Accessing Mental Health Services for their Children:

Experiences of South Asian Parents

by

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Abstract

Past research has shown a lack of South Asian utilization of mental health services which has been attributed to the different values and beliefs of this minority group. Little is known about the experience of South Asian parents who have attempted to seek mental health services for their children. The qualitative methodological design chosen to conduct this study was a collective case study. Community mental health team case managers and psychologists assisted in recruiting the participants. Six South Asian parents were interviewed using an interview guide. Before each interview parents were asked to complete a demographic questionnaire. Data analysis occurred simultaneously with data collection. Both single case and cross case analyses were performed. Spirituality played a major role in the parent's ability to cope with their child's mental health condition. South Asian parents in the present study respected and valued the role of the general practitioner and psychiatrist and attributed their child's wellness to these professionals.

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Acknowledgments

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Chapter One: Introduction

A considerable proportion of children living in Canada belong to minority ethnic groups. Mental health professionals recognize the growing need to improve services to ethnic minority children. Examining the impact of Western cultural values on ethnic minority children and their families during therapy has become an area of active research. In particular, researchers have begun to examine the reasons for underutilization of mental health service by specific cultural groups including South Asian families.

Overview of Topic

Over the past decade, many reasons have been given for South Asians underutilizing mental health services. A recurring but largely unexamined explanation of this underutilization has been cultural differences in beliefs about mental illness (Bhui, Strathdee, & Sufraz, 1993; Nickerson, Kim, Helms, & Terrell, 1994; Snowden & Cheung, 1990; Sussman, Robins, & Earls, 1987). Although stigma surrounds mental illness across all cultural groups, some cultural groups can overcome the stigma in order to seek support related to mental illness. Research indicates that South Asians find it much more challenging to let go of the stigma attached to mental illness and this interferes with their ability to seek support (Beliappa, 1991; Bhui et. al., 1993; Gupta, 1992; Jawed, 1991; Lloyd, 1993; Yamamoto, 1982). In addition, South Asians have a collectivist culture in which family members are able to support each other (Gupta, 1991; Laungani, 1999; Lin, Miller, Pollared, Nuccio & Yamaguchi, 1991; Nazroo, 1997). Many South Asians have found the attitudes of professionals as being at odds with their family beliefs and hence this impacted their receptivity to mental health services and effectiveness of mental health counsellors (Leong & Lau, 2001; Sue, Zane & Young,

1995; Tseng & McDermott, 1981; Tsui & Schultz, 1985). Most cross cultural mental health research to date has involved the use of surveys, scales, and questionnaires with college students. Few researchers have investigated the experience of families of children with a mental illness in the South Asian community. All families face multiple stressors in dealing with persons whose disorders may make them difficult to care for. Families must learn to cope both with the family member's behaviour and their own reactions; to balance the ill family member's needs against those of other family members; and to perceive when expectations are too high or too low. This experience would involve dealing with unwarranted guilt feelings, learning to handle their anger, tolerating the suffering of people they love, and avoiding being overwhelmed by the pain. Specifically the importance of understanding the impact on parents of mentally ill children in the South Asian community is essential as they play an important role in the daily lives of their children. Mental illness is subject to greater complexities of causation, definition of what constitutes deviant behaviour, and diagnosis. Objective verification is more difficult to determine than most aspects of physical illness. These complexities are compounded when dealing with South Asian parents for whom the perception and manifestation of mental illness may be different, and for whom English may not be the first language.

Significance of Topic

South Asian participation in mental health services needs to be understood due to the rapidly growing population of South Asians residing in Canada. According to Statistics Canada (Belanger, 2002) the dramatic increase in South Asians residing in Canada has been related to immigration from the countries of India and Pakistan. Immigration from these two countries ranked second and third in the total number of

immigrants to Canada in 2000, with 28,200 and 14,900 immigrants respectively. The number of immigrants from India in 2000 increased by 9,300 which is a 50% increase over the 18,800 admitted in 1999. The Pakistani contingent grew by 5,300, an increase of 55% compared with the figure for the previous year. Next to Ontario, British Columbia attracts the most immigrants, about 16% of new immigrants in 2000. Specifically, Vancouver, BC attracted a tenth of the total number of immigrants to Canada in 2000.

The major tasks facing immigrants are associated with meeting their physical, material, and emotional needs that are required for settling into the new host society (Hong, 1989; Hong & Ham, 1992; Lee, 1996; Shon & Ja, 1982). Their immediate attention is directed toward taking care of basic physical and economic needs, such as finding new jobs, and, for children in a family, starting new schools. On a family and societal level, adjusting to the new host society involves rebuilding one's support network and getting used to new family roles and routines. On the psychological level, migration involves a cognitive, structural, and affective transition to the new host culture (Shon & Ja, 1982).

Employment Issues. Finding employment in Canada is usually not a straightforward procedure for Asian immigrants (Hong & Ham, 1992; Lee, 1996; Shon & Ja, 1982). Employability of immigrants not fluent in English is usually limited to their own ethnic community. Some of these immigrants may eventually broaden their employability by attending English classes. However, this is not always feasible for those who are already busy trying to earn a living and raise a family. Even immigrants who are educated and fluent in English may have difficulty finding new jobs in the United States (Hong, 1989; Lee, 1996). Some may find their pre-migration work experience discounted

by employers. They may also encounter racism manifested through barriers of promotion. Others may hold professional credentials unrecognized in Canada.

School Issues. Adjusting to a new school system is a major stressor for many immigrant Asian families (Hong, 1996). Schools in Asia are much more structured and regimented, with stricter rules and regulations, than the public schools in Canada. For example, in India, students are typically required to wear school uniforms, and they accord high respect to teachers and other school personnel. In the classroom, students in India tend to stay quiet and listen to the teacher, and they are not accustomed to the open discussion format often encouraged in Canada schools. The more flexible, egalitarian and participatory atmosphere in Canadian schools, especially at the high school level, is often confusing for immigrant South Asian parents and their children. Some teenagers, for example, in their efforts to fit in with their peers, may overzealously respond to this more relaxed atmosphere by setting aside their parents' traditional discipline or motivation for academic achievement. Hence, immigrant parents often complain to teachers that not enough homework is assigned to their children, while the teachers advise them not to put so much academic pressure on their children. This incongruity is a constant point of misunderstanding between immigrant Asian parents and the public schools, as well as a source of tension between these parents and their children (Hong, 1996).

Most immigrants come to Canada, with the hope of creating more opportunities for their children; opportunities that these immigrant parents never had growing up in India. Hence, education holds a strong value in South Asian families. South Asian parents place a lot of emphasis on their child's performance in school and will encourage their

children to devote a lot of time to their studies. Parents are very concerned when their children need to miss school and encourage daily attendance; unless, the child is very ill.

The implications of this immigration for professional counsellors and mental health services providers include the need to increase their cultural sensitivity, knowledge of cultures, and culturally relevant counselling skills in order to meet the needs of the South Asian population. Mental health services need to be structured to optimize utilization by and effectiveness for ethnic/racial minority populations.

All families of the mentally ill, regardless of ethnicity, often endure years of uncertainty, disappointment, guilt, and anguish. An extreme sense of loss can be expected among parents who learn that their child has emotional and behavioural problems (Rando, 1986; Woolis, 1992). For parents the disability represents the loss of the wished-for normal child as a child is both a biological and a psychological extension of his or her parents (Keats, 1997). When an individual becomes mentally ill as an adolescent or young adult, parents have already accumulated an array of past images and experiences (Terkelsen, 1983) that forms the basis on which they project future hopes for their child. In the South Asian culture, these feelings of guilt and anguish are further compounded due to the stigma attached to having a child with a mental illness in the South Asian culture. South Asian parents who believe that their sons will take care of them in their old age often grieve the most, having the knowledge that their sons may not have the capacity to become caregivers to them.

Researchers have repeatedly documented the impact of mental illness in terms of family or caregiver burden; that is, the overall level of distress experienced as a result of the illness (Clark, 1994; Maurin & Boyd, 1990; Solomon & Draine, 1995). Research

utilizing surveys to determine what families wanted from mental health professionals identified families as wanting to be appropriately involved in treatment decisions; needing information about mental illnesses, including diagnosis, symptoms, and treatment options; understanding medications and their side effects; gaining concrete suggestions on how to manage troublesome behaviours; interacting with people who had had similar experiences; and understanding from friends, relatives, and professionals (Hanson & Rapp, 1992; Herman, 1997; Holden & Lewine, 1982). These surveys were conducted with largely white, educated, older, middle-class parents. The scant research describing how minority families view and cope with mental illnesses indicated sufficient difference in perceived burden, satisfaction with mental health services and concept of the ill member's problem to warrant caution in generalizing from non-representative surveys to all families and cultural groups (Guarnaccia, Parra, Deschamps, Milstein, & Argi, 1992; Lefley, 1994a).

In some cases of mental illness, extended family members play a central role in caregiving, including grandparents, aunts, uncles, cousins, and even close friends who function as informal members of the extended family. Family caregiving responsibility is also related to gender and marital status. Not surprisingly, researchers have found that taking care of relatives with mental illnesses is largely a female responsibility, one that intensifies the family burden (Birchwood & Cochrane, 1990). Mothers manifest higher levels of anxiety, depression, fear, and emotional drain than fathers (Eisner, 1990; Manuel, 2001; Russell & Russell, 1987; Thompson & Gustafson, 1996). Numerous variables influence the impact of mental illness on individuals and families, including their particular strengths and limitations, their roles and responsibilities, and other prior

or current problems. Increasingly, practitioners are also focusing on the role of culture and ethnicity on mental illness. In the past, professionals were often encouraged to maintain a stance of "cultural blindness" based on an assumption that effective practice required only an absence of bias (Fish, 1996). The current philosophy urges therapists to acknowledge and respect different cultures and to provide culturally sensitive services for patients and families. Therapists and psychologists are increasingly motivated to understand culture and ethnicity factors in order to provide appropriate psychological services. The American Psychological Association's Board of Ethnic Minority Affairs established a Task Force on the Delivery of Services to Ethnic Minority Populations in 1988. The DSM–IV now includes an outline for cultural formulation that is considered to be important when diagnosing clients from different cultural groups (Rogler, 1996). Unfortunately, many minority families find mainstream mental health services alien to their cultural values and traditions (Bhugra, 1997; Bhui, 1996). As a result, they may choose not to seek services, may terminate services prematurely, or may find treatment unhelpful.

Statement of Problem

The use of mental health services by the South Asian community has been studied using quantitative measures to highlight its underutilization by this group (Bhui & Takeuchi, 1992; Cheung & Snowden, 1990; Leong, 1994; Sue & Morishima, 1982). Surveys have been the primary data collection tool. However, these quantitative studies do not provide details of the subjective experience of the South Asians who do access mental health services. The importance of understanding the subjective experience of South Asian parents is that it may give insight into the realities of mental illness in their

homes and the thought processes involved in the decision to access and then utilize mental health services. Therapists often state that what happens with a client outside of the therapist's office is just as or more important than the clients' presentation inside the office. An understanding of the parents' experiences at the mental health center appointments and their experiences between appointments may assist professionals in gaining insight as to how parents present in mental health centers.

Based upon the absence of guidelines for professionals working with South Asian parents, the goal of this study is to examine the experience of South Asian clients utilizing mental health services. The current study is an in-depth analysis of the experience of South Asian parents that have a child with a mental illness as they seek support, from pre-diagnosis, through diagnosis, and then therapeutic intervention. This study will attempt to recognize the values and beliefs that guide the decision making of parents in dealing with their children's emotional difficulties.

The research questions chosen to highlight the experience of South Asian parents seeking mental health service for their child are as follows:

a) How do South Asian parents perceive mental health service?
b) How do South Asian parents decide when to consult with mental health service?
c) How does seeking mental health service fit with the South Asian parents' values and beliefs around mental illness?
d) Are there difficulties that South Asian parents face in accessing mental health services? If so, what are they?

Addressing the research problem will help develop an understanding of the experiences of South Asian parents whose children have emotional and behavioural problems. By developing a better understanding of the experiences of and challenges faced by South Asian parents, professionals will be better able to identify service gaps and service practices that act as barriers to this group. Additionally, community and social networks that facilitate or inhibit help-seeking may also be determined. By seeking recommendations and knowledge about barriers and facilitators to help-seeking, mental health and other helping professionals will be better able to supplement family and informal sources of help.

Parents were chosen for this study because they have the primary responsibility to decide whether or not to seek mental health services for their child who exhibits mental health symptoms. Although there are studies that focus on South Asian adults and college students seeking mental health services for themselves (Tracey, Leong, & Glidden, 1986) there is an absence of research concerning South Asian parents accessing service for their children (Bhugra, 1997). The focus on child and youth mental health has been on the children, with parents seen at the periphery of treatment, because the parents have been labeled "difficult to access" by psychologists and therapists (Hatfield, 1987).

South Asian parents may have a difficult time in accessing mental health services not only because of the stigma attached to mental illness within this cultural group (Srebnik, Cauce, & Baydar, 1996) but also, because they may experience difficulty in navigating the pathway to help-seeking for their child due to service characteristics including lack of transportation to visit mental health centres, wait-lists, inconvenient hours, distance to services, and language barriers (Srebnik et al., 1996). Some increase in

stressors at time of diagnosis is anticipated since the experience of mental illness could involve changes within the family, for example, difficulties in parenting.

Research in the past has shown differences in strategies of coping with stress in terms of internal and external targeted control strategies (Tweed, White, & Lehman, 2004). Theoretical models of stress and coping suggest that the effects of stress on parents are mediated by their cognitive appraisals and coping mechanisms (Lazarus & Folkman, 1984). According to Lazarus and Folkman, internal emotion-focused coping involves attempts to manage emotional reactions to stressful encounters including self-control, distancing, accepting responsibility, and positive reappraisal. In contrast, problem-focused coping includes planned problem solving and acting to alter the external world. Parents from a South Asian background are more likely than parents from a Western background to respond to stressful encounters by accommodating themselves to the demands of the environment, that is utilize an internally emotion-focused coping strategy. Parents from a Western background would more likely attempt to control or alter the environment; that is, an externally emotion-focused strategy. Several cultural variables increase the likelihood of South Asian parents to be internally controlling. South Asian parents, who come from a collectivist culture in which in-group harmony is emphasized, would not want to generate reactivity from others or jeopardize disrupting relationships (Parekh, 1996). In general, insight-oriented and psychodynamic therapies emphasize internal conflicts and difficulties with the personality of the individual and blame the client for his or her own problems. Many clients from the South Asian community believe that problems in their life emerge because of external conflicts with the environment and that other people should be blamed for their problems.

Research Purpose

Given the lack of knowledge regarding the experiences and needs of South Asian parents whose children have a mental health disorder, it is essential to examine what parents encounter when they seek mental health services. The purpose of the present study, therefore, is to develop a comprehensive understanding of the experiences, perceptions, and recommendations of parents whose children have mental health problems in order to enhance knowledge of how parents function and perceive and use social support. Parents views of their child's mental illness and the strategies used to cope and function in the face of this responsibility will be explored. Parents' perspectives on whether mental health service is beneficial to their child, the difficulties in utilizing mental health services, as well as their recommendations for increasing the accessibility of these services in the future will be examined.

Definition of Terms

In order to understand the research a few key terms will be defined.

Culture: "[A] set of explicit and implicit guidelines which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces of Gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation – by the use of symbols, language, art and ritual" (Helman, 1990, p. 216).

Ethnic group: "[A] social group characterized by distinctive social and cultural tradition, maintained with the group from generation to generation, a common history and origin, and a sense of identification with the group. Members of the group have distinctive

features in their way of life, shared experience, and often a common genetic heritage" (Last, 1995, p. 985).

South Asian: Similar terms are used in the literature to describe the population under study including Black, Asian Indian, Southeast Asian, East Indian, and Indo-Canadian. South Asians are individuals whose origins can be traced to India, Sri Lanka, Pakistan and Bangladesh.

Mental illness: "a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (American Psychological Association, 2000, p. xxxi).

Reflexivity

As a qualitative researcher it is important to locate myself in my research and to provide readers with my background, knowledge, and skills as a therapist. Prior to conducting this study I had completed approximately three years of therapeutic training at different community mental health teams. During this time; however, I had worked with South Asian clients individually and in the context of family. I noticed the under-representation of South Asian parents in the mental health system. I have both theoretical knowledge and practical experience of the impact of mental illness on South Asian children and families. I have witnessed how South Asians have been labeled by the mental health system as 'resistant' or 'in denial'. Being of South Asian origin myself I can understand some of the issues of stigma and shame around mental illness that exist in the South Asian community. A consequence of this was my research topic choice of mental health services and accessibility of these services for South Asian parents.

I am a South Asian woman, therapist, and a qualitative researcher – all of these identities are intermingled. The struggle, at times, was to separate and identify the different influences on my study. Knowing that these South Asian parents had already had experiences with therapists at mental health services, I felt that my research persona should be at the forefront. I would be a different person entering into their life story for very different reasons. At times during the interviews, I was aware of myself as a mental health therapist wishing to somehow make things better for the South Asian parents. I cringed at some of their experiences at the hands of mental health professionals and was embarrassed that I too, was a part of this group. On a few occasions, I found myself empathizing, sympathizing, and agreeing with the parents. Opie (1992) stresses the need for the researcher to recognize that her own processes impact on the research. The experience of being an insider and outsider in relation to my participants was challenging. Being South Asian, I was seen as an insider, who shared both language and culture with the parents. However, being a mental health therapist, I was seen as an outsider, aligned with the other professionals on the mental health service team.

The processes involved in the in-depth interview are not (and can never be) neutral, objective and unbiased acts: interviewer and participant are engaging (or failing to engage) with each other. As this process involved a mutual construction of the topics under discussion, both participants and myself as a researcher needed to be reflexive (Tomm, 1988). In-depth interviewing has important implications for both researcher and participant. The researcher needs to continually reflect on the research by 'staying with' the participant through the process of co-constructing their relationship. There were times when a strong connection between a particular participant and myself would have

impeded on the data collection process if I was not careful in remaining objective. As a sense of shared understanding developed two of the participants seemed to take it for granted that I understood what they were talking about and attempted to skip over important aspects of their stories. I realized from the onset of this study that a related risk in being an 'insider' was that I may think that I knew what the participant meant and impose assumptions on the data without checking them out with the participants. Miller and Glassner (1997) suggest that too close an identification with one position in relation to the social phenomenon being investigated may restrict "which cultural stories interviewees may tell and how these may be told" (p.104). Because I was aware of these risks before the data collection phase I was able to keep this in-check during the interview process and this allowed for openness to whatever perspective emerged when the participants told their stories.

During the analysis I found myself moving in and out of the data, revisiting and revising my own stance. It was a process that required time, thinking space, and engagement. I needed to be mindful as a researcher to be both immersed in the data and research process, but also to be able to draw back and contemplate what was occurring and how I contributed to what was occurring at different stages of the interviews. There were tensions and dilemmas. Burman & Parker (1993) note the ethical issues involved in interpreting the words of others. I struggled with interpretation myself and only with extensive dialogue with my supervisor was I able to come to some resolve. Stainton-Rogers (Stainton-Rogers, Stenner, Gleeson, & Stainton-Rogers, 1995) comments that "in order to weave my story, I must inevitably do violence to the ideas and understandings as they were originally expressed" (p.10). As I worked on my analysis, I asked questions as:

'Have I been symmetrical, equally respectful and non-blaming of all participants?' and 'Has there been any creeping intentionalism on my part?'

I believe that there is a danger when researchers lose their reflexivity and see themselves situated outside the discourse. One of the results of the research for me was the revelation that I, too, was located with the mental health discourse. Rather than seeing positioning as something others were doing, I recognized that I was also implicated; from the words and terms I used in the interviews and analysis; pointed out as being too clinical by my supervisor, to the fact that on some occasions, I found the beliefs of some of the parents to be extremely implausible. Clearly, the reflexive practice did present many challenges for myself, but engaging with these challenges did produce valuable insight into my subjectivities and the research process.

Summary

The need for research that will examine the experiences and recommendations of South Asian parents who have accessed mental health services for their children has been outlined. An explanation of the importance of guiding helping professionals to understand what South Asian parents of children with a mental illness endure was provided taking into account the increase of the South Asian population and their cultural values and beliefs. In addition, the statement of the problem and purpose were identified and relevant terms were defined. Finally, a reflexive piece has provided readers with this writer's orientation to the research.

Chapter two presents a review of the literature including the acculturation of South Asians. First generation and second generation South Asians are compared in their values and beliefs. Emphasis is placed on differences in understanding between Western

and Eastern values in relation to mental health and their utilization of mental health services. The limited research of the experiences of South Asian parents accessing mental health services is highlighted.

Chapter Two: Literature Review

Introduction

In this chapter, findings from the literature pertaining to the experience of South Asian parents accessing mental health services for their children are presented. The chapter opens with a discussion of first and second generation South Asians and the process of acculturation. In the next section, child rearing practices and expectations of mental health and treatment are presented from two perspectives: Western/European and South Asian. Mental health issues of South Asian children are outlined including South Asian utilization of mental health services in Western/European countries. Due to the limited literature on the South Asian population, Asian literature pertaining to Asian populations has also been employed to illustrate the mental health phenomena. At the same time, this writer is cognizant of the fact that many differences do exist between South Asians and Asians.

South Asian Culture and Generational Differences

First Generation South Asians

South Asians have been immigrating to the Vancouver area in Canada since 1902. The first immigrants were men from rural backgrounds who were employed in manual jobs (Ghosh, 1983) with the purpose of earning and saving as much as possible. There was great reliance on thrift and hard work. After the passing of the Immigration Act of 1967, there was a huge influx of people from India as wives and children came to join their husbands. As the South Asian communities grew in size, they re-created some of the cultural and social organizations of their home country. Places of worship for the South Asian communities were pivotal in this respect. The institution of religion helped in

maintaining their distinctive cultural traditions and social mores in addition to providing opportunities for collective worship and observance of religious customs and practices. South Asians come from three distinct religious backgrounds, namely, Sikh, Hindu, and Muslim. Run-down buildings were converted into places of prayer to ensure the spiritual welfare of the present and future generation (Mann, 1992). Thus Sikh temples, Hindu Mandirs, and Muslim Mosques came to play an important part in the lives of first-generation South Asians in Canada.

Values and Belief Systems. Traditionally, South Asian families lived in a single household in a patriarchal arrangement that included two or three generations. Resources were shared, incomes were pooled, and the weaker and elderly members of the family were supported. Cross-cultural psychologists (Kim & Gudykunst, 1988; Triandis, 1994) and anthropologists (Klucholn & Stodbeck, 1961; Levy-Bruhl, 1985) have attempted to pinpoint the differences between the value systems of traditional versus modern western societies. One of the differences that has surfaced from these extensive empirical investigations concerns the dimension of collective versus individual orientation. According to this conceptualization, collectively-oriented people seek achievement for the group's sake and stress the value of co-operation, order, and self-control. In contrast, individually-orientated people view achievement for self-glory, and believe in competition and the pursuit of power. In a wide-ranging and in-depth study of two generations of Asian people, Stopes-Roe and Cochrane (1990) report that compared with British populations, Asians considered the interest of the family before the individual. Parekh (1996) argues that "for the Indians, it is the family rather than the individual which is the basis of social structure." (p. 262). In another article Parekh (2000) noted,

"Children study for the family and believe that to fail to achieve what is expected of them is to let down the family." (p.7). Other attributes associated with collectivity are respect for and obedience to elders and accepting the decisions of the head of the family, particularly in marriage arrangements and choice of the work. These values have had strong bearing on the child-rearing practices of the first generation Punjabi immigrants.

Second Generation South Asians

The second generation of South Asians who were born in Canada have different expectations, values, and social attitudes compared with their parents. This generation has experienced two distinct cultural norms and value systems, one of the home and the other of the school and the wider western society. Researchers describe this group as 'Between Two Cultures' (Taylor & Hegarty, 1985); the generation who have the 'Best of Two Worlds' (Ghuman, 1994); and a generation caught up in a 'Culture Clash' (Cai, Wilson, & Drake, 2000; Wilson, 1978). To cope with the ensuing tension and anxieties some members have developed bicultural identities while others have rediscovered their religious values and anchored their identities in their ethnic culture. Others have constructed bicultural identities as a functional response to their predicament – to be Indian at home and English at school or place of work as an effective way of dealing with the world (Ghuman, 1994). As young people face racial discrimination and rejection from the host society and disenchantment with their families' rigid insistence on maintaining traditional values, they can become alienated from both cultures. The second generation, therefore, has different expectations, personal identities, and values from their elders. Objective evidence on the changing patterns of South Asian family life is sparse. However, Stopes-Roe and Cochrane (1989, 1990) have conducted a comprehensive

inquiry into the changing values and attitudes of second generation Asians in Britain. They found a rather mixed response to the question of living with parents. Two-thirds of the young men prefer to live in a joint household, compared to one-third of the young women who may be reluctant to move into father-in-laws' households. Stopes-Roe and Cochrane conclude that second generation children differ more than their first generation parents on their views on family structure. Even though second generation children still like to remain in close vicinity to their parents, they do not prefer to live in the same house. Stopes- Roe describes Asian young people wanting elbow room but still preferring to be closely and continuously involved in the parental family unit.

Acculturation and Assimilation

Acculturation is a cultural change, initiated by two or more cultural systems coming into contact, whereby an individual selectively adopts cultural values from another culture (Moyerman & Forman, 1992). Acculturation occurs when a newcomer absorbs the cultural norms, values, belief, and behavioural patterns of the "host" society. Acculturation is a multidimensional process which encompasses several phases: (1) contact – encounter of two groups of people; (2) conflict – a state of dissonance between giving up valued feature's of one's culture and accepting the values of the host culture; (3) rejection – self-imposed withdrawal from the larger society; and (4) deculturation – alienations which consists of several features, including a sense of powerlessness, purposelessness, conflict, a sense of social isolation, meaninglessness and self-entrapment.

Assimilation is the process of adjustment, which occurs as a result of two different cultures coming into contact with each other over a prolonged period. Here the

individual may acquire the attitudes of other groups and, through sharing of their history and experience, may well be absorbed into a common cultural theme. Assimilation is generally seen as a one-way process.

Acculturation is the process by which an individual undergoes change by contact with the dominant culture, and also as a result of general acculturative change in the broader cultural group. Thus, although acculturation works on the individual, the process may occur at both individual and group levels. Acculturation can be measured in four dimensions: integration, separation, assimilation and marginalization. When assessing an individual, different areas of psychological functioning have to be conceptualized, and these include language, cognitive style, personality traits, individual identity, attitudes, and acculturative stress. Culture and personality traits interact very closely, and therefore confusion between the two factors can occur. Individuals, who feel threatened by the majority or dominant culture, will likely become more isolated or withdraw into their own group. The four acculturative styles of assimilation, integration, marginalization, and ethnocentric coping may be seen. Each of these has implications for developing understanding models of mental illness and pathways to care.

Generational differences

Clinicians need to be aware of the heterogeneity and differences within groups. Children of migrants will have retained some aspects of their own culture and are also likely to have absorbed some aspects of the majority culture. Ethnic identity among second generation South Asians is inevitably tied to the process of assimilation and different factors can affect assimilation outcomes. Assimilation can occur in the forms of behavioural, structural, and socioeconomical assimilation. Behavioural assimilation

would involve major dimensions of collectivity versus individuality, deep religious versus secular orientation, and gender role differentiation and inequality versus gender role equality (1994). Structural assimilation would involve social contact interaction between dominant and minority groups in social institutions such as school, workplace, and politics. Socioeconomic assimilation would include the employment and earnings of minority groups relative to the dominant culture. These assimilations may produce some degree of culture conflict, but this is by no means universal. For example, not all young South Asians are likely to be traditional in their views or to be involved in cultural conflict either. A key feature to bear in mind is the fluidity of the culture: no culture remains static, and just as culture influences people, people continue to influence culture.

The patterns of psychological distress among the second generation appear quite different when compared with first generation. Whether this reflects true morbidity, or is an artifact of help-seeking and diagnostic processes in psychiatry remains controversial. It depends quite clearly on the sources and method of data collection. Nonetheless, the issues regarding identity crises will affect recovery in those who develop major mental illness, and those who suffer non-specific acculturative distress. Sensitivity towards cultural, religious and spiritual needs is vital. There must be a subtle process of evaluation of the degree of belonging and shades of identity which does justice to the complexity of personality and identity maturation in a multicultural society. Children and young adolescents are likely to be affected by the anxieties and worries faced by parents.

The South Asian Child

South Asian Child Development

A universal task of the family is to interpret for their children the values, beliefs, and appropriate behavioral patterns of their culture (Rosenthal & Feldman, 1990). The task for children is to acquire the cultural knowledge and skills that will enable them to participate effectively in the cultural life of the family, and later in the cultural life of the larger community (Ghuman, 1994). In order to accomplish this task, all families within a society establish patterns of interaction and communication, customs and beliefs, and expectations of behaviour and conduct. In South Asian families, numerous significant others are involved in the tasks of child rearing as well, and hence influence the transmission of cultural knowledge and skills (Hines, Garcia-Preto, McGoldrick, Almeida, & Weltman, 1992). For example, bathing a baby is usually a privilege reserved for the grandmother. Protocol dictates that the mother must allow anyone in the home the pleasure of joining in the child-rearing tasks and in nurturing the child. Parents are discouraged from being possessive and are encouraged to share their blessings with others (Kakar, 1979).

Although the child receives considerable attention, restraint is taught as well; modesty and humility are emphasized (Das & Kemp, 1997). Certain behavioural codes of dress are also enforced such as loose, non-revealing clothing. Restraint is also encouraged in interpersonal relationships. Individual desires are sometimes suppressed in the interest of the family (Berg & Jaya, 1993) and from the time a child can understand, he/she is conditioned to be fair and responsible in social participation (Crystal & Stevenson, 1995; Markus, Mullay, & Kitayama, 1998). Children are not encouraged to develop as

independent individuals but as cooperative members of the family and broader community. Contributing to society and to one's fellow beings are values inculcated from an early age (Cousins, 1989; Rosenthal & Feldman, 1992).

South Asians emphasize learning and mastery of knowledge (Ghuman, 1994; Ogbu, 1994). A child who performs poorly in school is often shamed. The parents are deeply involved in their children's education, to the extent of coaching them in completing homework assignments. A very large-scale research study (Tizard, Blatchford, Burke, Farquhar, & Pelwis, 1988) in the inner London area showed that South Asian mothers were supportive of their child's learning. They spent a lot of time encouraging their children and helping them with their homework. Achievement and excellence in school are a source of pride for parents who see their children as an extension of themselves and also a measure of their successful parenting. To please their parents and earn approval, the children often struggle hard to prove their worth which may cause difficulty for both parents and their children. The parents will often withhold praise and recognition if the child does not meet their expectations.

School-age children are exposed to mainstream culture, which offers alternate ways of problem solving that may not conform to the family's value system. This is the beginning of a journey through two cultures for these children, one at home and the other at school. For the parents, the questioning of their authority and values poses difficulty in disciplining and setting expectations for their child (Wakil, Siddique, & Wakil, 1981). South Asian parents and children find that adolescence is a difficult time because conflicts in value systems come to the forefront. Parents who do not believe in fostering independence at the cost of harmony may stress interdependence of the family even in

areas of career choice and marriage (Baptiste, 1993; Wakil et. al., 1981; Sinha, 1998). Adolescents may perceive their parents as intrusive. Parents, on the other hand, believe that they have the right to exercise authority because they supply emotional and financial support and are fulfilling their parental duty by providing guidance (Baptiste, 1993). Hence, perceived intrusion and demands placed on the youth could lead to acting-out behaviors or even suicidal attempts, particularly if the parents discover the adolescent has been sexually active or is performing poorly in school.

Role of Mother in Child Development. In the South Asian community, each family has a culture of its own. The various expressions may differ in detail, but the pattern of family life is basically the same. In South Asian families, the mother is the major source of sustenance and love. She has deeper emotional ties and more intimate contact with the children than the father. A father can also be affectionate, but only during his children's earliest years, becoming more authoritarian as they grow older. Relations between fathers and sons may become close as boys begin to work alongside their fathers in various tasks.

The mother is often viewed as the warm and nurturing figure by children of both sexes. The bond between mother and daughter is especially strong. Close association begins in childhood and continues into adolescence as mother and daughter cooperate in household and other chores, sharing common tasks and concerns. The young woman learns a majority of what she needs to know to cope with life as an adult female from her mother. Mothers and sons are very intimate during the boys' first years. Through adolescence and adulthood, sons continue to have abiding respect and deep affection for

their mothers through adolescence and adulthood. In comparison with daughters, sons are given much more independence and freedom (Eisenman & Sirgo, 1991).

After the marriage of her sons and daughters, mothers still have the responsibility in child care, and in the role of grandparent. In the South Asian community, the grandmother is considered the best person to take care of the grandchild. When young parents are away, or even in their presence, the grandmother may take care of the child or give advice. Therefore, the role of mother is important for development of the child in every period of life.

Role of Father in Child Development. The father's relationship with his son has been regarded as crucial for assuring the continuity of the family. Fathers tend to think of their sons as representatives of the family rather than as individuals. In South Asian culture the historical role of a father was to serve as a link between the private life of the family and the public life of society. Childcare, therefore, has historically been the mother's role while the father maintained autocratic and instrumental roles. However, there is a definite trend to the recognition of a more active role in childrearing for the father (especially in the second generation).

The quality of father-child relationships may also affect the emotional development and mental health of the child. A study undertaken in Thailand by Bhanthumnavin (1985) has demonstrated the influence of fathers on the psychological well being of Thai adolescents. First, the father has more influence than the mother on the son's mental health, while the mother has more influence on the daughter's mental health. Second, in working mothers' families, the father is more essential to the psychological well-being of children of both sexes than in the families of non-working

mothers. Finally, in more traditional families, the father plays an important role in the psychological make-up of adolescent compared to the father in more modern families in Thailand. Thus there is evidence that South Asian fathers exert a powerful influence upon the child's mental health, particularly upon the male children.

Gender of the Child. In South Asian families, boys are generally preferred to girls to the extent that in some families women who have girls are made to feel inadequate. The notion that a son would look after his parents is very much part of the South Asian psyche (Kakar, 1994). There is some statistical evidence (Booth & Verma, 1992) that parents in India treat their young children differentially in regard to medical care.

> *The magnitude of restricted access to hospital care for girls as shown by our data is impressive; it suggests that about three out of four (75%) who are ill enough to require hospitalization are denied this essential medical care simply because of their sex. (p. 1155)*

According to Booth and Verma, this accords with the social and cultural mores of South Asian society in which the sons inherit family land and are responsible for looking after the elderly parents. Daughters, on the other hand, have to be married off with dowries. Although this preference for boys over girls is not as prevalent in Canada, it does continue to be an influence in the South Asian community, especially for first generation immigrants.

Adolescence. The experience of adolescence for South Asian youth is quite diverse due to the assorted countries involved, languages spoken, social classes involved, religions practiced, and cultural values observed. While adolescents in general confront the complex tasks of identity formation and establishment of group affiliation, South

Asian adolescents confront normal developmental tasks within each culture, with the added burden of integrating the sometimes conflicting values of these coexisting, and occasionally competing, cultures. The experience can be stressful when tension develops between the younger and the older generations and when traditional values are seen as threatened. Children's identity is the product of experience and history represented through their parents and the consequence of the values and traditions parents pass on to their children. Cultural identity formation has been conceptualized by Andreou (2000) as both inherited and recreated through experience so that it may reside within the individual in memory and feeling. Ethnic minority children who are born into a Western society are exposed to markedly different social and family organization when compared to the type of care and upbringing they receive in their South Asian family. This disparity between practices in the larger society and their family context may result in confusion, anger, low self-esteem, or even loss of respect for their own ethnic and cultural identity for ethnic minority children.

Cultural Factors in Personality Development

Culture is a means of sharing and learning values and beliefs that structure meaning and has an influence on personality development. "Selves are always culturally and temporally situated" (Nucci, 1997, p. 7). Individual characteristics are molded by the surrounding environment. Erikson (1980) and Kakar (1978) show evidence that cultural factors in childrearing have an impact on the development of the personality and may reinforce or suppress certain specific internal conflicts. They may stimulate the use of certain types of defense mechanisms, or suppress others, in this way making the expression of certain behaviour culture-specific. In traditional South Asian culture

displays of strong emotion are not considered appropriate; young children are taught to be subdued and to mask their feelings. However, some South Asian children are more expressive than others.

Nucci (1997) suggests that cultural molding of child behaviour is accomplished initially through parental influence. During childhood, personal choice is relatively circumscribed, with parents having significant influence on moral and behavioural expectations. Parental responsibility for regulation of moral conduct continues into adolescence, while the sphere of behaviour considered personal expands. Domains of autonomy are culturally variable (Miller, 1997) so that what is considered personal in Western culture, for example, choice of a spouse or a career, might be considered a family or societal responsibility in the South Asian culture. Where personal choice is more confined, individuality may be expressed more subtly.

Erikson (1980) describes the central task of adolescence as achieving a sense of identity, a subjective sense of continuity and sameness that provides a foundation of one's adulthood. Failure to establish a coherent, stable identity may lead to confusion and psychological distress (Erikson). In South Asian culture, there is no developmental stage comparable to that of adolescence. Issues of individual identity formation and self-differentiation are minimized and have emerged only with increased contact with Western nations (Ibrahim, Ohnishi, & Sandhu, 1997). South Asian parents, therefore, emphasize inter-dependence, rather than independence. Western theories of child development are secular in contrast with the spiritual orientations of Hindu, Buddhist, and Islamic traditions (Holt & Keats, 1992) which stress harmony and respect for others.

These values are maintained by inculcating the adolescent with a moral obligation to accept a hierarchical social structure.

> *Parents, that is, an authoritarian father and a protective mother are one's first teachers whom one has to follow. They educate their children in a "paternalistic" way, in the sense that their guidance should be accepted without discussion. Dependency feelings and reliance on leadership are stimulated...Parents give and children receive. (Soriano, 1995, p.69)*

By Western standards, the South Asian parent-child relationship appears to be characterized by unequal obligations in which parents are always superior and children inferior. Hence, Western democratic childrearing practices are incompatible with South Asian views of child development. However, it is important to remember that although culture prescribes particular sets of values and beliefs, these are strongly mediated by individual characteristics such as education, breadth of experience, and a multitude of other factors.

Child development, including the role of mothers and fathers play in their child's development, gives some insight into how parents would react to mental health concerns with their children. The values and beliefs that guide South Asian parents in raising their children are also expected to impact the way in which they view and interpret their child's behaviour during their child's development. Hence, if parents' beliefs of what constitutes normal child development will guide their decision to seeking support services for their child who may be said to have behavioural or emotional difficulties by Western standards. South Asian adolescence sometimes face challenges as they try to live

in two cultures and the emotional turmoil that some adolescents face may make them more vulnerable to mental illness. Also the cultural norm of not expressing strong emotions and suppressing feelings also impacts development of depression and other mental illnesses. Furthermore, because emotions are not expressed parents may not know what their children are feeling and they may not recognize feelings as this would not be an area of focus for parents. The above factors would have an impact on whether South Asian parents feel that mental health support services are needed for their child.

Western vs. Eastern Conceptualization of Mental Health and Treatment

Worldview defines the nature of the world, the individual's place in it, and the range of possible relationships to that world and its parts. Included in one's worldview are the values, beliefs, and attitudes which serve to organize and shape perceptions, expectations, and behaviours. Cultural heritage as reflected in values, beliefs, language, practices, and individual identity or self-concept is also part of one's worldview (Dana, 1993; Landrine, 1992). Culture-specific elements of worldview can impact upon entry into treatment, its subsequent course, and its outcome. Ethnic specific components of worldview might include the individual's beliefs about mental illness and emotional difficulties (Hourani & Khlat, 1986); beliefs about the appropriate expression of emotion (Meinhardt & Vega, 1987; Trupin, Low, Forsyth-Stephens, Tarico, & Cox, 1988); and attitudes toward authority figures (Fischer & Turner, 1970). Once treatment has begun, any or all of these elements might prove to be significantly discrepant from the therapist's conceptualization and treatment of psychological distress (Kleinman, 1980). A therapist's failure to appreciate such discrepancies – how these elements may have differently

shaped a client's approach to life in general, and to therapy in particular, can result in early termination and impaired treatment effectiveness (Atkinson, Morton, & Sue, 1998).

In much of Western culture, medicine, religion, and psychology are clearly defined as separate and distinct. In South Asian culture, a more holistic view of health exists. The Western approach tends to be more individualist in orientation, placing a special value on the individual's ability to exercise control in his or her life. In comparison, in the South Asian community, the self is understood as always in relation to family and community (Draguns, 1988; Rack, 1982). However, a culturally congruent South Asian centered perspective would view mental health and treatment as holistically integrated phenomena whose processes are interwoven between individual and collective contributions to states and traits of mind and health, and the subsequent bio-psychosocial environment. The cultural understandings informing this view of mental health and treatment require careful examination and assessment of the health of the larger social context, its social institutions and the nature of the social environment created. Mental illness would represent the disruption of a healthy social context in which institutional structures and other systems of social organization functioned to support individual and collective well-being. An emphasis on anonymity, humility, and submission to the welfare of the group (both family and community) is valued (Bemak, 1989; Lee, 1988). Western psychotherapy is heavily influenced by language, class-bound values, and culture-bound values (Atkinson, et. al., 1998). The latter involves seeing therapy as: centering on the individual; encouraging verbal, emotional, and behavioural openness and intimacy between client and therapist; employing an analytic, linear and cause-and-effect approach to problem definition and solution; and making a clear distinction between

spiritual, physical, and mental functioning. South Asian healing emphasizes traditional beliefs, for example, the role of fate in the development of psychological problems or spirituality in accounting for psychological problems (Atkinson et al., 1998). Disparities between the Western model of the therapeutic enterprise and the worldview of South Asians can be found in all of the above dimensions (Baptiste, 1993). The intense focus on the individual, typical in Western therapy, is alien to these worldviews and can lead to ineffective treatment and early termination.

In a study of Western and non-Western views of disease causality (Murdock, Wilson, & Fredrick, 1980) Western models were found to be based largely on naturalistic views of disease causation including infection, stress, organic deterioration, accidents, and acts of overt human aggression. The theme of illness is consistently used in evaluating certain human problems; for example, deviant irrational behaviours by identifying a change, giving it a name, evaluating the causation, and finally making a judgment on interventions that are likely to counteract or alleviate the condition. The Western medical model of mental health implies a mind-body dichotomy, a strong adherence to a classification system, and clear-cut distinctions between psychology, religion, medicine, and spiritualism.

In contrast, among many non-Western societies, disease models are based on supernatural views including theories of mystical causation because of impersonal forces such as fate, ominous sensations, contagion, mystical retribution; theories of animistic causation because of personalized forces such as soul loss and spirit aggression; and theories of magical causation or actions of evil forces including sorcery and witchcraft. These non-Western notions of disease causality are seldom used by Western

professionals, and because of this, non-Western patient compliance is often a problem (Murdock et al., 1980).

Finley (1997) has also reviewed research concerned with ethnicity and serious mental illness, reporting that in comparison with ethnic minorities, the mainstream population tends to remain in treatment longer, to obtain more service hours, and to receive residential and social rehabilitation services. She observes that although people with serious mental illness are characterized by socioeconomic, ethnic, and cultural heterogeneity, this diversity is poorly reflected in the literature. Moreover, there are significant gaps in research, theory, knowledge, and innovative methods for dealing with culturally diverse patients and families.

Help-Seeking Behaviours in India

Help-seeking behaviours in India are dictated by community perception and beliefs about the nature of the psychiatric disorder. In a study of 300 patients with psychiatric disorders (Jiloha & Kishore, 1997), 55% attributed their psychiatric disorders to supernatural forces including ghosts, evil spirits, and witchcraft, and some patients chose to consult with traditional healers before seeking mental health services. In rural areas with populations of lower socio-economic status, studies have found that up to 80% of people who have psychiatric disorders seek help from traditional healers rather than physicians (Jiloha & Kishore). Traditional healers are the first care choice, however, if symptoms are acute and persistent, alternative services including modern medicine will be pursued (Banerjee, 1997). A close relationship between modern medicine and traditional healing systems exists in India. For example, major psychiatric clinics have units practicing Ayurvedic medicine, a traditional South Asian healing system

incorporating the body, nature, and religious elements. The World Health Organization has recognized the strengths of integrating traditional health into systems of care for psychiatric disorders. Traditional health methods provide culturally compatible care, holistic approaches to healing, strong therapeutic alliances, and close connections with family and community (World Health Organization, 1992).

Mental Health Services in India

In contrast to Western society, India has narrowly targeted its mental health resources to people with psychiatric issues. The lack of demand for services among the general population has meant that mental health professionals serve those most in need. However, despite this targeting, mental health services in India are extremely limited. In 1990, there were approximately 42 mental hospitals and approximately 400 psychiatric units in general hospitals in the entire country (Wig, 1990). In a country where six million people are estimated to have psychiatric disorders (Krishnamurthy, Venugopal, & Alimchandi, 2000), services are available to only 22,000 at any given time. Recently Nongovernmental Organizations (NGOs) have started to provide services at the community level because of the lack of government-funded community mental health care. The community mental health NGOs provide a range of services including halfway homes that offer skill training, family therapy, and vocational training (Murthy, 1998). The shortage of psychosocial rehabilitation facilities in India leaves many people with psychiatric disabilities, especially rural areas, without access to services. Additionally those with access to services often do not choose to utilize them due to discrimination and alternative beliefs about the nature of psychiatric disorders. However, despite the large numbers of people with psychiatric disabilities who are untreated, studies have

found better prognosis for people with psychiatric disabilities in India. Better prognosis rates in India may be due in part to bypassing the labeling process and subsuming a psychiatric disorder and its symptoms into ongoing social rituals, including indigenous healing systems (Chakraborty, 1995).

An individual's worldview, including ones values and beliefs, will impact the way in which one believes mental illness is caused and will impact the decisions with regards to the treatment of mental illness. Within the South Asian culture a more holistic view of health leads to thinking of treatment beyond the medical system to include religion and spiritualism. In this study, it would be important to pay attention to the spiritual beliefs of the South Asian parents and how it impacts the experience of the South Asian parents who eventually seek mental health services for their child. In addition, it is useful to have the knowledge that there is a lack of awareness and resources for mental illness in India because the South Asian parents in this study are first generation Canadians and have come from India. Hence, it is presumed that their knowledge or lack of knowledge about mental illness will impact the experience of these South Asian parents.

Child and Youth Mental Health

The rates of mental illness are high among children living in adversity throughout the world. Even in the most economically advanced nations, 8% to 10% of children have some type of diagnosable mental disturbance, and up to 20% of children who experience inner city poverty are impaired to some degree in their social, behavioural, and academic functioning (Visser, van der Ende, Koot, & Verhulst, 1999). A number of epidemiological studies on mental health disorders among children and adolescents have reported prevalence rates ranging from 12% to 20%. For example, Roberts, Atkinson, and

Rosenblatt (1998), in an international meta-analysis of 52 studies, reported a mean prevalence rate of 15.8%. Kazdin's (Kazdin & Wassell, 2000) review of studies from a number of countries estimated that between 17% and 22% of youth under 18 years of age experience emotional and behavioural problems.

Studies have also found gender differences in the presentation of mental disorders. Females tend to have more episodic problems, for example, as in depression. They also tend to have milder manifestations, for example, non-aggressive conduct disorders compared to males who tend to be diagnosed with aggressive conduct disorders (Bardone et al., 1998). Children are less likely than adults to arrive at mental health services or to enter treatment because children's problems tend to be context-specific, occurring in their particular families, at particular moments in their lives, or in particular school situations. Additionally, children typically earn more than one categorical diagnosis. For example, a child may satisfy the criteria for three diagnoses such as ADHD, conduct disorder, and learning disability. These problems often reflect many sources of strain including constitutional, familial, intra-psychic, and communal.

The referral process for children and adolescents is more coercive than that for adults because adults can initiate contact with community health centers on a more or less voluntary basis. Children and adolescents have little choice in the matter. They enter the mental health system primarily because their families or other social institutions decide that their behaviour warrants intervention.

Ethnicity and Child Mental Health Problems

Literature is scarce regarding the epidemiology of mental disorders in the South Asian children and youth who live in North America. There are very few studies from

Canada or the United States on South Asian children and youth utilizing mental health services, even though, there are many South Asian mental health professionals working with children in Canada and the United States. Most of the studies to date have focused on the issue of behaviour disorders involving children from the United Kingdom. Many problems exist in conducting research in the area of mental health because of the narrow categories of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV-TR, 2000) and the use of culturally and linguistically unsuitable scales and other measures. The mental status examination, a basic tool in assessment of mental disorders, does not take into consideration the ethnic cultural and socioeconomic background of the person being assessed (Bhugra & Bhui, 1997; Furnham & Shiekh, 1993; Nazroo, 1997).

Studies conducted on the use of child and adolescent mental health services have been quantitative in nature, with a widespread use of surveys to determine problem type, age, gender, and referral source of South Asians to mental health service. A significant amount of literature on strategies for working with South Asian clients is available (Balarajan & Raleigh, 1993; Bhui, 1996; Fernando, 1995; Gupta, 1992), however, a lack of qualitative inquiry as to the experience of South Asians who have accessed mental health services is notable. Parents cannot begin to seek help until a problem or mental health need is recognized. A mental health need can be defined epidemiologically or subjectively. Mental health practitioners tend to focus on symptoms while parents take a more subjective view of their child's problem (Pottick, Lerman, & Micchelli, 1992). For example, a child's problems at school are more likely to capture the attention of his or her parents than symptoms of anger, frustration, or sadness. The concept of normal or deviant behaviour as perceived by children and parents may differ based on their cultural belief

systems. For example, what can be termed as self-assertive behaviour in school may indeed be perceived by Indian parents as increased aggressive behaviour. Thus, a child exposed to two sets of expectations, one in school and another at home, may experience confusion and conflict (Phinney, 1989).

Unique Mental Health Issues

Ethnic minority youth present particular mental health issues because of their developmental status and membership in their ethnic culture. Some of the issues are related to socio-cultural conditions whereas others are developmental issues faced by all youth. Developmental tasks, however, are also influenced by cultural factors (Berlin, 1982). All children grow up within the context of a family, whose members bear primary responsibility for the socialization of the children. Some researchers (Phinney, Lochner, & Murphy, 1990) postulate that the common element among ethnic youth at risk for future psychological maladjustment is the maintenance of a foreclosed or diffuse identity status. In addition, cultural marginality and the stress associated with acculturation results in heightened anxiety, lowered self-esteem, and aggressive acting-out or withdrawal behaviour, which can contribute to such problems as substance abuse, academic underachievement, delinquency, violence, gang involvement, and suicide among ethnic minority youth.

South Asian Utilization of Child Mental Health Services

In a study of South Asian families' use of child mental health outpatient service (Burns et. al., 1995), the dropout rate for preschool Asian referrals was 50%. The range of problems reported in the Asian group was narrow in focus (primarily depression and somatic complaints) compared to the non-Asian group, who reported a broad range of

disorders. Referrals for Asian children originated from a pediatrician, or general practitioner, and very rarely from social or school services. The authors hypothesized that Indian parents find psychological problems couched in somatic complaints more acceptable.

Roberts and Cawthorpe (1995) conducted a 5-year retrospective study of children and adolescents from Asian families referred to the Bradford Child Psychiatry Clinic in Britain. Bradford is an industrial city with a long history of immigration dating back to the last century. At the time of their study 20% of the population of half a million was composed of ethnic minorities including South Asians from Kashmir, Bangladesh, Punjab, and East Africa. The researchers noted that a large percentage of Western European families were referred from social service agencies in comparison to South Asian families. They hypothesized that South Asian families may be reluctant to seek external help from social agencies because of a sense of alienation and lack of trust in the system. In addition, South Asian parents tended to focus more on the child's physical health. The diagnosis of adjustment disorder was frequent among Asian females and the diagnosis of conduct disturbance more frequent among the Western European children. In contrast to Western European parents, Asian parents' failure to recognize conduct disorder in males may be explained by their perceptions of such behaviour as naughtiness, stereotypical toughness, and bravery (Keats, 1997).

The relationship between ethnicity and other factors associated with the use of mental health services, such as problem pattern, referrer type, age, gender, and attendance rate is limited. Epidemiological studies of pre-school children have shown no difference in the prevalence of behavioural and emotional disturbance in Asian and Western

European English children (Newth & Corbett, 1993). Retrospective case note studies of older children have found lower rates of conduct disorder in children of Punjabi families and higher rates of adjustment disorder, when compared with Caucasian children (Roberts & Cawthorpe, 1995).

Failure to enlist parental cooperation and collaboration for the treatment of South Asian children is perhaps the primary cause of premature termination among ethnic minority children and adolescents (Ho, 1992). The premature termination and unsuccessful treatment outcomes that South Asians experience in the mental health system need to be closely examined in order for the system to be more responsive and effective. Professionals have a duty to develop counselling and therapeutic services that are appropriate and meaningful for the South Asian population (Canadian Counselling Association, 1999). Existing services need to be examined in terms of the concepts of mental health/illness on which they are based to determine appropriateness and sensitivity to South Asian clients.

The underutilization of mental health services by the South Asian population has been shown in a number of quantitative studies to date. There is a common perception amongst those providing counselling and therapy services that members of South Asian communities do not really suffer from mental health problems, however, there is little evidence that low rates of utilization are due to a lack of mental health problems among Asian Americans. Asians have been considered a "model minority" group who "...remain immune from emotional breakdown" (Lin & Cheung, 1999). Any problems which they may have are contained within their families and communities (Johnson & Nadirshaw, 1993). The low rate of reported mental illness has been attributed to fear of

stigmatization and a somatization of mental distress (Clark, 1983; Das & Kemp, 1997; Nguyen, 1985; Rack, 1982; Sue & Sue, 1990; Sveaass, 2001) which is another reason why help is sought only when the mental illness reaches severe psychosis (Banerjee, 1994; Desai & Coelho, 1980; Lipson & Meleis, 1983). Other studies emphasize the level of acculturation as determining mental health service utilization (Atkinson, Whiteley, & Gim, 1990). Such perceptions have also informed a widespread belief that South Asians do not need or want to use services (Jalali, 1982; Lipson & Meleis, 1983).

Recent studies now question and challenge this view (Bryan, 2002; Laszloffy, 2000) arguing that the "model minority" myth is detrimental to the interests of many Asians (Crystal, 1989; Min, 1995; Takaki, 1996). A number of explanations have been presented for underutilization and premature termination of services including the conflict between South Asian and Western values and the psychotherapy process. Root (1998) suggests that talking to a mental health worker about psychological problems may be viewed by South Asians as bringing disgrace on the family. Group work may create even more problems because group interaction may disclose family secrets. Instead, South Asians may try to resolve their problems on their own, believing that mental health can be maintained by avoiding bad thoughts and exercising will power (Root). A study in Birmingham, England (Commander, Dharan, & Odell, 1997) found that South Asians had the highest community rates of mental disorder and were the most frequent consumers in primary care, however, this population was less likely than the British population to have their mental disorder recognized. Of all the ethnic groups with a mental disorder, South Asians were the least likely to be referred to specialist care.

South Asians may also internalize stress and express symptoms through somatization and may therefore seek help from medical professionals (Sue & Morishima, 1982). One community survey revealed an alarmingly high rate of emotional distress within South Asian communities and showed little outlet for expressing this distress (Beliappa, 1991). The low uptake of services was due to factors such as lack of awareness of services, lack of confidence in their effectiveness and appropriateness, perception of cultural and language barriers, and fear that confidentiality would not be preserved.

South Asian clients come to the counselling session with the expectation of a hierarchical relationship and with the notion that the counsellor will function as a guide and teacher. They expect a direct, forceful, authoritative manner and a less personal demeanor from their counsellors. They anticipate counselling sessions that are structured and have more clearly defined roles (Atkinson & Lowe, 1995; Leong, 1986; Nishio & Bilmes, 1998; Root, 1998). The unstructured counselling session in which the client is expected to do most of the talking may be stressful.

The purpose of the present study is to understand South Asian parents' thoughts and feelings when deciding to seek mental health support services and to give voice to the experience of some of these people who have utilized mental health services. The intention is twofold, to build on the present knowledge associated with South Asian's access and utilization of mental health, but more importantly, to hear the experience of South Asian parents who have been consumers of mental health services for their children.

Summary

In chapter two, the literature concerning South Asian acculturation and the differences that exist between first and second generation South Asians has been presented. Also considered were the differences between western and eastern child rearing practices, and perception and utilization of mental health services. A review of the literature indicated that limited knowledge is available on the experience of South Asian parents who receive support from mental health services. This study will attempt to provide mental health service providers another lens through which to view their South Asian clients. In chapter three, the methodological means by which information was gathered from the parents in the study is presented.

Chapter Three: Methodology

Overview

In chapter three, the methodology of the study that seeks to answer the question, what are the experiences of South Asian parents seeking mental health services for their children is discussed. The research methodology, selection of participants, procedure for data collection, procedures for data analysis, and the criteria for evaluation are described.

Research Approach

Qualitative research is imbedded in the social context of individuals with the aim of understanding the phenomenon under study from the participant's or emic perspective (Merriam, 2000). Qualitative research is concerned with the meanings people attach to things in their lives (Taylor & Bogdan, 1998). All aspects of an individual's experiences are worthy of investigating and encouraged when doing qualitative research. Creswell (1994) describes qualitative research as *"an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting."* (p. 2). In-depth interviewing was used in understanding the context, experience, and the meaning parents made of their experience of having a child with a mental illness in their own words. The in-depth interview takes seriously the notion that people are experts on their own experience and so the best able to report how they experienced a phenomenon. In-depth interviews allow *"misunderstandings on the part of the interviewer or the interviewee to be checked immediately in a way that is just not possible when questionnaires are being completed or tests are being performed."* (Brenner, Brown, & Canter, 1985, p. 3).

Case studies help provide insight into meanings people give to the reality around them (Yin, 1994). The purpose of this study was to understand the experience of South Asian parents in seeking and utilizing professional mental health services for their children. A qualitative research approach allowed the participants in this study to freely describe their experience. The research was conducted in the participant's natural setting in a respectful manner; with the researcher being mindful of the culture and language of the participant. The findings from this study emerged naturally and were not tightly prefigured as in quantitative studies because the purpose in using a qualitative design was for the researcher to learn from the experiences of the participants.

Research about mental health issues of South Asians to date has been quantitative and as such has provided particular knowledge to our understanding of the lack of mental health utilization by the South Asian population. These studies have employed surveys and questionnaires to obtain information from a significant number of South Asians with regards to their utilization of mental health services and have employed statistical data analysis. Quantitative research with its use of surveys and questionnaires is limiting because it *"takes apart a phenomenon to examine component parts (which have become variables)"* (Merriam, 2000, p.56). Qualitative research, on the other hand, is holistic, as researchers look at the larger picture and the phenomenon being examined will unfold and evolve through sensitive inductive research. To this end, in this study I attempted to provide an increased depth in understanding with the goal of exploring the beliefs which underlie seeking/using mental health services and highlight the experience for South Asian parents accessing support for their children.

In qualitative investigations, researchers are the primary instruments for data collection who assume *"that a profound understanding of the world can be gained through conversation and observation in natural settings rather than through experimental manipulation under artificial conditions"* (Anderson & Arensault, 1998). In the present study, South Asian parents were interviewed in their homes using open-ended questions to assist them in describing their experience of using mental health services for their children. Furthermore, as described below, data collection was *"personal, face-to-face, and immediate"* (Janesick, 1994).

Research Design

The methodological design guiding this study was the collective case study. *"A qualitative case study is an intensive, holistic description and analysis of a single instance, phenomenon or social unit"* (Merriam, 1988, p. 21). An inductive approach was deemed appropriate for the exploratory and discovery-oriented goal of this study. This work can uncover reasons and meanings behind behaviours or attitudes. A case can be an individual or a group, for example, a family, institution, or community. The present study fits this characteristic of case study design in that it attempts to gain an in depth understanding of parents who accessed mental health services for their children. The case study methodology allowed for the flexibility and adaptability required to research this highly sensitive subject matter of mental illness within a minority population of South Asians. In this study the case is the South Asian parent who is seeking mental health service for his/her child. The participants in this study are similar in that they are parents, South Asian, and they have contact with mental health services.

Instrumental case studies *"provide insight into an issue"* (Stake, 1994, p. 239) allowing for analytical generalizations to be made about a particular situation, phenomenon, or general condition. In the current study, individual cases were studied in order to investigate the utilization of mental health services by the South Asian community. When the instrumental case study is extended to include several cases, the approach is known as a collective case study.

A case can also be seen as *"a phenomenon of some sort occurring in a bounded context"* (Miles & Huberman, 1994, p. 25). This bounded context may be time and activity, for example, a program, event, process, institution, or social group. Stake (1995) emphasizes, *"coherence and sequences are prominent"* (p. 2). Certain features are recognized as within the system and within the boundaries of the case, and other features are outside. The present study is naturally bounded by culture (South Asian), family relation (parents), and service (mental health). These factors are shared by all of the participants in this study and form the boundary within which the "case" is being investigated.

The emphasis in case studies is on obtaining rich description *"...with the intent of analyzing, interpreting, or theorizing about the phenomenon"* (Merriam, 2000). The concept of holism is important in case study as *"the whole is conceived of as more than the sum of the parts, and the researcher is obliged to piece together the parts theoretically in order to construct the whole"* (Sjoberg, Williams, Gill, & Himmel, 1995, p. 64). The complex circumstances which surround a parent's decision to seek mental health services, for their child are necessary to understand the experience and are intended to be captured in the interviewing process. Sjoberg et. al. emphasize, *"a case*

study can permit the researcher to examine not only the complexity of life in which people are implicated but also the impact on the beliefs and decisions of the complex web of social interaction" (p. 9). The case study involves examining the relationship of South Asian parents who hold a certain set of beliefs and values interacting with mental health services and mental health professionals.

Yin (1989) states that case study is an enquiry that *"...investigates a contemporary phenomenon within its real life context; when the boundaries between phenomenon and context are not clearly evident"* (p. 36). Understanding how participants act and how their context, seeking mental health service for their children, influences their action is the focus of this study (Maxwell, 1996).

Conceptual Lens

A cultural approach to mental health was the lens or conceptual framework applied to this study. A model developed to examine help-seeking of minority adolescents by Srebnik, Cauce, and Baydar (1996) was adopted to understand the help-seeking pathway of minority South Asian parents. This model identifies and describes three distinct stages in help-seeking: 1) problem recognition; 2) decision to seek help, and 3) selection of who will provide help. The first step of problem recognition attempts to differentiate between an epidemiologically defined need versus a perceived need by the client. The second step is divided into a coercive versus voluntary process, referring to client's perception of the decision to seek help. The third step of service selection is divided into three options including the use of informal supports, collateral services, or formal mental services. This model will be useful in guiding the understanding the role of

culture and context at each of these stages in help-seeking which is the intent of this study.

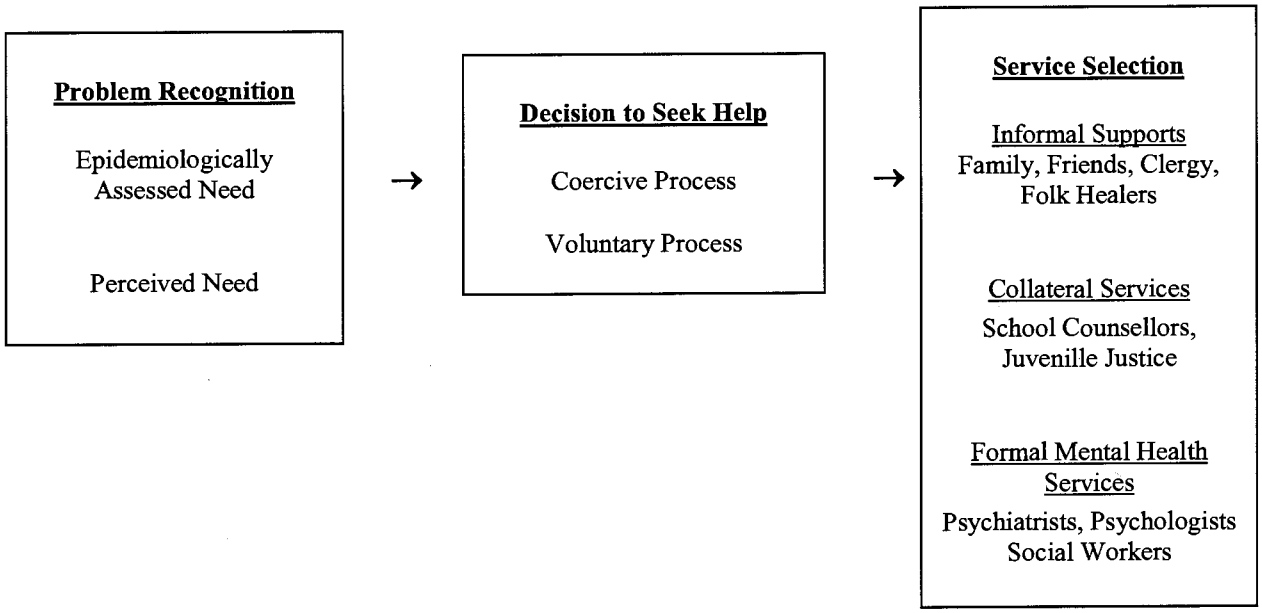

Figure 1 – A model for mental health help seeking.

This model was utilized in attempting to understand how the South Asian parents in this study recognized the problem in their child, when they decided to seek help, and finally how they decided on having formal mental health service involvement and if they also considered alternatives to formal mental health services. This model was useful in developing interview questions and focusing attention on the experiences and emotional impact on these parents at each of these stages of the parent's acceptance of their child's mental illness.

Researcher Assumptions

Particularly in qualitative research the role of the researcher as the primary data collection instrument necessitates the identification of personal values, assumptions, and biases at the outset of the study. Having worked at community mental health teams for approximately two years prior to conducting this study and being of South Asian descent have shaped some of my perceptions in relation to South Asian parents' experience of mental health services. I believe that my awareness, knowledge, and sensitivity around mental illness assisted me in working with the participants in this study. However having worked with mental health services I bring certain biases to this study. Although I ensured every effort to ensure objectivity, these biases may shape the way I view and understand the data I collect and the way I interpret my experiences. My assumptions included:

1) South Asians do not feel that mental health professionals understand or respect their values and beliefs around mental illness.
2) South Asian parents will not be comfortable talking about mental illness in the family due to the stigma associated with mental illness.
3) South Asian parents will find it difficult to respond to the open-ended questions that are posed and will find it difficult to elaborate on their experience.
4) South Asian parents do not understand what counselling/therapy is and how it can be useful for their mentally ill children and themselves as caregivers of these children.

Research Approval

Permission to conduct this study was solicited from the Human Research Council of the University of Victoria, and the Vancouver Coastal Health in Vancouver, British Columbia. The mental health teams in Vancouver were going to assist in the recruitment of participants; therefore, a Research Agreement was obtained from the Planning and Evaluation Department.

Participants

The sample consisted of six South Asian families with a child diagnosed with a mental illness and who were seeking mental health service. In case study research, no set number of participants is recommended; although most researchers aim for saturation of categories. The parents were recruited with the support of psychologists and psychiatrists at four Mental Health Teams in Vancouver, BC. Inclusion criteria for this study were as follows: mothers and fathers between 20 to 50 years of age; who have at least one child; and who are first or second generation South Asian immigrants. In addition, the age of the children diagnosed with a mental illness ranged from 5 to 18 years old and the children were of either gender. Parents were to be purposefully sampled because there is a need to discover, understand, and gain insight for a phenomenon that has limited exploration in the past. The most important aspect of purposeful sampling is selecting information-rich cases for in depth study (Patton, 1990). The potential for each case would be to aid the researcher in developing diverse insights and a broad range of perspectives into the South Asian parents' experiences with their mentally ill child. The plan was to have the sample of parents vary in years spent in Canada, primary language spoken, level of education, and socioeconomic status. Variation in the age range of the

children was attempted by having children from four age groupings: seven to nine years of age, 10 to 12 years of age, 13 to 15 years of age, and 16 to 18 years of age. These criteria were a part of a prepared statement describing the nature and purpose of the study which were provided to the psychologists who helped recruit participants. However, as the study progressed and recruitment continued, the challenge in recruiting participants was realized. Based on the literature (Bhugra & Bhui, 1998; Goldberg & Huxley, 1992), it is possible that parents were reluctant to participate because of the stigma associated with mental health issues in the South Asian community. The assistance from different mental health teams became critical in the identification of participants. Hence, the sampling technique shifted from being purposeful to snowballing. Snowballing technique involved introductions to other informants via the mental health team psychologists and mental health workers. In four of the cases, only the mother participated, in one case the father participated, and in one case both the mother and father participated.

Data Collection

The recruitment of participants for this study presented many challenges. In order to solicit support from mental health workers, presentations of the research proposal were made to mental health workers and psychologists at two mental health teams. The mental health workers contacted their South Asian clients as potential participants and asked if their name and phone number could be passed to me. I then contacted the participant and provided an explanation of the study over the phone. Out of the eight couples contacted four mothers participated, one father participated and one mother and father participated.

Initially, parents read and signed an informed consent (Appendix A). Participation in the study was voluntary. An additional assent form (Appendix B) was provided for the

mentally ill children of the parents who participated. This gave these children an understanding of the study and the reason for their parents' involvement in this study. Then parents were asked to fill out a questionnaire, which included a demographic snapshot of each participant (Appendix C). A semi-structured audio-taped interview was conducted to collect the data. The face to face interview, one to one and a half hours in length, was informal and interactive in nature and employed open-ended comments and questions. A series of interview questions were developed in advance aimed at evoking a comprehensive account of the parent's experience of the phenomenon (see Appendix D). These questions were used as a guide and served as a useful reminder of the core aspects of the research question to be explored. This researcher did not attempt to rigidly attempt to follow this guide in a set order because this would have interrupted the conversational flow and inhibit participants to talk about what was of importance in the eyes of the participant. Descriptive questions about what and how things happened were particularly useful in encouraging people to describe their experiences. 'Why' questions were avoided as they seemed interrogatory and had the potential of leading to dead ends. Even though the questions such as 'What were you feelings about...?' and 'What were your expectations of...?' were expected to elicit their personal experiences, according to qualitative research (Polkinghorne, 1989, p. 46), in this study a lot of questions were answered by parents describing what happened in concrete terms. In some cases more questions had to be asked to further clarify and elicit the information required to answer the research questions. Again, questions were explicitly tailored in an attempt to redirect the parents to their own experience. However, the focus very quickly shifted back to the child. It was found that the participants wanted to focus on their child instead of their

own experience as the parents [for their children] seeking mental health services for their children.

In order to create a climate where the research participants felt comfortable in responding honestly and comprehensively, the participants were give the choice of where they wanted the interview conducted, for example, at the mental health center or at their home. All the parents chose to have the interviews conducted in their homes. The participants were given the option of speaking Punjabi, Hindi, or English while participating in the study. Three interviews were conducted in Punjabi.

After each interview was audio-taped, it was transcribed verbatim and field notes were written by this researcher. Next, this researcher, reviewed the audio-taped interview and compared it to the transcription to ensure the transcript was accurate. In three cases this involved a verbatim transcription and in the three other cases this involved simultaneously translating from Punjabi to English and transcribing. Pseudonyms were assigned to the parents participating in this study, their children, and other professionals who were mentioned by the therapists during the interview.

Merriam (2000) and Marshall and Rossman (1999) contend that data collection and data analysis must be a simultaneous process in qualitative research. A preliminary analysis was performed after each interview transcription. This process highlighted important categories and generated other ideas or questions which were deemed important and explored in subsequent interviews. After each subsequent interview, data analysis was conducted using as many codes and categories as possible. These categories were described and interpreted to generate patterns and themes from the perspective of the participants (Agar, 1990). The transcripts and field notes were regularly reviewed

throughout the process of data collection. The field notes included the researchers own subjective experience of each interview and the bracketing that needed to occur during the interview and interpretation of the data collected.

Data Analysis

Marshall and Rossman (1999) describe six phases of data analysis procedures: a) organizing the data; b) generating categories, themes, and patterns; c) coding the data; d) testing the emergent understandings; e) searching for alternative explanations; and f) writing the report. Data analysis occurred simultaneously with data collection because results from each interview were used in subsequent interviews to adjust the interview questions according to new issues that emerged.

Organizing the data. The researcher reviewed each transcript immediately after each interview and made initial notes and comments and created memos related to the transcribed interviews. After the data had been organized by writing code names on the transcripts and by printing off transcripts with large margins, time was spent reading and re-reading the transcripts. It was anticipated that certain words, phrases, patterns of behavior, subjects' ways of thinking, and events would begin to repeat and stand out as the transcripts were re-read (Bogden & Biklen, 1992) and immersion in the transcripts occurred. As Riesmann (1993) explains, "A focus for analysis often emerges, or becomes clearer, as I see what respondents say at this stage" (p. 57). In an open-coding procedure (Strauss & Corbin, 1998), words and phrases were written to represent these topics and patterns. These substantive codes were then identified and grouped together and became more abstract coding categories.

Example of coding from transcript:

I : What else has helped your family?	
P: My main thing is, I have learned more now	*learned*
that only god can change some things. The same	*god can change*
thing the children are realizing…small, small	
things we can't change only god knows what to do.	*god knows*
We don't read much on god, religious magazines but	
100% we believe in god after V.'s thing. There is	*believe in god*
only one hope. We go to temple and do "bhajans" (sing hymns).	*go to temple; sing hymns*

Topic and patterns:

- Strong religious belief
- Practice religion

Abstract Category:

Impact of religious beliefs and spirituality on understanding of mental illness

Category Generation. The process of category generation involved noting patterns evident in what was expressed by participants (Marshall & Rossman, 1999). Merriam (2000) describes the following guidelines when determining categories:

- they should reflect the purpose of the study
- they should be exhaustive
- they should be mutually exclusive
- they should be sensitizing
- they should be conceptually congruent

These guidelines were utilized to ultimately determine which categories would best capture the codes identified.

Coding the data. Patton (1990) describes the processes of inductive analysis where the salient categories emerge from the data. This process of identifying salient themes, recurring ideas or language, and patterns of belief that linked parents' experiences together was the most intellectually challenging phase of data analysis. From the coded categories this writer then began to develop themes across participants.

Testing Emergent Understandings. During this process, this writer began the attempt of theorizing from the categories and themes. Theorizing is defined as "the cognitive process of discovering or manipulating abstract categories and the relationship among those categories" (LeCompte, Preissle, & Tesch, 1993, p. 239). Part of the theorizing process required testing emergent understandings that developed. The usefulness and centrality of data were also evaluated at this stage.

Alternative Explanations. Alternative explanations were sought for individual case data and the linkages among the cases. Plausible explanations were presented based on previous research and my experiences with South Asian clients. The final step in data analysis was reporting the findings in a written report.

Evaluation Criteria

All research must respond to canons of quality – criteria against which the trustworthiness of the project can be evaluated. These canons can be phrased as questions to which all social science research must respond. Lincoln and Guba (1985) refer to these questions as establishing the "truth value" (p.290) of the study, its applicability, consistency, and neutrality. This contemporary synthesis of validity

criteria in qualitative research facilitates the decision-making process for researchers and the evaluative process for consumers of research. Quality of research is dependent on honest and forthright investigations (Marshall, 1990). Validity cannot be assumed, and presentation of research finding must invite the opportunity for critical reflection. A reconceptualization of the concept of validity in qualitative research is illustrated through the explication and differentiation of primary criteria, secondary criteria, and techniques as presented by Whittemore, Chase, & Mandle (2001). In this contemporary synthesis of validity criteria; credibility, authenticity, criticality, and integrity are considered primary criteria, whereas explicitness, vividness, creativity, thoroughness, congruence, and sensitivity are considered secondary criteria.

I have provided answers to the specific recommended questions to assess each primary and secondary validity criteria below.

Primary Criteria

Credibility. Do the results of the research reflect the experience of the participant or the context in a believable way? Credibility was ensured by providing thick, rich, detailed descriptions and quotations when presenting the within case and cross-case analysis so that anyone interested in transferability will have a solid framework for comparison.

Authenticity. Does a representation of the emic perspective exhibit awareness to the subtle differences in the voices of all participants? In addition to identifying the commonalities in the experience to the South Asian parents interviewed in this study, the differences within certain experiences have also been highlighted. Based on their own

views and beliefs about mental illness and treatment all the parents responded in uniquely to the questions posed.

Integrity. Does the research reflect recursive and repetitive checks of validity as well as a humble presentation of findings? The triangulation of the data is utilized in order to ensure internal validity. The use of a variety of data sources included: participant interviewing, reviewing of mental health file, and interviewing of mental health therapists. In addition, two of the informants served as checks through the analysis process which allowed for the participant to comment on my interpretations of their reality and meanings to ensure that the data reflected their experience accurately. A graduate student of the Educational Psychology Department served as a peer examiner.

Secondary Criteria

Explicitness. Have methodological decisions, interpretations, and investigator biases been addressed? At the outset of this study, researcher assumptions were articulated.

Sensitivity. Has the investigation been implemented in ways that are sensitive to the nature of human, cultural, and social contexts? The researcher ensured that the investigation was conducted in a culturally sensitive manner. The researcher gave participants the option of where the interviews would be conducted. Participants were given the option of having the interviews conducted in English, Punjabi, or Hindi.

Summary

In this chapter, the qualitative research design employed in this study has been discussed. The research decisions at various stages of this study including research approach, research design, researcher's assumptions, strengths and limitations, sampling,

data collection, and data analysis have been explicitly stated and these decisions have been supported by qualitative research literature. An outline of the steps taken to ensure validity has been provided in the form of meeting evaluation criteria. Chapter four will focus on the data collected from each of the participants under categories that emerged.

Chapter Four: Single Case Description

Overview

In this chapter the experience of each parent in accessing mental health services for their child is presented. Patton (2002) states that each case should take the reader into the case situation and experience. Following this reasoning, I analyzed each case individually by coding each transcript. Reading and re-reading the codes allowed for salient information to emerge and this information was written on a separate piece of paper for each case. After this I read the notes for each case I began to note patterns that existed in this information. Next, I used index cards to cluster the patterns under categorical headings for each case. During this process of noting patterns in each case and clustering them, it became apparent that similar categorical headings were being generated. A description of each of the parents is provided followed by their experiences which are summarized into the following: 1) change in child; 2) family influence; 3) feelings about seeking mental health services; 4) understanding the therapist's role; 5) parent's role in therapy; 6) other ways of solving problem; and 7) expectations after therapy.

Mrs. Ram

Mrs. Ram is a 36 year old single mother of two sons. Mrs. Ram, who was born in India where she completed Grade 5, is a first generation Canadian. The primary language spoken in her home is Punjabi. Her husband passed away in a car accident when her youngest son Hardip was two years old. Mrs. Ram relies on income assistance and is a homemaker.

Mrs. Ram sought mental health services for Hardip when he was eight years of age after he was removed from his school and placed in a specialized academic program for children with behavioural/emotional concerns. His teacher felt that he was having difficulties in school. The social worker suspected that he was depressed. This was the first time Mrs. Ram sought mental health services. The service providers felt that he would do better in a smaller structured environment.

Change in Child

After their father's death, Mrs. Ram stated that her children were fine. However, the children's teachers reported to her that the children cried at school. In particular, teachers reported that Hardip was not studying or paying attention in class. Mrs. Ram understood from Hardip's social worker that Hardip was having problems in school because he did not have a father. Mrs. Ram felt very disappointed with these comments because she felt that this was not an accurate assessment. Her brother-in-law's children who were of a similar age and they too did not study. In fact, Mrs. Ram was puzzled by the social worker's comments because she did not see Hardip as being any different from other children. In fact she felt that the teachers were making too much of her son's behaviour as he seemed fine to her and therefore, she did not make many attempts to help her son. As Mrs. Ram stated, *"Kids are all the same. They pay more attention to playing games than studying. My son doesn't give me any trouble; the only problem is that he is not doing well in school."*

The decision to have Hardip assessed by a community mental health team was made by the social worker who suspected that Hardip was depressed. Mrs. Ram explained,

When my child was removed from school...3 or 4 months ago. The social worker said that Hardip needs to go to mental health services because he is depressed. I took Hardip to the doctor's office...I had to or they would think that I was a bad mother and that I did not care for my son.

Mrs. Ram did not understand how there could be a problem at school as she claimed that her sons were not upset at home. However, she did seem to realize that her sons' were likely impacted by their father's death.

I did not talk about the death of my husband to my sons. I did not want to weaken their hearts. I wanted them to be strong. Everyone is going to leave this earth someday, some go earlier others later. It was very difficult for me to bring up my kids without their father. A mother cannot replace a father's love and a father cannot replace a mother's love. I cannot fill the void that their father's death has left in my sons' hearts.

Family Influence

Being a single mother, Mrs. Ram relied on her extended family for guidance and she described them as being very supportive. She had consulted with her brother-in-law and eldest sister-in-law before seeking mental health services and her brother-in-law accompanied Mrs. Ram to some of her appointments. Mrs. Ram also trusted her brother-in-law to discipline her sons appropriately. Mrs. Ram expressed gratitude towards her youngest sister-in-law who invited Hardip and his brother to her home for the weekends.

Mrs. Ram especially appreciated the great deal of love and affection that this aunt directed towards Hardip.

Feelings About Seeking Mental Health Service

Once Mrs. Ram had decided to access mental health services for her son, she was very concerned about what the professionals at the mental health team would say about Hardip. *"I was afraid that someone would take my child away and say something wrong about me."* Mrs. Ram understood the role of the therapist as explaining how her child could improve. She saw her role as making sure Hardip arrived at his appointments on time. Mrs. Ram was very spiritual in her beliefs about her son's illness and treatment, resigning the outcome of her son's illness to God. *"I think everything is in God's hands. I needed to take him to mental health services. The doctors need to medicate him."*

Understanding of Therapist's Role

Mrs. Ram had a very pragmatic understanding of the role of the therapist in her son's treatment. She understood that the therapist would talk to Hardip in order for Hardip to express whatever was on his mind or to communicate his inner feelings. Mrs. Hardip did not have a preference as to the ethnicity of the therapist as long as an interpreter was available to translate into Punjabi. Her brother-in-law or another family member would accompany her to the appointments at the mental health team and she found it beneficial to have a doctor that spoke Punjabi so she could communicate through him

Parent's Role in Therapy

Mrs. Ram understood that she was to take Hardip to his appointments with the mental health team and to encourage him to attend when he lacked motivation. She found it difficult to help because Hardip would often meet alone with the therapist. Mrs. Ram said that she would not meet with the therapist regularly because she could not speak English. However, when she was informed of the medications that Hardip needed, she ensured that he took his medication. During the week she also encouraged him to follow the directions given by the therapist and doctor.

Other Ways of Solving Problem

In addition to Hardip seeing a therapist, Mrs. Ram's brother-in-law also spoke to Hardip about the importance of working hard in school. She mentioned going to the Sikh temple to pray for the health of her family. Since Hardip was removed from his school, Mrs. Ram encouraged him to attend any school that accepted him. She felt that she was doing her best to encourage Hardip to get back on track. However, Mrs. Ram was very angry when the social worker suggested that Hardip live in a residential resource or group home for youth. Mrs. Ram had no prior knowledge of this proposal when she met with the social worker. She did not understand how living in a group home was going to help Hardip. From Mrs. Ram's perspective, she was the mother and it was her responsibility to care for her son. She felt that the social worker was imposing her beliefs on Mrs. Ram and her family.

Expectations After Therapy

After therapy, Mrs. Ram expected Hardip to return to school and to studying. She expressed, *"I expect that my child will go back to school and study. I want the doctor to find out what is wrong and what needs to be done. I can't assess what is wrong with Hardip. I want the doctor to do this."* Mrs. Ram continued to be unconcerned about Hardip's ability to cope with his father's death. She felt that her son was managing to cope with the loss in a fairly healthy manner and that he was surrounded by love from her and extended family members.

Summary

Mrs. Ram did not comprehend the extent of her child's maladaptive behaviour and did not believe that her son had a problem. Mrs. Ram's experience was guided by a key factor of not having command of the English language. Her inability to understand and communicate in English meant that messages that she received from mental health professionals and then sent to mental health professionals were lost in the communication. Mrs. Ram, being a single-parent, faced a number of challenges in her own community. Mrs. Ram felt obliged to follow through with the requests of professionals around her as she did not want to jeopardize losing her son.

Mrs. Joshi

Description of the Parent

Mrs. Joshi, a 43 year old South Asian woman who immigrated from Fiji and is first generation Canadian, lives with her husband, son, daughter, and father-in-law. Mrs. Joshi has a Grade 12 education and the primary language spoken in her home is Hindi. She is a homemaker and has some significant physical health concerns of her own. Her

son Amar was diagnosed with schizophrenia at the age of 15 and has been in treatment with a community mental health team for three years.

Change in Child

For approximately six months prior to her son, Amar, being diagnosed with a mental illness, he isolated himself from his family. At the time, Mrs. Joshi thought that this was a phase for her 15 year old teenage son and that this behaviour was not uncommon among teenagers. Amar was not doing well in school and transferred himself to another school without involving his family in this decision. Additionally, Mrs. Joshi was not contacted by the school to inform her that Amar had changed schools. One day when she asked her son about school, she discovered that he had transferred schools. She explained how Amar would shower but not change his T-shirt. He would put on the same dirty T-shirt. She would tell him to change his shirt but he did not cooperate. In hindsight, Mrs. Joshi believes that she should have sought help at that time but she did not know where to go for help.

Amar began to hallucinate and one day he called the police. Mrs. Joshi explained how Amar was taken to UBC Hospital by a police officer and a psychiatric nurse. Mrs. Joshi could not comprehend what was taking place and she was very worried about her son. The next day Amar was transferred to BC Children's Hospital. Again Mrs. Joshi felt she was not informed as to what was happening to her son. Mrs. Joshi remembered visiting Amar at the hospital. She assumed he was sick but would get better. Mrs. Joshi believed God was making her son ill. Amar was transferred to a community mental health team from the children's hospital for psychiatric follow-up. Mrs. Joshi said that she was angry and felt helpless when Amar refused to go to the community mental health

team. Mrs. Joshi felt that the mental health team's involvement would be good for Amar in medical terms, but to her Amar did not show major symptoms *"...like being jumpy or becoming violent."*

Family Influence

Mrs. Joshi noticed some stress in her family as a result of Amar's mental illness. Her father-in-law lived with the family and his relationship with Amar was very close until Amar became ill at which time Amar's grandfather started to distance himself, and as a result their relationship became tense. However, Mrs. Joshi noticed that Amar's illness brought him closer to his sister. Before Amar became ill they would argue a lot; however, after Amar returned from hospital they became quite close as siblings. Mrs. Joshi felt that her relationship with Amar did not change during this process. She explained how it was very stressful for her and her husband because they were never told that Amar had schizophrenia. They did not blame one another for what had happened to Amar. Initially Mrs. Joshi thought that Amar would get better, but he did not.

Mrs. Joshi also felt like she was walking on eggshells as she didn't know what was going to upset her son. She described times when Amar would get angry for no reason. Mrs. Joshi also could not manage what she termed her son's *"laziness"* and in turn become very angry at him.

Feelings about Seeking Mental Health Service

Mrs. Joshi shared that she did not feel any shame or guilt in using mental health services. However, she admitted that she was not involved in many of the steps that led her son to the community mental health team. Mrs. Joshi describes, *"He went to UBC*

Hospital and then straight to Children's Hospital there. Then, he came home and then saw mental health services. I was not involved. I didn't have any connection."

Understanding of Therapist's Role

Mrs. Joshi described the role of the therapist as talking with Amar and giving him medication. She did not feel that the therapist had a lot of impact on Amar. She felt that the therapist was not assertive enough in dealing with Amar. Mrs. Joshi did not feel the ethnicity of the therapist mattered because she spoke English. However, she did comment that it was comforting having the psychiatrist (in her words "a South Asian doctor") because he could understand the culture.

Parent's Role in Therapy

Mrs. Joshi recalls doing all the talking because Amar would not talk. Even now, two years later, Mrs. Joshi finds herself doing most of the talking with the mental health professionals. She would like Amar to describe how he is doing, but he refuses to talk with the therapist. Mrs. Joshi questions whether it is right for her to do most of the talking on behalf of Amar. She contemplates,

> *Even now, we have to go to the psychologist next week and I don't know if I should go...for the first time maybe I should go...but I want him to do the talking himself. I will see how I feel.*

Other Ways of Solving Problem

Mrs. Joshi said that while Amar was in therapy she prayed. She added how Amar would not join her in her prayers. Mrs. Joshi was very disappointed when she heard that her son had started to eat beef. Mrs. Joshi has been a vegetarian all her life and her Hindu beliefs condemn eating beef. She said, *"this was the most upsetting thing that Amar had*

done and he has greatly disappointed me by eating beef. I wish he would not do this; but he really likes beef now...I don't know why." She also mentioned how she had seen a priest about Amar initially when Amar was not going to school. Her husband does not believe in seeking guidance from priests but her father-in-law encouraged Mrs. R. to seek guidance from a spiritual leader. She said that she hasn't tried seeking a priest presently, but maybe she should try again. However, she feels that it would not be appropriate now that Amar has started eating beef.

Expectations from Therapy

Mrs. Joshi feels that the mental health team should have been more involved. She feels that if the therapist at the mental health team told him that he has to go to school that he would listen. She is disappointed that there is nothing happening in his life. She expressed,

> *I talked to my sister in America and she said that there people with a mental illness are told what to do. They have to go and obey those things. But, here nobody does help, they say well if he is not going to school that it is his problem. I think it has been a long time now and still I don't see any change.*

Summary

Mrs. Joshi's experience was one of "not knowing". At the time of decline in her son's mental health, Mrs. Joshi admits that she did not see any symptoms that Amar was having difficulties. She expressed feeling very helpless when her son was hospitalized. The manner in which Mrs. Joshi made meaning of her son's illness was that it was a punishment from God. Her religious beliefs guided her understanding of the onset and

treatment of her son's mental illness. She did consider taking her son to a spiritual healer; however this was not supported by her husband. Mrs. Joshi did not feel that either the school system or the mental health system fully involved her in the treatment of her son. Mrs. Joshi felt quite powerless in providing support to her son although she complied with the decisions made by professionals around Amar's care.

Mrs. Dhillon

Description of Parent

Mrs. Dhillon is a 34 year old mother of two sons. She was born in India and is first generation Canadian. Mrs. Dhillon has a grade 12 education. She was married for 11 years before she separated seven years ago. At the time of the interview, Mrs. Dhillon had been seeking support from a mental health team for depression for approximately four years. Mrs. Dhillon's son was six years old when he first received mental health service and he was involved for approximately two years with a mental health team. At the time mental health service was accessed, her son was living with her ex-husband and in-laws.

Change in Child

Mrs. Dhillon became aware when Sunny was depressed very quickly because she also suffers from depression and is being followed by a community mental health team. She noticed symptoms of Sunny not eating properly and losing his appetite. These symptoms started when Mrs. Dhillon separated from her husband. Then, Sunny began to miss school and the teacher understood his problem to be emotional in nature. He would complain of having a fever and not feeling well. Also, Mrs. Dhillon's in-laws would keep

her children away from her and not allow them to see her because they felt her depression had a negative impact on the children and that she was unable to care for them.

Family Influence

Mrs. Dhillon believes the tension between herself and her husband and in-laws made the experience of helping her son very difficult. Most times she felt very helpless as her in-laws would not allow her to see her son. The in-laws did everything possible to keep Mrs. Dhillon away from her son. To make matters even more complicated there was a custody and access battle between herself and her husband.

Feelings About Seeking Mental Health Service

The in-laws made all the decisions around Sunny's care. They initially took him to the family doctor who said that Sunny needed to see a psychiatrist because there was nothing wrong with him in a physical sense. Because the in-laws knew that Mrs. Dhillon was accessing mental health services they thought that it would be beneficial for Sunny as well. Sunny went to the same mental health team as Mrs. Dhillon. The therapists at the team would give Mrs. Dhillon updates about her son's progress as she was not allowed to see him. Mrs. Dhillon found it very difficult emotionally, not being able to see her son. Because Mrs. Dhillon didn't accompany Sunny to mental health services she could not speak to that experience. Instead, Mrs. Dhillon described the first time she went to seek mental health service.

She recalled being very comfortable speaking with the psychiatrist and therapist about her life history and family history, although she did remember being afraid that she would be judged as a wife or mother. She did feel that the family doctor needed to be more proactive in making a referral to a mental health team. She added that in the South

Asian community GPs are well respected and trusted. Therefore, a doctor's recommendation or advice holds a great deal of credibility and validity. Therefore, she believes that the GPs should take the time to introduce and explain psychiatric services to their clients who may benefit from this service and to also explain the difference between a mental illness and a physical illness based on symptomology.

With regards to the psychiatrist and therapist she said it was beneficial to have professionals from her own culture. And with respect to gender she would have felt more comfortable with a female. She did not have any issues around the age of the professional. Mrs. Dhillon described the therapy that occurred with her son. She said that therapist would watch as Sunny played with toys and then try to change his way of interacting.

Summary

Mrs. Dhillon's perception of mental health services was influenced by her own past involvement. Having a positive experience with mental health services herself, she was very optimistic when Sunny was referred to the same service. Mrs. Dhillon focused on the physical symptoms of her son which led her to reach out for support from her family doctor. She did not attribute Sunny's behaviour as being related to any emotional difficulties that he may be having. She began to become quite concerned when he was missing weeks of school at a time because he expressed not feeling well. The school counsellor identified Sunny as possibly experiencing some emotional difficulties. Mrs. Dhillon was clearly aware that the separation between herself and her husband was impacting her son. She acknowledged that her son was dealing with many issues and did

not have the ability to express his feelings. Due to fact that Sunny was residing with her ex-husband and in-laws she did not have much control or involvement in his treatment.

Mr. and Mrs. Deol

Description of Parents

Mr. Deol is a 47 years old first generation Canadian, born in India. He works as a janitor. Mrs. Deol is 42 years old and was also born in India. She is a homemaker. The primary language spoken in their home is Punjabi. They have three children, two sons and a daughter. Their son, Sukhbir, was diagnosed with depression approximately two years ago.

Change in Child

Sukhbir underwent a number of surgical procedures in the span of two to three years. He needed a shunt surgically placed in his brain due to fluid accumulating in his brain. This operation needed to be performed three times in order to finally be successful. He also had appendicitis and which involved another surgical procedure. Mr. Deol expressed how this impacted Sukhbir tremendously.

Mr. Deol assumed that something was wrong when Sukhbir would not go to school and began complaining of headaches. Mrs. Deol explained how she gave Sukhbir Tylenol for his headaches but this did not prove to be effective in relieving the pain. Mr. and Mrs. Deol suspected that their son was being bullied at school and this was the reason he insisted that he did not want to go to school. They took him to a specialist as well but he could not understand what was happening with Sukhbir. Before seeking mental health services, Mr. Deol said that he would take Sukhbir for a walk on the

recommendation of his family doctor. Sukhbir would become tired very easily. Mr. and Mrs. Deol noticed that their son, who had been fairly active in the past, was no longer motivated to do anything.

Family Influence

Mr. and Mrs. Deol had some support from extended family, however extended family members did not influence or input into decision making around Sukhbir's treatment. Mr. and Mrs. Deol primarily relied on each other to support their son and other children. Mr. and Mrs. Deol had a very supportive relationship which helped in their caring for their son during the years of his medical complications.

Feelings about Seeking Mental Health Services

The teacher and principal asked Mr. and Mrs. Deol for consent to refer Sukhbir to mental health services. Mr. and Mrs. Deol were puzzled as to why these professionals were asking permission to help their child. Mr. Deol, *"For us we just wanted Sukhbir to get better...I told them to go ahead and do what they needed."* They were very comfortable taking Sukhbir to see a psychologist at the mental health team. They were anxious to get their son the support that he needed.

Understanding the Therapist's Role

Mr. and Mrs. Deol felt that the role of therapist was to converse with Sukhbir. However, they were more focused on the role of the doctor in their son's recovery. Mr. Deol expressed his enormous sense of relief when the doctor diagnosed Sukhbir as having depression. The doctor informed the parents that Sukhbir would need to take some antidepressant medication. A few weeks after he had been on the antidepressant medication Mr. Deol described Sukhbir as becoming stronger.

Mr. and Mrs. Deol believed that it was very helpful having a Punjabi speaking doctor as they were able to understand the diagnosis which they feel they would not have understood if it was explained to them in English. They also felt comfortable in knowing that the doctor had the same cultural background which allowed him to understand their concerns as South Asian parents.

Parent's Role in Therapy

Mr. Deol felt that his role was to make sure that Sukhbir attended his appointments at the mental health team. He recalled the difficulty in convincing Sukhbir to go to the second meeting at the mental health team. After his first session, Sukhbir shared with his father that the doctor was asking him "weird" questions. Mr. Deol would encourage his son to answer the questions the doctor was asking because Mr. Deol believed that this was the only way Sukhbir could be helped and cured.

Other Ways of Solving Problem

Mr. and Mrs. Deol did not explore alternative ways of treating Sukhbir. They would follow the directions of doctors in taking Sukhbir for walks and keeping him happy, but did not feel that they had any means of making Sukhbir better and that is why they felt that the medical system needed to assist them.

Summary

Mr. and Mrs. Deol experienced the change in Sukhbir very gradually. They recognize that he underwent a lot of complex medical procedures at a very young age. However, they did not link this to Sukhbir's emotional health being impacted. Mr. and Mrs. Deol were very grateful for the support that they received from the medical professionals involved in caring for Sukhbir. They described the process of seeking help

for their son as somewhat frustrating. From their perceptive the experts in child development and mental health should not have been asking them for permission to help their child. The role of the doctor was seen as much more prevalent than that of the therapist. Mr. Deol encouraged his son to engage in talking with the doctor.

Mrs. Parkash

Description of the Parent

Mrs. Parkash is a 39 year old woman who lives with her husband and three daughters. She was born in South India and is first generation Canadian. Mrs. Parkash has a Grade 12 education and is currently a homemaker. The family speaks Tamil at home. Her husband has a chronic illness and cannot work. The family is on income assistance. Mrs. Parkash holds traditional Indian values and believes strongly in her Hindu faith. Mrs. Parkash's daughter, now eighteen years old, has been receiving mental health support services for approximately two years in Canada. Previously, she was being supported by a psychiatrist in India.

Change in Child

Mrs. Parkash's first experience with seeking mental health services for her daughter was in India. Her daughter, Gita, was 14 years old when she started to complain about having headaches. Mrs. Parkash said that her remedy was to give her daughter Tylenol. Mrs. Parkash noticed that a few months later, Gita began to imagine seeing people who were not actually there. Mrs. Parkash tried to reassure her that there was no one and that it was impossible that someone was watching her. Gita then went and told a family friend.

Family Influence

Mrs. Parkash feels she has not received very much support from her husband. Mr. and Mrs. Parkash have kept Gita's mental illness a secret. Mr. and Mrs. Parkash differ immensely in their thoughts on how to deal with Gita's emotional difficulties. Mr. Parkash did not want Gita to take part in any treatment through community mental health. He is very resentful when Mrs. Parkash took Gita to be assessed by a psychiatrist in India and a community mental health team when they immigrated to Canada.

Feelings About Seeking Mental Health Services

When Mrs. Parkash and her family were in India, a family friend insisted on taking Gita to see a psychiatrist. Mr. and Mrs. Parkash did go to the appointment; however Mr. Parkash said that there was nothing wrong with his daughter and that Mrs. Parkash was crazy. Mrs. Parkash remembers crying the whole way to the doctor's office. Mrs. Parkash said that she did not do anything to fix Gita's problem before seeking mental health services because she was at a loss as what to do. Mrs. Parkash said that they did not tell anyone about Gita's problem. The psychiatrist placed Gita on medication and Gita was very cooperative in following the medical regimen.

When the family came to Canada, they sought the assistance of a community mental health team in Vancouver; however Mrs. Parkash described it as a very difficult experience. First, Gita had not been told that she was suffering from a mental illness, namely schizophrenia. Gita was told by her parents that she was suffering from migraines and that was the reason for her being on medication. When she went to the mental health team she saw the name of the office on the door "South Mental Health Team." The doctor and mental health worker indicated that Gita had a right to know about her

condition and to be given information. Mrs. Parkash was very upset about having to tell her daughter that she had a mental illness.

Understanding of Therapist's Role

In India Mrs. Parkash was accustomed to dealing with only the psychiatrist and was not familiar with the team approach to the services offered. As Mrs. Parkash expressed,

> *We only wanted to see Dr. M., there (in India) you just see the doctor, you come home, you give the tablet, and you don't talk to anybody. But, we were told that we only see Dr. M. once in three months and that in between the mental health worker M. was going to be talking to us. That all we didn't like. Why, why do we have to talk about this?*

Mrs. Parkash felt that things are made bigger than they need to be sometimes. Mrs. Parkash felt that all her daughter needed was the medication. She did not like the mental health team encouraging her daughter to participate in rehabilitation or support groups.

Parent's Role in Therapy

Mrs. Parkash felt that she was the one who did all the talking at their regular appointments at the mental health team. She felt that she needed to explain Gita's mood and behaviour during the week because Gita was not sharing this information readily with the mental health worker. Mrs. Parkash participated reluctantly in a psycho-educational group on schizophrenia for parents.

Mr. and Mrs. Parkash were asked to participate in a support group for parents but they did not see this as necessary.

> *They were asking us to come for some meeting, so my husband was deadly against it. He said we are not going to come because*

he was scared that other Indians were going to come and we don't want to tell anybody. Even now my husband won't come for anything.

Other Ways of Solving the Problem

Mrs. Parkash is very spiritual and she feels that having belief in a higher power gives her strength.

My main thing is I have learned more now that only God can change some things. The same thing the children are realizing...small, small things we can't change; only God knows what to do. We believe in God 100% after Gita's thing. There is only one hope. We go to temple and do bhajans. Gita wants to go...she loves to go.

Expectations of Therapy

Initially, Mrs. Parkash felt that her daughter would get better and would be "normal". Mrs. Parkash expected to be able to speak about Gita to the doctor at the community mental health team whenever she needed. She did not appreciate having to converse through the mental health worker.

We were not thinking that they would say that we can only see the doctor once a month...like there [India] it is not like that...like 250 rupees you give to the doctor and you can see the doctor anytime, you can talk anytime. And here [in Canada] we had to call the office and talk to Dr. Anand and we had to talk through Mary. So it was kind of annoying why do we have to talk in between people...like we

also want to talk something...and Mary would say, 'no I'll find out [the information] and get back to you'.

Mrs. Parkash also wanted the mental health team supporting her daughter to complete her college education.

Summary

Mrs. Parkash transitioned from receiving mental health services for her daughter in India to Canada. Mrs. Parkash found it difficult to adjust to the manner in which service was provided at the community mental health team in Vancouver. She found that too many professionals were involved in her daughters care. She appreciated the simplicity of service delivery in India which involved the psychiatrist prescribing medication without any therapeutic support. Although Mrs. Parkash admitted to resisting support services initially, she did find the psycho-educational group related to schizophrenia for parents quite useful.

Mr. Mann

Description of Parent

Mr. Mann is a 64 year old man who lives with his wife, two children, and father. He was born in Punjab, India and is first generation Canadian. The family speaks English at home. Mr. Mann has a Grade 12 education and is a retired sawmill worker. His 21 year old son, Jas, has been receiving mental health services for four years.

Change in Child

Mr. Mann was asked to come to attend his son's high school to talk about the difficulties that Jas was reported to be having. When Mr. Mann addressed these concerns

with Jas, his son attributed the blame to his teachers. In Grade 10 Jas refused to go to school and said that he needed to spend time at home. When Mr. Mann went to the school to ask for support they told him that nothing could be done. Mr. Mann was instructed to motivate Jas. Mr. Mann attempted to encourage his son to attend school. However, he would spend his day watching TV, playing on the computer, and sleeping.

Mr. Mann reported that Jas had become verbally and physically aggressive with his mother and sister. Mr. Mann contacted the family doctor and described Jas' behaviour which prompted the family doctor to contact BC Children's Hospital. When Jas refused to attend his appointment, the doctor at Children's Hospital invited the whole family. Mr. Mann would see the doctor at Children's Hospital every two weeks. Occasionally, Jas would join him for these appointments. Mr. Mann describes some stability in Jas for about six months where he went back to school, even though, he was not keeping up in his classes. After this six month time period, Jas stopped attending school once again. Mr. Mann described Jas as irritating his sister and arguing with his mother. Mr. Mann contacted the family doctor who arranged a follow-up visit to BC Children's Hospital.

Family Influence

Jas' illness did create some conflict between Mr. and Mrs. Mann. Mrs. Mann did not tolerate her son's abusiveness and began to shout back at him, telling him to stop. Mrs. Mann even went so far as to call the police and accuse her son of assault. Mr. Mann felt that his wife did not have the patience to deal with Jas and in turn he became distressed by his wife's response.

> *Sometimes it's very hard because my wife will lose her cool. And she feels that she has the right to be angry at him when he gets hostile with*

> *her because she doesn't see him as being sick. At that moment she just sees him as being her son shouting at her and being hostile. She gets hostile with him.*

Mr. Mann, in contrast, saw Jas' abusiveness as an exaggeration of the illness. He felt that he was able to give Jas the time he needed to control his anger and hostility. These differences caused difficulties in their marriage. Mr. Mann expressed, *"You know you become short tempered and you are unable to relate to one another. You are not in a good mood and you cannot enjoy life."*

Feelings about Seeking Mental Health Service

Mr. Mann felt encouraged by having seen a mental health professional. He shared,

> *I felt better and that we were back on the right track. I felt that they were listening to what we were saying. The doctor assured us that things would be better; he's a nice doctor. I had this expectation that after this doctor talks to him things would improve.*

Understanding of Therapist's Role

Mr. Mann had a very difficult time navigating the services available for his son. He was directed to take his son to see a psychologist. He felt that this service was expensive and that Jas would not cooperate with attending appointments. Mr. Mann did not find it useful for him and his wife to see a psychologist. He felt that there was no benefit in his wife and himself seeing a psychologist when Jas was the one who needed help, therefore, he said that they never went back. Mr. Mann thought that a doctor would

be able to figure out what was wrong with Jas and then give him some medicine. Mr. Mann became upset with the medical professionals as they were not able to detect what was happening to Jas. Mr. Mann felt that a therapist may be able to assist Jas in talking about what was bothering him. However, Mr. Mann was disappointed with the continuous change in therapists at the mental health team. Mr. Mann noted that Jas had four or five therapists in the span of three years. He felt very strongly that this did not give Jas an opportunity to develop a relationship with any of these therapists.

Parent's Role in Therapy

Mr. Mann was the only one in the family who was involved in finding therapeutic supports for his son. He did not have the support of his wife or daughter in this process. Mr. Mann gave much of his attention to his Jas' care. He showed great determination in finding the appropriate supports for his son. So, although, Mr. Mann described his role simply as transporting Jas to his medical appointments, he actually played a larger role in that he was the catalyst of his son getting support from mental health services. Mr. Mann describes,

> *The doctor said that he would send him to the hospital and sent him to Vancouver General Hospital this time. He stayed there for three or four days and then was sent to UBC Hospital because it fell in our area. So, I made it my daily job to see him. I didn't want him to feel that I had abandoned him.*

Mr. Mann would bring things to the hospital to make Jas stay more bearable. He reminisces,

I used to take Jas whatever he wanted; candy and other things he requested. Then, one day he wanted a CD player for his room. I asked the hospital nurse if he could have a CD player and she said that she would have to ask the doctor. He was allowed. I also used to bring him books from the library so that he could read.

Mr. Mann supported Jas by dealing with his court case and charges of assault that the police had interpreted from Mrs. Mann's statement. There was a no contact order issued against Jas which meant he could not see his sister or mother. Mr. Mann felt that he was the only person that could reach out and connect with Jas. He requested that Jas be released for Christmas Day. He drove Jas around to see the Christmas lights. Mr. Mann had crown counsel loosen the restrictions around contact so that Mrs. Mann and Jas' sister could see him. Mr. Mann made the effort to bring his wife to the hospital to see Jas even though he sensed many unresolved feelings around the incident which made it hard for Sunny and his mother to communicate.

Other Ways of Solving the Problem

Mr. Mann explained that concurrent with Jas' appointments with mental health services, Jas' diet was changed. Mr. Mann explained, *"We tried to change his diet. We would give him healthy food; more yogurt, buttermilk and fruit juice."* Mr. Mann said the family also turned to religion for guidance and support. He recalls, *"...me and my wife went to see a wise man."* Jas requested to have his palm read but Mr. Mann did not think this was a good idea because of *"Jas' fragile state of mind."*

Expectations of Therapy

After the initial meeting at the mental health team, Mr. Mann found new hope in the process of helping Jas get back on the right track. He felt that the psychiatrist and mental health worker were listening to him. Mr. Mann was hopeful Jas returning to school, "*After some sessions with the doctor he might be ready to go to school. Once he starts going to school, he will be on the right track. He needs to finish high school as a start.*"

Summary

Mr. Mann attempted to access a number of services for his son. These included a children's hospital, a private psychologist, and finally a community mental health team. He became very frustrated with the system of care as he knew that there was something wrong with his son. He believed that professionals had failed to detect the problem in the early stages and later the professionals could not cure Jas of his schizophrenia. Mr. Mann felt upset by the number of therapists that went in and out of his son's life as he felt that his son did not have the opportunity to build a relationship with any of the therapists. Jas' intense emotional state contributed to tension in the home and especially impacted Mr. Mann's relationship with his wife.

Summary

This chapter has provided a detailed description of each parents experience with their child's mental illness which includes the process of initial discovery of noticing a change in their child through to receiving support from a mental health service team. The individual case analysis allowed the unique experience of each of these South Asian parents to be illuminated, including the parents' feelings during the process of supporting their child. The next chapter will provide an analysis across these cases to further explain

the similarities and the uniqueness in the experience of South Asian parents when seeking mental health support.

Chapter Five: Cross Case Analysis

Overview

In this chapter, a cross-case comparison is made to identify how, despite the different situations that guided each parent's experience of the mental health system, similarities existed in their experience. I performed content analysis by reading through the transcripts and searching the text for recurring words, concepts, and patterns across the transcripts. These recurring words, concepts, and patterns were clustered on post-it notes and assigned core meanings. The core meanings constructed through content analysis were described by a few words and these words became the themes.

This chapter begins by outlining mental health help-seeking of South Asian parents. Next, the themes that emerged from the parents' experiences will be discussed. These themes regarding their child's mental illness related to: 1) spirituality as the cause of mental illness; 2) impact of mental illness on education; 3) understanding the role of therapy; 4) medication as the cure; and 5) presentation of physical complaints.

Mental Health Help-Seeking of South Asian Parents

The model for mental health help-seeking (Srebnick, Cause, & Baydar, 1996) which was introduced as a conceptual lens in the methodology of this study will now be utilized in analyzing the stages through which the South Asian parents progressed in recognizing that their child may have a problem, deciding to get help, and deciding who they would turn to for help.

Problem Recognition

Initial Reaction of Parents. In this study, two of the South Asian parents initially reacted by minimizing early changes they noted in their child. They ignored these

changes and there significance as predictors of more extensive changes to come. Some parents adopted the attitude that the changes in their child's behaviour would work themselves out in time. For example, Mr. Mann expressed, *"I thought, you know, that he was a little kid, only in Grade 7, and that when he grows up he will grow out of it."* Mrs. Joshi shared, *"I thought it was his age, being a teenager. He wanted to be left alone and was distancing himself from the family."* These two parents needed to justify to themselves that their child was like any other child and that, they as parents, did not need to worry too much about the child's behaviour. Mrs. Ram was waiting for her son to grow out of the phase of being a kid and Mrs. Joshi was recognizing her son's behaviour as typical teenage behaviour.

Other parents moved to find out what was troubling their child in a more proactive effort by providing assistance. They expected to solve the problem quickly. As Mr. Deol expressed, *"The school was asking if they could refer Sukhbir to mental health and we said of course go ahead and do what you need to make our son better. We wanted our son to get better, to get better quickly."* Mrs. Parkash tried to "nip it in the bud" by remedying Gita's symptoms. *"Always she had headaches. So our very easy remedy was giving her Tylenol. So every time she had a headache we gave her Tylenol; headache-Tylenol, headache-Tylenol."*

Initially, there is no recognition of the severity of the behavioural alterations. At this stage of the illness, parents approached unusual behaviour as manifestations of a temporary condition rather than as the first signs of an enduring condition. Since behavioural changes were minimized or normalized or seen as transient during the early phase of mental illness, the psychological impact of the illness was still circumscribed.

Emotional reactions of the parents were confined to intermittent anxiety and vague feelings that something "might" be seriously wrong.

Inability to Solve Child's Behaviour Problem, Helplessness, and Coping. At times, some of these South Asian parents found themselves stalled in open and continuing conflict regarding the affected child's problematic behaviour. They are no longer able to ignore, yet they are unable to act effectively. According to Mr. Mann,

> *This had an effect on my family. You know you become short tempered and you are unable to relate to one another. You are not in a good mood and you cannot enjoy life. At the same time, you don't know where to go and where to get help.*

Faced with a persistent disparity between evidence of a serious problem and inability to solve that problem, the South Asian parents attempted to cope by limiting or minimizing the implications. Mrs. Ram voiced,

> *The social worker was saying that Hardip was having problems in school because he did not have a father. I did not think this was right because my brother-in-law has kids the similar age and they don't study...Kids are all the same they pay more attention to playing games than studying.*

Mrs. Joshi felt that her son was just being lazy and she suspected that maybe his illness was not as severe as he was making it out to be. She expresses, "*If Amar would help out around the house it would be much better, but he doesn't do anything. Like putting out the garbage. He doesn't do anything but eat, sleep, and play video games.*"

Mr. Mann was told that he needed to motivate Jas because, "*all he would do at home was watch TV, play on the computer, and sleep.*"

At this stage the parents still experienced high levels of anxiety and continued to witness the disintegration of their child with a feeling of helplessness. However, there is still hope that their child would get better. The parents were not ready to face the problem as it grew worse.

Summary

The problem recognition phase of the process in seeking mental health support by South Asian parents were guided by their initial reaction to their child's behavioural changes. In this study, parents minimized and normalized their child's behaviour. This is reaction of parents is supportive by previous research which has shown that South Asian parents focus more on the child's physical health as opposed to mental health (Roberts & Cawthrope, 1995). Other research has shown that based on their worldview, South Asian parents may not pay attention to or focus on their child's emotional difficulties and therefore they cannot be expected to react (Hourani & Khlat, 1986). In addition, South Asian parents in the past have taken a more subjective view of their child's problem and have not noticed anything wrong without bothering to get an objective opinion (Pottick, Lerman, & Micchelli, 1992).

As the child's behavioural problem became more pronounced it could no longer be ignored by the South Asian parents. At this point, feelings of helplessness and frustration arouse which can be understood in relation to previous research which has show that restraint amongst children (Das & Kemp, 1997); cooperation (Cousins, 1989); and responsible social behaviour (Crystal & Stevenson, 1995; Markus, Mullay, &

Kitayama, 1998) are valued and emphasized by South Asian parents. Caring for the child at this stage can also become increasingly difficult and hence increased feelings of anxiety were experienced by parents in this study; especially by mothers who were the primary caregivers of the children. This is consistent with previous findings that suggest more anxiety, depression, and fear in mothers who are caring for their mentally ill children as opposed to fathers (Eisner, 1990, Thompson & Gustafson, 1996). As a coping mechanism the South Asian parents in this present study may have continued to minimize their child's behaviour. Acknowledging that their was a problem may have been difficult for the parents in this study, especially the mothers who would feel that they failed in their roles as mothers which is an important part of their role in life and identity (Ghuman, 1994).

Decision to Seek Help

Acknowledgement of Severity. Eventually something happened in all of these cases. The adaptive decline of the child or constriction of the child's daily activity escalated past some invisible threshold of severity, sufficient to trigger major concern in the parents. Mrs. Ram became concerned when her son was expelled from school while Mrs. Joshi realized the seriousness of the situation when Amar began hallucinating. Mr. and Mrs. Deol showed concern when Sukhbir lay on the sofa for hours at a time, no longer interested in school or play activities. When Mrs. Prakash witnessed her daughter's terror, because she thought someone was constantly watching her, she knew something was seriously wrong. Mr. Mann took note when his son became verbally aggressive towards his mother.

Response to Crisis. Eventually something very compelling and disastrous occurred where the child became impaired or out of control. For Mrs. Ram this moment occurred when her son was expelled from school. For Mrs. Joshi the turning point occurred when her son was hospitalized.

> *[A]fter six months or something...he was hallucinating that he said that he saw something. He said that someone is trying to kill him. Amar was talking to someone on the phone. Amar had actually called the police. The police came here and they saw what was wrong, they figured it out. There was a nurse here too. Amar didn't want to go with them and was fighting back. They took him to UBC Hospital.*

Mr. Mann explained how Jas became more violent and was sent to BC Children's Hospital numerous times.

> *...whenever we had a fight in the home my wife would call emergency and the ambulance would come and take Jas to the hospital. He would be released back home the next day. This would happen about once a month. He would pick a fight with his sister. Sometimes the police would come and then the ambulance and he would be taken to hospital.*

Mrs. Parkash became worried when Gita came home from school very upset.

> *[s]he came and cried that her physics teacher and somebody else was talking at the window and looking at her as she was changing her clothes. But, this was impossible because we live on the second*

floor of a house and there are heavy curtains. So, I told her that no one could look at her. Then she went to a family friend crying that she was seeing people following her.

It is evident from the process of these South Asian parents that the illness of the children was never accepted. The parents did not come to terms of their child being ill. In these cases, the children of these parents came to the attention of the professionals that were in close contact with them, for example, school teachers and school counsellors. The teachers then encouraged parents to have their children seen by a psychiatrist or mental health worker. The parents felt that they needed to comply with these requests. They feared the consequences of not complying would be having their children taken away or their children not being able to attend school. Therefore, the acceptance was in the form of compliance for these parents. Parents complied with the plan of professionals who were seen as authorities, controlling or guiding their children's future.

Underlying Stigmatization. Stigmatization was a reason for not seeking mental health service in a timely manner for the parents in five of the cases. Through the direction of general practitioners, social workers, and school educators, these parents were directed to mental health services for their children. However, instead of acknowledging the feelings of shame in seeking mental health services, these parents expressed "not knowing" what was happening to their child or where to go for help. Mrs. Joshi thought her son was acting like a typical teenager. Mr. and Mrs. Deol took their son to several physicians who could not pinpoint what was wrong. Mrs. Ram still does not understand and remains confused about her son's emotional difficulties. Mrs. Parkash felt

that her daughter was just overwhelmed because her long days at school and the pressure of excelling academically.

Summary

Despite the South Asian parents in this study recognizing the signs of the child's condition becoming more serious, the ultimate decision to provide treatment for the child was suggested by other professionals in the community such as teachers and not the parents. One reason for the parents' inability to reach out for support was the stigma attached to the mental illness in the South Asian community. There is evidence for a tremendous amount of stigmatization in the South Asian community (Beliappa, 1991; Bhui et. al., 1993, Gupta, 1993; Lloyd, 1993). Hence, the at this stage the South Asian parents justified there lack of help seeking behaviour by sharing that they did not know where they could go for help.

Service Selection

Heightened Anxiety and More Urgent Help-Seeking . At this juncture, several responses, variously represented in each family emerged. Some parents organized to get professional help by making calls and arranging visits to doctors, social workers, clinics, and hospitals. Parents relied on professional help or turned toward their own nonprofessional forms of assistance. Common themes at this phase of the child's mental illness were persistent and increasingly urgent help-seeking behaviours, intensifying anxiety, and dread of the now more compelling possibility of further worsening of the child's social and scholastic ability and of the appearance of life-threatening behaviours.

In the two cases of male teenagers, the experience of the parents was complicated by the males wanting control of their situation. This made the process of seeking help for

their children even more stressful for these parents. Amar and Jas were not able to recognize the implications of their changing mental health and rejected help, whether it was professional intervention or the assistance, interest, and inquiry of parents. This defiance, whether it was a manifestation of the illness or a reflection of the males own needs to minimize the significance of changes, disrupted Mrs. Joshi's and Mr. Mann's help-seeking efforts. Mrs. Joshi describes,

> *Amar would wear a T-shirt and would not change the T-shirt. When he would take a shower he would put on the same T-shirt and I would say 'Amar your T-shirt smells you know' and he would say 'no, there is nothing wrong, I just changed it'. I should have seeked help but I didn't know, you know...*

In addition, some parents felt when they attempted to seek outside help they were told that the situation was not as serious as they thought. The perspective of professionals may often differ from the parents. For example, the timetable for recognizing illness for professionals may be different than for parents. One parent in this study viewed this as a means for the professional to normalize and minimize the presenting symptoms of his child. Mr. Mann expressed his frustration with the mental health system.

> *The first report that was sent from Children's Hospital reported nothing wrong with my son. I felt that there was something wrong with him and I was not convinced with the report. However, I didn't know where to go or how the system worked.*

Furthermore, some professionals take a family systems approach which may be perceived by parents as diverting attention from the rising evidence of impairment in the affected family member, focusing instead on anxiety and discord among family members. Therapists may conclude that the family as a whole, or some particular members other than the child, require counselling. This perspective was very difficult for South Asian parents to comprehend. They could not understand how their own emotions might be adding to the difficulties of their child. Mr. Mann recalled,

> *I went to the government office in New Westminster to see a psychologist. I went twice with my wife, but my son didn't come. I thought that my wife and I going to see the psychologist was futile and was of no use if our son didn't go with us. I told the psychologist that there was no point in talking to him and we never went back.*

Summary

As their child's mental health continued to deteriorate more rapidly, the South Asian parents became more anxious and at this point contemplated reaching out for the professional medical support and nonprofessional spiritual support. When connecting with the mental health professionals some of the South Asian parents felt discrepancies in the their own belief systems relative to the professionals. Hence, the process of seeking support from doctors, social workers and psychiatrists became very challenging. Previous studies have shown that these discrepancies in beliefs and values among South Asian parents and mental health professionals have come in the way of treatment planning (Leong & Lau, 2001; Sue, Zane, & Young, 1995; Tsui & Schultz, 1985). The differences in conceptualizing and treating the mental illnesses of the children in this study mental

illness by medical professionals and the South Asian parents in this study was clearly evident.

Spiritual Beliefs about Mental Illness and Recovery

In all six cases, parents identified spirituality and God as the explanation of the their child's mental illness. Spiritual and religious beliefs were emphasized in different ways and to a different extent in each case.

For Mrs. Ram, everything was in God's hands. She believed that prayer would lead to her son getting better. *"I go to the temple regularly and pray for the health of my family. When God's eye is straight everything is straight. He [God] controls everything."*

Mrs. Joshi wanted to seek advice from a spiritual healer, however she felt that she could not take her son for spiritual help because he had committed a sin by eating beef. She continued to pray for her son.

> *We did not blame each other for what happened to Amar. I think God did it to him. In my mind, I thought it may be that it was a punishment from God because it does not run in my family or my husband's family. I don't know so maybe it was a sin that he [Amar] did or that I did too. Like I told the doctor the other day, I think it's a punishment.*

Mr. and Mrs. Deol felt that prayer was important in their son's recovery. Mr. Deol expressed, *"We are spiritual and when we would go to the temple we would pray that our son get better."* Mrs. Dhillon stressed the importance of professional treatment as well as prayer, in the treatment of her son's illness. She felt that God has given the ability and knowledge to utilize the services offered in the community. *"I do pray for my family,*

however I feel that it is also very important that I seek out medical treatment for my son. I think praying is separate but you need more than prayer to get better."

For Mrs. Parkash, after four years of service with the mental health team, she felt that only God could make Gita better.

> *My main thing is, I have learned more now that only God can change some things. The same thing the children are realizing...small, small things we can't change only God knows what to do. We don't read much about God, religious magazines, but one hundred percentage we believe in God after Gita's illness. There is only one hope. We go to temple and do bhajans.*

Alternate Healing Beliefs

Seeking the help of spiritual healers was considered in three of the six cases. Among the parents who did consider taking their child to a spiritual healer there was some pessimism expressed as to how beneficial this would be. As Mr. Mann described,

> *We also turned to religion for support and me and my wife went to see a wise man. But, they can't do anything; all they want to do is make money. And also because of his schizophrenia and his thoughts that he was communicating with God, we did not want to get him off track.*

Two of the mothers wanted to seek a spiritual healer but did not have the support of their husbands. Mrs. Joshi wanted to take her son to see a spiritual healer; however, she did not have the support of her husband.

> *I wanted Amar to see a priest. I think we went to a priest once before Amar*

got sick. The lady said that she knows something...God comes to her and that she has communication with God. She said that Amar would go to school and everything. My husband has always been against spiritual healers because he does not believe in all this. I tried going to see a spiritual healer. Maybe I should try again?

For the South Asian parents in this study, spiritual beliefs played an important role in making meaning of their child's mental illness. Studies in the past (Murdock, et. al, 1980; Baptiste, 1993; & Atkinson, et. al., 1998) have shown differences in Western and non-Western views of disease causation. The Western view of disease causation is often naturalistic; for example, the cause of mental illness may be attributed to stress. However, non-Western disease causation models emphasize supernatural views; for example, fate or mystical retribution.

Mental Illness and the Importance of Education

The impact of the mental illness on the education of the child was the prime motivator for seeking mental health service in all six cases. Mrs. Ram wanted her son to return to any school that would accept him. She thought that the therapist's job was to find her son a school to attend. Mrs. Joshi was very disappointed that her son had switched schools without informing her. Mrs. Joshi expressed her frustration,

I don't know how he is doing in school. He got transferred to Eastside. He was going to McGee and then he transferred himself to Eastside and he was not doing very good at this school too...The other day I asked him who said that he should go to Eastside and he said that he wanted to go. I think the school should have involved me. They

should of told me that Amar would have to go to Eastside.

Mrs. Joshi was also upset that Amar was refusing to attend school during the later stage of his illness.

Amar would never tell that he wanted to go back to school. He would never ask to have a school for him. Actually, he did not have any interest... I don't know where his interest went. He went to Hamber House a few times but didn't want to go. He doesn't do it ...In the day he would sleep and in the night he would play video games.

Mrs. Dhillon was concerned that her son was unable to attend school. She didn't want her son falling behind in class. "*He would miss school and would not go. He would say that he had a high temperature and that he did not feel good. He began to miss weeks at a time.*"

Mr. and Mrs. Deol were concerned when they could not understand what was causing their son's excruciatingly painful headaches which prevented him from attending school. "*He was missing school and this was a very precious time and he should learn and attend school because his education was falling behind.*" They brought professional support into the home in order that Sukhbir did not fall behind in his education.

A home teacher used to come to the home for two days. Then we used to get angry with Sukhbir because he would not go to school. He would say that he did not understand what was happening in class so didn't want to go. He didn't go to school for two years.

Mrs. Parkash has a hard time understanding the reason her daughter could not be supported in obtaining a university education. She felt that her daughter deserved the

opportunity to go to university. She believed that the mental health team should do more to ensure that her daughter continued with her education. *"Gita did very well at St. James Secondary, her only weakness was English and she would like to go to college."*

Mr. Mann became very concerned about his son and his schooling beginning in Grade 7. *"He started skipping and was not doing his homework. Then, I thought of special schools, you know like Sylvan Learning School would do him some good. But, he wanted to stay at home and do nothing."*

The South Asian parents in this study became very concerned when their child's education began to be impacted by the mental illness. This is not surprising as previous research has shown the emphasis placed on education and the tremendous amount of time and energy that parents devote to ensure that their children excel in school (Tizard et. al, 1988). Due to the fact the most of first generation South Asian parents did not have the chance to obtain a good education, it is something that they would really like to see happen for their children.

Understanding the Role of Therapist

In all but one of the six cases, the parents did not understand the role of therapy. Mrs. Joshi was unclear as to the role of the therapist in the treatment process. She did not see the therapist engaging with her son. *"I really don't know what the therapist did. He was together with the psychiatrist. He would sit there but didn't say a lot. I didn't know what his role was. I didn't know what he could do for my son."* Mrs. Joshi wanted the therapist to be more assertive when speaking with her son. *"I think there should be more encouragement...like push them [clients]. I know he won't listen...but, keep trying, keep trying."* Mr. and Mrs. Deol emphasized the contribution of the doctor in treatment of

their son. The therapist at the team was not seen as necessary. Mrs. Ram felt that her son would meet with the therapist regularly but she did not know how this was helping him. Mrs. Parkash did not believe that talking to a therapist would help her daughter; she simply wanted her daughter to receive her medication. This is consistent with previous research that emphasizes that minority groups including South Asians do not think that verbalization of their problems will have a therapeutic effect. Moreover they look at the doctor as an authority who prescribes medication as the treatment (Naidoo, 1992).

Importance of Medication in Recovery

Medication was seen as the answer to the child's problem in all six cases. The importance of the doctor and medication was emphasized by all of the parents. As Mrs. Ram expressed, *"It was my job to take my son to mental health services and it was the doctor's job to medicate him."* Similarly, Mrs. Parkash believed the role of the therapist was to give her daughter medication so that his health would improve. She did not believe that having her daughter talk about the problem was going to help. She said that they only needed to see the psychiatrist, get the medication, and give it to her daughter. Mrs. Dhillon also believed the medications made her son better. Mr. and Mrs. Deol were relieved when the pediatrician diagnosed their son with depression and was able to prescribe medication. Mr. Deol claimed to notice a difference in his son only a few days after his son had been on the medication. When explaining the different incidents of mental breakdown in his son's life, he noted that when the doctor's gave him medication his son was better for a while. He also talked about his son initially being on the wrong medication and now being on the right medication.

Presentation of Physical Complaints

In three of the cases, the parents spoke about their children's somatic complaints. Mrs. Dhillon's son complained of feeling sick to his stomach. He was not eating and was feeling nauseous much of the time. Mr. and Mrs. Deol's son consistently complained of having severe headaches. Mrs. Parkash's daughter had headaches all the time which were attributed to the high academic demands placed upon her. None of the parents noticed or placed emphasis on the emotional well-being of their child. For example, they admitted to not paying attention to whether their child was sad, angry, or frustrated. This is consistent with previous research indicating that very few South Asian patients with mental disorders presented to their doctor with psychological symptoms, except in Europe (World Health Organization, 1992). The common presentation of mental illnesses were because of pain and other physical symptoms in the South Asian population. Other research shows that a large proportion of psychiatric disorders are missed by general practitioners, largely as a result of the tendency of South Asian patients to present general practitioners with physical symptoms only (Goldberg & Huxley, 1992). In review of the literature discussing psychiatric stigma in non-Western societies, Fabrega (1992) confirms that such societies, including South Asians, tend to have a wide variation in the range of possible reactions to psychiatric disorders; some are treated no differently than physical illnesses. Furthermore, other studies are consistent in reporting that South Asian have been reported to be more likely to present their psychological symptoms somatically (Kirmayer, 1984; Krause, 1994; Mumford, 1992).

Summary

In this chapter commonalities in understanding the experiences of the South Asian parents' approach to their child's difficulties were presented. Their experiences are embedded in unique cultural beliefs and values of South Asians. The next chapter will further explain the experiences of these South Asian parents and link the findings from this cross-case analysis to the research literature. In this chapter differences in the experience of South Asian parents from parents in mainstream western culture will be discussed.

Chapter Six: Discussion

Overview

In this chapter, the knowledge gained from the participants' experiences will be integrated and compared with research previously conducted. The relevance of this information at the different stages of a parent's experience, from referral to treatment of their child's mental health concerns and the values that impinge on decisions to seek mental health services, will be discussed. A comparison of the parenting role and coping strategies of South Asian versus Western parents is provided. Finally, the limitations of this study, implications for mental health service provision, and direction for further research will be shared.

The purpose of this study was to examine the experiences of South Asian parents who seek mental health services for their children. The four research questions will guide the discussion of the findings.

a) How do South Asian parents perceive mental health service?
b) How do South Asian parents decide the time to consult with mental health service?
c) How does seeking mental health service fit with the South Asian parents' values and beliefs around mental illness?
d) Are there difficulties that South Asian parents face in accessing mental health services? If so, what are they?

South Asian Parents' Conceptions and Expectations of Mental Health Services

This study has identified commonalities and differences amongst the participants' experience of accessing mental health services. Each participant's experience was

affected by different combinations of external events. The nature of experiences varied from one case to another. To explicate the meaning of South Asian parents accessing mental health services, the results of this study will be linked to theoretical findings related to maintaining normalcy, spirituality and mental health, general practitioners' role in mental health, and cultural competency in mental health services. The present findings will also be discussed in term of implications of mental health service delivery and accessibility of services for South Asian parents. Numerous variables influence the impact of mental illness on individuals and families, including their particular strengths and limitations, their roles and responsibilities, and other prior or current life circumstances. The context in which the mental illness of a child enters into the families has a great influence on if and how mental illness is acknowledged.

In order to provide effective service to South Asian parents accessing mental health services for their children, helping professionals need to have some awareness of the conceptions and expectations that South Asians have of mental health services. This study provided a means for a few South Asian parents to describe their process of getting connected to and receiving support from community mental health. These narrative accounts have provided insights into the lives of a few South Asian families which mental health professionals may reflect on in further work with these families.

Family therapists sometimes use the phrase "the elephant in the living room" to refer to significant problems that cannot be discussed openly. Family members may walk around and ignore the presence of the illness which may prevent painful feelings and conflicts from surfacing. But this denial or disbelief also keeps family members from dealing with an overarching problem in their lives. South Asian families may treat the

mental illness as forbidden, or even nonexistent for many reasons. They may be poorly informed about the illness, thinking the symptoms are due to a difficult stage or life problem. At the onset of the illness, they may be confused about the diagnosis, the most appropriate treatment, and the expected outcome. In response to this confusion, and their own anguish, family members may refuse to acknowledge the mental illness or may minimize its seriousness. They may never come to terms with their child's mental illness; however may feel the pressure to comply with suggestions made by other professionals in their child's life.

South Asian families can internalize the stigma that pervades the larger society by retreating behind the façade of normalcy, fearful that the "family secret" of mental illness will be revealed. South Asian parents in the present study minimized the significance of the illness for the family's function or self-definition. This is consistent with previous research that shows South Asians do not want the community to know of mental illness in the family as it may affect other family members, such as marital prospects of siblings. Behavioural aspects of "normalizing" noted in this group of South Asian parents were their attempts to limit their ill child's contact with other mentally ill young people; to keep them out of structured mental health work or day treatment programs and/or rehabilitation groups; and to help the ill member maintain an appearance of normalcy, thereby avoiding the label of mental illness. Parents' central motivation for maintaining normalcy was their belief that it was the best way to keep their mentally ill child at a high level of functioning. They believed that if the mentally ill child was expected to act normally then he or she would do so to a greater extent. For some parents, efforts at

maintaining normality were additionally motivated by fears that the illness would reflect negatively on the family and mentally ill child.

Values and Beliefs About Mental Illness

In this present study, two of the parents felt that their child's suffering was potentially related to spiritual causal factors. They linked their child's mental illness as a punishment from God for sins committed by themselves or their child. In all six cases parents contemplated seeking spiritual help alongside mental health treatment. In order to truly empathize and support South Asian families in understanding and recovery from mental illness, mental health service providers need to be aware of the importance of spiritual belief in the lives of some South Asians, and in turn, how they interpret cause and treatment of mental health issues. Many South Asian parents view mental illness in strongly religious terms and consider psychiatric disorders to reflect the will of God (Kua, Chew, & Ko, 1993; Lefley, 1994b; Lefley & Bestman, 1984; Millet, Sullivan, Schwebel, & Meyers, 1996). They may believe that the best hope for recovery from mental illness is prayer or a stronger commitment to their faith. Often psychiatric illness is seen as a punishment from God for sins committed by the parents or children. If the mental illness becomes chronic and does not appear to respond to treatment, there is an increased tendency for the illness to be explained as a result of sorcery, witchcraft, or a punishment for breaking moral taboos (Fabrega, 1992). Moreover, evidence suggests that South Asians turn to prayer or consult religious leaders for help with personal and psychological problems more often than in western societies (Milstein, Guarnaccia, & Midlarsky, 1995; Taylor, Jackson & Chatters, 1997). Religious leaders often emphasize the importance of both prayer and willpower in overcoming psychiatric problems.

Consequently, South Asians are more likely than Western Europeans to attribute mental illness to bad or weak character, lack of willpower, and morbid thinking (Cinnirella & Loewenthal, 1996). Some research indicates that South Asians more frequently believe that disorders such as schizophrenia and depression are caused by lack of willpower (Bhugra & Bhui, 1998).

Kakar (1982) explains that in times of serious and sudden illnesses within the family, such 'experts' are summoned by the family members to exorcise spells, cast out the effect of 'evil eyes', undo the malevolence of magic, and undertake religious ceremonies to counteract the negative influences of inauspicious events in order help the person to recover. Due to the parents' beliefs that the cause of mental illness has a religious aspect, there are many religiously influenced beliefs and practices with regard to mental health care which could be brought to professional attention, and which deserve closer scientific investigation. These include prayer, meditation, and related practices. For example, there is the teaching and study of beliefs and ideas which may be helpful in coping with stress, and the many forms of practical and social support. Some of these alternative forms of support have been studied in the past and have shown to be beneficial physiologically and emotionally (Finney & Maloney, 1985; Loewenthal, 1995). South Asians who access mental health services may feel that religious forms of help are of no interest to the professional service provider who may be skeptical and possibly scornful of these unscientific and superstitious beliefs. Hence, non-judgmental listening on the part of the professional will, at the very least, improve trust and will enable the professional to build an explanatory framework for the illness. This enables the clinician to draw up treatment goals in collaboration with the patient, and to draw on

healing resources that are seen as appropriate, often using several different kinds of healing resource and cross-referring where necessary. For instance, ethnic minority families may perceive symptoms of mental illnesses as spiritual problems, emphasizing the role of religion and the supernatural. Similarly, these groups may seek out culturally compatible healers either in place of, or in addition to, Western methods and approaches (Bhopal, 1986; Wilson & McCarthy, 1994). Such folk healers speak the same language, live in the community, are sanctioned by community members, and may use cultural remedies both familiar and compatible with the extended family's religious and spiritual beliefs.

It could be argued that a task for mental health workers who are working with South Asians is to develop an understanding and skills in order to incorporate spirituality in the treatment plan. This will involve the development of modes of being and methods of care that can inject meaning, hope, value, and a sense of transcendence into the lives of people with mental health problems even in the midst of conditions that frequently seem to strip them of even the possibility of such things. Becoming spiritual healers will demand the development, not only of new skills, but more importantly of new ways of seeing the world and being in it. It will require looking beyond the cultural, historical, and professional boundaries and worldview that prevent us from seeing human beings in all of their fullness. It will involve developing an attitude of humility and openness to the possibility that the ways in which we have seen things in the past may not be the only way in which they can be viewed. It will involve opening ourselves to the possibility of a spiritual paradigm that sits alongside, yet challenges, the scientific paradigm. This spiritual healing will require us to participate in a paradigm shift in understanding that

moves caregivers beyond the confines of a scientific worldview towards an expanded scientific position. Such a position will allow scope to explore the issues and dimensions of the human person that have been highlighted thus far, and in so doing, may alter at least some aspects of the way in which we see the world and the care practices we choose to utilize to offer hope and new possibilities to people with mental health problems.

Some of the research literature has consistently reported that aspects of religious and spiritual involvement are associated with desirable mental health outcomes (Dyson, Cobb, & Foreman, 1997; Gartner, Larson, & Allen, 1991; Larson, Swyers & McCullough, 1997; Larson et. al., 1992, Martsolf & Mickley, 1998). Spirituality has been shown to be positively correlated with depression (Karp, 1996; Morris & Elizabeth, 1996), anxiety (Baker & Gorsuch, 1982), addictions (Koski-Jaennes & Turner, 1999; Miller, 1998), suicide prevention (Gartner et al., 1991), and schizophrenia (Chu & Klein, 1985). This type of research provides support for spirituality as relevant to mental health care practices and as having the potential to benefit outcome of people's experiences of a variety of mental health problems. The introduction of a spiritual dimension enables us to reframe mental health problems and mental health care in a way that places the person at the centre of our thinking and enables us to offer care that seeks to meet not only professional expectations, but also the perceived needs of clients. In reframing conditions such as depression and schizophrenia from a spiritual perspective we discover new priorities and fresh possibilities for intervention that do not fall within the remit of pure psychiatry. If the focus is placed on a person's spirituality rather than on their biological or psychological difficulties, their situation can be reframed from one of inevitable loss to

the possibility of hope, purpose and a meaningful existence, even in the midst of severe psychological disturbance.

Decision to Seek Mental Health Service

The decision to seek mental health services was not necessarily the decision of all of the parents in the present study. In three of the cases, the parents were passive participants in the process and referral to mental health services for their child. The linkage of children to mental health services was often initiated by different institutions within their community; for example, counsellors or teachers at school, or medical professionals.

Cultural context is likely to have a significant impact on family appraisal of mental illness and its management. Ethnic and cultural variables may also influence patient's symptom content, expression, and intensity; the verbal and nonverbal behaviour of children and families; and their perception of appropriate goals and strategies. Some South Asians may be readily able to cite potential social causes for personal problems and perceive these problems not as illnesses, but purely as a consequence of hard times (Sussman, Robins, & Earls, 1987). Hence, South Asians believe that the means of effectively dealing with these hard times would be to subscribing to a deterministic view of life. The law of karma, which involves determinism and fatalism, has shaped the Indian view of life over centuries (O'Flaherty, 1980; Reichenbach, 1990; Sinari, 1984). In its simplest form, the law of karma states that happiness or sorrow is the predetermined effect of actions committed by an individual, sometimes either in his/her present life or his/her past lives. Reichenbach points out that the law of karma is not concerned with the general relation between actions and their consequences. It is usually held to apply to the

moral sphere and is concerned with the moral quality of actions and their consequences. Thus according to karma we receive the results of our own actions. Given the deterministic nature of the law of karma, things do not happen because we make them happen. Things happen because they are destined to happen. Thus, it can be seen how the law of karma is invoked to explain not only the onset of mental illness but all sorts of misfortunes which may befall an individual to create hard times.

The decision to seek mental health services for their children is often very difficult for South Asian parents. Consequently many South Asian children present themselves to mental health services much later than children from the dominant culture. This could be related to lack of knowledge or the view that South Asians hold about emotional/behavioural problems and the attached stigma. They may see the difficulty facing their child stemming from other factors. South Asian parents may hold beliefs that are different from the mainstream about the causes of their child's problems and seek out ways of remedying the problem which are aligned with this different belief system (Leong , Wagner, & Kim, 1995; Ruiz, 1995; Sue, 1994). Help-seeking is most likely to occur when a child's behaviour is recognized as interfering with education or risking the safety of other family members in the home. Assessing the severity of the mental illness is often subjective. Due to a lack of congruence between how the South Asian parent views their child's behaviour and how the mental health worker views this behaviour may interfere with the treatment progress and compliance (Foulks, Persons,& Merkel, 1986).

Western versus South Asian Parents' Coping Strategies

When there is a mental illness in the family the life of family members is inevitably going to change. Some studies have shown that the most devastating consequence of living with a mentally ill child is the negative impact on the parents' social and leisure activities (Kelly & Kropf, 1995). All parents, regardless of ethnicity, need to make difficult choices and sacrifices to provide for their children. However, South Asian parents do not readily voice this conflict about their inability to fulfill their own goals (as may some parents in Western society) due to their emphasis on the care and attention that their child needs. Amongst most South Asians it is believed that the role of mother and father is to provide for their children and this sense of duty far outweighs any individual needs of some South Asian parents.

Many South Asian parents struggle to put themselves before family because of the collectivist thinking that is a big part of the South Asian culture (Laungani, 1998, 1999; Sinha & Kao, 1997). This was indicative in the present study where parents had a very difficult time talking about their experience and focused more on their mentally ill child. The parents did not talk about their own social isolation or sacrificing their personal interests.

Parenting Role in South Asian Culture

Although, the original intention of this study was to have both parents participate, however, there was only one case in which the mother and father participate together. Surprisingly in one case, the father was the participant. The remaining four cases involved mothers only. This is consistent with literature (Kakar, 1994) that suggests South Asian mothers were more likely to be involved in the emotional well-being of the

child than fathers. In the present study, men and women, in some respects, responded differently to their child's mental illness. The mothers were more emotionally expressive; whereas the fathers channeled their emotion into finding practical and concrete things to do for their child.

In this study, parents were very concerned about the disruption in their child's education. Parents wanted support in having their children continue to excel in school despite the child's mental illness. This study confirms previous research that South Asian parents are deeply concerned about their children's education (Ghuman, 1994; Ogbu, 1994; & Tizard, et. al, 1988). As a result, fear of their child falling behind in school was a prime motivator to seek mental health support.

Implications for Mental Health Services

Cultural Competency in Mental Health Services

Due to the increasing cultural diversity in Western society, cultural competence in approaching mental health service is essential. Cultural competence could be defined as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, and among professionals that allow work to be done effectively in cross-cultural situations. Mental health service teams in Vancouver are attuned to this need and already have multicultural workers that can be accessed for consultation on cases that involve different ethnic minorities.

The findings of the present research underscore the need for culturally competent mental health care policies which should continue to be brought into focus by considering key issues such as definition of mental illness, assessment of clients, accessibility of mental health services, methods and interventions to address mental health concerns,

therapists who provide interventions, and the anticipated outcomes of treatment. The central objective of mental health service should be to empower families in achieving mastery and control over the circumstances of their lives, including the mental illness of their relative. Accordingly, services must be delivered in a manner that acknowledges the strengths, resources, and expertise of families, that provides opportunities for them to strengthen family functioning, and that promotes a sense of intra-familial mastery and control (Dunst, Trivette, & Deal, 1988).

Expanding the definition and treatment of mental illness is critical in developing appropriate services for South Asians. The approach to reaching a psychiatric diagnosis should involve collaboration, an approach that considers the medical opinions as well as cultural aspects. Currently, the diagnostic criteria used often do not take into account the impact of race, ethnicity, and culture on the manifestation of symptoms and behaviours. Furthermore, the assessment instruments used to diagnose mental illness often do not take into account questions about ethnic identity, level of acculturation and assimilation, language spoken at home, race and country of origin, family's place of residence, educational level, and values orientation. The demographic survey in the present study attempted to address most of these points. It provided a context in which to work with each family understanding the experience of South Asian parents accessing mental health services for their children. For example, the primary language spoken and years in Canada gave some indication of the difficulty that parents may have had explaining their child's condition and getting the support that they needed. If verbal communication is hindered by language difficulties then the assessment of mental health will be very limited (Patel, 1995).

The literature often highlights the underutilization and prematurely terminated mental health services by ethnic minorities (Bhui & Takeuchi, 1992; Flisher, Kramer, & Gosser, 1997; McCabe, Yeh, & Hough, 1999; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003). Although cultural factors play a role in the underutilization of the mental health system, these studies suggest that service entry for ethnic minority children may be impeded. The accessibility of mental health services in terms of geographical location, referral process, interaction between the community and mental health teams, and community perception as to the function of mental health teams all need to be addressed in order have the South Asian community utilize this service. Many of the participants in the present study did not know the process of accessing mental health service or understand the role of the general practitioner in these services. This could be remedied by making information on mental illness accessible to the South Asian community. For example, agencies may engage in outreach to inform parents about the relevance of mental health services for children with sociologically influenced problems. Parents could also be educated on the full range of possible causes for emotional/behavioural problems. Referrals from community services that provide immigration services or social support may also be more readily accepted by ethnic minority families due to the context of sociological issues being addressed. Furthermore, the general practitioner could take the time to provide a brief explanation of mental health services available and how these services differ from the care provided by the general practitioner.

Pathology in the individual is presumed to be reflective of dysfunction in the larger social group and context, and, healing would be required for the collective, as well as the individual. Embracing mental health as a multi-dimensional construct concerned

with the entire community, past and future generations, and the physical environment, a range of psychological issues from mental illness to the problems of daily life, would all have to be potential targets for intervention. Treatment from a South Asian centered cultural perspective would focus on societal functioning and relationships from the individual's cognitions and behaviors to the collective institutionalization of ideas, beliefs, mores, practices and systems of organization. In this social context with its focus almost solely on an individual's "pathology," the statistics available on the treatment of South Asians are grossly insufficient, inadequate in meaning, and extremely lacking in terms of reflecting a culturally congruent, viable approach to treatment for this population.

South Asian parents will use interventions to address mental health problems of the child that fit with their understanding of the causes and consequences of the illness. Certain types of interventions are more effective with ethnic minority populations. Ethnic minority populations in general show preference for the following types of interventions: in home services, crisis intervention, problem-solving or brief-solution focused therapy, psycho-educational approaches, and family-focused therapy (Miklowitz, 2003). There are many benefits of treating individuals in their natural setting. The family therapist is able to get an understanding of the client's life and it gives more information and context from which the therapist can assess the family. The family appreciates when the therapist takes the concerns of all the family members into account. South Asian families may want extended family members to be involved in solving the problem. The wellness within minority families is impacted by the theoretically based intervention, as well as the professionals delivering the intervention.

Ethnic staffing for mental health services is a highly controversial issue whenever cultural competence is discussed. Studies in the United States indicate that the higher the number of staff from the minority group, the higher the rate of utilization of services by ethnic minority groups (Snowden, Storey, & Clancy, 1989). The cultural styles of therapists have been found to be important in mental health service delivery (Sue & Sue, 1990). When therapist and client share the same cultural worldview and the same values, therapy is more effective. The problem exists in lack of South Asian staff availability to serve the South Asian population. One way to resolve this dilemma would be to train majority staff to understand and work more effectively with different ethnic minority populations, that is, to develop a more culturally competent workforce; including learning to work with South Asians. As Pedersen and Lefley (1986) observe, *"the goal of cross-cultural training is to increase a counsellor's intentionality through increasing the person's purposive control over the assumptions which guide his or her behaviour, attitudes, and insights"* (p. 162).

In mental health services, measuring the outcomes and effectiveness of treatment has always been very difficult. However, some literature does suggest that ethnic matching between clients and therapists leads to higher utilization and length of stay in treatment than when clients are matched with ethnically dissimilar therapists (Snowden et al., 1989). In addition, culturally tailored services are more effective in reaching and engaging hard to reach ethnic minority populations (Neighbors, 1990). Simply having South Asian employees in a mental health center increases the comfort level of some South Asian families who are reassured by the presence of an individual of their own culture. This individual can identify with problems concerning mental illness based on

the values and beliefs within the South Asian community. This study shows that for some parents it proved comforting to have a mental health worker or psychiatrist of the same cultural background. The parents found it easier to relate, to explain their story, and to comply with the treatment plan. This could be due to the fact the mental illness was linked to emotional problems which are seen very differently in western society when compared with eastern society. These differences may have been more easily understood by a mental health professional from the same cultural background.

The Role of General Practitioners in Mental Health Care

General practitioners can play a role in the mental health care of their patients in addition to their focus on physical aliments. The general practitioner is in a system of care which enables continuity and constancy, and the development of a long-term relationship with patients and their families. The relationship that patients have with their general practitioners is often close. Usually, the language between doctors and patients is shared. However, it must also be recognized that doctor-patient negotiations are complex, dynamic, emotionally loaded, involve complex power dynamics, and are affected by all the preconceptions which both parties may bring (Fernando, 1991). This relationship is further complicated when there are cultural differences between the doctor and patient.

The general practitioner is often the first point of contact for physical problems. They are also in a position to monitor, opportunistically, for psychological symptoms. The presence of concurrent physical illness or the initial presentation of physical symptoms should be further investigated by the general practitioner to help determine that the cause is not psychological in nature, due to the propensity of South Asians to present psychological issues somatically (Kirmayer, 1984; Krause, 1994; Mumford,

1992). In the present study, parents felt that it would have been beneficial if their general practitioner had taken a more active role in having their child referred to mental health services by having the practitioner guide them through the process of seeking mental health support for their children. It is important for the general practitioner to be able to make a primary assessment of mental health. Thus, general practitioners need to become comfortable administering the basic test for mental illnesses, for example, a depression or anxiety screening test. If the results of some of this testing raises concern then the general practitioner should take an active role in referring their patient to a psychiatrist or mental health worker. One concern however, is that general practitioners with high proportions of patients from ethnic minorities are often those working with the least resources and for whom it is more difficult to obtain training in mental illness management (Phoroah, 1995). General practitioners may need more training in the area of mental health and this may be an important investment in order to recognize mental illnesses and provide treatment in a timely fashion. Due to the number of patients seen by general practitioners on a daily basis, there is little time to do a thorough investigation of clients' presenting symptoms.

Participants in the current study sought out their general practitioners only when their child became acutely ill and required a referral for hospitalization and/or mental health services. Previous research shows that South Asians are less likely to be referred for further psychiatric or psychological treatment (Kareem & Littlewood, 1992; Lipsedge, 1993). In addition, South Asians are not referred at early stages of their illness (Owens, Harrsion, & Boot, 1991) and are more likely to be compulsorily admitted to hospital by the police or social services, under a section of the Mental Health Act

(Moodley & Perkins, 1991). The referral to secondary psychiatric care is a complex process. Both general practitioners and mental health team workers need to begin working more collaboratively to ensure minority patients, including South Asians, receive proper psychiatric care. For effective and appropriate referrals, various factors are important: the patient must present their symptoms to their general practitioner at an early stage; in turn, general practitioners must recognize them as early symptoms of mental illness and both parties must appreciate the value of the referral and be able to discuss concerns openly. In addition, both patients and general practitioners must have access to suitable secondary care.

In summary, participants in this study were in crisis by the time they reached out for mental health services. Primary health care providers can play a key role in linking the South Asian community with mental health teams. Along with the physical health and social services, they could play a significant role in screening, consultation, and service coordination around mental health care needs of their patients. Primary care holds a valuable position, as it remains the point in the health care system governed by an explicit commitment to equity.

Assessment and Diagnosis of Culturally Diverse Individuals:

An in-depth consideration of culture is essential in the process of assessment, case formulation, and diagnosis of culturally diverse individuals. Clinicians having some knowledge of clients' cultural identities is a beginning. However, clinicians must be cautious in feeling certain about their actual knowledge of clients' histories, cultural values, and customs. The clinician's responsibility is to ask questions related to cultural identity instead of making assumptions.

The following items constitute the DSM-IV outline for cultural formulation (American Psychiatric Association, 1994):

Cultural identity of the individual (i.e., ethnic or cultural reference groups; degree of involvement in culture of origin and host culture; and language or languages used and preferred);

Cultural explanations of the individual's illness (i.e., nerves, somatic complaints, possessing spirits);

Cultural factors related to psychosocial environment and levels of functions (i.e., stress in the local social environment; support provided by religion and kin networks);

Cultural elements of the relationship between the individual and the clinician (i.e., differences in cultural and social status; difficulties emerging due to language problems; problems in negotiating a working relationship);

Overall cultural assessment for diagnosis and care (i.e., all cultural considerations that influence comprehensive diagnosis and care).

Exploring the above items would give the therapist a glimpse into the worldview of his/her client. Also, by having a more holistic understanding of the client, the therapist may be able to provide accurate empathy to the client and his/her situation. Empathy entails stepping into the clients shoes and providing accurate reflective responses to the client. Starting with the client's understanding of their illness may be much more beneficial than imposing a diagnosis on the client. This does not mean that the psychiatrist or mental health professional does not conduct an assessment; however, the

process is one of curiosity on the part of professional and collaborative from diagnosis and through treatment of the client.

Furthermore, in conducting the diagnostic study or assessment of a young client and family from another culture, the clinician must be clear about the developmental norms in the culture of origin. For example, what are the specific and typical parenting patterns and expectations of age-appropriate tasks? It is not uncommon for cultural dissonance to exist in a family. Children and adolescents often acquire specific Western behaviour styles and mores that can, and frequently do, put them at great odds with their parents, who often choose to reject Western standards and expectations. However, although a common pattern of generational conflict exists, one cannot assume that all non-dominant cultural families share this experience.

Principles of Practice in the Beginning Phase

The beginning phase of treatment consists of referral, assessment, diagnosis, selection of appropriate interventions, and initial engagement that ideally culminates in the development of a working alliance between client and clinician.

The referral process and the therapist's response to the referral set the tone for the assessment and treatment process. Referrals for children should emphasize the child's and parents' inner feelings, pain, and confusion, and involve the parents in preliminary work that deals with their initial resistances and objections. South Asian parents' resistance is related to fear, to stigma or disability, to concerns about confidentiality, or to guilt. Anxiety due to fear of the unknown is another cause of resistance (Bhui, 1996). Some parents may present an ongoing transference conflict, expressed as resentment of authority, professionals, and experts who are impinging on their private worlds. Such a

conflict may be especially likely when a patient has been referred for treatment by an outside institution or agency such as a school. Cultural counter transference and insufficient sensitivity to the client's cultural clash can produce irreconcilable differences resulting in treatment that flounders or never actual begins.

Ideally, during the assessment or the earliest stage of treatment, the client and therapist will come to have some similarity in the psychological conception of the problem. According to Basch (1980), what a clinician does formally in an initial interview is in many ways not much different from what all of us do, intuitively, all the time in our relationships. We continually form impressions of the person to whom we are talking, becoming aware of the feelings stirred up within ourselves, and of the thoughts and memories stimulated by the conversation, while monitoring the content of what is being said. In the same way, when listening as clinicians to patients, therapists form some opinion of their characters, what clients want from them, and whether or not therapists feel what they want is reasonable and feasible. Therapists then determine how they are going to communicate and implement their agreement with, or rejection of, the client's implicit and explicit wishes. When clinicians meet clients for the first time, they listen and attempt to identify various levels of meaning. Clinicians can learn a great deal by observing how the client sounds (e.g., anxious, guilty, matter-of-fact, oblivious, or condescending), and by examining what feelings the client stirs up in the clinician. As Basch notes, *"It is the therapist's inner reactions that are most important in evaluating a patient's situation, especially if there are discrepancies between the communications the patient is trying to make, and the reactions he arouses"* (p.4). The clinician's immediate

task is to become aware of his or her own hunches and impressions, and to avoid coming to premature conclusions about the client and the client's problems.

The goal of every initial interview is to allow client and clinician to become acquainted. Some clients may need more support and structure than others in sharing information in a cogent and coherent manner. In all assessments of children, adolescents, and adults it is critical to note how information is shared. The importance of this goes far beyond obtaining factual data about illness. The emotional tone in a family, and the attitudes, feelings, and styles of family members' relating are more telling that the mere hard data and facts. A psychiatric assessment is not a static or one-sided process, and must take into account social and cultural aspects of distress. The diagnostic process is two-sided, dynamic and complex, and is influenced by factors including culture, gender, education, training, experience, and power.

Qualitative Methodology in Research with South Asian Participants

In researching minority groups, a difficulty arises in applying research methods and instruments developed in one culture to subjects who live in another culture (Kleinman, 1988). Cross-cultural research needs to account for local meanings and related behaviours in order to improve the assessment of psychopathology and its treatment. When using research methods, one needs to be aware of their limitations, so that the data collected can receive authentic interpretation. In the present study, the methodological approach may not have been conducive to the South Asian culture. Most of the participants in this current study had difficulty speaking about lived experience. The language that surrounds this qualitative research concept is rooted in western research design. To gain a deeper understanding of South Asian parents' lived

experiences, Western methodologies may need to be modified. This should not compromise the authenticity of the research but allow researchers to capture the desired information and detail required to understand the lived experience of minority groups, including South Asians.

Good, Good, and Moradi (1985) stressed the importance of not just the interpretation of illness, but also the active, ongoing process for the sick person and those around them. The parent's perceptions of the child's illness is sometimes discredited. These researchers maintain that even though parents' perceptions may not fit the psychiatrically defined symptoms, they should not be discredited. Good and his colleagues criticize the notion of "culture as belief" on the grounds that this implies a contrast between the "beliefs" about their illnesses and the reality of psychiatric illness or disorder itself, which is disclosed in the terms and models of psychopathology and their procedures of diagnosis.

When using a qualitative methodology, one is requiring research participants to be able to communicate their experiences in order to provide a rich description to inform the research topic. For South Asian participants, this manner of speaking about their experiences may be unnatural. The level of education, level of acculturation, and socioeconomic status also influences the ability of participants to communicate. In addition, emotional difficulties are rarely communicated, therefore, participants struggle to find the words to describe these lived experiences in detail. Hence the experience of these participants is often not readily apparent or loses meaning as it cannot be put into words effectively by parents. For example, providing a description of the grief and turmoil that these parents felt when they first discovered the seriousness of their child's

mental health condition was difficult for the parents in this study. They were not able to use descriptive language to explain their feelings. It would not be fair to say that these parents did not have feelings simply because they were not able to describe their feelings.

Research in the area of parental stress and coping strategies as related to mental illness has often relied on closed-ended questionnaires and written surveys for comparing groups of families. A criticism of such closed-ended instruments was that they did not allow the families to define the issues themselves. Hence, qualitative descriptions were thought necessary to improve our knowledge of coping (Somerfield, 1997). Qualitative research with ethnic minorities requires researchers to take responsibility for modifying the way in which this research is conducted. For example, a few of the participants in the current study did not want to be audio-taped because they were worried about who would be listening to the tape and where it would end up, even though confidentiality was promised. The participants may have been much more comfortable sharing their experience in the absence of a tape recorder. Also, it has been shown in counselling practice that therapies which are more abstract and client-directed, such as narrative therapy, emotionally-focused therapy, and existential therapies are not suitable for the needs of many South Asian clients. Taking this information into consideration, researchers should critically analyze how research is being conducted with minorities, including the South Asian population. Most qualitative research methodologies require participants to answer open-ended questions to avoid biasing or steering their participants. However, as found in this study, open-ended questions can cause participants great discomfort as their ability to elaborate on their experience through a story or narrative account can be a very foreign means of communicating. For example,

when parents were asked to talk about their experience of seeking consultation for their child's mental health concerns and their feelings about a mental health counsellor working with their child they were not able to explain these feelings and how this affected them as a parent.

Cross-cultural issues also arise in analyzing the data collected. This is especially a concern in qualitative data analysis where the researcher is often interpreting the descriptive data collected through their own lens and social context. Denzin and Lincoln (1994) challenge historic assumptions of neutrality in inquiry and assert that all research is interpretive, "guided by a set of beliefs and feelings about the world and how it should be understood and studied" (p.13). Some participant responses may intimately be related to culture. A comparison which is commonly used in cross-cultural research is the collectivistic nature of some minority cultures versus the individualistic nature of Western society (Berry, 1994; Kagitcibasi, 1997; Sinha & Tripathi, 1994; Triandis, 1995). This difference may result in similar responses because the culture does not foster the development of unique and separate individuals. Instead the adherence to group norm and consensus is encouraged. Therefore an individual from a collectivistic culture may hesitate to respond or express their experience to the extreme whereas a person from an individualistic culture may not be so hesitant to respond more freely. Hence, the response to questions may confound the cultural differences observed in the data. Smith (2004) argues, *"[I]t is plausible to assume that the communication style that is being sampled is persistent, accessible to researchers, and revealing about cultural processes"* (p.42). In designing a study and interpreting results, some thought needs to be given to what kinds of underlying psychological dimensions of culture produced differences.

Cultural sensitivity in research requires substantive and methodological adaptations designed to integrate the study group's culture into the process of inquiry (Rogler, 1989). The effort should span the entire research process, from planning to choice of methodology, to data analysis, and interpretation of the findings. To date, attempts to attain such sensitivity are usually based on specific advice about how to cope with research problems in the study of culturally different groups, how to enhance the research participation of respondents, how to cope with response bias in the answers to questions, and how to interpret data (Marin & Marin, 1990; Rogler, Malgady & Rodriguez, 1989). Cultural insensitivities will be overcome only when we begin to analyze the cultural ramifications of the procedures followed when conducting research. The danger lies in uncritically transferring concepts cross-culturally. For example, replicating procedural norms and using standardized methods for qualitative research developed in Western culture and utilizing these procedure and instruments with South Asian culture can be problematic. The implementation of exact replications and the transfer of concepts are based on an assumption of respondents as culturally homogeneous. Hence dialogue is needed to scrutinize and modify the intricate connection between culture and customary methodologies (Rogler, Cortes, & Malgady, 1991). Procedures for identifying relevant meanings by decreasing the influence of the researcher's preconceptions and increasing the opportunities for the participants' cultural expressions have been developed in some research (Manson, 1997; Morgan, 1988; Stepick & Stepick, 1990). If we think of the researcher as a listener and the culturally different respondent as a speaker, formulations of how psychological explanations are made in everyday social interactions are relevant to the issue. "The speaker is to inform

the listener of the proper means of interpreting his or her actions" (Gergen, Hepburn, & Fisher, 1986). If researchers listen to culturally different speakers, the assumption of homogeneity is no longer relevant. Procedural norms can and should be sensitized to culture.

Directions for Future Research

This study has described the experiences of six South Asian parents who have utilized the mental health care system. From the descriptive accounts provided by these parents, mental health professionals may gain more insight into their clients' journey from initial referral for service, through diagnosis, and treatment. The South Asian parents in this study shared many similarities in connecting with and utilizing mental health services despite their diverse backgrounds and situations. Culture, values, and beliefs have all been shown to play a significant role in the South Asian parents' experiences of supporting their children by influencing how the problem was defined, when help was sought, and how it was received.

Research into how children reach mental health services and their treatment once within the mental health system is very limited. Therefore no single direction for future research is more compelling, than any other, however, some key areas are worth exploring. The congruence between epidemiologically assessed need, functional impairment, and individual perception of need in South Asian culture versus Western culture needs to be examined.

In the present study it was found that prayer and spirituality were used by South Asian parents as coping strategies and the role of spiritual healers as sources of support during times of distress appeared central. However, little is known about how these

support systems operate, their linkage to formal service systems, and their effectiveness. We need research to determine the extent to which mental health needs are being adequately addressed within spiritual and religious communities and the types of problems that spiritual leaders are likely to refer to conventional mental health providers.

Conclusion

The dramatic increase in the cultural diversity of the population has led to policy changes aiming to increase access to mental health services for ethnically diverse parents and children by paying more attention to culturally competent mental health service delivery. Perceptions of mental health service providers as culturally insensitive does play a role in the reluctance of South Asian parents to choose this service for their children. Understanding the process by which ethnic minority parents and children identify problems, seek help, and engage in treatment should consequently be a top priority for those concerned with service provision.

References

Agar, M. (1990). Text and fieldwork: exploring the excluded middle. *Journal of Contemporary Ethnography, 19* (1), 73-88.

American Psychological Association (2000). *Diagnostic and statistical manual of mental Disorders (DSM-IV-TR) 4th Edition, (text revision).* Washington, DC: Author.

Anderson, G. & Arsenault, N. (1998). *Fundamentals of Educational Research*. London: Falmer Press.

Andreou, E. (2000). Bully/victim problems and their association with psychological constructs in 8 to 12 year-old Greek school children. *Aggressive Behaviour, 26,* 49-56.

Atkinson, D. R., & Gim, R. (1989). Asian-American cultural identity and attitude toward mental health services. *Journal of Counseling Psychology, 36* (2), 209-212.

Atkinson, D. R., & Lowe, S. M. (1995). The role of ethnicity, cultural knowledge and conventional techniques in counseling and psychotherapy. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of Multicultural Counseling* (pp. 387-414). Thousand Oaks, CA: Sage.

Atkinson, D. R., Morton, G., & Sue, D. W. (1998). *Counseling American Minorities: A Cross-Cultural Perspective, 5th Edition*. Boston: McGraw-Hill.

Atkinson, D. R., Whiteley, S., & Gim, R. (1990). Asian-American acculturation and preferences for help providers. *Journal of College Student Development, 31*, 155-161.

Baker, M., & Gorsuch, R. (1982). Trait anxiety and intrinsic-extrinsic religiousness. *Journal for the Scientific Study of Religion, 21*(2), 119-122.

Balarajan, R., & Raleigh, S. V. (1993). *Health of the Nation. Ethnicity and Health. A*

Guide for the NHS. London: Department of Health.

Banerjee, S. (1994). The last ditch option: Indian American attitudes toward therapy. *Indian Currents, 8* (4), 22-24.

Banerjee, S. (1997). Help-seeking behaviours and belief systems. *Indian Journal of Social Psychiatry, 13* (3-4), 93-97.

Baptiste, D. A. (1993). Immigrant families, adolescents and acculturation: insight for therapists. *Marriage and Family Review, 19* (3), 341-363.

Bardone, M. A., Moffitt, T. E., Caspi, A., Dickson, N., Stanton, W. R., & Silva, P. A. (1998). Adult physical health outcomes of adolescent girls with conduct disorder, depression, and anxiety. *Journal of the American Academy of Child Psychiatry, 37* (6), 594-601.

Basch, M. F. (1980). *Doing Psychotherapy*. New York: Basic Books

Belanger, A. (2002). *Report on the Demographic Situation in Canada. Current Demographic Analysis.* Ottawa: Minister Responsible for Statistics Canada.

Beliappa, J. (1991). *Illness or Distress?: Alternative Models of Mental Health.* London: Confederation of Indian Organizations.

Bemak, F. (1989). Cross-cultural family therapy with Southeast Asian refugees. *Journal of Strategic and Systemic Therapies, 8,* 22-27.

Berg, I. K., & Jaya, A. (1993). Different and same: family therapy with Asian-American families. *Journal of Marital and Family Therapy, 19*, 31-38.

Berlin, I. N. (1982). Prevention of emotional problems among Native American children: overview of developmental issues. *Journal of Preventive Psychiatry, 1*, 319-330.

Berry, J. W. (1994). Ecology of individualism and collectivism. In U. Kim, H. C.

Triandis, C. Kagitcibasi, S. Choi, & G. Yoon (Eds.) *Individualism and Collectivism: Theory, Method and Applications* (pp.123-136). Thousand Oaks, CA: Sage.

Bhanthumnavin, D. (1985). Moral development and child-rearing. In C. Suvanatat, D. Bhanthumnavin, L. Bhuapirom, & D. M. Keats (Eds.) *Handbook of Asian Child Development and Child Rearing Practices* (pp. 59-76). Jossey-Bass: California.

Bhopal, R. (1986). The inter-relationship between folk, traditional and western medicine within an Asian community in Britain. *Social Science and Medicine, 22* (1), 99-105.

Bhugra, D. (1997). Setting up psychiatric services: cross-cultural issues in planning delivery. *International Journal of Social Psychiatry, 43,* 16-28.

Bhugra, D., & Bhui, K. (1997). Cross-cultural psychiatric assessment. *Advances in Psychiatric Treatment, 3,* 103-110.

Bhugra, D., & Bhui, K. (1998). Psychotherapy with ethnic minority clients. *British Journal of Psychotherapy, 14* (3), 310-326.

Bhui K. (1996). The language of compliance: health policy for the severely mentally ill. *International Journal of Social Psychiatry, 43* (3), 157-163.

Bhui, K., Strathdee, G., & Sufraz, R. (1993). Asian inpatients in a district psychiatric unit: an examination of presenting features and routes into care. *International Journal of Social Psychiatry, 39*, 208-220.

Bhui, K., & Takeuchi, D. (1992). Ethnic minority adolescents and the use of community mental health care services. *American Journal of Community Psychology, 20*, 403-417.

Birchwood, M., & Cochrane, R. (1990). Families coping with schizophrenia: coping

styles, their origins and correlates. *Psychological Medicine, 20*, 857-865.

Bogdan, R. C., & Biklen, S. K. (1992). *Qualitative Research for Education: An Introduction to Theory and Methods, 2nd Edition.* Needham Heights, Mass.: Allyn & Bacon.

Booth, E. B., & Verma, M. (1992). Decreased access to medical care for girls in Punjab, India: the roles of age, religion, and distance. *Public Health Briefs, 82* (2), 1155-7.

Brenner, M., Brown, J. & Canter, D. (1985). In M. Brenner, J. Brown, D. Canter (Eds.) *The Research Interview: Uses and Approaches* (pp.1-8). London: Academic Press.

Bryan, S. K. (2002). Effects of Asian American client adherence to Asian cultural values, session goal, and counselor emphasis of client expression on career counseling process. *Journal of Counseling Psychology, 49* (3), 342-354.

Burman, E., & Parker, I. (1993). *Discourse Analytic Research, Repertoires and Readings of Text in Action.* Routledge, London.

Burns, B., Costello, E., Angold, A., Tweed, D., Stangl, D., Farmer, E. M., & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs, 14*, 147–159.

Cai, D., Wilson, S., & Drake, L. (2000). Culture in the context of intercultural negotiation: individualism-collectivism and paths to integrative agreements. *Human Communication Research, 26* (4), 591-617.

Canadian Counselling Association (1999). *CCA: Code of Ethics.* Ottawa, Ontario.

Chakraborty, A. (1995). Psychotherapy revisited. *Indian Journal of Social Psychiatry, 2,* 4-9.

Cheung, F., & Snowden, L. (1990). Community mental health and ethnic minority

populations. *Community Mental Health Journal, 26*, 277-291.

Chu, C., & Klein, H. (1985). Psychological and environmental variables in outcome of Black schizophrenics. *Journal of National Medical Association, 77,* 793-796.

Cinnirella, M., & Loewenthal, K. M. (1996). *Religious Influences About Mental Illness in Minority Groups.* Royal Holloway: London University.

Clark, M. M. (1983, December). Cultural context of medical practice. *The Western Journal of Medicine, 139* (6), 806-810.

Clark, R. E. (1994). Family costs associated with severe mental illness and substance use. *Hospital & Community Psychiatry, 45*, 808-813.

Commander, M. J., Dharan, S. P. S., & Odell, S. M. (1997). Access to mental health care in an inner-city health district. Pathways into and within specialist psychiatric services. *British Journal of Psychiatry, 170*, 312-316.

Cousins, S. D. (1989). Culture and self-perception in Japan and the United States. *Journal of Personality and Social Psychology, 56*, 124-131.

Creswell, J. W. (1994). *Research Design: Qualitative and Quantitative Approaches.* Thousand Oaks, CA: Sage Publications.

Crystal, D. (1989). Asian Americans and the myth of the model minority. *Social Casework, 70,* 405-415.

Crystal, D. S., & Stevenson, H. W. (1995). What is a bad kid? Answers of adolescents and their mothers in three cultures. *Journal of Research on Adolescence, 5*, 71-91.

Dana, R. H. (1993). Asian Americans. In Dana (Ed.) *Multicultural Assessment Perspectives for Professional Psychology (*pp. 47-67). Boston: Allyn & Bacon.

Das, A., & Kemp, S. (1997). Between two worlds: counselling South Asian

Americans. *Journal of Multicultural Counselling and Development, 25*, 1, 23-33.

Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of Qualitative Research.* Thousand Oaks, CA: Sage Publications.

Desai, P. N., & Coelho, G. V. (1980). Indian immigrants in America: some cultural aspects of psychological adaptation. In P. Saran & E. Eames (Eds.) *The New Ethnics: Asian Indians in the United States* (pp. 363-385). New York: Praeger.

Draguns, J. G. (1988). Personality and culture: Are they relevant for the enhancement of quality of mental life? In P. R. Dasen, J.W. Berry, & N. Sartorius (Eds.), *Health and Cross-Cultural psychology: Toward Applications* (pp. 141-161). Newbury Park, CA: Sage.

Dunst, C. J., Trivette, C.M., Deal, A.G. (1988). *Enabling and Empowering Families: Principles and Guidelines for Practice.* Cambridge, MA: Brookline.

Dyson, J., Cobb, M., & Foreman, D. (1997). The meaning of spirituality: a literature review. *Journal of Advanced Nursing, 26,* 1183-1188.

Eisenman, R., & Sirgo, B. (1991). Liberals versus conservatives: personality, child-rearing attitudes, and birth order/sex differences. *Bulletin of the Psychonomic Society, 29* (3), 240-242.

Eisner, C. (1990). *Chronic Childhood Disease: An Introduction to Psychological Theory and Research.* Cambridge: Cambridge University Press.

Erikson, E. (1980). *Identity and the Life Cycle.* New York: Norton.

Fabrega, H. J. (1992). The role of culture in a theory of psychiatric illness. *Social Science and Medicine, 35* (1), 91-103.

Fernando, S. (1991). Applied psychiatry. In S. Fernando (Ed.), *Mental Health, Race, and*

Culture (pp.113-145). London: Macmillan.

Fernando, S. (1995). *Mental Health in a Multi-ethnic Society.* London: Routledge.

Finley, L. (1997). The multiple effects of culture and ethnicity on psychiatric disability. In L. Spaniol, C. Gagne, & M. Koehler (Eds.), *Psychological and Social Aspects of Psychiatric Disability* (pp. 497-510). Boston: Boston University Center for Psychiatric Rehabilitation.

Finney, J. R., & Maloney, H. N. (1985). An empirical study of contemplative prayer as an adjunct to psychotherapy. *Journal of Psychology and Theology, 13,* 284-290.

Fischer, E. H., & Turner, J. L. (1970). Orientations to seeking professional help: development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35*, 790.

Fish, J. (1996). *Culture and Therapy: An Integrative Approach.* Northvale, NJ: Jason Aronson.

Flisher, A. J., Kramer, J., & Grosser, R. (1997). Correlates of unmet need for mental health services by children and adolescents. *Psychological Medicine, 27,* 1145-1154.

Foulks, E., Persons, J., & Merkel, R. (1986). The effect of patients' beliefs about heir illnesses on compliance in psychotherapy. *American Journal of Psychiatry, 143,* 340-344.

Furnham, A., & Shiekh, R. (1993). Gender generation and social support correlates of mental health in Asian immigrants. *International Journal of Social Psychiatry, 39*, 22-33.

Gartner, J., Larson, D., & Allen, G. (1991). Religious Commitment and Mental Health: A Review of the Empirical Literature. *Journal of Psychology and Theology, 19* (1),

6-25.

Gergen, K. J., Hepburn, A., & Fisher, D. C. (1986). Hermeneutics of personality description. *Personality and Social Psychology, 50*, 1261-1270.

Ghosh, R. (1983). Sarees and the maple leaf: Indian women in Canada. In G. Kurian & R. Srivastava (Eds.), *Overseas Indians: A Study in Adaptation* (pp. 90-99). New Dehi: Vikas.

Ghuman, P. (1994). Canadian or Indo-Canadian: a study of South Asian adolescents. *International Journal of Adolescence of Youth, 4*, 229-243.

Goldberg, D., & Huxley, P. (1992). *Common Mental Disorders. A Bio-social Model.* London: Routledge.

Good, B. J., Good, M., & Moradi, R. (1985). The interpretation of Iranian depressive illness and dysphoric affect. In A. Kleinman & B. Good (Eds.), *Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder* (pp.369-428). Berkeley, CA: University of California Press.

Guarnaccia, P. J., Parra, P., Deschamps, A., Milstein, G., & Argi, N. (1992). Hispanic families' experience of caring for a seriously mentally ill family member. *Culture, Medicine, and Psychiatry, 16,* 187-215.

Gupta, S. (1991). Psychosis in migrants from the Indian sub-continent. A preliminary study on the use of psychiatric services. *British Journal of Psychiatry, 159*, 222-225.

Gupta, S. (1992). Psychosis in migrants from the Indian sub-continent: preliminary findings from a follow-up study including a survey of general practitioners. *Social Psychiatry and Psychiatric Epidemiology, 27*, 242-244.

Hanson, J. G., & Rapp, C. A. (1992). Families' perceptions of community mental health

programs for their relatives with a severe mental illness. *Community Mental Health Journal, 28,* 181-197.

Hatfield, A. B. (1987). Families as caregivers: a historical perspective. In A. B. Hatfield & H. P. Lefley (Eds.) *Families of the Mentally Ill: Coping and Adaptation* (pp. 3-29). New York: Guilford Press.

Helman, C. (1990). Cross-cultural psychiatry. In C. Helman (Ed.) *Culture, Health and Illness* (pp. 214-248). London: Wright.

Herman, J. L. (1997). *Trauma and Recovery.* New York: Basic Books.

Hines, P. M., Garcia-Preto, N., McGoldrick, M., Almeida, R., & Weltman, S. (1992). Intergenerational relationships across cultures. *Families in Society: The Journal of Contemporary Human Services, 23,* 323-338.

Ho, M. K. (1992). *Minority children and adolescents in therapy*. Newbury Park, CA: Sage.

Holt, J., & Keats, D. M. (1992). Work cognitions in multicultural interaction. *Journal of Cross-Cultural Psychology, 23 (*4), 421-443.

Holden, D. F., & Lewine, R. J. (1982). How families evaluate mental health professionals, resources, and effects of illness. *Schizophrenia Bulletin, 8,* 626-633.

Hong, G. K. (1989). Application of cultural and environmental issues in family therapy with immigrant Chinese Americans. *Journal of Strategic and Systemic Therapies, 8,* 14-21.

Hong, G. K. (1996). Culture and empowerment: counselling services for Chinese American families. *Journal for the Professional Counsellor, 11 (*1), 69-80.

Hong, G. K., & Ham, M. D. (1992). Impact of immigration of the family life cycle:

clinical implications for Chinese Americans. *Journal of Family Psychotherapy, 3* (3), 27-40.

Hourani, L., & Khlat, M. (1986). Determinants of perceived mental health status and help-seeking behavior: preliminary testing of a conceptual model. *Social Science and Medicine, 22*, 1081-1086.

Husserl, E. (1970). *The Idea of Phenomenology*. The Hague: Matunus Nijhoff.

Ibrahim, F., Ohnishi, H., & Sandhu, D. (1997). Asian American identity development: a culture specific model for South Asian Americans. *Journal of Multicultural Counselling and Development, 25*, 34-50.

Jalali, B. (1982). Iranian families. In M. McGoldrick, J. K. Pearce, & J. Giordano (Eds.), *Ethnicity & Family Therapy* (pp. 289-310). New York: Guildford Press.

Janesick, V. J. (1994). The Dance of Qualitative Research Design: Metaphor, Methodolatry, and Meaning. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 136-156). Thousand Oaks, Calif.: Sage.

Jawed, S. H. (1991). A survey of psychiatrically ill Asian children. *British Journal of Psychiatry, 158,* 268-270.

Jiloha, R., & Kishore, J. (1997). Supernatural beliefs, psychiatric disorder and treatment outcomes in Indian patients. *Indian Journal of Social Psychiatry, 13* (3-4), 24-31.

Johnson, A. W., & Nadirshaw. Z. (1993). Good practice in transcultural counselling: an Asian perspective. *British Journal of Guidance and Counselling, 21* (1), 20-29.

Kagitcibasi, C. (1997). Individualism and collectivism. In J. W. Berry, M. H. Segall, & C. Kagitcibasi (Eds.), *Handbook of Cross-Cultural Psychology. Social Behavior and Applications* (2nd ed., Vol.3, pp. 1-49). Boston: Allyn and Bacon.

Kakar, S. (1978). *The Inner World: A Psychoanalytic Study of Childhood and Society in India*. New York: Oxford University Press.

Kakar, S. (1979). *Indian Childhood: Cultural Ideals and Social Reality*. Delhi, India: Oxford University Press.

Kakar, S. (1982). *Shamans, Mystics, and Doctors.* London: Mandala Books

Kakar, S. (1994) *The Inner World: A Psycho-Analytical Study of Childhood and Society in India*. Delhi: Oxford University Press.

Kareem & Littlewood (1992). *Intercultural Therapy*: *Themes, Interpretations, and Practice.* Oxford: Blackwell Science.

Karp, D. (1996). *Speaking of Sadness: Depression, Disconnection, and the Meanings of Illness*. New York: Oxford University Press.

Kazdin, A.E., & Wassell, G. (2000). Therapeutic changes in children, parents, and families resulting from treatment of children with conduct problems. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 414-420.

Keats, D. M. (1997). *Culture and the Child: A Guide for Professionals in Child Care and Development.* Chichester, UK: Wiley.

Kelly, T. B. & Kropf, N. P. (1995). Stigmatized and perpetual parents: older parents caring for adult children with life-long disabilities. *Journal of Gerontological Social Work, 24* (1-2), 3-16.

Kim, Y., & Gudykunst, W. B. (1988). *Cross-Cultural Adaptation: Current Approaches*. Newbury Park, CA: Sage.

Kirmayer, L. (1984). Culture, affect, and somatisation. *Transcultural Psychiatric Research Review, 21,* 159-188.

Kleinman, A. (1980). Patients and healers in the context of the borderland between anthropology, medicine, and psychiatry. In Kleinman (Ed.), *Patients and their Healers in the Context of Culture* (pp. 138-145). Berkeley: University of California Press.

Kleinman, A. (1988) *Rethinking Psychiatry.* New York: Free Press.

Klucholn, F. R., & Strodbeck, F. L. (1961). *Variations in Value Orientations*. Chicago: Row, Peterson.

Koski-Jaennes, A., & Turner, N. (1999). Factors influencing recovery from different addictions. *Addiction Research, 7* (6), 469-492.

Krause, I. B. (1994). Numbers and meaning: a dialogue in cross-cultural psychiatry. *Journal of the Royal Society of Medicine, 87,* 278-282.

Krishnamurthy, K., Venugopal, D., & Alimchandi, A. (2000). Mental hospitals in India. *Indian Journal of Psychiatry, 42*(2), 3-13.

Kua, E. H., Chew, E. O., & Ko, S. M. (1993). Spirit possession and healing among Chinese psychiatric patients. *Acta Psychiatrica Scandinavica, 88*, 447-450.

Landrine, H. (1992). Clinical implications of cultural differences: the referential versus the indexical self. *Clinical Psychology Review, 12*, 401-415.

Larson, D., et. al. (1992). Associations between dimensions of religious commitment and mental health reported in the American Journal of Mental Health and Archives of General Psychiatry: 1978-1989. *American Journal of Psychiatry, 149*(4), 557-559.

Larson, D., Swyers, J., & McCullough, M. (1997). *Scientific Research on Spirituality and Health: A Consensus Report.* National Institute for Healthcare Research.

Last, J. M. (1995). *A Dictionary of Epidemiology* (3rd Ed., pp.985). Oxford University Press.

Laszloffy, T. (2000). Uncommon strategies for a common problem: addressing racism in family therapy. *Family Process, 31*, 391-397.

Laungani, P. (1999). Cultural influences on identity and behavior: India and Britain. In L. Yueh-Ting, C. R. McCauley, & J. G. Draguns (Eds.), *Personality and Person Perception Across Cultures* (pp.22-46). Mahwah, NJ: Lawrence Erlbaum.

Laungani, P. (1998). Client-centred or culture-centred counselling? In S. Palmer & P. Laungani (Eds.), *Counselling Across Cultures.* London: Sage Publications.

Lazarus, R., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.

LeCompte, M. D., Preissle, J., & Tesch, R. (1993). *Ethnography and Qualitative Design in Educational Research, Second Edition.* Orlando, Fla.: Academic Press.

Lee, E. (1988). Cultural factors in working with South-Eastern Asian refugee adolescents. *Journal of Adolescence, 1,* 167-179.

Lee, E. (1996). Asian American families. An overview. In M. McGoldrick, J. K. Pierce, & J. Giordano (Eds.), *Ethnicity and Family Therapy, Second Edition.* New York: Guilford.

Lefley, H. P. (1994a). Service needs of culturally diverse patients and families. In H. P. Lefley & M. Wasow (Eds.), *Helping Families Cope with Mental Illness* (pp. 232-242). Switzerland: Harwood Academic Publishers.

Lefley, H. P. (1994b). An overview of family-professional relationships. In D. T. Marsh (Ed.), *New Directions in the Psychological Treatment of Serious Mental Illness* (pp. 166-185). Westport, CT: Praeger.

Lefley, H. P., & Bestman, E. W. (1984). Community mental health and minority populations: a multi-ethnic approach. In S. Sue & T. Moore (Eds.), *The*

Pluralistic Society: A Community Mental Health Perspective (pp.116-148). NY: New York, Human Sciences Press.

Leong, F. (1986). Counseling and psychotherapy with Asian-Americans. *Journal of Counseling Psychology, 33*, 196-206.

Leong, F. (1994). Asian-Americans' differential patterns of utilization of inpatient and outpatient public mental health services in Hawaii. *Journal of Community Psychology, 22*, 82-96.

Leong, F., & Lau, A. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research, 3,* 201-214.

Leong, F., Wagner, N., & Kim, H. (1995). Group counseling expectations among Asian American students: The role of culture-specific factors. *Journal of Counseling Psychology, 42*, 217-222.

Levy-Bruhl, L. (1985). *How Natives Think.* New Jersey: Princeton University.

Lin, K., & Cheung, F. (1999). Mental Health Issues for Asian Americans. *Psychiatric Services, 50,* 774-780.

Lin, K., Miller, M., Pollard, R., Nuccio, I., & Yamaguchi (1991). Ethnicity and family involvement in the treatment of schizophrenic patients. *Journal of Nervous and Mental Disease, 179*, 631-633.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry.* Thousand Oaks: Sage.

Lipsedge, M. (1993). Mental health: access to care for black and ethnic minority people. In A. Hopkins & V. Bahl (Eds.), *Access to Health Care for people from Black and Ethnic Minorities* (pp. 169-183). London: Royal College of Physicians Publications.

Lipson, J. G., & Meleis, A. I. (1983). Issues in health care of Middle Eastern

patients. *The Western Journal of Medicine, 139* (6), 854-861.

Lloyd, K. (1993). Depression and anxiety among Afro-Caribbean general practice attenders in Britain. *International Journal of Psychiatry, 156,* 308-327.

Loewenthal (1995). *Mental Health and Religion.* London: Chapman and Hall.

Mann, B. (1992). *The New Scots.* Edinburgh: John Donald Publishers.

Manson, S. M. (1997). Ethnographic methods, cultural context, and mental illness: bringing different ways of knowing and experience. *Ethos, 25*, 249-258.

Manuel, J. (2001). Risk and resistance factors in the adaptation of mothers of children with children juvenile chronic arthritis. *Journal of Pediatric Psychology, 26*(4), 237-246.

Marin, B., & Marin, G. (1990). Effects of acculturation on knowledge of AIDS and HIV among Hispanics. *Hispanic Journal of Behavioural Sciences, 12,* (2), 10-21.

Markus, H. R., Mullay, R.,& Kitayama, S. (1998). The cultural psychology of personality. *Journal of Cross-Cultural Psychology, 29*, 63-87.

Marshall, C., & Rossman, B.(1999). *Designing Qualitative Research* (3rd ed.) Thousand Oaks, California: Sage.

Martsolf, D., & Mickley, J. (1998). The concept of spirituality in nursing theories: differing world-views and extent focus. *Journal of Advanced Nursing, 27,* 294-303.

Maurin, J. T., & Boyd, C. B. (1990). Burden of mental illness on the family: a critical review. *Archives of Psychiatric Nursing, 4,* 99-107.

Maxwell, J. A. (1996). *Qualitative research design: an interactive approach.* Thousand Oaks, CA: Sage.

McCabe, K. M., Yeh, M., & Hough, R. L. (1999). Racial/ethnic variation across five public systems of care for youth. *Journal of Emotional and Behavioural Disorders, 7,* 72-82.

Meinhardt, K., & Vega, W. (1987). A method for estimating underutilization of mental health services by ethnic groups. *Hospital and Community Psychiatry, 38*, 1186-1190.

Merriam, S. B. (1988). *Case Study Research in Education: A Qualitative Approach*. San Francisco: Jossey-Bass.

Merriam, S. B. (2000). *Qualitative Research and Case Study Applications in Education*. San Francisco: Jossey-Bass.

Miklowitz, D. (2003). A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Arch General Psychiatry, 60,* 904-12.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative Data: A Sourcebook of New Methods* (pp, 22-27). Beverly Hills: California.

Miller, J. (1997). Agency and context in cultural psychology: Implications for moral theory. In H. D. Saltzstein (Ed.), *Culture as a Context for Moral Development: New Perspectives on the Particular and the Universal* (pp. 69-85). San Francisco: Jossey-Bass.

Miller, J., & Glassner, B. (1997). The 'inside' and the 'outside': finding realities in interviews. In D. Silverman (Ed.), *Qualitative Research: Theory, Method and Practice* (pp.99-112). London: Sage Publications.

Miller, W. R. (1998). Researching the spiritual dimensions of alcohol and other drug problems. *Addictions, 93* (7), 979-990.

Millet, P. E., Sullivan, B. F., Schwebel, A. I., & Myers, L. J. (1996). Black Americans' and White Americans' views of the etiology and treatment of mental health problems. *Community Mental Health Journal, 32*, 235-242.

Milstein, G., Guarnaccia, P., & Midlarsky, E. (1995). Ethnic differences in the interpretation of mental illness: perspectives of caregivers. *Research in Community and Mental Health, 8,* 155-178.

Min, P.G. (1995). *Asian Americans: Contemporary Trends and Issues*. Thousand Oaks, CA: Sage.

Moodley, P., & Perkins, R. (1991). Routes to psychiatric inpatient care in an inner London. *Social, Psychiatric Epidemiology, 26*, 47-51

Morgan, D. L. (1988). *Focus Groups as Qualitative Research.* Newbury Park, CA: Sage.

Morris, L., & Elizabeth, H. (1996). A spiritual well-being model: use with older women who experience depression. *Issues in Mental Health Nursing, 17 (*5), 439-456.

Moyerman, D., & Forman, B. (1992). Acculturation and adjustment: a meta-analytic study. *Hispanic Journal of Behavioral Sciences, 14* (2), 163-200.

Mumford, D. (1992). Detection of psychiatric disorders among Asian patients presenting with somatic symptoms. *British Journal of Hospital Medicine, 47,* 202-204

Murdock, G. P., Wilson, S. F., & Fredrick, V. (1980). World distribution of theories of illness. *Transcultural Psychiatric Research Review, 17*, 37-64.

Murthy, R.S. (1998). Rural psychiatry in developing countries. *Psychiatric Services, 49*(7), 967-969.

Naidoo, J. C. (1992). The mental health of visible ethnic minorities in Canada.

Psychology and Developing Societies, 4(2), 165-186.

Nazroo, J. (1997). *Ethnicity and Mental Health.* London: Policy Studies Institute.

Neighbours, H. W. (1990). The prevention of psychopathology in African Americans: an epidemiologic perspective. *Community Mental Health Journal, 26* (2), 167-179.

Newth, S. J., & Corbett, J. (1993). Behavior and emotional problems in three-year-old children of Asian parentage. *Journal of Child Psychology and Psychiatry, 34*, 333-352.

Nguyen, S. D. (1985). Mental health services for refugees and immigrants in Canada. In T. C. Owan (Ed.), *Southeast Asian Mental Health Treatment, Prevention, Services, Training, and Research* (pp.261-282). Washington, DC: National Institute of Mental Health

Nickerson, K., Kim, J., Helms, J., & Terrell, F. (1994). Cultural mistrust, opinions about mental illness, and Black students' attitudes toward seeking psychological help from White counsellors. *Journal of Counseling Psychology, 41*, 378-85.

Nishio, K, & Bilmes, M. (1998). Psychotherapy with southeast Asian American clients. In D. R. Atkinson, G. Morten, & D. W. Sue (Eds.), *Counseling American Minorities.* (5th ed., pp. 65-83). New York: McGraw-Hill.

Nucci, L. (1997). Culture, universals, and the personal. In H. D. Saltzstein (Ed.), *Culture as a Context for Moral Development. New Perspectives on the Particular and the Universal* (pp.5-22). San Francisco: Jossey-Bass.

O'Flaherty, W. D. (1980). *Karma and Rebirth in Classical Indian Traditions.* Berkeley, CA: University of California Press.

Ogbu, J. (1994). Understanding cultural diversity and learning. *Journal of Education for*

the Gifted, 17 (4), 355-83.

Opie, A. (1992). Qualitative research appropriation of the 'other' and empowerment. *Feminist Review, 40,* 53-69.

Owens, D., Harrison, G., & Boot, D. (1991). Ethnic factors in voluntary and compulsory admissions. *Psychological Medicine, 21,* 185-196.

Parekh, B. (1996). Minority practices and principles of tolerance. *International Migration Review, 30* (1), 251-284.

Parekh, B. (2000). The commission on the future of multi-ethnic Britain: A summary of some of the main principles and recommendations. *Multicultural Cultural Therapy, 19* (1), 6-7.

Patel, S. (1995). Language is not the only barrier. *British Medical Journal, 310,* 194.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods.* Newbury Park, CA: Sage.

Patton, M. Q. (2002). *Qualitative Research and Evaluation Methods, Third Edition.* Thousand Oaks, CA: Sage.

Pedersen, P. B., & Lefley, H. P. (1986). Introduction to cross-cultural training. In H. P. Lefley & P. B. Pedersen (Eds.), *Cross-Cultural Training for Mental Health Professionals* (pp. 5-10). Springfield, Illinois: Charles C. Thomas.

Phinney, J. S. (1989). Stages of ethic identity development in minority group adolescents. *Journal of Early Adolescence, 9*, 34-49.

Phinney, J. S., Lochner, B. T., & Murphy, R. (1990). Ethnic identity development and psychological adjustment in adolescence. In A. R. Stiffman & L. E. Davis (Eds.), *Ethnic Issues in Adolescent Mental Health* (pp. 53-72). Newbury Park, CA: Sage.

Phoroah, C. (1995). *Primary Health Care for Elderly People from Black and Minority Ethnic Communities.* London: HMSO.

Polkinghorne, D. E. (1989). Phenomenological research methods. In R. S. Valle & S. Hallings (Eds.), *Existential- Phenomenological Perspectives in Psychology* (pp. 41-60). New York: Plenum Press.

Pottick, K., Lerman, P., & Micchelli, M. (1992). Of problems and perspectives: Predicting the use of mental health services by parents and urban youth. *Children and Youth Services Review, 18,* 363-378.

Rack, P. (1982). *Race, Culture, and Mental Disorder.* London: Tavistock.

Rando, T. A. (1986). *Parental Loss of Child.* Champaign, IL: Research Press.

Riessman, C. K. (1993). *Narrative Analysis*. Newbury Park, CA: Sage Publications.

Reichenbach, B. R. (1990). *The Law of Karma: A Philosophical Study*. Honolulu: University of Hawaii Press.

Roberts, N., & Cawthorpe, D. (1995). Immigrant child and adolescent psychiatric referrals: a five-year retrospective study of Asian and Caucasian families. *Canadian Journal of Psychiatry, 40*, 252-256.

Roberts, R. E., Atkinson, C. C., & Rosenblatt, A. (1998). Prevalence of psychopathology among children and adolescents. *American Journal of Psychiatry, 155* (6), 715-725.

Rogler, L. H. (1989). The meaning of culturally sensitive research in mental health. *American Journal of Psychiatry, 146*, 296-303.

Rogler, L. H. (1996). Framing research on culture in psychiatric diagnosis: the case of the DSM-IV. *Psychiatry, 59,* 145-155.

Rogler, L. H., Cortes, D. E., & Malgady, R. G. (1991). Acculturation and mental health status among Hispanics. convergence and new directions for research. *American Psychologist, 46*, 585-597.

Rogler, L. H., Malgady, R. G., & Rodriguez, O. (1989). *Hispanics and Mental Health: A Framework for Research.* Malabar, FL: Krieger.

Root, M. P. (1998). Facilitating psychotherapy with Asian American clients. In D. R. Atkinson, G. Morten, & D. W. Sue (Eds.), *Counseling American Minorities* (5th ed., pp. 36-45). New York: McGraw-Hill.

Rosenthal, D., & Feldman, S. (1990). The nature and stability of ethnic identity in Chinese youth. *Journal of Cross-Cultural Psychology, 23*, 214-227.

Rosenthal, D., & Feldman, S. (1992). The nature and stability of ethnic identity in Chinese youth: effects of length of residence in two cultural contexts. *Journal of Cross-Cultural Psychology, 23* (2), 214-27.

Ruiz, P. (1995). Assessing, diagnosing and treating culturally diverse individuals: a Hispanic perspective. *Psychiatry Quarterly, 66*, 329-341.

Russell, G., & Russell, A. (1987). Mother-child and father-child relationships in middle childhood. *Child Development, 58,* 1573-1585.

Shon, S. P., & Ja, D.Y. (1982). Asian families. In M. McGoldrick, J. K. Pierce, & J. Giordano (Eds.), *Ethnicity and family therapy* (pp.208-228). New York: Guildford.

Sinari, R. A. (1984). *The Structure of Indian Thought.* Dehli: Oxford University Press.

Sinha, D. (1998). Some recent changes in the Indian family and their implications for socialization. *Indian Journal of Social Work, 45,* 271-286.

Sinha, D., & Kao, H. S. (1997). The journey of the east: an introduction. In H. S. Kao

& D. Sinha (Eds.), *Asian Perspectives in Psychology* (pp. 9-22). New Delhi: Sage.

Sinha, D., & Tripathi, R. C. (1994). Individualism in a collectivist culture: a case of coexistence of opposites. In U. Kim, H. C. Triandis, C. Kagitcibasi, S. Choi, & G. Yoon (Eds.), *Individualism and Collectivism: Theory, Method and Applications* (pp. 123-36). Thousand Oaks, CA: Sage.

Sjoberg, G., Williams, N., Gill, E., & Himmel, K.F. (1995). Family life and racial and ethnic diversity: An assessment of communitarianism, liberalism, and conservation. *Journal of Family Issues, 16* (3), 246-274.

Smith, P. (2004). Acquiescent response bias as an aspect of cultural communication style *Journal of Cross-Cultural Psychology, 35* (1), 50-61.

Snowden, R., & Cheung, F. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist, 45*, 347-55.

Snowden, L., Storey, C., & Clancy, T. (1989). Ethnicity and continuation in treatment at a black community mental health center. *Journal of Community Psychology, 17,* 111-118.

Solomon, P, & Draine, J. (1995). Subjective burden among family members of mentally ill adults: relations to stress, coping and adaptation. *American Journal of Orthopsychiatry, 65,* 419-427.

Somerfield, M. (1997). The future of coping research as we know it: a response to commentaries. *Journal of Health Psychology, 2,* 173–183.

Soriano, M. (1995). Latinos in rehabilitation: Implications for culturally-appropriate counseling. *NARPPS Journal, 19*(2), 67-72.

Spradley, J. P. *Participant Observation.* Austin, Tex.: Holt, Rinehart and Winston.

Srebnik, D., Cauce, A., & Baydon, M. (1996). Help-seeking pathways for children and adolescents. *Journal of Emotional and Behavioural Disorders, 4* (4), 210-220.

Stainton-Rogers, R., Stenner, P., Gleeson, K., & Stainton-Rogers, W. (1995). *Social Psychology: A Critical Agenda.* Polity Press, Cambridge.

Stake, R. (1994). Case Study. In N. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 236-247). Thousand Oaks, CA: Sage.

Stake, R. (1995). *The Art of Case Study.* Thousand Oaks, CA: Sage.

Stepick, A., & Stepick, C. (1990). People in the shadows: a survey among Haitians in Miami. *Human Organization, 49*, 64-77.

Stopes-Roe, M., & Cochrane, R. (1989). Traditionalism in the family: a comparison between Asian and British cultures and between generations. *Journal of Comparative Family Studies XX* (2), 142-158.

Stopes-Roe, M., & Cochrane, R. (1990). The child-rearing values of Asian and British parents and young people: an inter-ethnic and inter-generational comparison in the evaluation of Kohn's qualities. *British Journal of Social Psychology, 29*, 149-160.

Strauss, A., & Corbin, J. (1998). *Basics of Qualitative Research: Grounded Theory, Procedures, and Techniques.* Newbury Park, CA: Sage Publications.

Sue, S. (1994). Mental Health. In N. Zane, D. Takeuchi, & K. Young (Eds.), *Confronting Critical Health Issues of Asian and Pacific Islander Americans* (pp.266-288). Thousand Oaks, CA: Sage.

Sue, S., & Morishima, J. K. (1982). *The Mental Health of Asian Americans.* San Francisco: Jossey-Bass.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice,*

Second Edition. New York: Wiley.

Sue, S., Zane, N., & Young, K. (1995). Research on psychotherapy with culturally diverse populations. In A. E. Bergin & S. L. Garfiled (Eds.), *Handbook of Psychotherapy and Behavior Change (*4th Ed., pp.53-75). New York: Wiley.

Sussman, L., Robins, L., & Earls, F. (1987). Treatment seeking for depression by Black and White Americans. *Social Science and Medicine, 24*, 187-196.

Sveaass, N. (2001). Engaging Refugee Families in Therapy: Exploring the benefits of including referring professionals in first family interviews. *Family Process, 40*, 95-114.

Takaki, R. (1996). The myth of the "model minority." In R. C. Monk (Ed), *Taking sides: Clashing Views on Controversial Issues in Race and Ethnicity* (2nd ed., pp.41-47).

Taylor, S. & Bogdan, R. (1998). *Introduction to Qualitative Research Methods: A Guidebook and Resource.* (3rd ed., pp. 134-165). Thousand Oaks, CA: Sage.

Taylor, R., Jackson, J., & Chatters, L. (1997). *Family Life in Black America.* Thousand Oaks, CA: Sage.

Taylor, M. J., & Hegarty, S. (1985). *The Best of Both Worlds...?* Windsor: NFER-Nelson.

Terkelsen, K. G. (1983). Schizophrenia and the family: adverse effects of family therapy. *Family Process, 22* (2), 191-200.

Thompson, R. J., & Gustafson, K. E. (1996). *Adaptation to Chronic Childhood Illness.* Washington, DC: American Psychological Association.

Tizard, B., Blatchford, P., Burke, J., Farquhar, C., & Pelwis, I. (1988). *Young Children*

at School in Inner City. London: Lawrence Erlbaum Associates Publishers.

Tomm, K. (1988). Interventive interviewing: Part III. Intending to ask lineal, circular, strategic or reflexive questions? *Family Process, 27*(1), 1-15.

Tracey, T., Leong, F., & Glidden, C. (1986). Help seeking and problem perception among Asian Americans. *Journal of Counseling Psychology, 13*, 331-336.

Triandis, H. C. (1995). *Individualism and Collectivism.* Boulder, CO: Westview.

Triandis, H. C. (1994). Theoretical and methodological approaches to the study of collectivism and individualism. In K. Uichol (Ed.), *Individualism and Collectivism: Theory, Method and Applications* (pp. 41-51). London Sage Publications.

Trupin, E., Low, B., Forsyth-Stephens, A., Tarico, V., & Cox, G. (1988). *Forgotten Children: The Mental Health Needs of Washington Children: A Systems Analysis.* Seattle: University of Washington, Division of Community Psychiatry.

Tseng, W. S., & McDermott, J. F., Jr. (1981). *Culture, Mind and Therapy: An Introduction to Cultural Psychiatry.* New York: Spectrum.

Tsui, P., & Schultz, G. L. (1985). Failure of rapport: why psychotherapeutic engagement fails in the treatment of Asian clients. *American Journal of Orthopsychiatry, 55*, 561-569.

Tweed, R., White, K., & Lehman, D. (2004). Culture, stress, and coping: internally- and externally-targeted control strategies of European Canadians, East Asian Canadians, and Japanese. *Journal of Cross-Cultural Psychology, 35* (6), 652-668.

Visser, J. H., van der Ende, J., Koot, H. M., & Verhulst, F. C. (1999). Continuity of psychopathology in youths referred to mental health services. *Journal of the*

American Academy of Child and Adolescent Psychiatry, 38, 1560-1568.

Wakil, S. P., Siddique, C. M., & Wakil, F. A. (1981). Between two cultures: a study in socialization of children of immigrants. *Journal of Marriage and the Family, 43,* 929-940.

Wilson, A. (1978). *Finding a Voice: Asian Women in Britain.* London: Virago.

Wilson, M., & McCarthy, B. (1994). GP consultation as a factor in the low rate of mental health service use by Asians. *Psychological Medicine, 24,* 113-119.

Whittemore, R., Chase, S., & Mandle, C. (2001). Validity in qualitative research. *Qualitative Health Research, 44* (2). 523-537.

Wig, N. (1990). Indian concepts of mental health and their impact on the care of the mentally ill. *International Journal of Mental Health, 18* (3), 71-80.

Woolis, R. (1992). *When Someone You Love Has a Mental Illness.* New York: Tarcher/Perigee.

World Health Organization (1992). *The Tenth Revision of the International Classification of Diseases and Related Health Problems (ICD-10).* Geneva: WHO.

Yamamoto, J. (1982). Mental Health Needs of Asian Americans and Pacific Islanders. In A. K. Murata, & J. Farquhar (Eds.), *Issues in Pacific/Asian American Health and Mental Health.* Chicago: Pacific/Asian American Mental Health Research Center.

Yeh, M., McCabe, K., Hough, R., Dupuis, D., & Hazen, A. (2003). Racial/ethnic differences in parental endorsement of barriers to mental health services for youth. *Mental Health Services Research, 5,* 65-77.

Yin, R. K. (1994). *Case Study Research: Design and Methods, Second Edition.* Thousand Oaks, Calif: Sage.

Appendix A: Participant Consent Form

ACCESSING MENTAL HEALTH SERVICES FOR THEIR CHILD: EXPERIENCE OF SOUTH ASIAN PARENTS

You are being invited to participate in a study entitled the ***Accessing Mental Health Services for their Child: Experience of South Asian Parents*** that is being conducted by Suman Jaswal. Suman is a Master's Student in the Counselling Psychology Program, in the Department of Education at the University of Victoria and you may contact her if you have further questions by calling (250) 454-9942 or via e-mail at suman_jaswal@hotmail.com.

As a graduate student, I am required to conduct research as part of the requirements for my Master of Arts degree in Counselling Psychology. This research is being conducted under the supervision of Dr. Blythe Shepard. You may contact my supervisor at (250) 721-7772 or via e-mail: blythes@uvic.ca.

The purpose of this study is to examine in-depth, the experience of South Asian parents who are accessing or have accessed mental health services in the past. The objectives of the study are:

- To understand South Asian parents' perception about mental health intervention, its values, and its impact on their lives
- To explore the quality of care available to South Asian parents using mental health services for their children from the parents' perspective.

Research of this type is very important in order to develop more effective and responsive mental health services to the South Asian population. You are being asked to participate in this research study because it is understood that you are accessing or have accessed mental health support for your child. You will be required to talk about your experience in detail.

If you agree to voluntarily participate in this research, your participation will include completing a demographic questionnaire; participating in an interview lasting 1-2 hours; participating in an ½ hour follow-up interview; and giving permission for the researcher to examine your child's client file and before the interview begins you will be asked to fill out a demographic questionnaire. The interview will begin with some general questions after which a set of interview questions will be used to guide the conversation. These interview questions will be available to you a day or two before the interview so that you have an opportunity to think about them before being interviewed if you so desire. The follow-up interview will give the researcher an opportunity to clarify any of your comments and also give you an opportunity to provide clarification by adding to or deleting statements made in the first interview. Both interviews will be audio-taped and transcribed by the researcher.

Participation in this study may cause some inconvenience to you because 1.5-2.5 hours are required to complete the two interviews. Another potential inconvenience will be arranging a mutual time and location to conduct the interview. The interview can be conducted at the mental health office during its hours of operation. However, the location and time of the interview will be flexible within reason. For example, if one or both of you are working, the interview could be held in the evening at your home or another preferable location. It is realized that you are being asked to provide a detailed account of an experience that may have been and still is very painful for you. To deal with these risks participants will be provided with referrals to counselling services.
The potential benefits of participating in this study include:

- You may gain new insights into your experience of mental health service to date and how you would approach this service in the future.
- Your participation may contribute to highlighting what is working in terms of service delivery and areas where service provision by professionals could be more effective.
- Your participation may contribute to an overall body of knowledge of multicultural counselling literature.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study, this will not effect services that you are receiving from the mental health team. If you withdraw the study after we have done some taped interviewing, your data will only be used in the analysis if you agree to this. In order to assure myself that you are continuing to give your consent to participate in this research, this consent form will be reviewed at the time of the interview and again at follow-up interview. Your child will also need to sign an Assent Form which is a brief description of the study which explains that even though your child will not be a direct participant in this study, he/she will be a part of the discussion between parent(s) and researcher during the course of this study.

Your anonymity will be partially protected as follows: Your name will be replaced by a code name when your data is being transcribed and when the findings of the study are presented. You will be given a copy of the transcribed interview so that you can check it for accuracy of your responses and so that you can edit any information that you feel will jeopardize your identification in your community. The therapists that helped in the recruitment process and I will be the only ones that know that you participated in this study.

Your confidentiality and the confidentiality of the data will be protected as follows: The demographic questionnaire, taped interviews, and transcripts will be kept in a locked filing cabinet. The audiotapes will be destroyed after my master's thesis defense. The transcripts will be kept in a lock filing cabinet indefinitely. These transcripts will only be used for further research by me.

Other planned uses of this data include the following: The results of this study will become a part of my masters thesis. My committee members and one outside member will read this work. I may also write some articles based on the study for publication in academic journals. The findings may also be presented at conferences or in class presentations.

In addition to being able to contact the researcher and supervisor at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4362).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

Name of Participant	Signature	Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix B: Assent Form

ACCESSING MENTAL HEALTH SERVICES FOR THEIR CHILD: EXPERIENCE OF SOUTH ASIAN PARENTS

I understand that my parents have been asked to participate in a research project entitled ***Accessing Mental Health Services for their Child: Experience of South Asian Parents*** That is being conducted by Suman Jaswal. Suman is a Master's Student in the Counselling Psychology Program, in the Department of Education at the University of Victoria and I may contact her if I have further questions by calling (250) 704-0211 or via e-mail: suman_jaswal@hotmail.com.

Suman is going to explore my parents' experience of seeking mental health service for myself. My parents' participation will involve filling out a demographic questionnaire, participating in two interviews, and allowing Suman to look at my file at the mental health office. I will not have any direct involvement in this study; however, will be involved indirectly. For example, the focus of the interviews is going to be my parents' experience of accessing mental health service for me; therefore, I understand that I will not be directly included in their conversation. However, the conversation between the researcher and my parent(s) will be about me. I have been told that there are no known risks or discomfort to me from my parents' participation in this project. A possible benefit of this study would be that knowledge gained from this study may contribute to a better understanding of South Asian parents' experience of the mental health delivery system.

The researcher, Suman Jaswal has offered to answer any questions that I may have about my involvement in this research project.

I understand that a signed statement of assent is required of all participants under the age of 18 whose parents are participating in this project. My signature indicates that I understand and voluntarily agree to the conditions of participation as described above. My signature indicates that I understand and voluntarily agree to the conditions of the participation described above.

_____ _____

Signature of child Date

Using language that is understandable and appropriate, I have discussed this project and the items above with my child.

_____ _____

Signature of Parent(s) Date

A copy of this assent will be left with you, and a copy will be taken by the researcher.

Appendix C: Demographic Questionnaire

Age:_____ Sex: Male___ Female___

Number of Children: _____

Gender of Child for whom mental health service being accessed ___

Age of Child for whom mental health service being accessed ___

Is this your first time seeking mental health services? Yes___ No___

How far are you in the treatment process at mental health services? months/years

Place of Birth: _____

Primary spoken language: _____

My generation of Canadian residency:

___ 1st generation

___ 2nd generation (at least on parent born and brought up in Canada)

Extended family status:

___1. living with parents or in-laws

___2. parents or in-laws live in same city; but separate household

___3. living with siblings

___4. sibling living in same city; but separate household

Highest grade/educational level attained: _____

Appendix D: Interview Guide

Prior to Seeking Mental Health Service:

1) What was your understanding of your child's problem prior to seeking mental health service? What did you believe caused the problem?

2) What had you tried to "fix" your child's problem before going for mental health service support?

3) Was there a change in the nuclear family and extended family relationships following the onset of the mental health problem?

4) When did you decide to seek mental health service for your child? What influenced your decision? Did this decision need to be negotiated with family members and if so, how did you do that?

5) What were your feelings about seeking mental health consultation for your child?

Initial Stage of Therapy:

6) What were your expectations and feelings when going for the initial interview at mental health? What went well? What would have made it easier?

7) What did you think the therapist was going to do?

8) How did your understand of the problem compare with the therapist? If there was a discrepancy in understandings, how did you deal with this?

9) Did you have a preference as to the ethnicity of the therapist (South Asian vs. non-South Asian; gender; age)?

Middle and End Phase of Therapy:

10) What happened in therapy?

11) Once therapy was in progress, what were other ways you were trying to solve your problem?

12) How much did you see your involvement in therapy affecting the therapeutic process?

13) What were your expectations after therapy?

14) How has your relationship (couple) been affected by your child's mental illness?