Voices of South Asian Women: Immigration and Mental Health

Farah Ahmad, MBBS, MPH, PhD (Candidate)
Angela Shik, PhD
Reena Vanza, BSc
Angela M. Cheung, PhD, MD, FRCPC
Usha George, PhD
Donna E. Stewart, MD, FRCPC

ABSTRACT. *Purpose:* This qualitative research aimed to elicit experiences and beliefs of recent South Asian immigrant women about their major health concerns after immigration.

Methods: Four focus groups were conducted with 24 Hindi-speaking women who had lived less than five years in Canada. The audiotaped data were transcribed, translated, and analyzed by identification of themes and subcategories.

Results: Mental health (MH) emerged as an overarching health concern with three major themes, i.e., appraisal of the mental burden (extent and general susceptibility), stress-inducing factors, and coping strategies. Many participants agreed that MH did not become a concern to them

Farah Ahmad, Angela M. Cheung, and Donna E. Stewart are affiliated with the University Health Network, Women's Health Program and the Faculty of Medicine, University of Toronto. Angela Shik and Reena Vanza are affiliated with University Health Network, Women's Health Program, University of Toronto. Usha George is affiliated with the Faculty of Social Work, University of Toronto.

Address correspondence to: Farah Ahmad, MBBS, MPH, St. Michael's Hospital, Inner City Health Research, 70 Richmond Street East, 4th Floor, 30 Bond Street, Toronto, Ontario, Canada M5B 1W8 (E-mail: ahmadf@smh.toronto.on.ca).

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until after immigration. Women discussed their compromised MH using verbal and symptomatic expressions. The stress-inducing factors identified by participants included loss of social support, economic uncertainties, downward social mobility, mechanistic lifestyle, barriers in accessing health services, and climatic and food changes. Women's major coping strategies included increased efforts to socialize, use of preventative health practices and self-awareness.

Conclusion: Although participant women discussed a number of ways to deal with post-immigration stressors, the women's perceived compromised mental health reflects the inadequacy of their coping strategies and the available resources. Despite access to healthcare providers, women failed to identify healthcare encounters as opportunities to seek help and discuss their mental health concerns. Health and social care programs need to actively address the compromised mental health perceived by the studied group.

KEYWORDS. Immigration, South Asian, mental health, stress, Canada

INTRODUCTION

Immigration is a life-change generally made to improve one's overall quality of life and well-being. However, it entails profound challenges that may culminate in compromised mental health especially when personal demands exceed resources. Studies show that acculturative stress may lead to serious psychological disturbances, such as clinical depression and incapacitating anxiety, when changes in the cultural context exceed the individuals' capacity or resources to cope because of the magnitude, speed, or some other aspect of the change (Berry & Kim 1988; Jayasuriya, Sang, & Fielding 1992). Evidence suggests that the risk of acculturative stress is often higher when the sociocultural milieu of the country of origin and the host country are less congruent (Berry 1974; Creed 1987). Higher sociocultural distance and limited resources may escalate a cycle of discord obstructing adjustment to the adopted country. This is a salient concern for countries with increasing population diversity such as Canada, the United States, the United Kingdom, and Australia.

Immigrants from the Indian subcontinent of South Asia comprise one of the fastest growing immigrant groups in North America (Statistics

Canada 2003; U.S. Department of Commerce 1997). For instance, the number of South Asian immigrants (which includes people from Bangladesh, Pakistan, India, and Sri Lanka) to Canada rose by 37% between 1996 and 2001. Although variability exists within and between the countries of South Asia (S.A.), people from the Indian subcontinent share many similarities in cultural beliefs, norms and values along with immigration and settlement challenges in the adopted country (Triandis 1995).

Evidence suggests that S.A. immigrant women are at particular risk of acculturative stress. Women from S.A. are likely to experience high magnitude of immigration and settlement challenges due to their rigid gender roles and, hence, time constraints to learn and integrate in the adopted country (George & Ramkissoon 1998). Other studies report compromised mental health status in this population. For instance, Creed et al. report elevated levels of anxiety and depressive symptoms among S.A. women compared to their male counterparts residing in the United Kingdom (Creed et al., 1999). A systematic review by Patel and Gaw reveals that suicide rates of young women immigrants from the Indian subcontinent were consistently higher than those of their male counterparts and of young women in the mainstream populations of the countries to which they immigrate (Patel & Gaw 1996). Despite evidence of the consequences of acculturative stress among S.A. immigrant women, there is little in depth understanding how these women experience stress at the intersection of culture and immigration. It is important to advance our understanding of the acculturative stressors and coping strategies to prevent the development of major psychopathological states. In Mirowsky and Ross's words "The misery, demoralization, or distress a person feels are not the problems. They are consequences of the problems . . . Suffering contains a message about the causes of suffering; a message that can be understood and acted upon" (Mirowsky & Ross 1989, p. 5).

This qualitative research aimed to elicit experiences and beliefs of recent S.A. immigrant women about their major health concerns after immigration to Canada, as part of a larger health promotion research study. Our study finds compromised mental health as an overarching health concern among the participants. Using the Transactional Model of Stress and Coping by Lazarus and Folkman (Lazarus & Folkman 1984), this paper presents the stress-inducing factors and coping strategies as experienced and perceived by the participant S.A. immigrant women. The Transactional model construes stressful experiences as person-environment transactions, wherein, the impact of external stressor or de-

mand is mediated by the person's *appraisal* of the stressor and the psychological, social, and cultural *resources* at his or her disposal. This conceptual underpinning has also laid the foundation of psychological acculturation framework by Berry (Berry 1997), where the stressors are intercultural and reside in the process of acculturation. It is anticipated that theoretically guided presentation of the study results would facilitate development of future health promotion programs and research aiming to reduce acculturative stress in the studied population.

METHODS

This qualitative research was conducted using focus group methodology. This methodology is especially useful when it involves people with limited power and influence, such as ethnic minorities (Morgan 1998). Interaction within focus group participants leads to greater insights. Study eligibility criteria comprised of being an immigrant woman, at least 18 years of age, who came to Canada from India within the last 5 years, and spoke Hindi. Following institutional ethical approval, participants were recruited through client lists of the immigration and settlement community organizations within the Greater Toronto Area. Four focus groups were organized in Hindi language at these collaborating centers according to the convenience of participants. After informed consent, a bilingual moderator and assistant moderator facilitated the discussions using an open-ended discussion guide. All discussions were audio taped and field notes were taken. Participants also completed a one-page background questionnaire.

The focus group data were transcribed verbatim by a bilingual research assistant. Translation challenges were resolved by discussions between bilingual research team members and data transcribers. The transcripts were read into QSR NUD*IST for summary and as an aid to analysis and interpretation (Meadow & Dohendorf 1999). The method of constant comparison was used to identify relevant themes and categories that emerged from the empirical data (Strauss & Corbin 1996). Thematic analysis was conducted by systematic reading of the text, independently by first three authors, followed by its organization into categories or preliminary codes established through consensus. Further interpretation and coding followed rereading of the text sorted by preliminary codes with open mindedness for disconfirming evidence

(Crabtree & Miller 1999). The data quality was augmented by the process of *member checking, debriefing*, and *triangulation* (Nicholas & Pope 1995). For details on methods, see Ahmad et al., 2004.

RESULTS

Twenty-four eligible S.A. immigrant women participated in the focus groups. The mean age of participants was 34 years (range of 18 to 69). Most of the women were married (91%) and had children (82%). Almost 86% had at least high school education while 50% had completed university. On average, women had lived one and a half years in Canada and 71% were not employed. Women were asked to rate their English language ability, health, and social support on a scale of 1 to 5 (poor, fair, good, very good, and excellent). Participants rated their English language ability as 'fair' (mean = 2), health as 'good' to 'very good' (mean = 3.5), and social support as 'fair' to 'good' (mean = 2.4). Eighty-six percent of women had a family physician.

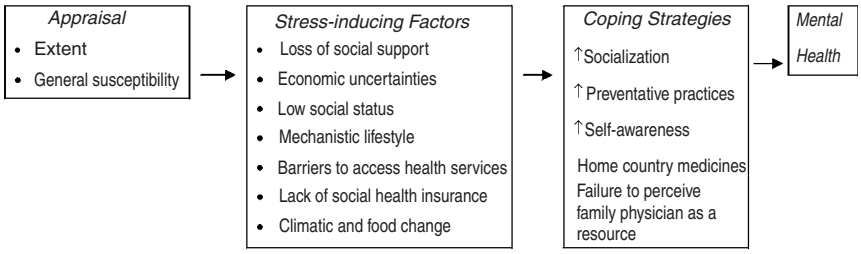
Women were asked to express their opinion on a women specific health issue that was of major concern to them after arriving in Canada, compared to their country of origin. Compromised mental health emerged as an overarching theme and seemed to be linked to immigration and settlement processes. Discussion on compromised mental health had three major themes, i.e., appraisal of the mental burden (extent and general susceptibility), stress-inducing factors, and coping strategies (Figure 1).

Appraisal

Women's compromised mental health emerged as a major health concern after immigration. This concern was reflected in the women's verbal and symptomatic expressions which included 'stress,' 'tension,' 'loneliness,' 'depression,' and 'doing nothing.'

> You see in India you are always busy with your family members (and) relatives. And here you feel more lonely, feel more loneliness. (FG3)
>
> Don't even feel like eating anything, nothing feels good! (FG2,)
>
> So we didn't know what the meaning of depression was, we only heard about it, now here we know what the meaning of depression is. (FG4)

FIGURE 1. Focus Group Discussion on Compromised Mental Health



Some physical complaints appeared to be psychosomatic expressions of depression and mental burden. For example, women were concerned about frequent headaches, back pain, joint pain, hair loss, and fatigue. Some women associated back pain with the labor they had to do after coming to Canada unlike their work in their home country.

> The pains and aches here most of them we never even heard of them. Our mothers, grandmothers never even knew about or heard about (what) we are getting at such a young age, such as back pain, knee pain, and stuff. (FG3)

In addition, women expressed an increased susceptibility to mental problems for both themselves and for the general Canadian population. A common belief was that mechanistic aspects of the Canadian lifestyle adversely affect people's mental health. In fact, some participants agreed that mental health did not become a concern to them until after immigration.

> That is right. The life here is so hectic, here (we) don't even have time to eat or drink. (FG2)
>
> Because of the increased mental stress here, may be that is the reason why there is more mental disease here. (FG3)
>
> In Canada, there are more psychological problems. See, even the kids here have more psychological disorders. It is not so common in India; here it is very common. (FG3)

Stress-Inducing Factors

Participants discussed a number of stress-inducing factors that compromised their mental health. These stressors included: loss of social

support, economic uncertainties, downward social mobility, mechanistic lifestyle, barriers in accessing health services, and climatic and food changes.

Loss of Social Support

For all participant women, the loss of social networks after immigration was a particular stress. Women attributed their depressive feelings and loneliness to the loss of their extended family system and related social activities.

> Yes in India, most of the women stay at home too but as soon as they finish their house work they talk with people for two to three hours in the afternoon. Then, in the evening they are with their families again. So, we didn't know what the meaning of depression was . . . (FG4)
>
> The social gatherings here are very limited, because you know, for your health it is very important to have, it is compulsory . . . In India, the ladies stay home but they have 'kitty parties' every month. It is fun and no one falls into depression. (FG4)

Participants also expressed fear of getting sick due to their limited social support.

> . . . social support that you have there (in India), if you are a little sick you will not feel as though you are sick. But here (in Canada) even if you get a little sick you feel as though you are very sick. Why? Because we are alone here! You don't have that support. (FG4)

Economic Uncertainties

All women expressed mental stress due to life uncertainties primarily caused by jobs and financial insecurities, after immigration. Most women's incomes were an important contribution to their households and, therefore, the fear of losing their jobs created anxiety. Participant women feared losing their jobs if they asked for sick leave. Many women stated that in India their health came first, but job insecurities and financial worries after immigration had given them no choice but to put their health concerns on hold.

> There is so much more stress here. More stress because your job is not secure. (FG3)
>
> You feel more insecure because you may go to work one day and your boss will say don't come tomorrow. (FG3)
>
> . . . But the thing is that we are immigrants and if anyone of us complains we are afraid we will lose our job. And at home if only one person (is earning), how are you going to run your house, how will you survive? (FG3)
>
> If they (women) do not go to work how will they pay the bills? (FG4)
>
> Yes! A friend of mine, her arm hurts and even though it is hurting she still goes to work and she has to operate a printing machine . . . despite having pain she goes to work. (FG4)

Downward Social Mobility

Many women discussed their downward social mobility after immigration as a source of mental and physical stress.

> . . . You do labor all day. They (immigration consultants) tell you, you will get a good job, but when you get here you pick up boxes all day. Because of the labor your body starts to hurt. We are not used to doing all these things, in India we did not do anything like that. (FG3)

Mechanistic Lifestyle

Almost all participants viewed Canadian lifestyles as very busy and hectic, attributing this to insufficient leisure time. Inadequate free time created tension for many women because it meant not being able to complete all the daily activities as expected. Hence, not meeting their expected gender roles was a stressor.

> Also women have to deal more with all this stress. Whether she stays home or not she has to deal with the mental stress . . . I read somewhere about the disease of the mind and body, Asian women are most effected by them. Why does this happen? If you research, you will find out that immigrant women have to work outside, take care of the kids and there is no job security. All the factors of Canada affect you even more and where is the poor lady to go? (FG3)

> No time! Whatever house work you have, do it on the weekend; how much can you do on the weekend? (FG4)

Women symbolized a busy and mechanistic lifestyle in Canada by the phrase lacking fresh air. Many participants felt that getting caught up with material things was unhealthy and could ultimately contribute to having health problems.

Barriers in Accessing Health Services

Women were dissatisfied with their access to healthcare services in the adopted country compared to the home country. Participants' dissatisfaction was associated with long waiting periods to see specialists or in the emergency departments, lack of control in the referral process and lack of a private sector.

> (in India) It is not like here where you have to wait two months to get an appointment, maximum it will take you four to five days to get an appointment . . . (FG3)
>
> The medical care (in India), even if it is for money . . . we get it immediately . . . (FG4)
>
> The other problem (in Canada) is that we can not go straight to a specialist . . . Yet, in India I could go to whomever I want, whenever I wanted. (FG2)
>
> . . . here (in Canada) if you want to go to a surgeon or specialist you can only go if your family doctor writes you a letter of referral. (FG3)

In addition to systemic barriers, participants discussed individual barriers in accessing health services such as limited knowledge about available health services, language insufficiency and cost of medication due to economic hardship.

> . . . here the medication bill is very expensive, they charge a lot . . . the visit is free but the medication is very expensive. (FG2)
>
> The other thing here is we don't earn as much, so it (medication cost) is heavier too. (FG1)
>
> Because of the language problem, that is why we can't learn as much. (FG2)

Lack of Social Health Insurance

Recent arrivals expressed stress with regards to the inaccessibility of the Canadian socialized healthcare system in the first three months after arrival. These women were worried about getting sick, particularly for their children. This worry was exacerbated due to the devaluation of their home country currency and insufficient income in the adopted country.

> When we come here it is such a big difference in the money. So after coming from India if someone gets sick, very sick, what is going to happen to that person? In India, all the relatives are together, they will get the money . . . Here, we have no one, right . . . What are we supposed to do for (the first) three months? (FG3)
>
> . . . We are adults, so it is okay. But if we come with a child, the little child can get sick whenever, so the three month (period) is very long. (FG3)

Climate and Food Change

The transition from a hot climate to the prolonged Canadian winter was described by many participants as being demanding and a source of stress. Some physical problems were also attributed to this climate change such as aches and body pains.

> Here, inside it is warm and once you get outside it gets so cold. This change in temperature is what causes diseases. (FG1)

The issue of freshness of food was a concern for many participant women. The main concern seemed to be freezing foods for long periods of time in Canada given that many women had access to fresh foods in India. Some women expressed concerns about fast food.

> India has more vitamins because we eat fresh foods . . . (FG1)
>
> It (frozen food) is a health hazard but if a lady works all day and then comes home obviously she is not going to cook fresh. She will warm up frozen food and eat it. (FG4)
>
> The main thing (that helped me to stay healthy here) is the food system. Well, I have not put myself on the fast food system. I cook fresh food every time. (FG4)

Coping Strategies

Women utilized a variety of coping strategies to overcome their worries, stress, anxiety, and feelings of loneliness and depression. These coping strategies included: increased efforts to socialize, use of preventative health practices, and self-awareness. Recent arrivals also described bringing medicine from their country of origin.

Socialization

Many women discussed their efforts to make friends and the importance of socialization after immigration. This mechanism was considered salient in order to maintain a healthy mind and body balance for an overall quality of life.

> Those who stay home they should go out so they can get some fresh air (refers to change). It is important to go out in the evenings, so you don't feel so burdened because here mostly everyone thinks about doing everything for money. (FG4)
>
> I think, women who are staying at home need some social activities you know. Because all the time they are staying home with the kids and they can't talk with anybody and they are keeping everything inside and they are getting depressed and stressed. Those are the things that are affecting the whole system (body). (FG4)

Preventative Practices

Many participants emphasized preventative health practices to maintain good health. It seems that prevention gained significance after immigration. The reasons provided for this shift included: lack of social or familial support, economic uncertainties, cost of medication and time constraints due to work pressure and responsibilities for children. Improved awareness was also associated with uptake of preventative practices.

> Here, we have started to think about our health a lot more, like No I don't want or can't get sick, because if I do, then finish . . . (FG3)

The preventative strategies described by women included regular physical check-ups, exercise or yoga, and use of home or alternative remedies such as ayurvedics and homeopathy.

> Also, the thing is in India we would only visit the doctor when we are sick. Here, even if you are healthy we still go for a check up. (FG3)
>
> Even here we use these remedies (traditional and home remedies), we don't go to the doctor right away. We try this stuff and if it doesn't work then we go to the doctor. We do as much as possible at home such as use eucalyptus, turmeric, salt milk, and ginger. Even if there is a cut or something we put turmeric on and it cures it. (FG3)

Self-Awareness

Self-awareness through education emerged as another coping strategy to overcome gaps in knowledge about the diseases, healthcare system, and services. Many participants felt that educating themselves about health issues was imperative since the types of health problems they encountered in Canada differed from those in their native countries. Women acknowledged the possibility of contracting diseases they were unaware of prior to coming to Canada.

> Sometimes we get these diseases that we have never heard of . . . and sometimes you do not even recognize or realize that you have these diseases because you don't know the symptoms . . . So if you know the symptoms before, you can be more conscious and help yourself more. (FG3)
>
> . . . We need the knowledge to say that for this disease the symptoms are this. (FG3)

Home Country Medicine or Visit

Recent immigrant participants described bringing medication from their home country to overcome their lack of social healthcare coverage in the first three months of arrival.

> We brought all the medicine from India because for three months we will not get a health card. So from India we got all the medicine for cough, flu everything we would need. (FG1)

In addition, women who were not recent arrivals described visiting their home country to receive treatments that they could not afford to wait or pay for in the adopted country.

Many go back for the treatment because here they do not get the appointments quickly. (FG3)

Even for the dental care, if you are not covered through work, they go back to India and get treated. (FG3)

DISCUSSION

The study results advance our understanding of the major sources of compromised mental health among S.A. immigrant women and their ways of coping with these stressors after immigration. Although participant women discussed a number of ways to deal with post-immigration stressors, their perceived compromised mental health reflects the inadequacy of their coping strategies and available resources. At the conceptual level, the study results emphasize the multiplicity of stressors underlying the single phrase of acculturative stress. At the pragmatic level, study identification of the salient stressors, coping strategies and resources are anticipated to contribute to the development of stress-reducing health and social service programs for the targeted subpopulation.

Often, immigrants encounter challenges in adjusting to the adopted country. The sources of these challenges or stressors could be: *physical*, such as climate or different places to live; *biological*, such as unfamiliar foods and diseases; *political*, such as distinct types of government and procedures; *economic*, such as different forms of employment and know-how skills; *cultural,* such as language, education, religion; and *social,* including intergroup and interpersonal relations and group dominance (Bin-Sira 1997). In our study, the major stressors perceived by the participants were social (loss of social support, low social status), economic (financial uncertainties), political and cultural (barriers in accessing health services) while physical challenges (climate and food change) were stressors of low intensity. Most of the stressors discussed by women were important contributors towards their compromised mental health as this discussion took place in response to an open-ended inquiry about their major health concerns after immigration with no specific probes on mental health. A few other studies also report major health concerns of South Asian immigrant women, such as physical pain, worry and uneasiness, but not in reference to their immigration experiences (Bottorff et al., 2001). Some studies report feelings of loneliness and depression among elderly South Asian immigrant women as

primary concerns (Choudhry 2001). Our study finds a similar pattern among recent arrivals and younger women, and, hence, it seems vital to address mental health issues of recent South Asian immigrant women, regardless of their age. This finding has several practical implications, including higher vigilance among healthcare providers about the risk of compromised mental health among recent South Asian immigrant women.

The insights gained by this study about salient stressors are anticipated to contribute to setting direction for future research, policy and program development to reduce stress and enhance adaptation within the targeted group. For instance, women were stressed about timely access to health care services. As higher perceived barriers to accessing health services predict poor help-seeking behavior (Levesque et al., 2000; Lord-Flynn 1989), there exists a need to address women's perceived barriers. In addition, participant women discussed multiple personal and environmental level stress-inducing factors within major stressor categories. This multiplicity of stressors emphasizes the need for an ecological health promotion approach when addressing acculturative stress.

In our study, the loss of social or familial support seemed to interrelate with several other stressors. This core role of social support across several stressors is in accordance with the Transaction Model of Stress and Coping where social support influences people's psychological adaptation to a stressful event via self-esteem and self-efficacy (Cohen & McKay 1984; Cohen & Wills 1985). Family systems play both a vital and a multipurpose role in the lives of most Indian women. Family provides the basis of the individual's identity as well as serves as the main support system. Other studies with Asian immigrants report that social support buffers symptoms of anxiety and depression (Kuo & Tsai 1986; Lin et al., 1979). Not surprisingly, losing extended family became a very important issue for most of the participant women after immigrating to a new country. Many of the problems participant women complained of were linked to having insufficient social support. Therefore, an important mechanism to reduce stress and enhance adaptation in the studied group may lie in the active strengthening of social networks after immigration. One such example could be 'host programs' where newcomers are linked with host families in the adopted country to provide social support and, hence, facilitate adaptation and reduce acculturative stress (Furukawa, Sarason, & Sarason 1998). Also, social and health care providers need to actively link these women to existing support groups and community alliances.

The study participants also identified several ways to cope with their post-immigration stressors. The heavily discussed coping strategies included enhanced socialization, preventative health practices, self- awareness and use of medicines brought from their home country. These coping strategies seem to be problem-focused and engaging in nature. Based on the Transaction Model of Stress and Coping, problem-focused coping refers to strategies directed at changing the stressful situation in contrast to emotion-focused coping, which aims not to alter the situation but to change the way one thinks or feels about it. The concept of coping has also begun to focus on the extent to which an individual engages versus disengages with the stressor (Carver et al., 1993). Empirical research suggests that people pursue engaging strategies (such as active coping, planning problem solving, information seeking, and using social support) when stress is not perceived as very threatening, while non-engaging strategies are used in threatening situations and may include: distancing, cognitive avoidance, behavioral avoidance, distraction and denial. In our study, participant women acknowledged and discussed their post-immigration stressors without much hesitation. Hence, it is reasonable to conclude that most of the participants seemed to be actively engaged in dealing with their stressors. It is possible that the active and engaging mode of coping was specific and overrepresented among the participants as they were recruited from the immigration and settlement community agencies. However, participants' failure to perceive a positive mental health state, despite their active and engaging coping strategies, speaks volumes about their constrained coping resources.

Furthermore, participants failed to identify family physicians as a resource for information and advice about their compromised mental health though more than two-third of participants had access to a regular family physician. This is of concern in light of other studies with South Asian women that report their use of mental health services is often limited to crisis situations (Chew-Graham et al., 2002). Certainly, there is a need to address knowledge gaps of the studied group about the range of available resources, including professional help, to cope with stress. In addition, there is a need to strengthen the cultural diversity component of the medical training programs and, hence, enhance sensitivity of health care providers to the specific needs of the recent immigrant groups. As social support had a pivotal role in the studied group, social services could play an important role in this community by strengthening community social networks. Future research with larger sample size is required to test the study findings.

CONCLUSION

Participants focused on their feelings of loneliness, stress, anxiety, and depression associated with immigration. The magnitude of stressors reported by the South Asian participant women reflects the inadequacy of their personal and environmental coping resources despite their problem-focused coping style. Health and social care programs need to actively address the compromised mental health perceived by these women. Community education and outreach initiatives along with emphasis of medical training programs on cultural diversity could be pivotal. Strengthening available resources to cope with acculturative stress in the studied group may improve their quality of life and reduce risk of psychopathological mental problems.

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