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Making connections: Greek and Sri Lankan Tamil perceptions of mental health, ways of coping, and help-seeking

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Making Connections: Greek and Sri Lankan Tamil Perceptions of Mental Health, Ways of Coping, and Help-seeking

By

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Abstract

This thesis explores the perceptions of mental health, mental health problems, depression, and the coping and help-seeking behaviour of Greeks and Sri Lankan Tamils in Toronto. The study was undertaken in collaboration with a community mental health agency located in the Toronto community council area of East York. The information from this study will be used to help the agency, "Alternatives," develop a strategy for reaching more members of diverse ethnic communities. In this study data were collected through interviews with Greek and Tamil service-providers and focus groups with lay community members using a qualitative, culturally sensitive, and participatory action research approach. For Greeks mental health is perceived as the ability to cope with the problems of everyday life. For Tamils mental health is part of one's approach to life, which includes the ability to cope with life and a good family life. For both ethnic groups, mental health problems are viewed as a disturbance in the mind and behaviour and as a disruption in one's life roles. Mental health problems are defined as visibly abnormal behaviour. Greeks perceive depression as unhappiness, while Tamils view it as a change in the mind or a health problem. In both groups depression is also believed to affect one's life roles. Greeks and Tamils attribute mental health problems to environmental, biological, and supernatural factors. Greeks attribute depression to environmental and individual factors, while Tamils attribute depression to environmental and biological factors. In coping with mental health problems and depression, Greeks and Tamils seek help from family members and medical professionals. They also use spiritual/religious approaches. In both ethnic groups, there is a stigma attached to mental health problems which affects the process of seeking outside help. In this study, I suggest a model of service that "Alternatives" can use to reach members of the diverse multicultural community.

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INTRODUCTION

In 1988, following the publication of Building Community Support for People: A Plan for Mental Health in Ontario (also known as the "Graham Report"), communities all over Ontario began to develop plans for community-focused and integrated mental health supports and services that would respond to the needs of people with serious mental health problems. In East York plans were developed to meet two key priority areas of case management and community support for residents with serious mental health problems. In 1992 "Alternatives," the East York Mental Health Counselling Services Agency, received funding from the Ministry of Health in order to meet these priorities. (In this thesis "Alternatives" will be subsequently referred to as Alternatives.)

When Alternatives began to provide services in 1994, it developed an interest in doing outreach into the ethnically diverse communities of East York. As part of its commitment to diversity, Alternatives formed an Ethno/racial Committee to explore how mental health is perceived by diverse ethnic groups in East York. I came onto the scene first as a volunteer member of the Ethno/racial Committee in the winter of 1995 and then again as a student exploring different possibilities for my thesis research the following summer. I hoped to do community research in the area of multicultural issues. After completing my course work in the M.A. Program in Community Psychology at Wilfrid Laurier University, I decided to approach Alternatives as a potential host setting for my thesis work. The Executive Director (ED) and I set up a meeting to discuss my involvement in the work of the Ethno/racial Committee. It was an ideal match. My relationship with the setting lasted for two years.

This thesis seeks to explore Greek and Sri Lankan Tamil perceptions of mental health and

ways of coping and help-seeking in the Canadian context. The information from this study will be used by Alternatives to develop a strategy for reaching more members of diverse ethnic communities. One of the guiding principles of community psychology is to understand and appreciate cultural diversity. In furthering the goal of diversity, Trickett, Watts, and Birman (1993) suggest a framework for integrating diversity into community psychology that would ground interventions in an understanding of the cultural and ecological context of diverse groups. In order to live up to its commitment to diversity, community psychology must address the way that mental health services are delivered to diverse groups. As will be noted in the literature review, there are a number of cultural barriers that prevent people from accessing services. One of the major challenges for community psychology in addressing diversity is the Western perspective which dominates mainstream mental health services and psychiatry and which fails to accommodate diversity. For example, in dealing with cultural minorities with mental health problems, medical professionals often fail to attend the importance of cultural information and information relating to social factors that may impact the mental health of clients. Thus, in designing culturally sensitive and relevant interventions, there is a need to understand the perspectives, beliefs, and behaviours of diverse groups (Vega & Murphy, 1990). The purpose of this thesis is to explore some of the beliefs and practices of two distinct groups.

This study was exploratory and based on a small sample of participants. Ethnicity was the key focus of the research. Ethnicity refers to "real or imputed descent from ancestors who shared a common culture or subculture manifested in distinctive ways of speaking and/or acting...in all cases, the kinship networks are the crucial bearers of the culture." An ethnic group is one that is "made up of people who share ethnicity...who share some sense of peoplehood or consciousness

of kind, who interact with one another in meaningful ways beyond the elementary family, and who are regarded by others as being in the one ethnic category" (Valle 1988, pp. 130-131, quoted in de Vries, 1990, p.232). The markers of ethnicity are language, religion, national origin, and/or physical characteristics (de Vries, 1990). In my thesis the terms "ethnicity" and "ethnic group" include people of European origin (Giordano & McGoldrick, 1996). Because ethnicity was the key emphasis in this research, differences related to age, social class, or education were not explored. Also, due to the small sample size and the fact that this was a study of two ethnic groups, I decided to focus on first-generation immigrants. Moreover, while it was not the explicit intention of this study to focus exclusively on women, the majority of participants who were recruited for the interviews turned out to be. Given that women are the predominant users of mental health services (Rhodes & Goering, 1994; Russo & Sobel, 1981; Smead, Smithy-Willis, & Smead, 1982; Veroff, Kulka, & Douvan, 1981), it is particularly appropriate that this convenience sample of women was used.

In this thesis I use the terms "mental health" and "mental health problems"/ "mental illness", not in terms of the Western biomedical model, which attributes certain symptoms to biological causes, but as a way to elicit how these terms are perceived by members of diverse ethnic groups. I use these terms because of the constraints imposed by the English language. The terms "mental health problems" and "mental illness" are used synonymously in this paper. However, I try to use the term "mental health problems" more frequently in an attempt not to bias thinking and to respect Alternatives's non-medical model of support. In this thesis the term "depression" is used to refer to a set of symptoms that North American medical professionals consider as major depression. The aim will be to elicit how these symptoms are perceived by

different ethnic groups.

This thesis is divided into two sections. In the first section of the thesis I do a brief review of the literature on mental health services and cultural diversity. I also present a framework for understanding how people perceive and respond to mental health problems by focusing on the sensitizing concepts of worldview and acculturation. The first section concludes with the purpose of the study and the research questions. In the second section of the thesis I present the method, findings and discussion, limitations, conclusion, and some personal reflections as a researcher.

LITERATURE REVIEW

Over the past 30 years, Canada has experienced a dramatic change in the nature of its population. Traditionally, the majority of Canada's immigrants have come from Europe. From 1867 to 1930, Canadian immigration policies were based on an ideology of assimilation that assumed that certain groups of immigrants would blend into the Canadian mold. The preferred sources of immigrants were from Northern Europe, followed by immigrants from Western Europe. People from Eastern and Southern Europe were less desirable, as were those of Asian origin. These groups of immigrants were believed to be less assimilable (Palmer, 1990). In the 1960s, as a result of changes to its immigration policy, Canada opened its doors to immigrants who had been restricted from entering Canada because of their national origin. These immigrants came from countries in Asia, Africa, and Latin America. Canada is now a rich mosaic of racial, ethnic, and linguistic communities. This diversity is mostly evident in urban centres where most immigrants settle, and particularly so in Toronto. Shaped by waves of immigration, Toronto has the highest concentration of Canada's visible minorities. According to a recent report on diversity, by 2000 visible minorities will comprise 54% of the population of Toronto (Carey, 1998).

A significant turning point in Canada's changing attitude toward diversity was the shift from biculturalism to cultural pluralism during the Trudeau era. With the introduction of the policy of multiculturalism in 1971, the federal government acknowledged the multicultural character of Canada. Sources of funding were allocated by the government to develop initiatives that would help ethnic groups to preserve their language and culture. The Multiculturalism Act of 1988 declared the government's official commitment to a policy of multiculturalism in Canada, which aimed to "preserve and enhance the multicultural heritage of Canadians..." (Elliott & Fleras, 1990, p.70).

Mental Health Services and Cultural Diversity

With the changing pattern of immigration in the 1960s researchers and practitioners in the fields of health, mental health, and education have been forced to grapple with the issue of diversity. Educators have long recognized that traditional philosophies and approaches are not effective in meeting the needs of Canada's multicultural population (Samuda & Wolfgang, 1985). The concepts of multicultural health have been incorporated into health care in order to better respond to diverse ethno/cultural communities (Masi, Mensah, & McLeod, 1993). Professional schools, such as nursing, have realized that monocultural models of care are not sufficient for equipping students with the skills needed to serve people from diverse communities and have taken steps to develop more culturally inclusive curricula (Committee for Intercultural Interacial [sic] Education in Professional Schools, 1994). In the field of mental health, an extensive review of the research was conducted on the mental health status of immigrants and refugees and the types of mental health services which are needed to meet their needs (Review of the Literature on Migrant Mental Health, 1988).

Although important developments relating to cultural diversity have occurred, there still remain a number of challenges that need to be overcome if diverse ethnic groups are to be served appropriately. As noted earlier, one of these challenges relates to the mainstream mental health system in North America. The mainstream mental health system is based on a perspective that places a strong emphasis on biological factors and drug therapy, some emphasis on psychosocial factors and treatments, but little emphasis on spiritual factors and healing. This perspective is not holistic because it focuses on the individual to the neglect of the person's social context. Rarely is there an attempt to diagnose or change the social context of person with mental health problems (Hare-Mustin & Maracek, 1997). I provide further detail about the worldview of North American medicine and psychiatry later in the literature review.

One issue that has plagued the community mental health field is its failure to serve the needs of ethnic minorities (Vega & Murphy, 1990). A basic concern that continues to be raised is the underutilization of mental health services by ethnic groups. In Canada, and especially in the province of Ontario, where the majority of Canada's immigrants settle, several studies have sought to identify the barriers preventing the access of immigrants, refugees, and ethnic groups of colour to mental health services. Among the barriers to access are cultural barriers, including the lack of culturally appropriate services. Other barriers to access include linguistic barriers, the stigma attached to mental health problems, gaps in information about services, the lack of information about mental health problems, financial barriers, and racism (After the Door Has Been Opened, 1988; Improving Mental Health Services and Supports for Diverse Ethno/racial Communities in Metro Toronto, 1992; Nguyen, 1984; Nyman, 1992).

One barrier that deserves attention is the subtext of racism surrounding the delivery of

care. In Canada systemic racism is pervasive, limiting the access of communities of colour to appropriate care. As one study found, racism was "identified repeatedly as a barrier to accessing services and to receiving care which respected the individual, was free of bias, and reflected the individual's experiences and needs" (Improving Mental Health Services and Supports for Diverse Ethno/racial Communities in Metro Toronto, 1992, p.32). Wong (1991) described racism as "an invisible barrier" to the access and participation of racially visible people in social and health services that is reflected in limited access, hiring practices, and the composition of volunteers and board members. Systemic racism is manifested in the marginalized position of the "ethnic worker" within agencies (Fong & Gibbs, 1995; Tator, 1996). It is perpetuated by structures including the education of social work students (Christensen, 1996) and the two-tiered social service system consisting of mainstream social agencies on the one hand, and poorly funded ethno-specific agencies, on the other (Chan, 1987). In addition to systemic racism, racism exists among Canadians on an individual level. A recent national survey of attitudes toward ethnic groups found that ethnic groups and immigrants of European origin were evaluated more positively than ethnic groups of colour (Berry & Kalin, 1995).

According to Nyman (1992), the most prevalent barriers that ethnic groups face are cultural barriers. One particular cultural barrier that the author notes which is of interest to the present study relates to the different perceptions that ethnic groups have about "mental health" and "mental illness." While too numerous to mention here, there is quite a substantial volume of research showing the influence of ethnicity on the way that people interpret mental health problems (e.g., Hall & Tucker, 1985; Milstein, Guarnaccia, & Midlarsky, 1995).

Ethnicity has a further influence that is of particular relevance for this study. The way that

an ethnic group perceives mental health and mental health problems also affects how members of the ethnic group express their symptoms and their help-seeking behaviour and use of mental health resources (Casimir & Morrison, 1993). In fact, one explanation that ethnic groups underutilize mental health services stems from their different perceptions of mental illness (After the Door Has Been Opened, 1988; Narikiyo & Kameoka, 1992; Torres, 1983; Ying, 1990).

Beliefs about Mental Health and Mental Health Problems, Help-Seeking Behaviour, and Cultural Diversity

An explanatory model (Kleinman, 1975; 1980) provides a useful theoretical framework for understanding the health beliefs and behaviours of people from any given culture. According to this framework, people perceive and respond to health problems and treatment based on explanatory models (EMs). EMs apply to specific health problems. They are held by clients, family members, and practitioners. When these group interact, their EMs may "clash." The discrepancy between client and practitioner EMs may be a result of problems in clinical communication and may affect the client's compliance with treatment and use of the health care system (Kleinman, 1980).

The importance of the explanatory model framework is that it explains how culture affects how people perceive and respond to health problems. Moreover, the model applies not only to people in their home countries, but also to acculturating groups (Kleinman, 1975). I would like to build further on this framework by introducing two sensitizing concepts that may help to shed light on culturally-based beliefs about "mental health" and "mental illness" from the perspective of Greeks and South Asians (i.e., people from India, Pakistan, Bangladesh, and Sri Lanka). First, in order to understand beliefs about mental health, the nature of these beliefs needs to be explored in

some depth. Beliefs about mental health are embedded in a culture's worldview and concepts about the self which need to be understood. In the section that follows I describe the worldview of the cultures of the Mediterranean area and the worldview of "Eastern" cultures. I also describe the worldview that forms the basis of Western mental health services (i.e., North American medicine and psychiatry). The purpose here is to illuminate the differences that exist between the worldview that guides North American mental health services, on the one hand, and those of Greeks and South Asians, on the other. Finally, I introduce the notion of acculturation since health and illness beliefs need to take into account the process of migration that ethnic groups experience and the potential influence of acculturation on these beliefs. The following sections deal with each of these concepts.

Worldview

According to Fernando (1991) and Kakar (1982), concepts about mental health need to be understood in the context of a culture's worldview. These ideas may be linked with identity, religious and spiritual beliefs, and ethical values. As Fernando stated: "The overall worldview, appertaining to health, religion, psychology, and spiritual concerns, determines the meaning within that culture of 'madness', mental illness, and mental health"(p.79).

The key to unlocking an ethnic group's worldview and beliefs about mental health is to understand the way in which the self is conceptualized in that ethnic group. In fact, several authors maintain that concepts about mental health reflect concepts about the self or person (Fabrega, 1989; Kakar, 1982; Lefley, 1994; White & Marsella, 1982). In their synthesis of a collection of papers exploring cross-cultural conceptions of self, White and Marsella (1982) state that concepts of self are not concrete and cannot be accessed directly. However, concepts of self

consist of a number of dimensions that are helpful in understanding culturally-based beliefs about mental health. These dimensions include: a) relations between the body, mind and environment; b) relations between self and other; and c) ideas about causality and responsibility (White & Marsella, 1982).

The themes of individualism and collectivism bring further clarity to the notions about self existing in different cultures. As Lefley (1994) maintained, in any given culture, there is a close relationship between concepts of self and the emphasis that is placed on the individual as compared to the group. According to Triandis (1995), individualism and collectivism are traits that exist in every culture, to varying degrees. Individualist societies include the following characteristics: an independent self, a lack of congruence between the goals of the individual and that of the group, and an emphasis on personal needs and rights. By contrast, in collectivist societies, there is an interdependent self, a congruence between personal and communal goals, and a focus on duties and obligations, as well as relationships. Triandis notes that the traits of individualism and collectivism are found in all individuals and cultures. Thus, a collectivist culture may have individualist tendencies, and vice versa. Furthermore, individualists attribute events to causes that are inside the individual, whereas collectivists attribute events to causes that are outside the individual. In individualistic cultures, the individual is responsible for wrongdoing, whereas in collectivist cultures, the collective is responsible if a member of an ingroup does wrong.

In understanding the worldview of people from different ethnic groups, some authors have made a comparison between people from "Eastern" and "Western" cultures. In the worldview of individuals from "Eastern" cultures, mental health is understood in terms of a

balance between the person and her/his social context (Fernando, 1991; Kakar, 1982). Among Eastern cultures, such as India, which consists of cultures with collectivist orientations (Triandis, 1995), there is an interconnection between the mind, body, and environment. There is also an interdependence between self and other (White & Marsella, 1982) (cf. Kakar, 1982). In addition, there is a belief that bodily events, supernatural forces, and social relations have multiple and interacting effects on one another. Finally, since boundaries between the self and other are blurred, there is the possibility that blame for illness may be shifted to others (Lefley, 1994; White & Marsella, 1982). This worldview is found in the Indian Ayurvedic system of belief (White & Marsella, 1982). In this health belief system, the mind, body, and soul are connected holistically (Ramakrishna & Weiss, 1992).

According to Gaines (1982), there are distinct cultural traditions in the West. The first is from Northern Europe and the second is from the Mediterranean. The difference in these traditions is based on religion (i.e., Protestantism versus Catholicism). The worldview of Protestant Europe is characterized by a practical, empiricist, and non-magical approach to solving problems. Explanations for events are found in the physical and tangible world and there is a belief that actions have to be achieved in this world, not in the world of the supernatural. The American field of medicine and psychiatry reflects this Northern European tradition.

In the Protestant European tradition, the self is defined as an autonomous and coherent whole (Gaines, 1982). Further information about the way that the self is conceptualized along the three dimensions of mind-body-environment relations, self-other relations, and causality and responsibility are provided by White and Marsella (1982). In the West distinctions are drawn between the mind and body, on the one hand, and the body and environment, on the other. In

terms of "self-other relations," the individual is viewed as autonomous. Mental illness is regarded as a disruption of one's "ego" or "identity." With regards to causation and responsibility, the cause of mental illness is believed to be in the psyche and the individual is viewed as responsible (White & Marsella, 1982). This emphasis on the independent self and the individual's responsibility for illness is consistent with some of the qualities of individualist societies, as noted earlier.

As was mentioned, there is a second Western tradition with a worldview and concept about self that are distinct from that of Northern Europe. According to Gaines (1982), the Mediterranean region, which includes the cultures of Latin Europe, is characterized by an "enchanted world view" and a "dualistic cosmology." This worldview is shared among Catholics, as well as fundamentalist groups. Among the many features of the Mediterranean Latin group are familism, masculine honour, familial honour, defined sex roles, sexual shame, and authoritarianism.

In the Mediterranean region, the self is not autonomous or distinct because it includes others as well. As Gaines (1982) stated, the "Mediterranean self is a social self"(p.184). In addition, the self may present itself in different contexts. Another characteristic of the Mediterranean self is that it is not distinguished from the natural and the supernatural world. Gaines compared the Mediterranean self to the Protestant self:

> The boundary of the Latin self is not drawn around a single biological unit, but around the "foyer", [sic] The self consists in part of significant others, primarily family. Thus, the self is partly composed of elements over which the individual has no control. Hence the self is seen as controlled from without by the demands of kith and kin, of fate or elements in the spiritual world. This self stands in stark contrast with the bounded, autonomous and, therefore, self-regulated and self-reflective Protestant individual. Rather than reflecting upon or examining motives and causes in one's behaviour, forces outside of the individual are seen as causative of the behaviour of the self and other. These forces are both material and

immaterial, of this world and the next. (Gaines, 1982, p.184)

Evidence indicates that Greeks share the Mediterranean concept of self (Gaines, 1982). Gaines reported that across the Mediterranean region, there is a prevalent belief in the "evil eye." This is reported by other authors (F. T. Elworthy, 1958, as cited in Blum & Blum, 1965; Moss & Cappannari, 1976). It is thought that an individual who has feelings of envy or admiration for another person has the ability to cause injury to that person by his or her glance. As a form of witchcraft, the evil eye can be removed from the sufferer by specific cures and ritual words (Blum & Blum, 1965; Skinner, 1966). Greeks are a Mediterranean culture (Primpas-Welts, 1982) who have a belief in the evil eye (Blum & Blum, 1965; Ontario Ministry of Culture and Recreation, 1976; Patterson, 1976; Primpas-Welts, 1982; Skinner, 1966). There is even more compelling evidence to support the claim that Greeks are Mediterranean in terms of their worldview and self-concept. First, Greeks share many of the features of Mediterranean Latin cultures that Gaines (1982) noted. For example, among Greeks, importance is placed on family honour (Campbell, 1964; Chimbos, 1980; Primpas-Welts, 1982), masculine honour (Campbell, 1964; Primpas-Welts, 1982), sexual shame (Campbell, 1964; Chimbos, 1980), and authoritarianism among males (Chimbos, 1980; Primpas-Welts, 1982). Second, the Greek concept of self is not autonomous, but rather it is defined in relation to the group. Greeks have no concept or word for privacy (Blum & Blum, 1965; Ontario Ministry of Culture and Recreation, 1976; Pollis, 1965; Skinner, 1966).

Because the self is defined in terms of others, personal goals and aspirations are not relevant to the person. Instead, there is an emphasis on fulfilling one's obligations and loyalties within a group. Greeks are only responsible for fulfilling obligations and loyalties vis-a-vis the group. However, unlike in the West, Greeks do not have an idea of personal responsibility. The

highest value among Greeks is *philotimo* (love of honour), which refers to the consistency of an individual's behaviour in the context of his/her membership group. One of the requirements of *philotimo* is that one needs to maintain a good public image. Members of one's ingroup do not admit that there are problems in the group because to do so would bring shame to the group (Pollis, 1965). Because of *philotimo*, Greeks do not take personal responsibility for their problems; neither are they blamed for their illness (Blum & Blum, 1965).

Acculturation

The second sensitizing concept relates to the notion of acculturation. Although acculturation is not identified as an explicit part of the explanatory model, the model does suggest the influence of acculturation on a client's health care decisions. For instance, information provided from a case example by Kleinman (1975) illustrated a Chinese patient with mental illness in the United States who used a combination of traditional Chinese and Western drug treatments. Kleinman referred to the fact that this individual was "acculturated sufficiently to enable him to shift his expectations somewhat and to use technologically-based medical care appropriately" (p.649).

To appreciate the notion of acculturative influences on health beliefs more fully, it is helpful to draw on the work of Berry (1989). Berry defined psychological acculturation as "the process by which individuals change, both by being influenced by contact with another culture and by being participants in the general acculturative changes under way in their own culture"(p.204). According to Berry, attitudes to acculturation depend on people's desire to maintain their cultural identity, on the one hand, and their desire to have relations with the dominant society, on the other. Acculturating groups respond in one of four different ways: assimilation, separation,

integration, or marginalization. Assimilation is the desire to give up one's cultural identity and to merge with the dominant culture. When separation occurs, there is an emphasis on maintaining one's culture and having no association with the dominant culture. With integration, there is both an interest in maintaining one's culture and interacting with the dominant culture. Marginalization occurs when there is no interest in maintaining one's culture or associating with the dominant culture, often because of discrimination (Berry, 1989).

There is some evidence that an ethnic group's beliefs about mental illness evolve over time and that there is a syncretism of beliefs. According to Vega and Murphy (1990), the set of beliefs that an ethnic group holds about mental illness undergo qualitative changes through the process of acculturation. While minimally acculturated individuals may hold on to one view of mental illness, highly acculturated members may have a different belief system. The authors also note that the members of an ethnic group may hold different beliefs about mental illness depending on their education and income.

By considering the influences of both tradition and change, the acculturation model provides a conceptual frame for situating a group's beliefs about illness (and illness behaviour) within its proper socio/cultural context. As Beliappa argued (1991), one should not presume that the illness beliefs of people who have left their home country have remain unchanged. As she stated, "...the tendency to transpose models of illness dominant in the home countries in order to explain local experience could lead to unrealistic assumptions of the immigrant population. Some of this is responsible for the static and stereotypical conceptions used to understand Asian communities"(p.2).

Greek and South Asian Perceptions of "Mental Health," "Mental Health Problems," Ways of Coping, and Help-seeking

Perceptions of "Mental Health" and "Mental Health Problems"

Greeks

Among Greeks, mental and emotional problems are perceived to be a physical or organic problem of the "nerves" (Patterson, 1976; Primpas-Welts, 1982). *Nevra* is a way of expressing distress among Greek women who experience work-related stress and the responsibility of caring for children (Dunk, 1989). Greeks do not like to admit that they have emotional or psychological problems (Dunkas & Nikelly, 1975; Ontario Ministry of Culture and Recreation, 1976; Patterson, 1976). To suggest that one has a psychological problem is equivalent to branding a person as crazy (Primpas-Welts, 1982). Problems are presented to service-providers in terms of physical/somatic complaints which are considered to be more acceptable to Greeks (Dunkas & Nikelly, 1975; Patterson, 1976; Primpas-Welts, 1982). Depression is viewed as a physical condition as well and is thought to be sadness (Primpas-Welts, 1982).

Among Greeks, there is stigma and shame attached to mental illness (Blum & Blum, 1965; Hartocollis, Georgas, & Katakis, 1966, as cited in Bouhoutsos & Roe, 1984; Kendall, 1989a; Ontario Ministry of Culture and Recreation, 1976). Mental illness reflects upon the entire family and has negative social consequences for the individual and the family, including social isolation and diminished prospects for marriage (Blum & Blum, 1965; Safilios-Rothschild, 1968). In rural Greece families try to conceal information relating to mental illness from others, including doctors (Blum & Blum, 1965).

South Asians

According to the Ayurvedic theories of medicine in India, the mind, body, and soul are viewed as a holistic system. A disruption in this system brings about illness (Ramakrishna & Weiss, 1992). South Asians share similar views about illness which are based on Ayurvedic medicine (Assanand, Dias, Richardson, & Waxler-Morrison, 1990). The literature is unclear as to whether depression is viewed as a physical and/or mental problem. Some evidence indicates that depression is considered to be a somatic problem among South Asians (Assanand et al., 1990). However, a cross-cultural study of community perceptions towards mental disorder found that depression is neither viewed as a physical problem nor as a mental health problem among people in India (Wig, Suckman, Routledge, Srinvasa, Murthy, Ladrido-Ignacio, Ibrahim, and Harding, 1980, as cited in Furnham & Malik, 1994).

Some studies have reported that there is stigma attached to mental illness in India (see Durvasula & Mylvaganam, 1994). Mental illness reflects on an entire extended family, affecting family honour. The stigma associated with mental illness reflects on the belief in the concept of Karma, which postulates that one's actions in a past life influence one's present life (Dr. Josephine Naidoo, personal communication, July 26, 1996). Durvasula and Mylvaganam (1994) suggested that traditional beliefs about mental illness, along with the perceptions relating to stigma and shame, are likely to persist among South Asians who have settled in the United States over the past 30 years. However, it should be noted that some have questioned the prevalence of stigma among South Asians, citing evidence that South Asians do not attach stigma to mental illness when they are in a counselling environment that is culturally sensitive (Webb-Johnson, 1991).

It has been widely reported that South Asians express their mental health problems in

physical/somatic terms (Ananth, 1984; Assanand et al., 1990; Bal, 1987; see Durvasula & Mylvaganam, 1994). A number of explanations have been given for this phenomenon. Somaticization may occur because of the holistic views that individuals hold about health (Durvasula & Mylvaganam, 1994; Webb-Johnson, 1991). Individuals may also conform to the expectations of the medical practitioner (Bal, 1987; Durvasula & Mylvaganam, 1994) or they may try to reduce the stigma associated with mental illness (Ananth, 1984; Bal, 1987; Durvasula & Mylvaganam, 1994).

Studies have found that somaticization occurs among Indian patients with depression. One study found that although 100% of the patients were rated as having the symptom of depressed mood, they emphasized their physical complaints, but only 20% reported their depressed mood. The authors concluded that this symptom was suppressed because of the stigma attached to negative emotions (Puri, Kumar, Mulhotra, & Puri, 1995). Another study found that there is stigma attached to depressive symptoms among patients in South India (Raguram, Weiss, Channabasavanna, & Devins, 1996). Again, it should be noted that the notion that South Asians somaticize their symptoms has also been challenged. Webb-Johnson (1991) asserted that all ethnic groups express their complaints in physical terms to some degree. South Asians do not somaticize any more than other ethnic groups and, therefore, they should not be singled out.

Views about Causation

Greeks

Greeks attribute mental illness to a number of causes. Mental illness may be attributed to heredity (Kendall, 1989a; Paras, 1992). Furthermore, Greeks attribute internal disturbance and distress to individuals or forces in the external environment (Dunkas & Nikelly, 1975; Skinner,

1966). Rural Greeks attribute madness to devils or demons (Blum & Blum, 1965). According to a community profile of Greeks in Toronto, Greeks believe that overwork, stress, and exhaustion cause mental illness (Kendall, 1989a). Depression is attributed to a "loss" or "trauma" or the evil eye (Primpas-Welts, 1982).

South Asians

South Asians have different explanations for mental illness. There are supernatural views of causation. These include the belief that mental health problems are related to Karma due to an experience in a past life (Building Bridges to the Community, 1994; Menon, 1984; Narayanan, Mohan, & Radhakrishnan, 1986). There is also a belief that evil spirits or demons may cause mental health problems (Srinivasa & Trivedi, 1982; Webb-Johnson, 1991). This belief is prevalent in Sri Lanka (Satkunanayagam, 1980). Furthermore, mental health problems may be attributed to a violation of taboo or sorcery (Weiss, Sharma, Gaur, Sharma, Desai, & Doongaji, 1986). Other explanations of mental health problems include heredity, mental worries (Srinivasa & Trivedi, 1982), a humoural imbalance, or a psycho-social stressor (Weiss et al., 1986).

Coping and Help-seeking

Greeks

In dealing with psychological problems, Greek-Canadians turn initially to their family for arriving at a solution to the problem. This is followed by friends and possibly also a priest (Patterson, 1976). In rural Greece, because of the shame associated with mental illness, residents may not seek treatment for fear that the mental illness will be known to others and that the family's honour and personal *philotimo* will be jeopardized (Blum & Blum, 1965). There is stigma attached to seeking help for emotional or psychiatric problems (Bouhoutsos & Roe, 1984;

Dunkas & Nikelly, 1975). However, Kendall (1989a) reported that Greek-Canadians accept psychiatric help, which suggests that they may have a greater acceptance toward help-seeking as a result of acculturation. A survey of help-seeking behaviour of people with mental illness conducted by Madianos, Madionou, and Stefanis (1993) in Greece found that there is stigma associated with seeking help from a psychiatrist. Among Greeks, psychiatrists are associated with crazy people (Dunk, 1989; Safilios-Rothschild, 1968). Psychiatrists are the last line of resort and are sought in the event of a crisis, as are social workers (Dunk, 1989; Patterson, 1976). Greeks prefer to seek help from family physicians (Madianos et al., 1993). However, Safilios-Rothschild (1968) reported that Greeks mistrust their doctors and delay the help-seeking process until the situation becomes acute. They prefer to seek help from a doctor who is a close friend or relative. Greeks do not usually go to individual or group therapy (Kendall, 1989a; Primpas-Welts, 1982) and are unwilling to go to psychologists and social workers because of the stigma attached to mental health problems (Dunk, 1989). In Greece there are few outpatient mental health services and psychologists. It was only until recently that psychology began to emerge as a science and profession (Bouhoutsos & Roe, 1984).

South Asians

South Asians use intra-familial coping[1], as well as spiritual/religious, and medical ways to cope with mental illness. In India the family takes a primary responsibility for caring for relatives with mental health problems. South Asians are family-oriented and believe that the family is responsible for taking on the caregiving role. Family members seek support from relatives and friends (Kakar, 1982; Shankar, 1994). In Canada individuals with serious mental illnesses may be

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[1]The term "intra-familial coping" was used by Lin, Tardiff, Donetz, and Goresky (1978).

hidden by their family members and not receive treatment for a long period until a major crisis occurs that brings them to a hospital emergency room (Assanand et al., 1990). In India there are a variety of healers to whom people turn for help (Kakar, 1982). Most Indians go to faith healers before going to a psychiatrist (Varma & Chakrabarti, 1995). In Sri Lanka a ceremony is performed to exorcise the demon or spirit that is believed to possess the mentally ill person (Satkunanayagam, 1980). Spiritual practices are still practiced by South Asians in North America. In Canada South Asian families may consult astrologers and palm readers (Assanand et al., 1990). South Asians in the United States may consult Hindu priests about emotional problems such as depressed mood (Durvasula & Mylvaganam, 1994). South Asians in North America may also go for medical help. In the United States, few healers exist and South Asians are likely to get medical help for problems that they view in terms of a humoural imbalance (Durvasula & Mylvaganam, 1994). In Canada most South Asians seek medical help for problems brought on by environmental stressors, such as family problems or problems associated with migrating to a new culture. In coping with depression, South Asians seek medicine from a doctor. Although some South Asians may go for psychiatric help, most prefer to get help from community agencies than psychiatrists or the mental health system (Assanand et al., 1990).

Summary

This literature review reveals that Greeks and South Asians attribute mental health problems to biological, environmental, and supernatural factors. In both groups there is stigma attached to mental health problems. In terms of coping and help-seeking, Greeks and South Asians turn to family, friends, spiritual/religious healers, and medical professionals. A more detailed exploration is needed about how Greeks and Sri Lankan Tamils perceive mental health

and mental health problems in the Canadian context. Further information needs to be gathered about Greek and Tamil views about causation in this context. As well, information about the acceptability of mental health problems and ways of coping and help-seeking in Canada is required.

Purpose of the Study and the Research Questions

Based on the literature review and a consultation with the ED at Alternatives, the host setting for the research, I identified the purpose of the study and the specific questions that the research should address. The purpose of the study was three-fold: a) to provide information about the way that Greeks and Sri Lankan Tamils in Canada perceive mental health and mental health problems, as well as the modes of coping and help-seeking that they use to deal with these problems; b) to use this information to develop an outreach strategy that will have implications for programming at Alternatives; and c) to raise the profile of Alternatives. I will suggest some directions that Alternatives may consider in supporting members of diverse ethnic communities.

The research aims to explore the following questions as they apply to the Canadian context:

1. How do Greeks and Sri Lankan Tamils perceive "mental health," "mental illness," and what North Americans regard as the symptoms of "major depression"? Is depression viewed as a "mental illness"?
2. What do they perceive are the causes of mental health problems and depression?
3. What types of coping and help-seeking do they use to respond to mental health problems and depression?
4. What role should Alternatives play in reaching out to people with serious mental health

problems from diverse communities in the context of the above research questions?

METHOD

Principles Guiding the Research

This study was guided by three general principles. The research used a qualitative approach; it was guided by a participatory action-research framework; and it aimed to be culturally sensitive.

Qualitative Research

According to Guba and Lincoln (1994), a "paradigm" refers to a set of beliefs about the nature of reality and the research methods that can be used to investigate that reality. There are four paradigms that guide qualitative research: positivism, post-positivism, critical theory, and constructivism. In qualitative approaches that are informed by the constructivist paradigm, it is assumed that there are several, socially constructed, and everchanging realities about the world. In these qualitative approaches to research, the aim is to understand the constructions that participants hold (Guba et al., 1994). In this research I worked from a social constructivist paradigm.

Participatory Action Research

Participatory action research is based upon the following principles: a) the research aims to bring about change; b) it focuses on understanding the perspectives that participants bring to the research; c) research questions are framed in a way that is clear and easy to understand; and d) the methods for collecting the data are appropriate to answering the research questions. In participatory action research, the researcher follows a number of guidelines regarding the design of research, the development of research questions, the statement of assumptions, and the

agreement to protect confidentiality. Furthermore, in analysing the data, the researcher reflects participants' experiences and gives details about how the conclusions were drawn. In participatory action research, the community has control of the research process (Barnsley & Ellis, 1992).

Culturally Sensitive Research

According to Hughes and Dumont (1993), there is a need to examine all stages of the research process for ethnocentric biases. These include the stages of problem formulation, population definition, research design, methodology, and data analysis. A number of strategies were used in this study to achieve these goals. The research tools were assessed, as much as possible, for their cultural sensitivity by people from the ethnic communities. Materials were translated in participants' home language in lay terms. Furthermore, participants were interviewed in their home language by people from their ethnic communities. Some attention was also given to understanding the diversity within both the Greek and Sri Lankan Tamil communities. As Vega (1992) emphasized, it is important to define a population under study in a way that captures within-group differences. Hence, this study attempted to collect background information from informants in the following areas: languages spoken, religion, whether respondents came from an urban or rural setting in their home country, and length of stay in Canada. Finally, throughout the research, I made an attempt to avoid stereotyping by reflecting on my assumptions as well as the way that I interpreted the findings.

Context of the Research

Description of the Setting

"Alternatives" is a small community-based mental health agency in Toronto's community council area of East York. Its mandate is to improve the quality of life of people with lengthy

and/or significant mental health problems through counselling and case management. The three criteria used to identify people with serious mental health problems are diagnosis, disability, and duration (Ontario Ministry of Health, 1993). Alternatives provides individual community support and counselling, groups, advocacy, and linkages to other services. The agency is guided by a set of values that include respect and the celebration of differences. Alternatives's approach to mental health is not based on a medical or illness model. It challenges the stigma of mental health problems and tries consciously to get individuals to see beyond their diagnoses. The staff consists of four counsellors, an outreach worker, an administrator, and an ED. The agency has a Board of Directors, committees and work groups, which include people with mental health problems, service-providers, family members, and members of the community.

Since Alternatives first began providing services in 1994, it has taken an active interest in looking into the diversity of the community. Alternatives was asked to become a site for a pilot study of ethno/racial outreach by the Ethno-racial Mental Health Committee, a working group at the DHC level concerned with putting anti-racism on the agenda of mental health reform. Alternatives decided to incorporate these concerns into its agenda by establishing the Ethno/racial Committee. As one of its terms of reference, this committee aimed to explore the perceptions of mental health of diverse ethnic groups in East York.

My Entry into the Setting

My involvement at Alternatives began after attending a day-long public educational event in January, 1995 organized by the agency's Outreach Worker called "The Survivor Voice Silent No Longer." The event was about the role that psychiatric consumer/survivors have played in mental health reform. During a break at the forum, I met a staff member from Alternatives who

encouraged me to join one of the agency's committees. My experience on the committee was highly positive. I was drawn to the respectful manner in which the ED worked on the committee and the commitment to integrity and authenticity among staff and volunteers that was rare in my experience with traditional mental health settings. Essentially, Alternatives worked from a value base that I shared and provided an environment where I felt safe, valued and respected as a volunteer. After a few months of working on the committee, I was accepted into the M.A. program in Community Psychology at Wilfrid Laurier University and thus, had to terminate my involvement with the agency.

Once I completed my course requirements in the program, I returned to my home in Toronto the following spring to begin my eager search for a thesis topic. In selecting a thesis topic, there were two personal goals that I hoped to fulfil. The first goal was to find a topic in the area of multicultural issues, an area which is of great interest me. The second goal was to offer my skills in community research to a human service organization in a way that was beneficial to the organization and the community. After exploring some possibilities, I contacted the ED at Alternatives in early July, expressing my interest in doing research with the agency that would also fulfil my thesis requirements. The ED suggested that I focus my research on the work of the Ethno/racial Committee, discussing ideas that the research could explore. The ED was interested in learning how different ethnic communities perceive mental health, who they turn to for help when mental health problems arise, and whether there is stigma associated with mental health problems. Excited about the prospects of working together, we set up a meeting to discuss these ideas in further depth.

In our meeting the ED informed me that Alternatives had completed an internal evaluation

of its services. This evaluation found that the majority of the agency's clients were English-speaking, but there was an under-representation of clients from the Greek, South Asian, and Chinese communities, which were demographically significant populations in East York. The report identified the need for an outreach strategy that would take into account "an understanding of cultural factors which impact how an individual accesses help and support, as well as how they define serious mental health problems" (Highlights of Alternatives' Evaluation Process, p.3). In meeting with the ED, I obtained more specific information regarding the purpose of the research and the research questions. The ED and I also discussed the idea of forming a "planning group." After the meeting, I translated my understanding of our discussion into a one-page proposal for the research which I sent to the ED for feedback. This later evolved into a full research proposal which was completed in the winter of 1996.

The Ethnic Composition of East York

Data obtained from the Census of Canada in 1991 indicated that Greek was the largest linguistic group in East York other than English, constituting 19.8% of the non English-speaking population. Of the South Asian languages, Gujarati (India) was the largest linguistic group in the district (5.7%), followed by Tamil (Sri Lanka) (2.9%) and Urdu (Pakistan) (1.2%) (East York Health Unit).

The Focus of the Research

In developing a method of programming for diverse communities, our initial goal was to do a study of four linguistic groups: Greeks, Sri Lankan Tamils, Gujaratis-speaking people from India, and Urdu-speakers from Pakistan. Given the scope of the research topic, it was important to put some clear and reasonable parameters around the study. In order to respect the complexity

of the study, we decided to do a smaller study in the hope that the agency could develop a model for outreach to diverse ethnic communities. The ED thought that a study of two ethnic groups would be the most practical for a study of this complexity. After narrowing down the study to two groups, we then had to select the ethnic communities for study. There were three main considerations guiding our selection. The first was to base our selection in light of demographic information regarding the predominant language groups in East York. For example, as the Census data for 1991 indicated, Greek was the largest linguistic group in East York other than English. The Greek community was, therefore, selected using this information. The second consideration was to determine the existing knowledge on the topic for each ethnic group. I found that there was quite an extensive literature on Chinese conceptions of mental illness and help-seeking behaviour which Alternatives could use. The third consideration was to have at least one ethnic group of colour represented in the sample because of the barriers facing these communities. Within the South Asian communities, Tamil (Sri Lanka) and Gujarati (India) were the two predominant linguistic groups in the region. So these two communities were selected, however, as it turned out, the research on the Gujarati-speaking community was not completed because of problems in obtaining data. Thus, Greeks and Sri Lankan Tamils became the final focus of the study.

Research Process

Planning Committee

In keeping with the principles of participatory action research, a Planning Committee, consisting of the key stakeholders, was developed to guide the research process. The purpose of the Planning Committee was to provide a process where the different stakeholders could have

input regarding the sources of data, the methods of gathering data, and the data collection tools. The committee was comprised of representatives from the following stakeholder groups: two members from the Greek community, two members from the Gujarati community, one member from the Tamil community, three staff members from Alternatives (the ED, the Outreach Worker, and a support counsellor), and myself, the research facilitator.

There were a number of qualities that we sought in representatives from the ethnic communities. We were interested in individuals who had connections and were involved with their community, who were able to articulate needs and issues on behalf of their community, as well as to represent the differing views within them. Consideration was also given to community members who had experience with mental health problems.

In recruiting community members on the committee, the ED and I sent out an invitation letter to several agencies and organizations that served the ethnic communities. This approach failed to bring about any responses from the communities. Later, an individual from the South Asian community told me that agencies were often "bombarded" by letters requesting help and that letters were not sufficient. I then tried to place a notice in a newsletter produced by the Coalition of Agencies Serving South Asians, but this brought no response. While doing outreach at a community-based agency in East York, the ED got a staff member interested in joining the committee. I sought recommendations from people in the communities and made personal requests to individuals for their help. I was far more successful with this approach. A key learning for me was that people are much more responsive and willing to help when you connect with them on a personal level.

The Ethno/racial Committee

A description of the research process would not be complete without mentioning the role of the Ethno/racial Committee. In order to give credibility to the study, the research became the exclusive focus of the Ethno/racial Committee's work. The committee, which consisted of the ED, the Outreach Worker, two Board members, a staff member from another agency, and myself, had a number of meetings over the course of the research to keep members informed about the project and to discuss and give input into the project. Information about the research was also relayed to the Board. I received helpful ideas from the committee about the research and the research process. Furthermore, I was able to share some of the challenges that I was facing in the research with committee members. Meeting regularly with the committee also helped me to maintain a sense of connection with the agency, which was especially important when the Planning Committee stopped meeting as a group. When doing research into ethnic communities, it is necessary to have organizational structures in place which support the researcher in her role. Support from the ED is also key to the success of the project. In this research, the ED participated on the Ethno/racial Committee and the Planning Committee and also maintained contact with me regularly throughout the study, thus playing a key supportive role.

Phase I: Getting My Feet Wet

The research involved two phases of data collection. In the first phase interviews were conducted with Greek and Tamil service-providers and in the second phase focus groups were conducted with lay members of the Greek and Tamil communities. In this section, I describe the research process, data collection method, participants, interview process, and procedures for analysing data for the first phase.

This phase of the research took place from November 1997 to December 1997 and began when the Ethno/racial Committee met to discuss aspects of my proposal and to think about the steps involved in forming the Planning Committee. These steps included developing a "job description" for committee members, considering the logistics, scheduling, and composition of the committee, and thinking about the types of qualities that we wanted in members. I carried out these tasks with the help of the ED. I then set out to form the committee, as described above.

The Planning Committee's first meeting was held in February, 1997. The committee met twice a month and then once a month until May, 1997 to plan the research. Meetings lasted for two hours and were held at Alternatives. One meeting was held at a Greek church in East York. At the meetings, members of the Planning Committee were oriented to the research and were asked to consider the most appropriate sources of data and the methods for collecting these data.

The Planning Committee was interested in collecting data from different stakeholders. The first group of stakeholders were Greek and Tamil service-providers whom we presumed would have clients from their own communities. Because the service-providers shared the same language and/or ethnic background as their clients, I thought of the service-providers somewhat as key informants who could provide a lens for understanding how their clients perceived and responded to mental health problems. Coming in with little knowledge of the area, my intention was that interviews with service-providers would be exploratory. I saw myself on a fishing expedition and I wanted to cast my net out as wide as possible and see what I might find. Essentially, my aim was to get a big picture of the issues. However, since people with serious mental health problems were the primary focus of Alternatives, members of the Planning Committee hoped that the providers would lead us ultimately to contacts with people with serious mental health problems from the

diverse communities. We believed that it was important to gather data from the perspective of people who had direct experience with the mental health system. Hence, people with mental health problems were selected as the second group of stakeholders.

Recruitment and Selection of Service-providers

I used a number of strategies to recruit service-providers for interviews. The first strategy was to make telephone calls to community agencies and organizations in the Greek and South Asian communities, asking providers if they would be willing to participate in interviews. I found that service-providers were quite happy to share their experience in an interview. The second strategy was to ask service-providers who I had contacted to suggest the names of other service-providers. This strategy was successful in two of my interviews. A key link to service-providers was the community members on the Planning Committee who either made a list of potential sources or contacted individuals that they knew personally or professionally on my behalf. This was especially important in the case of medical professionals who were difficult to reach due to their busy schedules. Clearly, having someone who was linked to the project and who could then approach their friends or colleagues for interviews gave a certain credibility to the project and was a key factor in motivating service-providers to agree to an interview. I found that calling the offices of medical professionals directly was not a successful method for obtaining interviews. Often the receptionist said that the professional would be too busy. I left numerous messages, but no one returned my call. However, I was successful in obtaining one interview with a medical professional using this approach. I should mention that all of the service-providers who agreed to an interview were extremely generous with their time, openly sharing their experience in the mental health field with people from their communities.

Participant Characteristics

Four female Greek service-providers were interviewed. Three are social workers and one is a physician. Two of the Greek providers were born in Greece and two were born in Canada. A total of five Tamil service-providers were interviewed. Of these providers, two are psychiatrists (one female, one male), two are counsellors (female), and one is a community health worker (female). All of the Tamil providers were from Sri Lanka, except one who was from India.

Data-gathering Methods

Individual interviews were conducted with service-providers. Interviews were selected because this method allows the interviewer to explore a number of topics in depth and is consistent with the qualitative and exploratory nature of the research. Questions in the interview took the form of an interview guide which was semi-structured. The questions evolved through successive interviews (The Service Provider Interview Guide is found in Appendix A).

In the interviews with service-providers, I selected a case vignette that could be used as a tool for helping service-providers to think about the way that their clients perceived and responded to mental health problems. Thus, case vignettes have been used by a number of researchers to explore how different ethnic groups interpret mental health problems (e.g., Star, 1973, see Dohrenwend & Dohrenwend, 1969). Beliefs about mental health are difficult to access directly since they may lie below one's conscious awareness (White & Marsella, 1982). Case vignettes provide a tool for eliciting these beliefs in a concrete form. A vignette on major depression developed by Ying (1990) was adapted so that it was relevant to people from the Greek and Sri Lankan Tamil communities (See "The Scenario" in Appendix A).

I want to explain the process for selecting a vignette on depression because it is important

that I talk about my assumptions. From the onset of the research, I had hoped to explore how different ethnic groups think about schizophrenia. I had read a study on ethnic perceptions of schizophrenia and became interested to investigate the same mental health issue in the present study. However, in reading around my thesis, I learned that depression and neuroses were not perceived as mental illnesses in certain cultures. I wondered whether these cultures did not define depression as a mental illness because it is not "visible" to an observer. When I approached the ED with these ideas, she responded by saying: "In choosing depression, we're raising a more provocative question of what people think mental illness is." She also said that depression is experienced across cultures, but it may not necessarily be understood the same way across cultures. After our conversation, I wondered whether people may fail to notice depression because it is not clearly "visible" and whether this had implications for help-seeking behaviour.

Interview Questions

Research question #1: Perceptions of mental health, mental illness, and depression. The following questions were developed to answer the first research question. "What does 'mental health' mean to patients/clients from your community? How do they define it?," "What does 'mental illness' mean to patients/clients from your community? How do they define it?," "How are people with serious mental health problems of Greek/Sri Lankan Tamil origin viewed by people in the community,?" and "How are they viewed by their family members?"

In addition, a series of questions were designed to find out how Greek/Sri Lankan Tamil clients perceived the symptoms of depression, some of which were based on questions developed by Kleinman (1980) to elicit the "explanatory model" and questions developed by Guarnaccia, Parra, Deschamps, Milstein, and Argiles (1992): "What kind of problem does Mrs. Poulos or Mrs.

Pragash say she has?," "What would she call the problem?," "What do you call the problem?," "Would she accept your view/assessment/diagnosis?," "How serious would the patient/client think that the problem is?," and "In your opinion, would the seriousness be minimized or exaggerated?"

Research question #2: Views about the causes of mental health problems and depression. In understanding the explanations for mental illness and depression the following questions were asked: "How do people with serious mental health problems understand their problem?," "What do your clients think are the causes of mental illness?," and "What would Mrs. Poulos or Mrs. Pragash think is the cause of her problem?"

Research question #3: Ways of coping and seeking help for mental health problems and depression. A number of interview questions were designed to answer the third research question: "What are the ways that Greeks/Sri Lankan Tamils deal with mental illness in terms of coping and help-seeking?," "How do families cope with the difficulties of having a relative experiencing serious mental health problems?," "How do your patients/clients with serious mental health problems cooperate with the help-seeking effort and treatment plan?," "Do situations occur when patients/clients of yours with serious mental problems refuse to cooperate with the help-seeking effort/treatment plan?," and "How are serious mental health problems handled here as compared to in Greece/Sri Lanka?"

The following questions aimed to find out how people would deal with depression: "How would Mrs. Poulos or Mrs. Pragash deal with her problem?," "Where would she go for help first? Where would she go next?," "Would Mrs. Poulos or Mrs. Pragash have any concerns about seeking help or advice?," and "Would she seek help or advice from people in the Greek/Sri Lankan Tamil community or outside it?"

Research question #4: The role of community-based agencies. The fourth research question was about the role of community agencies such as Alternatives and was answered by two questions: "Do you think that people of Greek/Sri Lankan Tamil origin with serious mental health problems could benefit from this service? Why or why not?," and "What are the specific ways that Alternatives can meet the needs of people of Greek/Sri Lankan Tamil origin with serious mental health problems?"

Interview Process

After establishing contact with service-providers, I arranged a convenient time to meet with them to conduct the interview. All of the interviews took place at the providers' place of work, except for one interview, which was conducted on the telephone. Interviews lasted from 45 minutes to one hour. Follow-up interviews were also conducted with providers on the telephone so that I could probe issues that I deemed to be important. The process of going back to the service-providers a number of times was key for understanding beliefs about mental health and can be compared to peeling away the layers of an onion to get at the core. All of the interviews were tape-recorded and transcribed for analysis.

Procedure for Data Analysis

Qualitative methods were used to analyse the data from service-provider interviews. After reading transcripts of the interviews for each ethnic group, I developed codes and organized these codes into themes. I followed this process for each research question.

Interviews with People with Mental Health Problems

As previously mentioned, we hoped that interviews with Greek and Tamil service-providers would lead to contacts with people with serious mental health problems. There were a

number of difficulties in obtaining interviews with members of this stakeholder group. Some of these included agency policies and practices that do not allow clients to be interviewed, the fact that I was an "outside researcher," and the sensitivity of mental health issues. In fact, some of the community members on the Planning Committee had said that people with mental health issues would be afraid to talk openly. This was a really important "cue" that was ignored. When I asked service-providers if they could suggest potential clients for the interviews, some providers told me that they did not know anyone who would be willing to talk. I made one attempt to interview a client through an interpreter but she was "closed up," in the words of the provider who had suggested her. In culturally sensitive research, it is important to think about the most non-threatening ways to gather information and the resources that are available to carry out the research. I will now move on to describe the second phase of the data-collection process.

Phase II: Cultural Immersion

Due to the difficulty in obtaining interviews with people with serious mental health problems, an alternate source of data had to be found. The ED asked me to write a letter to inform the Board and members of the Planning committee about the challenges that I had faced in the research and my thoughts about how to proceed with it. I suggested the idea of obtaining data from the lay community, one of the sources of data that was considered during the first phase of the research. Everyone on the Planning Committee was supportive of the idea.

Lay perceptions of health have been regarded as not offering much valuable information (Donovan, 1986). However, it is my belief that the lay community is a rich source of data. It allows one to tap the perceptions that exist in an ethnic community and to explore how people might respond to them in a direct way. The lay community provides important cultural

information that can guide the delivery of mental health services in a way that is culturally responsive (Vega & Murphy, 1990). Research that has explored perceptions of mental health has used lay perspectives (e.g., Ying, 1990).

The second phase of the research took place from December 1997 to May 1998. During this time, I planned focus groups. According to Krueger (1994), the key to successful focus groups is planning. I spent a great deal of time developing data collection tools with the helpful feedback of the Planning Committee, recruiting participants, and searching for translators, facilitators, and interpreters for the focus groups. I learned how important it is to develop networks in community-based research. There are several people in ethnic communities who have skills in translation and cultural interpretation, among other things, but one needs to have the patience and energy to find them. One should cast her net wide, ask around for information, and never rely on just one contact. Finding translators who have experience with translation, who understand the nuances of language, who take the time to clarify the meaning of words in order to capture the right word in their language, and who can write in lay terms, are all very important. Searching for facilitators who had previous experience working with focus groups was more difficult. After calling a number of agencies, I decided to search for individuals who had experience working with groups and who had a friendly attitude (Krueger, 1994), direct work experience in the area of mental health issues, and some experience with research in their community.

In developing the focus group interview guide, I used the results from a pilot focus group that I conducted in English with Greek women in December, 1997. A Greek member of the Planning Committee agreed to organize a focus group, but stipulated that the focus group had to

take place in December because of the limited time that she had available to organize a group in the new year. I decided to take advantage of the situation. Three of the participants in the focus group were born in Canada, while the other three were born in Greece. Some of the participants were related. In reflecting on the focus group, I learned that I needed only a few topics for discussion on the general discussion on mental health. One of my greatest learnings from this pilot focus group is that generation of immigration is a key factor to consider in selecting participants for future focus groups. I had observed that some of the participants who were born and raised in Greece had difficulty understanding and communicating fluently in English compared to their Canadian-born counterparts. Therefore, the language in which focus groups were conducted was a key consideration for the research.

After conducting the pilot study, I developed a draft interview guide, which was circulated to members of the Planning Committee for their feedback. Because we could not meet at a mutually convenient time, I arranged a time to speak to each member individually on the telephone. I tried to be open to people's input by changing the wording or adding new questions. My aim was to develop questions that were open-ended and that used everyday language. I also developed a letter explaining the study, in addition to a background information questionnaire with input from some members of the Planning Committee. The purpose of the questionnaire was to obtain a profile of participants. All of these materials were translated into Greek and Tamil. These materials were assessed by the focus group facilitators. The Greek facilitator translated the materials out loud to me in English so that I was able to verify its accuracy, while the Tamil facilitator checked the translation over and made appropriate changes (See the Invitation Letter, Consent Form, Community Focus Interview Guide, and Background Information Questionnaire in

Appendices C, D, E, and F, respectively).

Recruitment and Selection of Focus Group Participants

Focus groups are composed of people who have a number of characteristics in common, such as gender and age (Krueger, 1994; Morgan, 1988). According to Krueger (1994), the most important consideration in selecting participants is the purpose of the study. From the pilot study, generation of immigration emerged as a factor that differentiated focus group participants. Since the present study was on two ethnic groups, I decided to focus on one generational level since a study of two generation levels would have been far more complicated. Participants were also selected according to gender so that focus groups would be more homogenous. A convenience sample of women was used because women were easier to access than men. Hence, in the second phase of the research process, the purpose was to obtain community perceptions of mental health from first-generation Greek and Sri Lankan Tamil immigrant women.

Recruiting participants to the focus groups was a challenging process and involved a number of different strategies. Initially, I approached agencies and organizations in East York that serve the ethnic communities for their help in recruiting participants to the focus groups. At one organization, I met with one individual who agreed to organize a focus group on a mutually agreed upon date. I learned that researchers need to meet personally with people in their own setting so they can see who you are and how genuine you are about trying to make a difference in the community. Unfortunately, this strategy failed, when only two people arrived at the focus group. The second strategy was to approach members of the Planning Committee for help. Both of these women were able to recruit a group of women from their communities. One member used her personal network of contacts, such as friends, acquaintances, and people at her church.

The other member asked someone who works directly with new immigrants in a Language Instruction for Newcomers to Canada (LINC) training centre to find participants. The third strategy that I used was to contact a staff member at one another organization that ran LINC classes and ask if I could conduct a focus group. This individual agreed to find six women from different LINC classes for the focus group.

From these experiences, I learned that when the responsibility of recruiting participants is in the hands of individuals who are linked directly to the project, the outcome is much more successful than when a "middle person" is involved, such as the woman at the first organization that I approached. Sometimes a middle person has too many degrees of separation from a study. It takes a great deal of commitment on the part of someone to make a focus group work and make confirmations that participants will actually come to the focus group (Krueger, 1994). If one does decide to use a middle person, it is better to find an organization where the population can be readily accessed. For example, the LINC classes that were attended daily by women were an ideal site for recruiting focus group participants. I also learned that participants in the focus groups cannot always be selected at random. In one focus group, the person who recruited participants had to rely on her personal contacts with people in the community, while in the other focus groups, the participants were selected in a more random way. Krueger (1994) states:

> It is important to keep in mind that the intent of focus groups is not to infer but to understand, not to generalize but to determine the range, not to make statements about the population but to provide insights about how people perceive a situation. As a result, focus groups require a flexible research design, and although a degree of randomization may be used, it is not the primary factor in selection. (p.87)

Participant Characteristics

In the Greek focus group, there were six female participants, all of whom were born in

Greece. The parents of the participants were all born in Greece, except one, whose mother was born in Asia Minor. Five of the women came from an urban setting, while one woman came from a rural setting. In terms of the age groups, one woman was 35 to 39, one was 40 to 44, one was 55 to 59, one was 60 to 64, and two were 65 and over. The participants have been in Canada from 11 to 42 years, for an average of 28 years. All of the participants were Greek Orthodox.

There were two Tamil focus groups. In the first focus group, there were six female participants. Three of the participants came from an urban setting in Sri Lanka, while three participants came from a rural setting. The parents of the participants were all born in Sri Lanka. In terms of age groups, two participants were 30 to 34, three were 40 to 44, and one was 45 to 49.The women have lived in Canada for an average of 2.7 years. Five of the women were Hindu and one was Muslim. In the second focus group, there were six female participants. Five of them came from an urban setting in Sri Lanka, whereas one came from a rural setting. The women have been in Canada for an average of 3.6 years. All of the women were Hindu (See Table 1 for a more detailed summary of participant characteristics).

Data-gathering Methods

Focus groups are interviews with a group of 6 to 9 participants about a topic that is determined in advance. Focus groups have a number of advantages: they bring more people together at a given time; they involve an interaction among people that is more natural than the interaction that occurs in individual interviews; and they produce a high level of involvement and discussion (Krueger, 1994; Morgan, 1988). Perhaps the greatest benefit of focus groups is their use in facilitating culturally sensitive research. Focus groups help to illuminate the perspectives of cultural groups because they provide information about how people think and talk about a topic.

Table 1
Participant Characteristics for Focus Groups

Socio-demographic and other characteristics	Greek focus group	Tamil focus group #1	Tamil focus group #2
Country of birth	Greece	Sri Lanka	Sri Lanka
Region of birth			
Urban	5	3	5
Rural	1	3	1
Parents' country of birth	5 Greece (both parents) 1 Asia Minor (1 parent)	6 Sri Lanka	6 Sri Lanka
Class of immigrant			
Immigrant	3	1	0
Refugee	0	5	6
Family reunification	3	0	0
Entrepreneur	0	0	0
Number of years in Canada (average)	28	2.7	3.6
Languages spoken	2 Greek 4 Greek and English	6 Tamil and English	6 Tamil and English
Religion	6 Greek Orthodox	5 Hindu 1 Muslim	6 Hindu
Age group			
25-29	0	0	1
30-34	0	2	1
35-39	1	0	2
40-44	1	3	1
45-49	0	1	1
50-54	0	0	0
55-59	1	0	0
60-64	1	0	0
65+	2	0	0
Education (average)	3 elementary school 2 high school 1 college	grade 8	grade 9
Current work status			
Employed	*2	0	0
Are at home	2	5	3
Are retired	2**	1	0
Are a student	0	6	6
Are looking for work	0	5	2*
Other	2 never employed in labour force	0	0
Type of work	* interior decorating/restaurant **T.V. Phillips, sew curtains		*looking for work regarding 1. office skills and 2. factory work
Experience or knowledge of someone with mental health problems			
yes	3	2	0
no	3	4	6

As participants add details to each others' stories, the researcher discovers the meaning that people attach to their social world. S/he obtains shared cultural knowledge and gets a flavour for the different perspectives that people bring to the research (Hughes & DuMont, 1993).

Interview Questions

In order to produce a triangulation of findings, I developed parallel questions across stakeholder groups. Like the service-provider interview guide, some of the questions in the focus groups used in the guide were drawn from questions developed by Kleinman (1980) to elicit the "explanatory model." I also used a few questions developed by Fandetti and Gelfand (1978) and one question developed by Ying (1990). The remaining questions in the interview guide were developed with input from the Planning Committee. I present the interview questions here because they differ somewhat from those in service-provider interviews.

Research question #1: Perceptions of mental health, mental illness, and depression. There were a number of questions to understand general perceptions of mental health problems: "Are you familiar with the terms 'mental illness' and 'mental health,'? "What does 'mental illness' mean to you? How do you define it?," "What does 'mental health' mean to you? How do you define it?," "What do you think causes mental illness?," "What are ways to deal with mental illness?," and "How is mental illness handled here compared to in Greece/Sri Lanka?"

A series of questions were asked to elicit how participants perceived the symptoms of depression: "What do you think that Mrs. Poulos or Mrs. Pragash is experiencing?," "What do you call the problem?," "What do you think is the cause of her problem?," "How serious is the problem? Do you think that she will recover?," and "Is this a normal part of life or is it something unusual?"

Research question #2: Views about the causes of mental health problems and depression. The questions used to answer this question were as follows: "What do you think are the causes of mental illness?," and "What do you think caused Mrs. Poulos's or Mrs. Pragash's problem?"

Research question #3: Ways of coping and seeking help for mental health problems and depression. A number of questions were asked to elicit information related to coping and help-seeking: "What is the appropriate way to deal with the problem?," "What kind of help or advice does Mrs. Poulos or Mrs. Pragash need?," "Where would you first go for help or advice? Where would you go next?," "Do you have any concerns about seeking help or advice?," "Do you prefer to go for help or advice from people in the Greek/Sri Lankan community or outside it?," and "Do you regard Mrs. Poulos's or Mrs. Pragash's experience as a mental illness?"

Research Question #4: The role of community-based agencies. Finally, there were questions about the role that Alternatives could play: "Do you think that Mrs. Poulos or Mrs. Pragash could benefit from this service or services like this one? Why or why not?," and "What specific ways can Alternatives meet the needs of people like Mrs. Poulos or Mrs. Pragash?"

Interview Process

In focus groups with diverse ethnic groups, Krueger (1994) suggests that facilitators be of the same background as participants. Because of our commitment to culturally sensitive research, I suggested to the ED that we hire individuals from the Greek and Tamil communities to facilitate the focus groups. I had hoped to create a situation in which participants responded as naturally as possible in the focus groups. I had initially considered the possibility of conducting the interview through a cultural interpreter, but I was concerned that this approach would interrupt the natural flow of the focus group and possibly inhibit participants' responses. However, I discovered that

research can be conducted by people from different racial/ethnic backgrounds when I decided to conduct a focus group with Tamil women through an interpreter.

In searching for facilitators, I called a number of agencies and school boards. There are quite a number of skilled people in the community, but it is just an issue of developing a network of contacts. The facilitators worked in the health professionals or social work field and had previous experience with research. The facilitators participated in a two-hour training session, which included an overview of the facilitator's role and skills, a description of interviewing techniques, and a practice component.

During the focus group, the facilitator introduced herself, explained the purpose of the study, and obtained consent from the women to do the focus groups. She then presented the vignette and proceeded to conduct the interview. After the focus group, participants were asked to fill out the Background Information Questionnaire. I attended all of the focus groups so that I could introduce myself to the women and tape-record the sessions. In the focus group that I conducted, I worked through an interpreter. Her role was similar to the other facilitators in terms of introducing the focus group and asking the interview questions. However, while she interpreted the women's responses, I would often interject by asking the interpreter a question such as "What does she mean by...?" whenever I felt a need to probe a given response. Also, I helped the interview to stay focused. It often helps when two people can work as a team.

All of the focus group interviews were recorded on audiotape. After two of the focus groups, I set up a meeting with a cultural interpreter to interpret the responses from interviews in English. The interpreters listened to the audiotape and did simultaneous interpreting on a hand-held tape-recorder. This process was much more time-consuming than I had anticipated. It may be

more economical to have someone interpret the focus group responses during the interview itself. The researcher may want to consider the pros and cons of having a cultural interpreter present during a focus group. The focus group interviews were transcribed word-for-word and stored in files on a computer wordprocessor.

Procedure for Data Analysis

In analysing the data from the focus groups, I used a number of strategies. After the focus group, I met with each facilitator for a "debriefing" session in which I asked her the key themes, noteworthy quotes, and unexpected findings that emerged from interviews (Krueger, 1994). Also, while I was transcribing the focus group interviews, I wrote down any thoughts that came to my mind. In addition, I reflected regularly in my thesis journal. The data from focus groups were coded and analysed in a search for emergent themes (Hughes & DuMont, 1993).

FINDINGS AND DISCUSSION

Question #1: Perceptions of Mental Health, Mental Illness, and Depression

Greeks

Perceptions of "Mental Health" and "Mental Illness"

Coping with problems in living. Data from Greek service-provider and focus group interviews suggest that for Greek people, mental health is the process of everyday living. As one service-provider expressed:

> Mental health to a client...would mean...psychologically...when they function on an everyday basis, like the normal routine, for example,...the household...Things would be going in a very...easy pattern...But if...it's gone off course,...then....they have to get to the root of the problem....and ...it needs to be brought back on track.

Participants in the focus group described mental health in terms of the ability to face and solve the

problems of everyday life. As one respondent expressed:

> If you can deal with your problems, you have mental health.

By contrast, focus group participants understood mental illness as the inability to cope. As one respondent said:

> ...when you cannot face your life difficulties, you make a small problem a big one and from such difficulties of everyday life, you bring yourself to...illness....

The service-providers reported that mental health problems are perceived by clients as the inability to function in all areas of one's life:

> Mental illness- something that is basically affecting your life, your job, your family life, your social life, your job...they might not give the exact definition, but something ...affects your life in every aspect...

> They define it as...they wouldn't be functioning normally...on an everyday basis like the way that...people...go about their job,...what they do in household, how they interact with other people. It means their role sort of is different.

Absence of illness. Greeks understand the term mental health in terms of illness. In the words of service-providers:

> Mental health for them is something that will be mostly for illness...

> It means that someone does not have an illness...Like everybody else that's outside the mental institution is mentally healthy.

Extreme behaviour, disturbance of mind. The Greek term associated with mental illness is "mad person" ("*trelos*" in Greek). Mental illness is defined in terms of visible symptoms of abnormal behaviour. One respondent from the focus group shared her perceptions of a person with mental health problems:

> They usually stare. They...give you these signs when they're mentally disturbed...A normal person would greet you, would act normal. I mean whether they laugh, they shake hands, they do the initial stages the normal way. Somebody who is

> mentally sick wouldn't even, in my opinion, try to introduce themselves, would avoid to look at you.

Schizophrenia is perceived by Greek people as a mental illness. As one service-provider said:

> Mental illness to Greek people is a disease like schizophrenia, the things that they are aware of...But depression to them and nerves and other things are not necessarily mental illness. So it has to be more what we know as a mental illness from back home....There...nobody knows about depression....They know about schizophrenia people. But they don't know about the everyday things that we see.

According to focus group members, mental illness is the loss of control over one's mental faculties. Some participants shared their views:

> When the mind thinks and wonders different things, then we have no control because everything starts from the head.

> ...the problems take dimensions in their head and the problem becomes so big that they cannot think anymore and they stress so much themselves that can have those results and becomes sick. From the mind, from thinking about it, it can become sick.

In summary, the interviews with Greek service-providers and the lay members of the community revealed that for Greeks, mental health is the ability to cope with the problems of everyday life. However, mental health connotes someone who is not ill. People who are outside mental institutions are perceived to be mentally healthy. By contrast, mental illness is viewed as the inability to cope with one's life. It involves a disturbance in one's mind and behaviour. Mental illness is thought to be visible in terms of behaviour. According to Safilios-Rothschild (1968), Greeks define mental illness as behaviour that involves violence or hallucinations.

Expression of mental health problems

Somaticization. Data from service-provider interviews revealed that Greeks express their problems by focusing on physical complaints. As one reported:

> Some of them will just present with five million different problems. Physical problems...they focus, they somaticize, they put more attention to the physical problems.

Non-psychological label. Some Greek people apply labels to their problems that de-emphasize their psychological nature. As one service-provider stated:

> ...they come here and they say "Oh, my nerves are breaking. Send me to a neurologist." And I say, "That's not a neurologist you want to see. That's a psychiatrist." "No, no, no...I don't have anything wrong with me...It's my nerves." So it's okay to call it a neurological disorder...but it's not okay to call it a psychological disorder.

From the perspective of service-providers, Greeks may find it difficult to admit that they have a psychological or psychiatric problem. As comments from service-providers indicated:

> A lot of people that do have a mental health problem don't want...to admit that they have one. ..

According to service-providers and participants in the focus group, Greek people have a fear of being labelled with a mental health problem. As one community member stated:

> People don't like to be identified with mental health problems.

Similarly, one service-provider commented that:

> ...they are very paranoid that they are being labelled with mental health...Mental health means craziness...

In summary, as the interviews with service-providers revealed, Greeks who have mental health problems may view their problem in terms of a physical problem or "nerves." This is consistent with other research (Kendall, 1989a; Patterson, 1976; Primpas-Welts, 1982). The data also indicated that Greeks may have difficulty admitting that they have an emotional or psychological problem, which is also confirmed by other research (Dunkas & Nikelly, 1975; Patterson, 1976; Primpas-Welts, 1982). Distress is expressed in terms of physical complaints;

physical problems are accepted by Greeks (Dunkas & Nikelly, 1975; Patterson, 1976; Primpas-Welts, 1982). The finding that Greeks may request to see a neurologist is also supported by Patterson (1976) who reported that in Greece people with anxiety and depression seek the help of neurologists. Greeks prefer to see a neurologist rather than a psychiatrist because the latter is associated with mad people. Until 1964 Greek psychiatrists were trained in neurology and psychiatry and were given the title neurologist-psychiatrist (Safilios-Rothschild, 1968).

Perceptions of Depression

Unhappiness, internal, psychological problem. According to the service-providers, Mrs. Poulos would define her problem as "unhappiness." Lay members of the community described Mrs. Poulos in similar terms. They described her as "feeling down," "depressed," and as having "disappointment,...thoughts and...worries." Some members called her problem a "psychological" problem. Lay members also referred to Mrs. Poulos's isolation from others, stating that she is "closing herself in" or that "she's...all alone in the world."

In relating how the problem affected Mrs. Poulos, one focus group participant said that it affected her "peace of mind." Another participant stated:

She's stressful and has anxiety.

Effect on one's life roles. Lay members of the community also said that the problem would affect the ability to function in her roles/duties and family life. As one participant said:

She cannot function in her housework, around the family.

Similarly, according to the service-providers, Mrs. Poulos would view her problem as something that affected her role as a parent and spouse. As one commented:

...she's not able to do things the way she used to so she's...basically running out of

> time and the husband might come home and he will not find...things prepared as he used to, like the food, his clothing..., the maintenance of the house generally and she would be very concerned about that.

Normal problem. Most of the lay community members thought that Mrs. Poulos's problem was normal, saying that it "can happen to anybody." According to the service-providers, depression is perceived as a "normal emotion" that everybody experiences, except when it becomes severe. One service-provider said that Greeks would regard a suicidal person as "sick":

> Suicide is considered...as...an act of madness like someone who is not well... mentally...Not a normal person.

Another service-provider said that suicide is viewed as "a sin in the Greek community" and that the body of the person who commits suicide is not permitted to enter the church for the religious ceremony that takes place prior to burial.

Serious problem. The community members viewed depression as a serious problem, but one from which one can recover with proper help. Similarly, the service-providers said that Mrs. Poulos would perceive her problem as being very serious. However, one service-provider said that Mrs. Poulos would minimize the seriousness of the problem:

> ...she might try to minimize it because...Greek women...think that everything that is happening is a family affair and no other people should know. So in order to avoid...having to go to the doctor and bring up things that she really does not want to, she might try to minimize.

In summary, the findings indicated that Greeks regard depression as a problem that is internal and psychological in nature. They regard depression as unhappiness, which is consistent with Primpas-Welts (1982) who reported that Greeks view depression as sadness. As with mental illness, Greeks believe that depression affects one's life's roles, which may relate to the way that the self is viewed in relation to the group among Greeks (Primpas-Welts, 1982). There was some

difference of opinion regarding the normality of Mrs. Poulos's problem. One service-provider said that Mrs. Poulos would be perceived as crazy by people in the community. Some service-providers also said that severe depression is considered abnormal. However, lay members did not perceive the experience of depression as unusual, which they may relate to as immigrants. Hence, it appears that severe depression is on the border between normality and abnormality, between a psychological problem and a mental health problem.

Expression of depression

Somaticization. According to some Greek service-providers, depression is expressed as a physical problem by individuals such as Mrs. Poulos. As one comment illustrates:

> A lot of women tend to define the problem as maybe anemic. Since I lost my appetite and I can't sleep, I may need some pills to booster my blood...

Non-psychological label. People with emotional problems such as depression do not like to admit that they have a psychological problem, but prefer to define their problem in more acceptable terms, such as having "nerves" or "stress." As one service-provider noted:

> ...I find with the Greek people, it's sort of "No, I'm not depressed." "Well, yeah, but you are depressed. You're crying all the time." They don't want to label themselves. They can call themselves, "Oh I have nerves. I have stress. I have things is bothering me." But they can't go further back and admit to depression...

In brief, these findings suggested that there is stigma attached to depression. Greeks are uncomfortable about being labelled with psychological or emotional problems such as depression. This discomfort is expressed through physical/somatic complaints. This is consistent with the way that Greeks express emotional and psychological problems in general, as mentioned above.

Tamils

Perceptions of "Mental Health" and "Mental Illness"

Holistic view of health. The Tamil service-provider and focus group data indicated that Tamils have a holistic understanding of health. According to service-providers, Tamils do not have a concept or term for "mental health." As one service-provider stated:

> In Sri Lanka there is no word for mental health and we don't talk about mental health. We only talk about the physical health.

The holistic perception of health is evident in the comment of one service-provider:

> There's no mental health for them...It's not so defined as in the Western society. Mental health, physical health, nutritional food, these are all labels that have been put...onto and labelled into things we do in our lives and what it is.

Coping with problems in living. For Tamils mental health means the ability to cope with problems. As one participant expressed:

> Even though there can be problems, a person who can cope up with the problems will be healthy.

Family concept, life concept. Furthermore, for lay members of the community, the term "mental health" means having family "unity" and "cooperation." As one community member said:

> A family where the husband is good and the wife is good and the children behave themselves and there's family unity, then they will be mentally healthy.

The holistic view of health is captured in the comment of one Tamil community member:

> A person who has to be mentally healthy has to have peace as well as money as well as an occupation or employment and happiness at home so that he will not worry about other things.

Mental worries. Mental illness is defined by Tamil people in different terms than mental health. One term associated with mental illness is "mental worries." According to some lay people,

the person with mental health problems is viewed as someone who is always thinking and worrying. As one response indicated:

> When a person doesn't have happiness and also who is all the time thinking of the problems that a person has.

Extreme behaviour, disturbance of the mind. Lay members regard mental illness as abnormal behaviour that is extreme. As some participants expressed:

> You can find out from the way he acts differently that he has some sort of illness.

> A person who talks to herself is supposed to be mentally ill. A person who walks out of the house and roams about is also considered to be mentally ill.

Similarly, according to Tamil service-providers, mental illness is defined by Tamils as abnormal behaviour that involves extreme symptoms:

> A person who is not speaking sense and very aggressive behaviour, that kind of thing.

> ...they don't see that people have mental health problem other than people who are really going very extreme...people who can be seen outside as...acting crazy.

Other terms associated with mental illness are "madness" ("*visar*" in Tamil) and "losing one's mind."

Inability to function. According to Tamil service-providers, mental illness is conceived by clients in terms of the complete inability to function. As one comment illustrated:

> They define mental illness as not being able to function in the way that other family members are functioning. It has to be completely paralysing that they are unable to remember, they are [un]able to even function, do the regular things...

In summary, data from service-provider and community focus group interviews suggest a holistic approach to health. Mental health is built into the approach that Tamils have to daily life. The person with mental health is considered to have the ability to cope with problems in life, as

well as having family unity and financial security. Thus, mental health encompasses not only the individual, but also the individual in relation to the family and the society. This emphasis on family unity reflects the interdependence between the self and others and the group-focused orientation of South Asians (Durvasula & Mylvaganam, 1994). The findings also revealed that people with mental illness are believed to have mental worries. Like Greeks, mental illness is defined as noticeably abnormal behaviour that may be aggressive. Mental illness is also perceived as the inability to function.

Perceptions of Depression

Health condition. According to some service-providers and lay members of the community, depression is perceived by Tamils as a health condition. As one service-provider said:

> ...she thinks that she's sick, but the doctors are unable to diagnose her..something is going on in her internal body, but she doesn't know exactly what's wrong.

Change of mind. Lay community members perceived Mrs. Pragash's problem as a "change of mind," some of them calling it "depression."

Not mental illness. However, lay members did not identify it as a "mental illness" as they believed that mental illness has more noticeable symptoms. As one participant said:

> This is just two months that she has been like this and the other thing is if it is mental illness, there should be far more other symptoms that could identify.

Similarly, according to service-providers, Sri Lankan Tamils do not identify depression as a "mental illness." As one provider stated:

> ...these symptoms, they don't think that...this..could be something to do with mental health.

Some service-providers said that depression is not easily recognized by Tamils because its

symptoms are not visible. As one explained:

> ...If you have a wound, you can see it, right? But this you cannot see it... Physically, it's not visible...

According to service-providers, depression is not recognized because it is handled in Sri Lanka through the support of the extended family. As one respondent stated:

> ...the concept of depression is very new to them...depression is something which is not very common in our country mainly because there is extended family system where [if] they have...any problem, they go to their uncle, aunt, or grandparents or they get the proper help and advice and this depression is sorted out in the early part of their illness.

Normal problem, part of life, temporary. Lay members in the focus group considered the symptoms of depression to be normal. According to service-providers, some clients with depression view their problem as being normal, while others believe that their feelings are just part of life. As the service-providers said:

> ....these symptoms...they think, "Oh, this is part of life." And they ignore it...

> ...they may feel it's just they are just tired or overworked or they have marital difficulties or they feel...[it's] something everybody goes through normally.

Still other service-providers said that depression is viewed as a temporary problem. As one reported:

> Usually what's happening is...she... thinks that this will go away. She basically thinks she's going through a spell of loneliness...

Serious problem. All of the focus group members believed that Mrs. Pragash's problem was very serious. Some of them thought that she would recover, while others thought that she would not recover from her illness. According to some service-providers, Tamils understood that their problem was serious:

> ...she knows that it is serious. She has to get some help because internally she's not feeling well. But...she's unable to communicate that to the...family members and also to the health care providers at the beginning.

Some service-providers also expressed that clients with depression may minimize their experience. As one provider stated:

> Cause...maybe they are not aware of depression a lot...if there's...a genuine chemical imbalance..., they are not aware that much and the consequences of it and the people kill themselves.

Effect on one's life roles. In considering the effect of her problem, the service-providers and some lay members of the community said that Mrs. Pragash would perceive her problem as affecting her roles and duties. As one community member said:

> She's unable to look after the child properly and she's unable to do her daily duties and tasks properly.

Similarly, one service-provider commented:

> She may herself say that I am losing patience with my children. I am not caring for them. I don't have any interest in anything to look after their needs. So these may be the presenting complaints at times.

In summary, the interviews revealed that some Tamils perceive depression as a physical problem, while others perceive it as a change of mind. One study (Wig et al., 1980, as cited in Furnham & Malik, 1994) found that people in India did not consider depression to be either a health problem or a mental health problem. According to other research, depression is considered by South Asians to be a somatic problem (Assanand et al., 1990). One explanation for these conflicting findings is that depression may be considered to affect the mental, physical, and spiritual aspects of a person in keeping with a holistic worldview, but that it is easier to describe the problem in physical terms. Support for this notion is given in the next section. The finding that

Tamils perceive the symptoms of depression as something that interferes with one's roles and duties is consistent with the emphasis placed by South Asians on relationships and roles within the family (Webb-Johnson, 1991).

The interviews also showed that Tamils do not identify depression as a mental illness, as it is viewed by mental health practitioners in the West. Although Tamils consider depression to be a problem, it does not meet the definition of mental illness as noticeably abnormal behaviour, which emerged from the service-provider and focus group data. The notion that Tamils use the visibility of symptoms as a criterion for defining an illness is supported by Donovan (1986) in her study of health beliefs among South Asian and West Indian women in Britain where she states that "the definition of a feeling as an illness...depends on the severity of the condition, its visibility, the social obligations of the time..."(p.176). The data of the present study also showed that depression is a new concept for Tamils which is handled in Sri Lanka within the extended family. Moreover, the findings indicated that some Tamils regard depression as part of life. This has been reported among South Asians in Britain as well (Donovan, 1986). Referring to the study by Donovan (1986), Furnham and Malik (1994) said that South Asians may not recognize the feelings of depression because they may confuse it with the loneliness they experience after settling in a new country and, therefore, perceive it as part of life.

Expression of Depression

Somaticization. The health care professionals reported that depression is regarded by Tamil clients as a physical complaint. As statements from the interviews illustrate:

> Nothing to do with mental health. Just physical. Tired. Maybe anemic. Low vitamins.

> ...she always come with a physical complaint...she will either come with a headache or stomach ache or backache.

According to some service-providers, clients do not feel that it is appropriate to bring emotional problems to their doctor. As one service-provider commented.

> ..most of the people when they present...don't come out with their emotional problems mainly because they don't see that as an illness to come to the doctor.

Stigma. Clients were said to associate moods and feeling with madness. As one service-provider said:

> Usually in our community people think...if your mood is down, then you could get mad...So...actually they don't talk about that in our culture.

Holistic view of health. Somaticization may also occur because of the unity of the body, mind and spirit. One service-provider explained:

> The Tamil community...perceive body, mind, and spirit together...Most of the...community members...are spiritually inclined...and when they have the symptoms of depression, they think the mind is taken away from the body and spirit...But they are unable to express that so...they...somaticize because they think the physical body is the largest component...which is tangible...So...they'd say that they are having a headache or whatever...any somatic problems and little realizing that they have problems of the feelings or mind.

In summary, the interviews with health professionals showed that Tamils with depression express their problems in terms of physical complaints. There are a number of reasons why this may occur. As the findings indicated, some clients may associate moods and feelings with madness. Studies of patients with depression in India have reported that there is stigma attached to depressed mood (Puri et al., 1995; Raguram et al., 1996). Puri et al. (1995) found that although 100% of patients were rated as having depressed mood, only 20% reported this symptom. The majority of clients placed emphasis on their physical symptoms. Puri et al. (1995)

explain the meaning of depression in India:

> In our culture often the expression and perception of negative emotions like depressed mood is stigmatised and not valued. Depression connotes weakness, mood culpability, loss of face and mental illness...Physical complaints are better accepted expression of their problems and are legitimate cues for obtaining love, care and sympathy as they possess social efficacy. (p.104)

In South India depressive symptoms may decrease one's social status and prospects of marriage (Raguram et al., 1996). There may be other explanations for the presentation of physical complaints. As the findings showed, the holistic view of health may lead individuals to manifest physical symptoms, as Durvasula and Mylvaganam (1994) and Webb-Johnson (1991) noted. Finally, as the results showed, an individual may think that it is inappropriate to bring emotional symptoms to a service-provider. This is supported by other authors who suggested that South Asians may expect that they have to present physical complaints to the biomedical practitioner (Bal, 1987; Durvasula & Mylvaganam, 1994; Webb-Johnson, 1991).

Summary

In summary, Greeks view mental health as the ability to cope with the problems of everyday life. In keeping with a holistic orientation, Tamils view mental health as part of one's total approach to life. Both ethnic groups perceive mental illness as a disturbance in one's mind, behaviour, and ability to cope. In both groups mental illness is identified as an extreme and deviant form of behaviour. Greeks perceive depression as something that is internal, but which affects one's life roles. Tamils view depression as something that affects one's mind, body, and ability to cope with life roles, which may reflect the holistic view of the person in his/her social context. For Greeks, there is stigma attached to depression, which is expressed in the form of physical symptoms. For Tamils, the somaticization of depressive symptoms may be partly due to

the stigma attached to depression, but it may also be due to their holistic view of health.

Question #2: Beliefs about the Causes of Mental Illness and Depression

Greeks

Beliefs About the Causes of Mental Illness

Environmental factors. Greek people have a number of explanations for mental health problems. According to service-providers, some clients believe that mental health problems arise from "stressors" and "worries." As comments from the interviews illustrate:

> ...the situations of their lives basically. In other words, financial, lack of jobs, lack of security, problems with their children, not being able to deal with the problems of everyday life. That's what they perceive.

> They will probably refer it to worries in life, I mean the circumstances, like the change, the environment, the cultural shock, lack of communication between her and husband...

Biological factors. Mental health problems are also believed to be hereditary. As a focus group member said:

> Being born with it would be one cause.

Similarly, as one service-provider stated:

> Some of them think that there were born that way, that there was something wrong...from birth.

Lay members of the community believed that damage to a baby's brain could result in mental health problems. Some referred to a baby who developed a "high fever, " or a woman who "fell," or had the "chicken pox" during pregnancy. One participant believed that stress and the use of drugs during pregnancy could lead to mental health problems:

> I believe when the lady's pregnant, if she smokes, drinks and has stress, that's the worst for the baby.

Supernatural factors. In the spiritual/religious realm, there is a belief that mental health problems are caused by "possession by the devil." In addition, there is a belief in fate or punishment. As one service-provider said:

> They think that that's how God wants things or God made us this way or it's because I'm not religious enough. It's because I'm not going to church enough.

Some Greek people also believe that they were cursed by someone or that magic or the "evil eye" was responsible for their mental health problems. One service-provider related an experience with a client:

> She said that she was from a young girl very religious and people were jealous of her because...she's so religious and that's why they sort of gave her the evil eye. And when she has the evil eye, she does things that normally she doesn't know what she's doing....so she blames others for the reasons.

One service-provider noted that "very few people will go to this explanation."

Beyond one's control. Some Greek people perceive that mental health problems are beyond a person's control. As one respondent in the focus group said:

> ...Somebody else takes over the actions. They're not in control of their actions. So whatever those actions are, good or bad, it's not their fault. They're not themselves. So even if they do something to try to harm me, I don't think I would be able to be upset with them or mad at them.

Similarly, some service-providers reported that members of the Greek community perceive that mental health problems are beyond a person's control:

> They'd view it as an illness and the person has no control over it.
>
> It's not their fault.

In summary, like Western mental health professionals and clients, most Greeks see mental health problems as arising from environmental factors. These findings are supported by a profile

of Greeks in Toronto which reported that Greeks attribute mental illness to overwork, stresses, and exhaustion. They are also confirmed by evidence indicating that Greeks tend to externalize their internal distress or problems (Dunkas & Nikelly, 1975; Skinner, 1966). In addition, the findings that Greeks attribute mental health problems to biological factors, such as heredity, is supported by Kendall (1989a) and Paras (1992). The belief that mental illness could result from drug use is also supported by Paras (1992). As well as environmental and biological factors, the present study found that there are still some Greeks who believe in supernatural causes for mental health problems, suggesting the continued influence of the Mediterranean worldview among Greeks in Canada. In rural Greece, illness may be attributed to magical or supernatural causes, including the evil eye (Blum & Blum, 1965). Furthermore, the findings revealed that some Greeks believe that mental health problems are beyond a person's control, which may again relate to the Mediterranean worldview. As previously noted by Gaines (1982): "...the self is partly composed of elements over which the individual has no control"(p.184). Moreover, the data indicating that people with mental illness are freed from blame are consistent with the research by Blum and Blum (1965).

Beliefs About the Causes of Depression

Environmental factors. According to service-providers and participants in the Greek community focus group, Greeks perceive depression as relating to the changes associated with migrating to a new culture. As one community member said:

> I believe this integration has created a lot of problems with her...She's coming from a different culture and it takes a while to get used to the new surrounding.

Similarly, one service-provider said:

She would miss her previous lifestyle.

In speaking as if she were a client, another service-provider said:

> ...I feel kind of detached from my family because we emigrated from Greece and I don't have enough people around me from my family. I hardly have anyone actually.

Family problems were also cited by service-providers and lay people as a cause of depression. As one lay person said:

> Family reasons. Something must have happened.

Individual factors. Some lay people attributed the problem to a weakness in Mrs. Pragash's character. As one respondent said:

> ...maybe she was more sensitive and she didn't try to face the symptoms with a broad mind...

In summary, Greeks perceive depression is caused by environmental factors relating to family problems or to a change in culture and lifestyle. According to Primpas-Welts (1982), Greeks attribute depression to a loss or trauma. It may be that Greeks perceive the experience of changing their lifestyle as a loss. These results suggest the influence of acculturative stress (Berry, 1989) on how people interpret mental health problems. The data also indicated that some Greeks attribute depression to individual factors. There was no evidence that Greeks believe that depression results from the evil eye, as Primpas-Welts (1982) reported.

Tamils

Beliefs About the Causes of Mental Illness

Environmental factors. Like Greeks, Tamils have different explanations for mental health problems. Lay people believed that mental health problems are due to family problems. As one

respondent expressed:

> ...when you bring in your in-laws, they don't find room outside so they have got to stay with the same family and that can cause a lot of problems. And children who come over here from Sri Lanka, they get into a different culture and they find that the parents can't agree to this type of different culture and adjust to it so there is mental illness too.

Financial problems were also cited. As one member stated:

> Due to financial difficulties as well as unemployment, they can become mentally ill.

Likewise, according to service-providers, some clients attribute their problems to problems in adjusting to a new country, financial problems, interpersonal problems, isolation, and loneliness. As one service-provider stated:

> From their perspective, it's the stress they are going through in a new country and they have already gone through stress in their own country. So the transition plus any culture goes through the cultural shock. So combined to that is the language barrier. Some people are not very fluent in English....when they go for work, they feel isolated...

Biological factors. Tamils also believe that mental health problems are hereditary. One respondent stated:

> I have heard about it that when the father has it, the son also becomes mentally ill.

Similarly, as one service-provider said:

> ...they'll say, "She's got the mother's blood."

Some people believe that mental health problems are due to organic factors. As one service-provider noted:

> ...they also think that something wrong with the brain. It's a deformity in the brain.

Head injuries were cited by lay members, as a statement from the focus group indicates:

> A person who has met with an accident, the accident may have affected his head...

Individual factors. Furthermore, members of the community sample expressed that mental health problems are caused when "the person thinks a lot."

Supernatural, astrological influences[2]. There are also beliefs falling under a spiritual/religious worldview. Some family members understand their relative's experience in terms of Hindu beliefs about rebirth. As one service-provider noted:

> She had...some things in her mind...that's coming up from another time...She's talking about another life. Because they don't understand what she's saying,..it must be from another world that they don't know. In a birth.

Furthermore, some people believe that mental health problems are caused by a curse or a bad spirit that entered the individual's mind or soul. As some service-providers said:

> ...they seem to believe that somebody has done some religious act...to put a curse on them. So because of that act, these people have this mental problem.

> ...they say the spirit is working in the person or some spirit has taken over that person's mind...a bad spirit has got into their mind, or into their soul...some of them..bring that out.

Astrology was mentioned by some service-providers as well. As one comment illustrates:

> ...according to the astrology, they feel when certain planets are in certain positions, the patient or the person will be suffering with certain kind[s] of conditions.

In summary, like Greek service-providers and lay people, interviews with Tamils revealed that mental health problems are believed to be caused by environmental factors. Tamils also attribute mental health problems to biological factors and supernatural factors, including Karma and evil spirits. These findings are supported by research regarding Sri Lankan beliefs about demon possession (Satkunanayagam, 1980) and by a profile of the Sri Lankan Tamil community in Toronto which reported that Tamils attribute mental illness to Karma and evil spirits or demons

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[2]Participants in the focus groups did not cite supernatural causes of mental illness.

(Kendall, 1989b). One may also note that Tamils in South India attribute mental illness to biological factors and supernatural factors, such as Karma and evil spirits and demons (Srinivasa & Trivedi, 1982). Furthermore, the findings showed that some members of the community believe that internal factors, such as thinking or "mental worries" can result in mental illness. This belief exists among Tamils in South India (Srinivasa & Trivedi, 1982) and also among South Asians in Britain (Donovan, 1986).

Beliefs About the Causes of Depression

Environmental factors. The results from interviews indicate that Tamils attribute depression to a change in their environment. They believed that depression results from leaving one's family behind, financial problems, family problems, and the language barrier. As one member of the community expressed:

> The place is new to her. She doesn't have the language skills. She doesn't have the English skills. This might be a problem for her. The reason for her being depressed is mainly because she has the language problem. Because of financial problems also she might be like that.

According to service-providers, clients who have experienced depression perceive their problem as being due to "stress." As one service-provider stated:

> People with depression, they initially don't realize they have a condition called depression because they may feel they're not able to cope. They may feel they are losing their temper at home, or not concentrating at work, and things like that. So they may put...to the cause as "stress."

Biological factors. Some group members also attributed depression to an incurable disease. As one respondent said:

> It can be due to a disease that cannot be cured like cancer.

In summary, the findings indicated that Tamils believe that depression may be caused by

environmental factors. Some may also believe that it is caused by a physical disease.

Question #3: Ways of Coping and Help-seeking for Mental Health Problems and Depression

Greeks

Ways of Coping with Mental Health Problems

Among Greeks, a number of ways are used to deal with mental health problems. These include intra-familial approaches, spiritual/religious approaches, and medical forms of intervention. These approaches are not mutually exclusive.

Intra-familial approaches.

Mental health problems, a family matter: Greeks prefer to handle mental health problems within the family before turning for outside help. Mental health problems are regarded as a private matter that should not be shared with outsiders. As one lay member expressed:

> I believe that they're trying to hide it. We do have this weakness. We do not like to discuss our health problems.

One service-provider explained:

> In caring for Greeks, mental health problems is a very private matter...it's something that is...affecting the whole family so the family has to know first...in the initial stages...it might be...for the cure, so instead of expanding..., they will try with the family and the friends to see how they can solve it and then they will use other means...

Stigma and shame: Mental illness is hidden from outsiders because it is considered shameful to the family. As the following comments reveal:

> They all worry about this person...they are trying to support him, to bring it around but they're hiding it too. They don't want this to be known outside their family circle that somebody in the family, father, mother, or somebody else, suffers from a disease like that.

> They think it's a shame in the family and it's an offence...

Similarly, one service-provider stated:

> It's not socially acceptable to have a psychiatric illness attached to you and because of its lack of acceptability, they're very secretive about it if it's happening in the family and they want to keep it as within as possible.

The service-providers expressed that Greek people are concerned about revealing their problems to outsiders for fear of damaging their family's image. As one service-provider stated:

> They don't like to be talked about...or labelled...they have to sort of uphold...in society...a good reputation and...if it leaks out that this person is labelled, then it sorts of ruins...their family name...

Service-providers also noted that some families may isolate their relatives in order to conceal the problem from outsiders. As one service-provider stated:

> I'm aware of situations that when someone became mentally ill, the family had really nothing to do with social activity, for instance, inviting people over that they used to do or even visiting people because they didn't want anyone to know what is happening. So they become very isolated socially.

Social consequences of mental illness: Mental health problems can affect the prospects of marriage for Greek people. One service-provider described what happened when a prospective groom learned that his fiancée had mental health problems:

> She was engaged to a police officer and was just about to marry him and all plans made and she was diagnosed schizophrenic and he left her. Got in a state of panic ...said he's not going to marry a sick woman.

Endurance: Greek families try to cope with the mental health problem of their relative for as long as they can. One lay person said:

> They're trying. They don't identify it but when they see that things are getting worse, then they're looking into it. We say that we hope that we're going to get things around and try and things that they will change and improve and we're wasting a lot of time and the last minute we see that the person is suffering. It's our own person and we're trying to help, seek help medically but we're trying to hold onto it.

Spiritual/religious approaches. In dealing with mental health problems, Greeks may also seek spiritual/religious help. One service-provider referred to the importance of religion in healing:

> In the past and even now, Greeks always have thought that if people become...mentally ill, they need the blessing from the church to recover.
>
> ...Church always will play a very important role for Greek people...faith, I think it's part of healing.

In addition, Greek people may turn to a priest for counselling or advice. Some may feel that they can trust a priest with their problems. As one service-provider mentioned:

> ...the priest has to keep a certain level of confidentiality.

Religious/spiritual approaches sometimes come into conflict with the use of medical forms of intervention, as a service-provider stated:

> As a professional, I heard people saying that "No, you don't have to take the pills." Relatives and friends. Even if the medication was prescribed by the doctor because God will help you to recover from this. They don't believe in medical intervention in other words.

The conflict between medical and spiritual/religious approaches could sometimes result in the refusal of people to seek outside help. As one service-provider said:

> I have situations right now actually that they adamantly refuse to go for outside help. These are the ones who believe there was magic involved...and they become extremely religious...and they deny help altogether and they have certain ideas and they stick to these ideas and...any suggestion about getting outside help...becomes very threatening to them...

Medical intervention. Data from service-provider interviews revealed that Greeks often turn to family doctors for help, sometimes making multiple visits. They also noted that doctors are held in high regard by Greek people, as one comment reveals:

> They have a great deal of faith for the doctor...He is the authority of course. He's the one who has the knowledge.

A respondent from the focus group said:

> ...in my village if you have a doctor son or daughter...the whole village is proud of you...it's a very respectable person.

Greek people were said to be very comfortable about speaking with their doctors about the problems that they are having. As some providers stated:

> ...some clients have good relationships with their doctors and they feel very openly...in talking to them.

> They are more free to talk to me about all the problems they're having.

Stigma attached to seeking psychiatric help. As a general rule, Greeks do not go directly to psychiatrists for help. According to Greek service-providers, psychiatrists were the "last source" to whom Greeks turned for help because of the stigma attached to mental health problems. As one service-provider said:

> People who need help from psychiatrists are somehow labelled...Only crazy people go to the psychiatrist...They always refer to...people, "Oh, she has been sick; she was under psychiatric care..."

Some Greek people may not be so easily persuaded to see a psychiatrist. One service-provider described her experience with clients:

> They say..."I'm not crazy. You're not going to send me to a psychiatrist"...There's a stigma attached to it so it's kind of hard. If you tell them you need to go to a psychiatrist, it's a bit of a problem.

Changing Perceptions About Help-seeking

According to some lay members of the focus group, Greek families are more open about seeking help compared to in the past. As one member pointed out:

> In the old time ago they were locking the doors to problems like that. They didn't want to discuss it outside. Now the idea about facing a mental health problem is changed and they seek help.

In addition, some participants said that Greeks turn to psychologists for help more often than in the past:

> What the problems are that the Greek people in the old times they did not prefer to go to the psychologists but now they are starting to do so.

Similarly, a service-provider said that she referred clients to psychologists for help.

In summary, as the findings showed, mental health problems are handled by Greeks within the family and lay networks. As other Canadian studies have reported, Greeks turn to family and friends before seeking outside help (Kendall, 1989a; Patterson, 1976). Greeks do not discuss their family problems with outsiders due to their concern about maintaining family honour in the community (Dunk, 1989). The data also suggested that Greeks accept the responsibility of caring for their relative for as long as they can. According to Safilios-Rothschild (1968), Greeks live with a wide range of behaviour, including behaviour that is defined as abnormal. Some Greeks may normalize abnormal behaviour and accept it as idiosyncratic peculiarities of the individual in order to prevent their spouse from going to a hospital. The present study also found that there is tremendous stigma and shame attached to mental health problems which can affect the prospects for marriage of family members. This is confirmed by Safilios-Rothschild (1968) who reported that because of the stigma attached to mental illness, Greeks try to resolve the problem through other means before seeking professional help. Furthermore, in addition to intra-familial approaches, the present study revealed that Greeks use spiritual/religious approaches to deal with mental health problems. In rural Greece priests may be called to perform exorcisms in cases of

"insanity" (Blum & Blum, 1965). The use of spiritual/religious approaches by Greeks is also supported by Kendall (1989a) and Patterson (1976). The significance of the Greek Orthodox Church on the lives of Greek people (Chimbos, 1980; Kendall, 1989a; Patterson, 1976; Sanders, 1962) is evident in the connection between religion and beliefs about mental illness and suggests the continued hold of the Mediterranean worldview for Greeks.

The findings also showed that Greek people deal with mental health problems by seeking medical help. In their survey of help-seeking behaviour of people with serious mental health problems in Greece, Madianos et al. (1993) found that a significant proportion of the Greek population preferred to go to a physician rather than a psychiatrist for psychological and psychiatric reasons. However, the finding that Greeks trust their doctors was not supported by Safilios-Rothschild (1968) who reported that Greeks do not trust doctors and delay the help-seeking process for as long as possible or until acute circumstances arise. This author also reported that Greeks prefer to go to a doctor who is a close friend or relative. The finding that Greeks consult several doctors is confirmed by Blum and Blum (1965) and Patterson (1976) who suggested that Greeks may be dissatisfied with a given diagnosis. The present study also found that there still remains a stigma attached to seeking psychiatric help in the Greek community. This is supported by Madianos et al. (1993). Greeks associate psychiatrists with craziness (Dunk, 1989; Safilios-Rothschild, 1968). The finding that psychiatrists are used as the last resort to whom Greeks turn for help is supported by Patterson (1976) and Dunk (1989) who reported that Greeks turn to psychiatrists and social workers only during crises or when severe mental health problems arise. Data from the present study also indicated an increasing acceptance of mental health professionals. This is confirmed by some evidence that Greek-Canadians accept psychiatric help

(Kendall, 1989a).

In interviews with service-providers and lay people, there was some indication that Greeks use Greek social services. Some may also go to psychologists for help. However, the literature indicates that Greek people do not go to psychotherapy or group therapy (Kendall, 1989a; Primpas-Welts, 1982) and are reluctant to go to psychologists and social workers because of the stigma attached to mental health problems (Dunk, 1989). One explanation for this discrepancy in findings is that some Greeks have become more receptive about seeking help from mental health resources as a result of acculturation. Some may in fact be using these services but, unlike people from other communities who openly disclose that they are looking after their mental health needs, Greeks are discreet.

Ways of Coping with Depression

Approach to the problem. The perceptions of members of the Greek focus group about how to deal with the problem of depression will now be compared to the experiences of service-providers. In dealing with the specific issue of depression, community focus group participants suggested that Mrs. Poulos get help from many sources. The participants asserted that Mrs. Poulos should open up to other people about her problems. They believed that she should "get...whatever it is inside her out of her system," and "not be closing herself in." As one respondent said:

> For me, she has to open up her heart to somebody and not keep everything inside her and ask for friendly advice from somebody that she thinks that can help her...

Friends: Friends were cited as a source of aid. Similarly, service providers reported that Mrs. Poulos would turn a friend for support, one saying that she would turn to a "close" or "trusted

friend" and "tell her...whatever she's feeling."

Family support: Family support was also mentioned by lay members as a way to deal with depression, but this was not mentioned by service-providers.

Church: Church was mentioned as another avenue for support by service-providers and lay people. For example, one community member suggested that Mrs. Poulos "fill up her life" by "getting involved with the church." The service-providers said that Mrs. Poulos would seek help from her parish priest. As one service-provider said, "she would tell him exactly how she's feeling and the priest would probably tell her on..the religious side about...her feelings..."

Doctor: The community members were open about the idea about getting outside help and all mentioned the importance of seeking medical advice. For example, as one respondent asserted:

> ...the first person to talk to is her doctor and he will tell her what to do.

The service-providers also said that Greek people turn to their doctors.

Mental health professionals: The lay community members also believed that Mrs. Poulos should seek help from a psychologist or social worker. The service-providers also said that Greeks use Greek counselling services, however, most of them did not mention the use of psychologists.

Concerns about seeking help. According to Greek service-providers and members of community focus group, Greek have a concern about seeking outside help for their problems. As one participant in the focus group expressed:

> The Greeks specifically...do not want to open up their worries and problems. They don't speak about them...

Some of the participants were concerned about seeking help, one commenting that "I would have second thoughts." Similarly, the service-providers conveyed that Greek people such as Mrs.

Poulos would have feelings of fear and embarrassment in seeking help from outsiders. As they maintained:

> ...it's very threatening at the beginning to think that you are going to reveal your problem to another person, especially...to a stranger...It's not the immediate member of the family. It's not her close friend. It's someone outside who does not know...her problems...
>
> She might feel embarrassed...but she might want to talk to somebody but she wants to keep it sort of low key and not tell too many people...

One service-provider said that Greek people are concerned about being labelled:

> ...it's the labelling....They don't want to be labelled as psychologically ill.

Preferred ethnic background of service-provider. In dealing with depression, some Greek people prefer a service-provider who understands the Greek language and culture. For instance, one member disclosed that while she was open to seeking help outside the community, she preferred to seek help from within the Greek community:

> I wouldn't have a problem with a person or the doctor if it's [sic] English-speaking or whatever, but I would have preferred somebody that is familiar with our culture.

This view was shared by most of the respondents, except one. She gave her opinion:

> I would not have any problems to go and find the best doctor or the best service to help me, whether it's Greek or otherwise to help me.

According to the service-providers, Greek people with limited English skills prefer the help of Greek service-providers. Confidentiality is very important to clients. As one service-provider said:

> ...if her Greek is not very good, she would want to speak to someone that is...Greek but she would want to keep it strictly confidential.

On the other hand, people who have a better grasp of the English language are said to prefer the help of service-providers who are not Greek:

> Other times, people who speak the language...would prefer to go to somebody else. I had many requests here: "Send me to another doctor, but not Greek because I don't want to reveal my problem to Greek psychiatrist."
>
> If they speak English well, I think they prefer to be seen by outsiders... Confidentiality. Don't want their own to know their problems.

To sum up, in responding to depression, service-providers and lay members of community revealed that Greek people turn to their family, friends, church, doctors, and Greek counselling services. Some Greeks may also go to psychologists for help. The community members' insistence that an individual "open up" about her problems to mental health professionals indicates that the Greek perceptions about help-seeking have changed in this regard. However, the evidence indicates that most Greeks are reluctant to go to psychotherapy (Kendall, 1989a; Primpas-Welts, 1982) and use social workers as a last resort (Dunk, 1989; Patterson, 1976). Data also revealed that there is still a concern about seeking outside help for mental health problems due to embarrassment and the fear that one might be labelled, which may relate again to the concern about family honour (Dunk, 1989) and maintaining one's personal *philotimo*. In addition, the findings indicated that as Greeks acquire some degree of fluency in English and become more acculturated to Canadian society, they may decide to use the services of non-Greek professionals to prevent information about their problems from leaking out to the Greek community.

Tamils

Ways of Coping with Mental Health Problems and Depression

Intra-familial approaches.

Family responsibility. In sharing their perceptions of the way that family members deal with mental health problems, participants in the Tamil focus groups stressed the importance of caring

for and supporting one's relative. As one respondent stated:

> If supposing the husband was mentally ill, the wife should pay a lot of attention, help him out, caring for him and looking after him, keeping him company, as well as maybe his mother if she's there, she should also help in the process. Vice versa too...

Similarly, service-providers expressed that for Tamils who have family in Canada, family members take responsibility for caring for them. As one service-provider stated:

> The family members are supportive because they don't give up on these people. They still like to keep them in their family and care for them in spite of the difficulties they face financially and otherwise. So compared to other communities, they are very supportive.

However, caregiving was also mentioned as a burden on the family. As one participant in the focus group said:

> In some families, looking after a mentally ill patient becomes a real burden and they might even consider it a burden because it's a long process.

Similarly, a service-provider described the family as a system of support that was "stretched to the limit" in caring for someone with mental health problems.

Endurance: Some service-providers noted that family members coped with the illness until they noticed symptoms that they could no longer tolerate. As a service-provider expressed:

> ...until an abnormal behaviour doesn't arise,...then the family tries to cope with everything...they put up with everything what the clients do.

Family members may view abnormal behaviour as part of the individual's personality. As one statement shows:

> ...'til then, they feel he has a different personality and they try to adjust and deal with it.

Stigma and shame: Some family members may try to isolate their relatives. As one service-

provider noted:

> They try to hide the facts about their having serious problems. They don't take them out anywhere...what will happen is usually...these people hide them, put them in the room. Even when they get guests, they don't want to bring them out so they'll be housebound and they wouldn't take them anywhere.

In addition, as service-providers reported, some family members do not seek help from services or medical professionals in the fear that people in the Tamil community would find out. One service-provider noted:

> ...although they have the knowledge of these illnesses now, even then, they still have reluctancy in coming forward for treatment. I have known cases where the patient himself or herself...has asked for psychiatric help but the partner didn't want to take the patient to the doctor because they feel it's a taboo and people will look down at them.

Social consequences of mental illness: According to service-providers and participants in the community sample, mental health problems have social ramifications for the individual and family and can affect one's prospects of marriage. As one member of a focus group said:

> When marriages are arranged, you find that people look into their family history of mental illness because there is the chance of the children getting it so they always look into it and that can also affect her in the community.

Similarly, as comments from the service-providers revealed:

> ...no families will come to this family to get the daughter or the son to get married cause they think it can be hereditary and it can pass on to the children.

> They think of it as a shame, a shame that will sort of alter the whole situation [of] this family in the public...eye of the community. And it is a slur that nobody should know for reasons of marriage and interactions of other families.

Spiritual/religious approaches. According to service-providers, Tamils seek help through

spiritual ways[3]. Astrologers are consulted for advice about the use of appropriate remedies for the problem. People may also go to the temple to say prayers in the name of the patient. They also make religious vows or donations or go through a period of fasting. One health care professional said that Tamils use spiritual approaches before seeking help from medical professionals:

> ...their first action is to seek help from others who are not medically treating them. So usually they may come to the medical profession as a final resort.

Medical intervention. In dealing with mental health problems, members of the lay community believed that the family should seek medical advice. As one respondent expressed:

> You've got to get advice from the doctor...

This finding is consistent with data from the service-providers who said that Tamils often seek medical help when they have somatic problems or perceive that something is wrong with their health. They seek help from doctors of various specialities. Doctors were said to be highly regarded in the Tamil community, as indicated by one comment:

> ...in the Tamil community and also most of the South Asian community, they consider doctors as gods. So when the doctor says something, they kind of believe it. They believe the doctors more than anybody else.

Stigma associated with seeking psychiatric help. Some of the service-providers mentioned that psychiatrists are associated with "crazy" people in the Tamil community. For instance, one provider said that her client "...wouldn't go to a psychiatrist because of the social stigma." At the same time, some service-providers noted that the community's perceptions of psychiatrists have been changing in Canada. As one service-provider reported:

> ...back home...psychiatry means...crazy. So only crazy people see psychiatrists. So

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[3]In the general discussion of mental health problems, participants in the Tamil focus groups did not mention the use of spiritual means.

> that's very shameful...Like people don't accept or people look down on you...if you're a crazy person or something. So some people here also feel [that] if they see a psychiatrist. Not all the people. Like most of the people have knowledge. Like psychiatrists are not only for the crazy people. They can help...you with your problems.

Generally, Tamils go to psychiatrists through referrals, although some go directly to psychiatrists for help.

Crisis-oriented Approach to Help-Seeking

According to Tamil service-providers, Tamil people seek medical intervention during periods of crises and make frequent use of the emergency department of the hospital. As one service-provider stated:

> I went and discussed with...the psychiatrist with whom I used to work...and he said the problem with the Tamil people is when they come, they come when they are in a real critical situation to the hospital.
>
> ...it has gone beyond the stage of just mild observations...the community does not complain 'til things are very much out of whack...Tolerance of the community is very much, especially of women. They don't complain much.

Changing Perceptions About Help-seeking

Some service-providers mentioned that more and more Tamils have began to seek outside help as a result of education generated by the media and workshops about mental health problems. As one service-provider stated:

> ...now they're learning to seek help. They're getting used to it, but not spontaneously but with educational sessions and workshops.

This same service-provider noted a difference in the way that Tamils seek help in Canada as compared to in Sri Lanka. She said that in Sri Lanka:

> ...it... remains within the family and the family tries to cope with everything. But here they know that the families can get help, the client can get help. So they are

now trying to open up and... access help...in whichever [way] they can.

In summary, as the data showed, Tamils use different ways to cope with mental health problems. There is a great deal of support from family members. The caregiving role of the family has been reported among people in India (Kakar, 1982; Shankar, 1994) and also among South Asians in general (Durvasula & Mylvaganam, 1994). Similarly, the community profile of Tamils in Toronto reported that friends and relatives are consulted for advice among the older generation (Kendall, 1989b). The findings of the present study also indicated that Tamils try to cope with mental health problems for as long as possible and may view abnormal behaviour as part of the individual's personality. This is also supported by evidence from the Tamil community profile (Kendall, 1989b). The findings regarding the crisis-oriented approach to help-seeking is supported by Assanand et al.'s (1990) research on South Asians in Canada. Moreover, data from the present study showed that mental health problems are associated with stigma and shame and that family members may try to conceal these problems from outsiders. Among Tamils, mental health problems reduce the family's social standing in the community and affect the prospects for arranged marriages (Kendall, 1989b). South Asians may hide mental illness in order to protect these arrangements (Assanand et al., 1990).

The community profile had no information regarding Tamils' use of spiritual remedies. However, there was some support for the finding regarding the use of astrologers. South Asians in Canada may consult astrologers (Assanand et al., 1990). The finding that Tamils may delay the process of seeking medical help was also found in India among family members of patients with schizophrenia who used astrologers (Kumar, 1984).

In addition to family support and spiritual remedies, Tamils go for medical help, which is

also reported among South Asians generally (Assanand et al., 1990; Durvasula & Mylvaganam, 1994). The findings from the present study indicate that Tamils have become more open to seeking outside help through the process of acculturation. For example, attitudes toward psychiatrists are changing. However, the community profile of Tamils in Toronto reported that Tamils may not use mental health services due to the language barrier and their perception of mental health problems. Similarly, as some authors note, South Asians are less reluctant about using mental health services or psychiatrists (Assanand et al., 1990). In addition to mental health services, individual and group therapy may be uncomfortable for Tamils since these approaches involve the disclosure of one's feelings and thoughts to a stranger, which is not culturally acceptable (Kendall, 1989b). Some researchers have reported that South Asians are neither accustomed nor willing to seek psychological help and will probably not approach these types of services (Durvasula & Mylvaganam, 1994). However, other authors have asserted that mental health services that are based on Western models of therapy are not effective with South Asians and that more culturally relevant and sensitive mental health services and approaches incorporating the family into therapy should be developed to meet their needs (Steiner & Bansil, 1989; Webb-Johnson, 1991).

Ways of Coping with Depression

Approach to the problem. Among Tamils, there are various ways of coping with depression. The approaches suggested by lay members of the Tamil community will be compared to the experience of service-providers. Some members of the focus groups expressed that Mrs. Pragash did not want to talk about her problems to others. However, they insisted that she share her problems with others. As one participant said:

She has to openly talk about it then only people will know what her problem is.

Family and friends: Some lay members suggested talking to parents about the problem. Moreover, they believed that if Mrs. Pragash had a family problem, then this problem had to be sorted out in the family, specifically with her husband. As one participant explained:

> In our community, a family problem is not discussed with other people. So that is something that we keep within the family itself. So it has to be sorted out within the family itself, with the husband.

Lay members also suggested that Mrs. Pragash talk to friends about the problem. Some members mentioned the importance of peer support:

> If you have close friends, then of course we will discuss the problems with them.

> ...they may share it with the friends and it's far better to tell them so that she gets it out of her system rather than keep it within herself and that will help her.

Similarly, some service-providers said that Mrs. Pragash might seek help from her peers.

Other service-providers mentioned that friends or family members, most commonly the husband, would identify that Mrs. Pragash needed help. According to these service-providers, the family may consult relatives and close friends for advice. As one explained:

> Like even...before going to the family doctor, they will just talk to the...extended family or close friends about it and they advise to give her some...nutritious food ...or tonics.

Some focus group participants stressed that in cases of illness, it was important to seek the advice of people outside of the family. As one respondent stated:

> ...if it is an illness, then of course we will ask many of them, not only relatives, outsiders too for help because they will give us people and places where we can go to.

Doctor: Lay members believed that if the problem was a "disease," then medical advice was

deemed necessary. As one respondent said:

> ...if it is a bodily ailment, then I would have to go to a doctor...

Most service-providers said that outside help would be sought in dealing with Mrs. Pragash's problem in addition to peers. Some said that Mrs. Pragash might seek help from her family physician. A health care professional described one possible help-seeking route:

> ...she will struggle alone for some time, for a few months or sometimes a year and then maybe talk to a friend, saying..."I have these feelings"...But the friend may say:..."You have to see somebody who can help you." And a friend may bring her in...

Prayer. Some focus group members mentioned the use of prayer. As one participant said:

> She has stopped all her prayers. That is very necessary for a person and it gives peace.

According to service-providers, Mrs. Pragash's problem is usually identified when symptoms are far gone. One service-provider said that family members do not seek help because they believe that their relative has a behaviour condition, laziness:

> ...it's many of times been identified as she being lazy or nonproductive or not being able to do some things like the others. In that, the real concern for the ...individual is lost. So not until for about quite some time and more severe symptoms of need is shown, ...if it is a Tamil-speaking doctor, ...that's when it is coming to be noticed or if they are suicidal and they go to the hospital...

Concerns about seeking help. Community focus group members and service-providers had different opinions about whether Tamils are concerned about seeking outside help for the symptoms of depression. Some focus group members said that they had no concerns about seeking help from outsiders for an "illness." Seeking outside help was not an issue in the case of family problems since these problems would always be sorted out by the family alone.

Stigma and shame. On the other hand, the service-providers said that Sri Lankan Tamils fear that

the Tamil community will learn that someone in their family has a mental health issue if they seek outside help. As some providers said:

> First, they don't identify as mental illness. The moment they come through the realization, there is a great sadness with labelling and now their family will be marred for life and then they kind of find it difficult to accept that there is mental illness. A lot of times they won't seek help because the family doesn't want them to be known as mentally ill.
>
> ...they have a feeling that others might come to know...So because of that, they may not seek help.

Service-providers stressed that confidentiality was important to clients:

> ...sometimes they do come and seek help but they are very cautious...and they won't like the physician to tell anybody about their problem or to involve anybody.

Preferred ethnic background of the service-provider. Tamils prefer to talk about their feelings to people who speak their first language, which the service-providers reported:

> ..they feel more at ease to explain about their troubles in their own language which they may find it difficult when they go to an English-speaking consultant.
>
> ...usually these things are spoken only...in your first language. So you need a service-provider who speaks the first language. These things cannot be interpreted because these are all confidential and talking about feelings and thoughts.

In summary, Tamils may use different ways to cope with depression. They may consult friends and relatives for advice, which was also similar to the way that they cope with mental health problems in general. Tamils may also use prayer. Similarly, Donovan (1986) found that South Asians living in Britain used faith and prayer as a strategy for coping with depression and loneliness. The present study also suggested that Tamils go for medical help for problems that are defined as an illness or health condition. This is supported by evidence that South Asians seek medicine from doctors for depression (Assanand et al., 1990). Although this was not expressed by

lay members, service-providers indicated that there is some concern in the Tamil community about seeking help because of the fear of being labelled with a mental health issue. Furthermore, service-providers said that there is a delay in seeking outside help for depression until the symptoms become severe. This may relate partly to the fact that family members may not identify the seriousness of the condition. According to Furnham and Malik (1994), because of the emphasis that South Asians place on roles and relationships within the family, depression is regarded as being self-indulgent.

Question #4: The Role of Community-based Agencies

Lay members of the Greek community were not aware of Alternatives, however, they were familiar with the services that exist in the community. By contrast, Tamil community members were not aware that these types of services exist. This suggests that Greeks have developed a greater knowledge of mental health services through a process of acculturation.

The Greek and Tamil service-providers and members of the lay community believed that people with serious mental health problems could benefit from the support and case management services offered by community-based agencies, such as Alternatives. Members of the Tamil community believed that supportive counselling would be helpful. As one member said:

> The agency can help by means of listening to the problems that individuals have...Sometimes listening to them your problems can be solved.

Service-providers believed that these agencies had an important role to play because of the limited resources and time that they had to support all people in need. As one Tamil worker said:

> ...one or two agencies cannot serve the community need.

Also as a Greek doctor stated:

> ...the psychiatrist is too busy to see them or I don't have the time to see them. Sometimes I don't have the expertise to sit there and deal with the problem. So I think outside services, especially if they're trained people that speak the language, is important.

Members of the Tamil focus group suggested that community-based agencies advertise their services through flyers and in the Tamil media. Two strategies were suggested by service-providers to meet the needs of people from the ethnic communities. The first strategy was for agencies to hire people from the communities to work in the agencies. As a Greek provider said:

> If you want monitoring...and...understanding of what is happening...within the Greek population, I think you have to hire people who speak the language...

Also, as a Tamil worker said:

> ...They should really hire somebody who could work with the Tamil community who understands their language and who can speak their language, who can understand their problems, and care for them and help the families...

One Tamil service-provider suggested that community-based agencies, such as Alternatives, hire workers from these organizations to work in the agency's service area on a pro-rated basis. Alternatively, staff could be trained to provide culturally sensitive programming to individuals who have some fluency in English. Hence, partnerships would be developed between community agencies and ethnic organizations.

The second strategy was in the area of education and support. Suggestions included holding community workshops, educating women about resources, educating family members about how to cope with mental health problems, linking families with appropriate community resources, and offering help to families to "...avoid the situation from getting worse." Other suggestions included working with the family system, helping people on a preventive basis, and providing follow-up support to clients.

Table 2 presents a summary of the overall findings. This table indicates that Greek and Tamil perceptions of mental health and mental illness fall along a continuum, ranging from mental health to depression, which is acceptable and normal to mental illness, which is unacceptable, abnormal and shameful. It also illustrates the holistic view of health in both ethnic groups and how mental illness affects the person holistically. In terms of views of causation, Greeks and Tamils have a holistic view of mental health problems, which they attribute to environmental, biological, and supernatural factors. The table also illustrates the similar ways of coping and help-seeking in terms of family and friends, spiritual/religious approaches, and help from medical professionals. The main difference is the use of mental health professionals by Greeks. One may also note the preference in both communities for service-providers from one's ethnic background. Finally, the table identifies various ways that agencies can reach out to the communities.

A Proposed Model of Service for Alternatives

One of the purposes of this study was to provide information that will help Alternatives to develop a strategy for reaching more members of diverse ethnic communities. In order to provide feedback about the study to Alternatives, a meeting will be organized with the Ethno/racial Committee. I plan to participate in this information-sharing session through my continued involvement with this committee. Alternatives also plans to develop recommendations for reaching more members of diverse ethnic communities in partnership with other community-based agencies. In keeping with the principle of action research component in this thesis, I will suggest some directions that Alternatives may consider.

One of the guiding principles in any model of service delivery to ethnic communities is that there is an aim to increase the fit between the model and the client's needs and help-seeking

patterns and to alleviate the influence of social problems on the client (Zane, Sue, Castro & George, 1982). Three approaches have been used by mental health agencies to improve the fit between clients from diverse ethnic communities and the agency's services (Sue, 1978, as cited in Wallen, 1992). These approaches can be viewed as a guiding framework for developing ways to serve diverse ethnic communities. The first type of programming is to "find the right service outside the agency." It involves referring people to the appropriate institutions or resources, including churches, family and ethnic associations or to community helpers, such as healers or family doctors. This approach requires a knowledge of community resources but it also presumes that services exist in the community (Zane et al., 1982). The second type of programming is to "change the client to fit the service." In this approach clients are made aware of existing mental health resources and trained to use them. The third type of programming is to "change the service to fit the client." This approach is the most responsive but it is also the most difficult. It may include training service-providers to be culturally sensitive or hiring bilingual or bicultural staff. It may also include changing the delivery or structure of services. In planning appropriate services to the multicultural community, Wallen (1992) suggests that agencies consider administrative issues, the size of the ethnic population, and the extent to which clients are acculturated.

I believe that community mental health agencies need to develop innovative ways to reach out to ethnic groups that do not use these services. They have a shared responsibility to meet the needs of diverse communities (After the Door Has Been Opened, 1988). One model of service that Alternatives may consider is one that is based on the principles of liaison and consultation. In the Multicultural Mental Health Liaison Program (Peters, 1993), a multicultural liaison worker is hired by the agency to act as a link and change agent between the mental health agency, the ethnic

Table 2
Summary of Findings

	Greeks	Tamils
Question #1 Mental Health, Mental Illness, and Depression		
Mental health	-coping with problems in living -absence of illness -normal	-coping with problems in living -holistic -family concept, life concept -normal
Mental illness	-inability to cope with problems in living -extreme behaviour, disturbance of mind; madness -abnormal, stigmatizing, shameful	-inability to function -mental worries -extreme behaviour, disturbance of the mind, madness -abnormal, stigmatizing, shameful
Depression	-unhappiness, internal/psychological -physical problem -inability to function in life's roles -serious problem -normal; suicide -sin, abnormal -some stigma	-health condition, change of mind -not mental illness -inability to function in life's roles -serious problem -normal -some stigma
Question #2 Views of Causation		
Mental illness	-environmental -biological -supernatural -beyond one's control	-environmental -biological -internal -supernatural/astrology
Depression	-environmental -individual	-environmental -biological
Question #3 Coping and Help-seeking		
Mental illness	-family -church/spirituality -doctors -psychiatrists (last resort)	-family -spirituality, astrology -doctors -psychiatrists
Depression	-friends -family -church -doctor or psychologist (preferably Greek)	-friends -family -prayer -doctor (preferably Tamil)
Question #4 Role of Community Agencies		
	-advertising -hiring workers from ethnic communities -cultural sensitivity training for staff	-education, workshops -individual and family support

communities, and human service agencies that work with members of ethnic communities. Through consultation activities, the liaison worker connects with the general public, ethnic gatekeepers in organizations, and people in a variety of human service agencies in order to link people with serious mental health problems to appropriate mental health services. In addition, the liaison worker consults with agency staff about cultural issues. The agency is also involved in providing education about mental health problems to diverse ethnic groups from the general public (Peters, 1993).

I have modified this approach so that it is more culturally relevant to the coping and help-seeking process of Greeks and Tamils. A major role of the liaison worker would be to support the work of informal helpers, such as spiritual/religious healers, staff at neighbourhood resource centres, and settlement workers. According to Snowden (1987), community psychology should try to identify and support the systems of informal help that ethnic groups use. Through such an understanding, one aims to develop a process of consultation that helps to coordinate the work of informal and formal helpers and to develop a mutually cooperative relationship among these helpers (Snowden, 1987). The liaison worker would also consult with various types of formal helpers, such as family physicians, who are the primary professional contact for these groups. As noted in the first section of the thesis, there is a tendency among medical professionals to dismiss the cultural and social context of minorities with mental problems (Vega & Murphy, 1990). Hence, the liaison worker can act as a resource to physicians.

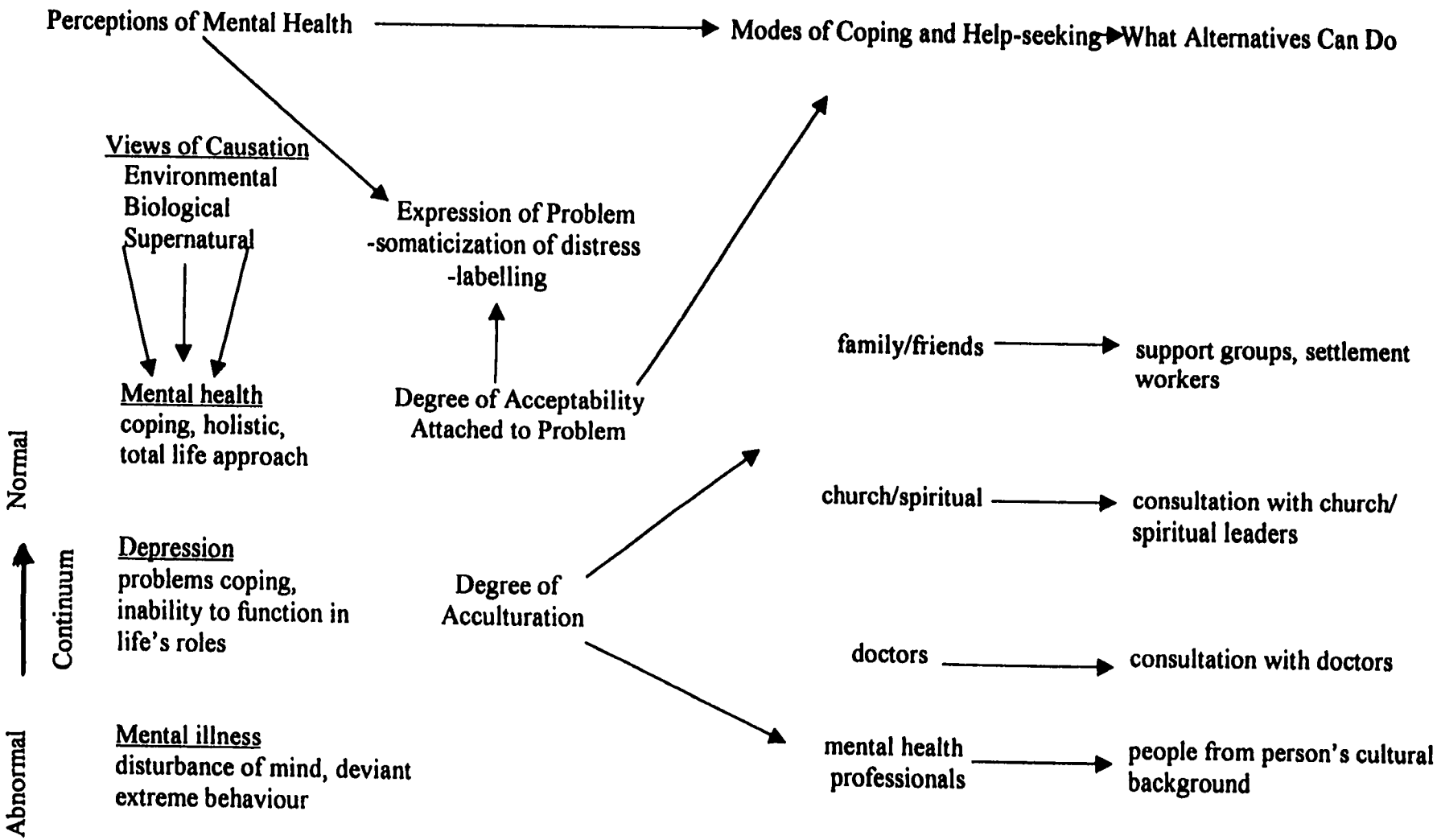
Whatever model of service that Alternatives decides to develop, it would be important to ensure that this service is culturally relevant to the communities. In order to ensure that the service fits with community needs, it is important to develop a process for community input (Zane

et al., 1982). The major implication for any mental health service is that it should be based on a philosophy of respect for the worldview, coping process, and use of alternative resources, such as spiritual advisors and family support, which Zane et al. (1982) note as important factors to improving the fit between the client and the service. In keeping with this philosophy of respect, the service should be able to accommodate the needs of individuals who may prefer to seek help from people or resources outside their ethnic community. Another important implication is that services would be provided which are non-stigmatizing and which avoid labelling mental health problems. Services could adopt a "problems in living" perspective as opposed to a mental illness perspective. The service should be evaluated to ensure that it meets the users' needs. In serving the diverse communities, it is also important for human services agencies to undergo a process of anti-racist organizational change (Ali, 1998).

Hence, in considering the findings in relation to the body of literature, a number of broad patterns can be seen to emerge. Figure 1 presents a grounded theory of Greek and Sri Lankan Tamil perceptions of mental health, coping, and help-seeking process. The figure illustrates a number of important relationships, which are indicated by the arrows. It indicates a connection between the perception of symptoms of behaviour and ways of coping and help-seeking. The mediating factors that affect how people cope are the degree of normality and acceptability associated with the symptoms. Acculturation is another important mediating influence in the help-seeking process, affecting decisions about where people turn to for help and whether they seek help inside or outside their ethnic community. The figure also shows how the perception of a problem affects the way that the problem is expressed and labelled by a person. Again, mediating

Figure 1

Grounded Theory of Greek and Sri Lankan Tamil Perceptions of Mental Health, Mental Illness, and Coping Process



factors in this relationship are the degree of normality and acceptability of the symtpoms. For example, the stigma associated with particular symptoms may lead to a process of somaticization, as confirmed in a literature review on help-seeking among people with mental illness (Greenley & Mullen, 1990). Somaticization is a culturally acceptable way of expressing distress (After the Door Has Been Opened, 1988). The figure also suggests various ways that Alternatives may support Greeks and Tamils. These include assisting in the development of culturally sensitive interventions such as support groups and consultations with various community helpers.

Limitations of the Study

As with any research, there were a number of limitations of this study. First, as noted at the outset of this thesis, there was a small sample of participants in the research. This sample cannot be considered to be representative of all individuals in the Greek and Tamil communities. There are many beliefs about mental illness in a community and members of an ethnic group do not all share the same beliefs (Vega & Murphy, 1990). Another issue that relates to sampling concerns the selection of focus group participants. I had hoped to select participants purposefully in terms of age, social class, and education. However, due to the fact that I had no control over the actual recruitment process, I used a convenience sample.

Second, one of the ways that this research could be strengthened would be to develop a process whereby the findings are further validated at various stages of the research. During the interviews, participants could be given an opportunity to make further comments. For example, focus group participants might be asked to respond to a summary of the findings prepared by the facilitator (Krueger, 1994). After the interviews, the participants could be invited to participate in a feedback-sharing session which allows them to add additional comments.

Third, the study was not free of ethnocentric bias. As a researcher who was born and educated in Canada, I brought my own biases and assumptions to the research, which certainly may have influenced the way that I collected, analysed, and interpreted the data. Furthermore, some of the interview questions had a Western bias, particularly the questions on "mental health" and "mental illness." In planning the research with the Planning Committee, there was some dilemma about whether to use the term "health" rather than the term "mental health" in interviews. Some members believed that the term "health" was more culturally sensitive and less stigmatizing, while others believed that it hid the true intent of the research and reinforced the stigma attached to mental health problems. Also, a discussion about health was believed to be too broad. I decided to use the terms "mental health" and "mental illness" due to the latter concern. As I discovered later, these terms did pose difficulty in translation into the Tamil language. Finding ways to do research on concepts that may not even exist in an ethnic group was a challenging process. However, I tried to approach the topic of mental health from different angles by not only exploring general beliefs about the phenomenon, but also specific beliefs about depression since people's beliefs depend on the nature of the problem.

Fourth, although service-providers provided a valuable source of data, they may have a limited knowledge about how their clients perceive mental health problems. In interviews I found that some service-providers sometimes struggled to define what mental health problems meant to their clients. This may relate to the degree of communication that occurs in the clinical encounter (Kleinman, 1975).

Fifth, because there were few studies about Sri Lankans, I had to rely mostly on literature on Indians. Historically, Tamils in Sri Lanka came from the southern part of India. There are

shared cultural patterns between Tamils and people from South India. However, broad comparisons between South Asians from different regions may not always be appropriate. South Asia is made up of a diverse group of people who differ according to language, religion, country of origin, class, and degree of urbanization. Although they share a similar cultural background, South Asians do have different health beliefs and practices (Assanand et al., 1990).

Finally, due to the scope of this study, I was unable to explore how Greeks and Tamils define normal and abnormal behaviour. Definitions of deviance and illness vary from culture to culture and affect decisions about seeking treatment and the types of treatment options (Vega & Murphy, 1990).

CONCLUSION

How do the coping and help-seeking patterns of Greeks and Tamils compare to those of people born in North America? A survey on help-seeking patterns in the United States from 1957 to 1976 (Veroff, Kulka, & Douvan, 1981) found that people continued to turn to family and friends for support. However, there was a shift over time with a decrease in the use of clergy and family doctors and an increase in the use of mental health professionals. This is also confirmed in a review of help-seeking behaviour (Greenley & Mullen, 1990). The study by Veroff et al. (1981) indicated that time and acculturation influence the coping and help-seeking process which people use. Thus, one may speculate that over time, as Greek and Tamils become acculturated to Canadian society, they will be more receptive to using mental health services. These changes may be more evident among second-generation Greeks and Tamils. However, the receptivity to mental health services will also depend on a number of factors, including education and income (Vega & Murphy, 1990). Another important factor is the effort taken by the mainstream mental health

system to design interventions that fit the needs of users from diverse ethnic groups. Until more culturally sensitive interventions are developed for Greeks and Tamils, mental health services may still be a last resort.

This research was undertaken to understand how members of diverse ethnic groups perceive and respond to mental health problems. In terms of future research, more information is needed to learn about how members of these communities define normal and abnormal symptoms of behaviour. This information would assist formal helpers to get a better understanding of the coping and help-seeking process of different communities. In addition, research that explores how the factors of gender, age, social class, and education affect the coping process would also be helpful.

SOME PERSONAL REFLECTIONS AS A RESEARCHER

In reflecting on my experience in this research, I often thought about what it was like to do research on ethnic groups different from my own. As someone coming into the research with little knowledge of the ethnic groups in question, I often had feelings of anxiety and self-doubt about my ability to do the research. Would I represent the communities in an accurate way? What if I were to interpret something in an ethnocentric way? As a student with a background in social/cultural anthropology and multicultural studies, I was conscious of my responsibility as a researcher to portray the communities with as much sensitivity as possible. For example, I often struggled with how to deal with information that might not be perceived in a positive light, such as the issues of stigma and somaticization, which I know are universal. These concerns continue to remain with me even after writing the thesis.

Another concern that I had coming into the research was how I would be received as "an

outsider" and how willing people would be to help a researcher who did not share their ethnic background or language. I was well aware of the suspicions that people may have about research conducted by outsiders. To my pleasant surprise, I found people to be more receptive to the research than I had expected. At times I was often struck by how willing people were to talk or meet with me. This was especially the case with service-providers, but it was evident among other individuals as well. Participants in the focus groups were also quite receptive to the research. I wondered whether my presence during the interview would be an intrusion, but I do not believe that this was the case. For instance, in the pilot focus group, participants shared their views openly and honestly and engaged fully in the discussion. In the focus group that I conducted with the help of an interpreter, I also found participants to be fairly open. Finally, members of the ethnic groups who were involved on the Planning Committee were also very helpful. Even months after the committee stopped meeting formally, I felt comfortable to call them anytime I wanted to obtain their input about the research.

Of course, there were some barriers that I faced as an outsider. It was not easy to mobilize people for research, especially when one does not speak the languages. For example, at one particular organization, I had difficulty communicating the purpose of the research to an individual, which may have affected the turnout of one of my focus groups. Gaining entry to clients was particularly challenging, but this may have had less to do with my ethnicity/language and more to do with the commitment to protecting the confidentiality of clients. I found that "mediators" from the ethnic groups were very helpful in helping me to make key contacts to people and places.

Finally in reflecting on the research, I believe that community-based research on diverse

ethnic communities requires a strong commitment to culturally sensitive research on the part of researchers and the host setting. It should involve a process where the researcher talks informally to a broad range of individuals in the community, asks questions, and is open to challenging her ideas and biased ways of thinking. The researcher must also acknowledge that her understanding and knowledge about a community will never be complete. This research study has opened my eyes to some of the beliefs and ways of coping and help-seeking among Greeks and Tamils, but there is still much for me to learn.

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Appendices

Appendix A

Service Provider Interview Guide

General Questions about Mental Health and Mental Illness

1. What does "mental health" mean to patients/clients from your community? How do they define it?
2. What does "mental illness" mean to patients/clients from your community? How do they define it?
3. What do your clients with serious mental health problems think are the causes of mental illness? How do your clients with serious mental health problems understand their problem?
4. What are the ways that Greeks/Sri Lankan clients deal with mental illness in terms of coping and help-seeking?
5. Generally speaking, how are people with serious mental health problems from your community viewed by people in the Greek/Sri Lankan Tamil community? How are people with serious mental health problems viewed by their family members?
7. How do family members cope with the difficulties of having a relative with serious mental health problems?
8. How do your patients/clients with serious mental health problems cooperate with the help-seeking effort and treatment plan?
9. How are people with serious mental health problems handled here as compared to in Greece/Sri Lanka?

Specific Questions about Depression

The Scenario

Mrs. Poulos/Mrs. Pragash is 37 years old. She and her husband emigrated from Greece/Sri Lanka to Canada. They have a four-year old son. During the last two months, Mrs. Poulos/Mrs. Pragash has lost interest in many things she usually enjoys, such as chatting with her neighbours, going to church/praying, and watching Greek television programs/South Asian television programs and movies. During this time, she lost her appetite, always feels tired but has trouble falling asleep. She has difficulty concentrating in her place of work. She has thought about ending her life.

Perception of Depression

1. What does Mrs. Poulos/Mrs. Pragash say that she is experiencing?
2. What kind of problem does she say she has?
3. What does she call the problem? What do you call it? Does she accept your diagnosis/view/assessment?
4. What would she think is the cause of her problem?
5. What effect does she say that the problem has on her?
6. How severe does she think the problem? In your view, is the problem minimized or exaggerated? Does she think that she will recover?

7. Does she think that the problem is a normal part of life or that is it something unusual?
8. Does Mrs. Poulos/Mrs. Pragash regard her problem as a mental illness?

Coping and Help-seeking

1. How does Mrs. Poulos/Mrs. Pragash deal with the problem (experience)?
2. Does she have any concerns about seeking help or advice?
3. Does Mrs. Poulos/Mrs. Pragash prefer to seek help from within the Greek/Tamil community or outside it?

Role of Community-based Agencies

Alternatives is a counselling and community support service for people 16 years of age and older. It works with people who have lengthy and/or significant mental health problems that seriously impact upon or disrupt their quality of life. Alternatives provides individual counselling, groups, advocacy, information, and referrals. It assists individuals to deal with housing and financial issues.

1. Do you think that people of Greek/South Asian origin with serious mental health problems could benefit from this service or services like this one? Why or why not?
2. What are the specific ways that agencies like this one could meet the needs of people with serious mental health problems of Greek/South Asian origin?

Appendix B

Pilot Focus Group Interview Guide

Part I

A. General beliefs about mental health and mental illness

-What does "mental health" mean to you?

You may have heard about or known someone who has a "serious mental health problem" or "mental illness."

-What are the first things that come to mind when you think about "mental illness"?

-What is your understanding of "mental illness"? What causes it?

-Do you have a word for "mental illness" in your language?

Let's suppose that you have a Greek friend and a member of your friend's family has a mental illness.

-Now how would the member of your friend's family be viewed by i) people in the Greek community, ii) her family, iii) friend?

B. Coping and help-seeking

-What approaches might be taken to deal with mental illness?

-Would anyone be consulted for help? Who? In what order?

-Would they consult health care practitioners from the Greek community?

-Would your friend's family prefer that the relative with mental illness live with them or somewhere else?

Part II

A. Beliefs about depression

Let's say Mrs. Poulos is someone who goes to your church or attends a social club in the community

-What kind of problem is it?

-What would you call the problem?

-What is the cause of the problem?

-How does her problem affect her?

-How serious is the problem?

-How would Mrs. Poulos be viewed by i) people in her community; ii) friends; iii) family members?

B. Coping and help-seeking

-Would Mrs. Poulos turn to someone for help, would others turn to help for her, would she deal with the problem herself, or would her problem continue?

-Who would she/they (clarify who "they" is) turn to for help? Anyone else?

-How are these people thought to be helpful?

-Who would be consulted first? Next? Next? Why?

Appendix C

Invitation Letter for Focus Group Interviews

Dear Community Member:
We are asking for your help in a study. My name is Margaret Douglin and I am a Masters in Community Psychology student at Wilfrid Laurier University and the coordinator of the study at Alternatives. Alternatives is a community-based mental health agency that works with people who have mental health problems. As an agency, we would like to reach more members of various ethnic communities that make up East Toronto. Our goal is that the agency will be better able to meet the cultural needs of the Greek/Tamil community.

In order to better respond to the needs of your community, it is important for us to learn how mental health is talked about in your community. To do so, we would like the opportunity to sit down and talk with a few members of your community. We hope to reach more people by meeting in a small group of 6 to 8 members. We have much to learn about the ideas that your community has about mental health. We would, therefore, highly welcome your participation in this small group.

We have prepared a number of questions to guide the small group discussion on this topic. The session will take about two hours. It will be conducted in your home language (Greek/Tamil) and at a time and place that is convenient for you. We hope to tape-record the session because what you say is important to us and we want to obtain information that is as accurate as possible. Refreshments will be provided at the session.

The information that I gather from this study will also be used for my thesis. My advisor's name is Professor Geoffrey Nelson (phone #: (519)884-0710, ext. 3314).

Everything that you share during the session will be kept confidential. I will be the only person who has the audio-tape from the session. After the session, I will meet with a cultural interpreter who will interpret the participants' responses from the session into English. I will erase the audio-tape after that meeting. At no time will anyone's name be mentioned on the audio-tape or in any written document related to this research. A summary of the results will be provided to you in English by September 1998, at your request.

Your participation in this study is voluntary. You are free not to participate, to withdraw from the study at any time, and not to answer questions which you do not wish to answer.

Your participation in the study is very important to us. We have much to learn from your community and we hope that you will take the opportunity to share your views with us.

If you have any further questions about the study, I can be reached at _____.
Sincerely, etc.

Appendix D

Consent Form for Participation in Community Study

Margaret Douglin, Principal Investigator, Department of Psychology,
Wilfrid Laurier University

I have been informed of the purpose of the community study that Margaret Douglin will coordinate under the support of her advisor Professor Geoffrey Nelson. I have also been informed about my rights as a participant in this study. My participatory in this study is voluntary. I am free not to participate, to withdraw from the study at any time, and not to answer questions which I do not wish to answer.

I agree to participate in the study.

Name (please print) _____

Signature _____

Date _____

Appendix E

Community Focus Group Interview Guide

Introduction

Good afternoon/evening. We would like to thank you for taking the time to be here today. My name is _____. Assisting me is _____. Did everyone get a copy of the letter that describes the study and the purpose of this session? (If not, distribute copies of the letter for people to read.) The purpose of this session is to talk with people in the Greek/Sri Lankan Tamil community about mental health. We have invited people with similar experiences to share their perceptions and ideas on this topic. The session will take about two hours. The discussion will focus on a short scenario which I will read to you. We want to hear as many different points of view as possible. There are no right or wrong answers to any of the questions we will be asking. During the session, we do not want you to use your names. Instead, we ask that you identify yourselves with this id# when you want to say something. This will help us to sort your responses (hand out id#s). Also, we want to hear from everyone so we will ask each person to share her views. You can speak in any order you like but please remember to identify yourselves first. We are tape recording the session because we cannot take notes as quickly as you speak and because we don't want to miss your comments. Please take a moment to read and sign the consent form. Before we begin, do you have any questions?

Understanding of "Mental Health" and "Mental Illness"

1. Are you familiar with the terms "mental illness" and "mental health"?
   (if yes, ask questions #2-4)
2.a)What does "mental illness" mean to you? How do you define it?
b) What does "mental health" mean to you? How do you define it?
c) Do you have a similar term(s) for "mental illness" in your language?

3. How are people with mental illness handled here as compared to in your country of origin?

Description of the Scenario

Mrs. _____ is 37 years old. She and her husband emigrated from Greece/Sri Lanka to Canada. They have a four-year old son. During the last two months, Mrs. _____ has lost interest in many things she usually enjoys, such as chatting with her neighbours, going to church/praying, and watching Greek television programs/South Asian television programs and movies. During this time, she lost her appetite, always feels tired but has trouble falling asleep. She has difficulty concentrating in her place of work. She has thought about ending her life.

I. Discussion of the Scenario

Understanding of the symptoms

1. What do you think that Mrs.____ is experiencing?
2. Do you think that it is a problem?
   (if yes, use the term "problem" for the rest of the interview; if no, use the term "experience")
3. What do you call this problem (experience)?
4. What do you think caused the problem (experience)?
5. What effect does this problem (experience) have on her?
6. How severe is the problem (experience)? Do you think that she will recover?
7. Is this problem (experience) a normal part of life or is it something unusual?

Coping and help-seeking

1. In your view, what is the appropriate way to deal with this problem (experience)?
   (if anyone mentions the need for help or advice, ask questions #2-6)
2. What kind of help or advice does Mrs.____ need?
3. Where would you first go for help or advice? Where would you go next?
4. Do you have any concerns about seeking help or advice?
5. Would you prefer to seek help or advice from people in the Greek/Tamil community or outside it? (refer to people's responses to question #3) (Why do you say that?)
6. Do you regard Mrs.____'s problem (experience) as a mental illness? (Why or why not?)

The Role of Community-based Agencies

There are different supports in the East Toronto community for people with serious mental health problems. As an example, Alternatives is a counselling and community support service for people 16 years of age and older. It works with people who have lengthy and/or significant mental health problems that seriously impact upon or disrupt their quality of life. Alternatives provides individual counselling, groups, advocacy, information, and referrals. It assists individuals to deal with housing and financial issues.

1. Are you aware that services like this one are available?
2. Do you think that this service could be of help to someone like Mrs.___? (Why or why not?)
3. What specific things can services like Alternatives do to help people with serious mental health problems who are Greek/Tamil?

We would like to thank you very much for the time that you have given us for this project. Is there anything that you would like to add?

Appendix F

Background Information Questionnaire

id#: _____
Date: _____

1. In what country were you born? _____

2. Did you come from an urban or rural setting?
☐ urban ☐ rural

3. In what countries were your parents born? _____

4. Under what circumstances did you come to Canada? (please check one)
☐ immigrant ☐ refugee ☐ family reunification ☐ entrepreneur

5. How many years have you lived in Canada? _____

6. Where do you live? (please check one)
☐ East York ☐ Scarborough ☐ Etobicoke ☐ York ☐ ☐ Toronto ☐ Other __

7. What languages do you speak? _____

8. What is your religion? _____

9. What age group do you belong to? (please check one)
☐ 25-29 ☐ 40-44 ☐ 55-59
☐ 30-34 ☐ 45-49 ☐ 60-64
☐ 35-39 ☐ 50-54 ☐ 65

10. What is the highest level of education that you have completed? _____
_____

11. What is your current work status?
☐ employed (work full-time or part-time for pay)
☐ are at home
☐ are retired
☐ are a student
☐ are looking for work
☐ other (specify) _____

12. If employed/retired/looking for work, what type of work [do you do/did you do before

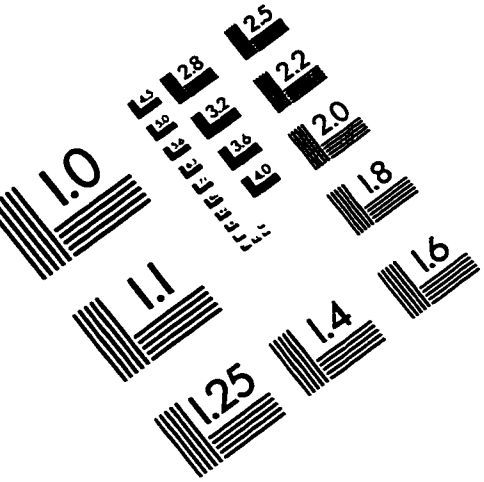
retiring/are you looking for]?

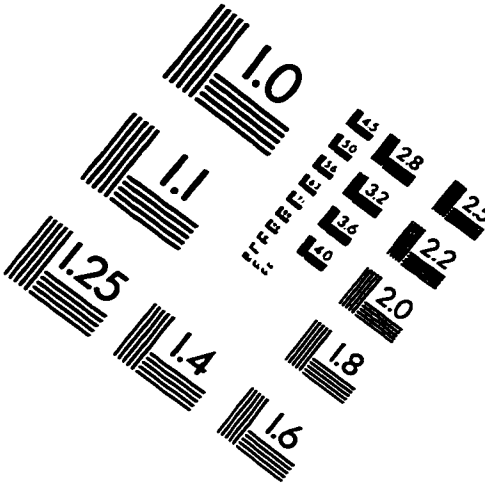
---

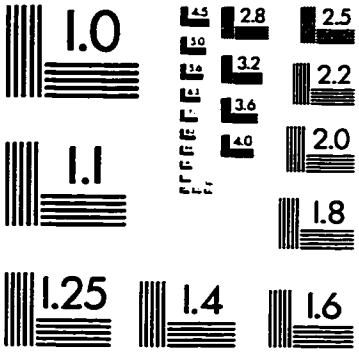
13. Have you personally experienced or do you know friends or family members who have gone through a problem related to mental health?
☐ yes ☐ no

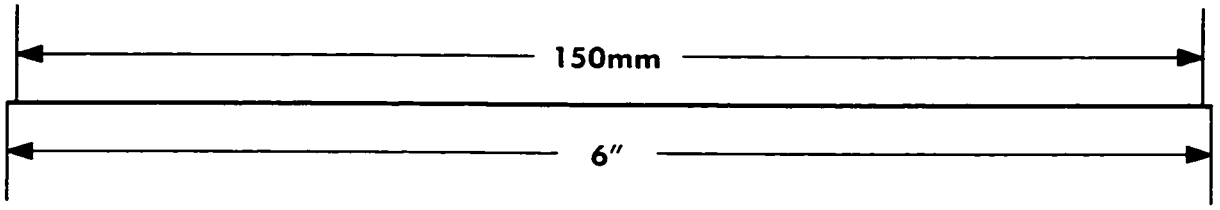
Thank you.

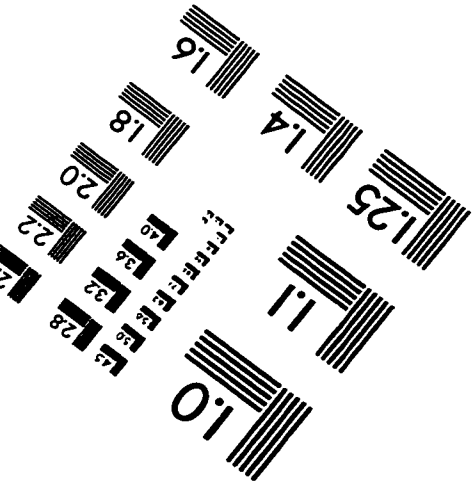
IMAGE EVALUATION
TEST TARGET (QA-3)

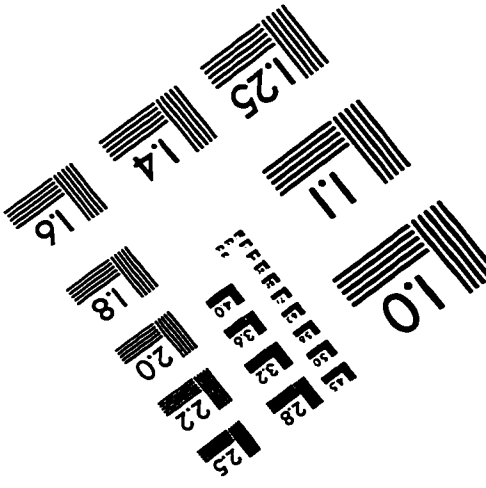












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