Exploring the South Asian Punjabi Community's Experience of Having Accessed Mental Health Services for Depression in Canada

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ABSTRACT

An interpretive description qualitative approach was utilized in this study. The main aim to was to understand the South Asian (SA) Punjabi community's experience of having accessed mental health services for depression within Ontario, Canada. A sub-aim was to capture the participants' conceptualizations and experiences of having depression, which provided context about this ethnic community and deepened insights into their accessibility experience. Six Punjabi persons living with depression (PLDs) and six family members were interviewed in Punjabi and/or English. Data analysis was guided by Thorne's strategy for interpretive description. Twelve major themes detailed the challenges of PLDs and their family members regarding i) identification and understanding of depression and ii) accessing mental health support. Major themes revealing the community's conceptualizations of depression are: *i) most of us didn't know what depression is, ii) we realized it was depression after getting help, iii) we keep depression a secret, iv) my family didn't understand my depression, v) my family helped, vi) my family didn't help- some made me sick,* and *vii) my family also became "sick"*. These themes supported a better understanding of the major themes discussing the community's access to mental health service for depression, which are: *viii) we didn't know where to get help, ix) my health providers' lack of familiarity with my culture caused stress, x) I waited to get help, xi) treating my depression cost me, and xii) knowing my culture will help you treat me better*. Findings of this qualitative study provide details of how these participants had their own unique cultural conceptualizations of depression and continue to experience difficulty with accessibility of mental health services while receiving care. Results suggest culturally tailored improvements of mental health service accessibility are required to support this population as they navigate the mental health system for their depression.

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This work that is presented before you is no way the effort of one individual, rather the unity of a community coming together to address a topic that has been tabooed for centuries. I feel humbled that God has hand selected me to be the voice for the thousands of individuals who have been silenced by mental health, especially in the South Asian community.

Reflecting back at how my life journey brought me to this point, I see the countless individuals and experiences that empowered me to choose the career path of a mental health nurse. I would first like to thank my parents for sacrificing their lives so I could spread my wings in a country where there are no limits for the heights reached by women. My parents (Jagpal Singh Chahal- father and Surinder Kaur Chahal- mother) moved to Canada from India in the 80's and since then have been working extremely hard for their children to get an education so we can give back to our society. *Seva* is an essential part of Sikhism (my faith), where serving those in need is part of our human purpose. The career of a nurse has allowed me to live my life serving others and mental health nursing has been my chosen path where this *seva* has surpassed at the individual level to challenge our society's *soch* (thinking) about mental health. Both my brothers, Munny and Jason, continue to push me along the way to keep rising within this field.

I am a firm believer that individuals grow from their challenges, which ultimately transforms you into a person you could have never imagined. It has been the mental health suffering in my home that has been instrumental on transforming me into the passionate mental health change-maker I am today. I am thankful to those challenges, for they have paved way for this work.

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This thesis would not have unfolded if it weren't for the clients I have had an opportunity to work with through my clinical in-hospital and community ACTT and SOCH Mental Health experience. Working part of a community mental health team in Brampton opened my eyes to the disparities in mental health, especially in the South Asian community. My fellow ACTT colleagues continued to keep me motivated, ensuring I persevered when full-time work and part-

time studies became difficult to manage. My work with SOCH Mental Health (my non-profit organization) continued my engagement with the South Asian community, where I saw the ongoing need for more evidence-based research in this community to change the way we work with this minority population. This provided ongoing insights and determination to keep going with my research work.

I am especially grateful to the research participants who trusted their life experiences with me and hoped to share their story to better mental health supports for the South Asian community at large. It has been my honor to have your voices heard.

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It is with great pleasure that I present my thesis work and once again thank all the souls who have made this dream come to light.

TABLE OF CONTENTS

LIST OF FIGURES AND TABLES

ABBREVIATIONS

CAMIAMH:	Canadian Alliance on Mental Illness and Mental Health
CCHS:	Canadian Community Health Survey
HAM-D:	Hamilton Depression Rating Scale
HCA:	Health care assistants
IRER:	Immigrant, refugee, ethno-cultural, and racialized
IPV:	Intimate partner violence
MHCC:	Mental Health Commission of Canada
PLD(s):	Person(s) living with depression
SA(s):	South Asian(s)

CHAPTER ONE: INTRODUCTION

Background

Depression, the most common mental illness, has now been recognized to be one of the leading causes of disability worldwide (Lépine & Briley, 2011; World Health Organization, 2018). The 2012 Canadian Community Health Survey (CCHS) captured that in Canada alone, 4.7% of the population reports having at least one episode of major depression (Statistics Canada, 2013a). The American Psychiatric Association (2016) describes how depression can negatively influence your thoughts, feelings, and actions; where "feelings of sadness and/or loss of interest in activities once enjoyed can lead to a variety of emotional and physical problems" (para 1). Not only can depression be a debilitating condition, but it is also the most common mental illness associated with suicide. To illustrate the impact of this, the rate of suicide in Canada in 2009 was reported to be 11.5 per 100,000 people (Statistics Canada, 2015), and has grown since.

There is no doubt that depression is on the rise in Canada and, as one of the most multicultural countries in the world, it is essential that a cross-cultural approach be taken to address the emerging mental health service needs (Canadian Mental Health Association, 2018; Hansson, Tuck, Lurie, & McKenzie, 2012). Currently, visible minorities make up 22.3% of Canada's total population, with one of the top groups (accounting for 5.6%) identifying as South Asian (SA) (Statistics Canada, 2017c). The SA community is made up of sub-groups who identify as East Indian, Pakistani, Punjabi, Sri Lankan, and Tamil (Statistics Canada, 2007).

Mental health is a concern within the overall SA community as it continues to be considered a taboo subject matter (Islam, Khanlou, & Tamin, 2014). As a result, many mental health difficulties prevalent in this community remain unaddressed. One particular concern within the SA community is the challenge they face with accessing mental health services

(Gadalla, 2010; Islam, Khanlou, & Tamin, 2014; Statistics Canada, 2013a). Analysis of the 2002 CCHS revealed that members of the SA community experiencing a major depressive episode reported the highest rate of unmet mental healthcare needs (48%) as well as the highest rate of perceived barriers for the availability of mental health services (33%) when compared to eight other ethnic groups in Canada (Black, Japanese/Chinese/Korean, Aboriginal, Southeast Asian, Filipino, Arab/West Asian, Latin American, & other/multiple) (Gadalla, 2010). Unmet mental health needs were categorized by exploring whether the reason for not getting adequate help was due to barriers in accessibility, acceptability, or availability. This concern regarding mental health service accessibility was once again present in the 2012 CCHS report, in which it was noted that 33% of the surveyed Canadian population reported difficulty in accessing care due to barriers in the mental health system (Statistics Canada, 2013a). Mental health services are defined as "assessment, diagnosis, treatment or counselling in a professional relationship to assist an individual or group in alleviating mental or emotional illness, symptoms, conditions or disorders" (Baylor Medical College, 2005, para 4). Examples of mental health professionals capable of providing mental health services include, but are not limited to, psychiatrists, family doctors, psychologists, social workers, occupational therapists, registered nurses, vocational therapists, addictions workers, recreational therapists, and peer support workers (Austin, Kunyk, Peternelj-Taylor, & Boyd, 2015).

As the above evidence indicates, the SA community is one of the largest minority populations in Canada and has experienced significant difficulty in accessing mental health services for depression. Although the analysis of the 2002 CCHS indicates SAs experiencing a major depressive episode have the highest rate of unmet mental healthcare needs and the highest rate of perceived barriers for the availability of mental health services (Gadalla, 2010), the statistical findings do not uncover the stories behind this ethnic community's experience of navigating the mental health system for support. The same can be said for the concerns raised in the 2012 CCHS report regarding mental health service accessibility (Statistics Canada, 2013a). The statistical findings do not unveil the actual lived experience of Canadians, particularly SAs. Thus, to address the existing gap in the mental health literature on understanding the SA community's difficulties with mental health service accessibility, a qualitative study is warranted.

The Region of Peel in Ontario, composed of Brampton, Caledon and Mississauga, is host to a large population of the above described SA community (Statistics Canada, 2017a). Almost 51% of the population is SA. From these three major cities, 73.3% of Brampton's total population (593,638) identify as a visible minority. Of this visible minority, the SA Punjabi sub-group constitutes the largest ethnic population (Statistics Canada, 2017a). This large and accessible SA sub-group within the city of Brampton could easily be approached to qualitatively examine their experiences of navigating the mental health system for depression. While SA sub-groups have large cultural overlap, these sub-groups also have distinct ethnic, religious, and social characteristics that can be lost when examining only the larger group (Hansson et al., 2012; Pannu, Zaman, Bhala, Zaman, 2009; Roberts, Mann, & Montgomery, 2016). Thus, the primary aim of this research is to investigate the experience of a sub-group of SAs identified as SA Punjabi, who have previously accessed mental health services for depression. An essential component to investigating this primary purpose is also uncovering how this sub-group conceptualizes and experiences depression itself. This sub-aim of the study can provide important context that may further help address the various elements of accessibility being explored by this research investigation.

The Researcher’s View

My SA Punjabi background and personal experiences as a community psychiatric nurse in the Region of Peel provided further insights into this project. As a Punjabi SA, I have witnessed many examples of considerable stigma within the SA Punjabi sub-group as well as the larger SA community toward those with mental health issues. This stigma appears to be primarily influenced by SA cultural stereotypes, beliefs, and values. These cultural views are glaringly present in my first-hand experiences with family and friends who were impacted by a mental illness and were unable to seek medical support in a timely manner. In my clinical practice of supporting various SA sub-groups, I have also witnessed their difficulties in navigating the mental health system due to cultural, educational, socioeconomic, language, and immigration related barriers. Furthermore, I have observed a lack of cultural safety among healthcare providers when working with SA families; which may be related to their limited knowledge, awareness, and training about how to best support the SA population. As a member of the SA community and a working mental health professional, I believe there is a need for an in-depth examination of the SA community’s concerns regarding mental healthcare and service accessibility. My SA Punjabi background and ability to communicate in Punjabi is an asset to examine these concerns within the SA Punjabi sub-group.

Theoretical Applications to the Research Study

Accessibility defined.

To conceptualize the notion of accessibility, which is a primary aim of the research investigation, the work of Leveseque, Harris, and Russell (2013) was applied. Leveseque and colleagues’ work defines accessibility within five key elements: approachability, acceptability, availability and accommodation, affordability, and appropriateness. Table 1 describes each element of accessibility in detail. This comprehensive definition is useful when exploring the various aspects of the experience of having accessed mental health services for depression by SA Punjabi participants.

Table 1

Five Dimensions of Accessibility (Levesque et al., 2013)

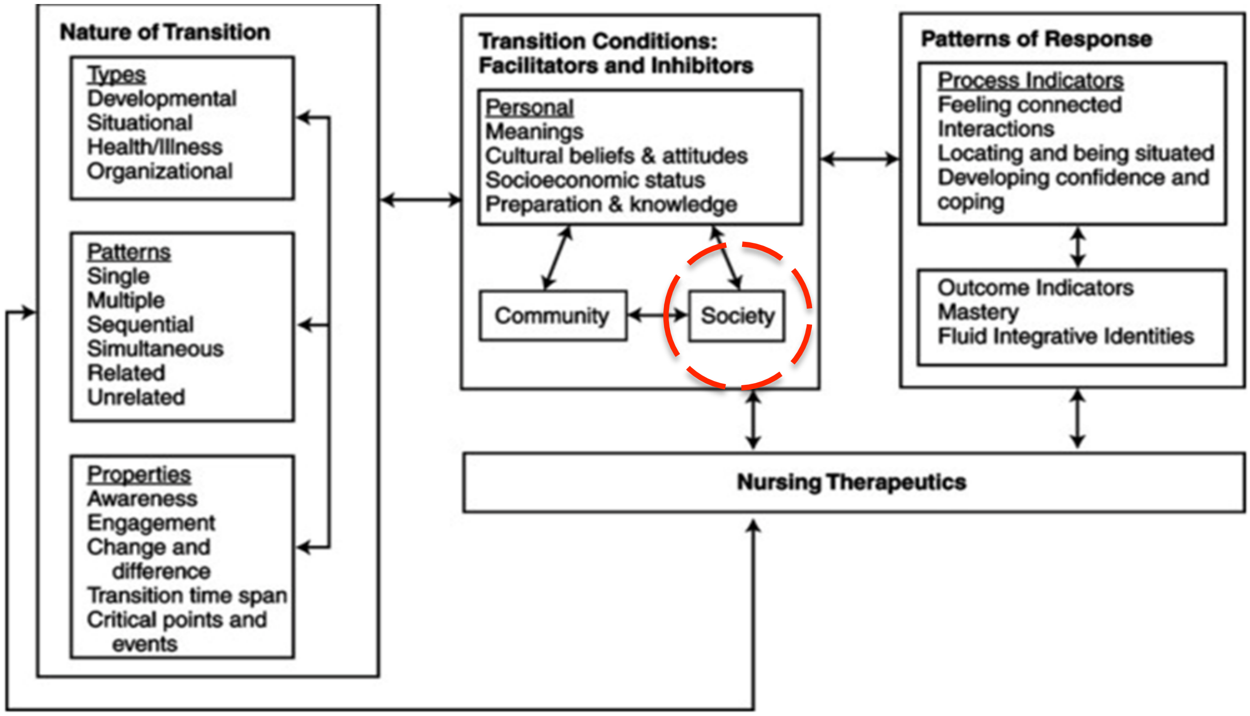
Element of Accessibility	Definition
Approachability	"Relates to the fact that people facing health needs can actually identify that some form of service exists, can be reached, and have an impact on the health of the individual (p. 5)"
Acceptability	"Relates to the cultural and social factors determining the possibility of people to accept the aspects of the service (ex: the sex or social group of the providers, the beliefs of the associated systems of medicine) and the judged appropriateness for the persons to seek care (p. 5)."
Availability & Accommodation	"Refers to the fact that health services (either the physical or those working in healthcare roles) can be reached both physically and in a timely manner (p. 6)".
Affordability	"Reflects the economic capacity of people to spend resources and time to use appropriate services. It results from direct prices of services and related expenses in addition to the opportunity costs related to loss of income (p. 6)".
Appropriateness	"Denotes to the fit between services and clients need, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment and the technical and interpersonal quality of the services provided (p. 6)".

Transition theory.

Meleis' (2000) transition theory is the nursing theory that was selected to further enhance this research investigation. Meleis (2010) defines transition as "passage from one fairly stable state to another fairly stable state, triggered by change" (p. 11). Meleis specifically focused on health transitions within her theory. In relation to the onset of depression, the transition process for persons living with depression (PLDs) would be moving from their stable state of health (prior to experiencing depression) to the new 'stable state' of being able to manage their symptoms of depression. Thus, transition theory explores this process of change through a nursing lens by identifying the elements of the transition, uncovering the role of personal, community, and societal transition conditions as either facilitators or inhibitors, and finally measuring the patterns of response to evaluate if individuals are mastering the skills to care for themselves. Figure 1 provides a diagrammatic presentation of the theory.

Figure 1

Transition Theory (Meleis et al., 2000).
(Permission to use this figure given by Meleis and by Wolters Kluwer Health Inc. December 6, 2018).



Meleis' (2010) transition theory encompasses the metaparadigm concepts of person, health, and environment, which are central to the practice of nursing. Meleis began her work of understanding transitions by studying the formation of support groups to assist individuals with health problems or developmental experiences. Meleis' theory evolved further through her collaborations with Chick and Schumacher to explore the human experience of transitions (Meleis, 2010; Meleis et al., 2000; Schumacher & Meleis, 1994; Chick & Meleis, 1986). As the theory was developed over forty years ago, it has been applied in a number of contexts that are applicable for nursing research, education, and practice. Transition theory has evolved and been refined over the years by application to an array of clinical settings, which include but are not limited to, becoming a new mother (Sawyer, 1999), understanding menopause in immigrant populations (Im & Meleis, 1999), parenting and diagnostic transitions (Messias, Gillis, Sparacino, Tong, & Foote, 1995), migration, work, and health (Messias, 1997), family caregiving (Schumacher, 1994), and transitions for the elderly (Schumacher, Jones, & Meleis, 1999). The wide application of transition theory to various contexts makes it an appropriate theory to apply to the current research investigation.

For the purpose of this research investigation, Meleis' (2000) transition theory was applied to conceptualize the SA Punjabi participants' experience of having accessed mental health services for depression as a societal transition condition. Societal transition conditions are an examination of larger factors within society that support the transition process and in relation to this study refer to mental health services for depression (Figure 1). Therefore, transition theory was used to understand SA Punjabi participants' experience of how accessing mental health services for depression facilitated or inhibited their transition forward with managing their depression. As the purpose of Meleis' transition theory is to "describe, explain, and predict human beings' experiences in various types of transitions" (Smith & Liehr, 2014, p. 254), applying this theory to studying the SA Punjabi community's experience of having accessed mental health services for depression could provide valuable insights on how to strengthen the delivery of services for this ethnic community.

Literature Review

The literature review will focus on a) depression rates in Canada, b) depression rates and service use in minority groups living in Canada, c) SA conceptualizations of mental illness d) perceived barriers to mental health support for SAs, and e) cultural safety of mental health services towards SAs. Although the current research is exploring the SA Punjabi sub-group, the literature review examines the existing SA mental health literature in its entirety, as there are cultural overlaps between SA sub-groups and there is a dearth of literature on the SA Punjabi sub-group. The literature review provides empirical support for the development of the primary research question of exploring the SA Punjabi community's experience of having accessed mental health services for depression and the sub-aim to examine their conceptualizations and experiences of this mental illness.

A search of the databases CINHAL, Google® scholar, EMBASE, PubMed, and PyschINFO was undertaken using the following key words: South Asian*, depression, mental health, and mental illness. Consultation with a research librarian confirmed the literature search strategy. English language articles from 2000 to 2018 were included. Research from the United Kingdom (UK) and the United States (US) was also included as they have a similar context to Canada with a minority population accessing a highly developed healthcare system. Moreover, the SA community has largely immigrated to the UK, US, and Canada. Research from Australia was not included, as SA immigration to that country has fluctuated given their history of having a white immigration policy (Anitha & Pearson, 2013). Details of the literature search summary are found in Appendix A, which also identifies the exclusion criteria. A total of 29 articles are included in this review, two directly on the SA Punjabi experience with mental health issues, and 27 on the SA community as a whole. On the few occasions that there is any literature directly related to the SA Punjabi community, these are noted. Otherwise, the literature reviewed is on the SA community as a whole.

Depression rates in Canada.

The 2012 Canadian Community Health Survey (CCHS) reported a significant need for improving mental health services (Statistics Canada, 2013a). Response rates from the survey indicate a large demand for supporting individuals with depression, as 5.4% of Canadians have been diagnosed with mood disorders, the majority of whom have reported symptoms of major depression. There is also a growing number of SAs who have been impacted by mood disorders. Analysis of the 2011 CCHS by Islam and colleagues (2014) indicates that 3.5% of Canadian born SAs and 3.5% of immigrant SAs have been diagnosed with a mood disorder. The lifetime prevalence of depression in Canada is 11.3%. Lifetime prevalence defined by the World Health Organization is the "proportion of the population reporting one or more major depressive episodes in their lifetime" (Patten et al., 2006, p. 15; Statistics Canada, 2013a). The Public Health Agency of Canada's (2016) report on The Economic Burden of Illness in Canada has calculated the current approximate cost for mood disorders as two billion dollars annually. Collectively, this information suggests that it is imperative to ensure that the Canadian healthcare system is prepared to provide mental health supports to address the growing needs of all Canadians, along with combating the economic costs associated with depression. Specific considerations need to be made to support the SA community, which is the largest growing ethnic community in Canada. There were no statistics available on the SA Punjabi sub-group, as this is not reported separately by Statistics Canada (Statistics Canada, 2013a).

Depression rates and mental health service use in minority groups living in Canada.

Canadian literature has found immigrants to have lower rates of depression than those who were Canadian born (Grace et al., 2016; Hansson et al., 2012; Patten et al., 2006; Wu, Noh, Kaspar, & Schimmele, 2003). The lower rate of depression among immigrants living in Canada, as evident in a Canadian review of mental illness and suicidality among immigrant, refugee, ethno-cultural, and racialized (IRER) groups, concluded that by combining all IRER groups together the literature does not uncover the true trends within these independent communities (Hansson et al., 2012). This concept can be understood when examining immigrant suicide rates as a whole, which may appear low, yet when combined together do not highlight the trends that are occurring within various national origin populations. Using this form of data may mislead the development of equitable mental health services at the local level. The review by Hannson and colleagues (2012) was conducted on 17 primary quantitative research papers, which examined IRER groups within Toronto, Montreal, and Vancouver. The quality of the articles within the review could have been improved by increased descriptions of the IRER groups and further analysis of sub-groups, for example exploring trends between first and second generations (Hansson et al., 2012). Beiser (2004) supports the need for more research on specific IRER groups, rather than examining the broader IRER community.

Mental health service use by ethnic minorities living in Canada is another area of literature that needs to be expanded, specifically for SAs experiencing depression. A cross-sectional survey ($n= 8235$) conducted in Ontario uncovered that the SA participants experienced the most severe levels of anxiety ($p= 0.048$), yet were the least likely to utilize mental health services ($p=<0.001$) in comparison to Caucasians (Grace et al., 2016). Further research is required to uncover the reasons for this trend in Canada. Comparably, an Ontario-based population-study (n=133,588) of SAs (n=2454) and Chinese (n=2582) discovered that both minority groups displayed increased mental illness severity on hospital admissions compared to the general population, where severity of illness was related to the underuse of outpatient mental health services (Chiu, Lebenbaum, Newman, Zaheer, & Kurdyak, 2016). The general population was classified as anyone who was not SA or Chinese. The majority of SAs and Chinese within the study were younger and identified as immigrants compared to the general population. Again, the underuse of outpatient mental health services is not well understood within the SA community living in Canada. Although Chiu and colleagues' (2016) research was exploring psychosis, if this pattern of service use is similar to that observed in those with untreated depression, then there may be extreme safety concerns with a higher risk of suicide among SAs. Both studies provide valuable statistics with large sample sizes of SAs and are additional evidence to the statistical analysis conducted by Gadalla (2010) of the 2002 CCHS revealing SAs had the highest rate of unmet healthcare needs and perceived barriers when accessing mental health services for major depression. With limited information on mental illness and service use in minority groups living in Canada (Hansson et al., 2012) and SAs being the largest growing Canadian ethnic population (Statistics Canada, 2013b), there is a need for further research on this community's experience of mental health service use in the context of depression.

South Asian conceptualizations of mental illness.

The growing mental health literature on the SA community has identified that this ethnic community has their own unique conceptualizations of depression. At present, there is only one Canadian and one American study examining the SA Punjabi sub-group's perceptions about depression and mental illness respectively. The first is a Masters thesis completed by Grewal (2010) which, through a narrative study, examined six Punjabi Sikh participants' experiences of having depression within a Canadian context. This dissertation uncovered SA Punjabi participants' understanding of the causes of their depression to be linked to pivotal life events, such as experiencing traumatic circumstances or having negative relationships. As such, these SA Punjabi participants only conceptualized the social factors contributing to depression, and their narratives lacked acknowledgement for potential biological and/or psychological factors. One limitation of the study was that it was conducted only in English. Language has been a limitation of existing mental health literature, as many studies have not been conducted in the SA language (Commander, Odell, Surtees, & Sashidharan, 2004).

The second study on the SA Punjabi sub-group was conducted in California, USA and is a quantitative examination of how Punjabi Sikhs view mental health (Roberts et al., 2016). This study had a large sample size (n=350) and surveys were collected in both English and Punjabi. Punjabi surveys were compiled through rigorous back translation methods, permitting the study to address existing language limitations of mental health literature on SA communities. The study found low rates of depression and anxiety among the survey respondents and allocates these results to existing research on SA Punjabi Sikhs having expectations of success and resilience, where one cannot admit to any mental weakness (Roberts et al., 2016). With Roberts and colleagues' research study identifying the existing stigma in the SA Punjabi community, such findings also suggest that SA Punjabi participants may perceive mental illness to be in control of the individual. A limitation acknowledged by this research is the need to examine this community's perspectives within a qualitative design, where in-depth knowledge can be gained about the SA Punjabi sub-group's understanding of depression.

Given the limited research available on the SA Punjabi sub-group, mental health literature examining the larger SA community's conceptualizations of depression and mental illness conducted in the US and the UK was examined. This evidence is considered in this review as SA sub-groups have cultural overlap and, to some extent, may experience mental illness in similar ways. A descriptive qualitative American study comparing conceptual models of depression between SA American women (n=36) and European American women (n=37) uncovered that SA participants conceptualized depression as a problem that was circumstantial and one that would pass (Karasz, 2005). Similar to Grewal's (2010) findings, SA Americans in this study understood depression to be a social problem triggered by family, home, and life circumstances. The participants also spoke about the existing stigma surrounding discussing one's depression, where they highlighted the SA community view of disclosing symptoms of depression was seen as complaining about life circumstances. This finding supports Roberts et al.'s (2016) study on the Punjabi Sikh community and their social perceptions of not revealing mental health concerns in fear that it would result in admitting a 'mental weakness'. In contrast, European Americans expressed a contradictory explanatory model, where they discussed depression to be a biological illness requiring professional treatment (Karasz, 2005). These researchers conducted interviews in Bengali, Urdu, and Gujarati and discussed back-translation methods, strengthening the study design. This evidence is limited in that it only gained the perspectives of SA women. There is also a possibility that the views of the SA women were influenced by the structure of the private American mental health system, which differs from the public system in Canada. The study sample consisted of upper middle class European Americans and working class non-English speaking SA Americans (Karasz, 2005).

The evidence from the UK, which has a similar mental health system to Canada, supports the work of Grewal (2010) and Karasz (2005). A qualitative cross-sectional study exploring explanatory models of psychosis of British SAs (n=45) uncovered that the majority of British

SAs conceptualized their illness to have supernatural causes or arise from stress, and only a small number of participants (n=2) attributed their illness to a biological cause (Bhika, Farooq, Chaudhry, Naeem, & Husain, 2015). Although this study did not compare British SA ideations to another community, the large sample size and data collection in ethnic languages provided valuable findings. This collective evidence from researching the SA Punjabi sub-groups as well as the larger SA community's conceptualizations of mental illness identifies a gap in their understanding about mental illness, specifically depression.

The summary of evidence that has been presented on the SA community's conceptualizations of depression and mental illness are important contexts to consider when examining how this community may access mental health services. The qualitative work conducted by Burr and Chapman (2004), which arises from the UK, makes insightful links between a community's understanding of depression and their use of mental health services. These authors examined SA women's (n=46) experiences of depression through focus group and individual interviews. Although the study only examined the views of UK-born English-speaking SAs, it provided insights on how this ethnic community only accepts professional support for 'legitimate' physical concerns, whereas seeking help for mental health symptoms is perceived as 'moaning'. Therefore, the SA participants interviewed in the study unveiled that the SA community only accesses healthcare services when the symptoms of depression become severe enough to impact one's physical health. As indicated within the work by Burr and Chapman (2004), recognizing an ethnic community's conceptualizations and experiences of an illness can influence their access for professional support. Similarly to understanding an ethnic community's experience of accessing mental health services for depression, it is important to capture their conceptualizations and experiences of the illness. With the limited research on mental health services accessibility of SAs experiencing depression in Canada, a qualitative exploration permitting participants to speak in their ethnic language is necessary.

Perceived barriers for mental health support for South Asians.

While there may be limited literature examining the SA community's experience of engaging with mental health services, there is sufficient literature examining the barriers that prevent the community from accessing mental health services. These barriers include low education level, acculturation (Lee, Martins, & Lee, 2015; Roberts et al., 2016; Pilkington, Msetfi, & Watson, 2012), lack of accessibility for mental health services, lack of cultural competence by service providers, racism, and low socioeconomic status (Lai & Surood, 2013; Lee et al., 2015; Neal, Worrell, & Randhawa, 2009). To elaborate, acculturation "refers to changes that take place as a result of contact with culturally dissimilar people, groups, and social influences" (Schwartz, Unger, Zamboanga, & Szapocznik, 2010, p. 237). Acculturation stressors can include "language barriers, culture nuances of gender roles, family structure, and intergenerational tensions" (Roberts et al., 2016, p. 31). These stressors can impact one's mental and physical health when international migrants have less familiarity with the receiving cultural context (Schwartz et al., 2010).

The evidence examining the barriers preventing the SA community from accessing mental health services arises from both quantitative and qualitative paradigms. The quantitative studies include works by Lee et al. (2015) examining the National Epidemiological Survey on Alcohol and Related conditions (mood & anxiety) from 2001-2002 on 298 American SAs, Roberts and colleagues' (2016) exploration of 350 American Sikh Punjabi's discussed previously, Pilkington and colleagues' (2012) survey of 94 British Muslims, and Lai & Surood's (2013) telephone survey of 250 SAs over the age of 55 living in Calgary. One qualitative study exploring barriers to service use by SAs emerges from the UK, which conducted five same-sex focus groups of Afro-Caribbean and SAs (Neal et al., 2009). The collective evidence is of moderate strength, with the quantitative studies contributing a large sample size and some studies allowing for participants to communicate in SA languages (Lai & Surood, 2013; Roberts et al., 2016). With only one qualitative exploration, this scientific evidence would be strengthened by more in-depth explorations of the stories behind this community's experience of accessing mental health services.

In addition to these barriers, the SA community's distinct cultural views have been shown to influence their use of mental health services, which is supported by research from Canada, the US, and the UK. Quantitative research by Tiwari and Wang (2008), which examined the 2003 CCHS, and a qualitative cross-sectional study of 10 English speaking SA women experiencing depression from Toronto (Ekanayake, Ahmad, & McKenzie, 2012) has uncovered that community factors, such as social supports, tend to influence mental health service usage by the SA community. For instance, on occasions where SA community members turn to families for support, their efforts to access mental health services decline; whereas turning to their friends results in an increased use of professional services (Ekanayake et al., 2012; Tiwari & Wang, 2008). These findings were echoed in a UK systematic review of 21 studies examining both quantitative and qualitative evidence of SA Pakistani women's usage of mental health services in the UK with examining the role of social networks (Kapadia, Brooks, Nazroo, & Tranmer, 2015). In comparison, a mixed methods study of SAs (n=33) and Caucasians (n=44) based in an urban area in the UK heavily populated with SAs (23%), found SA community members neither approached family nor friends due to mental health stigma, indicating they were more comfortable speaking to their family doctors (Commander et al., 2004). Interestingly, Burr and

Chapman's (2004) descriptive qualitative study, also based in the UK, expands on the findings by Commander et al. (2004). Commander and colleagues discovered the limitation of openly discussing mental health concerns with family doctors was seen in cases where an entire family visited the same practitioner. The SA community living in the inner city interviewed within this study hesitated to discuss their mental health concerns in fear that their doctors may jeopardize their confidentiality. This collective evidence, some of which was gathered in ethnic languages (Burr & Chapman, 2004; Commander et al., 2004), reveals the influence of social stigma within the SA community itself, which may affect their decision to access services.

Further evidence exploring the use of mental health services by SAs comes from a quantitative exploration of ethnic groups (24 SAs) in the UK (Agius, Talwar, Murphy, & Zaman, 2010) and a qualitative content-analysis of 29 clinicians from the US (Rastogi et al., 2014). Both literatures reveal that the SA minorities did not always follow-up with their scheduled doctor's appointments, and had missed appointments and reduced medication compliance in comparison to Caucasians and Afro-Caribbeans. Ultimately, a major factor influencing the SA community's ability to access mental health services in both countries is the SA group's stigma and denial of a mental illness. A limitation of applying the US research to Canadian and UK SAs is the difference in the American mental health system, which is privatized.

As the role of social supports has been identified as a barrier, specific evidence has emerged on the SA family acting as a barrier to access mental health services (Gilbert, Gilbert, & Sanghera, 2004). A small-scale qualitative phenomenological study, which took place in Derby, a heavily populated SA area in the UK, identified how openly discussing mental illness has been perceived as bringing shame to the family honor within the SA community (Gilbert et al., 2004). To support the findings of family honor, Grewal's (2010) Canadian study highlighted that only two of the six Punjabi Sikh participants accessed mental health services. The barriers preventing access to services for participants within Grewal's (2010) study was lack of knowledge of mental health services and family pressures to keep the issue hidden. The SA community is perceived to have values, which are allocentric, in other words group-oriented. Therefore, individuals within the SA family are seen to make sacrifices for the greater good of the family (Roy, Jayaram, Vassila, Keach, & Rao, 2014), and in cases of mental illness this may mean keeping one's mental illness hidden and therefore not seeking available services. While the issues preventing the SA community from accessing mental health services are highlighted by the literature, there is a gap on understanding this ethnic community's concerns while navigating the mental health system for depression, including hearing the voices of family members who may have an influence on this experience.

South Asian's experience within the mental health system.

A final yet critical finding of the existing SA mental health literature is this community's experience within the mental health system. Although this evidence is limited and emerges primarily from the US and UK, it illuminates some key concerns that need to be examined within the Canadian setting. One major concern encountered by this ethnic community is the lack of incorporation of SA ethnic languages within the delivery of mental health service as well as within research investigations. Language has been a major deterrent for the SA community to actively engage with mental health services (Agius et al., 2010; Commander et al., 2004; Hussain & Cochrane, 2004; Hussain & Cochrane, 2002; Kapadia et al., 2015; Karasz, 2005; Lai & Surood, 2013; Roberts et al., 2016; Tiwari & Wang; 2008; Virdee et al., 2017). Language has also been a limitation of existing mental health literature, as many studies have not been conducted in the SA language (Commander et al., 2004), limiting the quality of the evidence that is gathered. It must be noted that in the Punjabi language there is no word for depression (Karasz, 2005), which is why it is essential that participants be given the opportunity to describe their mental health journey in their cultural language (Roberts et al., 2016). Hussain and Cochrane (2002) conducted a small-scale (n=13) qualitative grounded theory study in Birmingham, UK, ensuring SA participants could participate in their ethnic language. Their work revealed that clients who encountered a language barrier while accessing mental health services did not feel they were a valued member in their treatment planning, which could impact their level of engagement with services. Markedly, language is an essential avenue to enhance the cultural safety of mental health services, which better allows ethnic communities to fully describe their mental health experiences.

Other difficulties SAs have encountered when engaging with mental health services include: cultural, socioeconomic, and institutional exclusions. A UK descriptive qualitative study (n=26) conducted by Bowl (2007) based in a metropolitan area reported that SA participants experienced cultural, socioeconomic, and institutional exclusions when accessing mental health services. These three forms of exclusion are originally drawn from McLean and colleagues (2003) framework, which has been applied to studying the mental health treatment of African-Caribbean communities in the UK. According to McLean et al. (2003), cultural exclusion occurs when mental health services are unable to support non-Caucasian service users due to a lack of familiarity with their language, an inability to understand what they mean (lack of cultural awareness), and a misunderstanding of their cultural behaviours as symptoms of a mental illness.

Cultural exclusion has been evident in SA mental health literature with study participants reporting a lack of recognition for their cultural and religious practices, hindering their mental health care and recovery (Agius et al., 2010; Bowl, 2007; Virdee et al., 2017). Furthermore, research exploring the views of SA women towards depression noted that culture and religion heavily influenced their conceptualization of their mental illness (Hussain & Cochrane, 2002). If healthcare providers are unaware of these fundamental cultural beliefs, they will be incapable of developing interventions that resonate with these community members. The ability to understand cultural beliefs was an identified facilitator to treatment in the research conducted by Rastogi et al. (2014). A lack of cultural knowledge can essentially result in healthcare providers relying on cultural stereotypes to inform their clinical practice (Burr, 2002).

Next, socioeconomic exclusion links socio-economic status with poor mental health. An example of this exclusion would be seen in communities who are exposed to stressors contributing to earning a low income and poor employment opportunities. Racism is also an element of socioeconomic exclusion (Bowl, 2007). Socioeconomic exclusion has been evident in both the UK and US SA mental health literature, settings that have public and private healthcare respectively. Bowl's (2007) interviews uncovered how SA's low level of education or poor financial position made it difficult to continuously access mental health services. Likewise, Pilkington and colleagues' (2012) quantitative exploration of 94 English-speaking British SA Muslims found that lower levels of education and acculturation contributed to lower access to mental health services. Karasz's (2005) work from America divulges how immigration pressures and low levels of education also contribute to the acculturation process, which impacts the community's conceptualization of depression. Healthcare providers need to have awareness of these socioeconomic factors that can influence an ethnic community's ability to access mental health services.

Finally, institutional exclusions are defined as "how institutions operate standard procedures that do not acknowledge differences and disadvantages among those who have specific needs, including those arising from ethnicity" (Bowl, 2007, p. 4). The SA community has encountered institutional exclusion during hospitalizations where they have felt unsafe to share their personal concerns with healthcare providers. They have also been reported to experience a pattern of limited or no family involvement in their psychiatric care (Agius et al., 2010; Bowl, 2007), which may be especially important to SA communities who hold allocentric values (group oriented values, where individuals within the SA family are seen to make sacrifices for the greater good of the family) (Roy et al., 2014). These exclusions prevent SA clients or their families from being meaningfully involved in their mental health treatment and recovery (Karasz, 2005). If the community continues to face these challenges when engaging with mental health services, then their willingness to seek professional support may be jeopardized. As the majority of the evidence on the SA community's experience of mental health services has emerged from the US and the UK, there is an existing gap in our understanding of the Canadian SAs experience with mental health services.

Gaps in the literature

The literature review on SA mental health has identified that this ethnic community, which is one of the largest minority groups in Canada, faces its own unique cultural challenges for understanding mental illness and accessing mental health services. Currently there is a gap in the Canadian literature on understanding how this ethnic community experiences depression and their experiences of accessing mental health services for support, while navigating through the mental health system. Analysis of the 2002 CCHS by Gadalla (2010) does highlight that this community encountered the highest rate of unmet mental healthcare needs and perceived barriers for the availability of services, however this statistical data does not fully capture the stories behind these concerns. This available research is also outdated. From the available qualitative evidence, although Grewal’s (2010) work explored the SA Punjabi communities’ experience of depression in Canada, it did not provide an opportunity for participants to share their stories in their native languages.

With the SA Punjabi sub-group being the largest accessible population in Brampton and the researcher’s ability to interview in Punjabi, an interpretive description study examining the SA Punjabi community’s experience of accessing mental health services for depression could begin to address the current gap. As the literature review revealed the important influence of SA families on relatives with accessing mental health services, it is also critical for the family perspective to be explored. To facilitate this inquiry, transition theory is an applicable nursing framework, which can guide the interpretations of understanding how current mental health services are acting as a societal facilitator or inhibitor in the transition of SA Punjabi participants’ management of depression.

CHAPTER TWO: RESEARCH METHODS

Research Question

What are the experiences of the SA Punjabi community who have previously accessed mental health services for depression in Brampton?

The sub-aim of this study is to explore the conceptualizations and experiences of depression in SA Punjabi persons living with depression (PLDs) and their family members. This sub-aim builds the context to deepen our understanding of the participants' experiences of accessing mental health services for depression.

Study Purpose

The purpose of this interpretive description study is to expand the understanding of the Canadian SA Punjabi and their experience with having depression and accessing mental health services for support. This thesis also examines the perspectives of PLDs and their respective family members, which is an important consideration to be made when conducting research with the SA community who maintain allocentric views, in other words group-oriented (SA families are seen to make sacrifices for the greater good of the family) (Roy et al., 2014). The literature review supported this premise by revealing the impact SA family members had on loved ones accessing mental health services (Gilbert et al., 2004; Grewal, 2010). Ultimately, the perceptions of SA Punjabi participants who engaged with mental health service providers are explored, to unearth not only facilitators and inhibitors of mental health services for depression as a societal transition condition as defined by Meleis and colleagues (2000), but also to examine mental health service accessibility successes and difficulties from a SA cultural standpoint. Mental health accessibility is explored through Levesque and colleagues (2013) five dimensions described within the introductory chapter: approachability, acceptability, availability and accommodation, affordability, and appropriateness. For the purpose of this study, a working definition of mental health services was developed, which includes receiving medical treatment and/or psychosocial programming for managing symptoms of depression. The mental health services included within this definition and reflected in the current study entail receiving mental health services from either one or a combination of the following: a family doctor, a community mental health agency, a counsellor, or a community psychiatrist. As outlined in the background section of this thesis, the city of Brampton in the Region of Peel has a large accessible SA Punjabi community to support this study and was the selected site for this project.

Study Design

The current qualitative study is guided by Sally Thorne's (2016) interpretive description method. Interpretive description is "aligned to a constructivist and naturalistic orientation to inquiry" (Hunt, 2009, p. 1285) and is a research approach that supports the expansion of nursing knowledge about human health (Thorne, Kirkham, & MacDonald-Emes, 1997). Nursing is a profession where caring for an individual evolves through the application of both objective and subjective knowledge (Thorne, 2008). Although interpretive description has the ability to recognize common themes and patterns when examining clinical phenomena, the design remains true to capturing individual voices to account for variations within findings (Hunt, 2009). As a research design, it extends qualitative description by involving the aspect of interpretation, where the researcher works together with the participants to co-construct an understanding of the phenomenon being investigated (Hunt, 2009). This fundamental aspect of interpretive description acknowledges the researcher's clinical nursing knowledge and experiences as foundational foreground for an investigation (Hunt, 2009; Thorne, 2016; Thorne, 2008; Thorne et al., 1997). The emergence of this design indicates that approaching the research inquiry from a naive perspective, where existing clinical nursing knowledge is discredited, can be counterproductive for developing nursing expertise (Thorne et al., 1997). Therefore, interpretive description as a study design for this research question not only captures SA Punjabi participants' experiences of mental health service accessibility for depression, but also allows my SA Punjabi background and my mental health nursing knowledge to guide this inquiry. My social-constructivist worldview aligns with the foundations of interpretive description, which allows the investigator to work in collaboration with participants to co-create an understanding of a phenomenon being explored (Hunt, 2009; Thorne, 2016; Thorne, 2008).

There are several benefits of using this research method. First, my six years of clinical experience of working in the mental health sector is valuable to understanding and interpreting the experiences of the SA Punjabi community who have previously accessed mental health services for depression. Importantly, my SA Punjabi background allows the cultural perspective of this research inquiry to be captured, via the use of the Punjabi language and cultural experiences, which addresses a major limitation in the existing literature. This lens further allows the SA Punjabi community's beliefs and values to be understood, and enables participants to share their mental health journey in their ethnic language. This study design may encourage individuals already facing pressures of belonging to a minority population and experiencing the stigma of a mental illness to feel more empowered to share their experiences in their own language. The open-ended interviews of the interpretive description design augment the autonomy of participants, promoting a naturalistic means to partake in this dialogue (Munhall, 1994). Implementing reflexivity, another element of interpretive description, allows for thoughtful interpretations to be drawn, while acknowledging the potential and actual biases I may possess.

Lastly, this design permits the application of the research findings, which emerge from an inductive process, to nursing practice (Thorne, 2016; Thorne, 2008). In doing so, interpretive description also allows Meleis' (2000) transition theory, a middle range nursing theory, to be applied to this research question where the theory supports the exploration of the health transition of depression within the SA Punjabi community. Upon doing this exploration, the theory is specifically applied to examine the transition condition of society (Figure 1), which in this study refers to mental health services for depression. Therefore, by examining the stories of SA PLDs within transition theory, nursing practice could be enhanced through understanding the factors that may inhibit accessibility of mental health services for depression. The insights of this research could support mental health professionals and decision-makers to examine if their mental health services for depression are meeting the needs of the SA Punjabi community. Above all, this study captures the voice of SA Punjabi PLDs and their family members who share their conceptualizations of depression, which allows for a better understanding of their collective experience of accessing mental health services for depression within the Canadian context.

Setting.

As outlined above, this study was completed within the city of Brampton, which has a SA population of 263,445. The SA Punjabi community makes up 29,465 people in this group (Statistics Canada, 2017b). Having access to a substantial SA Punjabi community was essential to facilitate adequate recruitment and therefore enable a rich understanding of the community's experience of having accessed mental health services for depression. Furthermore, the research investigation took place within the community mental health setting, where individuals were recruited from community mental health services (family doctors, community mental health agency, and/or community psychiatrists).

Sampling.

Purposeful sampling was used to recruit participants from a variety of community mental health outpatient settings. Purposeful sampling permits the researcher to intentionally select recruitment sites to gather individuals who are likely to provide an understanding of the phenomena under study (Creswell & Path, 2016). PLDs were recruited first who then supported recruitment of family members, using the snowball sampling technique. Snowball sampling takes place when existing study participants help recruit other suitable individuals for a study (Creswell & Path, 2016).

Interpretive description as a research paradigm has flexibility for estimating sample size and is informed by other qualitative research traditions (Thorne, 2016). As a novice researcher embarking on the task of capturing the experience of the SA Punjabi community, a sample of 16 participants was initially selected. This sample size was drawn from the qualitative design of phenomenology, which recommends a sample of 3 to 4 individuals, to a maximum of 10 to 15 (Creswell & Path, 2016). Recruitment of 16 participants would represent the perspectives of two parties within this research inquiry (PLDs and family members) and also account for any unexpected losses to participation. Interpretive description and phenomenology have similar purposes in effectively capturing the experiences of participants, which is one of the primary aims of this study. Furthermore, the concept of representation within the present study design (Thorne, 2016) included the experiences of both PLDs and family members. The inclusion of family members was intended to capture the family influence on accessibility, as the literature review has highlighted the role SA families can have on their loved ones with accessing mental health services.

The research study recruited participants who met the following inclusion criteria: age 19 or older, a resident of Canada for a minimum of five years, and a member of the SA Punjabi community who has been impacted by depression either directly or indirectly (PLD and family members). The rationale for selecting participants living in Canada for over five years was to seek participants who are long-term immigrants, rather than recent ones. The *Immigration and Ethno-cultural Health Report* by Peel Public Health (2012) classifies recent immigrants as those who have been residing in Canada for less than five years. As the process of acculturation may still be occurring in the lives of recent immigrants, the study focused on those individuals who have been residing in the city long enough to minimize this potential confounding influence. Exclusion criteria for PLDs were if they were experiencing an exacerbation of symptoms impacting their cognition, or if they were deemed at high risk for suicide, and/or psychosis. In cases of very severe depression (highest rating on the Hamilton Depression Rating Scale- HAM-D), cognitive impairments can result in PLD having difficulty with concentration and recall for events important to the interview. Furthermore, risk for suicide and/or psychosis would require the individual to seek immediate intervention, as this is a safety concern. To ensure appropriate inclusion in the study, the researcher conducted a preliminary phone screen to determine if PLDs were able to participate in the study. The researcher also administered the HAM-D as a second in-person screening tool prior to the interview (Hamilton, 1960). The HAM-D was selected as it is a validated tool and an appropriate depression-screening tool within a research setting (Ebell & Georgia, 2008). The scale is found in Appendix B.

The study recruited participants from two family doctors, one community mental health agency, and one community psychiatrist, as depression can be managed in any one of the recruitment outpatient settings. The recruitment sites were selected as these are mental health services providing depression support with a high percentage of SA Punjabi clients.

Recruitment.

The study flyer, which was posted at all recruitment sites, provided an overview of the research project inviting members of the SA Punjabi community to participate in a one-hour interview if they met the inclusion criteria (see Appendix C). The details of this flyer were made available in both English and Punjabi, to capture the interest of the SA Punjabi community and to communicate the option of participating in their own language. Healthcare providers were involved with recruitment as they were given a script to share study details with interested candidates (Appendix M). Once participants expressed an interest to enroll in the study to their healthcare providers, the recruitment sites released their contact information to the researcher who followed up with a phone call to screen for inclusion (Appendix N). Mental health service providers advised interested PLDs that family members were being recruited for the investigation.

The time allotted for recruitment was approximately four months (September to December 2017), as recruitment can be difficult for a hard-to-reach population who belong to a minority group and are further marginalized by the stigma of mental illness. For this reason, constant communication also took place with healthcare providers and receptionists of the identified mental health services to support recruitment of SA Punjabi participants. The study timeline is found in Appendix D. As a token of appreciation, the researcher provided $25 in a grocery store gift card of the participant’s choice (Freshco, Food Basics, No Frills, or Walmart).

Data collection.

This research project included four sources of data: demographic information, semi-structured participant interviews, field notes, and reflexive journaling. Demographic information included gender, age, education, number of years in Canada, and number of years diagnosed with depression (for PLDs only). Demographic data were collected to strengthen the contextual understanding of study participants, which supports the transferability of findings. See Appendix E for demographic questionnaire. Any forms used in the study were made available in both English and Punjabi, although the appendix only shares the English version.

Semi-structured interviews were conducted with participants, using open-ended probes, which served as prompts for deep and rich responses (Cohen, Kahn, & Steeves, 2000). In-depth interviews support an interpretive descriptive design, in which the researcher gathers detailed accounts of the participant's perspectives of the phenomena being studied (Thorne, 2016). The interview guides are located in Appendix F and G (for PLDs and family members respectively) and were devised by applying Levesque and colleagues' (2013) definition of accessibility. By speaking to SA Punjabi community members who had accessed mental health services, the researcher was be able to engage the participants in retrospective and reflective dialogue to share their actual experiences of the accessibility of these services.

Research participants received full disclosure of the study purposes (listed on the Information Sheet and Consent Forms in Appendix K and L), including a request to participate in a one-hour interview, and their permission to audio-record the interview. Interviews ranged from 30 to 90 in accordance with qualitative research. All interviews were transcribed verbatim. Interviews conducted in Punjabi were translated to English (further details provided below). The audio-recorded files were stored on an encrypted file on the researcher's password protected MacBook and deleted from the digital recording device.

Transcription and translation.

Notably, as this research study permitted participants to speak in Punjabi, specific guidelines were developed for the transcriptionist, who was a fourth year nursing student fluent in English and Punjabi. Prior to beginning her role, she signed a confidentiality agreement regarding the content of the interviews (Appendix H). The guidelines developed for the transcriptionist included directions to capture specific details of the interview such as pauses, emphasis, laughter, and other emotions. Instructions were provided to directly translate interviews conducted in Punjabi, without any interpretation. To strengthen the transcriptionist's skills for the study, the researcher transcribed the first two interviews (PLD and family member) to provide an example. One interview was in Punjabi and one in English. This process also supported Thorne's (2016) recommendation for the researcher to become immersed within the interview data to support data analysis. Reports in the literature suggest that at least two bilingual individuals should be involved in the translation process to increase accuracy of the transcripts (Regmi, Naidoo, & Pilkington, 2010; Xian, 2008). The researcher's own fluency with the Punjabi language permitted this recommendation to be met and strengthened the study design. In addition, the strategy of forward and back translation was employed to accurately transcribe interviews between Punjabi and English (Regmi et al., 2010; Xian, 2008).

Finally, field notes and reflexive journaling were data sources completed by the researcher. The researcher recorded her immediate thoughts and observations as field notes after the interviews in audio recordings. The purpose of field notes are to record aspects of the interview that cannot be recognized by the audio-recording such as body language, tone of voice, and other environmental cues (Cohen et al., 2000). To embed this into the data collection strategy, 30 minutes was scheduled after each interview to audio-record observations and to capture immediate impressions from the interview. Additionally, within 48 hours of the interview, further thoughts were expanded from the audio-recorded field notes as part of the reflexive journaling process. Reflexive journaling is an opportunity for the researcher to practice self-reflection, develop insights for the research topic, and elaborate on what is known and unknown about the topic under study (Watt, 2007). This data is essential for interpretive description, as the interpretive contributions from the researcher is what makes the research design unique for capturing the essence of the phenomenon being investigated (Cohen et al., 2000; Thorne, 2016; Thorne, 2008). Reflective journaling by the researcher was also employed during data analysis.

Data analysis.

The process of data analysis for interpretive description begins immediately after data collection commences, for example immediately after the first interview. Data analysis for this research paradigm is described as an iterative process, as the researcher engages in data collection and analysis simultaneously (Thorne, 2016). As such, interviews were transcribed soon after completion to support data analysis in this qualitative tradition. Having data analysis take place parallel to data collection supported modifying questions to clarify or expand on emerging themes. As the interviews needed to be translated from Punjabi to English, the transcriptionist was given approximately two weeks as a turnover period. NVivo 10 for MacBook was used to organize the data (QSR International, 2015). In the interim of receiving the transcripts, the researcher began the process of analysis by replaying audio-recorded interviews and immersing into the data.

Interpretive description employs an inductive rather than a deductive approach for data analysis (Thorne, 2016; Thorne et al., 1997). To guide this inductive analysis, the researcher applied Thorne's data analysis strategy, which makes reference to Morse's (1994) cognitive processes of comprehending, synthesizing, theorizing, and recontextualizing. Meleis' (2010) transition theory was also used as a guiding framework to examine specifically, the societal transition condition of mental health services for depression (Figure 1).

The first step in Morse's cognitive processing of comprehending is becoming familiar with the data during data collection and analysis, which overlaps with Thorne's concept of immersion (Thorne, 2016; Thorne, 2008). To initiate this step, the researcher reread the interviews while listening to the audio-recordings, which Thorne (2008) describes as, "The opportunity to really slow our attention to the nuances, words, phrases, and pauses, and to hear more deeply what the language contains" (p. 143). While replaying the interviews during the data analysis process, the researcher made notes in the margins, which enabled the researcher to move into the process of synthesizing the data. Thorne (2016) discusses how researchers can make marginal notes as an alternative means for coding, which assists in the process of immersion. These notes supported reflexivity and facilitated the creation of analytical memos to enhance the researcher's critical thinking, by not only examining the obvious, but also exploring elements of the interviews that were not evident at first glance. Replaying the interviews prior to the coding process prevented drawbacks such as premature coding, which can lead to superficial conclusions when using the interpretive description method (Thorne, 2016; Hunt, 2009; Thorne, 2008; Thorne et al, 1997). As a novice researcher, the strategy of line-by-line coding was also implemented to get closer to the data during this process of immersion. Although line-by-line coding is not a strategy recommended by Thorne (2008), the researcher's committee members supported the benefit of implementing such a tactic. As a result, the researcher found an opportunity to get even deeper within the various topics that were covered within an interview, resulting in stronger immersion with the data.

Next, the researcher exercised theorizing by implementing Thorne's recommendations for researchers to ask all encompassing questions of the data such as "what is happening here?" and "what am I learning from this?" This also stimulates the researcher to develop a higher-level understanding of the data, which can support the interpretation process (Hunt, 2009; Thorne, 2008; Thorne et al, 1997). Finally, recontextualizing is presenting the research findings in a manner that can be applied to similar contexts (Thorne, 2008). This final stage is displayed through the researcher sharing study findings of this project and making research decisions and analysis of the data transparent for the reader. This would meet the research objectives of making study findings transferable to SA Punjabi sub-group communities in other regions who have a similar context to Brampton and comparable demographics to study participants.

To facilitate this entire process of data analysis as a novice, the researcher coded two PLD and two family member interviews and then scheduled a committee meeting to receive feedback from the primary supervisor and committee members. This meeting provided an opportunity for more experienced qualitative researchers to provide further guidance on the coding techniques. Consequently, the researcher applied the feedback to progress in an iterative process, moving from the collective interview data to create categories and subsequently, themes. Several meetings followed between the primary researcher and the supervisor, before the major themes of the study were identified. Appendix I provides an example of coding a segment of an interview with a PLD and the overall audit trail of how data analysis transpired.

Trustworthiness and Rigor

Credibility.

To establish trustworthiness in this qualitative project, Lincoln and Guba's (1985) model was utilized, which focuses on "credibility, transferability, dependability, and confirmability" (p. 300). To begin with, credibility speaks to the truth-value of the research inquiry, which in the case of interpretive description would be accurately co-creating the meaning of the phenomena being studied (Thorne, 2015). Credibility was strengthened through supportive engagement, member checking, and data triangulation (Lincoln & Guba, 1985). Supportive engagement was exercised by providing participants the opportunity to communicate in either Punjabi or English, selecting a comfortable location for their interview, and using rapport-building strategies gained through the researcher's clinical nursing experience (see Interview Guide, Appendix F and G). These strategies fostered a safe environment for the participants to share the complete details of their experience of accessing mental health services for depression. Next, member checking was embedded into the interview process with each participant, where the researcher inserted two check points to ensure the true meaning of the interviewee's experience was captured (refer to interview guide). Thorne (2016) states that although it is essential to ensure that you capture the right facts from an individual, the interpretive description design does not require that participants agree with the insights that are drawn from the information they provide. Therefore, the researcher decided not to implement member checking through a subsequent interview with participants. Finally, the two types of triangulation that enhanced the credibility of the research project are data and researcher triangulation. Data triangulation took place by corroborating data from all three sources, which include interviews, field notes, and the reflexive journaling. As well, data triangulation occurred between family units and between PLDs and their family members. Furthermore, researcher triangulation transpired as the researcher collaborated with the thesis committee team to analyze the data.

Transferability.

The second component of Lincoln and Guba's model examines transferability of research findings (Lincoln & Guba, 1985). Qualitative research is not fixated on generalizing the results, as the purpose of the design is to examine a unique phenomenon (Krefting, 1991). The findings of a qualitative design can be transferred to other like phenomenon that are similar in context, however this is left to the discretion of the reader (Krefting, 1991). Findings from this study can be transferred to a SA Punjabi community living outside the city of Brampton, but readers would need to take into consideration both the demographic factors of the community and the context of Brampton. Due to the large cultural overlap of SA sub-groups, these findings may also be applicable to the larger SA community, however similar considerations need to be made in regards to the context of the study participants and the setting of Brampton. To combat this limitation and enhance transferability, a rich description of the background data has been provided including the context in which the phenomenon occurred, and demographic details about participants while maintaining their privacy.

Dependability.

The third criterion of Lincoln and Guba's model is dependability, which requires that the research findings are reproducible (Lincoln & Guba, 1985). Dependability is evident throughout the study with elaborate details about the research design along with making all research decisions transparent for the reader. In addition, researcher triangulation with the involvement of a research team further strengthened the dependability process of this study (Krefting, 1991).

Confirmability.

Finally, confirmability as the last component of Lincoln and Guba’s (1985) model ensures the research findings are representative of the participant’s perspective, where researcher bias is reduced. Confirmability was promoted as the researcher engaged in reflexive practice through reflective journaling, which is an essential piece of accountability when utilizing the interpretive description design (Lincoln & Guba, 1985; Thorne, 2015). The researcher has utilized all four steps of Lincoln and Guba’s model to maintain rigor of this study.

Ethical Considerations

Ethics approval was obtained from the Hamilton Integrated Research Ethics Board (HiREB) in September of 2017 (Appendix J). There were many ethical considerations made, as the research was conducted on an ethnic minority population who are also marginalized from having a mental illness. First, the researcher aimed to protect the autonomy of the participants in the study by making the consent process transparent and ongoing in nature. A copy of the Information Sheet and Consent Form is provided in Appendix K and L (for PLDs and family members respectively). Second, all data that were collected were kept in a private locked setting and password protected. Next, debriefing and mental health follow-ups were made available to those participants who identified the need. As a community mental health nurse working in the city of Brampton for five years, the researcher was prepared with mental crisis support information through Canadian Mental Health Association and other local mental health agencies. Although the researcher is a mental health professional, no mental health intervention was provided to participants to minimize role blurring. During the consent process, the participants were informed that if a PLD expressed suicidal or homicidal ideation, the researcher would breech confidentiality and connect the participant with the appropriate support to ensure their safety and the safety of those around them. Finally, with the dissemination of findings, the researcher maintained the confidentiality of study participants by protecting their identity (ex: using pseudonyms) and modifying identifying information. This was a necessary measure as there is significant stigma towards mental illness in the SA community and the breech of a community member's identity could jeopardize their mental well-being.

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CHAPTER THREE: FINDINGS

It is important to address the process of data collection and highlight any changes that transpired, before moving forward with the research findings. The current project was successful in following the outlined methodology with a few exceptions. Ideally, I was aiming to have eight sets of participants; each set would represent a person living with depression (PLD) and their family member respectively. I was able to recruit eleven participants of the intended sixteen, even though recruitment was extended by an extra month, until January of 2018. This was an expected outcome, as recruitment was known to be challenging with this minority population.

With regards to family interviews, exceptions were made on two occasions. First, I interviewed two children of PLDs (seventeen and eighteen-years-old respectively), which was below the inclusion age of nineteen-years-old. However, this is above the age of consent for inclusion in research projects and their participant parents were in agreement with their participation. Second, a family member who had not been living in Canada for over five years was included within the study. One participant was also interviewed as both a PLD and a family member, resulting to a total of twelve interviews. As for the recruitment site, even though I aimed to use maximum variation between all three sites to augment representation, recruitment efforts resulted in two PLDs from family doctors, one PLD from a community mental health agency, and three PLDs from a community psychiatrist. Consistent with the protocol, the Hamilton Depression Rating Scale (HAM-D) was administered to all PLD's prior to data collection to ensure that the exclusion criteria for the study was maintained (Hamilton, 1960). The results of the HAM-D scores for the recruited PLDs were two with mild depression, one with moderate depression, and one with severe depression and thus all were included in the study.

The highest score on the HAM-D indicates the individual may have very severe depression, which would have led to their disqualification from the study.

Once participants were recruited, there were minor changes that took place with the data collection process. The initial plan to conduct interviews within a private enclosed community setting (e.g., library, a community center, or any other accessible place) changed because of difficulty obtaining community spaces for interviews. Although, one cost-efficient community location was secured for interviews, participants did not find it convenient. The first participant who interviewed in this location expressed frustrations with convenience and requested the interview with her family member be completed in their home. The study design aimed to avoid conducting interviews at home due to the potential of having other family members present, which might influence the quality of the dialogue. This adjustment to interviewing in homes was the most convenient arrangement for the remaining participants and was completed privately away from other family members. Remaining interviews were completed at participants' homes, except for one participant pair (PLD and family member). In this case, the PLD and family member requested to meet at a coffee shop together, as they were unable to meet at separate times. To promote confidentiality a private table at the very back of the coffee shop was secured. Both parties provided consent to have the interview take place in each other's presence. The family member was briefly interviewed in private nearing the end of this interview segment.

Descriptive Demographic Information of Study Participants

There were eleven participants interviewed in this study, with one participant interviewed as both a PLD and a family member, resulting in a total of twelve interviews. Six were PLDs and six were family members. All participants are described below, with the dyads of PLDs and their family member grouped together. There was one triad, with one PLD and two family members.

To protect the identity of the study participants pseudonyms have been used and some details have been changed. Table 1 provides further demographic details about the study sample. The numbers within this table are not mutually exclusive.

Table 2
Demographic Data

Gender	Age	Recruitment Site of PLD's (n=6)	Interview Language
Female: 8	Range: 17-62	Family Doctor: 2	English: 4
Male: 3	Mean: 42.1	Mental Health Agency: 1	Punjabi: 4
Total: 11	SD: 15.4	Community Psychiatrist: 3	Mixed: 3

PLD: Kiran.

Family member: Gurjit.

Kiran is a 28 years old female who has been living in Canada for over 5 years. She is a Registered Nurse who works in a remote area in Ontario and is often travelling back and forth from her hometown to her working city. Her family lives in India, which includes her two brothers and her parents. She has been living away from home since she completed high school and has been described to be very hardworking by her father, Gurjit who is 54 years old. Kiran sponsored her parents to come visit her in Canada in the fall of 2017, which permitted her father to be interviewed for this study. Gurjit describes himself as a simple man who follows the Sikh religious teachings. After receiving his diploma he worked in the public sector in India and has a reputation for helping those in need. He came with his wife to visit his daughter in Canada, as they have been worried about her living independently and were also aware that she was experiencing mental health distress. The onset of Kiran’s depression was after her car accident in the summer of 2016.

PLD: Sarbjit.

Family member: Balwinder.

Sarbjit is a 56-year-old female who is a mother of two children, one in her twenty’s and one in his thirty’s. Sarbjit is a labor worker and has been residing in Canada for over 15 years with her husband, Balwinder who is 55 years old. Sarbjit and Balwinder have their Master’s degree from India and held reputable employment while living there, which is why their family members who still live in India advised against their immigration to Canada. Sarbjit and Balwinder admit to having a very small social circle locally. Sarbjit was on short-term disability as result of her depression during the time of the interview and Balwinder was the sole income provider for the household. Balwinder, who is also a labor worker, works 12-hour shifts. He is heavily involved in Sarbjit’s care. Sarbjit describes the onset of her depression when her mother passed away in 2016. She expresses much regret for leaving India and moving to Canada, as she feels it was her duty to care for her parents until their passing. In addition to losing both parents, Sarbjit has also lost her brother.

PLDs: Hardev and Mandeep.

Family member: Mandeep.

Hardev is a 48-year-old male who is labor worker and a father of two girls, one in elementary school and another in university. He has been living in Canada for over 25 years with his wife, Mandeep a 43-year-old female. Both have acquired their bachelor’s degree from India. During the time of the interview Hardev was on short-term disability and his wife Mandeep, who is also a labor worker, was actively employed. Hardev has been working night shifts for over 24 years. He first noticed a change in his mental health in 2012, where he experienced symptoms of depression and anxiety. Mandeep also suffers from depression, which she believes started over 10 years ago. She shares the trigger for her mental health distress has been ongoing family conflict, specifically with her in-laws. Hardev's parents and Mandeep's sister also reside with the family. Hardev and Mandeep were interviewed as participants with depression, along with Mandeep providing an interview as a family member.

PLD: Neha.

Family member: Hina.

Neha is a 44-year-old female who is a mother of five children, who range in age from 8 to 18 years old. She came to Canada as a young adult and got married shortly after to her husband without her parent's knowledge. She reports having her bachelor's degree. During the early years of her marriage she experienced many domestic issues with her in-laws, including intimate partner violence (IPV) with her husband. She has grown up witnessing IPV between her parents, experienced psychological trauma from her own marriage, and has had long-standing mental health issues since her first born when she was diagnosed with post-partum depression. Neha at one point made a police complaint about her husband's abuse and left him to reside with her family. During this time she encountered much difficulty caring for her children and additionally faced societal pressures of being a single SA mother, which led her to retract her police statement against her husband's physical abuse and return to living with him. Since that time, her parents and brother have returned to live in their homeland. She is currently unemployed and is focused on raising her children. Hina, an 18-year-old female, is Neha's eldest daughter. She is a first year university student and is passionate about becoming a doctor. She has witnessed her mother's mental health issues since she was young and recalls memories of her mother's self-inflicted harm as early as eight years of age. Since Hina was young she has taken on the role of protecting her siblings from the psychological trauma taking place within their home.

PLD: Priya.

Family members: Roop and Amandeep.

Priya is a 38-year-old female who is undergoing divorce from her husband who currently lives in India. She is a mother of three children, two girls and one boy. Priya is Canadian born with a Master's degree and went to India to get married, where she settled. In India she opened her own business, of which she was very proud. Priya experienced a substantial amount of domestic issues with her in-laws as well as IPV from her husband. She admits the intense family conflict has been the trigger for her depression. Priya's daughter, Roop, is currently in high school. She recalls that both she and her sister have witnessed her father and his parents treating their mother very poorly in India. They officially moved back to Canada six years ago. Priya's mother, Amandeep who is a 62-year-old female, has witnessed her daughter's struggles. Amandeep and her husband have spent time living in both India and Canada. In Canada, Amandeep has been a labor worker; however, she quit her job several years ago to help support her daughter and her grandchildren who have since moved in with her and her husband.

Participant Stories

Information from the 12 participant interviews has illuminated their experiences as a SA Punjabi accessing mental health services for depression. Their collective stories not only allowed for elements of mental health service accessibility to surface, but also created an opportunity for the PLD and the family to share their views and understanding of depression. It is essential to capture the PLDs' and families' conceptualizations of depression to further one's understanding of their experience of accessing mental health services. Therefore, the analysis of the interview data resulted in the following 12 major themes under three main categories: my experience of having depression, my family's experience of seeing depression in their loved one, and my experience of accessing mental health services for depression (Table 3). Two of the major themes have subthemes (*we keep depression a secret* and *my family didn't understand my depression*). The first two categories of themes, my experience of having depression and my family's experience of seeing depression in their loved ones, supports the sub-aim of the research question. These themes support a better understanding of the SA Punjabi participants' conceptualizations and experiences with depression in order to build context and deepen the understanding of the participants' experience of accessing mental health services for depression. The last category of themes, my experience of accessing mental health services for depression, directly answers the primary research question. These themes have been explored through the lens of the PLD and the family, as they are found to influence the identification and acceptance of mental illness and the process of accessing mental health services. Levesque and colleagues (2013) definition of accessibility was used to ensure all aspects of accessibility were discussed during data collection. The participants' interviews of discussing their experience of accessing mental health services for depression were interpreted through the lens of Meleis' (2000) transition theory. This will be further explored in the discussion. To facilitate hearing the voices of the study participants, the code [E] will represent a quote stated in English and [P] for a quote initially shared in Punjabi, which has been translated for this text.

Table 3
Study Themes

MY EXPERIENCE OF HAVING DEPRESSION		
i)	Most of us didn’t know what depression is	
ii)	We realized it was depression after getting help	
iii)	We keep depression a secret	**Sub-themes** a. I fear being judged as “pagal”[crazy] b. It’s my fault c. It’s a private family matter d. Talking about depression will make matters worse
MY FAMILY’S EXPERIENCE OF SEEING DEPRESSION IN A LOVED ONE		
iv)	My family didn’t understand my depression	**Sub-themes** a. There’s no science behind depression b. It’s about religion, black magic, and race c. We prefer “desi” [Indian] medications
v)	My family helped	
vi)	My family didn’t help- some made me sick	
vii)	My family also became “sick”	
MY EXPERIENCE OF ACCESSING MENTAL HEALTH SERVICES FOR DEPRESSION		
viii)	We didn’t know where to get help	
ix)	My health providers’ lack of familiarity with my culture caused stress	
x)	I waited to get help	
xi)	Treating my depression cost me	
xii)	Knowing my culture will help you treat me better	

My Experience of Having Depression

The category *my experience of having depression* has 3 major themes, which examines the challenges PLDs have encountered through having depression. The major themes examined in this category are: *i) most of us didn't know what depression is, ii) we realized it was depression after getting help, and iii) we keep depression a secret.* Collectively these themes explore the PLD's point of view, which was also supported by their family member's interviews.

Most of us didn't know what depression is.

The theme *most of us didn't know what depression is* captures the lack of knowledge about depression reported by the majority of PLDs within this study. Participants who identified with not knowing about depression are Kiran, Sarbjit, Hardev, and Mandeep. From this group of PLDs, Kiran, Hardev, and Mandeep were able to recognize a change in their overall health, however they all were completely puzzled about what illness was manifesting through their symptoms. They explained how they conceptualized their mental health concerns by an inability to manage changing life circumstances, a normal bodily response to stressful environments, or to having no plausible rationale for their symptoms. As these three PLDs recognized some form of variation in their health, Sarbjit was the sole PLD who did not recognize any changes in her mental health, regardless of encountering negative feedback on her work performance from her colleagues and ultimately being advised to take time off from work by her supervisor. For example, Sarbjit expressed her ambivalence with her supervisor's comments by sharing,

> "*Yeah I don't know. I didn't understand that. I didn't understand. If it's happening, what's all happening. Then when my supervisor said to me okay you need rest, you know then I was thinking like why she's telling to me I'm doing fine. I was thinking I'm doing fine.*" [E]

Whether or not these participants recognized a change in their mental health, they all identified their lack of knowledge regarding depression. Indeed, none of these participants had prior experience of closely witnessing this illness in another individual, which contributed to their lack of familiarity with depression. Even though Hardev and Mandeep knew about a relative's depression, they still had insufficient knowledge to draw comparisons to their own symptoms. The lack of mental health disclosure between families is a prominent occurrence in SA Punjabi families and the substantial amount of stigma prevents them openly discussing their mental health with one another. This finding will be discussed in subsequent findings. In addition, another factor influencing PLDs' recognition of depression was their lack of education surrounding mental health. Of all PLDs, only Kiran received formal education about mental health within her nursing degree, but she too failed to recognize her own signs and symptoms of depression. Her case was one that highlighted a PLD assuming their health changes were in fact a result of their poor coping related to changing life circumstances.

While the above four PLDs were unable to identify their symptoms as depression, Neha and Priya were the two PLDs who knew they had depression all along. A mutual aspect to Neha and Priya's lived experience was their collective exposure to domestic issues, whereby they both experienced intimate partner and family violence. Priya expressed her awareness of her depression during her interview,

> "*No, no, I knew that. Anybody could look at me. I look much better. I look perfectly alright now. That time when I was like I'm standing and talking. That happened until about 3-4 months ago too. I'm talking and I'm crying. What is that? Which sane person would do that? A mentally healthy person would not do that. I'm telling my story and I'm crying. That's what used to happen when I used to go to the psychiatrist. I would tell my story and he used to always keep a tissue box there because he knew I would start crying, but now I'm not like that anymore. I'm overcoming all those things. I knew it's depression and I knew since 5-6 years that I'm undergoing depression. Just that I was suppressing myself and not letting it out. One day it has to. The volcano has to erupt.*" [E]

The shared understanding of depression by Neha and Priya appeared to emerge from their common experience of enduring extreme violence. Among all PLDs in this study, these two

PLDs, who experienced extreme forms of intimate partner and family violence, recognized their depression in comparison to those experiencing some familial conflict. For example, Hardev and Mandeep reported familial conflict within their home, which was less extreme than Neha and Priya's experience. Thus, the degree of trauma within a PLD's life was found to influence their understanding and acceptance of depression, where in these PLDs more severe trauma resulted in recognition of depression. The overall analysis of PLDs found four participants of six lacking awareness for what depression was when their symptoms started.

We realized it was depression after getting help.

The theme *we realized it was depression after getting help* captures the process of PLDs and family members coming to recognize the health changes taking place in the individual were linked to mental illness, specifically depression. The analysis of these interviews shows that PLDs who did not know they were experiencing depression came to recognize the symptoms of the illness once they had accessed mental health services, whereas PLDs who knew they were having depression identified the signs and symptoms before accessing supports.

All PLDs commonly experienced symptoms that impacted their mood, sleep, appetite, interests, and ability to socialize. Irrespective of PLDs experiencing these symptoms, the actual identification of depression in these individuals occurred in one of three ways. The first took place through a family doctor detecting changes in the PLD's persona during a routine check-up. This was exemplified in Kiran, Mandeep, and Neha's cases who were all screened for depression during a doctor's appointment. For example, Mandeep shared that she began crying during a scheduled appointment, which prompted her family physician to assess her for depressive symptoms. Mandeep shared during her interview,

> "*Doctor found out. My family doctor. I was such that when I would go and I would cry a lot. I would sit and cry. I would want to cry loudly. I would think to myself why am I*

> *doing this. If I would be little sick, I would start crying. Then one day, I went to my doctor. I came home from work early too. I had anxiety but I didn't know properly. I felt a pain in my breast. Then I went to the doctor. He said why is this happening. I said I feel this pain. That time, there were lumps discovered in the breasts as well. That was treated. However, after that too, when I would go to the doctor, I wouldn't know how to tell my problem to the doctor. I couldn't explain it. The proper words…I would hesitate a little bit. But my family doctor found out that she has this (depression)."* [P]

The second means by which depressive symptoms were identified in a PLD was through family members becoming apprehensive about their loved one's state and taking them for medical attention. This form of identifying depression was seen with both Sarbjit and Hardev, who were taken to the emergency department and/or family doctor by their spouses. For instance, Sarbjit's symptoms of remaining in bed for several days, getting into arguments with her family, and taking time off work concerned Balwinder [husband] so that he took her to the emergency department. This visit to the emergency department triggered a cascade of events, resulting in Sarbjit being screened for depression by her family doctor and then referred to a psychiatrist for treatment. Finally, the last mechanism by which depression was identified by a PLD was through their own readiness to seek professional help. For example, Priya discussed the exacerbation of her symptoms, as she would have crying spells that would last hours, had difficulty with walking, and became suicidal. The severity of these symptoms alarmed Priya and prompted her to go to a psychiatrist in India, even though her in-laws were not accepting of this decision. Priya shared,

> *"In India I went myself (to the psychiatrist). You know you come to know that you are in depression. Because you want to jump. I don't know how many times I had went up to on the roof to jump in India and my daughters used to come and hold my back. But I'm telling you that's one thing I could never jump, even if I went up there and I wanted to. So there I used to take sleeping pills, 8-10 sleeping pills at once. I had taken sleeping pills, I don't know, 6-7 times. 10…10 pills at once, nothing happens."* [E]

While the detection of depression varies among these PLDs, one mutual finding is that their symptoms had to be of a certain severity before the individual, their family, or a healthcare provider became alarmed about the illness. As such, a concern brought forward by this SA

Punjabi participant group was their lack of awareness about depression and the early warning signs of this illness. Moreover, the findings also shed light on the mental health stigma that exists within this SA Punjabi community as the PLD or any family members may not have accessed help until the problem became unmanageable at home. The evidence supporting this form of stigma was exemplified in Priya's case. Although her parents were familiar with her attempts to access psychiatric supports in India, they waited until they could no longer manage her symptoms at home before taking her to the doctor again in Canada.

We keep depression a secret.

We keep depression a secret is a theme demonstrating that many PLDs and their respective family members withheld their experiences of depression from their larger social circles. Although each individual expressed his or her own unique reasons for not sharing the mental health distress they had been experiencing, many related this to the overall stigma and shame associated with mental illness within the SA Punjabi community. Sub-themes for this theme highlight why depression is kept secret. They include: *a) I fear being judged as "crazy"[pagal], b) it's my fault, c) it's a private family matter,* and *d) talking about depression will make it worse.*

I fear being judged as "pagal"[crazy].

Individuals kept their mental illness hidden due to fear and/or judgment of being labeled as crazy. The word "pagal", which translated from Punjabi to English means *crazy*, was used by the majority of interviewees to describe their community's understanding of mental illness. For instance, Sarbjit shared why she does not like talking about her depression to anyone,

> *"I don't know. Indian people (laughs), think it's a crazy lady. They don't think like the people here, right? They think differently. They are not going to help me, but they will make fun, oh she's a crazy. Whatever they say, oh she's crazy. At our workplace also, when our community people see these issues, they say oh she's crazy."* [E]

Sarbjit's workplace has a large SA community, where she witnessed this stigma first-hand toward others and, as a result, was unable to speak openly about her depression. She continues to worry about her return to work for this reason. For the participants, stigma was not only a prominent issue in the SA community in Canada, but was also experienced in India, as cited by Priya's experience. Priya shared that her family in India would not let her seek professional psychiatric support due to their belief that people would assume she is going to a *"pagal khana"* [P] meaning *crazy house* to seek treatment. She reported that her husband and in-laws prevented her from visiting a psychiatrist or taking any psychiatric medications because of the associated shame the family would have to face. In addition to Priya's family in India feeling the need to keep her illness hidden, Priya's mother Amandeep also shared in her interview,

> *"You don't go to that type of doctor unless the problem becomes severe enough."* [P]

This highlights the pattern of thinking towards mental illness that exists within the SA Punjabi community in India and also dominates in community members living in Canada, leading to keeping mental health issues hidden.

It's my fault.

An internal fear felt by PLDs or family members was that they would be blamed for the onset of the depression, which caused these individuals to keep the mental illness hidden. Some of the reasons prohibiting the disclosure of mental health issues were the beliefs that the depression was a consequence of making a decision against your family's wishes, or that depression resulted from being irresponsible. For example, Sarbjit and her husband Balwinder both shared their mutual decision to migrate to Canada against their family's wishes. They continue to withhold details of Sarbjit's depression, as they both believe that their family will blame depression on their decision to migrate to Canada. The outcome of this family dealing with Sarbjit's depression in isolation is evident in Balwinder recognizing a negative impact on his own mental well-being. Similar to Sarbjit and Balwinder, Kiran appeared to have withheld the onset of her depression and continues to keep key details about her illness from her parents due to her father's belief about how irresponsibility leads to negative consequences. Although it was not explicitly discussed in Kiran's interview, it was understood through Gurjit's [Kiran's father] account that he may be holding her responsible for her depression as its onset was after her accident. This is despite Kiran not being at fault as she was rear-ended. Gurjit noted that accidents happen when one is not paying attention. He further articulated that when individuals maintain a good character, practice their faith, and rightfully perform their work duties they are protected from mental ailments. He presumes that depression impacts those individuals who go astray from these teachings and firmly believes that individuals practicing the Sikh faith will not become depressed.

It's a private family matter.

Another assumption influencing participants keeping their mental health a hidden subject matter was the belief that disclosure of mental health issues would lead to the unveiling of private family matters. This form of thinking was evident especially in cases where family conflict was a variable influencing depression in PLDs. The individuals impacted by this assumption were Hardev, Mandeep, Neha, and Priya. For example, marriage is a highly valued union within the SA Punjabi community, and this community has strong beliefs against divorce [The researcher's insider views on the SA community is shared in Appendix P]. In Priya's case, not only were her aunts and uncles who witnessed her familial circumstances in India advising her to stay in the marriage and minimize her discussion of her household issues, but her own father initially advised her to stay in her marital home. Priya's daughter Roop mentioned in her interview that she was not able to disclose details about her mother's health to any of her teachers or friends due to it being seen as discussing personal family matters. It became an even more private matter when there was indication of intimate partner and family violence within the home. While Priya's immediate family has come to accept and partially support her decision to separate from her husband, she continues to encounter the negative stereotypes for her decision. To this day, Priya feels societal pressure to keep her marital separation a secret, resulting in her becoming even more socially withdrawn from family and friends with whom she was once close.

Talking about depression will make matters worse.

Similar to the view that discussing mental health issues will be perceived as unveiling private family matters, another pattern of thinking that emerged among the interviewees was the belief that speaking about depression can cause the PLD to become more unwell and/or trigger mental health distress in individuals who became aware of these concerns. There were repeated examples where PLDs or family members withheld details about the mental illness from other family members to protect them from becoming unwell themselves. For instance, Gurjit shared withholding details about Kiran's depression from his sons, as he does not want them to become *"stressed out."* [P] Within the same family, it is also seen that Kiran continues to reserve details about her illness from her mother as a means to protect her from further worry. As such, Kiran expressed her hesitation,

> *"She has already seen enough trauma in her life."* [E]

Where in these circumstances family members are protecting relatives from becoming worried, other family members are safeguarding the discussion surrounding the mental illness with the PLD as a means to prevent them from further deterioration. To illustrate, Amandeep shared that she refrains from asking her daughter Priya about her symptoms to protect her from becoming more symptomatic.

The collective evidence that has been brought forward when examining why participants feel compelled to hide their depression reveals how this SA Punjabi participant group conceptualized depression and how their cultural beliefs influence their ways of responding to mental health issues. Firstly, the SA Punjabi community label of "pagal" has existed for centuries within the community to identify a person with mental health issues and was a commonly used term within the study interviews. The lack of community mental health awareness and education within this participant group may explain why the mental health discourse continues to remain the same. As the evidence reveals, Priya's parents [referring to her mother Amandeep] who have been living in Canada for over fifteen years, still hold the same mental health stigma comparable to her in-laws in India. In addition, the perception that mental illness to some degree can be treated and controlled by the individual also contributes to the ongoing mental health stigma. This way of addressing mental health issues is derived from the community's understanding of how depression is caused and can be treated. Participants in this study believed that social factors influenced an individual's health, and discounted biological and psychological forces. A final yet critical component of addressing the stigma of mental illness is the larger social norms that influence how the SA Punjabi community responds to factors contributing to mental distress. The emerging study findings revealed that SA cultural beliefs surrounding marriage and the importance of respecting family privacy have impacted many individuals causing them to refrain from discussing their mental health issues (refer to the researcher's insider view on the SA community in Appendix O). As outlined, the rationale for *we* *keep depression a secret* has impacted PLDs' lives at the onset of their symptoms and continues to influence their level of engagement with others today.

My Family's Experience of Seeing Depression in Their Loved One

My family's experience of seeing depression in their loved one is the second category of themes, uncovering the large part family members played in the PLD's mental illness. Four major themes within this category are: *iv) my family didn't understand my depression, v) my family helped, vi) my family didn't help- some made me sick,* and *vii) my family also became "sick".*

My family didn't understand my depression.

My family didn't understand my depression provides information on the knowledge and awareness the PLD's family members had about their loved one's mental illness. This major theme had the following four sub-themes: *a) there is no science behind depression, b) it's about religion, black magic, and race,* and c) *we prefer "desi"[Indian] medications.*

There is no science behind depression.

The combined evidence from all the family members shows that they primarily have an understanding of the social factors influencing an individual's mental health, lacking knowledge about the impact of psychological and biological factors. To illustrate, the summation of interviews with Gurjit, Balwinder, Mandeep, Hina, Roop, and Amandeep identified how immigration, financial stressors, family conflict, grief, and workplace stress could be identified as contributing factors for an individual's depression. Overall, these family members were able to identify the social elements that can contribute to the development of an individual's depression. This finding overlaps with the understanding PLDs had about depression.

It’s about religion, black magic, and race.

In addition to these interviews revealing the family’s acknowledgement of social factors contributing to the development of depression, they also permitted unique cultural understandings to emerge such as ideations surrounding religion, black magic, and race. The connection between religion and depression was evident in the discussion with Gurjit [Kiran’s father] who has identified a foundational understanding of the social factors associated in the onset of depression. He also shared the belief that Sikhs should be exempt from this mental ailment.

> *“You see there can be many causes, right? Financially, familial arguments, sometimes siblings, socially, some can be from the government such as in India. Or if someone is unable to settle, that’s why. The rest, us Sikhs should not get depression because we have to bhana mananaa (accept the will of God), kirat karni (earn an honest living), before all else.”* [P]

Gurjit’s interview was heavily focused on the Sikh religion, whereby he referenced *Gurbani* (Sikh scriptures) to not only provide life lessons, but also to protect individuals from developing mental health ailments. In addition to following the Sikh teachings, Gurjit also spoke about individuals embodying a good character and being diligent with workplace responsibilities.

Another cultural ideology about depression that surfaced from the current study was the influence of black magic on one’s mental presentation. For example, Hardev disclosed how his parents were convinced his depression was in fact an act of black magic, an ideation he too almost believed.

> *“Like, dad says to mom, someone did something to you. Come, let me do prayer for you. I will do a prayer ceremony for you to help you get better. Parents worry more, you know?”* [P]

Hardev agreed that black magic was more heavily accepted as an explanation for mental illnesses in India in comparison to Canada.

The last cultural belief evident in this study linked depression to race. In conversation with Neha she disclosed that her husband believed that depression was actually a "*white person's illness"* [E]. Neha's husband accused her of using depression as a tactic to manipulate family and friends for attention. Equally, Priya's in-laws expressed the same stream of thinking, stating that her symptoms of depression were in fact her efforts to mask her true intentions of wanting to draw empathy and focus from other family members.

We prefer "desi"[Indian] medications.

The wide variation in familial understanding for the causes and manifestations of depression was also found in regard to having knowledge of treatments for depression. Gurjit, Balwinder, and Mandeep all discussed the significance of medications to support an individual's treatment for depression. However, Gurjit's perspective differed with the belief that medications are only to be implemented as a short-term plan, with PLDs finding other interventions to manage their symptoms and strengthen their minds. In contrast to these family members being supportive of psychopharmacological interventions for depression, there were also family members who were against the use of medications. For instance, Hardev and Priya's parents advised against antidepressants in their loved one's treatment for depression. Their rationale was to protect their loved ones from the long-standing side effects of antidepressants. In this case, they perceived the negative side effects of antidepressants to outweigh their benefits, and it was questionable if they saw any value to antidepressants. As an alternative, these family members had made suggestions for naturopathic remedies. For example, Hardev shared during his interview,

> *"Everyone, whoever I tell, you are taking sleep medications… they say all these medications you are taking they have side effects. They are bad. Take some desi (Indian) medication, take some homeopathic medication."* [P]

From the six PLDs interviewed for the study, four had been influenced at some point in the course of the illness to stop their medications.

Many of these examples indicate the family's conviction that depression is, in reality, under the control of the person. This belief was made obvious through Kiran's father, Gurjit, as well as her boyfriend advising her to *"not to take things to heart"* [E]. What these examples have depicted is this participant population's lack of understanding regarding the psychological and biological influences on an individual's depression.

Similar findings emerged with we *keep depression a secret,* where the SA Punjabi community was able to only identify the social factors contributing to an individual's depression. Thus, the lens through which these participants examined depression influenced their conceptualization of this mental illness. All in all, not only did many of these family members lack an understanding of depression at the onset of their loved one's illness, but they continue to remain uninformed even though many of the PLDs have been receiving mental health services for a number of years.

My family helped.

The impact family had on their loved one's depression varied from family members making efforts to support their loved ones with depression, or alternatively where they failed to provide such help. In some cases these family members were the triggers for the PLD's mental illness. Firstly, it was recognized that most family members attempted multiple strategies to help their loved ones with depression, all of which reflected their own understanding of mental health. For instance, family members attempted to support their loved ones with their depression through financial means. As an example, Priya's parents believed they could alleviate their daughter's depression by continuing to provide her with financial support. In Amandeep's interview [Priya's mother], she makes multiple references to giving her daughter Priya an extravagant wedding and providing her with funds for both her business and to support her family in India. With all these efforts, Amandeep still questioned how their family attempts fell short to support her daughter's recovery, as Priya continues to struggle with her depression. Consequently, Amandeep's conceptualization of mental illness illustrates her lack of understanding of how depression can evolve in an individual and the mechanisms of support required for their recovery.

Other methods which family members used to support their loved ones included taking on more household responsibilities. This was specifically displayed through various acts of service where family members assisted with domestic chores, became the sole income provider for the home, and/or took on additional role responsibilities such as caring for siblings. To illustrate the impact of taking on these responsibilities, Hina [Neha's daughter] shared her experience as an eight-year old caring for her younger siblings,

> *"Like when my mom would self harm and stuff I'd go to my sister and be like oh guys don't worry. I'd just try to distract them and stuff like that. But for me, I've always just tried to tell her not to hurt herself."* [E]

Hina's example sheds light to the magnitude of impact depression has on even children who may adapt their role to support a PLD.

Finally, one impactful way that some family members supported their loved one was by empathetically listening to their challenges. This was done through family members attempting to encourage their loved ones to openly share their mental anguish in an attempt to ease the pressure off their minds. To exemplify, Gurjit attempted to make efforts to connect with his daughter [Kiran] about her mental health struggles, but disclosed it has been challenging to find uninterrupted time as his wife is always present. These circumstances reveal the strong family presence within the SA Punjabi culture, where it can be problematic for an individual to find opportunities to connect with a single parent. For Kiran these family dynamics unearth her receptivity to discuss her mental health concerns with her father in comparison to her mother. Kiran's ambivalence to discuss her mental health with her mother stems from the lack of support her mother provided when Kiran first disclosed her mental health issues and to safeguard her mother from additional burden. Her mother's initial response to Kiran's mental health issues was,

> "*So I shared with my mom that I am not okay. She's like what do you mean? I'm like, like I explained her in Punjabi, my mental state is not okay. (Pause) That umm, there is something going on with my brain that's how I explained her. And she got stressed and she's like what happened? I'm like I don't know. I don't know. I don't know the reason. (tearful). I laughed (laugh) when she said, oh don't tell anyone (giggle). Yeah don't tell anyone, it's okay. Don't tell anyone you have this, you are experiencing this because people would say things about you, about your mental health."* [E]

The level of comfort which Kiran developed with Gurjit to share some of her mental health concerns only transpired once he started receiving psychoeducation from her SA family doctor. Similar to Kiran, Mandeep shared that she confided about her mental health issues with her parents and sister. The volume of this support speaks for itself, as it was the primary means by which Mandeep was able to manage her symptoms for eight years before receiving professional mental health support for depression

My family didn't help - some made me sick.

As the above cases indicate, some family members were more active with their attempts to help a PLD, there were also a few family members who showed a lack of involvement. Although Priya's parents failed to recognize the emotional turbulence she was experiencing within her marriage, her brothers wanted to intervene to provide her with support; however they were stopped by her parents. For example, Amandeep stated,

> *"The children, they understood. That this is depression. She is in depression. Let me talk. My younger son says, "I will talk to her." We stopped him. He would get angry, that they are*

> *doing this. He's very intelligent as well, the younger one. He knows everything. He would know that this is what happened and this is how it will happen. He would say I, myself will talk. And we wouldn't let him talk. The issue will grow then. It won't look nice. We wouldn't let him talk. He said it many times: I will go to India. I will talk to them [speak to Priya's in-laws in India]."* [P]

Essentially, Amandeep's interview demonstrates the social reputation marriages have within the SA Punjabi culture. It was more important to avoid interfering in her daughter Priya's marital home than to address Priya's mental health distress. These SA Punjabi cultural norms resulted in a late intervention for Priya's depression.

Beyond not actively supporting a PLD, some family members were triggers for depression; some even prevented the treatment process. For instance, Mandeep, Neha, and Priya endured domestic issues at home, and, in the cases of Neha and Priya, the family conflict escalated to include intimate partner and family violence. In these circumstances their family members not only triggered their depression, but through Priya's interview it was seen how her family members prevented her from seeking professional supports. As an example, Amandeep shared the following in her interview,

> *"We never spoke to them directly. Whatever we found out from our daughter. We would console her only, that don't worry, don't worry. That parents just say these things. Whatever it is, just let the time pass. But, we never talked to them [Priya's in-laws] directly. Recently we talked to them a little bit, but before we never talked to them."* [P]

In this dialogue Amandeep is found to be minimizing Priya's trauma and ultimately waited until her daughter's depression became insurmountable to seek professional help. These circumstances serve as a major roadblock for the PLD's treatment and recovery from depression. The interviews with these three women also reveal that although they may have shared small parts of their trauma with loved ones or professionals, they have not been able to share the full breadth of this experience. For many, this research opportunity gave these women the space to share the most intimate details of their experience to date. As an example, Neha shared, *"Not to this depth. No I can't. I can't tell anybody."* [E]

Neha expressed in her interview how she cannot share specifics about her mental health experience with her family, and has only had the opportunity to provide a brief synopsis of her personal trauma with her psychiatrist. Finally, another problematic area, which was also highlighted in *my family didn't understand my depression*, was that some family members advised PLDs not to take medications. Although most of these were verbal suggestions, in the case of Priya it was extreme enough that her family prohibited her from taking medications, even though she wanted to.

The results within two major themes, *my family helped* and *my family didn't help- some made me sick,* captures the range of impact family members had with supporting PLDs. These efforts were heavily influenced by their understanding of depression and their recognition of the type of support that would benefit the individual. PLDs not finding individuals to confide in about their depression stemmed from their inability to openly disclose their mental health issues. Many PLDs expressed to the interviewer that to date they had not shared as much depth as they had for this study. Overall, barriers for these participants to receiving the ideal level of support from family members stemmed from the social stigma affiliated with mental illness, the lack of knowledge regarding depression, and finally the cultural norms surrounding communication within the SA Punjabi community.

My family also became "sick".

My family also become "sick" provides details on the mental health implications of caregivers for PLDs. All six family members expressed being impacted to some degree by their loved one's depression. For example, Gurjit, Balwinder, Mandeep, and Amandeep all expressed their ongoing worry for their loved one's recovery from depression. Unfortunately, these family members also expressed difficulty leaning on their social circles for supports due to the vast amount of mental health stigma within the SA community. A common finding among study participants was that members of the household primarily managed their own mental health issues. One distinct finding in the level of support available for these family members was which member of the household was impacted by depression. For example, spouses whose children were experiencing depression appeared to have more support by turning to their respective partners in comparison to households where one of the spouses had become unwell, where the burden fell on the children. For instance, Gurjit and Amandeep both have the support of their partners as they manage their children's depression, however Balwinder, Hardev, and Mandeep primarily have their children's support. Unfortunately, the results revealed that none of Balwinder and Hardev and Mandeep's children have knowledge regarding depression and therefore have not been as active with providing support to their families. Notably, for Hardev and Mandeep there is much more difficulty as both husband and wife have been diagnosed with depression.

Along with adults being impacted by their loved one's depression, the data also revealed the influence it had on PLD's children. Both Hina and Roop discussed the negative ramifications of their mother's depression. For instance, Hina [Neha's daughter] disclosed the developmental impact from her mother's depression where she became an introvert during her early childhood years. She was only able to transition through this difficult time by rediscovering her career ambitions to become a doctor. This research project was the first time Hina has spoken about her mental health distress. Like Hina, Roop [Priya's daughter] has also shared the mental trauma both she and her sister endured from witnessing the domestic violence towards her mother, which ultimately triggered her mother's depression. Roop admitted that she has only ever spoken to her sister about the emotional distress she has experienced over the years.

The results of how PLDs' illness impacts their family members corresponds with findings within other emerging themes, where the SA Punjabi community has tendencies to keep their mental health challenges hidden due to the social stigma affiliated with the subject matter and their lack of understanding surrounding the issue. Within these results, five out of six family members continue to self-manage their emotional distress resulting from providing support for their loved one's depression. As such, they have not experienced circumstances where their symptoms exacerbated to the point of needing to access professional supports. Notably, Mandeep is the sole family member who has required professional intervention, resulting in her diagnosis of depression. Mandeep expressed,

> *"Even I didn't know what it was. I thought maybe because of the weather changing. But, the problem is that when he was depressed, I am also suffering. Depression also happened to me. It's been me 2 years now. I, too, due to the stress and pressure…I also take them. My doctor has also given me a medication."* [P]

Although, there are a multitude of factors that could have caused her depression to surface, one definitive element was the onset of her husband's depression, the affiliated roles she inherited as a caregiver, and ultimately managing all these hurdles on her own.

My Experience of Accessing Mental Health Services for Depression

As discussed in the literature review, the experience of accessing mental health services has been explored by using Levesque and colleagues' (2013) definition of accessibility which includes the elements of: approachability, acceptability, availability and accommodation, affordability, and appropriateness of services (Table 1). This category of themes specifically answers the primary research question and examines mental health services for depression as a societal transition condition as per Meleis' (2000) transition theory. The exploration of these various elements of accessibility within the SA Punjabi study sample enabled the following major themes to emerge: *viii) we didn't know where to get help, ix) my health providers' lack of familiarity with my culture caused stress, x) I waited to get help, xi) treating my depression cost me,* and *xii) knowing my culture will help you treat me better.* The major themes on access are viewed through the contextual lens of how the participants conceptualized and experienced depression (referencing the first two category of themes).

We didn't know where to get help.

The theme *we didn't know where to get help* relates to the element of approachability of mental health service accessibility where community members have awareness about these services. In relation to this study, examining the element approachability uncovered the lack of awareness SA Punjabi participants had about mental health services upon encountering their symptoms of depression. With reviewing the first two categories of themes (*my experience of having depression* and *my family's experience of seeing depression in their loved one*), the majority of the research participants reported both a lack of knowledge regarding depression in addition to encountering a substantial amount of social stigma to openly discuss their concerns. Both these factors have contributed to the general lack of awareness SA Punjabi PLDs and family members had, for example that mental health services even existed. For many of these PLDs, it took the family member, a healthcare professional, or in one rare case the individual to identify that they were in fact signs of depression. Unfortunately, as many of these interview respondents have expressed, this assessment took place once symptoms had exacerbated and became unmanageable by the PLD or their supports. The collective evidence supporting the lack of awareness of mental health services by these interview participants was first apparent in their knowledge gap surrounding mental health issues, then their repetitive visits to the emergency department and/or family physician, and finally their lack of self-help efforts to reach out to mental health professionals.

Firstly, the evidence provided within the categories of themes from *my experience of having depression* and *my family's experience of seeing depression in their loved one* reveals that a majority of PLDs (n=4) and their respective family members (n=6) were unaware of mental illnesses, specifically depression. This knowledge gap surrounding mental health issues suggests this participant population is likely unaware of any mental health services to treat a problem they do not even know exists.

Secondly, family members who came to recognize that some form of health problem was surfacing in their loved ones discussed making repetitive trips to the emergency department and/or family doctor during times when these symptoms had exacerbated. This scenario brings forth two critical points. The first is that neither the PLD nor the family member recognized any warning signs of depression or made attempts to reach out to mental health services on a preventative basis. Moreover, for those who continued to make repetitive visits to the emergency department and/or the family doctor and continued to have their depressive symptoms worsen, they remained unaware of any other additional mental health specific supports that could provide them with aid. For example, Mandeep disclosed that she continued to take her husband Hardev to the emergency department and family doctor without having any explanation provided to her regarding her husband's mental health concerns.

> *"Three four times I have taken him to the hospital. Once right after eating, I took him from here at night. At night we went and sat in the emergency room. Then by going there, after seeing how many other people feel sick, he would feel better. Then doctor would give some medication."* [P]

This cycle continued to repeat itself until Hardev's depressive symptoms worsened, allowing a second family doctor to screen him and then refer him to a psychiatrist.

Finally, PLDs and family members revealed a lack of self-help to connect with local mental health agencies. Mandeep's interview as a PLD provides one such example displaying the extent of harm an individual had experienced as a result of not being aware of local mental health services. During the start of her mental health concerns, Mandeep disclosed how after much deliberation she had approached her family doctor regarding her depressive symptoms, which was ten years ago. At that time her treating family doctor had advised her that there was no psychiatrist available who was accepting patients. As a result, Mandeep continued to self-manage her depression for another eight years before another family doctor was incidentally prompted to screen her for depression due to her becoming overly emotional during a full physical examination. The lack of awareness of mental health services resulted in this PLD trying to independently manage her illness for eight years, whereas approachability of mental health services could have provided her with help sooner. Mandeep shared her thoughts about the delayed intervention to her depression,

> *"Proper guide… we have Dr.[X] … with whom… maybe he could have been… naturally he could have been without medications. Rest is up to time. Maybe if we had proper guidance, treatment… what can I say… you know in a natural way without medications we can stop that sort of thing- the depression…we can say that you exercise. Now without taking medications, we won't be able to go on now. Have to take it now. I just think, that now we are in a habit, we have to take it. If we miss it, we relapse."* [P]

Mandeep highlights how an early intervention for her and her husband's depression could have possibly changed the outcome of the treatment they required for the management of their depression. An overall gap in treatment was observed to some degree in all PLDs, whereas awareness about mental health services could have ensured mental health concerns were addressed sooner.

The summary of evidence provided for *we didn't know where to get help* outlines the magnitude of impact of the lack of knowledge for depression and the existing mental health stigma can have on the SA Punjabi community on recognizing the process of accessing and navigating the mental health system. In these interviews a lack of approachability of mental health services prevented SA Punjabi participants from recognizing the nature of the problem and having awareness for the necessary services available to support them. The added layer of social stigma with the SA Punjabi culture inhibited these community members from gaining this knowledge from their peers or even taking the initiative to self-examine the problem.

My health providers' lack of familiarity with my culture caused stress.

My health providers' lack of familiarity with my culture caused stress is a theme that relates to acceptability of mental health services. Acceptability would be evident in the accessibility of mental health services by having the SA Punjabi community feeling reassured that mental health services are receptive to their cultural background. The findings from this study revealed that mental health services of depression were largely unacceptable for the SA Punjabi community. Both PLDs and their family members desired that their healthcare professionals either identified with or were more familiar with the SA culture. A lack of familiarity of the SA culture led to some participants experiencing frustrations, which impacted their level of engagement with service providers and in some cases, jeopardized their treatment through withdrawal from services. In comparison, when healthcare professionals communicated an understanding of the SA culture, participants revealed their positive experiences by being engaged in seamless rapport building, appreciating family involvement within the treatment modality, and finally adhering with treatment recommendations.

Challenges that were identified by some PLDs having to work with healthcare professionals who are not accustomed to the SA culture led to much frustration, as they had to explain common beliefs and values held by their community. This became a difficult task for

PLDs, as they were simultaneously challenged by their symptoms of depression. For instance, Hina described that her mother was frustrated with providing details about her cultural background and she became even more disappointed when her treating psychiatrist failed to implement this perspective into her treatment. Neha shares,

> "*First of all, I'm struggling with my own emotions. Secondly, I am making other person understand what he is not willing to understand because he is not from the same background. He does not know how these Pakistani desi's mentality is. I know I live in Canada. In spite of living in Canada, our problem is our culture moves with us. My culture came with me. Whether I was in Canada or even if I move to America, Australia, or anywhere else. I am still going to remain Pakistani. And I still have, even in Pakistan lots of people- not everybody is like us but- anyways so, I started going there. I went there for few times."* [E]

In Neha's case, this lack of cultural acceptability by mental health services resulted in service disengagement. Furthermore, when healthcare providers are not familiar with the SA culture it takes more effort on the part of the PLD to fill in their knowledge gaps, which poses much difficulty, as PLDs are likely impaired by their symptoms. Kiran expressed her difficulty to do this while combating her symptoms of depression*,*

> *"Because you know how things work, how the family dynamics are in your culture, and it would be easier to talk. Sometimes you just want to talk in your own language you know. Because there are some slangs or terms that you can't explain to them. Like lets say my dad is Amritari. So how do I explain a non-South Asian person, like I have to go into detail. First I have to prepare myself so I am not giving wrong information. So I would choose my words carefully and explain from scratch that this is what it is, as compared to a South Asian person would understand right away. Oh yes it would greatly help me if South Asian mental health services would be around me, would be much easier."* [E]

This added barrier in care was shown to impact study participants by delaying their management of their depressive symptoms and even jeopardizing their efforts to continue engagement with services. In the case of both PLDs, Kiran only found a suitable SA healthcare provider one year after the onset of her depression, whereas Neha found acceptable services by a SA psychiatrist a decade later. This gap in service accessibility created an opportunity for the mental health of these PLDs to continue to deteriorate, as they were not connected with professionals who understood their cultural background.

For some, it was not until PLDs and family members encountered SA healthcare providers or healthcare providers who were familiar with their culture that they felt an appreciation for their background to be well understood. This quality of engagement permitted the healthcare professionals to better recognize the multitude of factors impacting the service recipients' mental health. All individuals who worked with SA practitioners expressed an appreciation for the seamless rapport building that took place, the benefit it had for their family members to recognize and accept their mental illness, and finally supported a treatment approach that resonated with their own perspective.

To begin with, seamless rapport building was an asset in the PLD's care as it permitted the service recipient's focus to quickly shift from alleviating their fear that no one will understand their health problem, to placing emphasis on their mental health recovery. For instance, Kiran spoke about the immediate connection she developed with her SA family physician, whom she met one year after trying to manage her symptoms of depression under another non-SA physician's care. She discussed details from this initial appointment,

> "*When I first met him he kind of figured out just by seeing my face how I was explaining things he quickly got what I'm saying".* [E]

Kiran was astonished to feel so quickly understood by a healthcare professional, which raised her hopes about her mental health recovery. Similar rapport-building experiences were expressed with other PLDs [Hardev & Neha] who were relieved by the immediate acceptance they gained from working with professionals who were familiar with their cultural background.

Rapport building was seen as a remarkable benefit of working with healthcare professionals who understood the SA culture and extended beyond the PLD to having an impact on family members coming to accept their loved one's depression. The influence of the SA healthcare providers to support the family's recognition and acceptance of mental illness was captured through Kiran and Gurjit's example. Kiran's interview reveals that her father first received an explanation about depression during her initial appointment with a SA family doctor. This engagement, which took place primarily in Punjabi, was the first time her father came to acknowledge and accept Kiran's mental health concerns. The ripple effect of this appointment was extremely impactful as it resulted in her father becoming one of her primary supports. Gurjit [Kiran's father] also expressed his confidence in his daughter's treatment with her receiving care by a SA doctor,

> *"Our community is what and English-white people is what! They don't know about our community. What our culture is, how we live, what our relationships are, our behaviours".* [P]

With this SA Punjabi participant group vocalizing how family oriented their community is, the evidence revealed how essential it was for healthcare providers to communicate effectively to the PLD's loved ones. These family members were found to greatly influence the approach of PLDs to mental health acceptance, treatment, and recovery.

A final benefit of healthcare providers' receptivity of SA culture in their treatment approach was evident in the willingness of participants to engage with mental health services and further comply with treatment recommendations. All six PLDs are now connected with healthcare professionals who are of a SA background or understand the SA culture. For example, Priya's account of her most recent engagement of receiving mental health services, where a counsellor of a Chinese background displayed deep understanding of her SA culture, reveals the impact of service acceptability on PLDs.

> "*Almost the same. The same. But I found the [name of mental health agency] lady much better than what she was. Although she was Chinese, she understood the situation much*

> *more. I really wanted to have a few more sessions with her but they are restricted to two these days."* [E]

Priya is discussing her collective experience of working with a SA and non-SA counsellor, which illustrates the level of cultural acceptability non-SA healthcare providers can attain by being aware of a culture. This form of cultural acceptability permitted Priya to engage in her counselling sessions and now move forward with the recommendations that were provided to her. In addition, Gurjit has also witnessed his daughter Kiran following the treatment recommendations provided by her SA family doctor. Through Gurjit's own interactions with Kiran's family doctor, he has witnessed how the mental health problem was tackled through a holistic lens. He shared,

> *"Understanding English is a separate issue. Someone identifying with the Punjabi community will be more familiar with the community's relationships with one another, the way of life, and the stressors that occur."* [P]

This overall understanding has PLDs more compliant with their treatment teams.

Although in the above case it has been mentioned that speaking English is another issue and the main focus should be on understanding the culture, there was much value for PLDs receiving mental health services when healthcare providers were able to communicate in Punjabi. This benefit was seen in one case mentioned above, where Gurjit came to acknowledge and accept his daughter's depression after receiving mental health teaching in Punjabi from her SA family doctor. The advantage of language was for PLDs, who were able to thoroughly explain their experiences. Many PLDs shared that the meaning and intensity of their experience was lost when they attempted to say it in English. The inability to effectively communicate personal mental health experiences would almost certainly impact the type of intervention received from professionals. Hardev shared,

> *"There's no difference really but for us, Punjabi is better. Our symptoms…it gets difficult to explain. Like you were explaining. If the first time, you have to go to an English doctor? Anxiety is the word you've learnt now. You didn't know then, that this is anxiety. So language…sometimes the word doesn't come… yea... at that time I didn't know the word. Then I explained it as gabrahat (worry). These sorts of things couldn't say in English and explain to the doctor."* [P]

Because Hardev was not able to identify his symptoms early on, he had countless visits to the emergency department and his family doctor, where his mental health issues were not addressed. Thus, language is an essential part of the mental health system enabling services to be viewed as more acceptable by community members.

The summary of evidence provided through *my healthcare providers' lack of familiarity with my culture caused stress* reveals the value in mental health professionals expressing their openness to the cultural background of their service recipients. When community members witness a lack of regard for their culture, it jeopardizes their level of engagement with mental health services, and may result in negative mental health outcomes. Results of this study convey that it is essential for cultural understanding to be communicated to service recipients to enhance acceptability of mental health services. The most effective delivery of cultural understanding was seen through SA professionals supporting SA Punjabi PLDs, however the study also provides evidence that non-SA professionals can achieve cultural understanding.

I waited to get help.

I waited to get help is a theme that highlights availability and accommodation of mental health services. These elements of accessibility capture the time trajectory before being connected with mental health services and the existing flexibilities of services made available to PLDs. An overarching finding of speaking with all study participants was that the general time lag in getting connected with the appropriate care providers ranged from two months to ten years. In the most seamless scenario of PLDs, Kiran's timeline reveals a wait time of initially two months before she discussed her symptoms with her family doctor, to another one-month delay before getting connected with a counsellor, and then finally another one-year period before receiving care from a SA family doctor. This case is an example of rather quick engagement to services in comparison to Mandeep, whose ten-year timeline was described previously. Therefore, the gap in the availability of mental health services for Mandeep's case was nearly eight times more than Kiran's. Such a time lag for mental health interventions impacts the lives of PLDs where delayed interventions could result in treating more severe symptoms of depression. To outline another example, Balwinder attested to the delay in Sarbjit's treatment,

> "*First of all, waiting specialist appointment is so difficult we cannot get. See if you met Dr. (psychiatrist), first time… when her mother passed away then they were determine its depression. Then it would have been good for her, but you know you could not get. Again she get stressed out and went depression, then we met Dr. (psychiatrist).*" [E]

The delay in mental health interventions costs the PLD their mental health well-being and adds further pressures on their caregiver's mental health (evident in the theme *My family also became "sick"*). Moreover, this time gap also leads to increased emergency department and/or family doctor visits by those in need of support. As discussed, Mandeep had countless visits to the emergency department and family doctor before her husband [Hardev] was finally screened for depression by his family doctor and referred to a psychiatrist.

One aspect of availability and accommodation addresses the time trajectory to services, another aspect examines the flexibilities of existing services. Among those who are already connected with mental health services, there was notable variability in responses regarding the accommodation of services. For instance, Hardev and Priya both expressed the exceptions that were made for them to connect with their healthcare teams as the need arose. As an example, Hardev articulated the convenience he had experienced in connecting with his psychiatrist on short notice. This alleviated much distress, as Hardev was able to file disability forms in a timely manner. As some PLDs experienced supportive accommodations surrounding their services, other service recipients expressed frustrations with this matter. For example, Balwinder expressed that first he experienced difficulty with getting his wife Sarbjit referred to a psychiatrist and now that they are receiving his services they continue to experience barriers with communication. He shared his frustration,

> *"See, actually I called Dr. (psychiatrist)'s office many times but nobody lifted the phone. Because I wanted to explain that I've got an appointment in the month of June or so. June or July. And if he can cancel, or recommend it. But nobody lifted the phone in his office."* [E]

These lack of accommodations with mental health services pose accessibility concerns for those community members who are already connected to services.

The results for *I waited to get help* reveal the variability service recipients have experienced with both timely access to mental health services and the associated flexibility of these professional supports, all impacting their experiences and mental health outcomes. First, the availability and accommodation of mental health services drastically impacts how mental health services address the SA Punjabi community's needs. For instance, although Kiran's example appears to have been a much-improved scenario from Mandeep's, the fact she had to wait one full year before accessing mental health services that met her needs, reveals gaps within existing mental health services. During this period, Kiran disclosed the extreme challenges she endured with her mental health, the negative consequences that resulted from the lack of support, and ultimately the disappointment she felt towards the existing mental health system.

Availability and accommodation of services also highlights the type of flexibilities mental health services need to maintain in order to meet the participant's needs. The communication barriers that Sarbjit experienced with her psychiatrist was as an obstacle in the treatment of depression, as the family is unable to address their questions. Evidence brought forward from this study highlights the need to enhance service accessibility from an availability and accommodation standpoint for mental health services.

Treating my depression cost me.

Treating my depression cost me relates to the affordability of mental health services. This aspect of accessibility explores some of the socioeconomic factors that influence access to mental health services by the SA Punjabi community. Affordability of mental health services was seen as an issue with the financial divide on which PLDs could access counselling, the challenges PLDs experienced in getting short-term disability approval, and finally the loss of income due to the depression.

First, the ability to access counselling for the treatment of depression was an issue for three of the six PLDs. For example, Priya shared how she accessed a private therapist only because her brother paid for those sessions. Priya's financial status did not permit her to access counselling as she is currently unemployed and already requires her parent's financial assistance to care for herself and her three children. Furthermore, other individuals were able to access counselling through healthcare benefits at work or financial assistance through short-term disability. The three PLDs who did not access counselling were unable to do so due to their financial circumstances. The gap in service for these PLDs who did not receive counselling due to financial restraints could have been eliminated had they been aware of more affordable services, which relates to the approachability of mental health services.

Moreover, PLDs also experienced challenges for getting short-term disability approval, which was an added stressor to their mental health recovery. For instance, Balwinder shared that during the time his wife [Sarbjit] was not being approved for disability, it was impacting both their access to mental health treatments as well as managing the household on his sole income. He shared,

> *"And you know, other thing was, financing problem. Uh… this house can be managed with income of both. So if I work only, I have to pay the mortgage, bill this that, insurance, so many things. And some expenditure, actually her income is also required, otherwise with one-man income, it is not. So actually, what happen, her insurance was not approving the short-term disability claim, so she was so stressed out. But after the, after she's got the approval of short-term disability claim and Dr. (psychiatrist)'s approach and. And everything combined, it has improved.*" [E]

As a family member witnessing these hindrances in the healthcare system, he noted that a lack of financial support impacted the ability to purchase medications to treat the illness, making the depression worse.

Finally, another aspect of accessibility impacting individual's affordability of mental health services was the subsequent loss of income as a result of the depression. Of the six PLDs, only one was unemployed due to her personal choice of being a stay-at-home mother. Of the remaining five PLDs, two were currently working, two were on short-term disability, and one was off work but not receiving any government financial assistance. Even individuals who are currently employed experienced absenteeism as a result of their illness. Overall, all PLDs experienced loss of income as result of their symptoms becoming unmanageable, in addition to facing delayed intervention due to the complexities of navigating the mental health system.

The results indicate that affordability of mental health services impacted PLDs recovery as some individuals were unable to access counselling, others experienced difficulty with obtaining short-term disability, and finally some had a subsequent loss of income due to the onset of depression. There is an evident interaction with affordability of mental health services with mental health service approachability and availability and accommodation, in which awareness about mental health services and timely intervention could prevent substantial loss of income by PLDs. Finally, the evidence also shows that this SA Punjabi participant group were unaware of government assistance programs to alleviate their financial burden and allow them to focus on their mental health treatment and recovery.

Knowing my culture will help you treat me better.

Finally, *knowing my culture will help you treat me better* is a major theme exploring appropriateness of mental health services. Appropriateness is an element of service accessibility, in which healthcare services are assessed on their ability to address service recipients' needs and provide adequate interventions. Findings of this project indicate that mental health services addressed some aspects of participants' needs, however the fit between the service provider and the recipient needs to improve, especially from a cultural standpoint.

All service recipients expressed satisfaction with their current mental health service provider in relation to meeting some aspects of their needs. Each PLD is now connected with healthcare professionals who have an appreciation for their SA cultural background and to some degree incorporate this into the treatment model. For instance, Neha expressed her satisfaction about working with a SA psychiatrist,

> "*Now, Dr. [psychiatrist] he always help me in a way because he's South Asian. I always talk to him in Punjabi. Whatever I go through, I just you know whenever I talk to him, he gives me so much motivation. He compliments my personality. No, you're perfect. There's nothing wrong in you. You don't have to feel bad or guilty about yourself. This is how our society, how our culture is. Many things. You know the way he does mentoring?"* [E]

While Neha expressed service appropriateness about the care she received from her current psychiatrist, this was not always the case. The study's ability to capture both the perspective of PLDs and their family members revealed the immense challenges experienced by individuals to address service appropriateness. In Neha's case, she discussed her past experience of accessing mental health services for depression and working with healthcare providers who failed to incorporate her cultural values and beliefs into their treatment approach. Her daughter Hina also spoke about how this hindered her mother's recovery,

> "*The person, even if they're not South Asian or Punjabi or anything. They can't just throw out some advice and expect the patient to follow through with it completely. Because her, with her the problem was, they'd give some advice and be like oh, you didn't follow with it? Then okay, that's your fault. Because you're not complying. That's the problem. But, I feel like they need to be more understanding of the sort of hidden rules that a person may have in their life. Depending on their identity and their culture and everything. They just need to be more understanding of that."* [E]

This gap in service appropriateness was not an isolated to Neha's journey of accessing mental health services for depression, rather it was a common theme noted with all PLDs within this study. Findings suggest that there is a need for mental health services to deliver care so that their treatment interventions meet the cultural needs of the service recipients accessing care.

Not only was there a lack of culturally relevant treatment recommendations, but the evidence also supports the need for culturally appropriate health teaching surrounding mental illness. For example, Mandeep sheds light on the knowledge gap that continued to persist through her countless visits to the emergency department and/or family doctor for her husband [Hardev],

> *"No answer… yes by ourselves. Because we didn't know ourselves about what the problem is. We didn't have proper knowledge. When the person suffers, they don't know. What the starting symptoms are? Why they are happening? This way… we have been to the hospital. But once we were there, after seeing others, he would feel better and come home. After coming, same thing- the anxiety would start again. Even now, same anxiety but…now I know, that every time winter starts, his body turns different. Now I know."* [P]

During Mandeep and Hardev's visits to the hospital they did confirm meeting with healthcare professionals, but the ongoing knowledge gap reveals that mental health teaching did not take place in an effective manner that met the service recipient's needs.

Furthermore, there has already been much emphasis within the various themes on how the SA Punjabi community lacks knowledge about depression (*Most of us didn't know what depression is* and *My family didn't understand my depression*). The analysis of the appropriateness of services also highlighted the existing knowledge gaps of this participant population for the treatment of depression, specifically counselling. Although counselling in addition to psychopharmacotherapy is the first line of treatment for depression (Austin et al., 2015), none of the three PLDs who had accessed counselling found it to be beneficial. A common view that emerged from all three PLDs was that they expressed the counselor did not give much advice on how to improve their depression symptoms, rather continued to emphasize social engagement. As such, Balwinder shared,

> *"Actually counsellor, okay, actually he's okay. Only he will listen okay what it. But he is not giving advice, what to do then, how only go there, go to your community services, go to temple, religious prayers, meet your friends and families, but we have very limited friends, no family."* [E]

From the researcher's understanding this lack of fit between the counselor and the PLD stemmed from two reasons. The first is the lack of understanding by the community on how counselling is implemented and the second is the cultural lens that the counselor may have failed to apply. Counselors provide service recipients an array of tools to apply to their current circumstances to improve their mental health symptoms (Beck, 2011). It is up to the service recipients to decide what to implement within their daily life. Therefore counselling requires engagement on the part of the PLD. This would be facilitated by the individual accessing services having a complete understanding of what is communicated (language is critical); client participation in the intervention, which would also require family support (something that is lacking in the SA Punjabi community due to stigma); and suggestions that meet the PLD's cultural lens. The lack of appropriateness in counselling services was evident through the failed counselling attempts made by Neha's previous non-SA psychiatrist,

> *"Our culture is so different than these people. We have lots of dos and don'ts. They don't. Okay, she would suggest me: why don't you go outside and have more friends? I'm like: my husband doesn't like me to be very social. Oh! But it's your life. Why? I'm like this is*

> *how it is. So why don't you make him understand. I'm like this is how he is. He doesn't understand me. But yea… but you are smart, you're intelligent, you're grown up, you're enable, it's your life. I'm like yea but …".* [E]

Another critique that was made by two participants who accessed counselling was that they felt the counsellor was speaking to them as a friend. With the SA Punjabi culture only speaking about mental health concerns within close relations, it appears that the boundary between a PLD and a counselor is compared to an intimate relationship and was a deterring factor with participants seeing counselling as a professional service.

Ultimately, exploring the SA Punjabi community's experience of accessing mental health services for depression also provided study participants the opportunity to make recommendations to enhance the appropriateness of mental health services to meet this ethnic community's needs. Key suggestions that emerged from research participants include: 1) providing case management support for PLDs as they navigate through the mental health system, 2) increasing the number of SA professionals working in the field, and 3) providing mental health education to the SA Punjabi community. Initially, a common notion that transpired from the SA Punjabi participants from the current study was the need for a case management program, which would bridge the existing gaps within mental health services. For example, PLDs found it difficult to be service recipients, learning how to navigate the mental health system in parallel to managing their depression. Case management support, as suggested by PLDs, would have an essential role for providing mental health education on depression and symptom management to both the PLD and their family members, ensuring support is provided to navigate through the mental health system, and provide assistance in addressing various challenges that have been impacted by their illness (e.g. employment, sick leave, and/or disability coverage). PLDs expressed difficulty in managing their life changes as a whole as their symptoms of depression made it difficult to process what is going on with their health and to problem solve through transitions that are taking place around them. For example, Hardev expressed the need for further supports outside of receiving psychiatric services,

> "*Because the person doesn't have the strength to go, they are afraid. The person is afraid that what will I do if I go, how will I … at least someone who comes to your house and teaches you something about what you can do. I wish that there be something such as… the doctor will do his job. He will give medications. There should be some type of person that communicates with your family, your work, and all that."* [P]

Depression as a mental illness impacts various aspects of an individual's life, which can be difficult for PLDs to manage without case management support.

Moreover, another recommendation to improve appropriateness of services was the need for more SA healthcare professionals to be working within the mental health field. In all areas of service accessibility, PLDs and family members voiced the importance of healthcare professionals understanding their SA culture. Study results revealed the immense impact of SA healthcare professionals who provided interventions, to meet this community's needs. Such efforts have enhanced the mental health recovery of PLDs through rapid rapport building, improved family acceptance of mental health issues, reduced emergency department and/or family doctor visits, as well as improved adherence to treatment recommendations. For example, Kiran voiced her thoughts on the importance of SA professionals working in the mental health sector,

> "*They should be practicing. If there is no doctor from South Asian community then how can I connect? If there is no psychologist who is from South Asian community how can I get access to it? I don't know if there are any, so but it would be so much easier and helpful."* [E]

While these study results indicate the need for more SA working professionals, this research showed that non-SA healthcare professionals who understand the SA culture can also be effective.

Finally, the last recommendation for improving approachability of mental health services was promoting mental health awareness to the SA Punjabi community at large, which may combat the social stigma within this community and empower SA Punjabi individuals to seek services. As an example, Mandeep strongly believes that depression is extremely common within the SA community, however is not discussed as often as it should be. She shared,

> *"I would say, with proper guidance. Give them knowledge and awareness. I think, 100% in all our homes this problem of depression exists. Some know about it, others don't. But it exists, definitely exists."* [P]

Where Mandeep feels change can be brought with awareness and education, Priya had a different lens on the matter stating this would be nearly impossible,

> *"Those families, I think we cannot change that. That's in our culture, you know. I think because I know my neighbor that female had such a bad time. Her husband used to drink like crazy and he still drinks. So she had undergone a divorce and I know she is a wonderful lady, but nobody is going to see her right. Because you know it is so easy for a man to become a victim, you know to blame the female that she is not good by character and all those things. Look at yourself, you are always drunk. I think the mentality here cannot change. It's going to take a lot of time for the mentality to change."* [E]

Mandeep and Priya's responses highlights the varying levels of stigma that continues to dominate within the SA Punjabi culture. This requires a call to action for mental health services to meet the community's need for education and increased awareness for a change in the community views on mental health.

In summary, the theme *knowing my culture will help you treat me better* revealed that the SA Punjabi participant population perceived that mental health services were viewed positively when there was an active effort to recognize their cultural views within their mental health treatment. Although it should not be expected that SA healthcare providers only treat the SA Punjabi community, what these findings do emphasize is the need for more cultural awareness among professionals working with this population to ensure services are meeting their SA

Punjabi client's needs. More importantly, the interventions developed to support this community's recovery from depression require a culturally tailored framework, which works with both the PLD as well as their family members, who play an integral part in their recovery.

Summary of Findings

- Twelve primary themes were identified, two of which have subthemes, all under three categories of themes (Table 3).
- The first two categories *my experience of having depression* and *my family's experience of seeing depression in a loved one*, support the sub-aim of the study to capture the SA Punjabi participants' conceptualizations and experiences of depression. Becoming familiar with these conceptualizations and experiences with depression supported a better understanding for this participant group's experience with accessing mental health services for depression.
- PLDs encountered challenges with having depression such that: they had limited knowledge about depression, they learned about depression after their symptoms became severe and required professional support, and as a society the SA Punjabi community continues to view it as a taboo topic.
- Family members influenced how their loved ones dealt with their depression. PLDs were impacted by their families' unique cultural conceptualizations of depression. Family members also varied in the ways they provided support for their loved one, in some cases making them more unwell. Findings included how the pressures of caring for a loved one impacted the caregiver's health.
- The experience of accessing mental health services was challenging for study participants which was influenced by: their lack of knowledge about mental health

services, the lack of cultural acceptance offered by mental health services, the delay in getting help, costs associated with treatment, and the lack of fit between mental health services and PLDs' needs. These findings highlight the elements within current mental health services for depression that act as an inhibitor in the transition of PLDs managing their symptoms of depression.

CHAPTER FOUR: DISCUSSION

To the best of my knowledge, this is the first Canadian qualitative study examining the SA Punjabi community's experience of accessing mental health services for depression. While exploring their experience of accessibility, the SA Punjabi sub-group's conceptualizations and experiences of depression were gathered to provide context to better understand the primary research question. Twelve major themes, two of which have sub-themes, all falling under three main categories were identified. The first two categories, i) *my experience of having depression* and ii) *my family's experience of seeing depression in their loved one*, provide foundational knowledge about the SA Punjabi sub-group and support a better understanding of the last category, iii) *my experience of accessing mental health services for depression*. This discussion will examine study findings against existing background literature, underline emerging study findings with relevant research, and apply Meleis' (2000) transition theory to explore mental health services for depression as a societal transition condition. The discussion reviews the findings related to the SA Punjabi participants' illness experience, the impact of stigma, accessibility of mental health services for depression, and highlights the challenges that presented for SA PLDs as they accessed mental health services for depression.

Illness Experience

The first two categories of themes (*my experience of having depression* and *my family's experience of seeing depression in their loved* one) highlights the unique cultural conceptualizations that SA Punjabi participants possess about mental illness, allows for study participants' knowledge level about depression to be assessed, and permits a discussion surrounding the SA Punjabi community's stigma towards mental health. The results of the current study were consistent with Hussain and Cochrane's (2002) qualitative study based in the

UK, which identified that SA women's conceptualization of depression was influenced by cultural and religious viewpoints. Also, similar to a US research study discussing the Punjabi Sikh community portraying themselves as being resilient from mental illness, where they refrain from admitting any 'mental weakness' (Roberts et al., 2016), the findings of my research also found evidence to suggest that Sikhs "should" not become depressed if they are practicing their religion. This finding was captured within the sub-theme *it's about religion, black magic, and race*. The thesis work by Grewal (2010) on Canadian SAs also found that Punjabi Sikh participants used prayer as a coping mechanism for depression. These insights are important to build the context to understand the SA Punjabi community's experience of accessing mental health services, as it unveils important cultural conceptualizations that may influence the use of mental health services for depression. Taking an example from my study, the father (Gurjit) of a daughter (Kiran) who was struggling with depression initially had difficulty supporting her to access mental health services for an illness he believed should not exist within the Sikh faith. Therefore, an essential element enhancing the accessibility of mental health services is for healthcare professionals to be cognizant of these unique cultural ideations held by the SA Punjabi community about depression and mental illness.

Karaz's (2005) study identified how SA immigrant women in the US understood mental illness to be a problem that was triggered by family, home, and life circumstances in comparison to European American women who were more likely to recognize a biological cause for depression. Similarly, results from my study unveiled how SA Punjabi participants only identified the social factors influencing a PLD's illness; they lacked knowledge of the biological and psychological elements. Supporting evidence for this finding is found under the following themes: *most of us didn't know what depression is*, *we realized it was depression after getting* *help*, and *my family didn't understand my depression.* Gathering contextual information about the SA Punjabi community allows for a deeper understanding of why the SA Punjabi community may be reluctant to access and continuously engage with professional services for a mental illness they believe is caused by social factors. The SA Punjabi participants' experience of accessing mental health services, as reported in my study, reveals the need for more psychoeducation on the biopsychosocial model for depression. Specifically, this community may require education on both the biological and psychological factors contributing to depression. These are important points to consider when strengthening the approachability of mental health services, which will be discussed below.

Although the current project supports existing literature on the SA community's lack of understanding regarding the manifestations of depression, it provides new findings on the family's experience of seeing a loved one cope with depression. Previous evidence provided by Grewal (2010) discusses the impact of family expectations, roles, and relationships on SAs living with depression in Canada. However my study adds novel insights about the family influence on treatment. For instance, my study findings showed that SA Punjabi participants were unaware of how depression is treated. Specifically, four of the six PLDs were influenced by family members to stop their medical treatment for depression, as recommended by their family doctor, and instead implemented *"desi"* [Indian] medications. These results were captured within the sub-theme *we prefer "desi" [Indian] medications*. Literature reviews from the US (Rastogi et al., 2014) and the UK (Agius et al., 2010) highlighted that the SA community had lower medication compliance in comparison to Caucasians and Afro-Caribbeans when it came to adhering to their psychiatric treatment. My study contributes unique insights that the reduced compliance maybe a result of substituting "desi" [Indian] medications as result of family influence. This unique contextual finding from the current study is essential to deepen healthcare provider's understanding of how this sub-group may engage with mental health treatment, an important finding to improve the appropriateness of mental health services. As in the case above, this finding compounds problems associated with SA Punjabi participants lacking knowledge about the biopsychosocial model for depression and for healthcare professionals to be aware of the underlying reasons for non-compliance of SA Punjabi PLDs with their psychiatric treatment.

In addition to my study capturing the family influence on the treatment of depression, it contributes new findings on how the family's efforts to support their loved one was influenced by their limited knowledge of depression and how their own mental health was impacted in the caregiver role. Some family members within my study acted as triggers for the onset and continuous battle with depression for PLDs, which is supported by the previous work of Grewal (2010). For example, intimate partner violence (IPV) and family violence was heavily prevalent in two PLDs and family conflict in one PLD, resulting in three of the six PLDs being significantly impacted by family actions. While this serendipitous finding was not the focus of my research, it does bring forward a critical element for healthcare providers to consider when supporting SA Punjabi PLDs. A cross-sectional survey examining IPV in SA women (n=188), sixteen and older, living in southern Ontario discovered that one in five reported experiencing IPV in the past year (Madden, Scott, Sholaupaur, & Bhandari, 2016). The findings indicated single women were more likely to experience IPV compared to married women (p=0.035). The data was collected at a Sister's festival taking place in southern Ontario, which was primarily attended by SA women. Although the survey was designed in English, Punjabi speaking social workers were present to support with translation. The response rate for this survey was low, 45% (188 of the accessible 420 women participated), which is comparable to other studies examining

IPV (Madden et al., 2016). The study speculated that participants may have under reported the occurrence of IPV since the data was collected in a public setting. Given these findings, it is important for mental health professionals to be cognizant about IPV when providing support to SA Punjabi PLDs.

My study reiterates existing evidence on the SA Punjabi community having allocentric views, in which family members have not only played a vital role in the onset and management of depression, but also influenced how PLDs accessed services. Collectively, these findings indicate the need for healthcare providers to first be mindful about the family influence on SA Punjabi PLDs and second for interventions to be structured in a manner that family members are a targeted group for mental health promotion initiatives as well as included within the individual care plans of PLDs (specifically with receiving mental health education). This gap would need to be addressed through approachability of mental health services.

Findings from the current project also disclosed that whether participants were receiving care from their family doctor, their local community mental health agency, or from a psychiatrist, they all displayed a similar knowledge gap regarding the causes and treatment of depression. This was especially concerning as these participants have been engaging with mental health services for some time. No literature was found that examined the knowledge level of Ontarians about depression. However, the Canadian Alliance on Mental Illnesses and Mental Health (CAMIAMH) (2007) completed a mental health literacy project, which identified the mental health literacy of Canadians with respects to prevalence, causes of, and treatment for mental illnesses. In general, most Canadians have sufficient mental health literacy about the prevalence and warning signs of mental disorders (Canadian Alliance on Mental Illnesses and Mental Health, 2007). In regards to the causes of mental illnesses, Canadians were more inclined to refer to psychosocial explanations for mental illnesses and acknowledged biological factors when the mental illnesses were severe. Canadians are also likely to recommend medical attention for mental health distress, however some expressed ambivalence about using psychiatric medications for treatment. They essentially preferred to have more treatment options provided to them (Canadian Alliance on Mental Illnesses and Mental Health, 2007). Comparable to the mental health literacy of Canadians captured by CAMIAMH's (2007) report, the SA Punjabi participants in my study had less knowledge about causes, warning signs, and treatment of depression. My research provides valuable insights on how this overall lack of knowledge about depression influences the actions taken by SA Punjabi PLDs to access mental health services, for example not complying with psychiatric treatment recommendations to take antidepressants. Ultimately, these findings suggest for mental health services to strengthen their approachability and appropriateness to meet the current gaps in accessibility.

The Impact of Stigma

Findings from this study support existing literature highlighting the significant mental health stigma within the SA community (Islam et al., 2014). The literature review identified that SA community members are pressured to keep their mental illness hidden as a means to protect their family from shame (Gilbert et al., 2004; Grewal, 2010), and their preference to independently manage their illness within the household (relating to how they conceptualize mental health) (Ekanayake et al., 2012; Kapadia et al., 2015; Tiwari & Wang, 2008). My study provides further evidence that SA families may keep their depression hidden to protect their family from the shame that would result in the community becoming aware of conflict within the home. The theme *my family didn't help-some made me sick* uncovers the issues of IPV and family violence, which as mentioned above were key factors in the onset of depression in two

PLDs and posed as barriers to access support. In addition to these views, the theme *we keep depression a secret* revealed new insights explaining SA Punjabi participants keep their mental illness hidden to avoid being blamed for the onset of the illness or from their misconception that speaking about one's depression could make depressive symptoms worse. The sub-themes *it's my fault* and *talking about depression will make matters worse* provides supporting evidence from my study. Again, these contextual findings provide an opportunity for mental health service providers to better understand the SA Punjabi community's cultural experiences of depression, which influences PLDs' decision of accessing mental health services. Having this foundational knowledge about the community can improve accessibility of mental health services for depression, where specific attempts need to be made to combat the cultural stigma within the SA Punjabi sub-group. For example, this stigma can be deconstructed by providing psychoeducation to the ethnic community about the etiology of depression. Essentially, these research results highlight how SA Punjabi participants encountered both public stigma and self-stigma.

Public stigma, which is largely endorsed by the broader general community (Corrigan & Watson, 2002), was substantiated within my study findings as most PLDs and family members disclosed the SA community's negative views on depression. This form of stigma was seen to innately influence self-stigma in PLDs and their family members. Self-stigma is when individuals internalize stigmatizing ideas about themselves and consequently lose their sense of self-worth and develop low self-esteem (Corrigan & Watson, 2002). This form of stigma was illustrated in my study when family members withdrew from their social circle due to their loved one's depression. PLDs and their family members not only kept their challenges with depression hidden at the onset of the illness, but were also continuously pressured by both forms of stigma to remain quiet about this taboo topic. This was especially concerning when family members were experiencing various levels of distress as a result of their increased roles and responsibilities as a caregiver (evident in the theme *My family also became "sick"*). Mental health service providers should recognize and address the impact of stigma on both PLDs and their family members, as my findings suggest the need to target the health of caregivers.

Mental health stigma is not only experienced by the SA community, but is a challenge for all individuals (Kirby, 2008). As a means to address stigma through a national strategy, The Mental Health Commission of Canada (MHCC) was created in 2007 and since then has been working on an anti-stigma campaign (Kirby, 2008). In order to successfully combat stigma, six key approaches are needed. They include *education, contact-based education*, *protest, legislative reform, advocacy, and stigma-self management* (Arboleda-Florez & Stuart, 2012; Corbiere, Samson, Villotti, & Pelletier, 2012; Corrigan & Watson, 2002). First, *education* involves providing the community with accurate knowledge and facts about mental illness, whereby the public's strongly held myths and stereotypes are challenged. Findings of my study support that stigma campaigns to increase knowledge about the SA Punjabi community's cultural conceptualizations and widespread understanding about depression (captured within the first two category of themes). Second, c*ontact-based education* targets negative attitudes about mental illness through direct interactions with impacted individuals (Arboleda-Florez & Stuart, 2012; Corbiere et al., 2012; Corrigan & Watson, 2002). Results from my study reveal a need for SA Punjabi community members to have personal awareness about other SA Punjabi individuals who have encountered depression, whereby they see exemplars of lived experience in their community. This would be especially beneficial, as my findings and the literature reviewed identified that formal education is likely insufficient on its own for the community to modify their conceptualizations of mental illness. Third, *protest* involves advocacy work to empower individuals impacted by mental illness and combat misrepresentations of mental illness within society, for example media (Arboleda-Florez & Stuart, 2012; Corbiere et al., 2012; Corrigan & Watson, 2002). For this strategy to be effective, there is a need to access common ethnic communication media (e.g. ethnic TV or radio shows) where this advocacy work would reach the SA Punjabi community and is delivered in the Punjabi language.

Fourth, *legislative reform* aims to protect people with a mental illness from discriminatory acts and ensure they receive accommodations with housing, employment, and education (Arboleda-Florez & Stuart, 2012). With relevance to my research findings, *legislative reform* would have permitted SA Punjabi participants to be more supported to receive short-term disability leave from work as well as receive accommodations at their place of employment. Fifth, *advocacy* aims to make mental health issues a national agenda item to ensure that individuals encountering mental health issues can practice their rights and freedoms. This specific strategy would place much needed pressure on the mental health system to strengthen advocacy efforts to bring mental health awareness within SA Punjabi communities. Sixth, *stigma self-management* empowers individuals to see themselves as more than their illness and redefine their own personal meanings (Arboleda-Florez & Stuart, 2012). As mentioned above, self-stigma plays a heavy role in the lives of SA Punjabi participants whereby they require strategies to see themselves as more than their own or their loved one's depression.

In summary, the first two categories of themes, *my experience of having depression* and *my family's experience of seeing depression in their loved one*, provided important contextual information about the SA Punjabi participants' conceptualizations and experiences of depression. The results revealed the considerable stigma experienced by SA Punjabi participants, which could influence their access to mental health services. Cultural stigma needs to be addressed by service providers to strengthen accessibility of mental health services.

Accessibility of Mental Health Services

The last category of themes (*my experience of accessing mental health services for depression*) adds new evidence to the existing mental health literature about the SA Punjabi community's experience of accessing the Canadian mental health system for depression support. Where previous literature has identified the factors preventing SA community members from accessing mental health experiences, my study provides insights on the SA Punjabi participants' experience within the Canadian mental health system. SA Punjabi participants from my study described encountering comparable barriers as they navigated through the mental health system. Barriers included distinct cultural beliefs about mental illness (Hussain & Cochrane, 2002), solely relying on family support (Ekanayake et al., 2012; Kapadia et al., 2015; Tiwari & Wang, 2008), acculturation (Lee et al., 2015; Roberts et al., 2016; Pilkington et al., 2012), lack of cultural safety exercised by healthcare professionals, and socioeconomic status (Lai & Surood, 2013; Lee et al., 2015; Neal et al., 2009). Level of education (Lee et al., 2015; Roberts et al., 2016; Pilkington et al., 2012) and racism (Lai & Surood, 2013; Lee et al., 2015; Neal et al., 2009) were the two factors identified in the background literature, which did not emerge in my study's findings to negatively influence the SA Punjabi community's experience of access for depression services. The demographic data of the participants in my study reveal a high level of education, which may indicate why low level of education was not a barrier to access mental health services. In terms of racism, as discussed earlier in the paper, the city of Brampton is heavily populated with SAs, the recruitment sites employed SA healthcare professionals and were heavily accessed by SA Punjabi clients, which may provide a rationale for the lack of racism experienced by this participant group when accessing mental health services for depression. Some of the perceived barriers to navigating the mental health system for depression reported by PLDs and their family members within my study links to the existing literature. My project findings, however, reveal rich insights of this community's access experience while receiving care for depression.

The major theme, *we didn't know where to get help,* addresses the approachability of mental health services, where the SA Punjabi community lacked knowledge of mental health issues and mental health supports. Similar research conducted on SA youth (13 to 24 years old) in the Region of Peel, Ontario discovered that their study participants (n=10) were only aware of a third of mental health resources presented to them despite being active service users (Islam, Multani, Hynie, Shakya, & Kwame, 2017). These results implied that those who do not seek out mental health support have even lower levels of knowledge. This qualitative research study used interviews, which although participants were provided the option of participating in Punjabi, English, Urdu, Hindi, and Bengali, had mainly English interviews with only one Bengali interview. The interview guide nor the interview data was not back-translated, which is a limitation of the study. The primary purpose of Islam and colleagues' research was to examine SA youth's understanding of mental health, their independent mental health concerns, their awareness of local mental health resources, and the major barriers they encounter when seeking care (Islam et al., 2017). Although both Islam and colleague's work and my study provide evidence on barriers within the mental health system, my study is unique as it explored the experience of a sub-group of adult SAs on accessing mental health services specifically for depression. My study also accounts for the unique family perspective. Existing research has already identified that there is an overall lack of mental health service use by ethnic minorities such as Chinese and South East Asian people in comparison to Caucasians (Tiwari & Wang, 2008). Results from my study reveal that lack of access to mental health services might in fact be due to a lack of awareness of existing mental health services. Grewal (2010) also found this among his Sikh Punjabi participant group in that only two of the six participants had knowledge about mental health services in Vancouver.

Along with lacking mental health service knowledge, the first two category of themes from my study provided contextual information on how SA Punjabi participants also lacked knowledge about depression as a mental illness, even while receiving care. Although, the MHCC (2012) has identified in their *Mental Health Strategy of Canada* the need to "improve mental health services and supports by and for immigrant, refugee, ethno-cultural, and racialized (IRER) groups" (p. 82), my study results emphasize the importance of this support to be provided in an ethnically appropriate manner, whereby the community's language and cultural needs are considered. This need is highlighted by PLDs within the study and their family members lacking full knowledge about depression, while receiving care.

Notably, the value of language was captured as study participants recounted the benefit of being able to communicate in their native language. This is supported by Hussain and Cochrane (2004) who argue that allowing SA participants to speak in their ethnic language leads to a better description of their mental health experience. Improved descriptions are especially important considering the Punjabi language does not have a specific word for depression (Karasz, 2005). Even participants within my study who spoke primarily in English used the Punjabi language to describe some components of their experience to the researcher. Of the eleven participants interviewed, four spoke entirely in Punjabi and three with a mix of Punjabi and English. In addition to addressing language needs, the lack of knowledge regarding mental health services needs to be addressed within an understanding of the existing mental health stigma influenced by SA Punjabi participants' personal, familial, and community views on depression. The recommended strategies to deconstruct stigma discussed above need to be implemented to strengthen public awareness for mental health services.

Secondly, the major themes addressing acceptability of mental health services (*my providers' lack of familiarity with my culture caused stress*) and appropriateness of mental health services (*knowing my culture will help you treat me better*) underline the effect that the absence of cultural expertise among mental health professionals had on PLDs accessing care. The impact on SA participants varied from disengagement with mental health treatment to complete withdrawal from services. Concern for improved cultural safety within mental health services was discussed within the MHCC's (2012) strategic plan calling for improved mental health services for immigrant, refugee, ethno-cultural, and racialized (IRER) groups. The Canadian Nurses Association (2010) defines cultural safety as "a process and an outcome whose goal is to promote greater equity. Cultural safety focuses on root causes of power imbalances and inequitable social relationships in health care. Cultural safety includes cultural awareness, cultural sensitivity, and cultural competence" (p.1). With respect to building cultural expertise, healthcare providers should refer to their regulatory body for ongoing education and training (Bhui et al., 2007). For example, the College of Nurses of Ontario (CNO) has published practice guidelines on *Culturally Sensitive Care* (2009) as well as *Therapeutic Nurse-Client Relationships* (2006). However, it appears that at an organizational level a more concise framework needs to be applied to enhance the cultural safety of mental health services. The literature provides a *model for cultural competence in mental health services* (Hernandez, Nesman, Acevedo-Polakovich, & Callejas, 2009) whereby the following four factors are highlighted: *community context, cultural characteristics, organizational infrastructure,* and *direct service support*.

First, *community context* requires mental health agencies to study their target population with collecting full background information about the community they are serving. Secondly, *cultural context* builds on *community context*, where mental health providers are equipped to respond to the cultural needs of their target population by having a foundational understanding regarding their cultural characteristics (Hernandez et al., 2009). These two elements of the model overlap with recent research by Saurman (2016) exploring how awareness as an element of accessibility needs to work in two ways. One is by ensuring that service recipients have knowledge about mental health services and the other is for service providers to have better insight of the cultural context of their target population to strengthen the delivery of their services. Knowledge gained about the contextual information provided about the SA Punjabi participants' conceptualizations and experiences with depression in my study can help to address the first two elements of this model, which in turn can strengthen the accessibility of mental health services for depression.

Furthermore, *organizational structure* is made of eight factors which include: *value, communication, community participation, governance, planning and evaluation, human resources, service array, and technical support*" (Hernandez et al., 2009, p. 1047, 1048). The first element, *values,* discusses the importance of mental health services to identify the value of culturally competent care in their mission and vision statements. The second, *communication,* focuses on information exchange within the agency, between agencies, and with the community served. In relation to the SA Punjabi community, this communication should take place in their ethnic language, Punjabi. The third, *community participation,* outlines how mental health agencies move beyond community outreach to include community members to provide input on the functionality of mental health services. The fourth, *governance,* has in place “policies, procedures, and goals” (Hernandez et al., 2009, p. 1047) to deliver culturally competent care. The fifth, *planning and evaluation,* completes a needs assessment of the community served as well as evaluates the agency’s own cultural competence levels. The sixth, *human resources,* ensures that the organization has skilled workers with the appropriate knowledge to deliver culturally competent care. The seventh, *service array,* discusses the importance of adapting the arrangement of services to meet the community’s need, for example language. The eighth, *technical support* puts measures in place to have specific supplies required by the community (Hernandez et al., 2009).

The last aspect of the *model of cultural competence* is *direct service support*. This component consists of “*availability, accessibility, and utilization* of mental health services” (p. 1048). The first two aspects of *availability* and *accessibility* are already captured within Leveseque et al.’s (2013) definition of accessibility. As per the *model of cultural competence in mental health services, availability* ensures that the scope and capability of services meets the community’s needs. *Accessibility* ensures that individuals are able to seamlessly navigate through the mental health system. Finally, *utilization* aims to ensure there is promotion of services and service use is tracked (Hernandez et al., 2009). Essentially, my findings of the SA Punjabi community’s experience with acceptability and approachability of mental health services proposes for a critical cultural lens to be applied to enhance mental health service accessibility for this ethnic community.

Finally, the major themes of availability and accommodation of mental health services (*I waited to get help*) and affordability of mental health services (*treating my depression cost me*) highlight the logistical aspects of mental health service accessibility, which delayed timely and affordable interventions for PLDs. The Canadian Community Health Survey (CCHS) (2012) identified that of the 33% of the population who experienced unmet needs upon accessing mental health services, 19% voiced the cause to be related to the healthcare system where immediate help was unavailable (Statistics Canada, 2013a). Within my research findings, the time trajectory of study participants receiving adequate mental health service support varied widely between one to ten years. Comparable to the Canadian population with mood and anxiety disorders, the majority of Canadians (61.6%) who are 18 years and older receive their diagnosis a year after the onset of symptoms. Thirty percent of the Canadian population receives this information between one to five years, who experience a moderate delay, and 31.6% who receives their diagnosis after five years and experience a long delay (Ricky, Siobhan, Nawaf, Elliot, 2017). Although the delay in receiving adequate mental health services is not unique to the SA community alone, what my study highlights is the time it took participants to connect with appropriate supports who provided culturally safe and appropriate mental health information and treatment.

Along with having varying delays on accessing services, socioeconomic factors such as the cost for counseling, the need to apply for short-term disability, and the substantial loss of income due to the time taken to improve depressive symptoms were captured within affordability of mental health services in my study. Socioeconomic status has already been identified within the background literature as a barrier to accessing mental health services (Lai & Surood, 2013; Lee et al., 2015; Neal et al., 2009). A global concern regarding the rise in depression has resulted in emerging research to examine strategies to combat the high demands on the mental health system. Reports from the literature explored the implementation of both educational and organizational interventions to support the management of depression within healthcare settings.

This literature included two systematic reviews: the first included mostly research from America by Gilbody, Whitty, Grimshaw, and Thomas (2003) (36 studies) and the second based in Germany by Lehmann, Domdey, and Bramesfield (2010) (10 studies). There was also a descriptive qualitative study, which branched off a randomized controlled trial in Germany (Gensichen et al., 2011). The systematic review by Gillbody et al. (2003) provided evidence from “randomized controlled trials, nonrandomized controlled trials, controlled before and after studies, and interrupted time series studies” (p. 3145). It showed that patient outcomes for depression management improved with implementing clinical education, nursing case management, and stronger communication between primary and secondary mental health service providers. In relation to nursing case management, which is an enhanced role of the nurse, the study conducted by Gensichen et al. (2011) interviewed 23 doctors and discussed the option of training health care assistants (HCA), where either the nurse or the HCA perform the interventions. Interventions performed in Gensichen and colleagues’ study (2011) included telephone contact with patients to monitor their symptoms and compliance with medications, and support for behaviour activation in addition to receiving their regular care from their doctor. The systematic review by Lehmann et al. (2010) also discussed the importance of case management that includes elements of psychotherapy.

Overall, there were numerous benefits of implementing these additional interventions to support patients with depression in the community setting (Genischen et al., 2011; Lehmann et al., 2010). First, the research study by Genischen and colleagues (2011) found the positive outcomes of enhanced nursing interventions to include: improved doctor patient relationships leading to thorough consultations, more comprehensive management of patient’s depression symptoms, and better-quality team work by healthcare professionals within the practice setting.

Further benefits identified by the systematic review conducted by Lehmann and colleagues (2010) study revealed increased patient satisfaction with mental health services, and better medication compliance as long as there was a longer follow-up period of the case management support. Although the literature did not examine the interventions on SA Punjabi specific sub-groups, the quality of the evidence is strong due to the large number of studies referenced in the systematic reviews and the intervention being studied in a UK setting where the healthcare system is similar to Canada. Ultimately, the findings of my research project, supported by emerging evidence from mental health literature, suggest the need for individual support for SA Punjabi PLDs accessing the mental health system for depression such as a case management program.

Transition Process

Meleis' (2000) transition theory (Figure 1) was a guiding lens that supported insights drawn from examining the experience of SA Punjabi participants on accessing mental health services for depression. The theory was specifically applied to examine how mental health services for depression act as societal transition condition for PLDs, as they encounter a health transition of depression. Transition conditions are examined through identifying their facilitating and inhibiting elements.

The current study's findings, specifically in the last category of themes [*my experience of accessing mental health services for depression*], highlight accessibility barriers that existed for SA Punjabi participants as they sought support for their depression. Therefore, this discussion emphasizes the current inhibiting factors of accessibility of mental health service for depression explored within this study (family doctors, community mental health agencies, and community psychiatrists). These inhibiting elements need to be addressed to support SA Punjabi PLDs transition forward with managing depression. To begin with, approachability of mental health services highlights the existing knowledge gaps within study participants, whereby they lack an understanding of depression and are unaware of local mental health services. The current findings suggest stronger mental health outreach needs to take place by mental health services for the SA Punjabi community combating depression, as the majority of participants in this study have gaps in their knowledge about depression and available mental health supports. Those conducting these outreach attempts also need to be familiar with the SA Punjabi community's cultural conceptualizations and experiences of depression to ensure the outreach is conducted in a manner that resonates with the cultural views of this community. As there is cultural overlap between SA sub-groups, a similar gap may exist within the larger SA community.

Furthermore, examining the acceptability and appropriateness of mental health services for depression revealed how the absence of cultural expertise in mental health service providers working with SA Punjabi participants negatively impacted their transition to manage their depression. This lack of cultural safety resulted in PLDs becoming withdrawn and even permanently disengaging from some mental health service providers, which delayed timely intervention for the management of their symptoms. In addition to these inhibiting elements of mental health services impacting PLDs, the effect was also observed in family member's health as captured within the theme *my family also become "sick"*. To facilitate PLDs and their family members to transition with managing mental health symptoms of depression, healthcare providers need to engage in culturally safe practices to enhance the acceptability and appropriateness of mental health services for the Punjabi SAs.

Finally, examining the availability and accommodation and affordability of mental health services permitted a review of the logistical aspects of mental health service accessibility, where time and cost acted as inhibitors for PLDs to transition forward with managing their depression. Exploring availability and accommodation of mental health services for depression revealed how PLDs had delayed intervention to culturally appropriate mental health care. This delay contributed to PLDs and family members independently managing worsening symptoms of depression, impacting the health of PLD and their caregivers. Investigating the affordability of mental health services for depression showed how cost of treatment (e.g. counselling), employment disability, and the associated loss of household income acted as financial barriers for PLDs to manage their mental illness. Although these barriers are not unique to the SA Punjabi community, what this study revealed was the additional time and cost for SA Punjabi PLDs to receive culturally tailored mental health services for depression. Availability and accommodation, and affordability are essential elements of mental health service accessibility that need to be strengthened to support PLDs and their family members in managing depression.

Summary of Discussion

By integrating the study results with the background literature, applying new evidence to the emerging findings, and conceptualizing the transition process of PLDs through Meleis' (2000) theory, recommendations can be drawn to further support the SA Punjabi community as they access mental health services for depression. In order to critically examine and make recommendations for enhancing the accessibility of mental health services, it was important to capture the unique conceptualizations and experiences of having depression by SA Punjabi participants. Ultimately, the subsequent recommendations aim to enhance the transition process of PLDs with addressing current inhibiting factors in mental health services for depression.

CHAPTER FIVE: CONCLUSION

The current study is the first of its kind examining the SA Punjabi community's experience of accessing mental health services for depression in Canada and adds valuable literature on the experiences of this sub-group population. As the study findings have indicated, the SA Punjabi participants' unique cultural conceptualizations have provided a rich understanding of their experience of accessing mental health services for depression. The distinct contextual findings of the SA Punjabi community can be applied to make key recommendations to better inform mental health nursing practice, education, policy, and research in relation to the accessibility of mental health services for depression. Prior to highlighting these insights, the study's strengths and limitations will be discussed. This section will conclude with suggested strategies for knowledge translation and exchange.

Study Strengths

This research study has several strengths, which contributes new findings to SA mental health literature. First, with limited mental health literature on the SA Punjabi community residing within Canada, this qualitative study contributes valuable in-depth evidence on the illness experiences, as well as the experiences of accessing mental health services for depression. Furthermore, the SA Punjabi background of the researcher permitted this study to capture detailed accounts of the SA Punjabi participants' understanding of depression and their journeys of accessing mental health services for depression in both English and Punjabi. As previously discussed, there have been limited research opportunities for the SA community to share their mental health experiences in their ethnic language. Allowing participants to describe their conceptualizations and experiences of depression along with their experiences of accessing mental health services in Punjabi was especially valuable for this research study, as the Punjabi vocabulary does not have an exact word for depression (Karasz, 2005). The SA Punjabi background of the researcher and the transcriptionist also permitted for two bilingual individuals to complete forward and back translation to strengthen the accuracy of the translated interviews (Regmi et al., 2010; Xian, 2008). Notably, the interpretive description study design created an avenue for the primary researcher to apply her own knowledge as a practicing mental health nurse and identifying with the SA Punjabi background. This was also a strength in participant recruitment, data collection, and data analysis. Ongoing reflexive practice and continuous engagement with the research supervisor and committee members minimized the risk of bias. In addition, with the research aiming to gather the experience of the individual, another strength of the study design was speaking to the family members of PLDs. Along with family members providing an added perspective on the experience of PLDs accessing mental health services for depression, obtaining the family members' viewpoints was an important cultural consideration, as SA communities are known to be allocentric (Pilkington et al., 2012). Information from a diverse set of mental health services (family doctor, community mental health agency, and psychiatrist) that were accessed by the participants of the study also facilitated a rich exploration of accessibility. Finally, with the recruitment strategy aiming to speak with PLDs who had already accessed mental health services for support, the interviews allowed for a reflective perspective of study participants first encountering their symptoms of depression and subsequently, recalling their experience of navigating through the mental health system.

Study Limitations

Along with the strengths of this research project, there are important limitations to consider. First, the literature review did not examine grey literature. Second, the initial aim of the study was to recruit 16 participants allowing for 8 PLDs and at least on of their family members.

However recruitment was challenging for this minority population. The final sample was 12 involving 6 families. With recruitment efforts starting in September of 2017, it took until December of 2017 to reach 12 interviews. One participant also interviewed as both a PLD and a family member. The difficulty with recruiting ethnic minority populations is discussed earlier in this paper. Third, the interviews were dominated by female participants, with a total of 9 females and 3 males (PLDs: five female, one; family members: four females, two male), resulting in less evidence to support the SA Punjabi male experience. The CCHS showed in 2012, females had a higher rate of depression (5.8%) compared to males (3.6%) reported in the last 12 months (Statistics Canada, 2013a). Finally, the last unforeseen challenge was the difficulty in acquiring community space to conduct the interviews as well as, participants' preference for interviews to take place at home. Although the first interview was successfully conducted in a community space, the participant had expressed frustrations with having to meet the researcher in the community. As a result, the follow-up interview with the participant's family member was conducted within their home. Most participants requested the interviews to take place in their home, which was most convenient to them. To safeguard for privacy and permit for an open dialogue, the researcher conducted the interviews in private. This was possible in all except one case, where the participant and her daughter stated they could only meet with the researcher at a coffee shop together. Within this scenario, the data collection was influenced by the presence of a third party and the researcher had limited time to speak with the family member due to time constraints.

Implications and Recommendations

While considering the strengths and limitations of this research study, the key findings contribute valuable insights for clinical nursing practice, education, policy, and research within the mental health field specific to the accessibility of mental health services for depression. These recommendations arise from the insights provided directly from study participants, which are illustrated within study findings and the discussion sections of this paper.

Clinical nursing practice.

- Mental health services need to increase culturally tailored mental health education for the SA Punjabi community to combat the impact of their culture's mental health stigma. These efforts should apply *contact-based education* (Arboleda-Florez & Stuart, 2012; Corbiere et al., 2012; Corrigan, 2002) and empower SA Punjabi community members to facilitate the deconstruction of their community's strongly held negative views on mental health. These initiatives could take place, for example, by hosting community workshops.
- Mental health agencies should, at minimum, implement two key elements of *the model of cultural competence in mental health services*, which are *community context* and *cultural characteristics* (Hernandez et al., 2009). The application of these elements could result in increasing culturally tailored mental health education and support for the SA Punjabi community.
- Mental health awareness for the SA Punjabi community should address this community's current conceptualizations of depression with increased efforts to educate this population about the biopsychosocial model of depression (Austin et al., 2015). A specific target group for this education is family members of PLDs who greatly influence access to services.
- Mental health awareness initiatives should discuss intimate partner violence (IPV) and family violence and its influence on depression.

- Educational initiatives should focus on increasing the SA Punjabi community's knowledge on how to access mental health services for depression.
- Mental health awareness initiatives should increase the SA Punjabi community's understanding of how counselling works, so PLDs can better engage in this treatment modality.
- Mental health community awareness campaigns should take advantage of common communication media used within this ethnic group. These include, but are not limited to, faith institutes, ethnic radio stations, TV shows, newspapers, online forums, and other places of community gathering.
- Mental health services and educational initiatives should increase the use of the Punjabi language to effectively communicate with the SA Punjabi community.
- A nurse case management program should be created for SA Punjabi PLDs who access the mental health system for support.

Clinically focused education.

- There should be an increase in cultural training for mental health professionals on how to engage with the SA Punjabi community. This form of training could enhance cultural safety within mental health practice settings and increase compliance with treatment.
- Targeted educational interventions should be provided to mental health professionals on the SA Punjabi community's perceptions of mental illness.
    - *Contact-based educational* training should be provided to mental health professionals to build their cultural competency of working with the SA Punjabi community.

  - Educational interventions should promote increased awareness for healthcare professions on the issue of intimate partner violence (IPV) and family violence, as uncovered through this study.

Mental health policy.

- The *model of cultural competence in mental health services* (Hernandez et al., 2009) should be mandated by mental health service providers to enhance cultural safety of mental health agencies.
  - The *organizational structure* could be strengthened through the *human resources* strategy as per the model, ensuring that more SA mental health professionals are recruited to work with the SA Punjabi community.

Mental health nursing research.

- Research should be conducted examining the impact of a culturally tailored mental health-training program to enhance cultural safety of professionals to work with the SA Punjabi community.
- The benefit of a nurse case management program for the SA Punjabi community should be examined.
- Mental health research that explores other sub-groups of the larger SA community and other mental health illnesses in order to build literature that captures their unique experiences should be conducted.

Knowledge Translation and Exchange

With limited evidence on the SA Punjabi community within the field of mental health, it is very important to this researcher to take part in knowledge translation and exchange strategies that not only share findings with mental health professionals and/or agencies but also, the SA Punjabi community at large.

To reach mental health professionals, knowledge translation and exchange strategies include sharing the findings of this research project within professional journals, and at professional conferences. In addition, strategies include reaching out to universities and colleges training individuals to work in the field of mental health, and disseminating study findings to regulatory bodies for various mental health professionals (ex: physicians, nurses, social workers, occupational therapists, vocational therapists, and art therapists).

To reach mental health agencies, the researcher plans to contact mental health services in the Region of Peel to disseminate research findings and advocate for these services to review the cultural safety of their mental health services for the SA Punjabi community. These agencies include but are not limited to Canadian Mental Health Association, Services and Housing in the Province, Punjabi Community Health Services, and India Rainbow. In addition to reaching out to these mental health agencies, the researcher will also approach primary care practices and community psychiatrists. The aim is to advocate for mental health education days to explore mental health within diverse communities.

Finally, to reach the SA Punjabi community, the researcher plans to take research findings to various communication avenues such as SA Punjabi radio stations, TV shows, newspapers, faith institutes, and other places of community gathering to share research results. The researcher also aspires to create short films on the findings of this project, which will permit key messages of the research to reach the SA Punjabi community in a creative manner. Storytelling is large part of the SA Punjabi community and essentially these short films can be a valuable resource for educational purposes.

Summary of Conclusions

To conclude, this study contributed valuable research to the field of mental health nursing within the SA Punjabi community residing in a Canadian context. Although there are limitations to this research project, there are notable strengths with the quality of evidence generated. Therefore, the collective evidence of the findings with the emerging discussion highlights key recommendations for mental health nursing practice, education, policy, and research in the field of mental health specific to accessibility of services for depression. The success of these recommendations will be facilitated through the researcher's determination to take part in knowledge translation and exchange strategies for mental health professionals and/or agencies, as well as, the SA Punjabi community at large. Some of these study findings may overlap with the larger SA Canadian community's experience of accessing mental health services for depression. However, the purpose of this research was to examine the SA Punjabi community's experience. It is hoped that this evidence strengthens how the SA Punjabi community is supported for their depression by existing mental health services.

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APPENDICES

Appendix A: Literature Search Summary

Appendix B: Hamilton Depression Rating Scale

Appendix C: Study Flyer

Appendix D: Study Timeline

Appendix E: Demographic Questionnaire

Appendix F: Interview Guide Participant with Depression

Appendix G: Interview Guide Family Member of Participant with Depression

Appendix H: Confidentiality Form for Transcriptionist

Appendix I: Data Analysis- Coding

Appendix J: Ethics Approval

Appendix K: Information and Consent Forms for Participants with Depression

Appendix L: Information and Consent Forms for Family Members of Patients with Depression

Appendix M: Script for Family Doctors, Psychiatrists, and Community Mental Health Agency Worker

Appendix N: Telephone Script for Participants Referred by a Family Doctor, Psychiatrist, or Community Mental Health Agency Worker

Appendix O: The Researcher's Insider View on the SA Community

All forms were made available in Punjabi & English for study participants, although the appendix only shares the English version.

Appendix A:
Literature Search Summary

All databases were searched with the combination of key words: south asian*, depression, mental health, and mental illness. There was an overlap of the articles with the different databases. 29 articles were selected for the literature review. The search took place between September 2015 to July 2018.

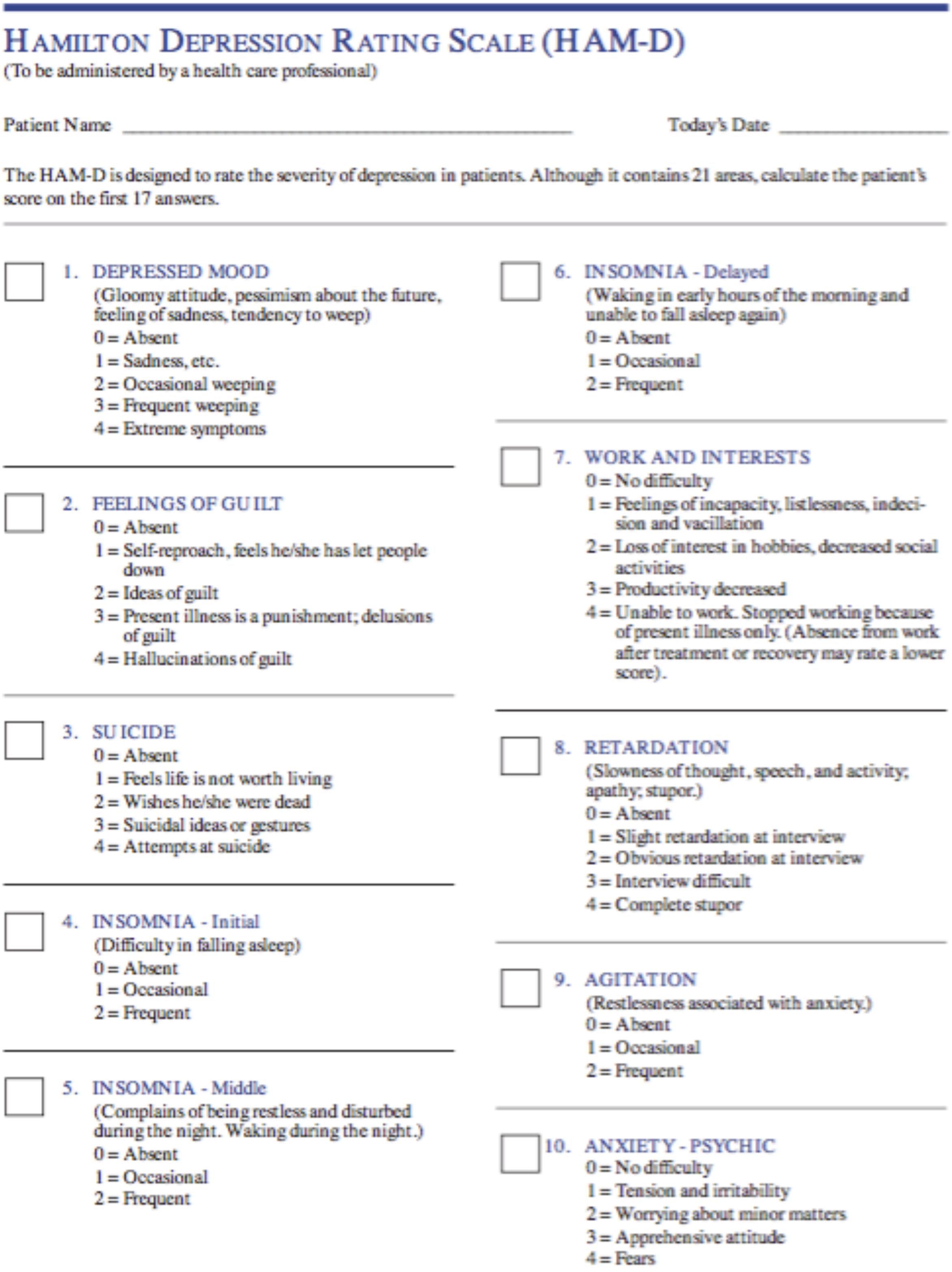
Database	Total Number of Hits	Articles Selected
CINHAL		
south asian*, depression, and mental health	17	**6**
south asian*, depression, and mental illness	8	
south asian*, and depression	54	
south asian*, and mental illness	27	
south asian*, and mental health	62	
EMBASE (Ovid)		
south asian*, depression, and mental health	7	**9**
south asian*, depression, and mental illness	42	
south asian*, and depression	124	
south asian*, and mental illness	41	
south asian*, and mental health	209	
Google® Scholar		
south asian*, depression, and mental health	259,000	**22**
south asian*, depression, and mental illness	133,000	
south asian*, and depression	660,000	
south asian*, and mental illness	239,000	
south asian*, and mental health	1,660,000	
PsychINFO (Ovid)		
south asian*, depression, and mental health	134	**2**
south asian*, depression, and mental illness	22	
south asian*, and depression	391	
south asian*, and mental illness	78	
south asian*, and mental health	492	
PubMed		
south asian*, depression, and mental health	53	**5**

south asian*, depression, and mental illness	61	
PubMed		
south asian*, and depression	127	
south asian*, and mental illness	220	
south asian*, and mental health	227	

Exclusion Criteria
Articles based outside of Canada, the UK, and the US.
Articles exploring mental health and/or depression outside of the South Asian community.
Grey literature.

Research Design (n=29)	**Number of Articles**
Quantitative	13
Qualitative	14
Mixed	2

Appendix B:
Hamilton Depression Rating Scale (HAM-D) (Hamilton, 1960)



HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name ____________________ Today's Date ____________

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, calculate the patient's score on the first 17 answers.

☐ 1. DEPRESSED MOOD
(Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
0 = Absent
1 = Sadness, etc.
2 = Occasional weeping
3 = Frequent weeping
4 = Extreme symptoms

☐ 2. FEELINGS OF GUILT
0 = Absent
1 = Self-reproach, feels he/she has let people down
2 = Ideas of guilt
3 = Present illness is a punishment; delusions of guilt
4 = Hallucinations of guilt

☐ 3. SUICIDE
0 = Absent
1 = Feels life is not worth living
2 = Wishes he/she were dead
3 = Suicidal ideas or gestures
4 = Attempts at suicide

☐ 4. INSOMNIA - Initial
(Difficulty in falling asleep)
0 = Absent
1 = Occasional
2 = Frequent

☐ 5. INSOMNIA - Middle
(Complains of being restless and disturbed during the night. Waking during the night.)
0 = Absent
1 = Occasional
2 = Frequent

☐ 6. INSOMNIA - Delayed
(Waking in early hours of the morning and unable to fall asleep again)
0 = Absent
1 = Occasional
2 = Frequent

☐ 7. WORK AND INTERESTS
0 = No difficulty
1 = Feelings of incapacity, listlessness, indecision and vacillation
2 = Loss of interest in hobbies, decreased social activities
3 = Productivity decreased
4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

☐ 8. RETARDATION
(Slowness of thought, speech, and activity; apathy; stupor.)
0 = Absent
1 = Slight retardation at interview
2 = Obvious retardation at interview
3 = Interview difficult
4 = Complete stupor

☐ 9. AGITATION
(Restlessness associated with anxiety.)
0 = Absent
1 = Occasional
2 = Frequent

☐ 10. ANXIETY - PSYCHIC
0 = No difficulty
1 = Tension and irritability
2 = Worrying about minor matters
3 = Apprehensive attitude
4 = Fears

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

☐ 11. **ANXIETY - SOMATIC**

Gastrointestinal, indigestion
Cardiovascular, palpitation, Headaches
Respiratory, Genito-urinary, etc.

- 0 = Absent
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Incapacitating

☐ 12. **SOMATIC SYMPTOMS - GASTROINTESTINAL**

(Loss of appetite , heavy feeling in abdomen; constipation)

- 0 = Absent
- 1 = Mild
- 2 = Severe

☐ 13. **SOMATIC SYMPTOMS - GENERAL**

(Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)

- 0 = Absent
- 1 = Mild
- 2 = Severe

☐ 14. **GENITAL SYMPTOMS**

(Loss of libido, menstrual disturbances)

- 0 = Absent
- 1 = Mild
- 2 = Severe

☐ 15. **HYPOCHONDRIASIS**

- 0 = Not present
- 1 = Self-absorption (bodily)
- 2 = Preoccupation with health
- 3 = Querulous attitude
- 4 = Hypochondriacal delusions

☐ 16. **WEIGHT LOSS**

- 0 = No weight loss
- 1 = Slight
- 2 = Obvious or severe

☐ 17. **INSIGHT**

(Insight must be interpreted in terms of patient's understanding and background.)

- 0 = No loss
- 1 = Partial or doubtfull loss
- 2 = Loss of insight

TOTAL ITEMS 1 TO 17: ____________

- 0 - 7 = Normal
- 8 - 13 = Mild Depression
- 14-18 = Moderate Depression
- 19 - 22 = Severe Depression
- ≥ 23 = Very Severe Depression

☐ 18. **DIURNAL VARIATION**

(Symptoms worse in morning or evening. Note which it is.)

- 0 = No variation
- 1 = Mild variation; AM (   ) PM (   )
- 2 = Severe variation; AM (   ) PM (   )

☐ 19. **DEPERSONALIZATION AND DEREALIZATION**

(feelings of unreality, nihilistic ideas)

- 0 = Absent
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Incapacitating

☐ 20. **PARANOID SYMPTOMS**

(Not with a depressive quality)

- 0 = None
- 1 = Suspicious
- 2 = Ideas of reference
- 3 = Delusions of reference and persecution
- 4 = Hallucinations, persecutory

☐ 21. **OBSESSIONAL SYMPTOMS**

(Obsessive thoughts and compulsions against which the patient struggles)

- 0 = Absent
- 1 = Mild
- 2 = Severe

Appendix C: Study Flyer


McMaster University
School of Nursing

GETTING HELP FOR DEPRESSION? SHARE YOUR PUNJABI EXPERIENCE

ਕੀ ਤੁਸੀ ਕੀ ਤੁਸੀ ਡਡਿਪਰੈਸ਼ਨ ਲਈ ਮਦਦ ਲੇ ਰਹੇ ਹੋ? ਆਪਣਾ ਪੰਜਾਬੀ ਤਜਰਬਾ

- Are you 19+, Punjabi, and a Brampton resident?
- Have you been living in Canada for over 5 years?
- Have you or your family member received help for depression by a family doctor, psychiatrist, or community mental health agency?

I WOULD LIKE TO SPEAK WITH YOU!

You will be compensated for your time with a $25 gift card to a grocery store.

Maneet Chahal
Masters of Nursing Student
McMaster University, Hamilton ON
Email: chahalm@mcmaster.ca
Telephone: 647-309-8389

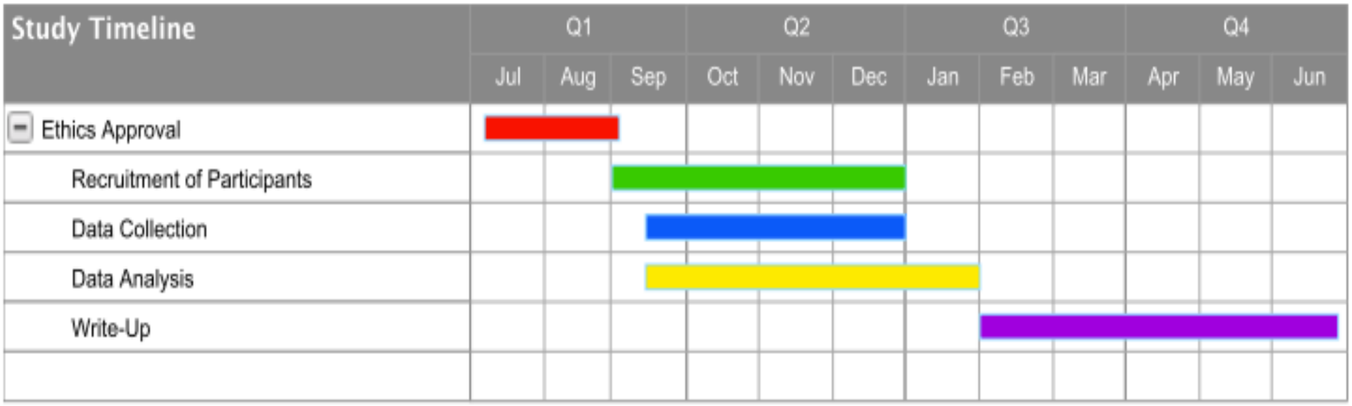
- ਕੀ ਤੁਸੀ ੧੯ ਸਾਲ ਜਾ ਵੱਧ ਉਮਰ ਦੇ, ਪੰਜਾਬੀ ਅਤੇ ਬਰੈਂਪਟਨ ਦੇ ਨਿਵਾਸੀ ਹੋ?
- ਕੀ ਤੁਸੀ ਕੈਨੇਡਾ ਵਿੱਚ ੫ ਸਾਲ ਜਾ ਵੱਧ ਰਹੇ ਹੋ?
- ਕੀ ਤੁਸੀ ਜਾ ਤੁਹਾਡੇ ਪਰਿਵਾਰ ਵਿੱਚ ਕਿਸੀ ਨੇ ਪਰਿਵਾਰ ਦੇ ਡਾਕਟਰ, ਸਾਈਕਾਏਟ੍ ਸਟ , ਜਾ ਕਮਿਊਨਿਟੀ ਮਾਨਸਿਕ ਸਿਹਤ ਇਜੰਸੀ ਦੁਆਰਾ ਡਿਪਰੈਸ਼ਨ ਲਈ ਪ੍ਰਾਪਤ ਕੀਤੀ ਹੈ?

ਮੈਂ ਤੁਹਾਡੇ ਨਾਲ ਗੱਲ ਕਰਨਾ ਚਾਹਾਂਗੀ !

ਤੁਹਾਡੇ ਸਮੇਂ ਲਈ ਤੁਹਾਨੂੰ $੨੫ ਦਾ ਗਰੋਸਰੀ ਸਟੋਰ ਦਾ ਗਿਫਟ ਕਾਰਡ ਦਿੱਤਾ ਜਾਵੇਗਾ !

Version Code: July 24th 2017 Page 1/1

Appendix D: Study Timeline



Study Timeline	Q1			Q2			Q3			Q4		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
⊟ Ethics Approval	🟥	🟥										
Recruitment of Participants			🟩	🟩	🟩	🟩						
Data Collection			🟦	🟦	🟦	🟦						
Data Analysis			🟨	🟨	🟨	🟨	🟨					
Write-Up								🟪	🟪	🟪	🟪	🟪

Appendix E: Demographic Questionnaire

McMaster University

School of Nursing

Participant Pseudonym or Number: __________________

1. Participant with depression ___
   OR
   Participant supporting a family member with depression ___
2. Age: ____
3. Gender: ____
4. Highest level of Education:
   - ☐ No Schooling
   - ☐ Elementary school (8th grade / less)
   - ☐ No high school diploma
   - ☐ High school diploma (or GED)
   - ☐ Registered Apprenticeship or other trades certificate or diploma
   - ☐ College, GCEP, or other non-university certificate or diploma
   - ☐ Bachelor’s degree
   - ☐ Master’s degree
   - ☐ Doctorate degree
5. Number of years in Canada: ____
6. Number of years experiencing depression (individual or family member): ____

McMaster University

School of Nursing

Appendix F: Interview Guide
Participant with Depression

Thank you for giving me your valuable time and agreeing to speak with me today about your experience with depression. I would first like to ensure you that anything that is discussed today will remain confidential, unless there are any safety concerns. Before we begin the interview, I will be going over the information and consent forms, which will provide you details about the study, your role as a voluntary participant, review confidentiality, highlight any risks, as well as measures that are in place to support you.

Do you have any questions before we review the forms?

Review Information and Consent Forms

Introduction

1. Thank you again for taking the time to meet with me today. I want to first start by getting to know you better.
    a. Describe your family to me, who's in your family household?
    b. Tell me about how you spend your day.
       School
       Work
    c. Tell me about your interest or hobbies. How you enjoy spending your time?

Perceptions

Thank you for sharing those details about your life. I wanted to now take the time to learn more about your health, in particular your experience with depression. Please take your time to answer any of the questions and at any point if you would like to take a break, skip a question, or stop the interview, please let me know. There are no right or wrong answers. I am interested in your experiences and what you think about those experiences.

2. So I would first like to begin with asking when did you first notice a change in your mental health, where you started feeling different/depressed? Describe that period of time for me?
3. Tell me how did you feel during that time?
4. Describe your understanding of depression at that time.
   The symptoms
   The causes
   The treatment
5. Tell me how about your immediate family. How did they respond?
6. Tell me about your relatives and friends. How did they respond?
7. During the time you were feeling unwell, how did others around you react? Think about your family, your friends or others in social situations.
8. Tell me about your own reactions to everything that was going on around you.

First member checkpoint. Summarize what has been communicated so far, without making any interpretations

How are you feeling so far? Can we continue?

Access

9. With all these changes going on, when did you realize that you needed help? Describe your feelings during that time for me.

10. How did you go about getting help?
   - **a.** *How were your family or friends involved?*
   - **b.** *How was anyone else from your community involved?*
   - **c.** *Did you talk to your doctor? If so, what was that experience like?*
   - **d.** *How did you come to know, if at all, about mental health services?*

11. Tell me about your experience of getting help (from your doctor, psychiatrist, or a mental health agency)?
   - **a.** *How long did it take?*
   - **b.** *Tell me how you managed while you waited for help?*
   - **c.** *Describe the help that you received?*
   - **d.** *How did you feel about the diagnosis and treatment?*
   - **e.** *How did your family feel?*
   - **f.** *How long have you been receiving professional help?*
   - **g.** *How easy or difficult was it to get help? Tell me about that.*
   - **h.** *How satisfied were you with the help you received? Tell me about that.*
   - **i.** *How satisfied was your family with the help you received? Tell me about that.*
   - **j.** *What difference did this help make in your health, if at all?*

How are you feeling so far? Can we continue?

12. Tell me about what it was like asking for professional help?
   - **a.** *Was there anything that got in the way of getting help?*
   - **b.** *Did you find anything got in the way of continuing with the help that was available? Anything to do with your culture?*
   - **c.** *What were your family's thoughts?*

13. Tell me from your own experience, are there ways to improve the help that you received for depression?
   - **a.** *What is working well and not very well?*
   - **b.** *What needs to change?*

14. Is there anything else you want to tell me?

15. Is there anything you thought I would ask you, but I didn't?

Second member checkpoint. Summarize second part of the interview.

At this point, I would like to ask how are you feeling? If this conversation made you feel uncomfortable at any point or you feel that you need further support, could you please let me know. Thank you again for giving me your valuable time today.

Appendix G: Interview Guide
Family Member of Participant with Depression

Thank you for giving me your valuable time and agreeing to speak with me today about your family's experience with supporting a loved one with depression. I would first like to ensure you that anything that is discussed today will remain confidential, unless there are any safety concerns. Before we begin the interview, I will be going over the information and consent forms, which will provide you details about the study, your role as a voluntary participant, review confidentiality, highlight any risks, as well as measures that are in place to support you.

Do you have any questions before we review the forms?

Review Information and Consent Forms

Introduction

1. Thank you again for taking the time to meet with me today. I want to first start by getting to know you better.
    a. Describe your family to me, who's in your family household?
    b. Tell me about how you spend your day.
       School
       Work
    c. Tell me about your interest or hobbies. How you enjoy spending your time?

Perceptions

Thank you for sharing those details about your life. I wanted to now take the time to learn more about your family's experience with depression. Please take your time to answer any of the questions and at any point if you would like to take a break, skip a question, or stop the interview, please let me know. There are no right or wrong answers. I am interested in your experiences and what you think about those experiences.

2. So I would first like to begin with asking when did you first notice a change in your family member's mental health, where they started feeling different/depressed? Describe that period of time for me.
3. Describe your understanding of depression at that time.
   The symptoms
   The causes
   The treatment
4. Tell me how about your family member (the patient). How did he/she respond?
5. Tell me about your relatives and friends. How did they respond?
6. During the time you were feeling unwell, how did others around you react? Think about your family, your friends or others in social situations.
7. Tell me about your own reactions to everything that was going on around you.

First member checkpoint. Summarize what has been communicated so far, without making any interpretations

How are you feeling so far? Can we continue?

Access

8. With all these changes going on, when did you realize that you needed to get help for your loved one? Describe your feelings as well as your family member's feelings during that time for me.
9. How did you go about getting help?
   a. *How were your family or friends involved?*
   b. *How was anyone else from your community involved?*
   c. *Did you talk to your doctor? If so, what was that experience like?*
   d. *How did you come to know, if at all, about mental health services?*
10. Tell me about your family's experience of getting help (from your doctor, psychiatrist, or a mental health agency)?
   a. *How long did it take?*
   b. *Tell me how your family member managed while he/she waited for help?*
   c. *Describe the help that they received?*
   d. *How did your family member feel about the diagnosis and treatment?*
   e. *How did you and the rest of your family feel?*
   f. *How long has your family member been receiving professional help?*
   g. *How easy or difficult was it to get help? Tell me about that.*
   h. *How satisfied has your family member been with the help they received? Tell me about that.*
   i. *How satisfied have you and your family been with the help you received? Tell me about that.*
   j. *What difference did this help make in your family member's health, if at all?*

How are you feeling so far? Can we continue?

11. Tell me about what it was like asking for your family member to get professional help?
   a. *Was there anything that got in the way of getting help?*
   b. *Did you find anything got in the way of continuing with the help that was available for your family member? Anything to do with your culture?*
   c. *What were your family member's thoughts?*
12. Tell me from your own experience, are there ways to improve the help that you received for depression?
   a. *What is working well and not very well?*
   b. *What needs to change?*
13. Is there anything else you want to tell me?
14. Is there anything you thought I would ask you, but I didn't?

Second member checkpoint. Summarize second part of the interview.

At this point, I would like to ask how are you feeling? If this conversation made you feel uncomfortable at any point or you feel that you need further support, could you please let me know. Thank you again for giving me your valuable time today.

Appendix H:
Confidentiality Agreement for Transcriptionist/Translator

I, ________________________________, agree to maintain confidentiality for the participants of this study. During the time that I am transcribing or translating interviews, I will ensure the documents are kept private, confidential, and password protected. Once I have completed my role as a transcriptionist/translator, I will destroy all documents.

Signature: __________________________
Date: __________________________

Principal Investigator Signature: ________________________
Date: __________________________

Appendix I: Data Analysis – Coding

Step 1

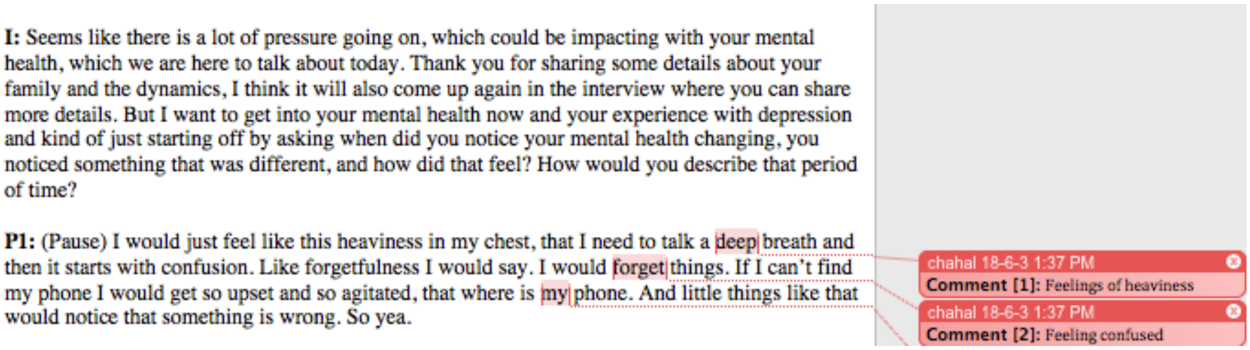
Researcher engaged in *comprehending* and *synthesizing* of Morse's cognitive processing, which Thorne (2016; 2008) recommends as per her data analysis strategy for interpretive description. The initial process of *comprehending* took place by replaying the audio recording of the interviews and making marginal jot notes. From doing this initial process of *comprehending* the researcher came up with the following categories from the marginal notes:

NVIVO Categories for Interview with Kiran.

- Access
- Awareness
- Family
- Support
- Symptoms
- Values

Step 2

The research supervisor provided feedback for the primary researcher to implement line-by-line coding to become further immersed with the data and facilitate the process of *comprehending* and *synthesizing.* This strategy allowed the researcher to identify the various categories that were emerging from the data and move in an iterative process to the larger themes. Here is a short excerpt of the interview with Kiran (P1) with line-by-line coding:



I: Seems like there is a lot of pressure going on, which could be impacting with your mental health, which we are here to talk about today. Thank you for sharing some details about your family and the dynamics, I think it will also come up again in the interview where you can share more details. But I want to get into your mental health now and your experience with depression and kind of just starting off by asking when did you notice your mental health changing, you noticed something that was different, and how did that feel? How would you describe that period of time?

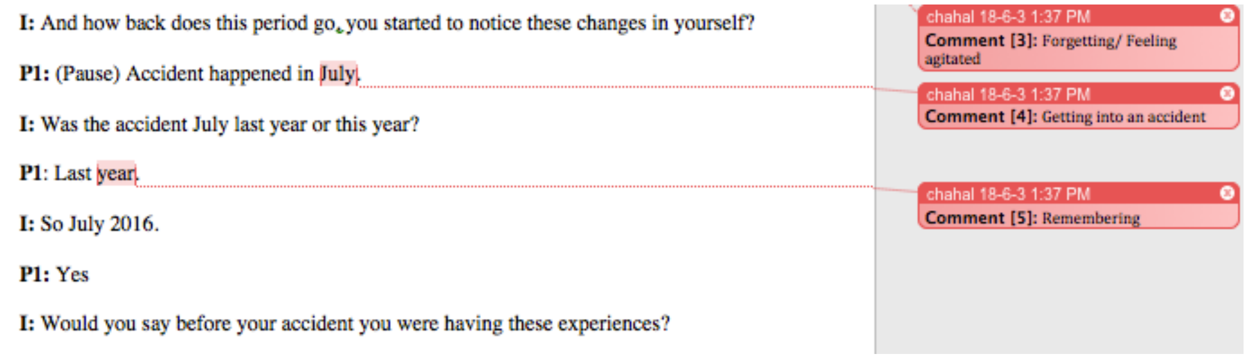
P1: (Pause) I would just feel like this heaviness in my chest, that I need to talk a deep breath and then it starts with confusion. Like forgetfulness I would say. I would forget things. If I can't find my phone I would get so upset and so agitated, that where is my phone. And little things like that would notice that something is wrong. So yea.

chahal 18-6-3 1:37 PM

Comment [1]: Feelings of heaviness

chahal 18-6-3 1:37 PM

Comment [2]: Feeling confused



I: And how back does this period go, you started to notice these changes in yourself?

P1: (Pause) Accident happened in July.

I: Was the accident July last year or this year?

P1: Last year.

I: So July 2016.

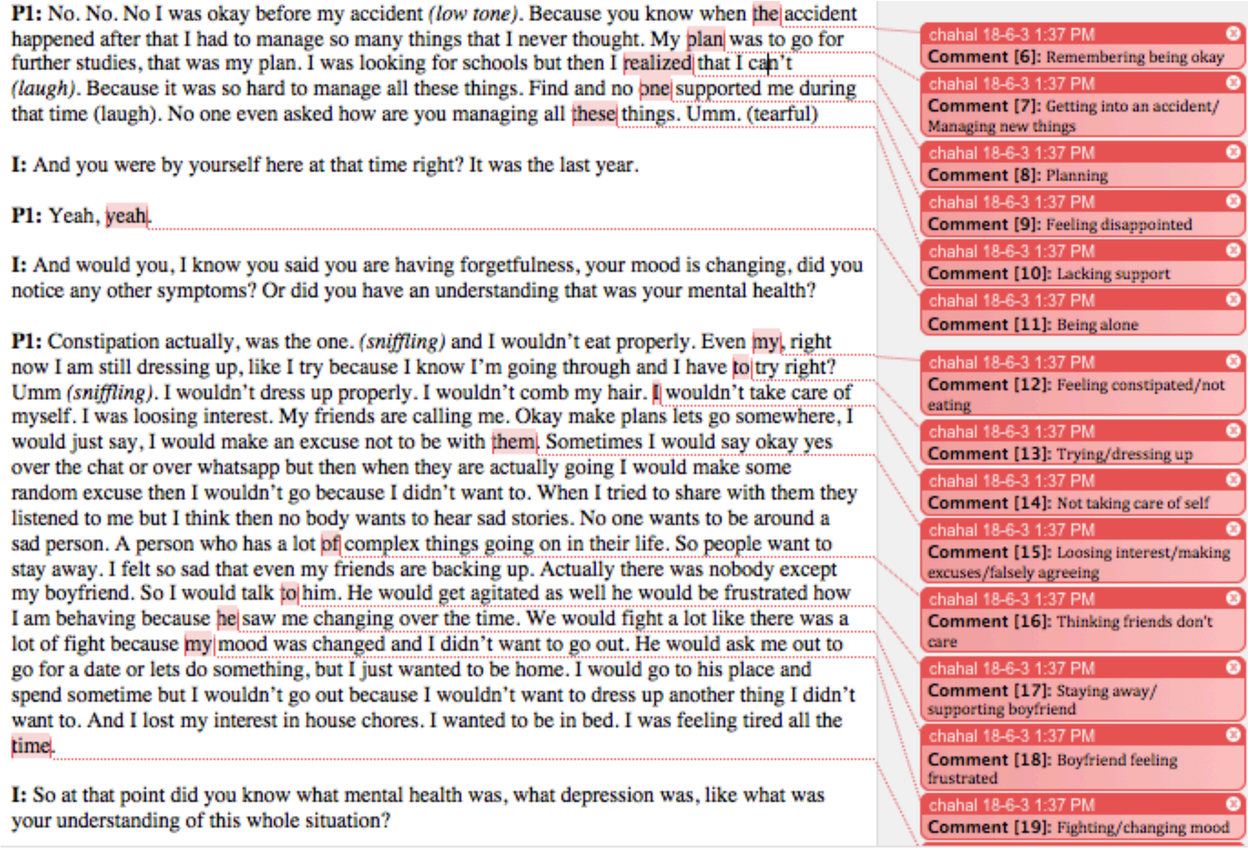
P1: Yes

I: Would you say before your accident you were having these experiences?

chahal 18-6-3 1:37 PM
Comment [3]: Forgetting/ Feeling agitated

chahal 18-6-3 1:37 PM
Comment [4]: Getting into an accident

chahal 18-6-3 1:37 PM
Comment [5]: Remembering



P1: No. No. No I was okay before my accident *(low tone)*. Because you know when the accident happened after that I had to manage so many things that I never thought. My plan was to go for further studies, that was my plan. I was looking for schools but then I realized that I can't *(laugh)*. Because it was so hard to manage all these things. Find and no one supported me during that time (laugh). No one even asked how are you managing all these things. Umm. (tearful)

I: And you were by yourself here at that time right? It was the last year.

P1: Yeah, yeah.

I: And would you, I know you said you are having forgetfulness, your mood is changing, did you notice any other symptoms? Or did you have an understanding that was your mental health?

P1: Constipation actually, was the one. *(sniffling)* and I wouldn't eat properly. Even my, right now I am still dressing up, like I try because I know I'm going through and I have to try right? Umm *(sniffling)*. I wouldn't dress up properly. I wouldn't comb my hair. I wouldn't take care of myself. I was loosing interest. My friends are calling me. Okay make plans lets go somewhere, I would just say, I would make an excuse not to be with them. Sometimes I would say okay yes over the chat or over whatsapp but then when they are actually going I would make some random excuse then I wouldn't go because I didn't want to. When I tried to share with them they listened to me but I think then no body wants to hear sad stories. No one wants to be around a sad person. A person who has a lot of complex things going on in their life. So people want to stay away. I felt so sad that even my friends are backing up. Actually there was nobody except my boyfriend. So I would talk to him. He would get agitated as well he would be frustrated how I am behaving because he saw me changing over the time. We would fight a lot like there was a lot of fight because my mood was changed and I didn't want to go out. He would ask me out to go for a date or lets do something, but I just wanted to be home. I would go to his place and spend sometime but I wouldn't go out because I wouldn't want to dress up another thing I didn't want to. And I lost my interest in house chores. I wanted to be in bed. I was feeling tired all the time.

I: So at that point did you know what mental health was, what depression was, like what was your understanding of this whole situation?

chahal 18-6-3 1:37 PM
Comment [6]: Remembering being okay

chahal 18-6-3 1:37 PM
Comment [7]: Getting into an accident/ Managing new things

chahal 18-6-3 1:37 PM
Comment [8]: Planning

chahal 18-6-3 1:37 PM
Comment [9]: Feeling disappointed

chahal 18-6-3 1:37 PM
Comment [10]: Lacking support

chahal 18-6-3 1:37 PM
Comment [11]: Being alone

chahal 18-6-3 1:37 PM
Comment [12]: Feeling constipated/not eating

chahal 18-6-3 1:37 PM
Comment [13]: Trying/dressing up

chahal 18-6-3 1:37 PM
Comment [14]: Not taking care of self

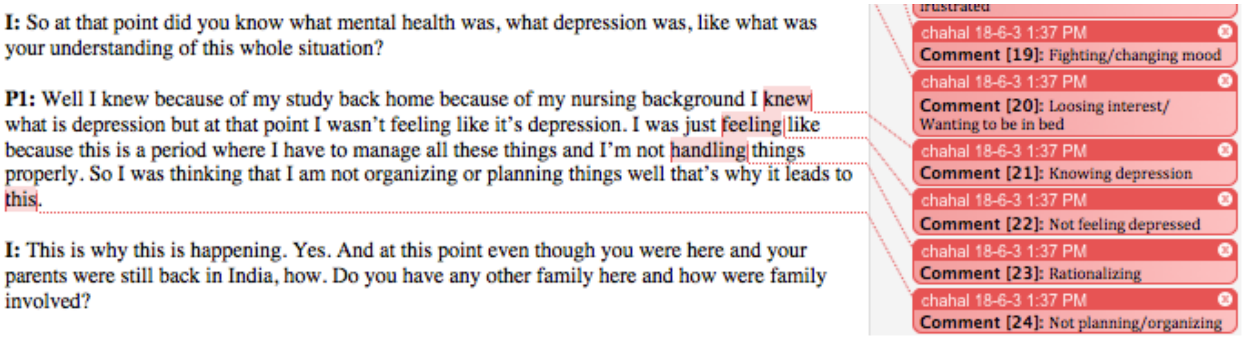
chahal 18-6-3 1:37 PM
Comment [15]: Loosing interest/making excuses/falsely agreeing

chahal 18-6-3 1:37 PM
Comment [16]: Thinking friends don't care

chahal 18-6-3 1:37 PM
Comment [17]: Staying away/ supporting boyfriend

chahal 18-6-3 1:37 PM
Comment [18]: Boyfriend feeling frustrated

chahal 18-6-3 1:37 PM
Comment [19]: Fighting/changing mood



I: So at that point did you know what mental health was, what depression was, like what was your understanding of this whole situation?

P1: Well I knew because of my study back home because of my nursing background I knew what is depression but at that point I wasn't feeling like it's depression. I was just feeling like because this is a period where I have to manage all these things and I'm not handling things properly. So I was thinking that I am not organizing or planning things well that's why it leads to this.

I: This is why this is happening. Yes. And at this point even though you were here and your parents were still back in India, how. Do you have any other family here and how were family involved?

chahal 18-6-3 1:37 PM
Comment [19]: Fighting/changing mood

chahal 18-6-3 1:37 PM
Comment [20]: Loosing interest/ Wanting to be in bed

chahal 18-6-3 1:37 PM
Comment [21]: Knowing depression

chahal 18-6-3 1:37 PM
Comment [22]: Not feeling depressed

chahal 18-6-3 1:37 PM
Comment [23]: Rationalizing

chahal 18-6-3 1:37 PM
Comment [24]: Not planning/organizing

In comparison to the initial process of making marginal notes, the line-by-line coding strategy lead to more topics and categories emerging from the interview. The following is an example of the category “the person” and ideas that emerged from Kiran’s interview after line-by-line coding:

The Person

- Moving
- Immigrating
- Living alone
- Early commuting
- Feeling tired
- Wanting time for self
- Feeling disappointed (with illness)
- Forgetting
- Experiencing heaviness/being out of breath
- Being constipated
- Falsely agreeing (plans with friends)/ “Expectations”
- Making excuses
- Managing changes (the accident)
- Being independent (cost of it)
- Making sick calls (work)
- Alone & in pain
- Facing responsibility

Step 3

The researcher then repeated the process of *comprehending* and *synthesizing* for interviews with another PLD and two of their respective family members. After completing these steps for four initial interviews of the study (two PLDs and two family members), a committee meeting was held to review this process and facilitate the continuation of coding. At this meeting the next steps were discussed for the researcher to expand on the codes to describe further details of the data that is being captured. For example *‘the person’* should be expanded to identify which ‘person’ the researcher is referring to and what data is emerging from within this category. Here is the audit trail showing the example of how the category of ‘*the person’* evolved after the committee meeting.

Reflexive Memo Feb 27th 2018.

Yesterday I began breaking down 'the person' into further categories. My brainstorming lead to the following items:

- My daytime routine
- My past experiences with depression
- My reaction to seeing depression for the first time
- How I could have prevented this
- How depression changed my life
- Having a purpose
- My role as a caregiver
- My values and beliefs about living a healthy lifestyle
- My view on depression
- The hardships I have endured
- The things I enjoy doing

Step 4

As the researcher continued to immerse oneself in the remaining interviews, working through *comprehending* and *synthesizing* the data, there was ongoing communication with the researcher supervisor. By looking at the collective interviews and asking deeper questions of the data such as "what am I seeing here?"/ "what am I not seeing here", the process of *theorizing* began to unfold. Here is an example of another reflexive memo showing how the category of 'the person' continued to evolve:

Reflexive Memo March 7th 2018.

I explored the section **'the person'** and completely eliminated the sub-topics by either parking the codes as a means to refer to when writing up the paper for descriptors or they fell under other categories.

I then went onto the section called **'the illness'**, which has now changed to **"My experience of having depression"**. The following are the sub-sections:

1. **How we identified the symptoms of depression:** The patient's experience of how depression has changed their lives, from hobbies, working, family relationships, to their future goals and aspirations.
2. **The trauma patients with depression have seen in their lives:** The traumatic events patients with depression have endured in their life. This includes:

marital conflict & abuse, a car accident, a work accident, and death of a loved one.

3. **My understanding of what depression is:** Patient's knowledge about depression as a mental illness.
4. **Keeping depression a secret:** Withholding the experience of having depression from family, friends, teachers, and colleagues.
5. **How depression has changed my life:** The symptoms both family members and participants experienced to recognize the individual was suffering from depression. This also includes their current symptoms.
6. **My view on medications treating depression:** Patient's views on how medications either support or don't support recovery from depression. Patient's experience of taking medications and the outcomes they have had.
7. **I have redefined my own purpose while living with depression:** A patient's new perspective on living with depression and coping with the symptoms.
8. **Where I stand in my recovery from depression:** Family and participant views on where the individual stands on the recovery spectrum. Whether they are still unwell, showing signs of improvements, or on their way to recovery.

Step 5

At the end of data analysis, twelve major themes surfaced. Reflexive journaling was taking place parallel to the coding process. For this first category 'the person', the data analysis process evolved to identify the major themes falling within the category of my experience of having depression. These themes are *most of us didn't know what depression is, we realized it was depression after getting help,* and *we keep depression a secret.*

Appendix J: Ethics Approval

HiREB

Hamilton Integrated Research Ethics Board

September 1 2017

Project Number: 3749

Project Title: Exploring the South Asian (SA) Punjabi Community's Experience of Having Accessed Mental Health Services for Depression in Canada

Principal Investigator: Dr. Janet Landeen

We have completed our review of your study and are pleased to issue our final approval. You may now begin your study.

McMaster
University
School of Nursing

Appendix K:
Information Sheet and Consent Form for Participants with Depression

Principal Investigator
Name: Maneet Chahal-MSc(c)
School of Nursing
McMaster University
Hamilton, ON
Telephone: 647-309-8389
Email: chahalm@mcmaster.ca

Thesis Supervisor
Name: Dr. Janet Landeen
School of Nursing
McMaster University
Hamilton, Ontario, Canada
Telephone: (905) 525-9140 ext. 22709
Email: landeen@mcmaster.ca

Committee Members

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School of Nursing
McMaster University
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Email: wahousho@mcmaster.ca

INFORMATION SHEET

Study Purpose:

The Mental Health Commission of Canada has identified the need to improve mental health services for immigrant populations. This is a growing need, especially with depression on the rise. As the South Asian Punjabi community is the second largest minority population in Brampton, there is a need to explore their experience of accessing mental health services for depression.

You are invited to participate in this research project to share your experience of accessing mental health services for depression in the city of Brampton. These services include visiting your family doctor, a psychiatrist, or receiving support from a community mental health agency.

What will happen during the study?

- You will be asked to participate in an interview, which will take place in a private community setting of your choice (enclosed room at a library or community centre).
- The interview will take from 1 to $1^{1/2}$ hours.
- You will be given the opportunity to conduct the interview in Punjabi or English.
- I will be asking about your understanding of depression and how you went about getting help.
- I will ask questions such as, “Tell me about your experience of getting help (from your doctor, psychiatrist, or community mental health agency)”.
- I will be taking notes during the interview as well as record the interview to ensure I don’t miss anything that is said.

Are there any risks to this study?

- Discussing your mental health experience can be difficult, and this may bring up difficult memories.
- You will be given the opportunity to take your time to answer questions, skip a question, or stop the interview at any point.
- You have the right to withdraw consent from the study at any point.
- I am going to ask you some questions about your current experience of depression to make sure that you feel well enough to participate in this study.
- If at any point, including after we have finished this interview, you are feeling distressed, I can connect you with mental health supports.

What are the benefits of this study?

- You will have the opportunity to share your experience of accessing mental health services for your depression.
- This information may be useful to improve mental health services for the South Asian Punjabi community.
- I will be sharing the results of this study with mental health agencies in the city of Brampton and with other professional groups.

Payment or Recruitment

You will be compensated by selecting a grocery card for $25 from a store of your liking (Freschco, No Frills, Food Basics, or Walmart) in appreciation for your valuable time.

Who will know what I said or did in the study?

- We will keep your identity confidential.
- What you share during the interview will be kept anonymous.
- We will not share any information that will identify you.
- Individuals will only know about your participation in the study, should you choose to share yourself.
- The information that is collected will be kept in a locked cabinet/desk and only available to the research team.
- Information on the computer will have password protection.
- Once the study is complete, the data will be kept up to 10 years, after which point it will be destroyed.

What if you change your mind about being in the study?

- Your participation in the study is voluntary.
- You are able to withdraw consent from the study at any point, including after the interview is completed.
- If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any information that you provide will be destroyed, unless you state otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

When may my confidentiality be broken?
If there are any immediate risks to your safety or the safety of others, confidentiality will need to be breeched to ensure you are referred to crisis supports. This may entail calling 911, informing your mental health supports, and/or informing your family.

How do I find out what was learned in the study?
If you would like to have information about what I have learned in this study, you can provide me with your contact information (email address or mailing address).

Questions about the Study:
If you have questions or need more information about the study itself, please contact me at:

Maneet Chahal, MSc(c)
School of Nursing
Email: chahalm@mcmaster.ca
Telephone: 647-309-8389

You may also contact my thesis supervisor at:

Dr. Janet Landeen
School of Nursing
McMaster University
Telephone: (905) 525-9140 ext. 22709
Email: landeen@mcmaster.ca

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HiREB). The HiREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call:

Office of the Chair
Telephone: 905.521.2100 EXT: 42013

CONSENT FORM

- I have read the information presented in the information letter about a study being conducted by Maneet Chahal, a Masters of Nursing Student at McMaster University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until approximately May 2018
- I have been given a signed copy of this form.
- I agree to participate in the study.

Name (Printed): ________________________________

Signature: _____________________________________ Date: ________________________

Individual obtaining consent

Name (Printed): ________________________________

Signature: _____________________________________ Date: ________________________

1. I agree that the interview can be audio recorded:

   Yes ____
   No ____

2. I would like to receive a summary of the study's results:

   Yes ____
   No ____

   Email address: _________________________________

   Or

   Mailing address: ____
   ____
   ____

3. I would like to receive reimbursement for the interview with a $25 gift card for:

   Freshco____
   Food Basics____
   No Frills____
   Walmart ____

McMaster University
School of Nursing

Appendix L:
Information Sheet and Consent Form for Family Members of Patients with Depression

Principal Investigator	Thesis Supervisor
Name: Maneet Chahal-MSc(c) School of Nursing McMaster University Hamilton, ON Telephone: 647-309-8389 Email: chahalm@mcmaster.ca	Name: Dr. Janet Landeen School of Nursing McMaster University Hamilton, Ontario, Canada Telephone: (905) 525-9140 ext. 22709 Email: landeen@mcmaster.ca

Committee Members

Name: Dr. Ruta Valaitis School of Nursing McMaster University Hamilton, Ontario, Canada E-mail: valaitis@mcmaster.ca	Name: Dr. Jeannette LeGris School of Nursing McMaster University Hamilton, Ontario, Canada Email: legrisj@mcmaster.ca	Name: Dr. Olive Wahoush School of Nursing McMaster University Hamilton, Ontario, Canada Email: wahousho@mcmaster.ca

INFORMATION SHEET

Study Purpose:

The Mental Health Commission of Canada has identified the need to improve mental health services for immigrant populations. This is a growing need, especially with depression on the rise. As the South Asian Punjabi community is the second largest minority population in Brampton, there is a need to explore their experience of accessing mental health services for depression.

You are invited to participate in this research project to share your experience of supporting a family member with accessing mental health services for depression in the city of Brampton. These services include visiting your family doctor, a psychiatrist, or receiving support from a community mental health agency.

What will happen during the study?

- You will be asked to participate in an interview, which will take place in a private community setting of your choice (enclosed room at a library or community centre).
- The interview will take from 1 to $1^{1/2}$ hours.
- You will be given the opportunity to conduct the interview in Punjabi or English.
- I will be asking about your understanding of depression and how you went about supporting your family member to get help with depression.
- I will ask questions such as, “Tell me about your family’s experience of getting help for your family member (from a doctor, psychiatrist, or community mental health agency)”.

- I will be taking notes during the interview as well as record the interview to ensure I don't miss anything that is said.

Are there any risks to this study?

- Discussing the mental health experience of your family member can be difficult, and this may bring up difficult memories.
- You will be given the opportunity to take your time to answer questions, skip a question, or stop the interview at any point.
- You have the right to withdraw consent from the study at any point.
- If at any point, including after we have finished this interview, you are feeling distressed, I can connect you with mental health supports.

What are the benefits of this study?

- You will have the opportunity to share your family's experience of accessing mental health services for your depression.
- This information may be useful to improve mental health services for the South Asian Punjabi community.
- I will be sharing the results of this study with mental health agencies in the city of Brampton and with other professional groups.

Payment or Recruitment

You will be compensated by selecting a grocery card for $25 from a store of your liking (Freschco, No Frills, Food Basics, or Walmart) in appreciation for your valuable time.

Who will know what I said or did in the study?

- We will keep your identity confidential.
- What you share during the interview will be kept anonymous.
- We will not share any information that will identify you.
- Individuals will only know about your participation in the study, should you choose to share yourself.
- The information that is collected will be kept in a locked cabinet/desk and only available to the research team.
- Information on the computer will have password protection.
- Once the study is complete, the data will be kept up to 10 years, after which point it will be destroyed.

What if you change your mind about being in the study?

- Your participation in the study is voluntary.
- You are able to withdraw consent from the study at any point, including after the interview is completed.
- If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any information that you provide will be destroyed, unless you state otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

When may my confidentiality be broken?
If there are any immediate risks to your safety or the safety of others, confidentiality will need to be breeched to ensure you are referred to crisis supports. This may entail calling 911, informing your mental health supports, and/or informing your family.

How do I find out what was learned in the study?
If you would like to have information about what I have learned in this study, you can provide me with your contact information (email address or mailing address).

Questions about the Study:
If you have questions or need more information about the study itself, please contact me at:

Maneet Chahal, MSc(c)
School of Nursing
McMaster University
Email: chahalm@mcmaster.ca
Telephone: 647-309-8389

You may also contact my thesis supervisor at:

Dr. Janet Landeen
School of Nursing
McMaster University
Telephone: (905) 525-9140 ext. 22709
Email: landeen@mcmaster.ca

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HiREB). The HiREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call:

Office of the Chair
Telephone: 905.521.2100 EXT: 42013

CONSENT FORM

- I have read the information presented in the information letter about a study being conducted by Maneet Chahal, a Masters of Nursing Student at McMaster University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until approximately May 2018
- I have been given a signed copy of this form.
- I agree to participate in the study.

Name (Printed): ________________________________

Signature: _____________________________________ Date: ________________________

Individual obtaining consent

Name (Printed): ________________________________

Signature: _____________________________________ Date: ________________________

4. I agree that the interview can be audio recorded:

   Yes ____
   No ____

5. I would like to receive a summary of the study's results:

   Yes ____
   No ____

   Email address: _________________________________

   Or

   Mailing address: ____
   ____
   ____

6. I would like to receive reimbursement for the interview with a $25 gift card for:

   Freshco____
   Food Basics____
   No Frills____
   Walmart ____

McMaster University

School of Nursing

Appendix M: Script for Family Doctor, Psychiatrist, and Community Mental Health Agency Healthcare Workers

I would like to provide information about a study that is taking place to understand the experience of the South Asian Punjabi community on getting help for depression.

(Show study flyer)

This study is being conducted by a Master's of Nursing student at McMaster University. I want to first tell you that you are under no obligation to participate nor will your care be impacted in any way. If you feel you may want to participate or would like more information, may I suggest you contact the researcher or I can share your contact information with her?

Appendix N:
Telephone Script for Participants Referred by a Family Doctor, Psychiatrist, or Community Mental Health Agency Worker

Hello, my name is Maneet Chahal and I am a Masters of Nursing student currently doing a thesis with McMaster University. I received your contact information from ___________________, as they had informed you about a study that I am conducting.

If you are still interested, may I provide you with further information?

If yes,

The Mental Health Commission of Canada has identified the need to improve mental health services for immigrant populations. This is a growing need, especially with depression on the rise. As the South Asian Punjabi community is the second largest minority population in Brampton, there is a need to explore their experience of accessing mental health services for depression.

You are invited to participate in this research project to share your experience of accessing mental health services for depression in the city of Brampton (or the experience of your family member). These services include visiting your family doctor, a psychiatrist, or receiving support from a community mental health agency.

Your participation is completely voluntary and will not impact your care in any way (or impact the care of your family member). Should you choose to participate, we can move forward with seeing that you meet the inclusion criteria.

Appendix O: The Researcher's Insider View on the SA Community

With limited mental health researcher on the SA community, I found it important to share some insider views as identifying with this minority population. As such, the primary item of disclosure about this ethnic community is the strong-held views of family honor and family relationships. Furthermore, the study interviews exposed key thoughts about marriage, which ties in with these family views. Marriage within the SA community is a highly respected union, whereby the communities' views on marriage are very strict. As such, divorce is not openly accepted within the community and all efforts are made to problem-solve any marital issues. Overall, the community values family privacy to maintain societal respect, whereby discussing concerns regarding family conflict, family violence, and even intimate partner violence (IPV) are socially unacceptable. These views on the SA community are important to highlight for the reader to appreciate the interpretations that are made for the study findings and discussion.