PERSPECTIVES ON MENTAL WELLNESS/HEALTH OF PUNJABI SIKH IMMIGRANTS IN THE CITY OF SURREY

by

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ABSTRACT

Punjabi Sikhs are the largest immigrant community in the City of Surrey. Providing culturally responsive mental wellness/health services for the Punjabi Sikh community is the focus of this study. In order to document the nature of mental wellness issues, as these are understood by members of this community, four service providers and twenty recent immigrant community members were interviewed.

Theories regarding processes of resettlement and adjustment to a new language and culture framed this investigation. Concurrently, a critical perspective on mainstream service provision is also an intrinsic part of the framework for this study. Specific issues related to accessing mainstream health services for minority communities are considered. The research questions that guided this analysis were: What mental wellness/health concerns are prevalent for members of the Punjabi Sikh immigrant community? In what ways does the process of resettling and adjusting to life in Canada contribute to changes in mental wellness/health? When members of the Punjabi Sikh immigrant community encounter mental wellness/health distress, which support services are accessed and what are the reasons given?

The findings of this investigation are that immigrants of Punjabi Sikh ancestry identify a wide range of social, cultural and economic issues in the process of adjusting to life in Canada. As well the social configuration of the Punjabi family, health and occupational practices, as these are re-structured by mainstream society, have implications for patterns of wellness. Changes in patterns of sociability, employment, gender relations and relations between the generations were seen as part of the new social system within which cultural beliefs and practices in health must operate. Difficulty in

accessing familiar and mainstream mental wellness/health supports could also deepen the stress of settlement. In extreme cases stress might lead to substance abuse, domestic violence, intergenerational conflicts and possibly mental illness.

This research has important implications for the provision of culturally responsive services by mental health centres, hospitals and multicultural immigrant servicing agencies. The dominant biomedical model in the Canadian health care system often ignores the familiar mental wellness/health support available and utilised in the community. This research suggests that it is critical to acknowledge these support systems as part of mental wellness/health assessment and plans for individual, family and community care.

DEDICATION

This thesis is dedicated to the joy and love of my life, my husband Gurpreet and my daughter Avneet. Thank you Gurpreet always for your support and encouragement and Avneet, for your hugs and kisses.

QUOTE

Guru Arjan Dev Ji's teachings, page 106, Sri Guru Granth Sahib Ji

'Man tan tayraa dhan bhee tayraa
Too (n) Thakur Su-aamee Prabh mayraa

Jee-o pind sabh raas tumaaree
Tayraa jor Gopaalaa jee-o'

Interpretation

God has given us a mind and body, which are both precious and therefore both need to be respected and maintained. By conditioning our minds and bodies we enrich our lives, strive towards a physiological and mental equilibrium. We are required to lead a balanced life in terms of fulfilling our many responsibilities and aspirations in life, however, with an emphasis on spiritual goals.

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Introduction

Diversity in Canada

The ethno-cultural/racial profile of the Canadian population has dramatically changed in the last two decades. Increases in the number of immigrants of non-European origin and in the total immigrant population are two factors of major significance in considering issues of service provision for immigrant minorities' mental well being. Through much of the early twentieth century, the United Kingdom, the United States and Europe, were the main sources of immigrants to Canada. In recent years, however, this trend has changed, with increasing numbers immigrating to Canada from Asia and the Middle East, Africa, Central and South America. Hong Kong, the People's Republic of China, India, the Philippines and Sri Lanka headed the list for recent immigrants.

In 1996, just over one million persons in Canada (1, 039,000) were immigrants who arrived between 1991 and 1996. The Asian-born accounted for more than half (57%) of these recent arrivals, up from 33% of immigrants who came in the 1970s, 12% of those who arrived in the 1960s; only 3% of those who arrived before 1961 (Statistics Canada, 1996).

Mental health of migrants: Status of service provision

In Canada, the publication in 1988 of the Task Force on Mental Health Issues Affecting Immigrants and Refugees, identified the under-utilisation of formal mental health services by immigrants as a major concern. Services provided by hospitals, mental health centres, health units and other mainstream wellness/health services were all seen as under-utilised. The report concluded that, "...[minority] ethnic groups in Canada avoid the mental health system because they feel that barriers impeding access to

appropriate services are often insurmountable" (23). Even if immigrants sometimes succeed in overcoming barriers, "...the treatment they receive is inappropriate or ineffective. These feelings are not confined to small communities or recent arrivals. Large cultural groups who have been in Canada for generations also feel disenfranchised from care"(24).

The Task Force also recommended that it is not feasible to create "parallel" mental health services for each language and cultural group in Canada. It was further recommended that institutions of higher learning identify cross-cultural education as a priority, particularly for students of education, medicine, nursing, psychiatry, psychology and social work. Such training was seen as a tool for integrating consideration of immigrant needs into mainstream institutions.

Some mental health professionals working in mainstream agencies in the Greater Vancouver Regional District have also expressed a desire to bridge barriers so that they may provide accessible and culturally acceptable mental health care for the various multilingual/multicultural communities (Popatia, 1994; Waxler-Morrison, 1990; Task Force, 1988). Each of these points assumes the predominance of mainstream institutions as the central service provider. It is likely that in the near future mainstream agencies and immigrant servicing organisations that liaise with these agencies will continue to follow this mainstream, biomedical model. In this context, the present research acknowledges the current priority accorded the biomedical model. However the research also explores the structural impediment to well being constructed by this model and asks the reader to consider complementary, pluralist perspectives.

South Asian/Punjabi Sikh Community Profile

For over a century, migrants of Punjabi Sikh ancestry have integrated themselves as members of Canadian communities. Despite their long-standing historical place in

Canadian society, in the 1980's and 1990's large numbers were born outside of and immigrated to Canada.

The South Asian community, the second largest foreign-born population in the Greater Vancouver Regional District, has been identified in underutilization of formal mental health services (Peters, 1987; Culture and Health 2000, 1996; Popatia, 1994, 1995). South Asians are people whose ethnic origin can be traced to the subcontinent of India, Pakistan, Bangladesh, Sri Lanka, or Nepal. People of South Asian descent may also be from Fiji, parts of Africa and some Caribbean islands.

The Punjabi Sikh immigrant members of the South Asian community living in the City of Surrey will be the particular focus of this research for two main reasons. First, the Punjabi Sikh community is the largest single ethnic and language group within the South Asian population. Second, in the last ten years, the City of Surrey's major population growth has been a result of immigrant populations, and the largest immigrant population is Punjabi Sikh South Asians (see Appendix I for demographic data).

Located in the lower mainland of British Columbia, the city of Surrey is part of the Greater Vancouver Regional District. It was difficult to get an accurate number of recent immigrants of Punjabi Sikh ancestry in the city of Surrey, however the following was clear: demographically, the City of Surrey has a large recent immigrant population. More than half of recent immigrants coming from India to the GVRD, chose Surrey to reside in. More than half of these recent immigrants without English language ability speak Punjabi (Statistics Canada, 1996; City of Surrey, 1999; British Columbia, 1999). Majorities of Punjabi Sikhs, have come under the family class immigration process.

Mental Wellness Issues Associated with Migration

Migration for any reason and within any context can be a source of major stress (Mental Health Task Force, 1988; Sandhu, 1996). Concerns surrounding immigrant

access to formal mental health services are often seen to be influenced by language and culture (Popatia, 1994). Structural issues such as political status and historical experiences are also significant considerations (Anderson and Kirkham, 1998; Ng, 1993). The data collected in this study will be considered from both a cultural and a structural perspective.

According to Grant & Rai (2000), the process of immigration may create a new social, spiritual and economic cultural environment for recent immigrants. The Punjabi Sikh immigrant community has experiences which make them different from the Punjabi Sikh community born and raised in Canada; and different from the Punjabi Sikh community continuously resident in India. For some Punjabi Sikh immigrants, feelings of alienation, loneliness and helplessness are overwhelming. One of the ways that health professionals may be able to deliver mental wellness/health support services is by understanding the immigrant experience in adapting to a new culture and to a new language. This thesis also gives consideration to support that might occur outside of the structures of mainstream agencies.

Focus of the Study: Punjabi Sikhs, mental wellness, and issues of settlement

This study focuses on effects on mental wellness/health in the process of settling and adjusting to life in Canada. In particular, inquires are made into how selected members of the Punjabi Sikh immigrant community in Surrey, British Columbia, perceive that they are affected by this process. The definition of mental wellness/health was established by reference to the Task Force on immigrant mental health and the World Health Organisation and through interviews with selected Punjabi Sikh community members and service providers. Health is defined as a state of relative physical, psychological and social well being of the individual and the family (World Health Organisation). To the extent that people feel happy, have a sense that they are

valued, productive members of the family and society, they are mentally well/healthy (Mental Health Task Force, 1988).

Documenting the support systems accessed by Punjabi Sikh immigrant communities when mental wellness/health distress is encountered and in which format the formal mental wellness/health system is being used; may help us to understand barriers encountered by individuals seeking formal services.

The questions posed in this research are: What mental wellness/health concerns are prevalent within the Punjabi Sikh immigrant community? Are changes in mental wellness/health influenced by the process of settling and adjusting to life in Canada? What are these changes? When members of the Punjabi Sikh Immigrant community encounter mental wellness/health distress, which support services are accessed and what are the reasons given? In what ways are differences in culture and societal structural barriers respectively implicated in settlement.

Assumptions and Limitations

Buchignani (1985) observes that South Asians exhibit a greater degree of cultural, linguistic and religious diversity than any other census designated population group in Canada. An assumption central to this thesis is that the South Asian community's cultural heterogeneity with respect to region/country of origin, language, and religion are various factors that are implicated in the migrant resettlement process. Structural factors implicated in migrant resettlement such as socio-economic, political history, age and gender will be of particular interest in the considerations of this thesis. For example, an elderly Punjabi Sikh speaking woman arriving from a small village would settle and adjust to life in Canada quite differently than a university graduate British-Hindi-English speaking woman arriving from a large urban centre such as London. Due to time limitations and recognition of significance of the above listed resettlement factors, it was

important to focus the investigation on a relatively discrete ethno-cultural linguistic/religious sub set of the South Asian community, and the Punjabi Sikh community is the most numerous in British Columbia.

Another assumption central to this thesis is that most recent Punjabi Sikh immigrants chose freely to come to Canada through the family re-unification immigration policy. In addition to joining family members they are also seeking, for the most part, to improve their economic circumstances. These structural features are also implicated in the issues of mental well being.

As a result of limitation of time and resources, this investigation focuses only on a small group of selected members of Surrey's Punjabi Sikh immigrant community. With the assessment focusing on a small number of community members, it is difficult to generalise about all the immigration issues pertinent to either the Punjabi Sikh immigrant community or to other members of the South Asian community. Despite the limitations, this investigation will still provide needed insights into mental wellness/health of the second largest immigrant group in British Columbia and the Greater Vancouver area.

Overview of the Chapters

Chapter one explores the issues related to accessing health services for the multicultural/multilingual communities. An overview of national, provincial, and regional reports demonstrates that these jurisdictions are concerned about cultural and structural factors which limit immigrant access to mainstream health services. These reports do not give much attention to care alternatives outside of the mainstream structures. Community based research on South Asian access to mainstream health services is also presented. The design and implementation of one strategy designated as culturally responsive, the mental health liaison program, is identified and described.

Chapter two provides a literature review on theories of resettlement and adjustment for migrants. Discussed are multicultural health care in Canada, factors that influence health of immigrants, migration process and phases of adjustment and resettlement; and structural circumstances particular to the South Asian immigrant community.

Chapter three presents a profile of the Punjabi Sikh community by providing a historical and background overview. Chapter four discusses qualitative research methodology and outlines the methodology used in the study. The section on the researcher's position and location is presented to specify how the perspective of the researcher may influence the interpretation of data.

Chapter five provides a brief background and demographic overview of both the service providers and the selected Punjabi Sikh community participants. Data from the interviews is presented, analysed and interpreted. Gender and age comparisons of the participants are made when ever possible.

Chapter six discusses the implications of the findings. In particular two main types of data are considered: 1) data relating to different culturally based meaning systems between the Punjabi Sikh community members and mainstream meanings around health and wellness and 2) data relating to structural barriers to accessing care systems of choice, either mainstream or complementary/pluralistic systems. The chapter concludes by outlining possible considerations and directions which could be taken by mainstream mental health services and multicultural immigrant servicing agencies which provide access to mental wellness/health support systems and services for members of the Punjabi Sikh immigrant community.

Chapter I

Accessing Health Services for the Multicultural/Multilingual Communities

While Canada's health care system often receives international recognition as one of the best in the world it is also problematic in a variety of ways. The underlying principles of universality, comprehensiveness, accessibility, portability and public administration, are assumed to be inclusive of diversity and supportive of social justice (Masi, 1998). But despite visionary polices and specific legislation (The Charter of Human Rights and Freedoms, Multiculturalism Act, Canada Health Act), there is growing evidence of inequality, as identified in government reports and local community assessments as specified below. There are clear signs of barriers to achieving the commitments articulated above.

Overview of Barriers in Accessing Health Services

Accessing community wide health services for minority groups is documented as very complex. In the last twenty years, Canadian research has indicated that while Canada is home to an increasingly diverse number of multicultural and multilingual immigrant communities, not all have been equally served by our institutions and service providers (Popatia 1994; Doyle and Visano 1987; Peters 1987; Sangha 1987; Sandhu 1996; Pendakur 1988; Masi, 1998,1986;Waxler-Morrison, Anderson, Richardson 1990; Task Force on Mental Health 1988; Culture and Health 2000, 1996). The health services, including "the mental health system, is confronted with the dilemma of adapting the clinical treatment approaches to the cultural reality of an ethnically diverse population" (Sandhu, 1996). Mental health services, for example, "have tended to embrace the mainstream, western culture, leaving the concerns of a significant portion of the population largely unmet" (New Light, 1993, p. 2). This concern is not only about

opening access to mainstream services but to encompassing complementary/pluralistic culturally based health services and practices as well.

National, Provincial and Regional reports on Migrants Access to Health Services

A number of national (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988) provincial (British Columbia's provincial Ministry of Health Policy Framework on Designated Population, 1995), and regional (Culture and Health 2000, 1996) studies indicate that for immigrants and their families, identifying and accessing services for mental health is a process which runs into many obstacles. Local studies (Popatia, 1994; Peters, 1987; Sangha, 1987) highlighting the South Asian community's access to community wide health services also had similar conclusions. The barriers include lack of information provided by community-wide service agencies; lack of linguistic capabilities by staff and immigrant communities; and cultural differences between staff and ethnic minority clients.

These studies provide bases for reinforcing the recurring theme in this paper, that minority language and cultural communities, such as the Punjabi Sikh community, are not being adequately served by the formal mainstream health care systems. However in using these studies as a guide to key issues in service delivery it is important to maintain a critical stance. These studies can make a useful contribution to service provision by mainstream and immigrant servicing agencies liaising with the mainstream. But, since they assume the centrality of these agencies and mainstream services they may obscure possibilities for complementary/pluralistic models.

In addition to general barriers identified for immigrant communities, the Mental Health Task Force attempted to identify migrant populations which experience high levels of difficulty as a result of immigration. Persons, whose pre-migration experience has been traumatic, women from 'traditional cultures', adolescents and the elderly are

considered at high risk for experiencing difficulties during resettlement. The Mental Health Task Force report also identifies immigrant females from 'traditional cultures' as being especially vulnerable.

This concern with women from 'traditional cultures' illustrates the problematic construction by the mainstream of females from a non-traditional source country as a homogeneous powerless group often located as implicit victims of particular socioeconomic systems (Mohanty, 1991). This mode of defining women primarily in terms of their object status is, according to non-Western feminists Parmar and Amos, a way of examining "our cultural practices as 'feudal residues' [which] label us 'traditional', [and] also portray us as politically immature women who need to be versed and schooled in the ethos of Western feminism. These [modes] need to be continually challenged..." (Mohanty, 1991, p. 57). The concern over essentializing modes equally needs to be brought to an examination of presuppositions that mainstream agencies may bring to their work with clients of minority ancestry.

Community Reports on South Asian Access to Mainstream Services

Popatia (1994), Peters (1987), and Sangha (1987) have all indicated that many South Asians are not being adequately served by mainstream community agencies. Sangha (1987), examining South Asian community access to services in South Vancouver found that programs offered by community-wide services agencies in the area "do not adequately reflect the changing composition of the population. None of these organisations have specialised programs which meet the needs of these new groups and their staff do not reflect the ethnic/racial composition of the area" (8).

A study conducted by the Greater Vancouver Mental Health Service Society (G.V.M.H.S.S.) on the under-utilization of mental health services by Indo-Canadians in Vancouver, suggests that access "is strongly affected by a lack of basic information"

about the services that are offered by the society (Peters, 1987). The same report states that staff within the G.V.M.H.S.S. need to be sensitive to the Indo-Canadian culture and staff fluent in Punjabi and Hindi languages are needed. This indicates that cultural and language differences between clients and workers are major barriers for Indo-Canadian access to the services of the G.V.M.H.S.S. Furthermore, Ron Peters (March, 1987) of the G.V.M.H.S.S., in his examination of caseloads of the community mental health teams showed "an under-representation of patients from various minority groups" (2).

The Vancouver Committee on Multiculturalism and Mental Health Treatment and Education (1989) reported multicultural/lingual communities such as the South Asian community, have strong negative attitudes toward mental disorders. Indigenous views that differ markedly from Western views on the causes, course, and treatabilty of mental health disorders contributed to the significant under-utilisation of community mental health services. This theme became apparent in the interviews conducted in the present research and will be articulated in chapter three in the profile of the Punjabi Sikh community.

An assessment of the Vancouver Indo-Canadian (South Asian) community with a specific focus on mental health needs and issues identified the need to hire multilingual staff (Popatia, 1994). Communication and "attitudinal" barriers are identified as significant but it is not clear whether these were perceived to be emanating from the prospective clients or the service providers.

> From the health care provider responses it is obvious that under utilisation of services by the Indo-Canadian population is perceived to be a major problem, and that this problem is primarily due to attitudinal [sic] and communication barriers. The need to provide culturally sensitive and appropriate care was strongly expressed. It was the HCPs' (Health Care Providers) impression that one of the

ways of providing culturally appropriate care would be to have more staff of the same ethnocultural background (Popatia, 1994).

The Culturally Responsive Strategy: Mental Health Liaison Counsellor

Since multicultural organisational change strategies put into place in 1987, the Greater Vancouver Mental Health Services (G.V.M.H.S.S.) has undertaken a planning process to improve its service delivery to members of enthnocultural communities (New Light, 1993). The Mental Health Liaison Counsellor program is one example of the design and implementation of strategies considered culturally responsive. This program is important to analyse as the "multiple strategies used by G.V.M.H.S.S. are identified as useful for community-wide service agencies that are asking to provide better client and organisational access for ethnic minority groups" (New Light, 1993, p. 11).

Development and Implementation of the Mental Health Liaison Program

First, the agency began research, focusing on three under-represented populations: Native Indians, South Asians and the Chinese (Peters, 1987). Second, G.V.M.H.S.S. established a standing inter-agency committee on multiculturalism and mental health services. This committee was to review the needs of various ethnic groups and develop recommendations. The third strategy used by G.V.M.H.S.S. was that of a Multicultural Consultative Service. A review of local community needs was conducted to develop a proposal for multicultural consultative service.

The Multicultural Mental Health Liaison Program, which began in 1991in Vancouver, is one outcome of the multicultural organisational change planning process. Perceived as successful, this program, in the fall of 1996, was established in the City of Surrey, South Fraser Health Region. The objective of the program was to increase the accessibility of community mental health services by staffing one worker for each of the target populations: South Asians (Indo-Pakistanis), Chinese, Latin Americans and

Southeast Asians. I will outline my involvement with this program in chapter four, where I describe my position and location in regard to this research project.

Ron Peters, Director of Policy Planning, Evaluation and Research, explains that "the primary focus of the program is to emphasize indirect service, which includes education and consultation services" (cited in New Light, 1993, p. 11). On the education front, liaison program workers target their services at several groups; including the ethnocultural communities, and immigrant service agency workers. As well as education, mental health liaison counselors provided consultation services to clinical staff at Greater Vancouver Mental Health Service (GVMHS), where they assist with client assessment and treatment planning. Consultation is also provided to those working in the community, such as immigrant service workers, who may be dealing with a client with mental health concerns.

The Multicultural Mental Health Liaison Program was intended to encourage more understanding and collaboration amongst stakeholders (mainstream mental health service providers and immigrant communities) of mainstream mental health services.

> We have the ethnic general public, ethnic human service providers and clinicians out there, and our hope is that this active interchange of information will help to get rid of some misconceptions on both sides, and bring people together in a more effective working relationship. These strategies are evolutionary in nature, and radical changes are not anticipated over the short-term. Hopefully, however, their on going nature will serve to keep the profile of these issues high within the agency, and promote a climate conducive to steady, albeit gradual, improvement (Peters cited in Pendakur, 1988, p. 40).

Critics of such programs recognize that having such a program can only fill the gaps in the short run (Pendakur, 1988). These programs, while attractive to some

linguistic and cultural characteristics of the client community do not address structural barriers to accessing mainstream health care such race, class and gender; differences in cultural definitions of health and wellness; nor complementary/pluralistic systems of cultural wellness practice and available in Canada and abroad. Each of these considerations regarding structural, cultural and complementary issues will be addressed in the theory, research and data presented in this study. Still an active effort to recruit staff from various ethnic minorities groups into mainstream health services can respond to some of the concerns regarding service provision, particularly when the mainstream biomedical model remains the norm. Noting the challenges and resistance of the mainstream to hiring appropriately qualified individuals, an employment equity policy which states that if "all qualifications are equal, preference will be given to candidates with language capabilities," (Shearer cited in Pendakur, 1988, p. 40) is essential to achieving this goal.

Summary

In the national, provincial and regional reports, and the local community assessment studies presented in this chapter, mainstream agencies and health professionals working within the mainstream health care services have documented barriers identified in access to health services for ethnic minority groups. The recommendations consist of the need for multilingual staff hiring and affirmative action, and translation of information on programs. These reports also identify the lack of immigrant knowledge and understanding of the mainstream formal health system, immigrant and minority group lack of fluency and literacy in English/French, cultural differences between health care provider and clients, stigma around mental illness and, fear of acknowledging mental illness, as salient concerns. As a result of these barriers, it is seen that health-servicing agencies do not reflect the multicultural population they

serve and minority ethnic group members have difficulty accessing health services to which they are entitled.

These initial findings and recommendations from the variety of studies summarised in this chapter provide a picture of the serious impediments to delivery of mainstream health services to immigrant communities. These findings also acknowledge concerns about entitlements, fairness and equity but do not address fundamental structural changes that might take place in the way health services are provided. Rather they maintain a focus on how to adjust current systems by having multi-lingual professionals and by translating materials so immigrants will have more information about the services provided. With this policy and service provision background outlined, this paper now focuses in chapter two on the theoretical literature on immigrant resettlement and adjustment, including concerns about structural inequities.

Chapter II

Literature Review: Cultural and Structural Analyses of Immigrant Resettlement

This chapter outlines the key arguments in culturally and structurally oriented theories of resettlement and adjustment and the perspectives they offer on mental wellness/health of immigrants. Both sets of literature contributed to the formation of interview questions in this study. In addition to the theoretical literature this chapter will highlight selected research studies framed respectively by cultural/psychological and structural theoretical perspectives. Both the cultural and structural orientations on resettlement and adjustment of immigrants establish that many difficulties arise for migrants, who were established and settled in their country of origin, and need to resettle in the country to which they immigrate. A variety of structurally and culturally oriented theorists also concur that a health care system is a social system, which integrates cultural components of society; such as patterns of belief, causes of illness, norms governing choice and evaluation of treatment (Kleinman, 1980; Hughes, 1993; Bhui, Strathdee & Sufraz, 1993; Aderibigbe and Pandurangi, 1995; Bose,1997; Gaw, 1993; Mumford, 1992); and structural systems; such as power relationships of race, gender and class (Jiwani, 2000; Anderson & Kirkham, 1998; Ng, 1993; Henry & Tator, 1994, Chabot, 1999).

In multicultural Canada, the health care system predominantly uses the scientific model of biomedicine as the dominant reference point for health care for immigrants. The majority of research into utilisation of health services and the general health care issues of immigrants assume a biomedical model of care. In this cultural/psychological

theoretical orientation barriers to accessing mainstream biomedical services, are seen as the lack of knowledge and understanding of linguistic and cultural factors, personal styles and techniques of interactions, communications strategies and unavailability of services. Culturally and psychologically based theories of immigrant adjustment consistent with the scientific model of biomedicine outline a process of migrant resettlement, which includes distinct stages, and anticipated duration of these stages.

Critics of the biomedical model and of research designed to improve access to this model make two main points; one is that such research suggests little in the way of dealing with systemic inequities within the health care institutions (Jiwani, 2000; Chabot, 1999; Anderson & Kirkham, 1998) and within society at large (Henry & Tator, 1995; Ng, 1993). From a structural perspective consideration of gender, socio-economics and age are implicated in constructing resettlement. Also in this structuralist view characteristics of mainstream services which potentially marginalize and/or discount complementary/pluralist community based systems of health and wellness need scrutiny.

As will be demonstrated below, culturally oriented discourses on multicultural health may also easily produce stereotypic notions and not adequately address the health needs of immigrant Canadians. In fact this approach may marginalize immigrant groups and reinforce the construction of Canada as white and Eurocentric.

The Cultural-psychological Theories of Settlement

Much mainstream research in previously outlined government and agency reports points out that many health care issues are associated with the process and the experience of immigration and resettlement (Masi, 1996; Almeida, 1996; Sandhu, 1996; World Health Forum, 1992; Mental Health Task Force, 1988). This literature establishes that migration is understandably complex and can be an extremely painful process involving circumstances that may exact 'serious toll' from immigrants in terms of mental, physical

perspective. "Many immigrants [are seen as] living on the fringes of two cultures which can be most distressing, painful and the cause of serious psychiatric illness" (Sandhu, 1996, p. 2). Incidence of mental illness among ethnic minorities has been attributed to the stress of migration, cultural change and other problems of a psychosocial nature that may be encountered in new society (World Health Forum, 1992).

Much of this research (Adler, 1975; Brink, 1976; Thompson & MacDonald, 1990; Training for Cross-Cultural Trainers, 1993) is predominantly concerned with cultural aspects of adjustment. While this research does acknowledge that prejudice and discrimination exist, these are conceptualised as affecting individuals, rather than being dimensions of structural inequalities in society.

These theories construct the process of immigration as one of adjustment and settlement that occurs in relatively predictable phases. Various researchers acknowledge that in the process of adjustment and settlement, new immigrants endure certain health/wellness difficulties (Adler, 1975; Brink, 1976; Thompson & MacDonald, 1990; Training for Cross-Cultural Trainers, 1993). Transitional experiences, in which individuals move from one environment into another tend to bring the individual's cultural predispositions into his or her awareness and potentially into conflict with those in the new setting. For many immigrants, the mental health services in Canada have tended to embrace the mainstream, western culture, leaving the concerns of transitional and acculturation experiences of the immigrant population largely unmet (New Light, 1993).

In the cultural/psychological perspective understanding issues of culture shock as one possible out come of migration is important. Adler's transitional model describes culture shock as:

> A set of emotional reactions to the loss of perceptual reinforcements from one's own culture, to new cultural stimuli, which have little or no meaning, and to the misunderstanding of new and diverse experiences. It may encompass feelings of helplessness; irritability; and fears of being cheated, contaminated, injured, or disregarded (1975, p. 13).

In their examination of experiences usually related to mental wellness/health of migrant resettlement and adjustment, Thompson and MacDonald (1990) consider the phases of the settlement experience. Similar to Adler (1975), Brink (1976) and SDISS (1996), these authors argue that these identified stages could be used as a framework for understanding the transitional experience most immigrants pass through as they adapt to a second culture and a second language.

Phases of adapting to a new language and culture

In the psychological cultural phase theories the initial phase often referred to as 'honeymoon' (Oberg 1954 cited in Thompson), 'arrival' (Cross-culturally Relevant Factors, 1993) or 'contact' (Adler, 1975) is said to be characterised by feelings of excitement and eagerness to learn about the new country and the belief that the new homeland will provide solutions to many previous problems.

The second phase, 'disenchantment' (Brink, 1976), 'disintegration' (Adler, 1975), or 'culture shock' (SDISS, 1996), which is seen as occurring three to six months following immigration, is characterised by depression, negative thoughts of the new country and longing for one's homeland (Thompson & MacDonald, 1990). After the initial positive feelings about living in a new country, many immigrants coming to Canada become overwhelmed with dealing with challenges such as finding housing, shopping, schooling and communicating in a second language. Newcomers start to see differently their new home country and their position in it. This is the period of

'psychological arrival' or assessment in which clarity about the challenges sets in (Adler, 1975). In a minority of cases, this phase can result in clinical depression and hospitalisation (Thompson & MacDonald, 1990).

During the final phase 'adaptation and acculturation' or 'acceptance and integration', immigrant individuals begin to adapt and to feel more secure. Through the process of adjustment immigrants choose the beliefs and practices of the new culture that they wish to take on, plus aspects of their traditional belief systems which they will maintain and discard, or modify. "The result is an amalgam of beliefs and practices from both the 'traditional' [sic] and mainstream Canadian culture" (Thompson, 1996). By identifying immigrant culture as 'traditional', as Thompson does, Canadian researchers continue to reinforce, however unconsciously, "western prejudices about the 'superiority' of western culture" (Narayan cited in Agnew, 1996, p. 200).

Other factors affecting the phases of adapting to a new language and culture

The above framework of adapting to a new language and culture implies a clear-cut process of migrant adjustment and resettlement. Some critics suggest however that the migrant experience may be different for each person; therefore, it cannot be generalised to all immigrants or even to members of a particular cultural group (Thompson, 1996). Hyman suggests that immigrants are not a homogeneous group and that within the immigrant population there is significant variation with respect to age at migration, gender, and length of stay, source country/ethnicity, knowledge host country languages and other demographic characteristics (Metropolis, 2000). Similarly, Jiwani states the importance of "the double or triple jeopardies that arise when multiple forms of oppression are intersecting and influencing a person's life" (2000, p. 99) as social determinants of health. For this reason the next chapter presents specific socio-cultural and historical information on the Punjabi Sikh community in British Columbia. This

information provides a context against which to view the specific information shared by the caregivers and community members interviewed in this study.

Structural Causes and Cultural Remedies

The following research identifies structural factors implicated in immigrant well being but suggests culturally adaptive responses rather than structural changes in mainstream institutions.

Salvendy as cited in Baker (1996), identified five factors that negatively influence adaptation and three, which have a positive effect. Conditions, which may create stress in settlement are seen to include both cultural and structural dimensions such as: previous psychosocial maladjustment; a large socio-cultural gap between the society of origin and the host country; a change in socio-economic status; a troubled economy in the host country and expectations based on information that does not realistically reflect conditions in the new society. The factors which might have positive effects are seen to include cultural responses such as: adequate information and preparation prior to immigration; mastery of the language of the host country and the existence of large local ethnic community of the immigrant's cultural group.

The Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988) concluded that, while moving from one country and culture to another can be stressful, it does not necessarily threaten mental health. Immigrant mental health becomes a concern primarily when additional risk factors combine with the stress of migration. These risk factors are identified as primarily structural in nature:

> In Canada, negative public attitudes, separation from family and community, inability to speak English or French, and failure to find suitable employment are among the most powerful predictors of emotional distress among migrants. (Canadian Task Force, 1988, p. i).

As detailed by Almedia (1996), for Asian Indian families in the United States, adaptational experiences vary depending on a combination of structural factors: education, class, caste, family size, economic support; and cultural/personal factors including: connections to their traditional culture, degree of religiosity, past migration history, and how immigrants have dealt with the loss of their country of origin. Almedia's orientation to ways in which diversity among immigrant communities is implicated in significant variation in migration experiences provides a useful tool in viewing the Punjabi Sikh immigrant community in the City of Surrey. However this approach does not adequately critique some implicit assumptions about migrant resettlement and mental wellness/health nor does it propose measures to attend to concerns in this area.

Structural Inequalities in Health Care

The structurally oriented theories outlined below analyse systemic impediments to mental wellness and amelioration measures that address structural inequities. Anderson and Kirkham (1998) point out that the ideals of class, gender and racial equality in Canada are not yet a reality. Access to health care for women, immigrants, refugees, and 'visible minorities', as well as those of lower socio-economic status, is often to a poorer quality of care (Jiwani, 2000; Mental Health Task Force, 1988; Peters, 1988; Masi, 1996). Identifying immigrant group reluctance to access formal health services in terms of immigrant groups not being aware of services, stigma around mental illness, fear of acknowledging mental illness, inability to speak English/French, cultural differences between consumer and service provider; all identify the immigrant and not the institution as the problem (Jiwani, 2000). Using the cultural/language barrier perspective discounts the importance of traditional forms of medicine and healing as they

are seen as a threat to the very privileged position held by western medicine. Jiwani argues that these ideologies permeate the working of multiculturalism (2000).

Jiwani illustrates that by using a multicultural approach which focuses on translation and cross-culturally sensitive care rather than viewing the situation in terms of power, the emphasis tends to be on providing culturally sensitive health care, instead of dealing with issues of exclusion. The integration approach in health care employs a 'piecemeal approach' that once again, attempts to get clients to conform to the dominant ideology and practices.

From a feminist and anti-racist perspective it is argued that the Canadian health care system does not uphold the multicultural principles of ensured access, sensitivity, accommodation and integration for all Canadians. It is a system based on North American principles of individualism (Anderson, 1990). The result of this is an assumption that all citizens have an equal opportunity to achieve optimum health because all have equal access to health care services. Thus, a level playing field is assumed and individuals are seen being largely independent of social constraints such as class, gender and race.

Henry and Tator (1994) argue that, a similar ideology of 'democratic racism' is prevalent in both Canadian society and in its' institutional policies. In this ideology "commitments to democratic principles, with their egalitarian notions of justice, equality, and fairness are valued positively," and are seen to conflict "with those attitudes and behaviors that include negative feelings about minority groups and the potential for differential treatment or discrimination against them" (Henry and Tator, 1994, p. 8). Ideologies of 'individualism and egalitarianism' or 'democratic racism', avoid promoting institutional policies and procedures which challenge the 'dominant hegemonic order' (Anderson, 1990; Henry and Tator, 1994).

The discussion of the ideology of 'individualism and egalitarianism' and 'democratic racism' sets the foundation for the Canadian health system that cannot be separated from broader social, economic and political contexts. These theories provide a useful tool for critical social science researchers analyzing immigrant health issues and immigrant access to health systems (Chabot, 1999). However, they do not provide an adequate critique of the ways in which class, gender, and race are conceptualized in mainstream health care. Anderson and Kirkham (1998), Ng (1993) and Jiwani (2000) go further in this area.

The Health Care System: issues of class, gender and race

In their examination of issues of class, gender and race in Canada's health care system, Anderson and Kirkham (1998) focus on the rhetoric of equal access. Similar to Jiwani (2000), Henry and Tator (1994) and Ng (1993), these authors argue that the notion of equality in Canada is more ideology than fact. The issues of class, race and gender inequality are much ignored in our nation's social, economic and political public policies and services, including our health care system. Anderson and Kirkham (1998), state that "now that equity and the social determinants of health have become entrenched in the discourse of government documents...people's health remains directly related to their economic status". Low income people, including older people, single women supporting children, and people from minority groups (such as immigrants) face health problems and risks not encountered by high-income people.

Like Ng (1993), Jiwani discusses racial and gender inequalities in the health care systems, which are permeated by assumptions, stereotypes, values and beliefs which manifest in the larger society as racism, sexism and homophobia. In the western health care system:

> The majority of doctors are male, and the majority of nurses are females – again power is gender based; where the people of colour tend to be found either in the rolls of the patients, or in the kitchens, laundries, and janitorial services of most hospitals. [The health care] system protects itself against incursions that it perceives as threats. One only has to look at how privilege is protected in terms of the lack of accreditation given to foreign doctors, or how nursing credentials from white commonwealth countries are recognised but not from those parts of the common wealth that consist of developing countries (Jiwani, 2000, p. 94).

As Anderson and Kirkham state, "not only is a health care system a product of a country's history and culture, but it is also instrumental in constructing a nation by shaping identities and experiences, institutions and policies, oppressions and inequalities" (1998). Jiwani (2000), and Anderson and Kirkham (1998) all contend that the history of Canada as a nation-state is based on the political and economic practices of colonial capitalism and is largely expressive of a patriarchal Eurocentric perspective. As a result, the issues of class, immigrant status, race and gender in Canada's multicultural health care system are inadequately addressed.

Additional Pressures for Adolescents, Seniors and Women

Consistent with Hyman's notion that differences in age and gender for immigrants are important social influences on adjustment and resettlement, Doyle and Visano (1987) illustrate how family life may be affected. Differences in values related to generational differences show up in the new country, women begin to participate in the labour force, and life cycle changes such as ageing are reflected in new demands.

Adolescents

Waxler-Morrison, Anderson and Richardson (1990) specify what the resettlement scenario may look like for adolescents.

> When a South Asian (Indo-Canadian) family moves to the West there are a number of common problems, mostly related to leaving home and living in a new culture, that seem to precipitate psychiatric symptoms. Adolescents and young adults often face an insoluble dilemma in trying to balance traditional parental expectations against peer group pressures. Thus a young South Asian girl may have two identities, one for home and one for school. The resulting stress may lead to depression which, if severe, may end in suicide attempts.

Seniors

The situation for senior migrants is often seen as even more difficult. Not only do they have to adjust to a new environment, a new culture, and a new language; they are more vulnerable to additional health/wellness risks (Lee & Cheong, 1993). A study of acculturation, ageing and alienation of Indo-Canadian seniors in Surrey in 1993, identified that seniors are more vulnerable in facing common 'pulls and pressures' of immigrant families' than younger family members. The dilemmas of the Indo-Canadian seniors included: language barriers and cultural differences; economic dependence; transportation and isolation; diminished family status, elder abuse, declining health and discrimination and racism (Lee & Cheong, 1993). For many seniors, the experience in reversal of roles in the family, often over laps with diminished health/wellness. Assanand (1990) expands on this point.

> The traditional dominance of the elderly within the family is frequently weakened after moving to Canada. Usually sponsored by a son or daughter, elderly people arrive here in a dependent role, not knowing the language or the culture. With their married children running the home they lose their traditional position of domestic control. This reversal of traditional patterns of dependence and

authority can cause conflicts and, a loss of self-esteem and depression in the elderly (p. 156).

Women

Researchers (Thompson, 1996; Assanand, 1990; Dosanjh et. al 1994) illustrate the additional pressures of change in gender roles, family circumstances and socio-economics factors, which are often encountered by female members of the South Asian community in the process of adapting and resettling in Canada. Thompson's (1996) interviews with a number of new immigrant Indo-Canadian females, undertaken to understand their experiences of adjustment, states that adjustment was seen as a long, hard struggle, fraught with feelings of inferiority, depression and discrimination.

Gune cited in Almedia (1996) suggests that South Asian women as immigrants, compared to their male counterparts, generally face additional adjustment pressures, as the women are usually in the home and have less opportunity to interact with the dominant culture. Research done by the Feminist Research, Education, Development & Action Centre at Simon Fraser University, on spousal abuse in the South Asian community, also highlights the gender differences (Dosanjh, Deo and Sidhu, 1994). Of the fifteen women who participated in the research, nine gained immigration status as a result of being sponsored directly by their husbands, while the majority of husbands were sponsored by members of their own extended family. As result, the husbands seem to have had a stronger personal, social and financial position in place upon their arrival to Canada and were not seen as dependent on their wives before or during the marriage. For the men:

> The immigration sponsorship [gave them] a form of new power over their wives. The result created nearly insurmountable inequity in their relationship and made the women socially, psychologically and financially dependent on their husband.

> Another barrier that emerged from the sponsorship in the cases of these women is their multi-level dependency on their husbands and the resulting isolation of the women from the rest of society. This severely limited their decision-making powers. In the absence of their own extended family and with no accessibility to community networks to which they could turn for support, these women had very little opportunity to develop their own personal and social base (Dosanjh, Deo & Sidhu, 1994).

Conversely, the economic needs for many South Asian immigrants in Canada, forced many women to find employment outside the home but this created new stresses in family relationships. For example:

> The experience of employment for women often results in their increased independence and assertiveness which husbands may again find threatening to their traditional dominance. The increased sense of independence may in turn cause women to be less willing to tolerate traditional marital and in-law conduct. Moreover, external employment places an additional strain on women who often must continue to shoulder the sole responsibility for the care of home and family (Assanand, Dias, Richardson, & Waxler-Morrison, 1990, p. 156).

The additional pressures for South Asian seniors, youth, and women identified in the above studies indicate that it is important to understand the diversity of structural circumstances which may be implicated in an individual's ability to access mainstream health services. The following chapter documents the history and circumstances of Punjabi Sikh settlement in British Columbia. The chapter illustrates the historical circumstances and patterns of insertion of Punjabi Sikhs into the British Columbia economy and social structure. It provides a preamble for analysing the data provided by

caregivers and clients about what mental wellness means to immigrants of Punjabi Sikh ancestry living in this province.

Chapter III

Profile of the Punjabi Sikh Immigrant Community

Diversity in the South Asian community

The Punjabi Sikh immigrant community, defined by country of origin, language, and religion, is one of the largest South Asian sub-cultural groups in British Columbia. In Canada, South Asians, are people who originated primarily from the subcontinent of India (White & Nanda, 1989). In the literature (Statistics Canada, 1996; Assanand, et al., 1990; Aaj, 1997) South Asians may be referred to as Indo-Canadians (Mehfil, 1997) or East Indians (Buchignani, 1985).

The South Asian community is diverse with respect to language, religion, customs, and country of birth, country of origin or emigration, and political and socio-economic background. While there are issues and challenges that all Canadians of South Asian origin face in common (e.g. racism, cultural conflict) there are significant variations depending on the specific group (Patel & Jantzen, 1998).

This paper focuses on the Punjabi Sikh immigrant community, because in British Columbia and particularly in the Greater Vancouver Region District, a large number of South Asians are from the subcontinent of India and largest group from India are Punjabi Sikhs. The community profile will, where possible, outline the historical background, socio-economic and educational backgrounds, the family structure, and the health beliefs and practices, in both Canada, and in Punjab.

Historical Background: India

The Indus Valley civilisation dates back over five thousand years. Arab, Turk, and Afghan Muslims invaded and traded with Northern India from the eighth to

eighteenth centuries. European traders from colonial countries such Portugal, France and the Netherlands influenced many Indian coastal communities, but it was the British who gained political control of this area in 1757 and remained in power until 1947.

After gaining independence from Britain in 1947, India's democratic government, its economic and social institutions, along with its general population, inherited a history of over two hundred years of colonialism. In India today, the foundation of many institutions (governance, justice and the education system) can be traced to its British heritage. English remains one of the official languages.

Many individuals living in India still seem to perceive that by migrating to Western countries (Canada, Britain and the US) they will achieve higher socio-economic status. Such an assumption was apparent from the interviews with the Punjabi Sikh community members in this investigation. Many respondents expressed that when they lived in Punjab their perceived goal of achieving greater socio-economic success would be possible by immigrating to Canada. One elderly male shares "when we were in India, our families [who lived in Canada] would tell us how difficult it is here, but we did not believe them, we thought they just did not want us to have that same success". Such an assumption is also apparent in the ethnocentric western ideology, as discussed in chapter one in, which often depicts the practices of countries like India and their people of the 'third world' as 'traditional', 'feudalistic' or 'primitive', an ideology which as been challenged by many contemporary 'third world' feminists or women of colour (Mohanty, 1991; Agnew, 1996; Jiwani, 2000).

Historical Background: Punjab

Immigrants of Punjabi Sikh ancestry are from Punjab, a province in northern India. The Punjab is mainly a rural and agricultural area. Seventy-five percent of its population lives in villages engaged in agricultural or allied occupations. Approximately

eighty percent of the village populations of Punjab are of Sikh religious ancestry and about twenty percent are Hindus, Muslims and followers of other faiths (Year Book of India, 1988).

Historical Background: in Canada

The earliest South Asian visitors to Canada arrived in 1897 when a Sikh lancers and infantry regiment visited Vancouver after celebrating Queen Victoria's Diamond Jubilee in London, England. In the year 1899, the first recorded South Asian pioneers to Vancouver and Victoria arrived (Aaj, 1997). By 1904, the census record listed 258 East Indians (South Asians) in British Columbia.

Nearly all the early settlers were Sikhs from the Indian state of Punjab and were retired soldiers of the British Indian army (Mehfil, 1997). These Sikhs became instrumental in launching an immigration of 6,000 Sikhs over the next five years. Most worked in the Canadian Pacific Railway, or in the forest industry on Vancouver Island and in the Greater Vancouver area (Assanand et al. 1990). A few of the earlier settlers were educated and skilled. Most of them were separated at a young age from their families. Their primary objective was to earn a livelihood and send savings to support families in Punjab.

From the beginnings of South Asian immigration to British Columbia in significant numbers, Sikhs faced the hostility of both civic authorities and the Euro-Canadian labour force. By 1910 new immigration laws effectively stopped most immigration of South Asians by discriminatory immigration regulations. Every Asian immigrant had to be in possession of two hundred dollars upon landing in Canada and by the requirement, the trip from the country of origin had to be one of a continuous voyage with no stops at other ports. This would be virtually impossible for someone travelling

from India. During this period, women and children were also not allowed entry (Mehfil 1997; Aaj, 1997).

In 1947, the year that India gained independence from Britain, immigration laws in Canada were changed, and South Asian immigration began to increase.

> Until 1961, the majority of South Asian immigrants were Sikh from rural areas in northern India who found employment as unskilled workers...changes in immigration laws in 1961 resulted in people coming from all parts of India and from Pakistan. The Sikhs from northern India, particularly the Punjab still represent the largest group of migrants from India. Most have come to Canada through sponsorship by relatives who are already settled in the country (Assanand, Dias, Richardson, & Waxler-Morrison, 1990, p. 144-145).

Until the 1960's, Canada's assimilationist government policy concerning immigration was based upon the principle that those who were admitted into Canadian society should be assimilable into the dominant British and French ethnic groups (Samuda, Berry and Laferiere, 1984). As a result of Canada's history of discrimination against South Asians, it is not surprising that the numbers of South Asian immigrants coming to Canada only increased in the last three decades. The introduction in the 1960's of immigration policies more favourable than ever before to non-Europeans accounted for this change. For example, seven out of ten (71%) of the South Asians living in Canada, in 1986 were foreign born. Of those, 94% arrived after 1966 (White & Nanda, 1989).

The recent growth in numbers of Punjabi Sikh immigrants settling predominantly in Surrey, British Columbia, makes this municipality one of the single largest receiving communities in Canada. The census data reflects the rapid growth of the South Asian

community nationally, provincially, and regionally; growth in the Punjabi Sikh community's location in Surrey, British Columbia is presented in Appendix I.

Educational and Occupational Profile

White and Nanda establish that in spite of considerable gender differences within the group, Canada's South Asian population has generally higher levels of formal education than the overall population. Moreover, even when individuals find jobs these are of a lower skill and income level than what their education has prepared them for. White & Nanda, (1986) show connections between employment, and high levels of education, and also address gender differences in this regard. They conclude that:

> while 25% of South Asian men were university graduates, the proportion among South Asian women was 17%. Nonetheless, both South Asian men and women were more than twice as likely as comparable Canadians to have a university degree. The corresponding figures for the Canadian population overall were 11% for men and 8% for women. [The gender differences] may be attributable to the different immigrant categories under which they are admitted to the country. Many South Asian men come as independent immigrants, and so are required to meet certain education and employment criteria. On the other hand, South Asian women are more likely to come to Canada as dependants sponsored by their husband or family...educational qualifications may not be as important [or are not recorded in immigration records as they come under the family reunification class] (White & Nanda, 1989, p. 8).

Similarly the occupational composition of the South Asian community indicates they are more likely than mainstream Canadians to be in the labour force. However their positions in the labour force are not commensurate with their high levels of education. For South Asian men, a higher percentage than the Canadian average is in professional,

clerical, processing, and/or product manufacturing. While South Asian women are over represented, relative to the average mainstream Canadian, in product fabricating, they are lower than average in professional services, managerial, and sales jobs, (White & Nanda, 1986). Despite the much higher than average (double) educational levels (White & Nanda, 1989; Das Gupta, 1994) than the Canadian population at large the average earned incomes for both South Asian men and women are slightly lower than the average for the wider Canadian population.

Other available research on the employment for the South Asian community also reflects the underlying discrimination, which has been cited earlier in by White and Nanda (1989) and with regard to immigrant employment access in health service (Jiwani, 2000). As Cardoz states:

> It is important to note that job discrimination is not new to this community [South Asian]. An employment study titled "Who Gets The Work In 1989?" commissioned by the Economic Council of Canada, found that in the Toronto area, Indo-Pakistani applicants face the greatest amount of discrimination of all groups tested, which included whites and other racial minorities (1994, p. A23).

The systemic racism in Canada's institutions is once again apparent in the access to employment opportunities available to Punjabi Sikh immigrants. Some mainstream as well as South Asian researchers indicate that many Punjabi Sikhs, in India, were farmers or landowners. Although by the standards of India's villages, they were relatively well off.

> In Canada, they work in lumber mills, the construction industry, and as janitors, farm workers, and taxi drivers. Many have started their own businesses. The majority of women work outside of the home as unskilled farm workers, janitors, and factory workers, and in restaurant kitchens and canneries. Educated, urban

Sikhs are employed in a variety of professions and technical positions (Assanand, Dias, Richardson, & Waxler-Morrison, 1990, p. 144-145).

Kinship and Social Community

For the Punjabi Sikh immigrants in Canada, family reunification immigration policy has made it possible to maintain extensive kinship ties and networks (Lee & Cheong, 1993; Buchignani, 1985; Assanand, Dias, Richardson, & Waxler-Morrison, 1990). "Connections and contacts are kept through visiting, reciprocal exchange, mutual aiding, and engaging in social and recreational activities" (Popatia, 1994, p. 16). For some, especially the elderly, maintaining the 'old ways' has not been as easy or straightforward as it was in the country of origin. For example, the upward and downward socio-economic mobility, which occurs with migration and settlement, has flexed the class boundaries; the busy and often hard working lifestyle has placed time restrictions on visiting and keeping contact (Buchignani, 1985).

In Punjab, patriarchy (Basran, 1995) and age (Popatia, 1994; Assanand, Dias, Richardson, & Waxler-Morrison, 1990) are often implicated in gender, family and social roles. When immigrating to Canada, many Punjabi Sikh immigrants are faced with the challenges of adapting and changing these roles to survive socially and economically. For example, some of the aged are becoming disempowered and isolated partly due to language, mobility, and social barriers; some women are becoming increasingly empowered partly due to financial independence and exposure to mainstream ideologies, households are changing from extended family living situations to more nuclear family living (Assanand, Dias, Richardson, & Waxler-Morrison, 1990; Buchignani, 1985).

According to a male respondent from a British Columbia study on Indo-Canadian families in Punjab:

> Women were not working. They were staying home and looking after the children, cooking. We did not ask anybody to look after our children –men did not like the idea of women working outside the home – we did not want to leave children alone at home. So, that was the idea of our people in those days (Basran, 1995, p. 19).

The changes resulting from immigrating to Canada are often seen to be challenging family held norms and creating conflicts and insecurities within individuals and within family relationships. It is also important to understand this important domain of the family as social institution, which hierarchically structures relations by gender and age. For example gender and inter-generation differences are implicated in keeping well/healthy. These conflicts and tensions, if unresolved for extended periods of time, may result in emotional problems such as mood and anxiety disorders, alcohol and substance abuse problems, role reversal, and domestic violence (Popatia, 1994). In addition to the above social and cultural factors, structural difficulties such as, discriminatory immigration regulations, racism, discrimination in recognition of education and access to suitable employment, also influenced mental wellness/health of the community members.

Chapter IV

Methodology

Chapter four provides a brief overview of the methodology and qualitative research design used in this study. Considerations influencing selection of a qualitative approach are presented first. The researcher's position and location; the description of the process of recruiting participants and the interview methods used both with service providers and Punjabi Sikh community members are also included.

Choosing a Methodology

In order to understand mental wellness/health issues of Surrey's Punjabi Sikh immigrant community, it is important to have a methodology which can broadly encompass a variety of dimensions of immigrant experience as these were perceived by Punjabi Sikh immigrants. These dimensions include perception of community, culture, language, race, religion, gender and mental wellbeing.

Ajita Chakraborty (1991) recommends changes are needed to the theoretical base and academic teaching of all areas connected with mental-health work. In order to understand the inter links of culture, colonialism and biomedical based psychiatry, psychiatric teaching must include cultural anthropology as "there is evidence of biased, value-based, and often racist undercurrents in psychiatry" (p. 1204). Arthur Kleinman (1987) also illustrates the positive contributions of anthropology and qualitative methodology to understanding the role of culture in cross-cultural research on illness.

> An anthropological reading of the literature in cross-cultural and international psychiatry reveals a strong bias of psychiatrists towards 'discovering' cross-cultural similarities and 'universals' in mental disorder. For much of cross-

> cultural psychiatric research has been initiated from a wish to demonstrate that psychiatric disorder is like other disorders: it occurs in all societies, and it can be detected if standardised diagnostic techniques are applied (Kleinman, 1987).

Kleinman points to the ways in which this approach leaves out those patients who fail to fit the template, patients from non-western or non-industrial societies, and ignores the important data that could be obtained through qualitative methods. He concludes by suggesting that ethnographic research would allow the understanding and connection of a particular social system to the process of observing and interpreting practical human-interest situations; rather than the bio-medical based research which has inherent Western Eurocentric biases.

Qualitative Research

Qualitative research is a valuable approach to studying the complexities of human interactions; it helps to describe and analyse the behaviour and culture of individuals and communities (Kleinman, 1987; Clifford, 1988; LeCompte & Goetz, 1982; Hirji, 1998; Agnew, 1996; Bernard, 1994; Friedman, 1995; Hirji & Beynon, 2000). In qualitative research, the goal is to examine the interplay of a variety of influences (LeCompte & Goetz, 1982). The data gathering techniques, such as unstructured and semi-structured interviewing, allow for in-depth and diverse interaction both from the participants and the investigator (Bernard, 1994).

Feminist and postcolonial scholars have criticised the unequal relations of power that often prevail in the positivist anthropology between the 'ethnographer' (researcher or investigator) and the 'subjects' (participants), comparing it to the one between colonizer and colonized (Friedman, 1995). For this reason, in qualitative research it is important that the point of view of those being studied is accurately represented. The investigator should therefore not be regarded as the 'expert' (Clarke, 1996 cited in Hirji, 1998) and

the methodology should allow respondents not to see themselves as passive subjects of the research but assumed the role of 'knowers' and experts (Agnew, 1996).

Although the qualitative research provided enriching insight into interviewee perceptions, it also had some limitations. Given the nature of qualitative research, LeCompte and Goetz point out in terms of reliability, it is difficult to:

> address the issue of whether independent researchers would discover the same phenomena or generate the same constructs in the same or similar settings... [The problem is] the results of ethnographic research often are regarded as unreliable and lacking in validity and generalizability (32).

Nevertheless this approach is useful because the "knowledge of the individual will help both in preventing the group perspective from becoming a stereotype and in designing initiatives which will respect the needs and concerns of individuals" (Beynon & Toohey, 1995, p. 456). In qualitative research it is also necessary to acknowledge the influence of the presence of the researcher on the participants. In qualitative studies, the researcher is the instrument and will use his or her experiences and perceptions to interpret the phenomena under investigation (Rossman cited in Hirji, 1998). Qualitative researchers must also recognise that the researcher's values, biases and beliefs affect the data analysis. The researchers cannot rid themselves of their experience, but need to be aware of biases and not consciously impose perceptions when interpreting participant narratives (Bernard, 1994; Hirji & Beynon, 2000). The following section outlines my own position and location as a researcher.

Researcher's Position, Location

Agnew outlines the importance of self-recognition, "who one is and what one's relationship is to the subject under investigation are issues that determine both one's questions and, to some extent one's answers about the subject" (1996, p. 194). I am a

woman of colour, first generation Canadian, and a Punjabi Sikh ancestry member of the middle class. The 'political' dimensions of this research are influence by my gender, ethnicity, education and the professional employment position I hold in the immigrant mental health support services. I was educated from grade one in the Canadian education system. Currently I am employed as mental health liaison counsellor in an immigrant-serving agency and continue supporting projects that look at societal change in order to enhance accessibility for ethnic minority communities to mainstream Canadian institutions.

As a mental health liaison counsellor, my role is to promote acceptability and accessibility of mental health services to members of the Punjabi Sikh and the larger South Asian community. My role is also to provide cross-cultural case consultation, education and training, with clinic staff at local mental health services and for South Asian community members. The cross-cultural case consultation for the clinical staff includes an assessment which provides understanding of the relationship of the South Asian individual's socio-economic and available support systems in Canada, to the prescribed biomedical mental health assessment and treatment plan. The cross-cultural case consultation for South Asian individuals and their families includes a process of explaining and educating the community members on the workings of the Canadian mainstream biomedical mental health services.

In this investigation, the process of understanding and analysing the multicultural health care services in Canada discussed earlier in chapter two, provided an alternative understanding of my position in this system. I see that multicultural positions similar to those of mental health liaison counsellor, are parts of a system designed to assist access to mainstream services. But the dominance of the biomedical model in Canada's health system does not provide South Asian community members access to other alternative

health systems such as Ayurvedic or Traditional Chinese Medicine, nor does it valorise legitimacy of these models.

From my position at an immigrant servicing agency which liases with mainstream organisations, I see that there is a growing need to have professionals knowledgeable about the perceptions, experiences and challenges of individuals and females in the Punjabi Sikh community. I acknowledge that agencies such as the one I work in implicitly must connect with and accept limitations of what the biomedical models have to offer.

Thus, while an integral part of my job is working to interconnect with mainstream health practices, the present investigation provides an opportunity to take a critical stance. From this stance I can examine potentially new ways of serving immigrants which go beyond translating into their language, practices which remain, nevertheless, unchanged. My cultural awareness of immigrant experiences based on my own experience of growing up in the Punjabi Sikh immigrant community, coupled with my skills in the Punjabi language, initially provided useful background to my position researching issues of mental wellness/health in the Punjabi Sikh immigrant community in Surrey.

To develop a respectful process of documenting the experiences of the community, service providers from Surrey Delta Immigrant Services Society and a Punjabi Sikh ancestry family physician were consulted. It was decided in order to best understand the issues on mental wellness in the process of resettling and adjusting to life in Canada, that it was important to interview both recent Punjabi Sikh immigrants and service providers who provided settlement and clinical support services for the Punjabi Sikh immigrants.

When I first considered doing an assessment with Punjabi Sikh community members, I assumed that issues of class, culture and language would not be a formidable barrier as I considered myself a member, through family ancestry and ability to converse in Punjabi, of the Punjabi Sikh community. However, in formulating the assessment, and administering mock interviews with three community members, issues of class, culture and language became apparent.

Participant Interview Methods

My ability to speak English, my education in the Canadian social and school system and working in a perceived professional occupation, confers on me a position of relative power and privilege. Difficulties around culture and language also became apparent. In a 1993 study on Indo-Canadian seniors acculturation, ageing and alienation, Lee & Cheong outline that culture and language are not objective factors but rather deep psychic structures which both interpret and provide meaning to the world of supposed facts, objects and events. How Punjabi Sikhs would translate Western concepts in their cultural lexicon of mental health, was one concern.

Another concern related to language was, as the interviews for community members were conducted in Punjabi, I quickly realised that translating from English to Punjabi word for word was not as easy as it seemed it would be. When translation was possible, the cultural meaning of the translation was not suitable. As Lek points out, translation of a word from one language to another is not a simple matter of finding as exact an equivalent as possible (1988). For example, during the pilot interviews with community members, it seemed that Punjabi cultural understanding issues of 'mental health' related to individuals who were crazy and locked up in mental hospitals. The Punjabi Sikh community members attached stigma to the term 'mental health' in effect translating it to mean mental illness and this narrowed the discussion with community

members. The 1988 Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees outlined that in Canadian health culture, ironically, the term "mental health" has come to mean both mental disorder and positive mental health, a cultural health understanding not shared by the Punjabi Sikh community.

While developing the final draft of questions for community members' interviews, the importance of establishing a culturally appropriate definition of being well/healthy rather than directly asking of mental health concerns became apparent. Interview questions needed to be developed which provided appropriate cultural translation and understanding of the Punjabi Sikh community's perception of language, the relationship between the individual and their family, and interconnection of physical and mental health.

For example using the English word 'happy' required no linguistic or cultural translation, as all of the participating Punjabi Sikh immigrant community members had similar cultural understanding of this word. Combining words such as mental wellness and health seemed to provide an important balance in establishing a Punjabi Sikh cultural understanding, which covered both physical and physiological aspects of health. This in turn allowed for more open discussion with community members. Overall, it seemed that words and a process of discussion, which encompassed a holistic understanding of wellness/health worked best. For example, a holistic approach, which discussed issues relating to the family, employment or immigration rules and regulations, worked well.

I conducted the Punjabi Sikh mental wellness/health interviews both with the community service providers and Punjabi Sikh community members. Procedures outlined to support culturally sensitive health programs contributed to the development of the interview questions. As Thompson illustrates:

> When developing and implementing health promotion programs with different cultural groups it is important to keep in mind the results of research that is related to health behaviour change, communication, social supports, empowerment and to the planning of educational programs (1996, p. 212).

Notwithstanding the limitation in the biomedical model, the purpose of the interviews was to understand circumstances needing consideration in order to usefully make mainstream mental health services more accessible to the Surrey Punjabi Sikh community. Having culturally appropriate questions, both for the service providers and community members, which addressed 'wearing a religious thread', 'believe in karma or fate' or 'drinking holy water' (see appendix II and III), were used to enhance discussion of the use complementary care systems. Understanding the links in community between these complementary services could provide insight for agencies such as the local mental health centres, hospitals and immigrant serving agencies such as Surrey Delta Immigrant Services Society to support culturally responsive care.

Service Providers

The semi-structured interviews with service providers were conducted with four counsellors on location at Surrey Delta Immigrant Services Society. Surrey Delta Immigrant Services Society is a non-profit immigrant-servicing agency offering immigrant and multicultural programs. Serman Chan, Director of Service Quality & Human Resources was approached regarding the research. He was very supportive and encouraged his staff to participate. In return Mr. Chan's expectation was that the findings of the study would be communicated back to the staff in an oral presentation.

As the name of the agency has not been changed in this thesis, issues relating to confidentiality were of concern. Such concerns were discussed with Mr. Chan; he indicated that using the agency name would reflect the support the agency has for

academic research. However, in the presentation of data in the next chapter the names of the individuals have been changed.

Each interview took from 45 minutes to one hour and all interviews were tape-recorded. The programs, which were of particular interest for this research, were settlement adjustment counselling for newcomers, family-counselling services and alcohol and drug services. Three counsellors were members of the larger Punjabi Sikh community and one was a non-Punjabi Sikh counsellor. All counsellors had been working with the Punjabi Sikh community for many years.

Community Members

The interviews with twenty community members were also done at Surrey Delta Immigrant Services Society (Appendix IV outlines the summary of demographic information on the community members). Each interview was between fifteen and thirty minutes. Volunteers were asked to participate in the research while they were receiving services at Surrey Delta Immigrant Services Society. Some participating community members were receiving settlement-counselling services while others were taking English Language Services for Adults classes. In return for participating in the research, community members were encouraged to ask questions of the researcher.

Most common inquiries made by the community members were: what is the process of sponsoring family members left in India?; which courses should be taken to develop additional skills in Canada?; and which job search programs can be taken to find employment. In response to the participants' inquiries, the researcher referred community members to programs such as settlement counselling services and employment services at Surrey Delta Immigrant Services Society.

Interview questions for both service providers and community members were designed based on review of government agency policy/reports; the theoretical literature,

my personal and professional experiences within the Punjabi Sikh community, and consultation with service providers and a family physician of Punjabi Sikh ancestry. Punjabi Sikh immigrant community understanding of being mentally well/healthy; the social, cultural and structural factors of resettlement and adjustment; and the preventive measures undertaken to maintain emotional well being; were the focus of the questions. Also important was understanding how social circumstances influenced the process of resettlement and adjustment and possible connections among these circumstances and emotional distress. Information was also sought on services commonly accessed in times of emotional distress. Specific questions guiding the interviews are outlined in Appendix III.

Chapter V

Interview Data Analysis

Carole, who provides family counselling, describes how self examination and self perception may commonly be affected in the process of migrant resettlement:

> It seems to have profound effect on their (immigrants) mental well being, insofar as it always requires them to some degree to see themselves in a different way. They (immigrants) are no longer the person of the past, who lived in the country of origin. ...and their dream of themselves in the future, always doesn't match what at least their initial experience is once they have immigrated. Their dream doesn't match the reality, the past is no longer attainable and that is extremely stressful.

Chapter five presents an analysis of the interview data from four service providers and twenty Punjabi Sikh community members. The data is analysed in correspondence to the inquiries outlined at the end of preceding chapter including: the perceptions of the preventive measures ordinarily undertaken to maintain emotional wellbeing, the process of resettlement and adjustment, and the supports and services commonly accessed in times of emotional distress. One purpose of the analysis is to develop an understanding of these individuals' beliefs about health and wellness. A related purpose is to ascertain structural barriers they encounter in maintaining health and wellness.

Finally the interviews focussed on the types of services and practices (mainstream and complementary) which individuals accessed in times of emotional distress. Differences and similarities in perceptions and experiences relating to gender and age are considered as well as possible implications of changes in socio-economic status

experienced by newcomers. Keeping in mind the theoretical frameworks, which respectively emphasise either cultural or structural dimensions of immigrant resettlement, it is apparent from the data that in the immigrants' lived experience these dimensions intersect and intertwine and cannot always be discretely separated.

Research Findings

Service Providers Responses

The four-service providers interviewed in this study all worked at Surrey Delta Immigrant Services Society located in Surrey, British Columbia. Carole, a family counsellor of Anglo-European ancestry, was born in Canada. Preet was a settlement counsellor of Punjabi Sikh ancestry, who was born and raised in Punjab and immigrated to Canada after marrying her Canadian raised husband. Jasbir, also of Punjabi Sikh ancestry, was born in India, worked as a family and women's counsellor. She had immigrated first to Britain, than to Canada, with her husband. Jagdave the only male service provider interviewed worked in the Alcohol and Drug services. He was also of Punjabi Sikh ancestry, born in India.

Definitions of wellness/health

All four-service providers pointed out apparent differences in how health and wellness and have different meanings are understood in the Punjabi Sikh socio-cultural community in comparison to the mainstream socio-cultural community. The health and wellness of the individual is more often seen as a collaborative relationship with one's family than an individual enterprise. Thus in this cultural meaning system health is not so much an individual as social project. Carole, a family counsellor of Anglo-European ancestry who has been working with the Punjabi Sikh community for the last six years points out:

> Everybody's functioning in the family, not just on their own...often hard to separate out what they are experiencing as an individual and what the family is experiencing.

Three of the four service providers described the community's understanding of wellness/health, which combined physical, mental and spiritual dimensions. Preet, a settlement counsellor of Punjabi Sikh ancestry, has worked with the Punjabi Sikh immigrant community for over seven years, shares this understanding and expressed it as follows:

> Feeling fit, doing physical activities, looking for employment, or it could be driving or it could be doing household chores...they (Punjabi Sikh community members) link themselves with fitness...they (Punjabi Sikh community members) see themselves with fitness. If they can do them fine; that means they are fit. But if there is some sort of barrier there because of health issues that is an unfit story to them.

Jasbir, a family counsellor and women's outreach worker, also of Punjabi Sikh ancestry, reiterated the importance for her Punjabi Sikh clients of the integrated nature of health and well being:

> Won't look into the issue of stress, of what I would say depression because most of the things come in physical form. Well/healthy means being happy, they (Punjabi Sikh community members) don't separate physical, mental, spiritual...if it's all there, you're doing well.

Jagdave, an alcohol and drug counsellor of Indo Punjabi ancestry concurs:

> My experience is that certainly the South Asians (Punjabi Sikh) I've had, will speak of emotion...they also speak of physical ailments in the same context.

These service providers reports quoted above are framed by a cultural observation related to different meaning systems.

Challenges associated with immigration

All four-service providers identified that the process of adjusting and settling to Canadian life provided challenges in the lives of many Punjabi Sikh immigrant community members. Key challenges outlined by services providers include increase in emotional stress due to resettlement in new country; loss of family support systems and not understanding new formal support systems available to them. In their discussion of these issues, they focussed primarily on the structural dimensions of resettlement and on social support systems available to respond to these stresses.

Jagdave, an alcohol and drug counsellor who is working in a program that provides early intervention and treatment services for the South Asian community, focused on the stressful circumstances of obtaining employment. Especially for individuals with higher levels of education who are unable to find satisfying work:

> For some (immigrants) because they can't speak the language, they look different, their education is not valued in Canada...even to get a job...it's easier if people were doing labour jobs back home...they'll get a quick low paying job and get on with it...those people who come with an education and from wealthy families, they have hardest time.

Jagdave's observations pinpoint the stress caused by difficulties in gaining access to mainstream economic structures.

A women's counsellor highlights another structural concern; gender related increases in emotional stress experienced by immigrant women because of new social structural challenges posed by insertion into a new socio-economic system and because of the absence of customary social support systems.

> The stress can increase once they (women) come to a new land. There is also a new arena that many of them are entering into...women are alone in this country because families are left behind and they've been sponsored by their husbands to come here...issues affects them because there is no one to go to and talk to about the stresses.

Jasbir, the family and women's counsellor creates programs which are designed to prevent mental wellness/health breakdown and the disintegration of families. In the context of this program she sees that isolation and loss of familiar family supports are implicated in domestic violence and substance abuse. She describes some outcomes of the social isolation and separation from family and the consequent broken support systems for women:

> It is difficult establishing themselves in new relations. They become lonely and if there is an issue of violence and abuse so is the intensity of hiding or staying in isolation. For women, separating from family (in Punjabi) destroyed familiar support system.

Preet, whose settlement program provides support services (information/referral, interpretation/translation, and liaison with mainstream services, group orientation for newcomers) tries to better equip newcomers to continue a healthy settlement and integration process. She notices that some new immigrant Punjabi Sikh females will access her program for settlement issues such as filing out taxes, and in the process of accessing settlement services, they will share issues of spousal abuse or other family related problems. Preet explains how resettlement in Canada creates new structural circumstances where the separation from customary familiar social supports creates dilemmas.

> Back home, there are the chances for you to go back to your parents to vent your feelings or you can go and share your experiences with your friends...but once you leave the support system behind there is nothing to fall back on. Receiving services from formal support system in Canada is often not initially considered.

Accessing new kinds of support systems

Jasbir followed through in describing this dilemma of difficulty in accessing both customary and new support systems. His comments illustrate the ways in which cultural discontinuities regarding support systems are exacerbated by lack of familiarity with and ability to access mainstream support structures. Being unaware of alternatives to culturally familiar support systems, Punjabi Sikh community members often:

> Don't have the concept of going to counselling until a drastic thing happens in their life...their understanding of support system is related to family, friends. Through immigration when that's lost they may not naturally consider the other support systems like the formal support systems...they're not considering that (formal support system) ... it's never been a part of the country they come from. So that's a new thing for them too (Jasbir, women's counsellor).

In this way the stress of resettlement is entwined in both cultural and structural discontinuities.

Prevention and Supports Accessed in Emotional Distress

When discussing prevention within the Punjabi Sikh community, service providers suggested the following salient themes: Punjabi Sikh new immigrants often put material (housing, employment) primary settlement needs before emotional needs. Prevention and formal and informal supports and services accessed during emotional distress in order of priority include: family and friends, spiritual practices, family physicians and lastly mainstream mental health services.

Differences in Understanding Illness Prevention

Cultural differences

One-service provider addressed the fact that the concept of prevention as understood in the Canadian cultural context has a very different meaning than in Punjabi Sikh immigrant communities. The Punjabi Sikh community is carefully attuned to the social and emotional dimensions of wellness and illness prevention and less attuned to physical preventative measures and danger signs. Carole describes these complex relationships as follows:

> South Asian community doesn't think preventative...some may believe if you talk about it, it may happen...I think in North America we anticipate illness quite a bit...I remember growing up learning the seven danger signals that you might have cancer. They are on the bus advertisements. I think that we (Canadian raised) have a perspective of expectation of illness and look for warning signs, that we have to eat the right things and do the right things. My clients from the South Asian Community have an expectation of wellness, I would say. When distress comes into their lives, like emotional, they are very perplexed by it because ...they are doing all the right things. Fulfilling their role in the family, in their jobs and fulfilling them selves spiritually perhaps (family counsellor).

Gender differences

Differences in gender roles in relations to health care prevention were also identified. In addition to being a family and women's counsellor in Canada, Jasbir was a practising teacher in India before she married her husband in England. She immigrated to Canada over ten year ago and recalls her personal and professional role of being a female of Punjabi Sikh ancestry while growing up in India and now living in Canada:

> Women do less self care...I'm thinking about myself growing up, being professional or something, I would never ever think of myself first... because that's what I grew up with. So, it's like when I made myself as a part of the family –it becomes like me. And your priority is gone out the window because you will be doing things for the family...as a women you will be working and looking after the family or we'll be doing all of the social status things. So there is not time left to you as a woman to think of yourself.

Jasbir's narrative illustrates the way in which new structural economic demands combined with the customary demands associated with her role of wife and mother create a set of circumstances which could easily lead to stress overload. Where can immigrant males and females gain support and guidance for the challenges they face in accommodating the demands generated by the new positions they occupy in mainstream society?

Material needs

Three of the four service providers explained that Punjabi Sikh immigrants often are so focused on material demands of establishing themselves and their families, they often ignore their emotional needs. For most immigrants, the main focus is to meet their primary needs of getting employment, a house, or a car.

> Looking at prevention, for many of them, they need to find jobs and that's one thing that brings them like freedom to stand on their own two feet and that change their status in the family...that sometimes may help them to have the empowerment here (Preet, settlement counsellor).

Another service provider assessed the relationship between providing for material needs and prevention as follows:

> Preventative work in the South Asian community might not occur because they are working so hard on their primary needs. If we could only imagine if we were uprooted completely and moved to a country where you don't even speak the language or you may have some access to the language, but not to great degree and have to start everything over. All your training is lost, all your work experience is lost, all your proficiency in any thing that you thought you were good at doing is gone. You probably can't even cope...Yeah, they just literally put their head down and get to work for a number of years (Jasbir, women's counsellor).

Jagdave adds:

> They say...if I have to sit back then I have to think. That's another thing they dread in themselves. I think mental health issue is not a issues for them until it starts affecting them physically...and they can't push it back any more (alcohol and drug counsellor).

Thus the structural conditions of their insertion into Canadian society are implicated not only in creating stress but also in working against accessing assistance that might reduce the stress.

Complementary Mental Wellness/health Support Services

Spiritual Support

Three of the four service providers identified the role of religion as a form of prevention and maintenance of good health and wellness. Spiritual healing is one familiar and accessible support system available to immigrants in their new life in Canada. These counsellors saw the use of spiritual healing as a way for immigrants to take back control of their mental wellness/health. Some immigrants resorted to prayers, others engaged in their spiritual journeys by baptism or consulting spiritual healers.

Religious Prayers

Jasbir illustrates:

> When you say prevention it's the religion...one of my clients says she does 'phat' (prayers) ...you know her morning rituals and that give her peace (women's counsellor).

Preet recounts religion as one among many responses:

> Religion is used to keep[ing] themselves busy...that's what many of my women clients do...they've been working two jobs and they'd still be doing housework chores. Many times I tell them why is it that there is not time for you (settlement counsellor).

Spiritual Journey: Baptism

> Jagdave relates that adult baptism is a step for healing:
>
> I have seen many of them go back to be baptised and that is how some of them try to ease the pain (alcohol and drug counsellor).

Spiritual Journey: consulting a spiritual healer

Three of the four-service providers recall the Punjabi Sikh community members disclosing the use of alternative healing professionals. These non-mainstream mental wellness/health professionals are still utilised both in Punjab, India and in Canada. Jasbir gives examples:

> Spiritual healers, all of those things, which they believe in, they, have exhausted before they come to us. Even here, in the community many of them (community members) are going and visiting them (spiritual healers). They will tell me that's what we are doing or I have seen they will not go to a temple but there are like some sects – they call them "Baba ji's" – and they will go, and you know, become their followers. So, that's how some of them are, you know, easing their

pain. This "Baba ji" has given name and he's giving blessing or she – he or she – giving blessing and hope that all the things will go away. So they are still using that system living in Canada (women's counselor).

Preet gives other examples:

That's another one (spiritual healer) which I have seen them going to...or, astrologers. They have been going and getting the stone (healing stones) before they will go and see a psychiatrist or a psychologist or a counsellor (settlement counsellor).

This spiritual journey of enhancing family mental wellness/health may include also travelling to India as well as carrying out financial commitments. Jagdave said:

I think some go to India and get help from "sants" or religious places. They pray...they make deals with god...if my family member get better I will have a "Phaat", a Sikh religious pray...I will donate money to temples here or send some money back home to a temple in India (alcohol and drug counsellor).

The process of the journey of spiritual healing may include Punjabi Sikh community members returning to India. As Carole, recalls:

I have seen a lot of families, and it they can afford it, send the person who is suffering, back to India for healing. That is often talked about as a spiritual journey...they are not going to back specifically to see a doctor or anything like that, they may, but it is much more about the nourishment that they get from being in India and there is a sense that the healing can take place there.

Carole also recounted:

For example, we had a case where the oldest son in the family was schizophrenic. The family would routinely send them back to India and he would stay for six and then come back and this would happen once every two years or so and they

always claimed that he was much better when he was there. My sense was that it had to do with a lessening of stress and his feeling more connected and more supported back in India, than he felt here (family counsellor).

Recognising the complementary mental wellness/health supports and practices of the Punjabi Sikh community provides important insight into planning for culturally responsive health services which need to encompass, along with the mainstream biomedical system, complementary/pluralistic systems of care. In addition to the spiritual practices and spiritual journey, other services accessed by Punjabi Sikh immigrants included: family and friends, the family physician, immigrant servicing agencies and the mainstream mental health services (mental health centre and hospital), and these are described in the following sections.

Family/Friends and Family Physician for Support

All four service providers endorsed that in time of emotional distress, Punjabi Sikh immigrants will most likely turn to family or friends, and the family doctor.

The family's the first one and then the doctors and family or friend. I would have to say that the friend has to be like family, only then they would be opening up secret to them (Jasbir, women's counsellor).

They go to family doctors...they come to us...they come with issues of income assistance and then they let it all out...the issues of depression, stress (Preet, settlement counsellor).

In the Punjabi Sikh community, it is important to understand the accessible and acceptable role family/friends and family physician play in time of mental wellness/health distress. The findings validate the interconnections of the family and individual which has been documented in research (Lee & Cheong, 1993; Buchignani, 1985; Assanand, Dias, Richardson, & Waxler-Morrison, 1990; Henry, Tator, Mattis &

Rees, 1995). Responses of the service providers also illustrate the accessibility and acceptability of the family physician.

Mainstream Mental Health Services

Of the four service providers only one identifies the Punjabi Sikh use of mainstream mental health services. When the community accessed the hospitals and other mainstream mental health services, it was often because that was the last option available to them, or it was a forced application by mainstream government based institutions. Carole's comments below relate how this sequence of events might occur. She did not specifically indicate that she perceived all mental health concerns as necessarily related to stresses of immigration and resettlement. Her comments were a more general appraisal of the mismatch between mental health crises and the biomedical system of mainstream services.

> Thinking about things like schizophrenia, bipolar moods, that kind of major depressive episodes, then they are hospitalised... going through emergency and spend time on the psych ward, they are assessed and then sent into the system (mental health centres). Going to the mental health centres only through mandate by social worker at the hospital...they have been hospitalised and then routed through the mental health centres on discharge (family counsellor).
>
> She goes on to say:
>
> What makes it a vicious circle is that because they are not accessing services earlier, like doctors and health centres, they end up being triaged in the emergency ward which can be the most disrespectful place in the world for anyone. They are restrained, thrown on a psych ward, given the drugs, and family members are just horrified, it's a chaotic system to enter into. It only

confirms their belief of being disrespected and unacknowledged and misunderstood.

As illustrated, there is apparent lack of acceptance of other mainstream bio-medical services in supporting mental wellness/health distress for the Punjabi Sikh community. One concern is that they lack cultural, but another concern is the structural factors which include not wanting to use biomedical medication, and the discomfort with processes and procedures in the 'psych' ward.

Difficulties in Accessing Formal Mainstream Mental Health Care Services

All four services provider identified many difficulties encountered by the Punjabi Sikh immigrant community in accessing mainstream mental health services. Such barriers include: language difficulties; misdiagnoses by mainstream agencies and inappropriate referrals; not understanding the role of formal mental health services; not receiving support from family physicians; families not wanting others to know about their problems; and a belief that "kismet" (destiny, fate) is responsible for the mental distress and consequently the formal mainstream mental wellness/health services will not be useful.

Language Difficulties

Two service providing respondents identified language difficulties as a significant barrier in receiving services. Jasbir, relates the language barrier often encountered by her clients to her own difficult experience with formal mainstream mental health services. She illustrates her own personal experiences as well as those of her clients:

> I think the language barrier is one thing I would most say. Because I have been myself been through mental health, try to get services for my clients.

Jasbir goes on to say:

> I think, and what I was just thinking to myself. When I am a worker, we needed to know more about mental health services in the community. So people can give out the information to the maximum, so that the client can get, you know the comfort zone level. They don't even have that information. So, I mean, many times we tell them to tell their doctor to phone to mental health but they have never ever heard...the procedure even. (women's counsellor).

As a settlement counsellor, Preet also sees:

> The language itself is a barrier. Or perhaps, you know there is the stigma because mental health has a big stigma to them. It's like a mental institution. In addition to language difficulties, not understanding the role of the service providers.

Stereotyping /Essentializing

Carole discussed the need to make the system more responsible in seeing and changing the less visible barriers to making the formal mainstream mental health services inclusive and accessible to immigrant communities.

> The largest problem we have is we often get referrals where we are told from the mental health centres, oh it is a cultural issue, and the assumption has been made because the person doesn't appear to be from the dominant culture. I have had people who have been sent to me for cultural issues who have lived in BC five times as long as I have. It is silliness, so they (mental health staff) are trying to fit everybody into the same box and are really nervous because they can't do it...and so their idea is that well, we will call it a cultural awareness if you don't fit into this box, and we will send you some place where they can help you, which is insulting.

Responses by Family Physicians

Another barrier in accessing mainstream mental health service, was seen as a result of clients not receiving support from their family physicians. Most often the family physician was seen as a figure of authority, and he/she was the most often identified professional within the formal mainstream mental wellness/health system accessed by the Punjabi Sikh immigrant community. Three of the four service providers highlighted the experiences of the community members and their families. As a settlement counsellor, Preet has observed the reluctance of her clients to communicate their personal or family mental wellness/health distress.

> Well, I think doctors don't have time. And part of them is that they (family doctors) don't have time and that people don't talk to doctors very openly about it (mental wellness/health distress). Because of, I don't know, there's not enough time or perhaps people aren't ready yet. Yet they will be going to spiritual healers before even seeing the doctors.

When community members try to discuss issues surrounding mental wellness/health distress with their family physician, they often feel unsupported. As Jasbir recalls:

> They usually don't go to the doctor, and if do...they come and say, well I have tried my doctor. I notice frequently is they are not getting any kind of concrete help from the medical profession and they are quite intimidated to go somewhere else usually because they can't express themselves well in English. They will try everything. They'll try everything because if I think of it, many of us who are coming from India they're coming from rural areas and doctors are not available so the spiritual healers are the ones who have been (women's counsellor).

Even if the family physician is from an Indo-Canadian background and speaks Punjabi difficulties arise.

> Western-trained South Asian physicians, they are South Asian by origin, western-trained doctors by what they practice. [Clients] and their families will go see family practitioners that happen to be South Asian. But they are western trained. They are going to be seeing the illness in the way that the dominant culture, medical profession sees it. The doctors see them as requiring medication and are often quite negative about them insofar as there is no treatment for this; he (the client) is going to have to take this medication for the rest of his life, which is pretty harsh for the family to hear. They are not accessing psychiatrists necessarily; they wouldn't get them unless they are in the hospital (Carole, family counsellor).

Families not wanting others to know/shame

Jagdave identified that one of reasons for not accessing services is families do not want others to know about their problems. The respondent describes:

> There is also the idea what can an outsider do. They don't want an outsider to know. Certainly not someone from the community...and often not anyone.

Jagdave further expands his point:

> There is some sense of shame or fear as there is with any family dealing with mental illness. Illness is not an uncommon experience; maybe harsh to say, but my clients don't expect respect going to these places (formal mainstream mental health services). I think they have experiences every day of racism, which cumulatively add up. To risk going in showing their family member who is like out to lunch and get dismissed...they decide...we'll take care of it ourselves (alcohol and drug counsellor).

Fate/Kismet

A belief that "kismet" (destiny, fate) is responsible for mental wellness/health distress restricted some Punjabi Sikh community members from accessing formal mental health services. Two of the four service providers gave such examples. Carole recalls that with her family counselling clients:

> Probably 80 per cent of clients, I see will have some concept of destiny, fate being involved in what they are experiencing.

Jasbir remembers her women's counselling clients expressing related beliefs:

> "Mere Karm". It's my "kismet". It's a big part because then they say they can't do anything better now and that's written there. I was just thinking of some of the families where they've been given [the marriage has been arranged by families] to a schizophrenic partner. I think it's just, we talked about the karma story; talked about the religious belief system so that was done. It was written in my past, so I have to do something different here, and then it will go away. So the treatment that they (spiritual healers) recommend will be quite different from, say, for example, western doctors.

The treatment recommended by spiritual healers may include certain rituals such as prayers, giving financial donations to temples, or even changes in eating patterns. The individuals, or other family members may carry out such rituals.

Once again the difficulties identified in accessing mainstream mental health care services illustrate both cultural and structural dimensions. Although certain issues are clearly cultural (families not wanting others to know/shame, fate/kismet) or structural (stereotyping/essentializing, biomedical background of the family physician, others such language difficulties are both cultural and structural.

Overcoming Barriers to Accessing Mental Health Care Services

All service providers were asked to give some input on ways of overcoming some barriers in accessing mental health care services for the Punjabi Sikh immigrant community. The need to shift the mental health institutional system and to improve the format and tools used in assessment of clients was considered central to modifying the mainstream mental health system. Carole the family counsellor concluded:

> Health professionals today have to be aware of the total context of a person's life. That the kind of categorisation and discreet categories that, you know a lot of assessment forms even have little boxes you check off, aren't as useful as when they were constructed.

She goes on to discuss how as health professionals, we need to be aware of the importance of client assessment, which in return influences appropriate treatment:

> We really need to think how we gather information about a client and then how we are going to use it. So right from the beginning, when you are sitting with someone, you need to be aware of the assessment devices are defining assumptions and constructing assumptions about that person even as they go along. Like what questions are they asking him; why or where do these questions come from? What is the idea behind the pathology of this? You know, is it a western model of behaviour that we're now deciding is the pathology if the person doesn't exhibit it or does exhibit it, like independence versus dependency? So the whole thing has to be thought about, how you are collecting the information on the person to begin with, then you should go on looking at how are we going to put into a plan of care for this person.

Carole disclosed the racism encountered by some of her clients and suggests that mental health institution also need to change:

Without acknowledging that they (Punjabi Sikh clients) get disrespect and even racism all the time, we can't begin to acknowledge or remedy the barriers that exist in earlier preventative services (family counsellor).

Overcoming barriers to accessing mental health care services included a combined shift in both cultural and structural dimensions in the mainstream health care systems.

Community Members Responses

All twenty of the Punjabi Sikh immigrant community members interviewed in this study, were receiving either settlement services or adult English improvement classes at Surrey Delta Immigrant Services Society. Most of these individuals had come to the agency seeking assistance in job training courses or to improve their English ability so they would be able to find suitable employment.

Twelve participants were females and eight were males. Nineteen of the twenty community members interviewed arrived to the suburban City of Surrey, after living in rural villages in Punjab all their lives. Of the twelve females in this study, nine came to Canada through their husbands' sponsoring them after marriage, while extended family members sponsored (one female was adapted by an uncle) the other three. Eleven of the female participants had arrived in Canada less than four months prior to the interview, while one lived here for more than two years. The age of the females ranged between nineteen and twenty-six. Their completed education level on arrival to Canada, ranged from grade school (three) to college/university (nine). One of participants had completed her MA in Punjabi Studies.

For the male participants, seven came to Canada through family sponsorship while one immigrated through spousal sponsorship. Of the eight males, four had, at the time of the interview, been in Canada less than six months, while the other four had lived

here from a year and half to three years. The age of the participants ranged from eighteen to sixty two years. Their completed education level on arrival to Canada, ranged from grade school (four) to college/university (four). The sixty-two year old participant had worked as a teacher in Punjab. Data was analysed by gender and age within the community group; analysis by gender and age revealed some differences.

Definition of wellness/health

Establishing understanding of wellness and health with community member respondents proved to be very valuable. Such discussion allowed for the Punjabi Sikh immigrants to express their understandings of wellness and health, and by contrast what constituted distress of mental wellness/health. Some common themes: a stable and prosperous functioning family, having employment, having the freedom to making one's own choices, not having emotional stress or physical disability, and displaying good manners, behaviour and habits.

Of the 20 respondents 15 (7 males and 8 females), expressed the importance of healthy family functioning and individual wellness and health. Following are a selection of statements regarding what contributes to mental wellness/health:

> Having a good family, no family problems, no fighting in family...that's the only way to be healthy.
>
> Having kids and they are well educated, brings family happiness (62-year old elderly male).

For five (1 female and 4 males) of the twenty community members, employment was seen to contribute to good health and wellness. A young female explains:

> Being employed keeps you busy, when you're busy there is no time to have bad thought in your mind.

Some gender differences were observed in the answers. More males identified employment in relation to good health and wellness. Three of the four males also put emphasis on not only having employment but the importance of having a 'good' job. High paying employment, which would be suitable to their skills and education level, seemed to define a 'good' job. A male community member put it this way:

> I will be truly happy, when I get a good job, at that time I will be able to buy what I want.

In this study, the importance of having the freedom to make one's own choices appeared to relate to gender. Of the 20 participants, only females identified such a concern. Five of the twelve females expressed comparable ideas regarding following their own choices and having the finances to do so:

> What is in you heart, mind (23-year-old female).
>
> Not depend on others (26-year-old female).
>
> In India you are depending on your husband...because I have not found a job, I'm still depending on husband (24-year-old female).
>
> Able to buy what you want (27-year-old female).

Other answers included: not having emotional stress or physical disability (one male), and having appropriate social skills (three males and one female).

> No pressure on mind, no tension, no pains in your body, not having a disability (physically disabled male).
>
> Display good behaviour, manners, and habits (18-year-old-male).
>
> Nice behaviour and be nice to everyone (23-year-old female).

Similar to the responses from the service providers, community members also expressed the importance of the family to individual, in relation to mental

wellness/health. A holistic approach, which included both cultural and structural factors, was also apparent.

Challenges of Immigration support systems

The stress of settling in a new country and adapting to a new culture, and leaving family behind, were some of the issues identified which affect wellness for many new immigrants. Community members identified some common positive and negative cultural differences in their process of adjusting to life in Canada. Some common themes emerged: the importance of employment; the reduction of available leisure time for all; government and administrative differences; and separation of families.

Social/Leisure Time

Eight participants, all whom had lived their entire lives in rural Punjab villages prior to immigration, identified a significant decrease in social/leisure time. One interviewee explained:

> In India people have more time...here you don't see anyone during the week...only on weekends...no one has time to talk here. The only way to socialise here is through work...if you're not working, you don't know what to do.
>
> Everyone works here...living is different here...you can't drop off at any people's house without phoning...they're busy and not at home (24-year-old female).

Two female community members share their observation of change in social interaction time available to them and their families:

> Canadian life is busy, India more leisure time (21-year-old female).
>
> No one has time to talk...even living in one family, you never see each other (26-old-female).

Standard of living

The difference in material culture and daily services was another common theme identified. Several community members explain:

> In Canada there are better homes, better roads here...traffic rules, driving...government rules are great here...rules are different here...police is good here (many community members).
>
> Kitchen is different, food is not as fresh...no water problem (in Canada), electricity not a problem. School is very different here...less discipline...need more homework (female community member)

Employment

Although many Punjabi Sikh community members identified the ease in obtaining material goods in Canada, they also recognised stresses and pressures in the importance in finding employment.

> In India no need to find a job...lots of pressure in Canada...not having a driver's license you can't do anything (23 year old married female).
>
> India is free life...coming here...need to find job...never learned how to find job, work outside the home...in India, after marriage the expectation was to work inside the home (26 year old married female).
>
> We were settled (in Punjab)...now having to find a job, a home...a car...your mind does feel sad (24 year old single female)

Family Separation

The stress and difficulties expressed in separating from families also demonstrated significant gender differences. Only females identified the issues of isolation and lack of support in relation to separation from family. All eight females had

immigrated through family sponsorship, seven through marriage and one through adoption. Various female community members had this to say:

> Very modern people here...no parents/brother can't talk to anyone...life is very stressful here, people are away all the time...only see them two days (young female adopted by her uncle).
>
> Coming to Canada...have to live with in-laws...the way you speak to your own family, you can't with in-laws (young newlywed female).
>
> Stresses of not having my family here...miss not being able to talk to my mother...miss family very much (26-year-old newlywed female).

Once again community members highlight challenges of immigration, which include both cultural and structural dimensions.

Prevention of emotional distress

Community members shared a variety of ways keeping themselves emotionally well/healthy. Activities mentioned include spiritual and religious practices; physical fitness; taking time to socialise; and consulting with family members for making individual decisions. Community members share their experiences:

> Exercise, go out and socialise (22 year old married male)
>
> Watch Hindi movie, go shopping (30 year old single male)
>
> Take English classes, takes courses, listening to and abiding to elders' wishes (18 years old single male)
>
> Get jobs and eat good food (23 year old married female).

The only area where there appeared to be gender difference was in the use of spiritual and religious practice in preventive health and wellness. Six respondents (five females and one male) were involved in spiritual and religious practice for self/family

wellness. All the female respondents were in their twenties while the single male respondent was in his early sixties.

All six participants talked about reading the 'Guruanth Shab' (Sikh holy book) or doing 'phat' (praying). Two of the five females revealed that they also were wearing rings made with spiritual stones. The colour of the stone was customised from interpreting individual 'Junam Pathra' (scriptures relating your birth date and time). One young female recalled her family completing a 'Sukia Sukinee' (promises made to God for blessing and in return, family may organise religious readings, sent monies to Gurudwara (Sikh temple) in India or visit a certain Gurudwara in India) for her after she safely entered Canada.

Supports Accessed in Emotional Distress

Of the twenty community members interviewed, all had identified that they would seek support from their families when they are emotionally distressed. Two participants identified seeking support from a religious leader or place of worship. As outlined in the earlier literature review and interview with service providers, emotional distress for many South Asian clients is often expressed in physical sensations. It is not surprising then that the only medical professional identified by the participants (two females) in support for emotional distress was the family physician.

When interviewing community members, it was difficult to discuss barriers in mental health care services. Nineteen of the twenty participants were not aware of the role of mental health professionals such as psychiatrists or psychologists. Nine community members identified the presence of social workers in India. But one community member clarified that these social workers were mostly in the larger cities such as Delhi and not in villages of Punjab.

In the findings of this investigation both service providers and community members indicated that the individual's mental wellness/health is inter linked to social, cultural and structural factors. For the Punjabi Sikh immigrant community the structural and economic challenges of resettlement, racism, employment discrimination, and cultural challenges relating to language for example, affect the community in accessing mainstream community servicing agencies.

Chapter VI

Interpretation: mental wellness/health concerns in the Punjabi Sikh immigrant community

Chapter six will interpret and present the implications of the findings. The chapter concludes with an outline of considerations for mainstream health care practitioners in providing accessible and culturally responsive mental wellness/health care for the Punjabi Sikh immigrant community and by extension, possible implications for other minority communities and the structure of mainstream health care as well. The data analysis in conjunction with the research and theory suggests two main perspectives for interpreting mental wellness/health concerns in the Punjabi Sikh immigrant community. The first of these perspectives relates to differences in respective meaning systems, regarding mental wellness, of mainstream health care systems and Punjabi Sikhs. The second perspective relates to structural factors implicated in mental wellness. In some instances insights provided by the data suggest places where these two theoretical orientations coincide.

Differences between mainstream and Punjabi Sikh meaning systems relating to mental wellness/health

A variety of ethno-specific studies and a body of theoretical literature focus on cultural discontinuities between ethnic minority community members and mainstream agencies. Waxler-Morrison, Anderson and Richardson (1990) illustrated the importance of understanding that health care is a social and cultural process, where the mainstream caregiver and the immigrant client likely bring different beliefs, expectations, and practices to the encounter. In these cultural and social analyses regarding immigrant communities' understandings of wellness/health two main areas have become a focus.

First the culturally based differences in the notion of sickness and treatment, and second, the respective perceptions of caregiver and clients regarding the role and responsibilities of clients. Peters (1987), Popatia (1995), Task Force on Mental Health (1988), Culture and Health 2000 (1996), and Hughes (1993), all indicate there are cultural differences between the ways in which mainstream health services and ethnic minority communities understand the sources and nature of illness and health and respective responsibilities of caregivers and client. The differences in notions of sickness and treatment identified in this research are, interconnection of family and the individual, and the holistic approach to wellness/health. The respective responsibility of the client and caregiver are also presented.

Interconnection of family and the individual

The differences between understandings that members of the Punjabi Sikh immigrant community have of mental wellness/health, and those of representative Canadian mainstream society and health services, were apparent from the experiences shared both by the service providers and the community members. The service providers specified that the mental wellness/health of the Punjabi Sikh individual is often interconnected with his/her family. The interconnection or lack of connection with the family was seen as a source of support or alternatively the cause of stress/distress for the individual.

Carole, pointed out that "everybody's functioning in the family, not just on their own...[making it] hard to separate out what they are experiencing as an individual and what the family is experiencing". Similar to the service providers, most of the community members expressed the importance of wellness/health of family functioning in relation to individual wellness/health. Various community members gave examples of "having a good family, no family problems, no fighting in family...that's the only way to

be healthy". The enormous value placed on interdependence, co-operation, and loyalty to the family has been documented elsewhere (Henry, Tator, Mattis & Rees, 1995). It is seen that for immigrant cultures independence from the family is not a primary goal. In fact each family member is expected to put the family's needs ahead of individual desires (British Columbia Task Force cited in Henry, Tator, Mattis & Rees, 1995).

Accessing the family unit in time of distress, as service providers point out, was because many Punjabi Sikh families did not want others to know about their problems or that "for many minorities, sharing intimate aspects of one's experiences only occurs after a long and intense relationship has been established" (Henry, Tator, Mattis, & Rees, 1995, p.160). This interconnection of family and the individual is apparent to both the service providers and community members as they note that the available family network was the most acceptable support system initially considered in times of emotional distress.

The importance of maintaining the interconnections of the family unit in mental wellness/health is also supported by the historical pattern of Punjabi Sikh immigration to Canada. Ethno-specific research on the South Asian community also establishes that the family reunification immigration process is the process commonly undertaken by South Asian families (Lee & Cheong, 1993; Buchignani, 1985; Assanand, Dias, Richardson, & Waxler-Morrison, 1990).

It is also apparent in data from this investigation that immigration as structured by the Canadian government contributes to family interconnections. For example, of the twenty-community participants in this investigation, all came to Canada through family sponsorship. The immigration process has very important structural implications for family connectedness. In this regard theoretical considerations raised by structural

analyses and cultural analyses coincide to illustrate how specific structural arrangements may appear culturally supportive but may nevertheless create problems and stresses.

Thus, family reunification as a criterion for immigration can play a supportive role, however, it can also create stress of a variety of types in relation to diverse circumstances of particular individuals. For example, while the cultural notion of united families and the structural requirements of immigration policy have apparent similarities, the economic requirement associated with sponsorship and ten year economic responsibility of the sponsor, imposes a structural demand which is difficult and stressful for many to comply with.

The positive aspect of family reunification is that it brings families together so more individuals have assistance in initial processes of setting up households. However the newly settled individual is often expected to serve as a sponsor for family in Punjab. Women who immigrate to Canada and marry already settled men lose close contact with their families. Moreover there are expectations that as soon as they are settled and have met economic requirements laid out by Canada Immigration, they will sponsor their families. It became apparent from the questions many female community members addressed to me after the formal interviews were concluded that they were experiencing stress about the mechanics, feasibility and timing of themselves being sponsors. This was especially difficult for women in comparison to men because of the greater challenges they experience finding employment.

Holistic approach to wellness/health

For Punjabi Sikh community participants in this research, mental wellness/health included a holistic understanding of social, economic, physical and emotional factors. Community members expressed that having a stable and prosperous functioning family,

having employment, absence of emotional stress and physical disability and behaving in socially acceptable ways were all important in maintaining wellness/health.

Service providers specified, that the Punjabi Sikh community's understanding of wellness/health often combines all aspects of physical, mental and spiritual wellness/health. A family counsellor outlined that different understandings of mental wellness/health between mainstream health services and the Punjabi Sikh immigrant community have led to misdiagnoses by mainstream agencies and resulted in inappropriate referrals.

In the present study this is illustrated by Carole's statement that because of these differences in understanding:

> health professionals today have to be aware of the total context of a person's life...categorisation and discreet categories that...a lot of assessment forms even have little boxes you check off, aren't as useful as when they were constructed. [Health professional] need to be aware the assessment devices are defining assumptions and constructing assumptions about that person...So the whole thing has to be thought about, how you are collecting the information on the person to begin with, then you should go on looking at how are we going to put into action a plan of care for this person.

This relationship has been documented by Belliapa (1991) who points out that for South Asians, the distinction between the mind and body is not prominent and emotional states may not be regarded as pathological but within the realms of normality and connected to social roles. Belliapa's observations correspond with the perspective articulated by Jagdave, the alcohol and drug counsellor, who understands that Punjabi Sikh community members speak of emotion and physical ailments in an interconnected way.

For these reasons, Krause (1989), in *Sinking Heart: A Punjabi Communication of Distress* develops a model in which physical, emotional and social distresses are part of the same "illness complex". In the immigrant Punjabi community in Bradford, England, he observed that the expression of heart symptoms was associated with circumstances in which individuals feel loss of control emotionally and socially. Sinking heart, '*dil ghirda hai*', is not only a metaphor for emotional and social distress but physical symptoms as well. In the Bradford study the Punjabis also emphasise the role of the heart in facilitating processes of transformation. The heart is primarily seen as a regulator of life forces throughout the body. As one Punjabi immigrant pointed out, "The heart is very important, it is more important than the brain "*dimaag*" (Krause, 1989).

Notion of sickness

According to Waxler-Morrison, Anderson, and Richardson (1990) Western health models often attribute disease to individual behaviour, such as exposing oneself to germs or eating improperly. For example, in the area of mental health, mainstream notions about sickness and treatment of mental illnesses are derived primarily from the fields of psychiatry, psychology, and sociology (Popatia, 1995). Mental illness or disorders are thought to result from biological and psychological pathologies in individuals who are genetically vulnerable and predisposed. This is consistent with a culture of medicine in which the patient and the practitioner both believe that bacteria and viruses, for example, cause disease.

In contrast, many South Asians view illnesses from principles of Ayurvedic health. In this approach illness is a result of imbalance in the body humours, bile, wind and phlegm and the purpose of treatment is to re-establish the balance (Assanand, Dias, Richardson, & Waxler-Morrison, 1990). An imbalance in humours can result from various sources, but dietary imbalance is probably the most common cause of illness.

For example, a headache may be explained as result of eating too many eggs, which are believed to be "hot" foods. For mental illnesses, possession by a demon or the "evil eye" of a jealous neighbour may explain such illness.

Difference in the notion of sickness for Punjabi Sikhs has been identified by service providers in this investigation. Carole describes:

> South Asian community doesn't think preventative...some may believe if you talk about it, it may happen...I think in North America we anticipate illness quite a bit...I remember growing up learning the seven danger signals that you might have cancer. They are on the bus advertisements. I think that we (Canadian raised) have a perspective of expectation of illness and look for warning signs, that we have to eat the right things and do the right things. My clients from the South Asian Community have an expectation of wellness, I would say. When distress comes into their life, like emotional, they are very perplexed by it because ...they are doing all the right things. Fulfilling their role in the family, in their jobs and fulfilling them selves spiritually perhaps.

From the Punjabi Sikh community members, it appeared they do not plan for sickness prevention in the same way mainstream community members do as described by Carole above. For example, for these Punjabi Sikh immigrants mental distress was seen as a result of reduction of available social/leisure time, the stresses and pressures of finding employment, or the separation from family.

Notion of treatment

Popatia's (1995) research on South Asians' notions of sickness and treatment of mental illness contrasts with Canadian or Western explanatory health models. One goal of this research is to understand differences and similarities in the two models in order to promote the deconstruction of cultural barriers between mental health professionals and

the South Asian population. Popatia's findings illustrate that in most of South Asia, the bio-medical model of health care co-exists within the matrix of a pluralistic system which consists of a variety of practitioners, schools of thought, disciplines and ways of accessing services. She concludes that the health care system in South Asia is pluralistic and access to the professional (bio-medical, Ayurvedic), the folk (astrologers, herbalists, temples, shrines and others) and popular (lay public) sectors allows clients to control the process of seeking and receiving treatment. In contrast, in Canada, with the domination of a bio-medical health care system, healers with magical, supernatural, and spiritual powers are marginalized (Popatia, 1995).

For immigrants of Punjabi Sikh ancestry in this study their confidence in non-bio-medical wellness/health care systems were of prime importance. In interpreting the use of these complementary healing systems it is important to recognise the ways in which these health systems are growing and changing and to avoid stereotyping and viewing these healing systems as exotic, unchanging, or as the 'other'. Both service providers and community members in this investigation discussed the importance of the familiar spiritual healing support system accessed by Punjabi Sikh immigrants in their new life in Canada. This complementary system of care included engaging in religious prayers or taking a spiritual journey (baptism, consulting a spiritual healer). One female community member told about her family's completion of 'Sukia Sukinee' (promises made to God for blessing) after she arrived safely into Canada.

Service provider Jasbir also gives examples, "even here [in Canada], in the community many...go to the temple...to ease their pain...this 'Baba ji'...[will give] blessing and hope that all the things [distress] will go away". The 'Baba ji', are often seen to hold wisdom and often some connection to God. Their advice is guiding the family/individual from their physical/emotional distress. Generally, most of these

spiritual healers accepted or tolerated the role of biomedicine and do not seem to have a competitive relationship (Popatia, 1995).

Carole shares that the spiritual journey, "had to do with lessening of stress and ...feeling more connected and more supported back in India, than [in Canada]". The spiritual journey to enhance family mental wellness/health may include travelling to India as well as carrying out financial commitments. As Jagdave describes:

> some go to India and get help from 'sants' or religious places. They pray...they make deals with God.... if my family members set better I will have a 'Phaat' (three days of reading the Sikh holy book)...I will donate money to temples here or send some money back home to a temple in India.

These services providers saw the use of spiritual healing as a way for Punjabi Sikh immigrants to take back control of their mental wellness/health through their spiritual journeys to be baptised, consulting spiritual healers or engaging in prayers.

Responsibility of the individual client and caregiver

Waxler-Morrison, Anderson and Richardson (1990), Henry, Tator, Mattis, and Rees (1995) and Hughes, (1993) highlight that cultural differences, respectively between mainstream and immigrant minority communities, in perceptions of the role and responsibility of the individual client, can be a barrier for immigrant minority communities' access to health services. In the mainstream, the responsibility and expectation is that the individual client is largely responsible for getting well (Waxler-Morrison, Anderson, & Richardson, 1990). The client should provide concise and relevant information about his or her symptoms to the caregiver; and the client should follow the technical recommendations of the health professional if the illness is to be cured (Hughes, 1993).

However, the fact that many minority groups consider social and health concerns to be a collective problem, affecting others as well as the person seeking help, is seen to be a significant barrier between immigrant clients and mainstream human services (Henry, Tator, Mattis, & Rees, 1995). The concept that members of both the immediate and extended family, especially elders, are expected to be involved in the assessment and treatment of the problem, conflicts with centrality of the individual which is a foundation of human services in Western societies.

Data from the service providers and the community members further supports the collective family unit's role in assessment and plan of care, as the family was often the most acceptable support considered by Punjabi Sikhs. An eighteen-year-old single male community member expressed the importance of consulting with family members for making individual decisions. He felt that "listening to and abiding to elders' wishes" would support keeping him emotionally well/healthy.

Structural factors implicated in mental wellness/health

Counter poised to the cultural and social analyses outlined in the preceding sections, there is a complementary body of theory arguing from a structural perspective on inequalities. In this perspective Canada's socially constructed health care system in which biomedicine is the dominant medical model (Jiwani, 2000, Chabot, 1999; Anderson & Kirkham, 1998) is seen as rooted in principles of individualism (Anderson, 1990). In these analyses not only is culture, but also gender, class, and racial power differences, are seen to be implicated in health care provision.

The theoretical orientations stressing analysis of structural inequalities help us to better understand challenges for minority ethnic communities in the process of resettlement and adjustment to socio-economic life in Canada. The dominance of the bio-medical health care and racism are salient dimensions. The role of employment in these

structural inequalities, as well as how employment concerns differentially affect men and women, are also of particular concern.

The understanding by Punjabi Sikh community members of structural inequalities was not apparent from this study. One reason for this may be that for many community members the primary needs of finding employment, establishing economic stability, and finding ways to continue family unity, are on the forefront. Time to think of the structural inequalities may appear later as these community members become more settled in the country. However, service providers in this investigation did highlight both structural inequalities of dominance of bio-medical health care and the existence of racism.

Dominance of Bio-Medical health care

Service providers describe difficulties in mainstream health professional's assessment of mental wellness/health distress and the plan of care for Punjabi Sikh community members because of the dominance of bio-medical model. Family counsellor, Carole, illustrates how for the family physician, even physicians of South Asian origin, understanding of mental wellness/health is embedded in the dominant bio-medical cultural notion of distress and plan of care. Such an understanding of the notion of sickness often does not allow equal referral to pluralist systems of care. For example the family physician plan of care often includes prescription drugs, which are not considered the most acceptable care by community members. The importance of the family physician is highlighted, as he/she is most common mainstream health professional accessed by Punjab Sikh community members.

When the bio-medical plan of care is not considered acceptable for community members, it is documented that complementary/pluralistic systems of care, including spiritual systems, are utilised by Punjabi Sikh community members. The spiritual plan of

care may include religious prayers and spiritual journey as discussed earlier in notion of treatment.

Racism

The racism, which exists in the mainstream health care system and acceptance of this racism by Punjabi community members, were also of concern. As a family counsellor working in a multicultural organisation, Carole gave examples of how the mainstream health services categorise all concerns of visible minorities as problems relating to immigration, even when the visible minority client is not a new immigrant. She says,

> the largest problem we have is we often get referrals where we are told from mental health centres, oh it is a cultural issue, and the assumption has been made because the person doesn't appear to be from the dominant culture. It is silliness, so they [mental health staff] are trying to fit everybody into the same box and really nervous because they can't do it...and so their idea is that well, we will call it a cultural awareness if you don't fit into this box, and will send you some place [immigrant service agency] where they can help you, which is insulting.

Carole's point illustrates how for visible minority clients, multicultural agencies are often referred to as a place of care, even if the issues presented by the client are not specifically related to cultural considerations.

Documented also in the data is the internalised racism experienced by Punjabi Sikh community members. Jagdave relates that his clients don't expect respect going in to formal mainstream health services, because of the cumulative racism they encountered from the wider Canadian society. Carole, further discusses that without acknowledging that the Punjabi Sikh community faces disrespect and racism in institutional encounters

and in encounters in the community, it is difficult to plan for overcoming barriers that exist in health care services.

Employment

The importance and stresses associated with employment were repeatedly discussed throughout this investigation. Many Punjabi Sikh community members recognised the stress and pressures of finding employment. A newly married Punjabi Sikh female relates, "in India no need to find a job...lots of pressure in Canada". Service providers also emphasised the stressful circumstances of obtaining employment for Punjabi immigrant community members, especially for individuals with higher levels of education. As Jagdave explains,

> for some because they can't speak the language, they look different, their education is not valued in Canada...even to get a job...it's easier if people were doing labour jobs back home...they'll get a quick low paying job and get on with it...those how come with an education and from wealthy families, they have the hardest time.

The research of White & Nanda (1989) and Jiwani (2000) also identify this problem of mismatch between levels of skill and employment opportunities. As illustrated by White & Nanda (1989) despite much higher than average educational levels in the Canadian population at large, the average earned incomes for both South Asian men and women are slightly less than the average Canadian population at large. Jiwani (2000) also gives examples of employment difficulties where Canadian privilege is protected. Foreign doctors or nurses from 'developing countries' have difficulty in meeting the requirements for recertification. These examples demonstrate the systemic racism in Canada's institutions, made apparent in the limited access to employment opportunities available to ethnic minority immigrant communities such as Punjabi Sikhs.

Difficulty in gaining appropriate employment can in turn create stresses to mental wellbeing.

Gender

From the data collected from the community members, high paying employment, which would be suitable to their skills and education level, was more often identified as important by Punjabi Sikh community males than females. The findings of White and Nanda (1989) also supports that more South Asian men than women, are in skilled professions and have a higher earned income.

In this study, service providers did not identify any apparent employment gender differences. However, from the Punjabi Sikh community respondents and from studies on South Asian women and employment (Naidoo, 1990; Ng, 1990; Ralston, 1991), gender differences appeared regarding the role of employment. A Punjabi Sikh female in her mid-twenties shares, "India is free life...coming here...need to find a job...[I] never learned how to find a job, work outside the home...in India, after marriage the expectation was to work inside the home".

For the female members of the Punjabi Sikh community, employment was seen as important because it provided the freedom to make one's own choices and this was connected to having their own discretionary income. Some female community members expressed it this way, "in India you are depending on you husband...because I have not found a job, I'm still depending on [my] husband".

The importance of employment has also been identified by many studies on economic variables in maintaining wellness/health (Naidoo, 1990; Ng, 1990; Ralston, 1991). From the perspective of role/identity conflict and feminist empowerment theory, Naidoo (1990) addresses the impact on "visible" Asian minority women's self-identity and self-esteem in relation to barriers to successful employment. She illustrates that for

Asian women, in addition to obstacles generated by gender, language, education/skills or Canadian work experiences, racist values that still plague Canadian society also affect employment opportunities and upward mobility for women.

Ralston (1991), suggests, that to understand South Asian immigrant women's employment experience, the dynamic interrelationships of race, class and gender must be considered, particularly with respect to their interconnectedness in specific Canadian contexts, namely, the location of immigrant women within the political economy. Without understanding the social/economic inequitable structures both outside and within the home, ethnic minority women will continue to be in positions where they are more vulnerable to exploitation, isolation and alienation.

Importance of Social, Cultural, and Structural Factors Implicated in Mental Wellness/health of the Punjabi Sikh Immigrant Community

The experiences of immigrants of Punjabi Sikh ancestry provide us with an opportunity to examine social, cultural and structural factors implicated in mental wellness/health of the community and to consider ways in which mental health professionals could better support ethnic minority immigrant communities to access appropriate mental wellness/health services.

It is commonly assumed in a variety of cultural studies that if we know how an immigrant client groups defines wellness and their customary approaches to supporting wellness that mainstream western services might be appropriately adapted and certainly adaptation would be advisable. However simply addressing the cultural dimensions does not take into account that these beliefs and practices are being inserted into entirely new social structures. Part of what is new is the Canadian mainstream services but another part that is new is the social configuration of the Punjabi family, health and occupational practices, as these are re-structured by mainstream society. Changes in patterns of

sociability, employment, gender relations and relations between the generations are now part of the new social system within which cultural beliefs and practices in health must operate.

Therefore in providing assistance to Punjabi-Sikh immigrants it is essential to look not only at the cultural practices but also at the new social structures in which these will need to be practised. There are possibilities for these changed circumstances creating opportunities for new approaches for both mainstream and minority immigrant communities.

At present because of the privileged positions and structural power of mainstream health and employment systems and the way these construct family and community life, the possibilities for acknowledging and supporting minority practices and meaning system are minimised. Nevertheless these meanings and practices do endure and provide potential complementary systems of well being for Punjabi Sikh as well as other groups in Canada.

Recommendations

Documenting the social, cultural and structural circumstances of the Punjabi Sikh immigrant community may provide valuable insight in providing culturally responsive services by mainstream and immigrant servicing mental wellness/health service providers, planners and for Canadian society at large.

To provide culturally responsive mental wellness/health services for clients of Punjabi Sikh ancestry, there first needs to be an understanding of complexities: the social, cultural and structural factors involved in mental wellness/health distress of the client. For example, realising Punjabi Sikh immigrant women may be faced with the stresses associated with unemployment, low income, lack of own family support, change in gender role, change in economic position in family unit, stress of marriage, stress of

maintaining a household as well as the stress of trying to bring family members over from Punjab gives insight into the complexities of care.

Culturally and Structurally Responsive Strategies for Mental Wellness/health: Roles of Service Professionals

Service professionals need to acknowledge that there are differences between mainstream and Punjabi Sikh meaning systems relating to mental wellness/health. For example, the intake person should be knowledgeable about the interconnections of family and the individual; responsibility of the individual client; the interconnection of physical and mental wellness/health; cultural and social interconnections; notion of sickness; and notion of treatment. Giving equal respect to the Punjabi Sikh complementary practices of health care without stereotyping should be part of the frame of reference for the intake professional.

Secondly, intake professionals need to make use of assessment processes, which address the social, cultural and structural factors salient in their clients' lives. For example, in one section of the assessment, have a variety of questions, which address not only mental health, but also, the physical health and the economic circumstances of the client. In a second section, have a set of questions on the social and cultural environment. For example: Which members of the family do you consider supportive? Which members of the family are contributing to the mental wellness/health distress? Are you separated from family members who would have customarily supported you during mental wellness/health distress? In a third section, have questions, which address structural factors. For women, it may be the stress of employment, the changing of her role in the family socially and economically, and how these factors are implicated in her and her family's mental wellness/health.

Thirdly, the intake person needs to develop a plan of care, which supports the various social, cultural and structural factors. For example, if a Punjabi Sikh client has expressed the need for consulting a spiritual healer, the intake person needs to acknowledge and include this in the overall plan of care of this client.

Finally, intake professionals need to take a pro-active role to insure that their agencies, mainstream and immigrant servicing, bringing these issues to the attention of program funding sources such as Ministry of Health, and other government agencies.

Culturally and Structurally Responsive Strategies for Mental Wellness/health: Planners

In planning culturally responsive mental wellness/health services for clients of Punjabi Sikh ancestry, social and health planners need also to understand social, cultural and structural complexities involved in mental wellness/health distress of the client. Such an understanding in planning could lead to provisions for programs, which provide equal access to complementary along with the biomedical health care. Planning should take a holistic approach, which provides support not only for specific episodes of emotional distress but also support for issues relating to the broad ranging stresses of family, racism, or employment. For individuals in the Punjabi Sikh community an effective care plan will need to examine the social context, view the circumstances from a community perspective and develop a care plan which includes the interlinking of the extended family in Canada and possibly in the country of origin as well.

Popatia (1994) suggests when planning mental health programs for the South Asian community, related economic issues of hidden and direct financial costs, time schedules and program content would have to be addressed and negotiated in order to maximise effectiveness. For example, to state that a group of Indo-Canadian women

were not motivated for therapy because they did not take time off from work to attend weekly sessions would not be a fair statement in light of their economic situations.

As Canadians, we have been asked by government to recognise that immigrant communities play a vital role in the country's social, cultural and economic structures. Having mainstream health services accessible to the Punjabi Sikh community, and other ethnic minority communities living in Canada, is going to require not only a social and cultural, but also a structural shift. It is going to require a mainstream set of structural arrangements, which allow for plurality.

Culturally responsive health services should include acceptance of the collective and individual understanding of health care, and equal access to complementary/pluralistic and biomedical health care not only for minorities but for mainstream individuals, families and communities who are also finding that the stresses of life in contemporary Canada cannot always be most beneficially addressed by biomedical approaches. In a truly multicultural/pluralistic society all members would be able to select from a range of approaches enriched by a variety of cultural meaning systems about what is necessary for individual and communal health and wellness. Removal of structural barriers to employment and racism in the society at large would also lead to a less fraught process of settlement. Mainstream and immigrant serving agencies need seriously to consider how they can become involved in preventative care by dismantling the racism and structural barriers that contribute to stress.

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Glossary of Terms

Family Class or Family : One of three classes of admissible immigrants under the 1976 Immigration Act, formed of close relatives of a sponsor in Canada. Includes the sponsor's spouse, unmarried children under age 21, parents and grandparents.

Mainstream: It refers to individuals, communities or institutions, which are similar to the English/French Canadian culturally and ethnically. A term, which defines Canada's image of a multicultural society where all cultures, have equal status and none more power than others.

Multiculturalism: The official ideology of cultural pluralism, where all cultures have equal status and merit in Canadian society, and none have more power than another. Multiculturalism policies promote integration, not assimilation, of minority group into society.

Stress: Resulting from a situation or experience which overwhelms the individual's typical ways of coping and which usually results in a reaction, physical or psychological, or both.

Ayurvedic medicine: the indigenous component of the professional sector in South Asian medicine. It is the science of long life, a formal paradigm based on principles of five basic elements of the universe (wind, water, earth, and fire), three humors and seven physical components of the body. Health is maintained when the three humors of body, wind (*vata*), bile (*pitta),* and phlegm (*kapha*), are in harmonic balance. When the five basic universal elements contained in food are processed in the body, they are transformed into seven components: food juice, blood, flesh, fat, bone marrow, semen (Obeyesekere, 1982).

Glossary of Punjabi Words

dil ghirda hai: the heart is sinking or falling

dimaag: brain

sukia sukinee: promises made to God for blessing and completion of promises when blessing has occurred.

Baba ji: perceived person of spiritual healing powers.

Sants: spiritual/holy person

Phaat: continuous Sikh religious prayer or reading from the holy book (could be three days or shorter)

Kismet: destiny, fate

Mere Karam: my destiny, fate

Guruanth Shab: Sikh holy book

Junam Pahhra: scriptures relating to birth date and time

APPENDIX I

Profile of the Current South Asian Population in Canada

According to1996 Canadian census, there were 353,515 South Asian immigrants in Canada. From the period 1991to 1996, 140,055 South Asian immigrants arrived in Canada, 40% of the total immigrant South Asian population. Table-1 illustrates the growth of the South Asian population from 1961 to 1996.

Table-1

South Asian population by birth and period of immigration, 1996 Canada Census

Place of birth	Total Immigrant Population	Before 1961	1960-1970	1971-1980	1981-1990	1991-1996
Southern Asia	353,515	4,565	28,875	80,755	99,270	140,055
Period of Immigration		1.3%	8%	29%	28%	40%

Geographic concentrations in Canada

The South Asian population is concentrated in three Canadian provinces: Ontario, British Columbia and Alberta (White & Nanda, 1989). In 1996, 90% of all South Asians lived in Ontario (58%), British Columbia (24%), and Alberta (8%). Table-2 composes a 1996 provincial distribution of the South Asian population in Canada.

Table-2

Provincial Distribution of South Asian Population 1996				
	Canada	Alberta	British Columbia	Ontario
Total South Asian Population	590,145	46,515	141,750	342,375
Percentage of Total Population		8%	24%	58%

The South Asian Population in British Columbia

In 1996, British Columbia had the second largest immigrant population after Ontario. The ethnic composition of the South Asian foreign-born population in British Columbia has changed since 1986. The proportion of South Asian immigrant population increased from 8 percent of the immigrant population in 1986 to 10 percent in 1996. The two charts below (Figures 1 and Figures 2) illustrate the change in British Co South Asian population the ten-year period of 1986 to 1996.

Figure 1

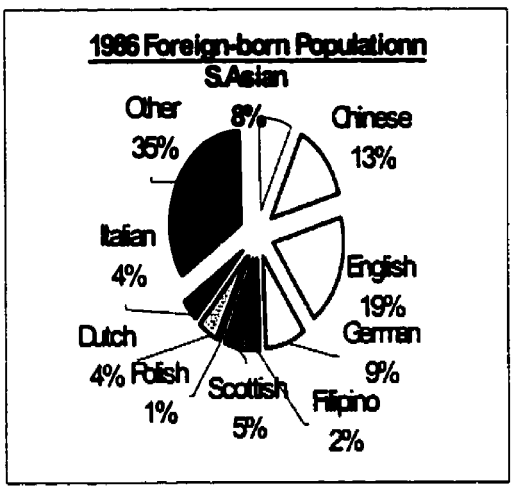
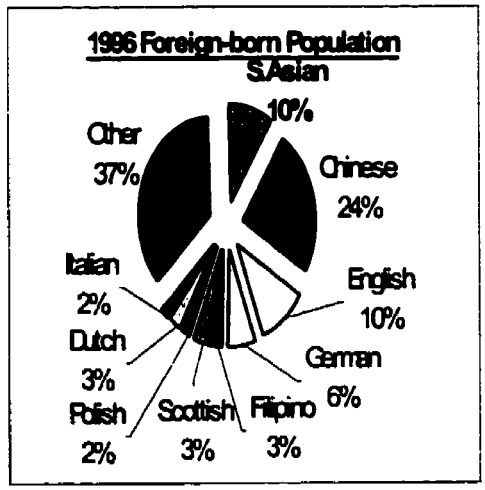


Figure 2



Migration to Large Urban Centres

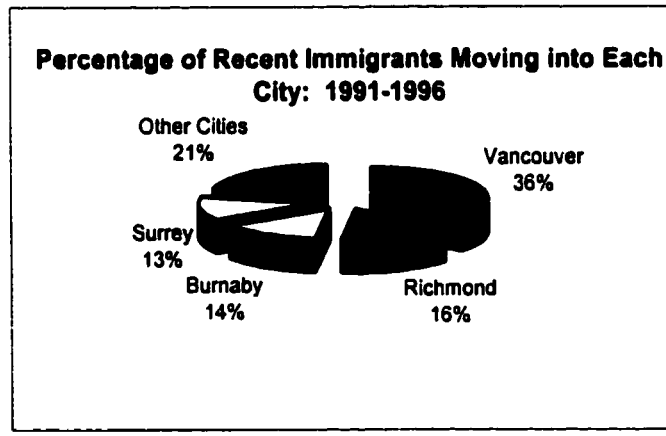
Overall, immigrants accounted for over 24% of British Columbia's total population in 1996, compared with 22% in 1991. Seven of every ten immigrants in British Columbia lived in the census metropolitan area of Vancouver, compared with four in ten of the province's Canadian-born population. The settlement patterns of these immigrants upon arrival to Canada display that immigrants, particularly recent arrivals, are more likely than people born in Canada, to live in large urban centres.

The South Asian Population in the Greater Vancouver Regional District

About 88% of the recent immigrants to British Columbia chose to live in the Greater Vancouver Regional District (GVRD). The GVRD consists of fourteen cities. The largest are Vancouver, Richmond, Burnaby, and Surrey. Immigrants accounted for over a third (35%) of Greater Vancouver Regional District's population in 1996, making it the census metropolitan area with the second largest immigrant population in Canada. The GVRD attracted 18% of all recent immigrants to Canada, three times higher than its share of Canada's total immigrant population (6%) as reported in 1996 census.

From 1991 to 1996, Vancouver took in the largest number of recent immigrants, followed by Richmond, Burnaby, and Surrey (Figure3).

Figure 3



The Majority of immigrants from India (56%) settled in Surrey, while 19% chose Vancouver (City of Surrey, Planning & Development Department). A change in the Greater Vancouver Regional District of South Asian foreign-born population from 8 percent in 1986 to 11 percent in 1996. Figure 4 and 5 below illustrate the change in South Asian population the Greater Vancouver Regional District from 1986 to 1996.

Figure 4

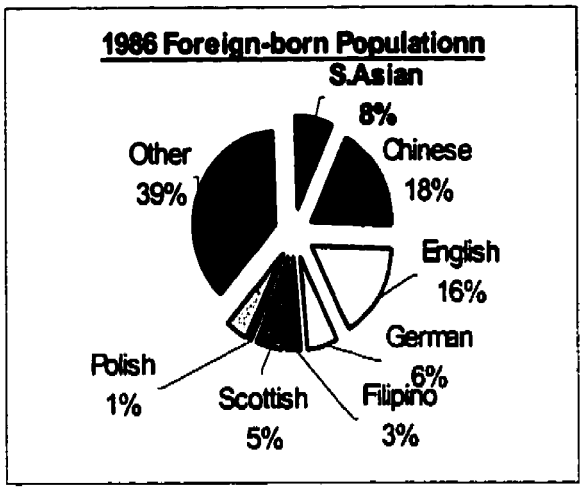
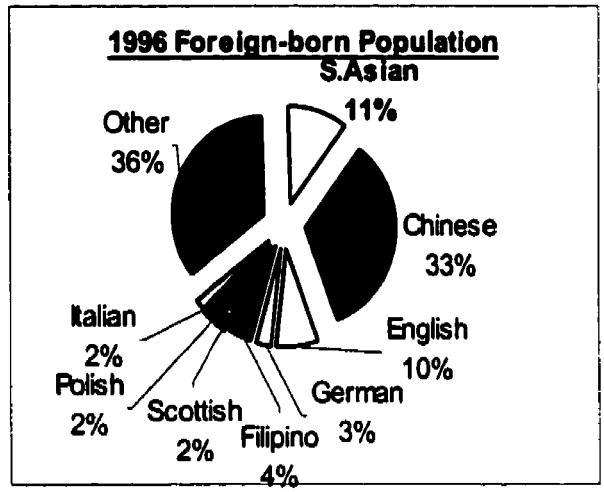


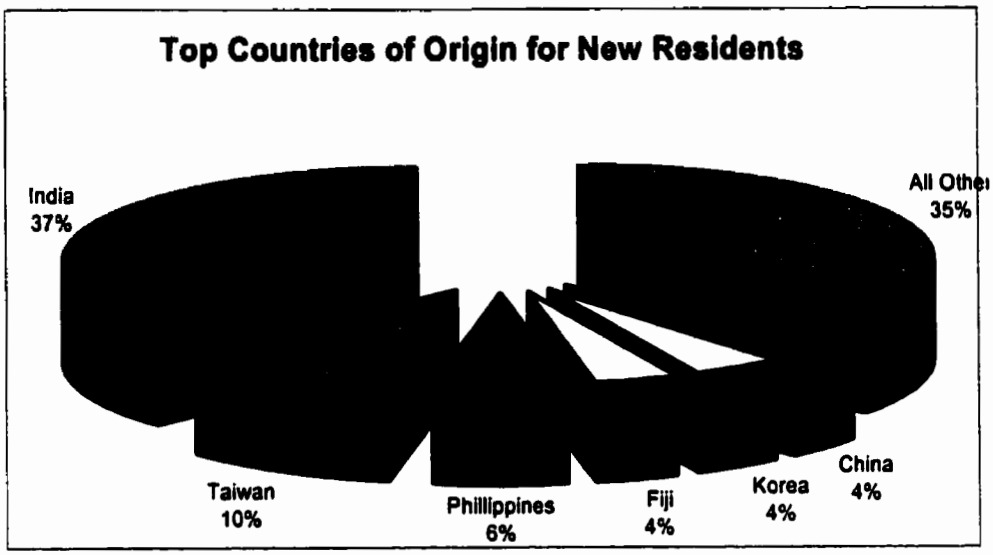
Figure 5



The South Asian Population in Surrey

In the Greater Vancouver Regional District, the City of Surrey in 1996 had a foreign-born population of 89,975 second only to Vancouver with 228,230. For the City of Surrey, immigration was a major part of population growth between 1991 and 1996. During this period, there were 24,230 new residents to Surrey from another country, accounting for about 41% of Surrey's total population growth. The majority, 37% came from India, with 10% from Taiwan, 7% from Fiji, and 4% each from South Korea and China (figure 6).

Figure 6



The ethnic composition of the foreign-born population in Surrey changed significantly between 1986 and 1996. The proportion of the foreign-born population of South Asian ethnic origin increased from 14 percent in 1986 to 33 percent in 1996. Figure 7 and 8 below illustrate the shift in the South Asian population in this ten-year period.

Figure 7

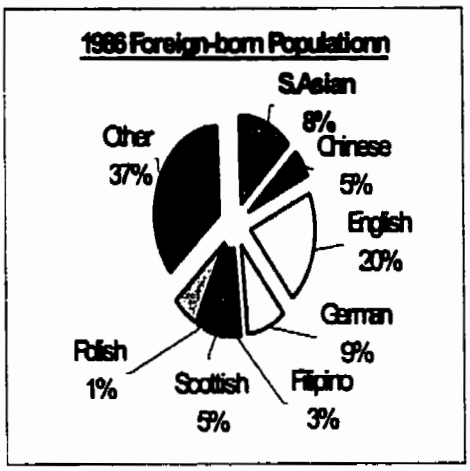
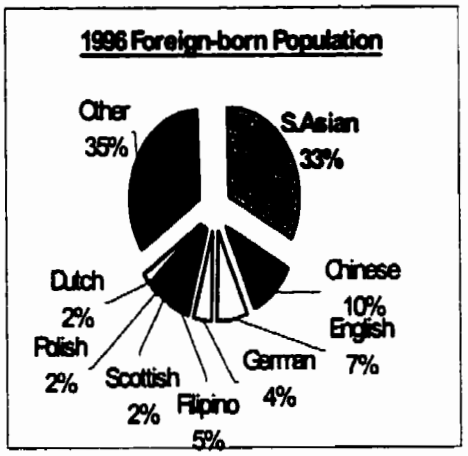


Figure 8



Immigration by Language: Canada

The changing sources of immigration have also influenced the presence of languages other than Canada's official languages (English or French), and reflect the ethnic and linguistic diversity that characterises the nation. Almost 80% of the 1,039,000 immigrants who came to Canada between 1991 and 1996 reported a non-official language as mother tongue in the 1996 Census. Mother tongue is the first language learned at home in childhood and still understood by the individual. After Chinese, Punjabi, Arabic and Tagalog were the three other non-official language groups, which had the strongest growth between 1991 and 1996. The non-official mother tongues (table-3) below exhibits, Punjabi is the third most frequent non-official mother tongue in Canada.

Table-3

Non-Official Mother Tongues in 1996

Home Language	Number	%
Chinese	630,520	2.2
Italian	258,050	0.9
Punjabi	182,895	0.6
Spanish	173,040	0.6
Portuguese	142,975	0.5
Polish	137,330	0.5
German	134,615	0.5
Arabic	118,605	0.4
Tagalog (Filipino)	111,865	0.4
Vietnamese	102,905	0.4
Aboriginal Languages	146,120	0.5

The Indo-Punjabi Population in Canada

In Canada 154,485 report Punjabi as a mother tongue. British Columbia has the largest Punjabi speaking population in Canada, 48% of the Punjabi speaking community of the country overall. Ontario has the second largest, followed next by Alberta. What is significant for this present research that while, Ontario has larger South Asian population than BC, the number of South Asians who speak Punjabi is larger in British Columbia. The provincial distribution of South Asian languages (table-3) provides an overview of the provincial distribution of Punjabi speakers.

Table-4

Provincial Distribution of South Asian Languages				
	Canada	Alberta	British Columbia	Ontario
Punjabi	154,485	12,325	74,015	58,570
Percentage of Population		8%	48%	38%

The Indo-Punjabi Population in British Columbia

In British Columbia the most common South Asian languages are Punjabi, Hindi, Gujarati and Urdu. Census data from 1996 indicates, 74,015 individuals are Punjabi speaking (85%), 8,995 are Hindi speaking (10%), and 2,940 are Gujarati speaking (3%) and 1,555 are Urdu speaking (2%). Table-5 provides a comparison of the four most common South Asian languages in British Columbia.

Table-5

Punjabi in Comparison to other South Asian Languages in British Columbia		
	Total	
South Asian Languages	87,505	Percentage of South Asian Population Speaking Language
Punjabi	74,015	85%
Hindi	8,995	10%
Gujarati	2,940	3%
Urdu	1,555	2%

The Indo-Punjabi Population in the Greater Vancouver Regional District

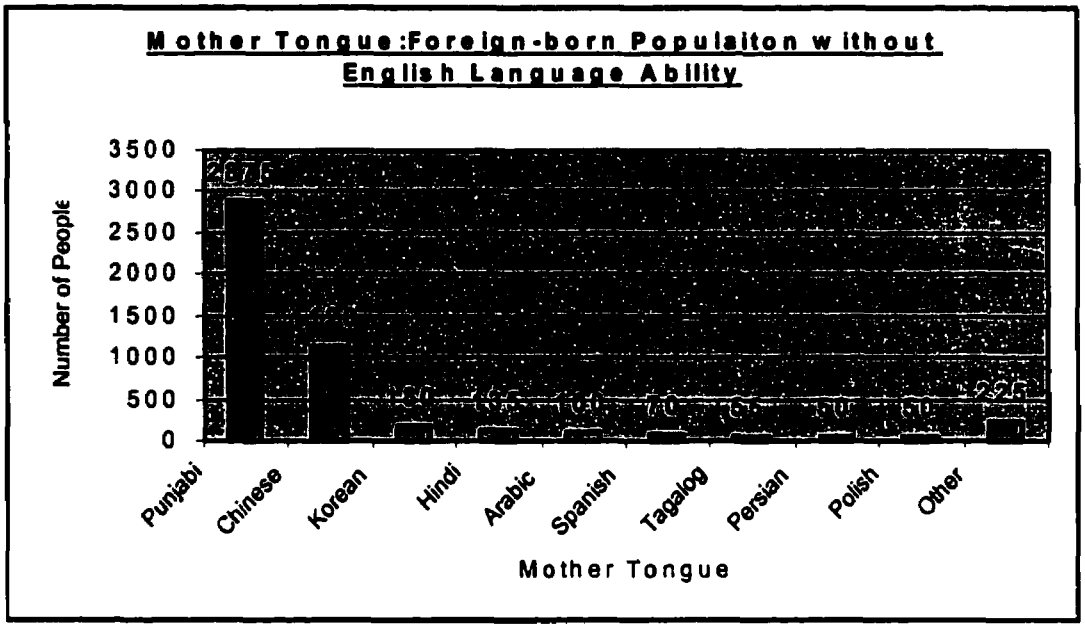
The changes in immigrant population both in Canada and British Columbia over the past five years has also greatly increased the language diversity of all GVRD cities. Overall, 34% of the people in the GVRD had non-official language as their mother tongue, with 30% of the residents the city of Surrey have a non-official language as their mother tongue.

The Indo-Punjabi Population in the Surrey

In the City of Surrey, Punjabi has the largest number of non-official language speakers. Of the recently arrived (0 to 5 years in Canada as of 1996) foreign-born population without

English language ability, 59 percent had the mother tongue of Punjabi. Table-5 illustrates the foreign born population without English language ability; Punjabi speakers are the largest numbers.

Table-6



City of Surrey, Planning & Development Department

APPENDIX II

INTERVIEW QUESTIONS (service providers)

1. What is being well/healthy mean to your clients? (elaboration of physical, mental)
2. Do you see the process of immigration influencing clients' mental/physical health?
3. What are some of the common mental health issues your clients identify?
4. What kind of things do you see clients doing to keep emotionally well/healthy?
5. What kind of things do they do to prevent emotional illness?
6. Who would they go to find out more about ways to stay emotionally healthy?
7. Some people in the culture wear religious thread because they believe that it will prevent illness or heal them, do you see these similar types of beliefs or practices?
8. How is karma or fate seen in relation to mental health?
9. When clients require help with mental illness, where do they get this information?
10. What problems (if any) do you see when they try to use this information or advice?
11. Where do clients go when they have questions or concerns of mental health issues? Family, relative, or close friend? South Asian healer? Religious leader or place of worships...a western doctor, or mental health centre?
12. What difficulties have been seen in getting them information they need from: -family, relative, or close friend? South Asian healer? Religious leader or place of worship? A western doctor or mental health centre?
13. How do you see them getting over these barriers?

APPENDIX III

INTERVIEW QUESTIONS (community members)

1. What does being well/healthy mean to you? (could elaboration of physically, mentally)
2. Before immigrating to Canada do you recall yourself having not being well/healthy? (probe for mental health)
3. After you immigrated, what kind of mental health changes did you see in yourself?
4. What kinds of things did you do to keep emotionally well/healthy?

As culturally appropriate – could ask:

(Example) Some people in our culture wear a religious thread because they believe that it will prevent illness or heal them, do you/your family have similar beliefs or practices?

5. What kinds of things did or do you do to prevent emotional illness?

As culturally appropriate – could ask:

Some people in our culture drink holy water because they believe it will heal them, do you have similar beliefs?

8. How do you see karma or fate in relation to mental health?
9. Who have you gone to find out more about ways to stay emotionally health?
   Family, /relatives/close friends?
   South Asian healer?
   Religious leader or place of worship?
   Western doctor or Mental Health centre?
10. If you have questions or concerns about mental health issues where would you go to:
    Family, /relatives/close friends?
    South Asian healer?
    Religious leader or place of worship?
    Western doctor or Mental Health centre?
11. What difficulties have you had in getting the information you need from?
    Family, relatives, or close friends?
    South Asian healer?
    Religious leader or place of worship?
    Western doctor or Mental Health centre?

12. What are some difficulties you have experienced in getting the mental health care you desire or need?
13. How do you see yourself getting over these barriers?

APPENDIX IV

Summary of Demographic Information (community members)

The following is a summary of the demographic information of the twenty Punjabi Sikh community members interviewed:

Male: 8
Female: 12

Age: range of ages varied between 18 to 62

Level of Education Completed:
2 - Grade School
7 - High School
9 - College (most in the process completely BA)
2 - University (MA)

Current Employment Status: 14 - full-time students
5 – full-time student, working part-time

Marital Status:
12 - Married
8- never been married

# of years in Canada: range varied between 1 month to 3 years

Country of Origin: all 20 were from Punjab, India

Coming from living in:
Urban settings: 1
Rural settings: 19

Immigration type: All 20 came to Canada through family sponsorship