children, and did not describe any barriers in access or substandard quality of care.

Ethnicity of provider.

Two women reported that preferred not to consult service providers of the same ethnic background. They explained that they felt they were being stereotyped by others because of their marital status. One of the women (P7) said that although she had not had a negative experience thus far, she would not want
to consult a doctor of the same ethnic background as her because she felt discriminated against or stereotyped because she is divorced. She felt uncomfortable meeting people from her community, in general, because they felt it was odd for a South Asian woman to be divorced.

The other participant (P8) reported that she preferred not to see a doctor of South Asian background, because of her negative experience with a South Asian medical resident in Toronto, Canada. She felt that the resident was stereotyping her because she was a 42-year old South Asian woman who had not married. She felt that the young Indian doctor was influencing her care and the consequences were that she did not return to her again. She explained that she sacrificed feeling better so that she would not have to go back to that doctor again.

Once I really felt sick. Maybe I thought it was because of psychologically tied to my physical well-being... So when in Toronto I had a xxx. But ... what happened was one lady, she was a doctor, like ... she was a Canadian. She was nice. But my subsequent visits to the same clinic, when a young – a very young Indian Asian doctor, she was a student, I think, [even?] coming for some practice, or something.....The reaction of other interpreter whatever I said ... about these issues, totally changed, and I didn’t want to go back...... She was very sarcastic and nasty and ridiculing me. Like laughing...... I had fever. And then also I had these emotional issues also came up. So because she was a – I think she was also a psychotherapist. Not psychotherapist – no, I don’t know. She was some ... physician... Because she was – I was alone and it was almost really feeling really bad, very bad shape.... I didn’t feel like going back. (P8)

Fee for service.

Cost of services was voiced as a particular concern for one woman (P9). Although cost of services may have been a concern for other women as well, particularly those in bad financial conditions who require any prescriptions or services not covered, it was not brought up in any of the other interviews. Participant 9 said that she suffered from severe migraines and had frequent
contact with health services and providers. She talked extensively about her experience with 911 emergency services in Montreal. She felt strongly about her right to equal access and quality care, but believed that there is unequal access to certain services for people who cannot afford services or are homeless. In the following excerpt, she described her experience with 911 and the inability to pay for the services that they offer. The consequences have been that she will not call 911 in the future.

I had problem of migraine. I fainted when I was in the third month of pregnancy, maybe fourth month. I fainted, and that time my husband he tried a lot to make me relax but ... but I was totally unconscious. And then my husband, he called 911 and he said that I had no other choice...and they brought me to the hospital. And there I – first time I went to the X Hospital. They gave medication and everything and I came back to my apartment. After one month I got the bill of 911, Urgent Sante. And it was one hundred and something...my husband he called 911. He called the lady there, he said that I got this bill, why should I pay this bill? Because it was a service that provided by the government. She said no, you have to pay. He said “That I’m a student. I can’t pay.” He said “Sorry. You have to pay because here if anybody call 911 he should pay.” He said ok, if I will not pay? He said “Ok, then no need to call 911.” He said that it means that if somebody is in trouble he should die? She said “It’s upon you. If you are not able to pay the bill you should not call 911.” ....Yeah, the third time when, when I was fainted, I told my husband that no need to call 911. It’s better to die, to go to 911. I do not want – let me die. If I have any problem, please do whatever else by yourself. No need to call them. (P9)

This interview was particularly emotional because of the extremely negative experiences that this participant had had with accessing health care services and because she also was crying while recounting many of her stories. She reported that she has lost hope in services, providers and the government due to her many negative experiences. She communicated other stories that were also tied to her
financial condition and impacted her access to care. At the end of the interview she reported feeling better because she was able to talk about these experiences to someone who would listen.

*Economic marginalization.*

Participant 9 also discussed economic marginalization as a barrier to accessing services. She reported that many providers were not sensitive to financial situations of immigrants. Not having a job, or welfare, she explained that she cannot afford to take transportation to any health care facility. She recounted a time when she had to consult a physician for her newborn, because of a rash that had developed on her rear. To get to the health facility, she walked each way for about one hour and forty-five minutes and stopped three times along the way to breastfeed. She said that health care providers do not consider that people without money have trouble accessing their services. Location of services and time to get to a service both become barriers because of the lack of financial support.

During the consultation that this woman had for her baby’s rash, she said that the doctor was quick state that her baby developed a severe rash due to using cheap diapers, and perhaps infrequent changing of diapers. This participant felt that the doctor was insensitive to her financial condition and the fact that she could not afford better diapers, or other things to care for their baby. She said that she knows that it can affect the health of her baby, but wanted to see a doctor who would be sensitive to her situation and suggest a solution that would be affordable.

She has severe problem of fungus. Because I was using the diapers that were cheap. And that’s why the doctor, she was saying again and again that you have to change the diaper. How can I change the diapers? Because it needs money. And my husband, he’s not much affording to do like this (P9)

*Long waiting times.*

Participant 9 also talked about the long waiting times in hospitals and private clinics to see a doctor. She explained that this is a barrier for her because
of her frequent migraines and inability to sit for long periods during her pregnancy. She described an occasion when she went to a private clinic and felt that the staff were insensitive to make her wait such long periods while she was in her final months of pregnancy. As well, she felt her time was not valued, as she could have also had other appointments.

She talked about another incident where she waited several hours in an emergency room. She had just given birth, her stitches had not healed fully, and she had pain due to hemorrhoids bursting during the delivery. She felt that the nurses were insensitive to not recognize the pain she still felt. Since she was waiting several hours, she had also not eaten. Due to her financial condition, she could also not afford to buy any food. Not only had she not eaten, she reported that her baby could not be breast fed for those eight hours because she needed to do it lying down, and there are no beds in the waiting room. So, she explained that the long waiting times affected her access to care and her health.

One week after delivery. And I went to the emergency, I was in severe pain and I had a baby also, and I told them, and I request them that “Madame, please, if you can help me, I know that there is waiting of the urgencies, but please if you can help me, send me in before because I’m not in a condition... She was saying you have to wait there. And believe me, seven to eight hours I sit there with the baby, and I was crying a lot... I say to my husband that I will NOT sit here. I will go back. I do not need any medication because it’s too much. I’m saying again and again that I am in this problem, and they are not helping me. My husband, he went inside. He told the ... nurse, and he said that “Please, my wife, she is in severe problem and she is with the baby.” And then they called us, and believe me, in the emergency, inside the emergency, I spent two hours there, and no doctor came there and see me.... And after two hours the doctor came and, and he saw me in very hurried condition. And then he said you have problems, you do this, this, this, and he give me the prescription...when I went there it was morning, and I came back it was evening (P9)
In this excerpt, this participant described the insensitivity of staff in the waiting rooms in hospitals and the long wait times to see a doctor. She also referred to the rushed appointments with the doctor. She explained that the doctor came after about eight hours of waiting, but left after just writing a prescription.

*Racism.*

In the interview, participant 9 reported that the insensitivity of staff and the long waiting times were a result of discrimination. She had noticed situations in which other women, who appeared to be White, would be attended to much faster than her, although she felt her case was equally urgent, if not more. She described one occasion when she had just delivered her baby, and had buzzed for the nurse who came after two hours. When the French lady in the hospital bed next to her buzzed the nurse, she had come within ten minutes. She felt that people in Montreal do not like South Asians.

Many people they hate Asians. They do not like Asians. And I know that here the English people even, they do not like Asians. I was in the same room in which there was a lady, she was French and I was Muslim. And the nurses, they ... they didn’t come to me. They went to her..... When my baby cry, cried a lot, I called them, and there was a buzzer, you know, near the bed. I called them many times and they came after two hours. And the lady with me on the other bed, she called them and she pressed the buzzer, within ten minutes the nurse came (P9)

*Summary*

Again, only one participant (P7) had sought help for depression and had experience accessing mental health care services in Montreal. Another participant (P8) talked about some of the barriers she perceived that prevent South Asian women from accessing mental health services in Canada, which was a similar case in their home country. These barriers include a lack of knowledge and awareness of services and the stigma of having a mental health problem.

Other women talked about their experiences with primary health care services. Although the interviews uncovered that the majority of the women had not accessed mental health services, and would not consider it, they did report
accessing primary health care. Some of the barriers in accessing this type of care, particularly in private clinics and hospitals, were identified by the women to be: a service provider of the same ethnicity, cost of services and transportation to services, economic marginalization or the insensitivity of a provider in not recognizing a woman’s financial condition, long waiting times to see a doctor, and racism. The stories of the women show the interconnectedness of their post-migration experiences and their health. A woman (P9) talked about her financial struggles in Montreal and how this has affected her access to services because she can not pay to get to services, can not afford services like 911, or afford to buy food while she is waiting long hours to see a doctor. The barriers that the women talked about prevented them from accessing care, receiving quality care and influenced their perspectives on health services and providers.
Chapter 4: Discussion

Reviewing Research Questions and Final Categories

The previous chapter revealed the findings from the qualitative interviews that were conducted with nine South Asian immigrant women who migrated to Montreal in the last four years. The interviews were semi-structured so that they could help to answer the research questions that formed the basis of this thesis. The four research questions that guided this inquiry were, 1) what are the salient post-migration stresses that shape their experiences as South Asian immigrant women living in Montreal? in what way is adjustment in gender roles a significant stressor? 2) in what ways and where do they prefer to seek help? 3) what barriers do they encounter in accessing appropriate services? and how are these linked to culture and gender?, and 4) in what ways and under what circumstances do they feel services are useful?

The nine women that were interviewed consisted of a heterogeneous and complex group of individuals, with varying experiences in their home countries, living in different parts of India or Pakistan, speaking different languages, following different religions and having different demographics such as age, marital status and length of time in Canada. The demographics of the population is outlined in the previous chapter (see Table 2). Despite these differences, they related stories that show similarities and patterns in their pre-migration and post-migration experiences.

The similarities, or common categories, that were identified through the data were 1) reasons for migrating to Canada and pre-migration perspectives, 2) post-migration stresses, linked primarily to finances, employment, education 3) negative impacts of these experiences on health and stress levels, 4) positive experiences and benefits in Canada 5) coping strategies for addressing the difficulties in their lives, mainly personal / religious, family and community, and avoidance, 6) barriers to accessing primary and mental health care. These categories were all described in detail in the previous chapter with references made to the participants' narratives. These six categories were important in all nine of the interviews, some more centrally than others, and formed the focus of
the analysis of this study. These six categories are discussed further with reference to literature and linked to the research questions to confirm the appropriateness of the inquiry.

Significance of Final Categories

Research Question 1

This research question intended to uncover the salient post-migration stresses that immigrant South Asian women experience, and whether adjustment to gender roles was a significant stressor. To answer this question, the nine women described the process of why they decided to come to Canada, their pre-migration perspectives on Canadian life, the reality of life after migration, and their settlement experiences, both positive and negative.

Salient post-migration stresses and effects on health.

The research findings confirm that there are salient post-migration stresses that immigrant South Asian women encounter during the settlement process. Although the women defined a few benefits of coming to Canada, their experiences were predominantly negative. These experiences included financial struggle, occupational challenges, and educational challenges. The women discussed these experiences in detail, and confirmed, as Choudhry (2001) also suggested, that the settlement process in Canada is not easy. Unlike Choudhry’s (2001) study, the women who participated in my study did not describe the integration process as the cause of stress. Rather, they felt that the integration process was democratic and enabled them to adapt to some Western values and ways of life, and not to others that are related to gender roles and child rearing, as will be discussed later in this chapter. Resettlement and integration can be more of a salient post-migration stress for elderly women because of their firm traditional beliefs and difficulty in accepting new modern ways at a latter stage in their life (Choudhry, 2001). Despite this difference, the immigrant experience in Canada is described as a time of crisis by both older and younger immigrant women.

The women in this study also made an association between their immigration experience and their psychological health. The women described
their emotional and psychological decline in various ways. Some women referred to words such as “tension” and “severe stress” to describe how they felt about the effects of post-migration, while others (P7, P8, P9) openly stated that they felt depressed at times and made references to death. Other studies with South Asian women have also found that the settlement experience can be a source of declining health (Choudhry, 2001) and women have made verbal expressions such as the ones observed in this thesis (Ahmad et al., 2004). This downward mobility is an outcome of the loss of the social, economic, and occupational status that they had worked towards and accomplished in their host country. Many of the women that did not work in their native country, are now trying to find work to supplement their spouse’s income in Canada (True, 1990). However, True (1990) reported that Asian American women receive lower wages than other women with comparable educational backgrounds. Experiencing under/unemployment, or a “de-skilling” process (Mojab, 1999) and loss of their middle class quality of life is very difficult for immigrants.

Racism.

Although racism was identified as a barrier to seeking appropriate care in this research, as is reported in chapter three, it has also been cited in literature as being a cause for depression in Pakistani women living in the UK (Chew-Graham et al., 2002; Currer, 1984). Therefore, the racism that participant 9 experienced in the hospitals, could also be a cause for further depression. Although the women in this study talked about discrimination, they never explicitly reported that it has affected their health. None of them identified racism as a cause for depression, but this could be due to many factors. For example, it could be their level of trust in disclosing such a view, they are unable to articulate it, they have not recognized it as racism and they have been in Canada for only a short time, or they are grateful for the other opportunities they have obtained that the racism has been ignored up to this point. There are many reasons participants may not have disclosed such feelings, but it was clear in the interviews that some women did not like the attitudes towards them or South Asian people in general.
Three Pakistani women (P3, P6, P7) in this study reported experiencing discrimination post-9/11. They talked about having to change their attire from traditional to Western clothing when leaving the house. They also described very fearful experiences when going out of the house to the grocery store, going to pick up their children from school, or when their husbands left for work. Another woman (P9) discussed an incident in her apartment building that led her to believe that people in Canada did not like Asians.

The narratives of the three women suggest that racism is an important issue to explore and that the events of 9/11 have had an impact on South Asians in Canada. Although racism was not explicitly reported as a post-migration stress, partly because it was not a focus of the research study, some of the experiences that the women articulated should be given attention.

**Gender roles.**

This research question also inquired about the changes in gender roles following migration and whether it was significant stressor for the women. Although they did not directly report any stress related to this process, it seemed to be a complex process. Discussions of (re)negotiation of gender roles and child rearing emerged. The women explained that it was a complex process because of the negotiation of two cultures, so adapting to certain values of Western culture, but maintaining proximity to their own culture.

Dion and Dion (2001) stated that resettlement in a new society can initiate changes in immigrant families, including a (re)negotiation of gender roles. In my study, it was reported that the women underwent a particular integration process, which allowed them to adapt to certain values in Western culture, pertaining to roles of women, and not others. The women felt they had the agency in making decisions about what they would change and what they would not with respect to their roles. Therefore, there were not any significant changes in gender roles that the women reported but there was a renegotiation of their gender roles. These women could gain a sense of agency and confidence, but it had to be balanced with ideals of the South Asian female, which are described in chapter one.
The women explained that they benefited from the independence, freedom and safety that women are given in Canada. The equal status of women really impacted their confidence level as South Asian women, and they hoped that their daughters would also benefit from this change, although they still reported that they believed that there was a limit to freedom and independence of women. They wished to also stay close to their cultural values and respected certain traditions. For example, they did not respect or wish to accept Canadian values or behaviours such as divorce, raising children, styles of dressing, and food (Hussain & Cochrane, 2002). Similar to the reports of South Asian immigrant women, it was found that Filipina women in San Diego also did not like the way children in Western society are raised and female interactions with the opposite sex (Espiritu, 2001).

Another study on South Asian women in Canada (Naidoo & Davis, 1988) found that with respect to certain values, the sample of South Asian women was “unacculturated”, or traditional. These values related to marriage, religion, and views about the roles of men and women in society. On the other hand, they exhibited contemporary, future oriented desires with respect to personal success, careers outside the home, and ambitions for their daughters. They could easily adjust to some aspects of Western culture in order to make the adjustment easier for themselves and their children, but not to others where certain values are connected to their gender and cultural beliefs. Therefore, the South Asian family living in Canada encounters many culture conflicts while trying to retain their own culture and also assimilate into the culture of the West. This Ontario study describes the duality that exists in the lives of South Asian women and the complex (re)negotiation of gender roles.

The women in my study also reported that they had firm beliefs on what the role of a South Asian woman should be, and would want to continue to uphold those roles. Not only was renegotiation of gender roles a complex process, but so was child rearing.
Child rearing.

Raising children in Canada was also an important part of the discussion in most of the interviews. Women felt their ways of raising children were different than those of Western parents (Maiter & George, 2003). The women who had children reported that they were open to raising their children in both Western and Eastern cultures, only when it did not involve drastic change for the children in terms of cultural and religious beliefs. Maiter and George (2003) also reported that the South Asian mothers that they interviewed wanted their children to develop a dual identity rather than to assimilate into the dominant culture. Khanlou and Hajdukowski-Ahmed (1999) reported that the South Asian female youth that they interviewed talked about this duality, as fitting into Canadian society and maintaining their own South Asian culture.

Research Question 2

This was a challenging research question as it aimed to uncover the women’s help-seeking patterns and pathways to care for the psychological stress they experienced following migration. For women that come from a country where there is a high level of stigma associated with mental health services and illness, as discussed in chapter one and also explained by participant 8 in chapter 3, it was confirmed that there was a pattern of underutilization of mental health services in Canada. Although all nine women were asked if they had accessed mental health services, eight of them reported that they had not, aside from one woman (P7) who reported accessing a mental health service provider in Montreal. Therefore, accessing mental health care was not an evident choice or option for these South Asian women. Alternatively, the women discussed other strategies that helped them cope with the post-migration stresses and their emotional distress.

There has been increasing efforts to understand how people respond to stress (Miller & Kaiser, 2001), but limited research studies that examine help-seeking patterns in South Asian women (Hilton et al., 2001). This study found that the predominant strategies that South Asian women used for dealing with stress were, 1) personal or religious self-care, 2) accessing family or community
networks, 3) avoidance, and 4) accessing primary health care if needed. Although the women reported some traditional health practices, like prayer, they did not report accessing traditional healers as found by Hilton et al. (2001).

**Resiliency strategies.**

Lazurus and Folkman (1984, in Hussain & Cochrane, 2003) report that individuals use coping strategies that help them to deal with distressing events. The first three strategies that are highlighted above are referred to as resiliency, where the women find ways to resolve their own stress. Through resiliency, they are able to overcome adversities in life (Alperstein & Raman, 2003). Resiliency is commonly defined as the ability of an individual to negotiate with the environment they live in to maintain what they think of as healthy (Ungar, 2004). To cope with distress, the women did not seek help from service providers or mainstream organizations. These strategies included behaviours such as, relying on religion and God, engaging in activities that will take their mind off their problems, talking to family or friends in their community, remembering to be strong, as South Asian females should be, normalizing their problems to say that most women also endure the same post-migration stresses, or denying that any existed.

An immigrant’s culture shapes the way one views health, distress, coping styles and outcomes (Donnelly, 2002). Previous studies and literature have shown that resiliency or self-care strategies are commonly used by immigrants to cope with distress. Researchers have found that South Asian women rely strongly on religion or faith as a coping strategy, because ultimately, they think that destiny is controlled by God and not individuals (Choudhry, 1998; Hussain & Cochrane, 2002; Hussain & Cochrane, 2003). In my study, the women talked about praying, attending one’s place of worship, and trusting God.

Talking to family and friends from their community was also important for South Asian women (Choudhry, 1998; Hussain & Cochrane, 2003). Similarly, my study showed that South Asian women wanted to talk to friends who shared the same language, culture, values and experiences as them. Only two women (P7, P8) preferred not to communicate with people from their community because
of lack of confidentiality, and the stereotypes the felt people held about single women. Hussain and Cochrane (2002) also found that this was common in some South Asian women, who isolated themselves from their community in order to avoid breech of confidentiality. Therefore, this behaviour or strategy of dealing with distress suggests that South Asian women might have reservations about entering into therapeutic relationships with people that are not from the same cultures as them, while other South Asian women prefer not to engage with practitioners or helpers of the same community. As mentioned, the latter was expressed by two women, one who was still single and over forty years old and another who was divorced. Along with confidentiality issues, perhaps these characteristics placed them in a stigmatized position and they felt threatened by the attitudes of someone of the same culture. As Guzder and Krishna (1991) outline, females are identified more often as wives and mothers, and not as individuals. Therefore, women who are still unmarried or divorced are not equated with ideals of femininity.

Another qualitative study carried out by Scattolan and Stoppard (1999) interviewed fifteen women living in rural New Brunswick about their experiences and coping styles with depression. They found that women employ a more avoidant coping style than men, ignoring the problem or believing that it is a part of life. Denial and normalizing of problems was also common in the group of South Asian immigrant women that I interviewed. It was also discovered that women feel they need to portray the ideals of a woman, these being linked to not expressing emotions (Choudhry, 2001; Guzder & Krishna, 1991; Moghaddam et al., 2002). Literature suggests that there is a negative connotation associated to the expression of emotions for South Asian females. Kirmayer (2001) also reported that most cultures around the world do not openly talk about their feelings or conflicts. This was also evident in the South Asian women in my study. All of the women felt that they needed to be strong so that they could succeed in their roles as wives and mothers. Therefore, most of them discussed these particular resiliency strategies to deal with stress in their life since migration. As well, the importance of family honour, also known in Urdu as izzat,
Mental health of South Asian women

In South Asia (Guzder & Krishna, 1991) might also suggest that the women were hesitant in sharing their emotions during the interview, and also perhaps with mental health service providers leading to the underutilization of services. So, although these women have their own coping strategies in place of mental health services, it is important to wonder if they are suffering silently and the consequences that this might have in the future. Choudhry (2001) found that South Asian women are reluctant to voice their problems or worries, which may put them at risk for further emotional distress or physical illness.

In addition to there being an underutilization of mental health services, it was also not reported by any of the women that they had accessed or considered traditional healers or healing practices. As discussed in chapter one, ayurvedic medicine and home remedies are a common form of healing in South Asia, but it was not discussed by any of the women. This did not mean that they would not consider it or had not accessed it in Canada, but it was not a part of the discussion.

Health system.

There was a significant underutilization of mental health services by these women. Most women had family doctors that they saw for problems that their children had, but not for psychological distress. Again, accessing the public health system or social services was not common, where as private resiliency strategies were. Although they did not discuss systemic or organizational barriers related to access, they highlighted some of the characteristics that would be important in a mental health service provider if they were to consider accessing services. One woman (P6) reported that it is important for a service provider to understand her culture, offer treatment that is practical and take her beliefs into account. Hussain and Cochrane (2002) found that South Asian women in the UK also desired that service providers understand cultural differences, because this affected how much and what kind of information would be communicated by the client. As P6 explained, it was not necessary that a service provider be of the same ethnic background (Hussain & Cochrane, 2002), but understand the client's background and context for there to be a good relationship and trust. This is an interesting comment since six of the nine women interviewed reported that their
family doctor was of the same cultural and linguistic background as them. Although ethnic-matching seems to be important, this participant suggests that it goes beyond just ethnic-matching.

Research Question 3

Since there was a pattern of underutilization of mental health services in Montreal, it was difficult to determine what the systemic or organizational barriers might be for South Asian immigrant women accessing mental health services. Rather, this thesis supports literature in the first chapter that suggests that help-seeking is avoided because of lack of knowledge of existing services, shame and stigma. Therefore, lack of knowledge of existing services and stigma associated with mental health were the key barriers to accessing mental health services for psychological distress. This, and the fact that these women described alternate coping strategies, is consistent with other studies that have shown that ethnic minority clients (non-English speaking persons) tend to underutilize mental health services. A study carried out in Australia also suggested that it was due to a lack of awareness in the ethnic community, stigma, and use of alternate strategies for coping (Ziguras, Klimidis, Lewis, & Stuart, 2003). Other research shows that Mexican immigrant in California also tend to underutilize mental health services, compared to U.S. born Mexican Americans because they have a higher rate of using providers in the general medical health care system (Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). This implies that many immigrant populations would prefer to seek help from general practitioners rather than mental health service providers. However, none of the women as part of my study reported accessing even general practitioners for distress.

Two women (P7, P8) who reported accessing primary health care services explained that a service provider of the same ethnic background would be a barrier for them. In contrast to the six women that reported having general practitioners from the same cultural and linguistic background, these two women preferred not to associate with people from their community, because of the stereotypes and discrimination they felt were linked to them being single South Asian women and the potential breech of confidentiality that might take place.
Although there not much was uncovered in terms of barriers to accessing mental health care, one participant (P9) articulated systemic and organizational barriers that she has encountered in accessing primary health care services, particularly in hospital settings. These barriers included: cost of extra services, economic marginalization, long waiting times, and racism, which are all described in detail in the chapter 3. These are important to mention because interaction with primary health care services is the only contact that most of these women have with the health care system, and in some cases, these are or will be the primary outlets that they use for mental health issues (Vega et al., 1999). Racism in particular is a barrier that needs to be acknowledged and addressed by the health care system. If clients feel that a service provider was discriminating or stereotyping, they would not disclose any emotional distress to the provider. Although only one woman (P9) revealed racism as a barrier for her in accessing care and receiving quality care in hospitals, six women reported that they had a family doctor from their background. This might suggest that they had a previous encounter that they did not mention or feared seeing a non-South Asian practitioner for that reason.

My research supports other research that has shown that there are barriers to accessing primary care for ethnic minority populations (Chew-Graham et al., 2002; Kagawa-Singer & Kassim-Lakha, 2003). Chew-Graham et al. report that the focus groups held with South Asian women revealed that they were hesitant to say that they would approach any service for help, and they also foresaw many barriers to mainstream services, such as a White provider not being able to understand their culture. In my thesis study, participant 9 clearly reported that she had experience many barriers in accessing primary health care services and also had lost trust in the system. For women to access care for personal distress, trust is an important factor in their relationship with a provider. Chew-Graham et al. also explain that South Asian women in the UK do not seek formal help for psychological distress until they reach a point where they need to. In this research study, many of the women also reported that they did not feel they needed help at this stage of their migration. Because most of the women that I interviewed had
recently immigrated to Canada, perhaps they were not able to recognize their distress or really did not think it was severe enough to seek help. However, the women did express, directly and indirectly, their distress. For example, participant 9 reported her direct wish to die after losing trust in the health system and indirectly by reporting “tension” in her life.

Research Question 4

This research question inquired about what South Asian women considered useful or what made them feel comfortable if they were to seek help, in primary or mental health care settings, in general. They reported that services should be culturally and linguistically appropriate for them to be useful.

Culturally appropriate.

Aside from two women (P7, P8) who had family doctors that were not from the South Asian community and one woman (P9) who did not have a regular family doctor, the other six women had a regular family doctor that was of Indian or Pakistani origin. These six women expressed contentment in their care. Their contact with the family doctor was mostly for their children for common sicknesses and shots. Although none of the women emphasized that the gender of a practitioner was important to them, they did report that culturally appropriate services were important. One woman (P6) noted that this did not necessarily mean that the service provider had to be of the same cultural background as the client, but should be able to understand the context of her problems and deliver services in a culturally appropriate way (Kagawa-Singer & Kassim-Lakha, 2003; Maramba & Hall, 2002). This includes a focus on the family and not the individual (Ito & Maramba, 2002; True, 1990). Kirmayer (2001) reported that people from non-Western cultures would discuss emotional distress with someone who is aware of the family context.

Nonetheless, six women still reported that they would prefer a service provider of the same ethnicity. Other researchers have also commented on Asian clients preferring treatment with therapists of their background because of the cultural sensitivity they bring to the alliance (True, 1990). This is also consistent with Hussain and Cochrane’s (2002) study that found that South Asian women in
the UK seek help for depression from a doctor within their own community. Interestingly, their treatment outcome was also linked to religious beliefs that the success of the care would depend on God. Therefore, religion is found to be an important part of their treatment for psychological distress.

*Linguistically appropriate.*

In this study, language was also identified by the women to play an important role in their contact with a service or service provider. Statistics show that almost 44% of all immigrants do not speak English or French (CIC, 2005). Five of the nine women interviewed still preferred to communicate in their native language in Canada and six women, as noted earlier, had a family doctor that spoke the same language. It was reported that this facilitates communication because it is easier to express themselves and also understand what a service provider is saying (Hussain & Cochrane, 2002). Further, Fenton and Sadiq (1990, in Hussain & Cochrane, 2002) discuss that language can be a barrier because it can lead to misunderstanding of symptoms and misdiagnosis when working with South Asian women suffering from depression. The authors also explain that there are cultural variations in how people experience psychological distress and verbalize that experience. This supports literature mentioned in chapter one. Therefore, contact with a service provider that shares the same language can prove to be beneficial for South Asian women. Ziguras et al. (2003) found that non-English speaking clients, men and women, seeking psychiatric services in Australia that were matched with a provider that spoke the same language, or bilingual, tended to have more direct contact and longer contact with community services, perhaps due to increased comfort levels, than those that were not matched. This resulted in less crisis intervention and shorter hospitalizations.

Since language was widely reported as an important access factor, it might suggest that women would prefer to have an interpreter or culture broker present in their meeting with a provider. However, none of the women had had any experience in the use of interpreters, except one woman (P2), perhaps showing that they preferred direct contact with a service provider. Some of the women reported that they believed that they would be offered an interpreter if they
wanted to seek services at a hospital or CLSC. The findings of this thesis suggest the importance and significance of having interpreters and culture brokers who can facilitate communication between clients and providers, where a service provider is not able to speak the same language as a client.

Language is also important in prevention work and outreach to the South Asian community. Ahmad et al. (2004) reported that South Asian immigrant women, who have lived in Canada less than five years, felt that one of the major barriers to accessing health promotion or education materials was language. Women explained that they could not fully understand the messages of these resources, because of their lack of English proficiency. In addition, they had limited social networks from whom they could get information.

**Limitations to Research**

I feel that this qualitative descriptive study captured important information through the narratives of women in their own words and the design of the study was considered carefully to avoid any inconsistencies or limitations. However, given the timeline for this thesis, there were some limitations that were anticipated. For example, had there been more time, 1) there might have been the opportunity to meet with each participant for a longer time or increase the sample size, and 2) determine the trustworthiness of the findings of this study. Another limitation, although it can only be inferred, might be 3) whether the identity of the interviewer impacted the disclosure of information.

The data for this thesis was collected through interviewing nine South Asian women. Given the time frame for the thesis, it was difficult to recruit more than nine women. However, regardless of sample size, it is important that saturation is reached (Russell, 2004). This concept refers to when the participant’s accounts become repetitive and no new information is being uncovered. I do not think that my sample size hindered this process, because I think that saturation was reached. However, the time limitation did prevent the interview from going longer, or meeting with each participant more than once.

Time limitations also prevented determining the trustworthiness of the findings. This is an important step in qualitative research, and is considered
similar to the concept of validity in quantitative research. Determining trustworthiness can be done through a concept referred to as confirmability (Russell, 2004), which requires the participants to confirm the findings in some way. For example, for the research to be credible, the participants should confirm that the findings are an appropriate interpretation of their lived experiences that they described in the interviews. This involves consulting the community and obtaining feedback from informants (Macaulay, Commanda, Freeman, Gibson, McCabe, Robbins, & Twohig, 1999; Miles & Huberman, 1994) by taking transcripts and interpretations back to the participant following the data analysis stage (Kvale, 1996). Other literature in qualitative research has referred to this process as “member checking” (Ahmad et al., 2004; Mays & Pope, 2000; Polit & Beck, 2006). In my study, to determine trustworthiness, I would have verbally explained what recurring themes and patterns emerged from the interview. At this point, the participant would be able to change any information that they found inaccurate, add information, or verify some questions that I may have. It is always a worry of a researcher that the voices and perspectives of our participants might be lost or overshadowed by our own beliefs, stereotypes or interests (Luttrell, 2000), therefore it is important to confirm the trustworthiness of our results by incorporating the participant’s feedback into the study (Mays & Pope, 2000). To avoid any bias since time did not permit getting feedback from the participants, it was important to give an accurate account of the methods and results of the thesis (Mays & Pope, 2000) which is done in chapters two and three.

Meeting with a stranger and talking about personal details of your life can be difficult for an immigrant, or any person for that matter. Therefore, one limitation to this thesis may be that some important information might not have been disclosed, perhaps due to my identity. Although I think that my cultural, linguistic, and gender identity added strength to the relationship between interviewer and participant, and facilitated communication, as highlighted in chapter two, it may have also hindered communication. My religious background, which is Hindu, my age, or my acculturation level into Canadian
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society, as would be evident from my accent and dressing style, might have played a role in limiting disclosure of information by some women.

Significance of Findings

This thesis is unique because it is one of a handful of qualitative studies that examines the effects of post-migration on health, help-seeking patterns, and coping strategies of South Asian immigrant women who have lived in Montreal less than five years. Most of the research that was found in this area was conducted in the United Kingdom. As well, although the research was conducted in Montreal, at McGill University, the emerging findings can have implications for immigrant-receiving cities across Canada.

This kind of research can have many implications for practice and research. Identifying and understanding the salient post migration stresses can help to reorganize or develop new programs that will help resettlement (Hyman, Vu, & Beiser, 2000). One participant (P8) suggested having information centres either back home or in Canada that would help immigrants learn about Canadian life. Further, these findings could also help to develop health promotion and prevention programs, and culturally appropriate coping models to help immigrants with the effects of post-migration. The participants in this study highlighted factors that would make services useful and characteristics of service providers that help to build rapport with South Asian women. This thesis has expanded our understanding of the importance of culture, gender roles and language to South Asian immigrant women.

This thesis is also significant because it can also provide a foundation for future research. Although this research supports previous research, it also raises questions for future inquiry. As mentioned in chapter two, there is no mandate for qualitative descriptive research but to provide a comprehensive summary of the data in an organized way, but it can also provide access to or questions for future research (Sandelowski, 2000).

Directions for Future Research

Researchers have identified that commonly used models or theories of coping exist (Donnelly, 2002; Hussain & Cochrane, 2003). However, no models
or theories of coping have been developed on coping with distress for South Asian women, or the Asian population in general (Hussain & Cochrane, 2003). Also, there are limitations to the applicability of traditional coping models to immigrants (Donnelly, 2002). For example, most theories on resilience, which is a common strategy identified by the South Asian women in this study, have been conducted in a Western context (Ungar, 2004). This study can inform future research to develop a culturally and gender appropriate model of coping for South Asian women and incorporate strategies that are sensitive to religious and cultural beliefs. Religion and culture were reported to be integral to the perceptions of mental distress and impacted coping styles for the nine women.

Also, further qualitative research with immigrants of all communities can help to provide a better understanding of their post-migration difficulties and coping patterns, including resilience, which otherwise would not be known (Ungar, 2004). It is important to understand the intersection of their lived experiences, including gender, race, and class, to understand the context of their distress, how it affects preference of and access to services, the development of coping strategies and meaning of resilience (Ungar, 2004).

Future research with the children of South Asian immigrant women would also be interesting to study. In 2003, it was reported that close to 15% of the total immigrant population was youth, or people between the ages of 15-24 (CIC, 2005). Although many studies have looked at the migration effects on adults, there is still a lack of literature available on immigrant youth (Khanlou et al., 2002), who are deeply affected by settlement (Suarez-Orozco, 2000). Hyman, Vu & Beiser (2000) found that migration leads to stress in youth, who are the children of Southeast Asian refugees in Canada, in the form of intergenerational, school, and cultural conflict. Choudhry (2001) also found that South Asian immigrant parents and their children experience intergenerational conflict. Research studies have also shown that female children are more likely to develop conflicts with their parents than male children, because of the privileges denied to them and the stricter parenting style (Espiritu, 2001). This conflict arises because females are encouraged to conform to traditional roles for women carved out by
their culture, yet they also want to fit into Canadian society (Khanlou et al., 2002). Children are generally young when they immigrate with their families, or are born here, and do not have a firm understanding of their parents culture. It would be valuable to investigate how this generation of South Asians negotiates the two cultures, that of their parents and the country they live in. Research with youth should focus on the effects of living in two cultures on health, stress levels and coping strategies that youth use, also highlighting any differences in gender (Khanlou et al., 2002). In 2003, females comprised more than half the immigrant youth population, or almost 9% of the total immigrant population (CIC, 2005). South Asian female youth in Toronto felt they experienced more stress than males, suggesting gender differences in stress levels among South Asian youth (Khanlou & Hajdukowski-Ahmed, 1999). Research that helps to contextualize the experiences of immigrant youth in Canada, can lead to effective prevention programs or coping models that emphasize the strengths and resilience of this group (Rousseau, Drapeau, Lacroix, Bagilishya, & Heusch, 2005).

This research study can also inform future research with immigrants who have settled in Canada longer than five years. This would help to understand the stress level of immigrants, the change in their help-seeking preferences, levels of awareness of services, and changes in levels of integration in Canadian society. It would be helpful to understand at what stage immigrants start to access services or feel a decrease in post-migration stresses. Further research around issues of racism and post-9/11 should also be explored, not only in recent immigrants, but also immigrants who have lived in Canada for longer periods because they might be able to better articulate their feelings around such issues. It is important to understand the ways in which post-9/11 has impacted their health.

This research thesis also discovered that South Asian women, other than developing resilience, have the potential to access primary health care services and are well-aware of the characteristics they would want a service provider to have. Therefore, future research can focus on developing models or strategies that deliver prevention and treatment programs to this population in a culturally, linguistically and gender appropriate manner. Developing holistic approaches
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would also be helpful, since it is equally important to understand a woman’s different lived experiences, like for most of the participants in this study who had an array of interconnected experiences.

Final Conclusions

The findings of this qualitative descriptive research study have helped to understand the unique experiences of the South Asian female community, by giving voice to the women and enabling them to talk about their settlement and health in their own words. Particularly, they suggest that immigrant women suffer from salient post-migration stresses that they report cause psychological distress. Settlement in Canada can be a difficult experience, since most of the women reported coming from comfortable lifestyles in their home country and had many positive expectations of Canada. The downward mobility they experience with respect to financial struggle, educational challenges and under/un-employment is shocking for them. Many women referred to the “tension” and strong feelings of distress that these factors have caused. All of the women experienced an interconnection of these post-migration factors.

The women reported that they were not seeking any help in primary or mental health care settings at this stage of their migration. Although this can be related to their cultural perceptions of mental health and illness, it was also discovered that these women have different coping strategies, than I expected, to deal with psychological distress. These strategies were primarily personal / religious activities, confiding in family and community, and avoidance. Only one woman had accessed mental health care services, while other women discussed that they would consider primary or mental health services if they felt they needed it. Therefore, these findings confirmed an underutilization of mental health services, but also highlighted the strategies, both cultural and religious, that these women prefer. The resiliency with which these women cope with post-migration stresses are representative of a South Asian woman. These women are strong individuals whose primary roles are to be wives and nurturers, and they are aware of the private and public boundaries within which one can discuss distress related to the families’ problems. However, I commend these women for being able to
talk to me, a stranger to them, about personal issues involving their families and private matters such as their health. Although there may be women who refused to participate in the study when approached by the staff at the community organization where recruitment was taking place, these nine women came forward to discuss their experiences. Although they may have withheld some information, perhaps due to their comfort level in discussing certain issues with a stranger, nonetheless, their stories were extremely helpful for my research and my own personal education.

In conclusion, I hope that this research study is able to provide insight and understanding to researchers and practitioners around South Asian immigrant women, through investigating the four initial research questions. Researchers and practitioners should be able identify, understand and respect the context and interconnections of South Asian women's immigrant experiences. This thesis has highlighted the importance of integrating religion and culture into models of care for South Asian women (Hussain & Cochrane, 2002), which would help to make services ever more accessible and appropriate if South Asian women considered primary or mental health services for coping with distress. This would also hopefully alleviate some of the barriers that women experience in accessing primary and mental health care. One participant (P9) talked extensively of her experiences with racism. Racism was reported not only as a barrier to access, but also a factor that can cause further distress, like for P3, P6, P7 and P9.

The women in this research study could not have emphasized more the importance of their roles, their religion and their culture. Therefore, being open to diversity and various lived experiences can help build or strengthen rapport between practitioners or researchers and the South Asian women that they work with. Being able to communicate and build rapport also entails being linguistically equipped. Language was important to most of the women, given five of the nine women still prefer to communicate in their mother tongue and six women had family doctors that were of the same cultural and linguistic background as them. Therefore, having interpreters or culture brokers can
facilitate communication between service providers and clients, increasing trust level and perhaps disclosure or expression of feelings.

In addition to highlighting many important issues related to post-migration, this thesis has also proposed directions for future research that would interest not only researchers but also practitioners who work in multicultural health settings. This qualitative research can be a stepping stone for future work in the area of access to mental health services and South Asian immigrant women.
References


Appendix A

Ethics Approval – McGill University Health Centre
Re. MCH004-08 Transcultural Mental Health: Cases with Immigrant South Asian Women

Dear Dr. Rousseau,

The above-named research proposal received Full Board review at the convened meeting of the Montreal Children's Hospital Research Ethics Board on March 22, 2004 and was found to be within ethical guidelines for conduct at the McGill University Health Centre, and was entered into the minutes of the Research Ethics Board (REB) meeting. At the MUHC, sponsored research activities that require US federal assurance are conducted under Federal Wide Assurance (FWA) 00000840.

Final approval for the research protocol and validated consent document (version 04/04) was provided by Dr. Jane McDonald, Chairperson of the Montreal Children's Hospital Research Ethics Board on May 26, 2004.

All research involving human subjects requires review at a recurring interval and the current study approval is in effect until March 21, 2005 (anniversary of original review). It is the responsibility of the principal investigator to submit an Application for Continuing Review to the REB prior to the expiration of approval to comply with the regulation for continuing review of "at least once per year".

It is important to note that validation for the translated version of the consent documents and information leaflet was certified by an MUHC translator. Any further modification to the REB approved and certified consent and assent documents must be identified by a revised date in the document footer, and re-submitted for review prior to its use.

The Research Ethics Boards (REBs) of the McGill University Health Centre are registered REBs working under the published guidelines of the Tri-Council Policy Statement, in compliance with the "Plan d'action ministériel en éthique de la recherche et en intégrité scientifique" (MSSS, 1998) and the Food and Drugs Act (7 June, 2001), acting in conformity with standards set forth in the (US) Code of Federal Regulations governing human subjects research, and functioning in a manner consistent with internationally accepted principles of good clinical practice.

We wish to advise you that this document completely satisfies the requirement for Research Ethics Board Attestation as stipulated by Health Canada.

The project was assigned MUHC Study Number MCH004-08 that is required as MUHC reference when communicating about the research. Should any revision to the study, or other unanticipated development occur prior to the next required review, you must advise the REB without delay. Regulation does not permit initiation of a proposed study modification prior to REB approval for the amendment.

Sincerely,

Jane McDonald, M.D., F.R.C.P©
Chairperson
Montreal Children's Hospital Research Ethics Board

Cc: Danuta Rylski, Montreal Children's Hospital Research Institute
Appendix B

Consent Form
Transcultural mental health: Cases with immigrant South Asian women

Researchers: Dr. Cécile Rousseau, Dr. Jaswant Guzder, Tulika Agarwal

Consent Form for Participants

The purpose of this project is to learn more about the health of South Asian women living in Montreal. Therefore, it is important to ask the South Asian community about what is important for them, what helps them and what does not. The goal of this project is to increase awareness of issues affecting the health of South Asian immigrant women and propose educational initiatives among health care professionals practicing in multicultural settings so that they can help the South Asian community. Your participation in this project would help us to reach our goal.

Questions will address your experiences as an immigrant woman in Montreal, sources of stress, help-seeking behaviours and strategies, barriers in accessing health services and barriers in working with clinicians. The interviewer will also be asking questions that will ask for your viewpoint on various things such as your role as a woman and what role culture plays in your life.

There are no risks anticipated for participating in this project. The benefits of participating in this project will be to help identify issues concerning South Asian immigrant women and their interaction with health services. Overall, this will help to improve the services and care that the South Asian community receives and health care professionals’ understanding of South Asian immigrant women.

Please read the following before providing consent:

1) I agree to participate in this study.
2) My participation involves a one-time individual interview that will last between 60 minutes to 120 minutes. The interview will take place at the South Asian Women’s Community Centre or at a location that is convenient for me.
3) I am aware that the interview will be audio-taped for accuracy reasons. This tape will be listened to and transcribed by the interviewer. The audio tape will be kept by the interviewer and erased once the tape has been transcribed.
4) The interview will be completely confidential and my identity will remain anonymous. The information I provide in the interview will only be shared with the research team.
5) The Research Ethics Board can be granted direct access to my records for verification of study procedures without violating my confidentiality, to the extent permitted by the law.
6) Should the results of this project be published or if direct quotes from my interview are used, all identifying information will be kept confidential and my answers will be treated anonymously.

7) My participation is voluntary.

8) I can withdraw my participation at any time and request for my information not to be used. This will not impact the services or care I am receiving at the South Asian Women’s Community Centre.

9) I am free to ask any questions regarding the project during and after my participation.

I have read the consent form and have had an opportunity to discuss it with the interviewer (a member of the research team). During the course of the study should I have any questions or concerns I am aware that I may contact either Tulika Agarwal or Dr. Cecile Rousseau at the Montreal Children’s Hospital (Transcultural Psychiatry Department) at (514) 412-4400 Ext. 23783. I may also contact the ombudsman at the Montreal Children’s Hospital, Elizabeth Gibbon at 514-412-4400, Ext. 22223 with questions regarding my rights as a research subject.

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Participant (please print) ___________________________ Signature ___________________________ Date ______________

Interviewer (please print) ___________________________ Signature ___________________________ Date ______________

Witness (please print) ______________________________ Signature ___________________________ Date ______________

Date of Interview ___________________________ Dr. Rousseau’s Signature ___________________________
Appendix C

Audio Taping Consent Form
Audio consent

Mental health of South Asian women: Dialogues with recent immigrants on post-migration, help-seeking and coping strategies

I hereby grant permission to the Research Team of this project (MUHC) (Name of institution) to make an audio recording.

The specific event or activity to be recorded is: Research Interview

The Date(s) upon which the recording will occur is:

The recording is being prepared for the following purpose: Research

And may be heard by: the Research Team (Interviewer and Supervisors)

I understand:

1. That the recording cannot be used for any other purpose or shown to any other audience than is listed on this form.

2. That although the recording may identify me as a member of the South Asian community, my personal identity WILL NOT be disclosed and my agreement or refusal to participate will in no way influence my access to services.

3. That I am entitled to withdraw my consent at any time. If I choose to withdraw my consent, I will inform Tulika Agarwal at the Montreal Children's Hospital at (514) 412-4400 Ext. 23783.

__________________________ (print name) ____________________________ (signature)

Date: _______________________

I have explained the content of the form and the implications of consent to this participant.

I believe that the participant's consent is freely given.

__________________________ (print name and position) ____________________________ (signature)

Date: _______________________

Appendix D

Demographic Questionnaire
Demographic Questionnaire

Mental health of South Asian women: Dialogues with recent immigrants on post-migration, help-seeking and coping strategies

PARTICIPANT INI ___ ___ ___

CODE ___ ___ ___

INTERVIEW DATE ___ ___ ___ / ___ / ___ ___

INTerviewer INI ___ ___ ___

Sex: M F Age: ___ ___

Date of Birth: ___ ___ ___ / ___ / ___ ___

Country of Birth: _________________________

How long have you been in Canada? ________________

Date of Arrival: ___ ___ ___ / ___ / ___ ___

First language learned at home? _______________________

Preferred language in Canada? _______________________

Do you speak English fluently? YES NO
Appendix E

Interview Guide
Interview Guide

Mental health of South Asian women: Dialogues with recent immigrants on post-migration, help-seeking and coping strategies

BACKGROUND:
Can you tell me about yourself and about your life back home?
Did you live with other people? Who were you living with?
If married, when did you get married?
What education did you have in India?
Did you work in India? If YES, what type of work were you doing? What did you like about it? If NO, did you want to work? What type of work would you like to do?
(If married) Did your husband work? What type of work did he do in India?
Do you have children? How many? What ages and gender? Did they live with you?

GENDER ROLES:
What were your duties as a woman in India?
How is a woman’s role viewed in India?
What did you find difficult or stressful as a woman in India?
What did you like about yourself as a woman?
Did you feel that your duties were different as a daughter? How is the role of a daughter viewed? What did you like or dislike about this role?
Did you feel that your duties were different as a wife? How is the role of a wife viewed? What did you like or dislike about this role?
(If married) Did you feel that your duties were different as a daughter-in-law? How is the role of a daughter-in-law viewed? What did you like or dislike about this role?
(If has children) Did you feel that your duties were different as a mother? How is the role of a mother viewed? What did you like or dislike about this role?

MIGRATION:
Why did you come to Canada? How did you feel about it?
Why did you come to Montreal?
Who moved here with you? Family or friends?
Have you met people from the same community in Montreal?
Did anyone move here with you?
Who do you live with now? What about when you first came here?
Did you know anyone living in Canada or Montreal before you came here? If yes, who? And how did you feel about knowing someone already? If no, how did you feel about not knowing anyone before?

MIGRATIONAL EXPERIENCES (Stresses and Opportunities):
Can you tell me about your experiences when you moved here?
Is it what you expected? Can you explain what you expected or did not expect?
What were the most common stresses or difficulties you faced when coming to Canada? Were there any additional stresses because of coming to Montreal? If so, can you explain what?
Which of these stresses were most difficult for you as a woman?
(If married) What about for your husband?
(If children) What about for your children?
Is there anything that you still have a hard time accepting or adjusting to?
Was there anything that caused more difficulty in moving here?
Did you feel language was a problem?

Do you feel there was anything that helped you in your move? (ie. religious or social)
Did you feel you had more opportunities by moving here?
What do you feel were the advantages to moving here for you?
(If married) What do you feel were the advantages for your husband?
(If children) What do you feel were the advantages for your children?

CHANGES OR CONTINUITY IN GENDER OR CULTURAL ROLES:
How do you feel women are viewed in Canada?
How do you feel women from India living here are viewed? Do you feel people stereotype you as an Indian woman?
How do you feel you are viewed by people outside of your culture as a wife? As a daughter-in-law? As a mother? As a daughter?
Has your role as a woman changed since moving here? Can you describe any changes?
Do you feel your role as a daughter has changed? What are the advantages or disadvantages?
(If married) Do you feel your role as a wife has changed? What are the advantages or disadvantages?
What about your role as a daughter-in-law? What are the advantages or disadvantages?
(If children) Do you feel your role as a mother has changed? What are the advantages or disadvantages?
Do these changes affect your husband or children or other relatives? How do they feel about these changes?

Is there anything that has not changed for you, with respect to your gender or your culture? Can you describe the things that have not changed or that you will not change?
Do you still keep in touch with relatives in India? How?
How do you think you husband or children feel about these changes?

REASON FOR VISITING SAWCC:
Why did you initially come to SAWCC? What did you expect when coming?
Did you have any concerns? What factors did you consider before coming here?
What role does SAWCC play for you? How?
Do you get support in other ways from SAWCC? How? In what ways? (ie. From staff or other women)
Do you feel coming here has helped you? How?
Do you feel there were any disadvantages or problems with coming here?
Does your family know you come here? How do you think they feel about it or would feel about it?
Do you feel things have changed for you since visiting SAWCC?
Is confidentiality important to you?

INTERACTION WITH SAWCC STAFF AND OTHER WOMEN:
What sorts of activities do you participate in? How do you feel about these?
Who do you meet at SAWCC?
How do you feel about your interaction with staff? What do you like or dislike about it?
What about your interaction with other women at the centre? What do you like or dislike about it?

What language do you prefer to communicate in?
Has SAWCC been able to communicate with you the way you want?
Would you consider meeting with someone who does not speak the same language as you? Why or why not? What advantages or disadvantages does this have for you?
Would you consider meeting with male staff? What advantages or disadvantages would this have for you?
Would there be anything that you would change about your visits to SAWCC?

OTHER PRIMARY FACILITY?
Have you ever visited or sought help at any other facility other than SAWCC?
(religious, social services, hospital, traditional)
If YES, continue with questions below.
If NO, would you consider going to a primary health facility or any other facility? Why or why not?

Have you ever visited a religious place (ie.temple)? If YES, for what purpose?
What did you feel were the advantages or disadvantages of going there? What did you find helpful about it? Were they sensitive to your gender and culture? Do you still visit there? Would you visit there again in the future? If NO, what are your reasons for not going there? What are your concerns? What changes would you make to the facility?

Have you ever visited a social services organization? If YES, for what purpose?
What did you feel were the advantages or disadvantages of going there? What did you find helpful about it? Were they sensitive to your gender and culture? Do you still visit there? Would you visit there again in the future? If NO, what are
your reasons for not going there? What are your concerns? What changes would you make to the facility?

**Have you ever visited a hospital or CLSC?** If YES, for what purpose? What did you feel are/were the advantages or disadvantages of going there? What did you find helpful about it? Were they sensitive to your gender and culture? Do you still visit there? Would you visit there again in the future? If NO, what are your reasons for not going there? What are your concerns? What changes would you make to the facility?

**Have you ever visited a traditional place (i.e. astrologer, traditional healer, homeopath)?** If YES, for what purpose? What did you feel are/were the advantages or disadvantages of going there? What did you find helpful about it? Were they sensitive to your gender and culture? Do you still visit there? Would you visit there again in the future? If NO, what are your reasons for not going there? What are your concerns? What changes would you make to the facility?