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LITERACY

Tensions along the path towards mental health literacy for new immigrant mothers:

Perspectives on Mental Health and Mental Illness

By

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### Abstract

New immigrants to Canada are identified as a vulnerable population in mental health and, as a result, organizations are signaling the need to enhance their mental health supports. The research uses focus groups and questions based on the messaging of a Canadian school mental health program to understand how new immigrant mothers interpret and develop key aspects of their mental health literacy and how they attain parent empowerment. A thematic assessment of the knowledge, interpretation, action and decision-making of the study participants (n=7), all recent immigrants to Canada and mothers of high school students, shows that new immigrant mothers are prepared to follow a path towards mental health literacy. At the same time, however, there are barriers that can block progression towards mental health literacy for this audience. These findings are supported by three umbrella themes: the first main theme “home as haven” espouses maternal roles in mental health maintenance such as protector and communicator, the second main theme “knowledge versus suspicions of mental health and mental illness” represents informed views and support of mental illness and myths and illusions of mental illness, and the third main theme, “additional barriers to mental health literacy” includes the hardships of immigration and fear of knowledge. The study concludes that new immigrant mothers appreciate the importance of fostering mental health understanding and discussion with their children at the same time that they encounter obstacles to the advancement of their mental health literacy. This study is relevant to the field of communication in that it demonstrates the experience of new immigrant mothers as a secondary audience in mental health programming. As the

caregivers of their children, they are in position to enforce the messages and health maintenance behaviours of a school-based mental health program aimed at adolescents.

*Keywords:* mental health literacy, communication, barriers, parent empowerment, new immigrants, secondary audience, vulnerable populations, focus groups

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## CHAPTER ONE: INTRODUCTION

Canadian policy experts have been calling for a health care system that focuses on both care through service and maintenance as a result of personal well-being. For example, the Conference Board of Canada identifies this position as a priority and has called on governments to “focus on the wellness of Canadians overall, striving for a system that also recognizes wellness as part of health care, while working with employers, community organizations and families to take responsibility and embrace individual wellness” (Conference Board of Canada, n.d., Priorities section, para. 4).

One related area that has been a constant priority for the federal government is concern about mental health. As a result, the Mental Health Commission of Canada (MHCC) was given a government mandate to develop a national mental health strategy in response to the mental health challenges that all Canadians were facing, thereby considering a variety of target, at-risk populations (MHCC, 2012). Examples of mental health needs of any individual can include mental health and suicide prevention training at home, work, and school, enhanced mental illness recovery options, and access to services, treatments and supports (MHCC, 2012). Examples of groups deemed to be “populations of concern” because of disparities in risk factors compared to other Canadians include Aboriginal Canadians, senior citizens, youth, gay, lesbian, bisexual, and transgendered youth, women and, finally, immigrants (MHCC, 2012). The mental health needs of newcomers has become an issue of concern as noted by the MHCC Diversity Task Group who documented “increased rate of illnesses, poorer access to care and care outcomes and poorer satisfaction with health services for immigrants in Canada” (MHCC, 2009, p. 6).

### The Context

Access to health care is affected by social determinants of health: the economic and social conditions that influence the health of people and communities and are shaped by the distribution of money, power, and resources that people have (World Health Organization, 2008). According to Aday (1994), the concept of health can be considered through positive and negative indicators (p. 489). Positive indicators could include stable employment, steady income, professional livelihood, abundance of food and health resources and knowledge of health services, residence in established communities, and higher levels of education all of which can enrich the healthcare experience of the individual and negative indicators could include poorer conditions such as unemployment, low-income, working-class livelihood, limited access to food, health services, community housing status, and lower level of education, all of which can impede enhanced knowledge of and access to health services (Centers for Disease Control and Prevention, 2013).

The risk that makes vulnerable populations susceptible to problematic health conditions is exacerbated by the of absence positive social determinants of health. The presence of adverse social determinants increases the likelihood of exposure to risk for these individuals. Aday (1994) defines vulnerable populations as people who face risks that result in “poor physical, psychological, and/or social health” (p. 487). Populations whose health status and needs should be of primary concern were identified by Aday (1994) as “those populations for whom poor physical, psychological, or social health has or is likely to become a reality and included immigrants and refugees,” (p. 490).

While it is commonly recognized that everyone’s health needs matter, Aday (1994)

goes on to use a variety of rationale for focusing on the health needs of vulnerable populations such as “their requirement of an extensive menu of health services, and growth in their number and magnitude of need resulting in a greater demand on the healthcare system,” (p. 490). This rationale aligns with the position of the MHCC, which has identified the influx of immigrants into Canada as a driver for an increased focus on their mental health experiences. According to census data there are 6,186,950 newcomers in Canada, which is equivalent to one in five (19.8%) of the total population (Canada, 2007). Canada’s diversity is growing as a result of the continued immigration that stimulates population growth (MHCC, 2009, p. 6).

These facts serve as the catalyst to increase mental health supports for immigrants, refugees, ethno-cultural and racialized groups (MHCC, 2012, p. 82). In this group, “an increased rate of illnesses, poorer access to care and care outcomes and poorer satisfaction with services” both here in Canada and internationally has been documented due to the incidence of one or more negative conditions (MHCC, 2009, p. 6). On top of financial and housing constraints, other factors that exacerbate risk for immigrants include low computer and language literacy, lack of information and health literacy, mental illness stigma, and religious/cultural differences affecting mental health attitudes in their households (Reitmanova & Gustafson, 2009, p. 615).

Considering recent mental health policies and programming directions, the MHCC also supports mental health initiatives for youth that aim to help youth understand mental health issues and reduce mental health stigma. Some of these programs, such as an awareness program titled “Talking About Mental Illness” (TAMI), developed by the Canadian Mental Health Association (CMHA) and the Centre for

Addiction and Mental Health (CAMH), recognize the need for youth to be able to communicate about mental illness with their family (Centre for Addiction and Mental Health [CAMH], 2001, p. 10). The goal of this program is to help youth enhance their understanding of mental health issues and reduce mental health stigma. This program is being delivered to high school students nationally and has been for several years.

The TAMI program also recognizes the need for youth to be able to communicate about mental illness with their family (CAMH, 2001, p. 10). It sees the identification of ethnic groups in each audience as important, since “different ethnic groups may have different perceptions/attitudes toward mental illness,” (CAMH, p. 12). The MHCC goes on to state that “school based efforts for at-risk youth need be supplemented by additional home and community supports” (MHCC, 2012, p. 25). So far studies evaluating the efficacy of similar mental health interventions have started by focusing on youth as the main population of interest (Johansson et al., 2007; Phillipson et al., 2009; Pinto-Foltz et al., 2011). By looking at the dates of research publication, it can be inferred that the importance of interventions has become more prevalent in the last ten years. With youth as the main target audience, studies using parents as a population of interest in mental health programming have not become priority yet. By examining the recommendations of related youth studies, the need to explore a parental role in enhancing the mental health literacy of teenagers is inherent.

Johansson et al. (2007) attest to these integral roles of parental perception in the mental health attitudes of youth. More specifically, Wisdom and Agnor (2007) have suggested that a common pattern amongst young people is to go to their mothers with regards to mental health related matters. Such studies implicate future research on

parental roles in the effective delivery of interventions as a secondary audience in the communication of program messages. Furthermore, these studies point out that mothers are more likely than fathers to engage in parent-child dialogues on mental health. In short, mothers are crucial to effective intervention delivery because as recipients of health information they can support and reinforce desirable outcomes. These findings confirm the importance of mothers in the cycle of health communication messages and programs and underscore the contributions of this thesis to the field of communication.

#### *Defining (Mental) Health Literacy and Mental Health Stigma*

Mental health awareness programs such as TAMI were designed to improve mental health literacy by dispelling popular beliefs and stigmatizing responses to mental illness through education and reducing mental health stigma.

For purposes of this research mental health literacy can be understood in the broader context of *health literacy*, which is the ability to “read, understand and act on health information” (Schiavo, 2007). Considering the litany of challenges that ethnic new immigrants face, including securing employment, language barriers, and knowledge of services to name a few, their ability to properly interpret messaging can be compromised. Furthermore, Schiavo (2007) states that the “overall purpose of any materials or verbal communication is defeated if people cannot understand it” (p. 63). While many Canadian mental health programs identify students and teachers as the target and primary audiences there are other secondary audiences such as families that have been recognized as having pivotal roles in program success (MHCC, 2012). According to Pinto-Foltz et al. (2011), and for purposes of this study, *mental health literacy* is defined as the

knowledge and beliefs about mental illness and mental health that assist people in the recognition, management, and prevention of related diseases and conditions.

Mental illness stigma is the devaluing, disgracing, and disfavoring by the general public of individuals with mental illnesses and is a serious problem because of its many harmful affects on stigmatized individuals including a reluctance by others to interact with a person suffering from mental illness (Abdullah & Brown, 2011, p. 935). This negative perception of mental illness is because of a result of limited understanding (Pinto-Foltz et al., 2011). Pinto-Foltz et al. (2011), in their study on reducing mental illness stigma amongst adolescents through the establishment of a program based on peer experiences to enhance mental health literacy demonstrated that mental illness stigma was displayed by adolescents who showed moderate levels of negative responses related to mental disorders and low mental-health literacy. In other words, the way people view mental illness affects their wider perception of mental health thereby affecting an individual's level of mental health literacy (Pinto-Foltz et al., 2011). Looked at another way, the cultivation of mental health literacy of adolescents presents an opportunity to reduce mental illness stigma (Pinto-Foltz et al., 2011). Rao, Feinglass, and Corrigan (2007) recommend that stigma be considered separately amongst cultural populations (not merely as a pattern amongst a general population) since diagnoses of mental illness are given based on deviations from sociocultural or behavioral norms. This stipulates that a person's aberration from a typical lifestyle and desired behaviour varies between cultures based on norms and what is acceptable to that specific cultural community, and is pronounced as a mental health related concern on that basis.

*Theoretical Context*

Reinforcing the importance of parental involvement in their children's health needs is a theory-based intervention of parent empowerment. Heflinger and Bickman (1996) define parent empowerment as the knowledge, skills and self-efficacy that assist families in staying engaged and understanding their children's mental health treatment. Specifically, it is a "process through which people become more able to influence those people and organizations that affect their lives and the lives of those they care about," (p. 105). Heflinger and Bickman (1996) postulate that the "facet of self-efficacy," defined as "parents' belief that their involvement in their children's mental health treatment will make a difference" is a motivating and necessary component to empowerment (p. 106). Therefore, Bickman et al. (1998) add to the concept of empowerment high levels of self-efficacy that together promote an active role in an experience.

*Research Objectives and Overview of the Study*

The need to understand how to enhance the mental health literacy of newcomer mothers is supported by this parent empowerment intervention in addition to the facts that that immigrants are a large part of the Canadian population, and are at risk for low mental health literacy given their exposure to difficult economic, social, and physical conditions such as low-income, loss of social networks, or inadequate housing (MHCC, 2009, p. 15). Furthermore, research indicating that parents have a role to play as a secondary audience in mental health programming is recent and studies in this area have yet to be developed. Finally, evidence shows that women are usually the main family caregiver and, thus, are concerned with the health maintenance of their families.

The objective of the study is to explore how the experiences of ethnic new immigrants, influence their mental health perspectives. Using the TAMI program messages to stimulate dialogue, the perspectives of immigrant mothers were assessed using a focus group discussion. This research endeavours to allow the voices of these women to be heard so that future programs can be sensitive to their experience.

The purpose of this study was to understand the empowerment of these new immigrant mothers in developing mental health literacy, through an exploration of the dialogue that the TAMI program messaging stimulated for them. The study aimed to assess how mental health messaging triggers newcomer mental health literacy levels: their knowledge, interpretation, and attitudes, and explore their communication needs in relation to their empowerment.

### *Research Questions*

The study's research questions were developed in conjunction with the outlined theoretical perspective and were as follows:

1. How do new immigrant mothers perceive their roles with regard to the maintenance of their children's mental health?
2. What is the nature of existing mental health perceptions and attitudes that TAMI program messaging triggers for new immigrant mothers?
3. How do TAMI mental health messages both contribute to and build upon immigrant mothers' perceptions and attitudes of mental health?

The first question speaks to the role of parent empowerment in mental health literacy, and sought to understand how these new immigrant mothers see their own responsibilities in terms of responding to their children's mental health needs.

Immigrants were operationalized under the category of “new” immigrant if they were a newcomer to Canada in the last three years, following the Career Bridge eligibility criteria (P. Calderon, personal communication, January 18, 2013). Women from the following countries were selected as eligible for this study on the basis of popular countries of origin as indicated by Canadian immigration statistics: India, Iran, Pakistan, Bangladesh, Sri Lanka, Ukraine, Russia, Republic of Moldova, Romania, and Poland.

The second question uses the TAMI messaging as a way of starting the dialogue in order to understand the associated mental health perceptions and attitudes that new immigrant mothers may already have. The last question was designed to explore how messages are enhancing and representing immigrant mothers’ mental health perceptions and attitudes.

### *Methodology*

This research embraces a phenomenological approach in that it aimed to understand the essence of a human, lived experience (Creswell, 2009) with mental health literacy to be depicted through the experience of the individual, the immigrant mother. The qualitative study took place using a focus group format of two sessions of purposefully selected participants each.

The focus group method was considered appropriate as it has been used to foster dialogue in similar research areas. According to Ginossar and Nelson (2005) dialogue “motivates individuals to take control over their lives” (p. 334). It has also been noted successful by Muturi (2005) in that it “empowers women by offering a chance for more free expression” (p. 85). Muturi (2005), who studied socio-cultural considerations for health communication on HIV/AIDs prevention in Kenya, also a sensitive health issue

within a cultural context, cites Wimmer and Dominic (1991) by quoting that “qualitative research attempts to produce a unique explanation about a given situation or individual where the researcher examines believing that reality is holistic and cannot be subdivided” (p. 84). This research was designed under that premise; that immigrant needs in developing mental health literacy and cultivating empowerment are universal. Citing Kitzinger (1995) and Kemmis and McTaggart (2000), Simich et al. (2009) contended that focus groups are suitable when trying to uncover people’s thoughts and the rationale behind them, and also mentioned the added benefit of interactive dialogue, and finally the co-construction of knowledge (p. 256). These focus groups were orchestrated to allow perceptions emanating from the TAMI program to empower ethnic peers through the sharing of ideas and experiences.

The Canadian Mental Health Association (CMHA) approved the use of the TAMI program messages to prompt discussion. The TAMI messages were integrated into a semi-structured discussion guide featuring questions that test the reaction to the school curriculum as offered to adolescents in order to facilitate an open-ended exchange on their mental health attitudes.

Ethnic new immigrant parents were recruited through the Career Edge Organization. The sample population was comprised of current registrants of the Career Bridge Program, a national initiative offered by Career Edge that helps foreign trained professionals get their first Canadian job experiences. Using this sample population offered benefits for the study. Firstly, all Career Bridge program participants are recent newcomers to Canada; the program does not accept candidates who have immigrated to the country more than three years ago so as to ensure a pool is representative of new

immigrants (P. Calderon, personal communication, January 18, 2013). Secondly, because of the rigorous pre-screening criteria of a post-secondary degree or diploma, fluency in English as a second language at a benchmark level of 8 (out of 10), and work place communication skills participants were able to interact fluidly with the researcher in English (P. Calderon, personal communication, January 18, 2013).

### *Operationalization*

Since the study's focus is understanding the immigrant experience of parent empowerment in their mental health literacy and since mothers have a role to play in their children's mental well-being and receptivity to behavioural change that promotes it, participants had to meet the criteria of being a mother of a child, under the age of 18 who attends school in Ontario.

The TAMI messages were operationalized based on the program information and lessons. Actual excerpts and direct quotes from the high school program were taken out and integrated in to the focus group questions.

Mental health literacy was operationalized according to Pinto-Foltz et al. (2011) definition to include knowledge and beliefs about mental illness and mental health that assist people in the recognition, management, and prevention of related diseases and conditions. Empowerment was operationalized as references to active roles, self-confidence, control, power, influence and motivation" (Bickman et al. 1998; Helfinger & Bickman 1996; Ginossar & Nelson 2010).

*Overview of Study*

The study uses the following structure:

## Chapter one – Introduction

The introduction lays out the context for this research project. It does so by describing Canada's current focus on health and more specifically mental health issues. It shifts focus to vulnerable populations and the link between these groups and the social determinants of health, with specific focus on immigrants in Canada and what makes them at risk for health and mental health concerns. It presents the role of programming in mental health awareness alongside the concepts of mental health literacy and mental health stigma, in addition to parental roles in health maintenance of their families. It brings forward the theoretical lens through which this study was framed—the intervention of parent empowerment—before introducing the central research questions, problem statement, research purpose, and describing the methodology and operationalization used.

## Chapter two – Literature Review

The literature review that follows describes immigrants as a vulnerable population, discusses recent Canadian immigration trends and reviews studies documenting their mental health experiences. It also illustrates the role of parents in fostering an understanding of mental health for their children with a particular focus on mothers as caregivers and adolescent-parent communication. This chapter then defines the concepts of mental health promotion, mental health literacy, and mental health stigma, each with examples and the theoretical intervention of parent empowerment,

while considering reactance as an outcome of empowerment. Finally it will review similar methods reflective of this study design.

#### Chapter three – Methodology

Beyond outlining the research strategy, the methodology section describes the focus group details and sampling procedures before going in to detail on the discussion guide and coding frames that resulted in the thematic analysis. Finally, it discusses the data analysis technique.

#### Chapter four – Results and Analysis

The results and analysis section follows with a summary of the recurring themes in the focus groups and discussion of those results. It uses supporting data by offering quotations and review key findings linking them to the research questions.

#### Chapter five – Discussion

The discussion chapter reviews the key findings relevant to each theme and links the findings to the research questions. It also grounds the findings by referencing other findings stemming from previous research as highlighted in the literature review.

#### Chapter six – Conclusion

Finally, the study concludes by reiterating a summary of main highlights alongside explanations of why the findings are important to the field of health communication and mental health promotion. It also includes limitations of the study before considering future research avenues.

## CHAPTER TWO: LITERATURE REVIEW

This literature review starts by describing the social determinants of health and the health risks facing new immigrants. It then considers recent Canadian immigration trends and a recount of studies documenting mental health experiences of interest to this study. Following that, it defines the central concepts of mental health literacy and mental health stigma before addressing individual perceptions of mental health as influenced by family and culture and mental health promotion. From there, the literature review moves towards illustrating the role of parents in fostering an understanding of mental health for their children with a particular focus on mothers as caregivers and adolescent-parent communication. Finally, the chapter reviews research on the theoretical intervention of parent empowerment.

## Social Determinants of Health and Immigrants as a Vulnerable Population

Access to care is affected by social determinants of health: the economic and social conditions that influence the health of people and communities and are shaped by the distribution of money, power, and resources that people have (World Health Organization, 2008). According to Aday's (1994) conceptual framework designed to profile and define vulnerable populations, the concept of health can be considered through positive and negative indicators varying across groups (p. 489). For example, poorer conditions in areas such as employment, income, livelihood, access to food, access to health services, housing status, and level of education can impede enhanced knowledge of and access to health services (Centers for Disease Control and Prevention, 2013).

Populations are defined by the beneficial or detrimental incidence of social

determinants of health. Aday (1994) defines vulnerable populations as those individuals who face risks that result in “poor physical, psychological, and/or social health” (p. 487). This definition is best understood along side the concept of epidemiological risk, in that there is a greater chance that a vulnerable person or their family could encounter illness at any time (Aday, 1994, p. 487). Various vulnerable populations whose health status and health needs should be primary concern are identified by Aday (1994) as “those populations for whom poor physical, psychological, or social health has or is likely to become a reality: high-risk mothers and infants; chronically ill and disabled; persons with AIDS; the mentally ill and disabled; alcohol or substance abusers; suicide- or homicide-prone individuals; abusing families; the homeless; and immigrants and refugees” (p.490).

Similarly, Canadian mental health experts have supported the need to focus on some of these groups and others. In its national strategy, the MHCC distinguishes the need to focus on Aboriginal Canadians, senior citizens, youth, gay, lesbian, bisexual, transgendered and queer (LGBTQ) youth, minority official language communities (Francophones living outside Quebec and Anglophones living in Quebec), women and, finally, immigrants, refugees, ethno-cultural and racialized groups (MHCC, 2012).

Aday (1994) goes on to further describe the risk facing immigrant populations noting that in some particular cultural groups, “bipolar clusters typically occur as a result of social and economic advantage versus disadvantaged statuses based on migration cohort” (p. 506). In other words the gravity of the risk facing immigrants from the same cultural group can vary between extremes to a degree of benefit or detriment. This points to a limitation: varying degrees of risk amongst immigrant populations suggest that not

all immigrants of the same origin are necessarily prone to the same vulnerabilities. For example, many new immigrants are considered wealthy by Canadian standards and have unlimited financial resources within their family that could support the newcomers upon their arrival, making common experiences like unemployment a non-issue for them. In contrast, other new immigrants from the same country could be entering in to poverty as a result of their personal experience. For example, they may possess a weaker financial safety net such as a lack of financial resources. Aday (1994) identifies another challenge in “estimating the prevalence and health status of vulnerable people” on the basis of limited, incomplete, and poor quality data stemming from medical diagnosis, health and other government records and individual patient self-reporting (p. 495). This pattern is often intensified by the fact that new immigrants often have a difficult time accessing and navigating health services and information: whether it is finding a family physician or understanding critical information due to language or lack of familiarity with the system (Reitmanova & Gustafson, 2011). In sum, these studies suggest that it cannot be assumed that all new immigrants are vulnerable. The magnitude of the risk they face is specific to their own situation.

In a study that assesses the settlement and program needs of immigrant youth, Van Ngo (2009) exposed the increased vulnerability that young newcomers face in the Canadian context. Factors identified by Van Ngo and other researchers as catalysts for challenging life experiences were linguistic, acculturative, psychological, economic, or linked to the stress of migration (Pereirra & Ornelas, 2011, p. 196; Van Ngo, 2009, p. 82). Van Ngo points to a spectrum of physical and mental health challenges as a result of socioeconomic status, malnutrition, religious and cultural “taboos and practice

preventing access to health education,” and country of origin particularly for individuals who come from countries haunted by atrocities such as war, genocide, oppression, racism and discrimination (p. 84). While the focus of Van Ngo’s study was specific immigrant settlement programs and not broader programs in the area of health promotion, he concludes that the voice of immigrant families needs to be heard in the development of services, and that service providers must let the immigrant perspective be integrated in to the programs they receive so that they may reflect the levels of “strength and resilience” immigrants espouse (p. 95). Despite that this suggestion is limited to settlement programs, it offers broader application that could offer relevance to other program types particularly in the area of health. It also offers a positive consideration in that the ability of immigrants to bounce back and endure hard times should not be overlooked. Van Ngo’s analysis is also useful in illustrating the vulnerable position in which youth find themselves in Canadian society. The impression is left that immigrant youth often find themselves torn between cultural ties in their families of origin and the new ties they aspire to build as they attempt to assimilate in school and community settings (Van Ngo, 2009).

In their study of the physical and psychological well-being of immigrant children, Pereira and Ornelas (2011) examined the risk factors, life outcomes, and cyclical generational health issues to which immigrants and immigrant children are vulnerable. Pereira and Ornelas (2011) emphasize the importance of health status as a vital aspect of human capital, and point to the burden on society as a result of unhealthy workers who are less productive, more expensive, and limited in their earning potential. Finally, they link the health status of immigrant children to their exposure during childhood to

challenges such as poverty, the stresses of migration and assimilation that increase the risk for physical and mental health issues (p. 196). Perreirra and Ornelas (2011) concur with the findings of Fletcher (2008), and underscore the impact of the relationship between mental health and behavioural issues and poor academic performances. For example, depression and hyperactivity have a proven link with inadequate reading and math skills and students suffering learning deficits in these areas often drop out of high school and do not attend college (Pereirra & Ornelas, 2011, p. 196). This example suggests that if an individual had a chance to improve their depressive or hyperactive behaviour, or seek health services to address it, they could become more productive and higher achieving in school and post-secondary studies. This cycle is one that repeats economic and societal consequences, such as minimal skills training and education that results in lower worker productivity and unemployment.

Mental health experiences of immigrant children can also stem from the patterns established by generations before them, with risks or patterns of family separation being passed on to children and contributing to the rotation of a family cycle (Pereirra & Ornelas, 2011; Vega & Rumbaut, 1991). In their meta-analytic review, Vega and Rumbaut (1991) contend that family patterns influence the mental health experiences of minority immigrants, especially children, and that such patterns are often characteristic of “personal vulnerability” and “family disintegration” making for a unique “sociological experience” with corresponding “psychological outcomes” (p. 378). This suggests that mental health of immigrants is more than likely at risk, given that family disintegration defined as disruption in the family unit is a natural part of their settlement process, and that other personal risks such as loss of networks, income, and employment, are likely as

immigrants look towards a fresh start in their new country.

Migration is a process that not only involves the crossing of borders but the altering of mental landscapes (Simich et al., 2009, p. 253) and it imposes risk on migrant populations (Pereirra & Ornelas, 2011; Simich et al., 2009 ). The experience of migration includes the processes of acculturation and enculturation in the new host country that influence child development and health outcomes (Simich et al., 2009, p. 197).

Acculturation is the process that describes the intersection of two or more ethnic groups results in change and adaptation while enculturation is the opposite whereby members of an ethnic group protect and retain their cultural identity, beliefs and norms (Simich et al., 2009, p. 197). Associated with migration are distinct sources of stress and conditions impacting childhood development. The difficulty for children is part of the adaptation process. To adapt, immigrant children and their families choose different combinations of acculturation and enculturation strategies” (Pereirra & Ornelas, 2011, p. 197). These choices are stressful and confusing, especially for children, as they experience the following stages of immigration. In the first phase, focused on the process itself of migration, children often face turmoil alongside their families that can take on many forms including the risk of persecution, family separation and the desire to reunite with family members whom have already migrated. During the second phase of settlement, immigrant children often encounter additional challenges including navigating life in a new country, the realization of changes in family economic situations, dynamics and social roles (Vega & Rumbaut, 1991; Pereirra & Ornelas, 2011, p. 197). This experience can lead to problematic health consequences such as increased stress and anxiety and the inability to access health services as a result of poor integration in to the new society.

Factors that are often seen as due to these effects of migration include socioeconomic status and income levels of parents, which were seen to ultimately add to the vulnerabilities faced by new immigrants. The policy review of Pereira and Ornelas (2011) is relevant as it captures how several potential factors feed a cycle of risk faced by immigrants, passed on through generations. It suggests that undesirable circumstances such as unemployment and underemployment, weak problem solving or stress management abilities, lack of academic progress and attainment, and exposure to traumatic or stressful events amongst others adversely affect the physical and emotional health of immigrant children, and eventually take their toll on society. Not only do such factors reinforce unhealthy behaviours, but they impede access to health services and limit an individual's human capital (Pereira & Ornelas, 2011). This article might have had even stronger policy implications had it deployed a scientific examination of different health-related factors amongst the immigrant population. Nonetheless its description of factors and their role in promoting a cycle of unhealthy outcomes for newcomers is still noteworthy.

In understanding the effects of acculturation, Vega and Rumbaut (1991) cite Durkheim's (1951) work on suicide that explained social areas "undergoing rapid change" and "disorganizing effects" as part of anomie (p. 376). Anomie is interpreted by Vega and Rumbaut (1991) as a construct that brings an "increasing availability of behavioral choices, and a weakening of social controls, which potentially overwhelmed individuals who had been reared in a milieu characterized by well-defined, stable social expectations," which transpires during the process of acculturation (p. 376). It is suggested that there is a link between anomie and the placement of individuals in

environments characterized by contrasting behaviour expectations, leading to the associated experiences of alienation and powerlessness during the acculturative process (Vega & Rumbaut, 1991, p. 376). Acculturative effects, mainly behavioural changes, are typically experienced at a disproportionate rate by family members such as parents and children and are viewed as a catalyst for family tension (Vega & Rumbaut, 1991, p. 377). For example, a teenager might question the need to abide by household rules and adhere to roles as set out by their parents given his or her exposure to different family rules and structures in the new country. Vega and Rumbaut (1991) suggest that the perception of “weakened commitments compel negative, rigid, and authoritative reactions from parents and incite feelings of threat, depreciation, and fear of family customs overtaken by suspicious new cultural practices” as children experience their own acculturation and attempt to break away from a traditional cultural family model (p. 377). In considering the acculturative process, Vega and Rumbaut posit that the experience can impose risk causing psychopathological issues for parents and deviance and addiction issues for youth as they try to carve out their identity.

For each immigrant a moment comes when they start to integrate more deeply in to their new lives and homes, typically after their periods of acculturation and enculturation, and become open to assimilation, sometimes as a result of earning their new citizenship. Experts have concluded that risks can become more minimal depending on whether the nature of their settlement process is positive or negative. Rumbaut (1985) noted that the psychological impact of immigration tends to be concentrated in the first three years after arrival (p. 377): “There is an initial euphoria that characterizes the first year, followed by a strong disenchantment and demoralization reaction during the second

year, with a gradual return to early levels of well-being and satisfaction after the third year”, (Vega & Rumbaut, p. 377). In their book, Portes and Rumbaut (1990) plotted this pattern on a U-shaped curve, labeling the first phase as “elation”, the second phase as “depression” and third phase “recovery” charting the course of psychological adjustment from year one to year three.

A limitation of this three-year concept is its supposition that immigrants are capable of entering a recovery phase marking the end to a positive settlement process. Given that each immigrant experience has been characterized as unique, this can certainly not be the case for all newcomers, given the multitude of risk factors and combinations of vulnerabilities potentially faced. Furthermore, the work of Rumbaut (1985) and Portes and Rumbaut (1990) provides evidence that immigrants can be considered as vulnerable as a result of their settlement process alone.

A study recently conducted by the Ontario Council of Agencies Serving Immigrants (OCASI) with the goal of building capacity of newcomer services and contributing to immigration policy was “one of the largest surveys of immigrants and refugees of this nature to ever been undertaken in Ontario” (OCASI, 2012, p. 6). A major strength of this study was its reach of the sample population. In 2011, an online survey was made available in 11 languages resulting in a sample of 2,530 respondents, The survey included a category about service and settlement needs. A breakdown of year of arrival of the sample was described as follows: “31.2%, of survey respondents arrived in Canada between 2000 and 2005, and 68.8% arrived between 2006 and 2010. Of all respondents, 22.1% of respondents had arrived as recently as 2010 (OCASI, 2012, p. 20). Given the timing of the fieldwork, it can be concluded that a large number of the

participants were still within three years of their arrival to Canada. It is of further interest to note that “the common settlement and integration barriers reported by respondents were: finding employment (61.8%); limited English language skills (32.7%); social isolation (26.5%); and finding housing (23.4%), (OCASI, 2012, p. 7). This study further confirms that job access, language skills, loss of networks, and access to housing are social determinants affecting the lives of Ontario’s most recent immigrants, and that these issues are typically faced at the start of the settlement process.

In summary, unlike the general population, vulnerable populations are delineated by disadvantageous social determinants that are a significant risk for their physical, psychological, and social health. These at-risk populations include several groups including the disabled, low-income earners, Aboriginals, seniors, LGBTQ youth, the homeless, substance addicts, and immigrants and refugees. All of these groups typically face socio-economic hardships that compromise their health overall on top of those challenges. However, it is a given that all immigrants and refugees often face many others including linguistic barriers, acculturation, the effects of migration, and different religious and cultural taboos and practice. Social determinants of health can affect both mind and body, triggering undesirable health outcomes. The following section will examine the immigrant experience of mental health overall and the nature of those barriers they face, as well as their needs, perceptions and common tendencies.

### The New Immigrant Experience of Mental Health

Aday (1994) uses a variety of rationale for focusing on the health needs of vulnerable populations such as “life-threatening or debilitating need, their requirement of an extensive menu of medical and nonmedical services, and growth in their number and

magnitude of need resulting in greater demand on medical care” (p.490). The population growth and magnitude of need for services rationale aligns with the justification of the MHCC. As mentioned at the start of this thesis, Canada’s immigrant population growth is a driver to focus on their mental health experiences. As this population grows so can the incidence of immigrant mental health problems and demands on the system. The high volume of the immigrants in comparison to other groups is best illustrated by considering Canadian 2006 census data. In 2006, the Aboriginal population was hovering over one million (Canada, 2007). The Canadian immigrant population is exactly six times that amount. Furthermore, the other group labels are not mutually exclusive to immigrants; meaning immigrants may be members of other interest groups. To illustrate that point, the following examples can be taken into account; an immigrant teenager could be a member of the LGBTQ community, or immigrants naturally become senior citizens. The majority of other vulnerable populations are for the most part (with the exception of Aboriginals) all encompassing and identified on the basis of gender, and life stages/phenomena. Whereas the immigrant experience on the other hand is a unique experience and is not a lived one for every human being. While other groups including Aboriginals, LGBTQ, and seniors are also important to consider, their understandings of mental health have commonly been studied (Kaspar, 2013; Norman & Redfern, 1997; Williams and Chapman, 2011).

Reitmanova and Gustafson (2009) agree that immigrants can be vulnerable to other challenges affecting mental health in their households in addition to employment, income, livelihood, access to food, access to health services, housing status, and level of education; on top of this list they add limited computer and language literacy, lack of

information and health literacy, the stigma associated with mental illness, and religious/cultural differences affecting mental health attitudes in their households (p. 615). While this research acknowledges such detrimental factors, its focus is on ethnic immigrant experience as a whole, (influenced by one or more determinants) and the effects on communicating mental health awareness.

Stodolska (2008) adds, citing Portes and Rumbaut (2001), that the lives of immigrants encompass experiences of loss, change, conflict and demands and these can take their toll on an immigrant's emotional state (p. 36). This suggests that countries with large numbers of new immigrants need to pay close attention to their psychosocial needs, particularly at the start of their settlement process.

Cultural barriers and economic challenges facing new immigrants make it more difficult to access and make sense of relevant health information which can exacerbate overall health literacy difficulties (Kreps et al., 2008). This is significant given the many demands that settling in a new country create, enforced by cultural differences and possibly language barriers. The risk facing new immigrants for negative perceptions of mental health was well detailed by the MHCC (2009): "social factors influence people throughout their lives and impose risks to develop a mental health problem or illness, increase vulnerability and susceptibility, and prolong the illness experience while others can prevent illness and restore health" (p. 15). MHCC (2009) also states that at various life stages, in particular migration, the danger is more likely due to major personal stress "at a time when the social safety net may be weaker" (p. 15). This suggests that new immigrants are at high risk for negative mental health patterns upon their arrival. At a time when the benefits of resources, such as social networks could be helpful in the

prevention of health risks, such beneficial resources may be modest.

It has been suggested that cultural differences can be reflected in the conceptualization of mental health, which factors in to mental health literacy. This term will be defined in the following section. Research to date also suggests that immigrants also have unique mental health experiences as a result of the notion of stigma. Rao, Feinglass, and Corrigan (2007) recommend that stigma be considered separately amongst cultural populations (not merely as a pattern amongst a general population) since diagnoses of mental illness are given based on deviations from sociocultural or behavioral norms. In other words, Rao, Feinglass and Corrigan (2007) argue that mental illness is deeply tied to culture and other determinants and, as such, mental illness stigma is likely to vary across cultures (p. 935). As a result, Abdullah and Brown (2011) warn that if cultural groups are lumped together in mental health research, important ways that societal groups differ may be overlooked (p. 935). This suggestion of exploring differences of mental health perceptions among cultures, and not on a broad basis supports this research proposal's approach of looking at distinct cultural groups. Culture-based research examining mental health communication, promotion, literacy, stigma and other barriers amongst ethnic minorities were most often based on the experiences of Chinese and Korean (Asian), Mexican (Hispanic) and, more generally, African, Afro-American, Arab, and Southeast Asian individuals.

Several studies have examined how familial and cultural influences, when combined; establish patterns in the mental health experiences and help-seeking behaviours of ethnic populations. As cited by Lindsey et al. (2010), help-seeking is defined as a process involving influence from individuals in one's social network

whether they be family members, friends, or colleagues in developing a pathway with an expectation of resolving, and confirming one's emotional or psychological problem (p. 462). For example, the roots of mental health stigma have been traced to family perception and this phenomenon is signaled as a malevolent influence that shapes the nature of help-seeking behaviours amongst children. Studies contend that "family social support exercises primacy over other networks such as professional and peer support" for children in need (Lindsey et al., 2010, p. 458) and that there is a need to work with families on a holistic level to improve the help-seeking experiences of their children (Lindsey et al., 2010; Vera and Conner, 2007).

The influence of stigma and culture on help-seeking behaviours was explored in a mixed-method study that examined how African American boys in outpatient treatment sought support. The authors used both open-ended questions and close-ended questions in an established help-seeking scale with a specific focus on stigma tolerance, that is "the extent to which participants might be concerned about what others might think if he visited a "mental health professional for treatment" in addition to measures for social support and depressive symptoms (Lindsey et al., 2010, p. 465). Lindsey et al. were able to illustrate a link between stigma and help-seeking behaviour (p. 465). These authors demonstrate how the help-seeking process is predicated by the presence or absence of stigma: help seeking can be either a constructive experience whereby an individual can rely on family "to assist in arriving at a solution, to provide emotional support, remind them of appointments, assist with transportation, and ensure that proper aftercare recommendations are adhered to" or a pernicious experience where "network members might transmit stigma, negative messages, and feelings of distrust about formal services,

thereby influencing both an individual's mental health symptoms and their help-seeking behaviors", suggesting that it becomes more difficult for them to get ahead in the process (Lindsey et al., 2010, p. 462). The finding that "a primacy of family and parental support for the affected teens, combined with the prevalence of frequent distrust of professionals and peer networks in this ethnic population" which lead Lindsey et al., 2010, to suggest that "working with families may improve initial identification of depression among African American adolescent boys and decrease their barriers to care" (p. 459) offers significance to this thesis. It signifies that progress such as increasing access to mental services can be achieved by addressing mental health from a familial perspective. It also implies that perceptions suspicious toward mental health professionals and peer networks can often be embedded in the cultural persona of an ethnic group and family, and supports the notion that initiatives are required to dispel stigmatizing mental health attitudes and beliefs of these parents and caregivers, which could be in the form of community education and mental health promotion.

To synthesize, the immigrant experience of mental health is a unique experience due to a multitude of potential barriers that new immigrants face upon their settlement in a new country. The variables they encounter are collectively identified by a phenomenon called social liminality, which depicts how immigrants "perceive themselves to be in a psychologically stressful, transitional state" (Simich et al., 2009, p. 253). On top of economic concerns such as unemployment or limited income, they face innate challenges on the basis of their origin, namely cultural, religious and familial values that incite the level of stigma they espouse with regards to mental health. This cultural stigma can result in undesirable ripple affects in the family unit, such as a reluctance towards help-

seeking, mistrust of mental health professionals, or the inability for children to share their feelings with elders with regards to mental health out of fear of negative reactions within one's own family. Given that culture has considerable effects on the immigrant experience of mental health and that it varies from country to country, the next section will review recent statistics of Canada's immigration patterns, in order to paint the portrait of the most recent immigrants that make up its multicultural mosaic.

#### Canadian Immigration Patterns

The 2006 Canadian Census provided a detailed portrait of the country's foreign-born population. It reported that the highest volume of immigrants to Canada came from Asia, with a total of 58 percent (Canada, 2007). While the People's Republic of China was the "leading source of newcomers to Canada at 14 percent, it was closely followed by India representing 11.6 per cent of new immigrants, the Philippines seven per cent, and Pakistan five per cent" (Canada, 2007). According to the Census, China, India, the Phillipines, Pakistan, South Korea and Iran comprise part of the common source countries for recent immigrants to Canada (Canada, 2007). The origin of the second highest group of new immigrants to Canada came from Eastern Europe (16 %), with most immigrants coming from Romania. While this data was collected in 2006, it is the last date of official and comprehensive census publication in Canada since the Government's decision of moving toward optional household surveys in 2011. Despite the fact that the information is over five years old, it is still useful in establishing Canadian immigration patterns that currently still hold true.

Given these recent immigration patterns to Canada, and the fact that mental health experiences of the Chinese population have been commonly studied (Lai, 2009; Xiang et

al., 2010) the mental health experiences of Eastern European and other Asian immigrants will be more closely examined. While the available literature on mental health and these cultures was scant, the literature echoed the theme of cultural and familial differences in understanding mental health as discussed in the previous section. Given the common countries of origin to Canada representing recent waves of new immigrants, and the sample population for this study, the following paragraphs will disseminate literature focusing on Eastern European, South Asian and Iranian mental health attitudes.

Coleman et al. (2010) explored Eastern European tendencies towards mental health and examined, specifically, the levels of spiritual belief, social support, and physical functioning and depression amongst Bulgarians and Romanians. While it was a study limited to a sample population of older people, and without focus on general public attitudes towards mental health or the importance of family perceptions, it still offered some useful conclusions. The researchers conducted a series of interviews with individuals over the age of 60 and justified the need to assess the experience of older people in this age bracket because of their diminished quality of life stemming from the demise of communism in these countries, as well as the need for comparison as a result of the dichotomy between Bulgarian and Romanian religions. While the Bulgarian Orthodox church experienced “repression” and “stagnation” in a post-communist era, the Romanian Orthodox Church became more “prominent,” leading this research team to hypothesize that religious belief would have a positive association with mental health most prevalent in the Romanian community (p. 328). This article chartered direction for future study in its findings. Firstly, Coleman et al. (2010) found high levels of depressive symptoms for individuals from both countries but not necessarily attributable to religion

alone but due to other feelings also reminiscent of social capital such as “lack of social belonging” and “informal social networks”, as well as “integration deficits” feelings of uselessness, inferiority and being left out of society. These findings are relevant to this study as such feelings could be more pronounced for new immigrants to Canada who are integrating in to a new society facing similar challenges. Coleman et al. (2010) also uncovered that women were more commonly affected by depression (p. 332). This suggests an angle under which the mental health experiences of Eastern Europeans might be explored: through the perspective of women.

Masood and Okazaki (2009) considered the mental health experiences of South Asian Americans, operationalized as individuals from India, Pakistan, Bangladesh, Sri Lanka, Nepal, and the Maldives from basis of gender, family and community standpoints. According to the authors, South Asians are typified as the “fastest growing Asian population in the United States” (a similar case could be made for Canada’s own South Asian population) and this population faces psycho-social barriers such as domestic and sexual violence, AIDS and immigration related stress (p. 265). On the influence of gender on South Asian American mental health, Masood and Okazaki (2009) cited a variety of sources that underscored South Asian women’s psychological pressures such as a mother putting her own needs aside for the collective good of the family unit, focusing on the needs of the whole, culture adjustment difficulties, culture clashes on issues such as dating and female autonomy, or the need to shoulder responsibility of cultural continuity during a period of American assimilation (p. 266). From a family context, given the importance of family needs instead of individual needs, Masood and Okazaki referenced the findings of Dugsin (2001), who found that it “ is

possible that a sense of closeness in some families may make it more difficult for a family member to pursue individual goals that are discrepant from the family's expectations" (p. 266). In other words, given the level of familial involvement typical of South Asian culture, an individual seeking help or support for mental health concerns from their family could encounter discomfort coming forward. From a community angle, Masood and Okazaki note the South Asian population's strength in community cohesiveness despite "geographic dispersal." While prominent community ties offer many benefits, it was noted that such networks can also breed a certain sensitivity with regards to self-perception and "status-anxiety," a reflection of an individual's desire to place themselves favorably within the fluid, multilayered social hierarchies of their communities (Masood and Okazaki, 2009, p. 266).

Through their multi-regression model applied to South Asians, Masood and Okazaki (2009) were able to discover gender differences in levels of psychological distress tied to family factors. For women, "lack of extended family support was related to higher levels of distress, and family factors alone accounted for an overwhelming majority of variability in distress" while for men their more moderate stress levels were more correlated with "lower community social position, and greater conflict with evolving family culture and traditional values" (p. 272). It was also noted that factors beyond the family, stemming from the community, had a psychological impact for South Asian American men. For example, a "lower social position in the community for those who had not achieved professional success and mobility had a positive association with assimilation" (Masood & Okazaki, 2009, p. 272). These results offer significance for this study on multiple levels. Firstly it suggests that there is a need to better understand

gender differences in mental health for the South Asian community. Furthermore, the recurring theme and omnipresent link of family to mental health suggests there would be merit in exploring the mental health needs for the benefit of South Asian families as a whole. Lastly, the authors advocated for the need to understand the “impact of psychological functioning on South Asian American mental health” and how that factors in to “culturally appropriate strategies of intervention” (p. 272). More specifically, this South Asian example advocates for greater understanding of cultural sensitivities in the help-seeking and information sharing approaches in addressing mental health and additional research in this regard, supporting the direction of this study.

Finally from an Iranian angle, Martin (2009) notes apparent cultural gaps in understanding mental health on the basis of language, definitions, and terminology in older Iranian immigrants. In this study, a series of interviews were conducted with Iranian immigrants to the United States in order to assess how they understood mental health. The findings indicate that this sample population considered mental health as part of overall health as a result of language and culture. Health was always considered on a holistic level; “mind, body and spirit were inseparable in their view” stemming from broad Farsi definitions for health that included physical and spiritual aspects. As such Iranian immigrant sample was unable to identify symptoms specific to mental health (Martin, 2009, p.123). For study participants, the lines of physical and mental symptoms were often blurred. It is also evident from this study that Iranian immigrants were suspicious of medical treatment for mental health issues, whether seeking mental health care or taking prescribed medications as a result of their cultural views of health and mental health. For example, the interview subjects felt that American medical experts

spent “too much time focusing on the mind” and therefore would be inclined to prescribe “too many medications” (Martin, 2009, p. 123). This proves to be consistent with the Iranian belief of mind and body as one entity and with the results of other studies that also identify mistrust as a barrier due to fears of deportation or persecution in unstable political regimes (Dow, 2011).

Considering the Census data and most recent immigration patterns for Canada and the reinforced need to understand mental health amongst other distinct cultural groups, this research will focus on the experiences of immigrants from the most common countries of origin to Canada. These countries will be operationalized in the methodology section. For example, the need to look at South and Middle Eastern Asian and Eastern European immigrants is supported by the finding that literature on the mental health needs and experiences of these ethnic groups is not readily available. The results of this literature review echoed the findings of other researchers who endeavoured to examine specific cultural groups (Coleman et al., 2009; Martin, 2009; & Masood & Okazaki, 2009). Furthermore, while these three regions of the world are distinct culturally speaking, the results of these specific articles pointed to some common factors that were found to negatively affect mental health such as religious beliefs, gender differences, family values, and community ties (Coleman et al., 2009; Martin, 2009; Masood & Okazaki, 2009).

Now that vulnerable populations, the immigrant experience and Canadian Census data have been explored, the majority of the remaining sections of this literature review will turn to relevant mental health topics for this study, namely definitions of mental health literacy and mental health stigma, mental health perceptions and the effects of mental

health promotion, and finally the role of parents as caregivers in mental health and of parent child communication which dovetails toward parent empowerment theory.

#### (Mental) Health Literacy and Mental Illness Stigma

The concepts of mental health literacy and mental illness stigma are significant to mental health programming as this study that focuses on the communication needs of immigrant mothers in enhancing their knowledge of mental health to ultimately attain a level of empowerment. According to Pinto-Foltz et al. (2011) the two are linked. Mental health literacy aims to dispel widely held beliefs and stigmatizing responses to mental illness through education and mental illness stigma is a negative perception of mental illness as a result limited understanding (Pinto-Foltz et al., 2011). The terms will now be defined.

First, mental health literacy can be understood in the broader context of *health literacy* as the ability to “read, understand and act on health information” (Schiavo, 2007). Considering the litany of challenges that ethnic new immigrants face, their ability to properly interpret messaging can be compromised. Other researchers have confirmed the importance of health literacy in the lives of immigrants, and a role for communication research in understanding it. Rudd et al. (2012), for example, advocate for “research or action plans that make the distinct link between health literacy and health communication research and practice,” (p. 26) basing their conclusions on the need for improvement of health literacy in many facets, including in the lives of immigrants. Rudd et al. (2012) reviewed studies ranging on topics such as “the use of antipsychotic medications”, “understanding asthma information”, and chronic disease care for illnesses such as diabetes and cancer each amongst immigrant populations and

were able to identify the same outcomes; mainly that “language and culture are important barriers that need to be addressed” for the immigrant experience of health literacy (p. 22). This suggests that an immigrant’s ability to communicate health related concerns is integral in enhancing their level of health literacy which is also applicable to mental health and mental health literacy.

Furthermore, Schiavo (2007) states that the “overall purpose of any health materials or verbal communication is defeated if people cannot understand it” (p. 63). While mental health programming has been thoroughly designed for students, teachers, and mainstream parents, such an approach may not work for everyone. According to Pinto-Foltz et al. (2011) and consistent with the definition of Kelly et al. (1997) *mental health literacy* is defined as the knowledge and beliefs about mental illness and mental states that assist people in the recognition, management, and prevention of related diseases. Often it has been suggested that there is a role for communication to play in developing mental health literacy, for example, in designing key messages that take audience sensitivities into account and speak to the needs of all audiences.

Secondly, Abdullah and Brown (2011) define mental illness stigma as the devaluing, disgracing, and disfavoring by the general public of individuals with mental illnesses. These authors suggest that mental illness stigma is a serious problem because of its many harmful effects on stigmatized individuals including a reluctance by others to interact with a person suffering from mental illness and limited access to employment opportunities (p. 935). Pinto-Foltz et al. (2011) were able to illustrate that mental illness stigma was displayed by adolescents who showed moderate levels of negative responses related to mental disorders and low mental-health literacy. In other words the way people

view mental illness affects their wider perception of mental health and factors into an individual's mental health literacy (Pinto-Foltz et al., 2011). Looked at another way, the cultivation of mental health literacy of adolescents presents an opportunity to reduce mental illness stigma (Pinto-Foltz et al., 2011).

Abdullah and Brown (2011) make a key suggestion that mental illness stigma has higher prevalence amongst multicultural populations. To support this viewpoint, they cite the work of Whaley, who examined a broad "sample of 1468 American Indian, Asian American/Pacific Islander, African American, Latino, and Caucasian participants to determine ethnic/racial differences in perceptions of dangerousness of those with mental illness, a proxy for public stigma" (Abdullah & Brown, 2011, p. 938). A highlight of this study was the indication that Asian Americans/Pacific Islanders, African Americans, and Latinos perceived those with mental illness as significantly more dangerous than did Caucasians (Abdullah & Brown, 2011, p. 938). This example suggests that mental illness stigma is an even greater problem affecting the viewpoints and perceptions for ethno-cultural groups more so than Caucasian ones.

Unlike social determinants (of mental health) such as income and housing, which can be overcome through concrete material solutions, cultural stigma is deeply rooted in the minds and experiences of the individual, and often results in future generations of families adhering to those views. Abdullah (2011) affirms the generational effects of cultural values. Using the example of Latinos, Asians and Africans she states how their values of collectivism, interdependence, and cooperation counteract mainstream North American ideals including individualism and autonomy as promoted through the mental health care system, (p. 943). Kreps et al. (2008) reaffirms that it remains a concern that

cultural barriers and economic challenges exacerbate immigrants' language and health literacy difficulties in turn making it harder to access and make sense of relevant health information. This suggests that barriers can become more onerous to overcome. Given the variety of demands of settling compounded with cultural differences upon settling in to a new country, it has already been made clear that new immigrants can be considered an at-risk population for mental health problems and illnesses. The barriers they face cannot only encumber their actual experience of mental health but their experience of mental health literacy, which shares a direct relationship with their levels of stigma towards mental illness. Often new immigrants have negative views of mental illness which impede their ability to develop practical perceptions of mental health and helpful knowledge levels resulting in greater mental health literacy that ultimately better serve their families.

#### Mental Health, Mental Illness and Mental Health Promotion

The Canadian Mental Health Association (CMHA) defines mental health promotion as activity that assists people in developing “capacity to enjoy life, use abilities, achieve goals, develop resiliency, face adversities, contribute to the community and maintain relationships with others” (CMHA, 2012). As noted above, public health officials around the world have made the key differentiation that mental health is not mental illness by stipulating that just because a person may have mental illness does not mean they are not experiencing mental well-being, it is not the absence of mental disorder (CMHA 2012, World Health Organization [WHO], 2007). According to WHO (2013) mental health is defined as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work

productively and fruitfully, and is able to make a contribution to her or his community” (“What is Mental Health”, 2007).

Mental illnesses are diagnosed conditions that disrupt a person's life patterns, including their thoughts, feelings, moods, and daily functions. Despite the fact that mental illness can impede an individual's ability to live an ordinary life, treatment and management can lead to recovery (National Alliance Against Mental Illness [NAMI], 2013). Diagnoses of mental illness include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD) and borderline personality disorder and many others defined in the American Psychological Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, (4th ed.; *DSM-IV*; American Psychiatric Association, 1994).

#### Mental Health Promotion

The concept of mental health promotion refers to wellness, and “actions taken to strengthen mental health for all people, whether they be specific groups or the general population (CMHA, 2012). Actions can include school programmes, advertising campaigns, grassroots community activities, seminars and the cultivation of mental health champions. It has been suggested that mental health promotion can play a key role in improving the public's understanding and response to mental disorders (Kelly et al., 2007).

In an assessment on mental health literacy research, Kelly et al. (2007) concluded that “mental disorders are not well recognized by the public and this may contribute to delays in seeking and to inappropriate help-seeking” (p. 87). In addition, Kelly et al. noted that there was a lack of alignment between public and professional beliefs about

treatment and lack of adherence to recommended courses of action (p. 87). Through the use of survey data, taken from a questionnaire that was administered to the Australian public, these authors demonstrated that “first aid skills” in mental health were deficient, meaning that both adults and adolescents did not understand how to adequately respond to mental health urgencies (Kelly et al., 2007, p. 83). However, Kelly et al. credited mental health interventions such as websites, publicity, school-based interventions, and individual training courses for their capacity to change public beliefs and response to mental health concerns as supported by the repeated survey results over that ten year time span.

An example of a school-based intervention is an awareness program titled “Talking About Mental Illness” (TAMI), which was developed by the Canadian Mental Health Association (CMHA) and the Centre of Addiction and Mental Health (CAMH). The goal of the program is to help youth understand mental health issues and reduce mental health stigma. This program is being delivered to high school students nationally. The inclusion of “mental illness” in the TAMI program’s name can be misleading to the public. While the program does touch upon mental illness, its main purpose is to promote mental health. It does so by teaching its audiences about the differences between the two terms, while making important links between mental illness stigma and mental health perception. The program recognizes the need for youth to be able to communicate about mental illness with their family (CAMH, 2001, p. 10). It sees the identification of ethnic groups in each audience as important, since “different ethnic groups may have different perceptions/attitudes toward mental illness,” (CAMH p. 12). The MHCC goes on to state “school based efforts for at-risk youth need to be supplemented by additional home and

community supports” (MHCC, 2011, p. 25). How the concepts and messages of this program impact the mental health literacy experience of new immigrant mothers is to be explored in this study.

Another example of an awareness initiative that endeavoured to strengthen mental health for Latina women in the United States through a grass-roots information intervention used “bilingual, low literacy level websites and training” carried out by the women themselves and concluded that the approach fostered a sense of empowerment and improved access to health care for this immigrant population (Ginossar & Nelson, 2011, pp. 328-329). Ginossar and Nelson (2011) credit the success to “culturally sensitive communication strategies that effectively engaged immigrants while mitigating health literacy barriers” (p. 329). This illustrates the benefit of tailoring communication to a group’s needs. They also demonstrated the effectiveness of health education delivered through community ambassadors, ultimately resulting in increased access to healthcare.

Some programs, called knowledge-based contact programs, use a model whereby knowledge is provided about a phenomenon by a person living the experience (Pinto-Foltz et al., 2011, p. 2011). Pinto-Foltz et al. (2011) facilitated intergroup contact with individuals suffering from mental illness as a tool to reduce mental illness stigma and improve adolescents’ levels of mental health literacy (p. 2012). Among the adolescents in this study, a correlation with moderate levels of negative responses related to mental disorders and low mental-health literacy was discovered (p. 2011). The findings of Pinto-Foltz et al. (2011) identify a relationship between mental illness stigma and a lack of relevant knowledge and suggest that an improvement in mental health literacy in

adolescents could bring about a reduction in stigma, (p. 2016). While a limitation of this study is that it does not identify additional factors beyond age that impede mental health literacy and exacerbate mental illness stigma, the relationship it uncovers between stigma and mental health literacy is still relevant. Furthermore, Pinto-Foltz et al. (2011) made a valuable contribution in their assessment of content acceptability; a measure of teen-parent discussion as shown in the following quote where a teen explained that she “received positive reinforcement from her parents” (p. 2016). This example contributes to the idea that parents influence the effects of mental health messaging on their children.

In their research, Pinto-Foltz et al. (2011) evaluated the efficacy of a knowledge based contact program to reduce mental illness stigma and improve adolescents’ levels of mental health literacy using a survey. Their study shows among adolescents a correlation with moderate levels of negative responses related to mental disorders and low mental health literacy (2011). Through their work she suggests that an improvement in mental health literacy in adolescents could bring about a reduction in the stigma. Pinto-Foltz et al. also pointed to the finding “teens have shown preferences to discussing mental health issues with their peers but are reluctant to do so because they anticipate a negative and stigmatizing response” (p. 2012). While a limitation of this study is that it does not identify additional factors beyond age as variables that impede mental health literacy and promote mental illness stigma, for example family structure and culture, it does point to the roles of knowledge enhancement and discussion amongst peers to improve literacy and dispel stigma. It implies that teenagers can enhance their mental health literacy by talking about it and prefer to do so amongst their peers if they are

comfortable. This is significant as the findings could be applied in the study of other populations such as parents. In this regard Pinto-Foltz et al. made a relevant consideration and measured the content acceptability by recognizing the narrative comments of intervention participants. Their measure of program acceptability included teen-parent discussion. For example, the researchers quoted one adolescent who said that she received positive reinforcement from her parents who were happy that their daughter got to hear real experiences of mental illness and learn more about it (p. 2016). This suggests that parents can influence how their children interpret mental health messaging.

Research geared towards understanding how to develop local communication strategies with the goal of encouraging adolescents' and young adults' levels of "help-seeking behaviour" for mental health services was undertaken in Australia by Phillipson et al. (2009). While the need for a local campaign with concise communication channels and clear messages with suitable content were central to the conclusions of this study, the importance of inclusivity of other secondary audiences, including parents, was also underscored in contemplating communication approaches. Specifically, Phillipson et al. emphasized how "high school students clearly communicated the important role of their parents in decisions concerning health service usage" (p. 58).

Another study, on the perceptions of mental health through the eyes of teenage boys and girls, held a series of interviews with adolescents either individually or in a focus group setting (Johansson et al., 2007). A key discovery of this study was that "family was one of the most important determinants for young people's mental health" (p. 183). To further support this position, the research team referred to the following responses as positive perceptions of mental health: "To be able to tell your parents things

if there is a problem and, well, just enjoy talking to your parents. Having the courage to tell parents things” (Johansson et al., 2007, p. 194). It was found that youth signaled their parents to be “important persons” in mental health discussions (Johansson et al., 2007, p. 195) and that a positive home environment, that is “a good atmosphere for talking about various things with parents” was a determinant for better mental health (Johansson et al., 2007, p.196).

Focusing more specifically on the importance of cultural perceptions in health education initiatives, an study investigating the social sides of health risks and the influence of stigma and collective efficacy by Smith et al. (2007) suggests that “health issues may not occur in a vacuum; one may need others’ support to address a given health condition (p. 55). Using the example of Africans in Namibia and HIV, Smith et al. concluded that when people do not feel personally threatened by a health risk as a result of their perception of the severity of the risk and their own susceptibility to it, social threats such as being stigmatized or punished by their peer group might motivate them to act and change their behaviour (p. 56). They added to the “extended parallel process model” to include key social perceptions about “stigma” and “collective efficacy” and found that “Namibian respondents who did not feel threatened by HIV personally showed a relationship between these social perceptions and their willingness to support those living with HIV and their willingness to adopt AIDS orphans,” (p. 61). The relevance of this research to the current study stems from the links it illustrates between individual and social perceptions and desirable behavioural outcomes on a cultural basis. It might also explain gaps in mental health literacy amongst immigrants, on the basis of cultural perceptions and one’s self-analysis of threat of mental issues.

All of the available literature related to mental health promotion support the premise that it has the ability to enhance mental health literacy and decrease mental illness stigma for its intended audiences. However, the school-based intervention examples indicate that more work is yet to be done, as they established that adolescents and children have a need to be able to engage with their parents on the topic, in order to develop sustainable and favourable behavioural changes towards mental health when it comes to the recognition, management and prevention of mental health problems and mental illness (Johansson et al., 2007; Pinto-Foltz et al., 2011). It was apparent that supportive and well-informed family dialogue on mental health could make a difference in mental health outcomes for any child. The roles of parents in mental health promotion, and in engaging in help-seeking behaviour will now be more closely scrutinized.

#### Understanding Parental Roles in Mental Health Promotion

Some of the studies reviewed so far have indicated that parents have a role to play in the effective delivery of such interventions as a secondary audience in the communication cycle of program messages. This concept will now be explored on a deeper basis. A search of relevant literature on the role of parents in successful school-based mental health programming outcomes showed limited research on this area. While there is an abundance of material available on the role of parents in the delivery of mental health services, it predicated their involvement on the basis of their child in treatment or in need of help, not for the broader mental health of children as a whole. Therefore the evidence reviewed was limited to sources that evaluate youth mental health programs and signal for parental involvement in addition to articles that highlight the importance of parent-child communication on the topic.

Phillipson et al. (2009) sought to understand how to develop communication strategies with the goal of encouraging adolescents' and young adults' levels of "help-seeking behavior" (p. 51). A suggestion emanating from this research is the importance of including of parents as secondary audiences in contemplating communication approaches (Phillipson et al., 2009). In other words, an approach reflecting this concept would use messages that encourage family discussion and address parental sensitivities. Furthermore, Phillipson et al. (2009) emphasized how "high school students clearly communicated the important role of their parents in decisions concerning health service usage", (p. 58). These findings support a role for parents in help-seeking behaviour and parallel Johansson et al.'s (2007) emphasis on the influence of family on the perceptions of mental health through the eyes of teenage boys and girls.

The position supporting parental roles in help-seeking behaviours was reiterated by Lindsey et al. (2010) who found that a majority of their sample of Afro-American boys (61 per cent of those interviewed in their mixed method study) indicated their desire to seek help with depressive symptoms from family members and "felt comfortable with taking their problems to family members before going to "outsiders" (p. 472). Of all the family members whom they could turn to, mothers were perceived to have the best answers and feedback on solutions (Lindsey et al., 2010, p. 472).

Another study that concluded that families and peers impact adolescent attitudes toward mental health problems, emotional issues and mental health treatment and their help-seeking behaviour and that often teens make informal attempts to get health information in general from those closest to them also placed strong emphasis on the maternal role (Wisdom & Agnor, 2007, p. 336). When teenagers in treatment were

interviewed, the results indicated that the majority respondents were cases where the teenager's mother initiated their child's access to health providers and that most often mothers would set up the appointments and accompany the teen to treatment," (Wisdom & Agnor, 2007, p. 338). Fathers did not stand out as mental health resources for their children in this study.

From these articles it is evident that families and more specifically parents have a major role to play in how their children interpret and use mental health program messages and in the maintenance of their mental health. While it has been postulated that peers have a role to play in influencing perceptions of teen mental health, studies on youth mental health and mental health promotion maintain that parents have an important influence, particularly in discussion, help-seeking and maintenance. While teens may look to their friends for information and views, it is upon parents that remedial steps and actions still fall (Johansson et al., 2007; Lindsey et al., 2010; Phillipson et al., 2009; Pinto-Foltz et al., 2011; Wisdom & Agnor, 2007). Furthermore, amongst the newcomer population, it has already been noted in previous sections of this thesis that family becomes more important at a time of personal stress such as immigration process – given that many newcomers and their families lose their social network and are therefore in a process of rebuilding and establishing new friendships. Collectively, the findings reviewed call attention to the need to assess the influences of mental health promotion and mental health literacy levels on immigrant mothers.

The articles also suggest that help-seeking starts with family dialogue and most often with mothers. The next section will briefly discuss the role of mothers as family caregivers. Moreover while youth as a key audience for anti-stigma programs have been

widely considered, it was evident from the literature review that investigation of the role of parents as a secondary audience in student mental health promotion still needs to more thoughtfully understood.

#### Defining the Role of Mothers as Caregivers

Studies have shown that a common tendency amongst teenagers is to speak to their mothers about mental health related issues: their feelings, sadness, symptoms and other sensitive health issues such as sex (Jaccard, Dittus & Gordon, 2000; Wisdom & Agnor, 2007). In addition, studies associate mothers with main caregiving responsibilities (Farinelli & Guerrero, 2011; Grewal et al., 2005).

Similarly, a study that explored how Latina mothers perceive mental health and mental health promotion found mothers to be “monitors of their children’s emotional needs” (Vera & Conner, 2007, p. 235). This study also found that ethnic mothers understood how stability and happiness contribute to a person’s mentally healthy outlook, and mental health is interpersonal in nature (Vera & Conner, 2007, p. 235). Examples of responses that illustrated these points included “harmonious relationships within the family”, “providing support to others”, “fostering interdependence”, and the view of parents as role models whereby “happy parents make happy children” (Vera & Conner, 2007, p. 235). In summary, mothers have consistently been viewed as gatekeepers to their children’s mental health, which could be attributed to gender roles and higher emotional sensitivity and acuity for females. It also appears that ethnic minority women understand that importance of strong emotional support of their children. These findings will be applied to this study as it will focus on the how new immigrant mothers perceive their role in maintaining their children’s mental health.

## Theoretical Framework

### *Parent Empowerment*

Heflinger and Bickman (1996) made a significant contribution to the concept of family empowerment which became widely used in the late 1980's in mental health and social services (p. 105). While Heflinger and Bickman (1996) found that that family empowerment had "no single definition," they cite Vanderslice's summary of the term as a "process through which people become more able to influence those people and organizations that affect their lives and the lives of those they care about," (p. 105). They also noted that the term was often focused on the resources and competence aspects such as knowledge about services and communication skills for problem solving in the mental health and developmental disability arenas (p. 105). Heflinger and Bickman (1996) found this problematic in that it limited parents to roles as advocates instead of cooperators and collaborators (p. 105). They suggested that "programs that teach skills to promote access to needed information and resources" could be helpful in enhancing the capacity of parents (p. 106). Further, they argued that self-efficacy, which they defined as "parents' belief that their involvement in their children's mental health treatment will make a difference" was more motivating and a necessary component to empowerment (p. 106). To that effect, Bickman et al. (1998) define empowerment as comprehensive knowledge combined with high levels of self-efficacy promoting an active role in an experience.

The work of Bickman et al. (1998) is closely linked with the self-efficacy theories of Albert Bandura (p. 271). Schiavo (2007) cites Bandura's (1977) definition of self-efficacy as "an individual's confidence in his or her ability to perform or sustain the

action with little or no help from others, playing a major role in the actual performance of the desired health behavior” (p.39). In terms of performance, Bickman et al. (1998) point to the importance of Bandura’s self-efficacy training techniques. These include enactive attainment (practicing a new skill), vicarious experiences (observing or imagining others performing successfully), modeling (imitating the successful performance of others), and verbal persuasion (words that foster the belief that goals are attainable) (p. 271). The model’s training technique that is most applicable to this research focus of messaging is that of verbal persuasion because it can be used to “encourage beliefs that individuals are capable of achieving their goals” (p. 272). Verbal persuasion can also lead an individual to try out the desired behaviour, take cues from those around them, and to picture successful outcomes. As such, self-efficacy can be viewed as both a pre-condition that can lead to empowerment as well as part of the empowerment process. Its presence is integral in the development of an empowered outcome.

A limitation of the entire empowerment concept is its reactive, narrow focus on mental health services and not mental health awareness. As highlighted in the literature review, the former term is connected to mental illness and is based on an individual patient experience and the latter term is significant for the well-being of the general population. As such, a parent’s path of empowerment should not only be confined to whether or not his or her child is in treatment. However the premise of empowerment as a state of confidence and self-efficacy is still valid. The application of Bickman et al.’s empowerment model towards preventative mental health programming in this proposed study offers a footing for understanding the mental health literacy needs of newcomer

parents.

Ginossar and Nelson (2010) reported the empowerment of Latina women in understanding healthcare and efficacy of the community based interventions through “self-reported increases” of knowledge as well as through the positive measures of self-efficacy of the community ambassadors and promoters as a result of their enhanced ability to use computer manuals and online databases of health information (p. 335).

In this study, the empowerment of new immigrant mothers is defined on a similar basis using the same tenets proposed by Heflinger and Bickman (1996) and Bickman et al. (1998) but in the context of mental health literacy (and not mental health services) as follows: the belief of mothers that (1) their knowledge of mental health can positively impact their child’s learning outcomes on the issue, (2) they have the ability to participate in the learning (mental health promotion) process, (3) their understanding of mental health can help attain a favourable difference leading to a healthier existence for their child.

Parent empowerment was evaluated through the development of a program that was concentrated on establishing the confidence and self-efficacy levels of parents with children with emotional and behavioural problems (Olin et al., 2010). Olin and her colleagues developed a parent empowerment model based on previous findings about barriers families face in accessing mental health services including stigma, perceptions of providers, attitudes towards mental illness, service availability (Olin et al., 2010). This study reiterated that there is need to encourage parents to become champions of change, and to strive toward efficacy in their empowered roles, particularly for the mental well being of their children.

*Reactance as a Result of Empowerment*

While the theory of empowerment represents a positive response to health intervention, it has another limitation in that it does not serve all members of the public, especially since individuals can have varying personal beliefs and strength in their self-efficacy levels. Another theory, called *reactance theory* (Brehm, 1966), explains opposing and less desirable responses to enhanced knowledge as a result of health intervention. The goal of empowerment may not always necessarily lead to adoption of healthy behaviours and actions. Reactance theory posits that when “elimination or threat of elimination of the freedom to engage in given behaviour is apparent to an individual, a response of psychological reactance in that person is triggered, to the extent that they become motivated to engage in that same behaviour and experience that same freedom that is threatened or eliminated” (Brehm, 1966, p. 301). In summary, reactance theory consists of four main tenets: freedom, threat to freedom, reactance, and restoration of freedom (Dillard & Shen, 2005).

To test the theory, Brehm (1966) conducted a pair of experiments. The first experiment, which had college students rate the “attractiveness” of four recordings of music and respond by choosing the song of their liking, concluded that the third most attractive record “increased in attractiveness when it became unavailable as one of the choice alternatives” (p. 306). To reinforce this finding, Brehm (1966) conducted a secondary experiment that stipulated a “condition in which some subjects were given no prior freedom to choose which record they would receive” and demonstrated a “tendency to see the eliminated record as attractive only when subjects had prior freedom to choose which record they would take” (p. 301). The other participants, who “had no prior

freedom to choose tended to see the eliminated record as having decreased in attractiveness” (Brehm, 1966, p. 308). These results supported the premise of reactance theory. To summarize, when an object or an activity is restricted or prohibited to an individual, it makes that selection even more enticing, encouraging the individual to want what they cannot or should not have.

Research on reactance theory and health communication contexts has been conducted in order to assess the efficacy of health education in the form of programs, campaigns and other interventions. Studies in particular highlighted undesirable responses to health initiatives which endeavoured to empower subjects, mainly teenagers on the importance healthy lifestyle goals such as proper oral hygiene, smoking cessation, nutritious eating and the avoidance of trans-fats and fast foods, on a variety of alcohol use related topics such as legal drinking age, limiting consumption, alcohol education and alcoholic beverage warnings (Dillard & Shen, 2005; Robinson & Killen, 1997). For example, some undesirable responses included underage drinking, binge eating fatty foods, and nicotine addiction amongst youth.

While empowerment as part of health promotion endeavours to create healthy, desirable outcomes, it is important to note that the process has shortcomings as it could lead to opposite, less desirable effects as a result of reactance.

### Operational Definitions

To ensure consistency in the use of mental health terminology and other key definitions in this thesis, the following operational definitions will be used for purposes of the study.

*New immigrant* is defined as recent immigrants to Canada who have been in the country for no longer than three years, the period marking the start of their settlement and when their settlement, emotional, and psychological needs tend to be higher, according to (Rumbaut, 1985).

*Mental health perception* is defined as beliefs and attitudes of mental health that stem from views of mental illness (CAMH, 2001).

*Mental health literacy* is defined as the knowledge and beliefs about mental illness and mental states that assist people in the recognition, management, and prevention of related diseases (Kelly et al., 1997; Pinto-Foltz et al., 2011).

*Empowerment* is defined as confidence in one's knowledge, ability to participate and to apply their understanding in order to attain a favourable difference and healthier existence for their child (Bickman et al., 1998).

### Conceptual Model

The following conceptual model (Appendix A) illustrates how the topics discussed in this literature review relate to each other on a bidirectional basis and how they factor in to exploring the empowerment of new immigrant mothers in their experience of mental health literacy.

The first category of mental health and vulnerable populations (highlighted in purple) begins by identifying the at-risk populations and by typifying the nature of social determinants of health that act as barriers to mental wellness. It also outlines the key social, economic and personal effects on the individual and on society. It then considers Canadian new immigrant statistics in addition to new immigrant experiences in general in order to affirm the need to study this population more closely.

The second category (highlighted in red) focuses on the main mental health concepts central to this study through its definitions of mental health literacy, mental illness stigma, mental health promotion, and mental health perception. The intersection of lines between these categories outlines the relationships between them. For example, the impact of mental illness stigma and mental health literacy on perceptions or the impact of mental health promotional initiatives on beliefs, attitudes, and personal experiences of mental health. It also points to the need to study these phenomena more closely particularly amongst ethnic populations. In addition, this section represents the effects of these concepts on help-seeking behaviours and the role that parents have to play in this experience. It suggests the need for in-depth research on parents and their roles in mental health maintenance. Lastly, it shows the link between new immigrants in the first category and beliefs, attitudes and personal experiences of mental health that vary and are often correlated with levels of mental health literacy and mental illness stigma.

The third and last category (highlighted in orange) is focused on parental roles in mental health promotion and the theoretical concept of parent empowerment. It emphasizes the importance of communication and the roles of mothers as caregivers and as the parent most commonly associated with emotional support. Parallel to that it defines parents' empowerment as the ability to influence an outcome, along with self-efficacy that results in the realization of a difference. It makes links within its category, such as the affects of communication on self-efficacy or the sharing of concerns and health information on the ability to influence, and beyond by confirming the earlier suggestion that parents influence mental health promotion and perception. It confirms

that mothers often take on that role. Also represented in this final orange category is the theory of reactance which stems from mental health promotion and potentially contravenes the positive effects of parent empowerment and in turn has the ability to impact mothers in their caregiving roles. Finally as a result of the relationships between the variables presented, this section establishes the need to study the empowerment of new immigrant mothers and mental health literacy.

### Research Questions

The following questions are advanced in conjunction with the theoretical perspectives and arguments outlined in the literature review and subsequent links illustrated in the conceptual map:

1. *How do new immigrant mothers perceive their roles with regard to the maintenance of their children's mental health?*
2. *What is the nature of the mental health perceptions and attitudes that TAMI program messaging triggers for new immigrant mothers?*
3. *How do TAMI mental health messages contribute to and build upon new immigrant mothers' perceptions of and attitudes toward mental health?*

The first question seeks to address the role of parent empowerment in mental health literacy and understand how these new immigrant mothers see their own responsibilities in regard to their children's mental health needs. The second question pertains to the TAMI messaging and the perceptions and attitudes that new immigrant mothers may have in response to this mental health communication campaign. The last question addresses whether TAMI messages enhance and represent immigrant mothers' mental health perceptions and attitudes.

## CHAPTER THREE: METHODOLOGY

This study embraces a phenomenological approach and aims to understand empowerment and mental health literacy through the eyes of immigrant mothers. Data was collected from focus group discussions with immigrant mothers in order to understand their perspectives in this regard.

Phenomenologism is defined by Palys (1997) as an approach to understanding the world through people's minds and exploring their perceptions and interpretations of it. Max Weber, a German social scientist used the word "verstehen" to describe the development of an understanding "based on the ability to appreciate a person's behaviour in terms of the interpretative meaning he or she attaches to it," (Palys, 1997, p. 18). Phenomenology is the realization of that interpretation, the process that "verstehen" encompasses. The approach to inquiry applied to this study was phenomenological given that the research sought to understand "the essence of human experiences as lived by people," (Creswell, 2009, p.13) in this case immigrant mothers. In conducting this study, the researcher followed the recommendations of Moustakas (1994) as cited in Creswell (2009) by interviewing a small number of participants. In addition she also considered the recommendation of Nieswiadomy (1993) by "setting aside her own experiences" also cited in Creswell (2009) with a view towards better understanding the experiences of the subjects.

Focus group discussions were chosen as the appropriate method to field data for this study on a sensitive health topic. In her definition of focus groups, Wilson (1997) encapsulates the following criteria; small gatherings of four to twelve people convened by a trained researcher/moderator in a non-threatening environment, sessions that last for

a duration of up to two hours, discussions of selected topics, explorations of participants' perceptions, attitudes, feelings and ideas and the facilitation of group interaction (p. 211).

This study adheres to these principles in the following ways; the focus groups congregated three and four participants each, both sessions lasted for two hours and concentrated on discussing perspectives of mental health knowledge in a dynamic environment, and the discussion groups took place in a neutral, accessible, classroom style setting.

Focus groups have proven to be a reliable and effective research tool in the area of health and mental health, particularly in the following areas of interest linked to this study: understanding attitudes toward depression (Wisdom & Agnor, 2007), help-seeking behaviour (Phillipson et al., 2009) and family occurrences of mental health disorders (Piedra & Byoun, 2012), the efficacy of health interventions and programs (Cashman et al., 2011), and the health behaviours of vulnerable populations including immigrants and Aboriginal groups (Dawson et al., 2013).

Kitsinger (1995) highlights several benefits to using focus group discussion in health-related research including the exploration and clarification of views as a result of group processes, the opportunity for research participants to discern what aspects of an issue are important to them and express themselves in their own vocabulary, access to a variety of a communication especially since knowledge and attitudes are not necessarily revealed in close-ended questions, the use of a non-discriminatory approach that does not exclude people who have potential language or literacy barriers, and the encouragement of participation of those participants who may otherwise be unwilling and intimidated by a one on one interview. Most of all, Kisting (1995) views the essence of

communication between people on an interpersonal level as important because of its ability to highlight (sub) cultural values or group norms allowing the researcher to determine shared and common knowledge, whether it is through consensus, dissent, humour, or types of narrative used. These advantages make focus groups more attuned to cultural variables and a popular choice in cross-cultural and ethnic minority research. As well, this approach is suitable for studies that explore the experiences of various population groups in health services (Kitsinger, 1995). This study's focus on immigrant mothers of ethnic minority descent, its cross-cultural reach, and interest in understanding maternal experiences of health maintenance parallel those recommendations.

The dialogue and nature of focus groups is viewed as integral in assessing the efficacy of health interventions on sensitive topics and developing responses to the health concerns of specific populations (Cashman et al., 2011; Piedra & Byoun, 2012). It has also been suggested that focus group research is useful in assessing public needs and gathering necessary feedback on school, community, and health programs (Eubanks & Abbott, 2003; Wilson, 1997) because they encourage thoughts on message interpretation and associated meanings and a safe and secure environment for participants who share their views in a small group setting and are not obligated to answer all the questions (Barbour, 2010; Kitsinger, 1995).

While focus groups offer many advantages, this approach can impose limitations as well because of its socially dynamic nature. Palys (1997) suggests that some people may experience shyness in comparison with their peers when expressing their opinions and that this can foster dominance for those who are more comfortable in doing so. Furthermore, focus group participants may feel reluctant to share extreme or different

views because of fear of judgement and, possible, insecurity as a result of maintaining their image in the eyes of others (p. 157). The restricted size of focus groups also renders the research results non-generalizable to the general population (Bonneville et al., 2007) as can the non-confidential nature of a group setting (Kitsinger, 1995; Palys, 1997). Creswell (2009) also indicates that the influence of bias and social desirability is always present in qualitative research, often stemming from the presence of the researcher. Palys (1997) also echoes a similar concern that participants may be concerned about maintaining a certain image in the presence of a researcher and peers. However, Kitsinger (1995) considers the group dynamic to be more beneficial, especially in examining sensitive topics. She credits the group factor as “the facilitator of discussion of taboo topics, and as an opportunity to provide mutual support between peers” (Kitsinger, 1995). Offering participants the chance to freely express themselves and develop their views alongside members of their community gives them a chance to be actively engaged on the topic.

Given that the purpose of this study is to better understand the mental health literacy perspectives of specific cultural groups of new immigrant mothers by introducing them to a mental health program, to provide encouragement toward personal empowerment in mental health maintenance of their families, and that mental health is considered to be a taboo topic to many, it is clear that the choice of focus groups to uncover these experiences is justified and appropriate.

## Sample and Procedures

### *Sample population*

The study design included two evening focus groups to accommodate up to six people per session. Research participants were recruited purposefully. The Career Edge Organization committed to this study by supporting the sampling procedure with the goal of selecting new immigrant mothers from the most common countries of origin to Canada. The Career Edge Organization was approached because of its extensive multi-cultural reach; it runs the Career Bridge Program, a national initiative that helps foreign-trained professional new immigrants get their first Canadian job experiences, with a pool of candidates enumerating in the thousands. The variety of countries represented in the Career Bridge database echo the countries listed in official Canadian immigration statistics.

Furthermore the Career Edge sample population offers several other benefits relevant to this study. Firstly, program participants are recent newcomers to Canada; the Career Bridge program does not accept candidates who have immigrated to the country more than three years ago so as to ensure a pool is representative of new immigrants. This is consistent with the findings of Rumbaut (1985) and Portes and Rumbaut (1990) who noted that within the three year time frame, the psychological impact of settlement and the settlement needs of immigrants tend to be highest. Secondly, because of the rigorous pre-screening criteria necessary to participate in Career Bridge of a post-secondary degree or diploma, fluency in English as a second language at a benchmark level of 8 (out of 10), and workplace communication skills, participants were able to interact with the researcher in English (Career Bridge, 2013). This pre-screening process

also provides for homogeneity within the sample. The sample population has consistent degrees of language proficiency and levels of post-secondary education, and it does not have major time gaps and discrepancies with regards to date of arrival to Canada between all of its registrants. In her recommendations for recruitment, Kitsinger (1995) points out that selecting discussion group members on the basis of homogenous characteristics allows the researcher to bring together shared experiences. On a contrary note, Kitsinger (1995) also says that a diverse group can allow for more variety of perspective to be shared. As such, the focus groups in this study were not exclusive to any distinct culture. Dates within the invitation were kept flexible in order to encourage a mixed presence of a variety of immigrant women from the most common countries of origin to Canada and provide for some variability in the discussion.

#### *Selection Criteria*

To facilitate participation, the study was conducted in the same city that the sample was drawn from, the Toronto area, where the majority of the Career Bridge program registrants live. Only those registrants who lived in Toronto or the Greater Toronto Area were selected as part of the study participant pool.

Since the study's focus is understanding the immigrant experience of parent empowerment in mental health literacy and since mothers have a role to play in their children's mental well-being and receptivity to behavioural change that promotes it, the study participant pool was narrowed to women only, and to mothers of children (under the age of 18) who attend school in Ontario to meet this objective.

Immigrant women were selected through consultation with the most recent 2010 entry data of an annual world-wide list published by Citizenship and Immigration

Canada, “Permanent Residents by Source Country,” (Canada, 2010). This yielded the following most countries of origin for prospective participants which had rarely been studied in mental health promotion, mental health literacy or generally speaking in mental health. The final sample population was made up of immigrant mothers of children under the age of 18, living in Toronto, from the following countries:

Bangladesh, India, Iran, Pakistan, Poland, Republic of Moldova, Russia, Romania, Sri Lanka, and the Ukraine. The total eligible sample population was comprised of 253 women.

### *Recruitment*

The Career Edge Organization also assisted in participant recruitment in order to protect the confidentiality of the personal information of the potential participants including names, countries of origin, and email addresses. After receiving ethical clearance from the University of Ottawa to conduct the research, and in order to assure no bias or perception of coercion associated with receiving the email from a specific Career Edge contact that the recipient might know, one of their staff members sent out a recruitment message (Appendix B) to their participants using the Career Edge generic email address “info@careeredge” instead. This message included a copy of the recruitment letter (Appendix C) from the Researcher herself. Email recipients were asked to email the Researcher to express interest in the study, assess their candidacy and confirm their participation.

In total 253 invitation emails were sent, to which 14 women responded yielding a response rate of six per cent. Of these 14 women, the majority, 12 of them (86 per cent) were confirmed as eligible and available on the selected dates and accepted the invitation

to participate. A limitation of this process was that it required participants to take an extra step and the initiative to contact the Researcher on their own. While it would have been optimal to have the Researcher make contact with the sample population directly, it was important to respect the privacy and proprietary nature of the Career Edge Organization's data. This process as designed responds to the Career Edge Organization's preferred and specified direction.

Follow-up reminder emails were sent to the 12 women who confirmed their presence one week before the session. Despite this effort, only seven women ended up attending, yielding a participation rate of 58 per cent. A breakdown of the participants' profiles is illustrated in the following table.

*Figure 3.1 Focus Group Participants*

<b>Alias</b>	<b>Country of Origin</b>	<b>Number of Years in Canada</b>
Geeta	India	1
Dipa	Bangladesh	3
Farnaz	Iran	1
Bahar	Iran	2
Mona	Iran	less than 1
Samireh	Iran	1

### *Focus Group Procedures*

*Logistics and Mechanics.* Two 120 minute focus group sessions were set-up on the evenings of June 11 and 12, 2013. The groups were conducted in a modest training style room at the Ontario Institute of Studies in Education on the University of Toronto campus. This site was ideal as its location right above the subway line was easily

accessible to participants. Participants were asked to arrive half an hour early in order to review (and sign) the consent forms (see Appendix D) with the researcher and receive their incentive. Gift cards were provided to the participants for ten dollars each for Tim Horton's as an incentive for participation. Light refreshments were also provided since the sessions went over the dinner hour. Participants were also provided with a hard copy version of the discussion questions in large print formatted in Powerpoint and pens so that any additional thoughts not expressed verbally could be attained. In addition, the dialogue that emanated from the sessions was captured on an audio-recorder.

A semi-structured focus group guide (See Appendix E) was developed that featured ten questions tied to the research questions. The open-ended questions were centered on themes such as family communication, cultural perceptions, maternal roles in health maintenance, parent empowerment, mental illness stigma, understandings of mental health and family dynamics and were designed to facilitate an open-ended dialogue on the mental health attitudes, perceptions, and hypothetical actions of the participants. Some of the questions incorporated messages from the TAMI program in order to evoke reaction and address mental health literacy, and were situational in nature. Program staff at the Canadian Mental Health Association's Ontario - Champlain East office endorsed the use of its TAMI program messages for discussion purposes. A draft version of this interview guide was pre-tested before it was finalized and used in the focus groups. The researcher met with a mother she knew from her professional network, a new immigrant to Canada of South Asian descent who had other characteristics in common with the sample population such as language, education, and number of years in Canada. This individual was able to provide feedback on the nature of the questions and

her comprehension of each one, and suggest alternatives for the language and wording used where necessary.

The following steps were taken as recommended by experts in order to mitigate risks of bias and social desirability. First of all, the researcher kept a single person or a small coalition of people from dominating the discussion. Secondly all respondents were given a chance to participate by going around the table and were given equal response time. Next, terms of engagement and participation were outlined at the outset of the focus groups, highlighting the importance of freedom of expression, non-interruption, and mutual respect for one another's responses and response time (see Appendix E). Finally, as noted in the upcoming section on validation strategies, the researcher maintained an objective discussion by setting aside her own experiences and views on the matters discussed. It should be noted that the views on mental health and mental illness that were shared could still be influenced by social desirability bias although these steps were taken to mitigate such effects. Therefore the results are not easily generalizable.

*Data Analysis.* In terms of data analysis, Creswell (2009) recommends following a series of “interactive” and “interrelated” steps that encompass organizing the data including transcripts and field notes and prepping it for analysis, reading through all the data in its entirety, coding the data with attention towards themes and descriptions before determining how they intersect and overlap, and identifying the overall meaning of these patterns (p. 185). Creswell (2009) also recommends following the procedure recommended by Bogdan and Biklen (1992): codes can be developed for results including “perspectives held by subjects and action codes” (p. 187). For example, a code

representing a perspective could stand for a particular opinion on a message and an action code could represent how the participants maintain their children's mental health.

The audio data files were transcribed by the Researcher. In order to capture the true essence of the dialogue, words were not changed. Upon completion of the transcription, emerging themes were confirmed by identifying "significant phrases or sentences that pertained directly to the experience" and "meanings were formulated and clustered into themes common to all of the participants" following the data analysis steps recommended by Creswell (2013) for phenomenological study (p. 115). The participant responses were then organized into groups according to theme by moving around the electronic data on a data worksheet and placing the information under appropriate subheadings.

*Validation Strategies.* In order to ensure accuracy of the findings a series of validation strategies were deployed. Following the suggested procedures of Gibbs (2007), transcripts were double checked to confirm that they did not contain any mistakes made during transcription process, and definitions of the codes were pre-established to make sure there was no "shift in their meaning" during the coding process (Creswell, 2009, p. 190). Data was also triangulated by referencing findings from other sources in order to rationalize the themes (Creswell, 2009, p. 192). From the point of view of the researcher, the bias she brings to the study is addressed in the following section in order to create an "open and honest narrative" (Creswell, 2009, p. 192). On that note, the researcher bracketed her own experience by leaving her previous knowledge and beliefs outside of the discussion and also by keeping detailed notes that clearly distinguished between her thoughts and those of the participants (Martin, 2009).

Lastly, the coding schema were reviewed by a secondary source in the Communication Department, the researcher's thesis supervisor, as an additional trustworthiness strategy. Each of these steps helped to establish the overall credibility of the study.

#### Role of the Researcher

The researcher, Natalie Dimitra Montgomery, comes from a background of public relations across government, government agencies, and the university setting. Ten years ago she worked for the Career Edge Organization in communications and launched the Career Bridge Program. She understands the program's extensive pre-screening procedures. She implemented the first ethnic media relations outreach strategy for the Prime Minister of Canada. She has also developed extensive experience facilitating stakeholder consultations, needs assessments and discussions in addition to focus groups for government programs at all three levels. As a third generation Canadian of ethnic descent who is interested in psychology and the maintenance of personal well-being she has an interest in contributing to a greater understanding of mental health communication for immigrants. This clarification of the researcher's interests and potential biases, supports the study's validity by suggesting how her background, culture and history could shape the results (Creswell, 2009, p.192).

## CHAPTER FOUR: RESULTS

A total of six themes emanated from the data. Each theme was linked to the theory and concepts presented in the literature review and represented by the research questions. The themes are overarching and encompass aspects of parent empowerment theory, mental health literacy, mental illness stigma, mental health promotion and perception, the social determinants of health and reactance theory. Similar to the analytical approach used by Terrion (2012), the following paragraphs will explain each theme, will provide the coding indicators (responses that were reflective of each theme) that stemmed from the focus group discussion and finally will highlight quotes representing those themes. In order to protect anonymity, instead of using names, unique pseudonyms have been assigned to each participant.

## Main Theme: Home as Haven

The phrase “Home as Haven” was coined to represent how mothers perceived their roles with regards to the maintenance of their children’s mental health through fostering both a nurturing and secure relationship and environment for their child’s benefit. The roles that mothers identified were reflective of parent empowerment in that they positioned the women to take on tasks associated with Helfinger and Bickman’s (1996) definition of the concept; caregiving, emotional support, realizing a difference, and attaining self-efficacy. Each theme under this umbrella represents aspects and actions associated with parent empowerment. The themes identified in this regard are the roles of mother as protector and mother as communicator.

*Theme One: Mother as Protector*

This theme represents how mothers perceived their responsibility in ensuring that their child would be protected from harm or any negative influence that could impact their child's life. Many of the codes associated with "protector" were related to healthy living (references to the importance of maintaining proper habits) in areas such as eating, exercise, studies, etiquette, play, computer and television. They were also related to protective actions taken by mothers (to ensure the overall health maintenance of their children) such as understanding new social norms, and responsibilities such as administering medication, maintaining regular doctor's visits, monitoring healing progress, providing encouragement, acting out of concern, and establishing a calm, safe, and comfortable atmosphere. Out of the two roles in this category, most often, mothers viewed themselves and characterized their actions as guardians.

Considering habits, more than one participant expressed worry about their child's social and cultural norms as well as diet. The following examples highlight mothers' nutritional concerns and the influence the new cultural surroundings of their children.

*I like to say something about our culture, like how to behave around people, how we will greet them and talk with them –manners. I also like to talk about food habits, fish rather than meat, vegetables, not drinking too much pop. (Dipa)*

*I also talk to him about the food habits, same thing. They like their pizza and bread items and we were not used to eat these items everyday back home. (Geeta)*

These examples are just a couple of several references to how mothers would encourage their child's nutrition particularly in the context of being a newcomer to Canada. Respondents showed that health starts at home.

In addition, other areas of common maternal concern that focused on habits included study practices and finding a balance with recreational computer time, as well

as the friends with whom their children kept company. The following examples depict how mothers would protect their child's extra-curricular, academic and social interests.

*I am talking about school, homework, friends, if she is ok with her friends... And also about TV programs.... I am concerned about physical activity, most of the time she spend time at home. I like she go outside and do some physical activity, but she likes to hear music and she's mostly spend time studying at home and listening to music in her room. (Farnaz)*

*My daughter explains about her teachers, especially her French and music teacher. We always communicate about her friends -- boys and girls. Almost every day I ask her about how was school, and what she did in a team for her project or science class. (Mona)*

These responses described how mothers protect their children's academic and developmental progress fostering a safe environment at home that responds to those needs.

In addition, respondents typically took responsibility for protective health actions, such as taking the child to the doctor, following medical advice, staying alert for health symptoms and setting a standard for healthy living. The following examples show how mothers take care of their children on a proactive and reactive basis.

*I think as a mother, I should take care of my children's mental and physical health like emotions on the face. I would like to go with my son for regular exercise so he can feel mentally good. I encourage him to go. I also like that he read good storybooks, good moral thoughts and feel strong to face any situation. (Bahar)*

*I would take him to the doctor and make sure he takes medication. (Geeta)*

*Once when my son had a hockey accident I talked to the coach when the game was over to understand what I need to do and what precaution I need to take. I did not let him sleep alone. Whole night I did not go to bed, I was sitting beside him. (Dipa)*

These comments depict mothers in caregiving roles in response to whatever health concern their child faced, offering remedy and salvation for their youngsters.

Finally the idea that mothers were best able to establishing a peaceful home environment and fostering a calm approach had significant mention as something participants considered to be in their children's interest. In the following examples, mothers consider a relaxing environment to be integral in conjunction with their ability to properly maintain their children's mental health.

*If we talk about mental health I stay calm and relaxed when we talk and ask her to be relaxed. I can better contact with them and transfer my relaxation to her. (Mona)*

*If my daughter said she was feeling anxious, in a calm condition I would listen and let her explain everything to me. (Samireh)*

*When I came here I changed my role in the family. Before I really was a mother. But now days I am a really a friend who keep a home environment friendly and supportive so children come back home for all their issues; it does not matter mental, physical or whatever. (Bahar)*

This variety of references reinforces that newcomer mothers feel that the ability to maintain a calm, friendly environment for their children particularly in approaching communication on mental health is important. It is evident this demeanour was considered pivotal in arriving at an effective outcome.

#### *Theme Two: Mother as Communicator*

This theme represents mothers' communicative actions and how they perceived themselves as able to make a difference in the lives of their children by talking to them about issues of mental concern and about life in general. Mentions of encouraging family discussion, conversation, open dialogue on sensitive issues, problem solving, asking questions, talking, listening and sharing, and positive effects of communication were labeled under "communicator".

The concept of family discussions of mental health was viewed as an important principle to the majority of the participants. In the following examples mothers recount

their experiences and share their perspective in encouraging dialogue between family members on mental health.

*I agree about talking. If husbands and wives, mothers and children talk and listen the problem is solved. Inside the family we can solve the problem. (Bahar)*

*It is very helpful to talk about mental health in the family. If a child talks about a mental issue with his or her friend, friends can mislead. (Mona)*

*Parents can give ideas about solutions and share experiences (about mental health).(Dipa)*

These examples illustrate the perceived benefits of family discussion, implicating all members. The respondents viewed themselves as well positioned to encourage communication within the family unit.

There was a slight emphasis on the relevance of the nature of the dialogue, often described as open, two-way communication, where the individuals would share and listen in references that depicted mothers as communicators. The following examples frame the discussion between mothers and their children, as well as community peers on topics such as health, mental health, and well being according to those terms.

*If my son came home and said he was feeling anxious, I would listen what he would want to tell us. First I will listen, what he learned about mental health. I all the time try to discuss with them and give them something to stick in their mind...*

*I hope to be open to him and discussing all the problems with him in the future. Discussing with him regularly. Discussion is more important in a family. Everyone is free to say views. (Dipa)*

*Open discussion in family would make me feel really good. I would make the family feel closer to one another. (Geeta)*

*To access health services the best way for us as newcomer is to ask other people. People know. (Samireh)*

These references depict the style of newcomer mothers' communication and their appreciation of in-depth, fulsome discussion with their children, which was significant according to their views.

#### Main Theme: Knowledge versus Suspicions of Mental Health and Mental Illness

This section represents participant perspectives of mental illness and it describes their levels of real understanding but also their misconceptions. While it reinforces that immigrant mothers have a capacity to embrace mental health literacy it also speaks to the need for increased mental health literacy of this vulnerable population given the perceptions that mental health messaging on mental illness stigma triggered. The nature of the associated mental health perceptions and attitudes triggered by program messages and the discussion overall will be reviewed in the next section on knowledge and support of mental illness.

#### *Theme Three: Informed Views and Support of Mental Health and Mental Illness*

This theme encompasses the ideas and supportive actions that participant mothers shared on mental illness and on mental health in general. As noted in the literature review, there is a relationship between perspectives of mental illness and one's attitudes toward mental health. Associations that connoted mental health and mental illness in the eyes of the participants showed that these new immigrant mothers had informed views. This was evident since responses reflected various mental health and mental illness influences that were highlighted in the literature review. References that included mentions of family attachment, depressive feelings of a family member or child, sheltering one's self from others, feelings of happiness, levels of social acceptance, social activity, addiction and stress, effects of puberty, prevention of a mental disorder

and personal satisfaction were concurrent with identified causes of mental health issues in accordance with the TAMI program messaging that included variables such *family history, chemical imbalance, physical factors, substance use, traumatic life events, psychological and social factors* in mental health and mental illness definitions.

Appropriate references were coded as “informed views of mental health and mental illness”. In addition mentions that were favourable of mental health prevention, and that encouraged mental health maintenance action were coded as “support of mental health and mental illness”.

The following examples show how some of the participants understood the meaning of mental health.

*I understand that mental health is a feeling that leads people to activity. If children feel bad or depressed he will not open up to others. He will keep himself away from others.*  
(Dipa)

*In my view it is feelings about happiness, satisfaction that make me feel that I have good mental health. Someone who acts rational and acceptable to society means that she is in good mental health. That individual is socially active and not preventing from society.*  
(Farnaz)

*Mental health is for example preventing mental disorders like anxiety, depression and addiction. Something like this mean mental health.* (Mona)

These examples represent participants’ insights and awareness of mental health.

Throughout the discussion participants showed a certain degree of support of mental health and mental illness by suggesting preventative actions. The following examples illustrate steps the participants said they would take and steps they would support concerning the emotional states of their children and in some cases other family members.

*This is a very good course, (referring to a program excerpt titled “Suicide Talk”) that will help him to learn about the topics. It is not that knowing these things that is a bad thing. (Geeta)*

*I have more responsibility, definitely more concern, and the decision would depend on me to take my children to a psychologist. (Farnaz)*

*I would consult with a professional to find out why these feelings. (Bahar)*

*If it was my child thinking about suicide it would require taking them to a psychologist. (Mona)*

*It is ok because they want to teach the students about preventing suicide, and teaching them about how they can ask for help when those thoughts come to their mind and teach them skills. (Mona)*

Each participant’s comment illustrates a belief in proactive responses that have an ability to protect the mental health of loved ones.

#### *Theme Four: Myths and Illusions of Mental Illness*

This theme represents misconceptions about mental illness and stigmatized responses towards an individual suffering from mental illness. This was determined by presenting a purposefully stigmatized message of mental illness taken from the TAMI program to the participants. All of the participants agreed with the message that “I think that people with mental illness are making up excuses” revealing their belief in such a statement by sharing negative and stigmatized responses (supportive of the statement) and misunderstanding. Responses that espoused the following beliefs were coded as “myths and illusions of mental illness”: religion has a role in preventing mental problems, mental health requires medication or pills, people with mental illness can not accept their behaviour, people with mental illness make excuses, mental illness is not normal, and body adornments are a sign of poor mental health.

*Mentally ill don’t agree they have mental illness. They try to act as normal people maybe for a few hours but after that they can not continue like normal people. (Dipa)*

*People with mental illness take pills or go to the rehab system. So why should they have excuses? If they know they have mental illness they have to take medication. Rationalizing is unacceptable. (Bahar)*

*I think mental illness has two categories. One is resistant to medications and psychotherapy, some of them not. When people are effective in psychotherapy excuses are not acceptable. (Mona)*

*Some opportunistic people try to take advantage of the situation. They refuse to be treated because they can have some advantage of being in this condition like these kinds of excuses ... "I can not work because I don't feel good", "I did this thing wrong because at that time I wasn't in a good mental condition". (Samireh)*

All of these responses show a clear and consistent emphasis on the idea that mental illness requires rehabilitation, medication, and is inexcusable.

#### Main Theme: Additional Barriers to Mental Health Literacy

Two other themes were derived from the data that represented limitations to new immigrant mothers' experience of mental health literacy, mainly their ability to understand and support the enhancement of knowledge and maintain well-being. The first theme represents the hardships of immigration, touching upon the social determinants of health and confirming the true vulnerabilities faced by new immigrants as the literature review indicates. The second theme was an emerging one and was captured as fear of knowledge. This theme represents a negative response to mental health training and promotion, and the concerns mothers have with regards to training their children on the sensitive topic of mental health and the potentially dangerous and undesirable effects of such learning.

#### *Theme Five: Hardships of Immigration*

This theme focuses on the stresses of migration, consistent with the social determinants of health described in the literature review. The codes that qualified

responses under “hardships of immigration” included mentions of the following; job search, accepting work in another field, stress an immigrant, survival, constant anxiety, loss of network and family, acculturation and enculturation, the immigration process, language barriers, feelings of disappointment and children’s concern. In the following examples respondents describe the challenges faced as a result of their immigration.

*I don't have experience how to act with my daughter or what I should talk to her. Like physical changes in the body because in our culture wearing clothes is important not to expose body. Culture here is different. My daughter likes to wear some open clothes. (Farnaz)*

*It was my daughter's first year here in Canada; we had lots of problem because she did not have JK SK grade one. As a newcomer she didn't know English. We had lots of problem with language when she started in Grade 2, in the first three months of school. She did not know the English alphabet. She did not get special ESL teacher. (Samireh)*

*You may feel disappointed when you can't find a job in your professional area of study. I didn't have Canadian experience. (Bahar)*

The challenges portrayed by the respondents touched up a variety of social determinants of health. These included the effects of acculturation/enculturation, language barriers, job search, loss of extended family and community networks. Three of the participants went further and were able to establish links between the hardships they faced as new immigrants and their risk for mental health issues, mainly stress, isolation and anxiety.

*At the same time as a newcomer we have a lot of stress about ourself our job, survival, our children all the time we are stressed. I can say that this our mental problem.*

*Because we are here alone. Our families aren't here, no parents, relatives, nobody is here. In our countries we have so many people so I can discuss things with them and get a solution from society.*

*It is helpful to have family asking after someone instead of feeling all alone and feeling something is wrong with me. (Dipa)*

*Stress is very harmful; anxiety, uncertainty about the job and the future. When we talk about our culture there is other culture. Our own culture is different than others. It may*

*not be same and it causes mental pressure. Also sometimes kids would like to do something different it cause mental pressure is stressful for everyone. (Farnaz)*

*I should tolerate my husband's anxiety. He worry more than me about money and living here and he transfers anxiety to me. These may be side effect of mental health but also side effects of immigration. (Bahar)*

These are examples of how the participants understand the vulnerability and risk that they face as immigrants to Canada.

#### *Theme Six: Fear of Knowledge*

This theme represents the level of discomfort and concerns that participants raised with school education on mental health as well as other health programs on sensitive “taboo” topics such as sexual education and drug abuse. The uneasiness about school programs stemmed from the belief children were too young to be exposed to sensitive health information and that as a result they would be unable to objectify their learnings. The ultimate fear of this knowledge is that it would evoke a negative, undesirable reaction amongst students. Responses that referenced child maturity in the learning program context, mentioned other health programs, an element of curiosity, too much information, general information as better, negative thoughts and discomfort were coded as “fear of knowledge”. The following examples characterize many of the participants’ feelings about how too much knowledge could backfire and encourage the opposite of the desired reaction in their children with respect to mental health.

*I am always scared that my daughter touch smoking or alcohol. When they talk about in the school about drug abuse I get scared that she is learning how to use drugs. This is the subject in the school that they are teaching. I am not comfortable with the subject because I think it's a way she would think about alcohol or drugs. (Geeta)*

*It may improve their knowledge. But that's why the age is very important. For example my daughter said her drug abuse lesson had many bad words. It's good for eighteen years old and older but not for young teenagers. (Farnaz)*

*Sometimes it's scary because they know mental illness, know why it happens and the causes, sometimes if they have mental illness they can do something like suicide  
Sometimes it gives me scary idea they know the causes and effects. (Dipa)*

*My daughter once told me that police came to her school and that the officer was explaining about drugs about how to use drugs. My daughter told me that she was teaching us how to use drugs. It was more than general information. Why should a 12 year old girl know about drugs? (Bahar)*

It is clear that participants felt strongly about the adverse effects of education on sensitive health topics and had concerns about their child's age and over exposure to issues including drug abuse, sex education, and the darker sides of mental health; suicide.

In closing, the thematic analysis resulted in three overarching sections: home as haven, knowledge versus suspicions of mental health and mental illness, and additional barriers to mental health literacy representing six themes. To start, home as haven represented the roles of mothers in protecting their child's well being at home as protectors and communicators. The first theme, mother as protector represented respondents' views that the main responsibility of their child's care and development was their own whether it came to homework, school, friends, nutrition, exercise, medical treatment, or cultural transition or establishing a non-threatening environment. The second theme mother as communicator represented mothers' views that they were well positioned and happy to interact with their child in the spirit of fostering effective, open and balanced communication within the family. Next, knowledge versus suspicions of mental health and mental illness represented a contrast between informed views and support of mental health and mental illness on one hand and myths and illusions of mental illness on the other. The third theme, informed views and support of mental health and mental illness embraced real associations and influences on one's emotional

state stemming from new immigrant mothers' understanding. The fourth theme, myths and illusions of mental illness stood for stigmatized reactions and opinions on mental conditions, which participants voiced in response to a message that negatively labeled those suffering from a mental disorder. Lastly, additional barriers to mental health literacy incorporates other influences that hinder an enhanced understanding of mental health for new immigrant mothers; the hardships of immigration and fear of knowledge. The fifth theme, hardships of immigration focuses on the stresses of immigration as endured by participants in their personal experiences as newcomers to Canada. The sixth and final theme, fear of knowledge emerged from dialogue on the importance of mental health education and education on other sensitive health topics for adolescents. It included new immigrant mothers' concerns about the undesirable and possible boomerang effects of information sharing that could have serious consequences on their child's well being.

In the following section, the meaning of these results and their links to the themes will be discussed and explored.

## CHAPTER FIVE: DISCUSSION

The purpose of this study was to explore the empowerment of new immigrant mothers by discussing their insights associated with mental health literacy. Messages from an existing school mental health program, TAMI, were used in part to stimulate and frame the dialogue. The study endeavoured to understand how the mental health messaging and the sharing of mental health concepts impacted new immigrant mothers' sense of self-efficacy with a view towards encouraging confidence in their abilities to make a difference in the mental health of their children. The following section will discuss the important mental health literacy perspectives of new immigrant mothers that were uncovered and respond to the research questions in three ways. First, it will touch upon how the participants perceive their roles with regards to the maintenance of their children's mental health. Next, it will discuss the nature of immigrant mothers' existing mental health perceptions and attitudes as triggered by the TAMI program messaging. Finally, it will show how the program messaging helps build upon immigrant mothers' perceptions and attitudes toward mental health while also touching upon some of the challenges in enhancing the mental health literacy of this audience.

The exploration and combination of the themes under "home as haven", "knowledge versus suspicions about mental health and mental illness" and "additional barriers to mental health literacy suggest that participants were motivated and confident about their capacity to take the path towards an empowering experience in the mental health maintenance of their children. At the same time, however, there were still obstacles along the way towards the realization of this goal.

### Main Theme: Home as Haven

The umbrella theme of “Home as Haven” speaks to how mothers perceived their roles in creating a safe, open environment at home for their children and positioned their abilities to look out for their child’s best interest. The following paragraphs will shed light on the capacities that participants proclaimed towards realizing empowerment as a result of the roles and associated tasks they identified with “protector” and “communicator”.

#### *Theme One: Mother as Protector*

Participants described a variety of ways through which they safeguarded their child’s health and well-being. Their responses focused on two “protective” aspects: the nature of the suggestions and lifestyle choices they would prescribe for their child and on protective actions they would and have been known to take as a mother.

In terms of *lifestyle choices* they advocated for, there was a strong emphasis placed on nutrition and meal options, study habits, and exercise. It was evident from their responses that participants felt confident about the types of behaviour they supported, and the conversation seemingly took a tone that, as mothers, they “knew best”. This is consistent with research that has positioned mothers as the most knowledgeable when it comes their child’s health (Jaccard, Dittus & Gordon, 2000; Lindsey et al., 2010; Wisdom & Agnor, 2007) and therefore illustrates the sound judgment and natural instincts immigrant mothers have when it comes to the lifestyle choices that will impact their child’s development.

These responses were complimented by *protective actions* participants assumed as part of maternal responsibility for their children’s health which consistently included

maintaining a high level of awareness, taking the child to the doctor, administering medication, and monitoring health progress and deterioration. These responses echo the results of others studies that associate the main caregiving responsibilities of children with mothers (Farinelli & Guerrero, 2011; Grewal et al., 2005) and show that immigrant mothers take their roles in this regard seriously. A response that represented all participants was how the establishment of a calm environment by mothers could nurture an open approach and dialogue in response to their children's mental health needs. This is related to research that has shown that teenagers have a tendency to approach their mothers (rather than other caregivers) when it comes to discussing their emotional state and feelings (Jaccard, Dittus & Gordon, 2000; Wisdom & Agnor, 2007) and offers a possible justification as to why mothers are perceived by their children as most receptive to their mental health needs. Also, these results directly support a study that examined how Latina mothers perceive mental health and found that harmony within the family was a factor in maintaining a healthy mental state, for children and parents (Vera & Conner, 2007) and demonstrate that this outlook is not only typical of Latina mothers, but also associated with mothers of other ethnic descents, South Asian and Iranian. Most significantly, previous research has shown that a positive home environment that encourages family discussion was related to more optimal mental health of teenagers (Johansson et al., 2007). The concurrence between the participants' responses and the results of other studies shows that the immigrant mothers' convictions with regard to how to protect their children's mental health are grounded.

*Theme Two: Mother As Communicator*

Participants firmly supported the premise that communication with their children about life in general and on issues of mental health concern were integral in fostering a nurturing relationship with their children. Their responses were best encapsulated by the clear presence of two response categories that emerged: the importance of family discussion on mental health, and the relevance of establishing comfortable grounds for free mental health discussion.

Responses that advocated for family discussion on mental health showed that mothers perceived that the inclusion of both parents in the dialogue would lead to the most optimal outcomes. Specifically, immigrant mothers espoused the belief that having both parents participate would lead to better problem solving, the sharing of more accurate information and personal experiences, and the fulsome brainstorming of ideal solutions. These beliefs are congruent with previous research findings. One study concluded that teen-parent discussions of mental health issues are important, given that these conversations could lead to positive reinforcement and influence of mental health messaging (Pinto-Foltz et al., 2011). Pinto-Foltz et al.'s (2011) findings were based on a study that used a sample of adolescents. The fact that in the current research similar answers came from mothers suggests that immigrant mothers also support this important idea of parental involvement. Other relevant studies have concluded that parents were seen to have a central role in discussion and decisions regarding mental health service usage (Johansson et al., 2007; Phillipson et al., 2009) that is reflective of remarks such as "parents can give ideas about solutions". The participants showed that they had a

promising approach in mind when it came communicating as a family unit about mental health.

The second response category that was evident related to “mothers as communicators” and focused on an open nature of mental discussion stemming from the establishment of an agreeable atmosphere that fostered such dialogue. Some of the ideas that pointed to the importance of a safe setting for discussion were depicted by words such as “listening, open, free, improve, solutions, and closeness”. Participants felt that by encouraging open discussion they would be best positioned to answer to their child’s mental health needs. Johansson et al.’s (2007) study on teen perceptions of mental health also underscored parallel characteristics of family discussion on mental health such as the approachability of parents and the ability of a teenager to sense that openness. The fact that participants supported the type of dialogue that teenagers view as so important positions new immigrant mothers to make a positive impact in their children’s mental health experiences.

The concept of parent empowerment was previously defined in part as a process through which parents can use their knowledge to attain a high level of self-efficacy and have an active role in the experience of their child, to the extent that they can make a meaningful difference. The roles with which immigrant mothers identified -- “protector” and “communicator” -- promote involvement in their children’s mental health and positioned them to be able to use their own experiences and previous knowledge in order to better assist them. Moreover, participants felt confident about these roles, as shown by excerpts of answers that, for example, included “would make me feel really good”, “my child would come to me for all of their issues mental physical or whatever” and “inside

the family we can solve the problem”. The nature of their responses showed a degree of self-efficacy in that the participants felt positive about their roles and abilities in response to their child’s mental health needs. Other responses that highlighted lists of protective actions, such as taking the child to the doctor or maintaining a calm home environment, suggested the participants believed in their own active parts in their children’s lives. It was clear that these immigrant mothers saw themselves as prepared to participate in their children’s lives, in a far from passive way.

#### Main Theme: Knowledge versus Suspicions about Mental Health and Mental Illness

This general theme represents the existing perceptions of mental health and mental illness of participants that comes in two forms. The first theme, informed views and support of mental health and mental illness, represents a capacity for mental health literacy based on the knowledge that immigrant mothers shared. While the accuracy of this knowledge was not measured, it did show that the group was somewhat informed in their perspectives of mental health and prepared to take the necessary steps to ensure the mental health of their children (and families). The second theme, myths and illusions of mental illness, speaks to the stigma of mental illness that had evidently distorted the views of immigrant mothers and suggests that more work needs to be done to dispel these polarizing ideas with hard facts.

#### *Theme Three: Informed Views and Support of Mental Health and Mental Illness*

The mental health and mental illness perspectives of new immigrant mothers included a series of appropriate words and symptoms in the various responses. This indicated that participants possessed basic facts on mental health and mental illness to start.

In terms of informed views, it was notable that the immigrant mothers were able to define mental health using relevant wording and in their own terms such as “activity, depression, happiness, satisfaction, social acceptance, and preventing mental disorders”. The possession of mental health knowledge is confirmed by research to be a key part of mental health literacy (Kelly et al., 1997; Pinto-Foltz et al., 2011). Mental health literacy has been defined as knowledge and beliefs about mental illness and mental states that assist people in the recognition, management, and prevention of related diseases (Kelly et al., 1997; Pinto-Foltz et al., 2011). Stated another way and through the lens of health literacy in general, Schiavo (2007) sees it as the ability to read, understand and act on health information. The TAMI program messaging triggered responses that revealed a foundation for enhanced mental health literacy.

In terms of support of mental health and mental illness, the participants most often expressed a willingness to encourage remedial action and recognized the importance of doing so. This theme of support is pronounced in the second part of these mental health literacy definitions that include management, prevention and acting on health information (Kelly et al., 1997; Pinto-Foltz et al., 2011; Schiavo, 2007). Action that immigrant mothers identified as the types of actions they would take to respond to a mental health threat facing their child included consulting professionals, taking the child to a psychologist, and supporting school mental health programming by helping their child learn about the issue. This finding aligns with the overarching principles of the TAMI program, which underscores the importance of additional home supports in effective program delivery (CAMH, 2001). Somewhat consistent with this finding, other research has found that such mental health “first aid skills” are lacking for parents (Kelly

et al., 2007). While it can be argued that the participants showed the opposite, with an adequate response to mental health crisis, it is unclear what motivated that response, and how the circumstance of group discussion on the topic may have prejudiced their answers. The degree to which they would have responded in this way in a private circumstance, or without exposure to a program was not explored. The research conducted by Kelly et al. (2007) views mental health interventions such as the TAMI program as integral in positively changing public mental health beliefs. While the mentions of TAMI program messages were brief and in the form of questions, the program position could have had some influence over the responses of the participants during the session. This implies that the messaging contributed to immigrant mothers' perception and attitudes toward mental health as they agreed that taking action was an appropriate next step.

The mental health maintenance actions that mothers said they would take for their child's wellbeing as outlined above are also relevant to parent empowerment, as an outcome to increased mental health literacy. Mothers stood behind actions that would allow them to realize a "meaningful difference for their child" whether this meant taking their child to a mental health professional or assisting them with mental health program concepts learned at school. These results are reflective to those of a study that found that mental health training techniques for Latina women mitigated mental health literacy barriers at the same time that the culturally sensitive tools fostered a sense of empowerment amongst them (Ginossar & Nelson, 2011).

The nature of the informed views and the existing mental health perceptions and attitudes that emanated from the discussion showed a series of founded ideas. These

perspectives illustrate that there is a base from which to build and expand up on that knowledge. By using TAMI program messaging to stimulate discussion, participants' responses and positions were steered in progressive directions. This pattern indicates that there is an opportunity to continue this path, by reinforcing accurate mental health information and discussion amongst peers.

*Theme Four: Myths and Illusions of Mental Illness*

Towards the end of the focus group discussions participants were presented with the following stigmatized message about people with mental illness: "I think people with mental illness are making up excuses". Despite the fact that participants had already shown during the focus group discussion how they could take proactive action towards mental health maintenance for their children, there was uniform consensus with the stigmatized statement. All of the responses supported the message by reiterating why and how it could be true. It is relevant to note that many of the immigrant mothers also shared their perception that mentally ill people required hospitalization and prescription drugs to be treated. In their opinions, mental illness required serious intervention. While this could be rationalized through previous studies that showed that ethnic minorities view the mentally ill as "significantly more dangerous" than Caucasians (Abdullah & Brown, 2011) the ideas advocating for prescription drugs were contrary to previous findings that echoed concern by --- about over-medicalization of mental illness (Martin, 2009).

A common opinion also surfaced that viewed making up excuses and the perceived fact that the mentally ill are able to get away with "not working" and "doing the wrong things" as unfair. This position is also consistent with the definition of mental

illness stigma used by Abdullah and Brown (2011) in that the participants disapproved and discredited those who suffer from it. It is particularly interesting to see that these participants felt it was not fair that individuals suffering from mental illness could get away with making up excuses and not working, given that the sample population in this study faces barriers to finding employment in their field on top of other hardships as a result of the immigration process. This could be a possible direction for future research on examining the nature of mental illness stigma experienced by new immigrants.

Moreover, the absolute concurrence with the statement suggests a dichotomy within the mental health views of immigrant mothers. Despite their previously shown willingness to support the concept of mental health maintenance such as taking their child to a professional and talking about mental illness with their teenagers, participants voiced a polarizing response when presented with the statement. This suggests that although participants exhibited overtures towards mental health literacy (and acting upon it) they still had degrees of mental illness stigma that cannot be overlooked. Experts whose findings state that how people view mental illness affects their global view of mental health and affects their mental health literacy levels uphold a similar position (Pinto-Foltz et al., 2011). The recommendation that stems from this finding is that there is a need for more in-depth training on mental health literacy and more awareness of mental illness stigma to be raised in this audience.

#### Main Theme: Additional Barriers to Mental Health Literacy

The last two themes surfaced throughout the sessions in response to variety of questions. Although they do not respond to the research questions directly, they provide useful insights relevant to understanding the mental health experiences of new immigrant

mothers. The first theme *hardships of immigration*, is directly tied to the social determinants of health and confirms the nature of the vulnerability of immigrants. The second theme, *fear of knowledge* regularly came up in response to TAMI program messaging and speaks to the perceptions that new immigrant mothers have towards mental health programming that impedes mental health literacy progress and building upon their knowledge base.

*Theme 5: Hardships of Immigration*

Participants consistently referenced social determinants of health when they were asked to describe how and what they communicate with their children about, explain how mental health is viewed in their culture, make associations with the warning signs of mental illness, and explain how they see their role in influencing how their family sees mental health. Most often these challenges were alluded to in a general way but some participants went further and were able to discern links between the hardships they endured and the mental health of their families.

From the general standpoint, concern was expressed on difficulties such as children's adaptation to a new culture (Pereirra & Ornelas, 2011; Van Ngo, 2009), the acquisition of a new language for parents and children (Pereirra & Ornelas, 2011; Van Ngo, 2009), and success in securing employment in one's field (OCASI, 2012; Van Ngo, 2009). The nature of the challenges that these processes present in the lives and health of immigrants were previously documented by experts and included loss of social networks, language barriers, acculturation, and financial strain amongst others and were confirmed in the focus group sessions.

From an angle specific to mental health, participants were adept at ascertaining how the social determinants of health could negatively affect their mental state. This became evident when the discussion touched upon the role of social networks and other family members in providing support and guidance in response to mental health needs, as well as symptoms of poor mental health. Responses covered the following areas of concern: financial stress and anxiety due to lack of employment, ability to survive in new surroundings, loss of family support network in times of health need, isolation, and cultural differences causing identity stress and confusion. This aligns with previous research that focused on the psychological adjustment for the individual new immigrant and their family as an outcome of acculturative, socially integrative processes (Portes and Rumbaut, 1990; Simich et al., 2009; Vega & Rumbaut, 1991) as well as studies that designated those variables specifically as having an impact on the mental state of the immigrant (Reitmanova & Gustafson, 2009; Stodolska, 2008).

In considering mental health from a specific cultural perspectives, the participants of South Asian descent drew a correlation between their lack of familial support networks due to their immigration and their emotional states. This is consistent with the finding that South Asian women attribute psychological distress to family factors and lack of extended family support (Masood & Okazaki, 2009). In contrast, the Iranian participants did not make cultural links with the social determinants of or barriers to mental health. Instead they consistently expressed the need to treat individuals with a mental disorder through prescribed drugs and hospitalization. It is interesting to note that this is contrary to the conclusions of Martin (2009), who found that Iranian subjects expressed concern that American mental health experts overprescribed medications.

The acute awareness of these psychological affects demonstrated by the participants suggests that new immigrants have an ability to understand their mental health needs and the mental health risks facing them, which plays an integral part in their mental health literacy and capacity to use it to maintain the emotional health of themselves and their loved ones. This could prove to be a useful foundation on which immigrant levels of mental health literacy can become more enhanced.

*Theme Six: Fear of Knowledge*

As the discussion stemming from program messaging unfolded, it became apparent that participants consistently had fears with regards to certain aspects of the enhancement of their children's mental health knowledge through programs such as TAMI. The most prevalent of their preoccupations was the opportunity for their teenagers to learn about issues that could be detrimental to their mental health and their lives should their child react undesirably to the new knowledge by trying and acting out the risky behaviour. Participants expressed the most concern about actions such as suicide and drug use and exhibited low confidence in their children's interpretative abilities, surmising that they could take things too far if they were to explore with these risky behaviors.

This reaction is contrary to that of parental empowerment, in that it evokes perceptions of the threat of knowledge rather than perceptions of knowledge as contributing beneficially to a child's health. The participants felt that sharing suicide and drug use information could lead to experimentation or exploration with these activities. While drug education programming is beyond the scope of this research, there are irrefutable links between drug use and mental health (Alterman et al., 2010 & Havliceck, 2013). The participant concerns brought forward Brehm (1966)'s theory of reactance as

an emerging concept; a perception of a “threat of elimination” and elicitation of “a response of psychological reactance and motivation to act out that behaviour”. In other words, participants worried that their children would react to mental health programming by adopting undesirable and dangerous behaviours.

Findings from research on other sensitive health promotion targets (smoking, drugs, and nutrition) that were ineffective in sustaining positive behavioural changes, particularly amongst youth (Dillard & Shen, 2005; Feingold & Knapp, 1977), validate the concerns of immigrant mothers. The presence of views that such programs are futile reduces the capacity for parent empowerment through mental health literacy. Specifically, their worries could hinder their confidence levels to make a meaningful difference in the lives of their children through mental health literacy, and make it difficult to build upon the constructive knowledge and perceptions they do have.

It is also important to note that immigrant mothers consistently questioned their child’s maturity, judgment and preparedness for such programming and claimed that their children were too impressionable to be exposed to messages such as those from “Suicide Talk”. While this perspective could be cultural and stem from family authority structures, claims about the rationale behind this outcome are difficult to make without deeper investigation and are beyond the scope of this research. Future research could further explore such attitudes of parents that are condescending in their views towards the development of their children’s understanding of mental health, and could also incorporate measures of reactance theory in mental health program development.

In summary, the emerging themes of *hardships of immigration* and *fear of knowledge* represented relevant observations that factor in to the research questions as they represented barriers to enhanced mental health literacy of new immigrant mothers. The results suggest that new immigrant mothers have been exposed to a variety of circumstances exacerbated by negative indices of social determinants of health as a result of their settlement process, which increases their and their children's vulnerability to mental health risks. The results also suggest that new immigrant mothers have compelling and founded concerns about their children's exposure to extreme mental health messages and program content.

To close, this discussion chapter looked at the mental health literacy experiences of new immigrant mothers and considered the affects on their experience of parental empowerment. By examining how they perceive their roles in their children's mental health maintenance, and exploring how the TAMI program triggered and built upon existing mental health perceptions and attitudes, promise and room for improvement were uncovered on their self-efficacy and mental health literacy journeys.

Potential for new immigrant mothers in this regard was evident according to three themes. Under *home as haven*, it showed how participants embraced the roles of *mother as protector* and *mother as communicator*. The new immigrant mothers in this study take their maternal responsibilities seriously, and were prepared to take the necessary action in their child's best interest. The participants also expressed *informed views* and showed *support for mental health and mental illness* in their ability to use suitable words to define mental health and identify appropriate action in response to their children's mental health needs.

Room for improvement was also evident according to the remaining three themes. Under *myths and illusions of mental illness*, it was clear that mental illness stigma exists amongst this audience and that they are uninformed on various aspects. This was made clear by the common beliefs that mental illness requires medication and rehab treatment and the support shown for the statement that people with mental illnesses make up excuses. *Hardships of immigration* confirmed the exposure of new immigrant mothers to detrimental degrees of social determinants of health that they recognized as harmful to their mental health. *Fear of knowledge* revealed their concerns about the possible reactive consequences of mental health education for adolescents. These themes suggest that in order for future mental health program efforts to be effective, these issues need to be better understood and addressed.

The following chapter will conclude this study and consider its limitations as well as future research avenues.

## CHAPTER SIX: CONCLUSION

In closing, by exploring attitudes relevant to the empowerment of new immigrant mothers and the development of enhanced mental health literacy, this thesis allowed the mental health perspectives of new immigrant mothers to be revealed. This was accomplished through focus groups that featured a protocol of general mental health questions as well as TAMI program messages to incite the discussion. The focus groups disclosed important aspects relevant to the development of new immigrant mothers' mental health literacy levels and attainment of self-efficacy in order to experience parent empowerment such as their knowledge, interpretation and attitudes, and their communication needs. The following three sections will focus on the significance of the study, address the limitations and finally consider future research avenues.

## Significance of the Study

This research illustrated that this cohort of new immigrant mothers have the ability to follow a clear and propitious path potentially leading to their own empowerment when it comes to the mental health maintenance of their children. It was clear that they had a good grasp of the necessary tools; the knowledge, ability, and understanding that together can lead to a healthier emotional existence for their child. This was evidenced through some of their basic mental health knowledge and ideas, but most of all by their motivation to enhance the knowledge of their children along with their emotional and physical care as seen through their perceived roles as communicator and protector. These can be seen as positive forces.

For example, the findings support the principles of parent empowerment as defined by Heflinger and Bickman (1996) and Bickman et al. (1998) as shown through

the following beliefs that new immigrant mothers shared: that their knowledge of mental health can positively impact their child's learning outcomes on the issue, that they have the ability to participate in the learning (mental health promotion) process, and that their understanding of mental health can help attain a favourable difference leading to a healthier existence for their child. It was evident that the participants felt naturally inclined to take on the roles of protector and communicator in key aspects of their children's lives that are complimentary to parent empowerment. These roles embraced actions that would allow immigrant mothers to participate in their child's learning process on mental health issues and gave them confidence that they could make a positive impact. Furthermore, the participants were open to supporting and responding to specific mental health needs, whether it was through facilitation of help-seeking, enhanced communication, or support of school-based mental health promotion.

On a similar note, the study revealed that this cohort of new immigrant mothers, who are highly qualified in their professions and have superior English language competencies, have seeds of general mental health knowledge from which more extensive mental health literacy can grow. This was shown through their ability to define mental health and make associations with mental health symptoms using appropriate terms and is parallel with literature that defines mental health literacy.

However at the same time, from a constructive standpoint, there was an unequivocal indication that this path has its obstacles. There is still progress to be made in order for these new immigrant mothers to have a complete understanding of mental health and feel fully empowered in their roles. This finding is significant and is grounded in the results that confirmed negative forces such as the presence of mental illness

stigma, detrimental incidence levels of social determinants of health, and fears that knowledge could give rise to reactance and undesirable outcomes. In embracing new immigrant mothers as a key secondary audience in mental health promotion and the communication of mental health messaging, these challenges should be addressed.

First, participants supported a stigmatized statement about mental illness and shared views that espoused common myths about mental disorders, such as a resolute opinion on the need to treat individuals who require mental health treatment through drugs and medical treatment. Next they consistently identified challenges that they and their families endured as a result of their immigration process, such as loss of familial and social networks, acculturation/enculturation, the acquisition of a new language, and finding suitable employment. They understood how these challenges pose barriers to their mental health and that of their loved ones. Since these variables impacted their emotional state, there could be a correlation with their development of mental health literacy and feelings of empowerment. Lastly, they voiced concern about the unintended side effects of mental health promotion and their children's development of new knowledge on the topic. There was consensus that in-depth mental health program units, for example information on suicide, could lead to a situation of reactance amongst their adolescents.

#### Limitations

There are four limitations of this study that need to be highlighted. In order of their emergence, they include the sample population, the recruitment method, the sample size, and the potential bias imposed by the chosen method of focus groups.

To start, the sample population of new immigrant mothers was limited to those who are registrants of the Career Bridge program and members of their candidate pool. As such they were highly educated, fluent in English as a second language, and recent newcomers having arrived here in the last three years. While it is difficult to discern what impact their backgrounds had on their responses, as that remained unmeasured, it would have been useful to have access to a more representative new immigrant population of mothers, who have a variety of different experiences, language abilities and educational achievements. The participants' ability to speak English fluently was certainly a benefit to the discussion; however it could also have been a factor in their ability to discern and develop mental health knowledge. Education levels have also been noted by experts as having an influence on the tenets of health knowledge, health services access, and self-efficacy beliefs that are applicable to mental health literacy and sense of empowerment (Ginossar and Nelson, 2010). For example, people with lower education are typically categorized as laggards in adopting desirable health maintenance behaviours (Ginossar and Nelson, 2010). This suggests that there may be certain subsets of the vulnerable population of immigrants that require more support in mental health literacy development than others. This is definitely an area for future research.

A second limitation of this study concerns the recruitment method. It is recognized that it was integral to have the support of the Career Edge Organization to carry out the sampling procedures. The chosen methods were meant to yield a purposive sample group and enable participation and meaningful representation from specific countries of origin for Canadian immigrants. However the procedures agreed upon had some drawbacks stemming from the lack of direct contact.

Firstly, the researcher could not be granted access to the sample population's email addresses for privacy and proprietary reasons. As such, she did not have the first personal contact with the sample population to introduce them to the study and impress its goals upon them. Instead, they were contacted by the organization, and were asked to take the initiative to personally email the researcher if interested. As a result, email contact proved to generate a low overall response rate of six per cent. It may have been more ideal to have in-person contact with this sample population, and offer a more personal touch to engage this group on a sensitive health topic. There may have been more optimal means through which higher and more reliable responses could have been yielded. For example, in their Eastern European mental health study, Coleman et al. (2010) recruited participants by doing a door-to-door canvass in Romania and Bulgaria and reported a good response. This approach offers valuable information on best practices for investigating issues of mental health concern amongst ethnic populations, and suggests that face-to-face recruitment may be the most effective of way of yielding a better response rate. By contrast, Martin (2009), who explored Iranian perceptions of mental health recruited participants by posting flyers in grocery stores and restaurants frequented by members of the local Iranian community and yielded lower response rates. Similar to the method used in this study, Martin's (2009) indirect method required a certain level of personal initiative on behalf of the respondent, whereas Coleman et al.'s study was face-to-face and more direct, resulting in a larger sample. This comparison indicates that an in-person recruitment process conducted through Career Edge Organization, or through no organization at all, for example a booth at a Career Bridge program training or information session, or a general job fair or immigrant settlement

session may have yielded a higher number and more representative sample of participants for each focus group session.

The limitations posed by the recruitment method are related to the third limitation of sample size. The final participation rate that was yielded by the recruitment method was lower than the anticipated goal with a total of seven participants. The combined factors of a small number of participants, as well as the nature of focus groups, makes the results challenging to generalize of the immigrant population at large, and more specifically of the ethnicities represented. The sample size was also prohibitive in its representation of Eastern Europeans as the recruitment process was not successful in reaching members of this population. Coleman et al. (2010) describe the rationale used by respondents in their study in their refusals to participate, as “suspicion of government involvement” (p. 329). This could be interpreted as a typical response for individuals whom have experienced life under communist regimes and could be a possible reason that explains why the majority of Eastern European women did not respond to the recruitment efforts in this study. It could also be surmised this population that might have benefited from mental health discussion even more than others, if there are unprepared to entertain the dialogue, or not having the discussion for cultural reasons. Furthermore, the women who did volunteer and select themselves for the study, may have already been interested in and predisposed to mental health discussion. This suggests a need to find ways to better engage Eastern European women and other less inclined immigrant women in research on their experiences of mental health.

Lastly, using a focus group as the research tool might have imposed some bias on the results due to the nature of the dynamics it imposes on the sample population. This choice of method made it difficult at times to discern how much participants genuinely believed in their response or idea, and to what extent they felt influenced by other members in the discussion group. This is tied to the common caveat of dominance of ideas and certain members in focus group situations (Palys, 1997). However this drawback was mediated by the collegial group dynamic and encouragement of mutual support, the development of ideas and shared meanings, and general comfort levels that characterized the sessions.

#### Future Research

This research serves as a foundation for several future research avenues in the area of the new immigrant experience of mental health literacy. Related studies could expand the sample population and sample criteria, provide culture specific perspectives, observe the sustainability of behavioural changes, evaluate pilot versions of mental programs, and offer more comparison wherever possible.

In regards to sample population, in future studies it would be useful to be more inclusive of the wide variety of Canadian immigrant and refugees regardless of their language or educational level. Furthermore, it would be valuable to be able to compare mental health literacy perspectives amongst immigrants who have been in Canada for different periods of time (e.g. less than and greater than three years). In this way, comparison could also be factored in the sample criteria. For example, it would be of interest to see how the mental health literacy experiences differ between immigrant children and their actual parents. On that note it would also be useful to compare the

view of mothers and fathers. Studies that are more inclusive of other family members would be well positioned to make mental health maintenance recommendations and encourage empowerment for the entire family unit.

Subsequent research on mental health literacy could provide more in depth cultural perspective where possible and necessary by focusing on unique ethnic populations. However this could be difficult as there are many ethnic groups to choose from. Instead, it may be more worthwhile to reconsider sampling strategies that are more friendly and motivating to the general immigrant population. In-person, face-to-face options could be more effective in encouraging increased participation, by putting participants' minds at ease through more intimate contact and the opportunity to establish trust in the researcher. Researchers should look towards the establishment of relationships with settlement organizations and immigrant community support services for sampling purposes in order to yield larger, more inclusive immigrant sample populations for future studies.

Future research could also be participatory and action based for ethnic subjects. It would be beneficial for researchers to explore the participation of new immigrants in an actual mental health promotion initiative. Just as Olin et al. (2010) identified barriers and perspectives of parents in general in their parent empowerment experiences, applying this model to new immigrants could offer observations on behavioural change, cast light on certain barriers and evaluate the efficacy of mental health initiatives specific to this vulnerable population. Moreover, program messaging and concepts could be tested in experimental and control groups to explore their affect on parent empowerment.

### Conclusion

This study confirms that new immigrants are a vulnerable population that requires further study in the area of mental health literacy and their experiences of parent empowerment. This is particularly important as mental health programs and promotion tools become increasingly common in school and community settings. Immigrant parents are a key secondary audience that warrants more in-depth consideration for the future success of mental health promotion. This was shown through new immigrant mothers' interest in enhancing the mental health knowledge and care of their children at home and the impact of various barriers on these processes.

In closing, the future possibilities for research in the areas of mental health literacy and new immigrant parents are vast. It would behoove researchers interested in exploring this audience and mental health to further to endeavour to do the following; conduct comparative analyses that account for perspectives and actual experiences of parents and children, conceive of more ideal recruitment strategies with in person, face-to-face interaction, find access to broader immigrant sample population groups with varying language abilities and educational backgrounds, and evaluate the communication efficacy of such programs and messages through participatory research, whereby the audience actually experiences whole initiatives from start to finish. The opportunities are boundless, just as new immigrants to Canada are faced with countless possibilities upon their arrivals to their new home. Canada is well served when the well-being of all her people is accounted for so that they in turn may strive towards a prosperous future. The mobility of new immigrants in developing mental health literacy matters to each and every Canadian and plays a part in that. A tension exists between the forces of mental

health literacy, more specifically perspectives of mental health and mental illness. There is a path to empowerment for new immigrant mothers in mental health maintenance but, it must be noted, there obstacles along the way.

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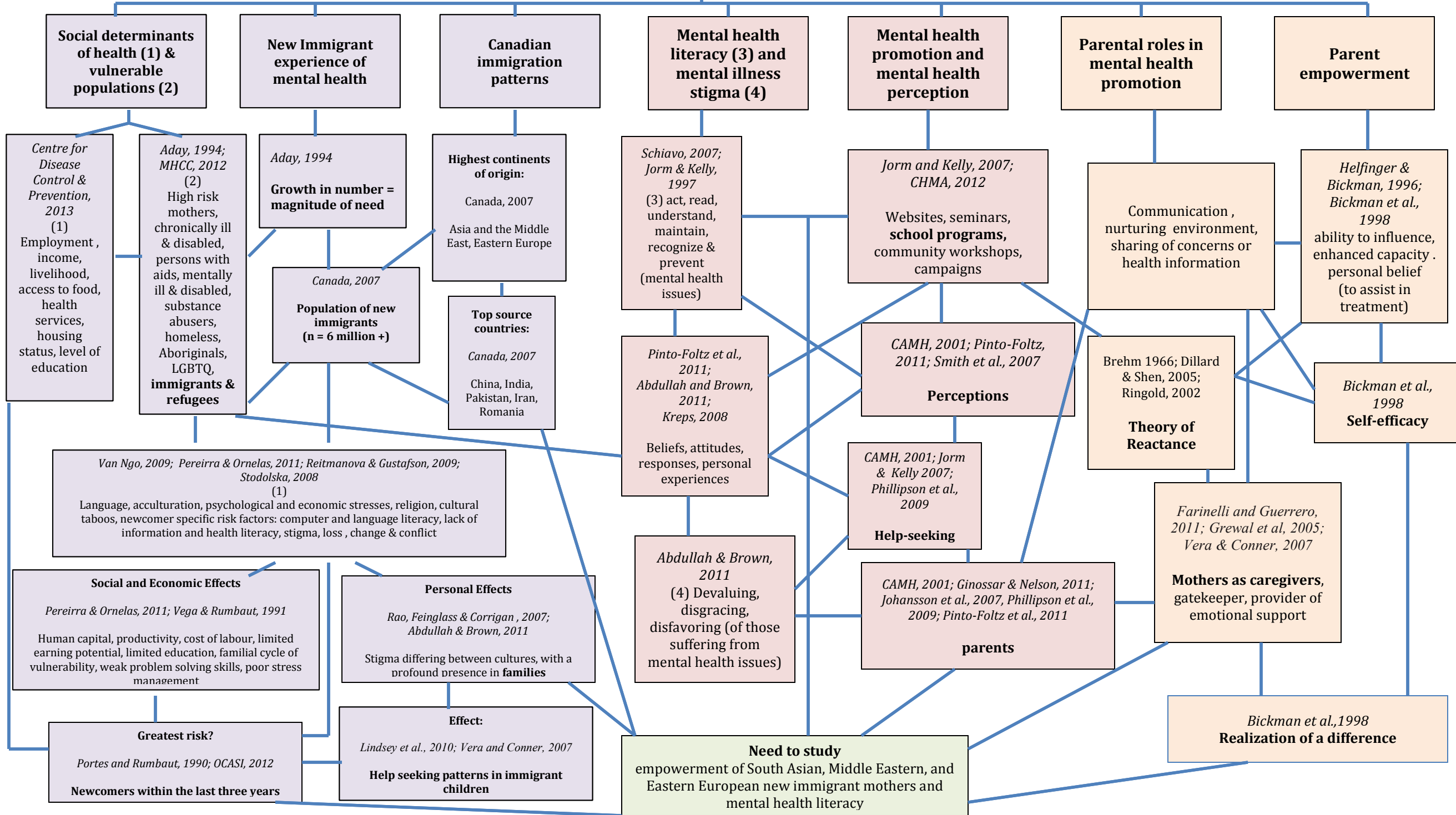
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Appendix A

Refer to chart insert on proceeding page.

**Immigrant Mothers' Mental Health Literacy and Empowerment**



## Appendix B

## Recruitment Email Text from the Career Edge Organization to Career Bridge Registrants

Dear Career Bridge Registrant,

The Career Edge Organization occasionally works with third party researchers on projects of national, Canadian interest.

The following project on perspectives of new immigrant mothers on mental health knowledge is seeking participants. It is being carried out independently of Career Edge Organization. We do not benefit directly from your participation. Career Bridge registrants are being invited as a courtesy to the research team. Your participation in this research will have no effect on the services you receive from Career Edge.

If you are interested in participating in the focus group study you will need to meet the following eligibility criteria:

- gender: female
- parental status: mother of at least one child between 6-18 years of who attends school in Ontario
- ethnic origin: from India, Iran, Pakistan, Bangladesh, Sri Lanka, Ukraine, Russia, Republic of Moldova, Romania, or Poland
- residence: lives in Toronto or the Greater Toronto Area

This is a relevant research project that will shed light on the needs of new immigrants upon settlement in Canada. This is a chance for you to contribute to a greater understanding of how to engage all newcomers in the dialogue that Canadians are having on the issue of mental health.

Please note that as a Career Bridge registrant you are under no obligation to participate. This is a strictly voluntary exercise and Career Edge Organization will not be made aware by the researcher of your choice to pursue this invitation or not.

Please read the attached recruitment letter and if you are interested and believe that you meet the eligibility criteria, please email the Principal Researcher, Natalie Montgomery directly at [XXXXX.YYYY@uottawa.ca](mailto:XXXXX.YYYY@uottawa.ca) so that she may assess and confirm your candidacy and participation.

PLEASE SEE ATTACHED RECRUITMENT LETTER

Thank you,  
Natalie

## Appendix C

## Recruitment Letter to Sample Population

Dear Registrant,

I am a full-time Master's student in the Department of Communication, University of Ottawa and I am conducting research on new immigrant mothers and mental health knowledge. You were contacted by Career Edge Organization with permission from the University's Research Ethics Board because you are a current registrant of the Career Bridge Program and a recent newcomer to Canada. This study is being carried out independently of the Career Edge Organization and your participation in this research will have no effect on the services you receive from Career Edge.

I hope that you are interested in contributing to this study. Your feedback could make a difference in the experience of other new Canadian new immigrants.

I would like to invite you to participate in a discussion group on mental health knowledge and communication. Since the goal of this research project is to understand the experience of new immigrant mothers in understanding mental health, prior to confirming your participation, I require confirmation that you are a mother of a child between the ages of 6-18 years of age who lives with you and attends school in Ontario.

In addition, because we know that ethnicity contributes to Canada's multicultural dialogue, eligible participants will be selected on the basis of country of origin. We are looking for participants from:

India, Iran, Pakistan, Bangladesh, or Sri Lanka OR

Ukraine, Russia, Republic of Moldova, Romania, or Poland

The focus group discussion will be 2 hours long and you will be participating in one session along with 5 other Career Bridge registrants who are also mothers. Examples of the kinds of questions you will be asked include: *What is your role as a mother for issues of health concern? What types of things do you communicate about with your children? What does mental health mean to you?* The focus groups will be conducted in English only.

Furthermore, in order to facilitate comfort and open discussion in an optimal environment, only women have been invited to participate who also come from the same region of the world.

The discussion groups will take place in the City of Toronto at Ontario Institute of Studies in Education (OISE) Building located at Bedford and Bloor, 252 Bloor Street West – one block west of Avenue Road and Bloor and accessible by the TTC, Bloor-

Danforth line, St. George Station. Exact room number and floor will be provided once your participation is confirmed.

Participants have the choice of the evening session they would like to attend:

The first focus group will be on **Tuesday June 11, 2013 from 5:30 pm – 8:00 pm. OR**

The second focus group with participants will be on **Wednesday June 12, 2013 from 5:30 pm – 8:00 pm.**

A light dinner will be provided, and participants will be given a gift card incentive to acknowledge the contribution to this research. Further details will be provided upon confirmation of your participation. No further requests will be made of you with respect to this research project or your participation. The nature of the questions is general and hypothetical, and poses minimal risk to you, as a research participant.

The answers that you provide in the discussion will be tape-recorded and, later, transcribed and printed. Your answers will be treated as confidential, and therefore will be kept in a secure area. Once the data from the completed discussions have been transcribed, any information that could identify you, the individual - for example, your name – will be omitted and will not be used in any of the analyses or subsequent reports or published articles.

I hope you will agree to participate in this study. This is a chance to be part of research that could enhance the quality of programming for immigrants who, as a significant portion of the Canadian population, are a big piece of the fabric of our society and contribute to a dialogue that all Canadians are engaging in.

If you are interested in participating in the discussion group, please contact me by reply to this email at [XXXXX.YYYYY@uottawa.ca](mailto:XXXXX.YYYYY@uottawa.ca) so that I can confirm your participation. Please let me know the best way to contact you.

Sincerely,

Natalie Dimitra Montgomery

## Appendix D

## Participant Consent Form

**Invitation to Participate:** I have been invited to participate in a research project on immigrant mothers and mental health knowledge that is being conducted by Natalie Montgomery. Natalie is a Graduate Student in the department of Communication at the University of Ottawa and can be contacted if I have further questions by email at XXXX.YYYY@uottawa.ca or by phone at ###.###.#### As a Graduate student, she is required to conduct research as part of the requirements for a Master's degree with thesis in Health Communication. It is being conducted under the supervision of Jenepher Lennox Terrien who can be contacted at ###.###.#### x #### or [YYYYYY@uottawa.ca](mailto:YYYYYY@uottawa.ca).

**Purpose of the Study:** The purpose of this project is to understand the communication needs of new immigrant mothers on the issue of mental health. It will involve a focus group discussion about an awareness program and its messages. This awareness program is currently offered to teenagers in many Ontario high schools and your son or daughter may have participated in it or might in the future. This research study aims to assess aspects of mental health knowledge of new immigrant mothers: their perceptions, interpretation, action and decision-making. It will also explore the communication challenges in this experience.

**Participation:** My participation will consist of being part of a 120-minute (maximum) focus group discussion facilitated by Natalie Montgomery in the City of Toronto at the Ontario Institute of Studies in Education Building, on Tuesday June 11<sup>th</sup> or Wednesday June 12<sup>th</sup> at 5:30 pm who will ask me to respond to questions and participate in group discussion. A total of 12 (2 groups of 6) new immigrant mothers to Canada will participate in the study.

**Risks and Discomforts of Participation:** Participation in this study requires approximately 2 hours of your time to participate in the discussion. There is a risk for emotional discomfort such as anxiety and regret for disclosing personal perspectives and family experiences on mental health which some people see as very private.

**Benefits of Participation:** Benefits include contributing to an important discussion that could influence mental health programs for new immigrants to Canada, becoming comfortable with the Canadian cultural context that encourages discussion around mental health, learning about mental health facts, techniques on discussing the topic, and how to experience empowerment in one's family mental health maintenance and enhancing one's outlook for family life, discussion and acceptance of ideas.

**Confidentiality:** I have been assured that my anonymity will be protected. I will chose a pseudonym (alternate name) if I wish for all references made to my feedback. I

understand that all names will be removed from the data and if necessary, any identifying stories or circumstances will be slightly altered to protect my confidentiality.

I will not be identifiable in publications or presentations but may be directly quoted from the discussion in publications or in presentations. Only the researchers will have access to the raw data and anonymity in publications and presentations will be preserved. Discussion audio-tapes and transcripts will be kept in the locked office of the researcher's supervisor. I know that the confidentiality of the data will be protected by ensuring that all data from the interview is stored in password protected computer files.

I am also aware that efforts will be made to remove all identifying features from focus group transcripts before they undergo group analysis so that my answers will not be identifiable.

I further understand that as a focus group involves a group discussion it is impossible to provide complete confidentiality or anonymity, but guidelines will be presented to the group to ensure that the focus group space is a safe space for open discussion that respects the confidentiality of other members of the group. I will adhere to these guidelines and respect the confidentiality of my peers in the group discussion.

**Compensation:** Tokens of appreciation include a light dinner and \$10 gift card for Tim Horton's. Compensation will still be given if participants decide to withdraw from the study.

**Voluntary Participation:** Participation in this research is completely voluntary. I am free to choose to participate or not to participate in this research study. If I agree to participate in this study, I may choose to withdraw your participation at any time. I may also refuse to answer any specific questions. If I choose to withdraw, all data gathered until the time of withdrawal will still be used in the research. I also understand that once the focus group is finished, data cannot be withdrawn given the interdependent nature of focus group transcripts.

### **Consent to Participate in Research**

I understand that I am being asked to participate in a research study on immigrant mothers and mental health knowledge.

I have read and understood this Consent Form. All my questions at this time have been answered to my satisfaction.

If I have any further questions about the study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5

Tel.: (613) 562-####  
Email: XXXX@uottawa.ca

I voluntarily agree to participate in this study.

There are two copies of this form, one of which is mine to keep.

Participant's signature:

Date:

Researcher's signature:

Date:

## Appendix E

### Discussion Guide

#### Guidelines:

Thank you for attending this focus group tonight and your enthusiasm to participate in this research project on Empowering Canadian New Immigrant Mothers Through Mental Health Literacy.

Before we start to the discussion group and begin with the questions, I wanted to establish and review some guidelines and terms of engagement.

The purpose of a discussion group is to allow ideas, thoughts and answers to be exchanged amongst around the table. By sharing with each to other, sometimes it brings out related points stemming from our own personal experiences allowing for group interactivity. As such it is important that each person is given a chance to express their view point free of interruption.

Furthermore, in this environment one another's comfort level must be respected. Each of you is welcome to share their ideas and it is expected that we listen and participate in the discussion free of judgement. Most of all, identifying information and personal experiences of the people who participated cannot be disclosed outside of this room.

To respect your anonymous participation, please do not state or use your last names or indicate your home addresses or neighbourhoods. It is also important that you do not disclose the names of your family members.

I will be moderating the discussion by asking questions and follow up questions and encouraging your feedback by going around the table. You are not required to answer or comment on any point you do not wish to. If there is someone talking and you would like to add to that idea, you may wait until that person is done or signal to me that you have something to add.

Thank you and now we can get started by introducing ourselves. Please state your first name, country of origin, how long you have been in Canada, how many kids you have and their ages.

Questions:

\* NOTE: subheadings were for the Researcher's purpose only

### **1. family communication**

*What kinds of things do you talk about with your children and what are these conversations like?*

Follow-up questions

*Can you please describe the dialogue (tone, mood, length of discussion, reactions) and type of topics that you initiate conversations about?*

*Can you please describe the dialogue (tone, mood, length of discussion, reactions) and types of topics that they initiate conversations about?*

### **2. perception, cultural perceptions**

*What does mental health mean to you? How is mental health viewed in your culture? How does your understanding align with the common understanding of mental health in your own culture? Is it similar or different?*

*Please describe any feelings, behaviours, actions, associations, or judgments that come to mind.*

**Follow-up**

*What causes mental health problems in your opinion?*

*CHECK for mentions of family history, chemical imbalance, physical factors, substance use, traumatic life events, psychological and social factors*

### **3. role of mother**

*What is your role as a mother for issues of health concern? Please share the types of actions do you take for your children's health, and specify which areas of health ex. taking your child to the doctor for a flu shot, administering medication*

#### 4. **stigma, parent empowerment**

DISPLAY *warning signs of mental illness on screen per the TAMI guide (without sub-heading)*

**Noticeable personality change, excessive anxiety, sadness, abuse of alcohol or drugs, uncontrollable fears, extreme highs or lows, excessive anger, hostility, noticeable changes in eating or sleeping patterns**

*What associations do you make with these characteristics?*

*Suppose your child came home and display signs of (mention characteristics they named) What actions would you take? Please describe them in detail.*

#### 5. **interpretation and empowerment**

DISPLAY TAMI HANDOUT ON SUICIDE PREVENTION

Suppose your child left their computer open on an internet site they were browsing. You happen to notice that the site and document they were looking at. You see the document that is called “Suicide Talk”.

It includes messages such as:

***I need someone to ask me about my thoughts of suicide.***

***I need help keeping safe from suicide.***

***Together we can prevent suicide.***

And it encourages that youth take recommendations such as:

***Have a family discussion about suicide.***

***Practice reframing life circumstance in positive terms.***

*How would you react? What steps would you take next?*

*How do these types of messages make you feel and why?*

**6. parent empowerment, family dynamics**

*Have you ever talked about mental health before in your family? Could you share this experience please and tell us about it? Please be as detailed as possible - tone, mood, length of discussions, reactions.*

*Why do you feel the experience was as you described?*

*Have you ever witnessed or heard about mental health experiences before in your family?*

*If so, please describe how these experiences have contributed to your perceptions of mental health. How does your knowledge of these experiences make you feel and why?*

**7. interpretation and empowerment**

*Currently your children could be exposed to mental health ideas and messages in their schools.*

*Imagine your son or daughter came home and told you that they were feeling high anxiety and that they learned it is important to talk to someone about mental health. Describe how you might react. If this has happened before please explain in as much detail as you can.*

**8. stigma**

***"I think people with mental illness are making up excuses."***

*What could make a person think this way? Have you ever experienced a situation that has influenced your feelings in a similar way? How did this affect your view? Please share your thoughts.*

**9. parent empowerment**

*The main principle of a program called Talking About Mental Illness is the importance of helping youth communicate their own feelings to their family, particularly a parent, about mental health. How do you feel about that principle and why? What do you see as the effects of talking or not talking about mental health?*

**10. behavioural change – empowerment**

*Please describe how you see your role in influencing how your family sees mental health.*

*Now that you have heard from others, and exchanged information on the topic please describe what actions you could take to protect the mental health of your children in the future.*

*How does that make you feel?*

*Is there anything else that you would like to add to what you have shared today? Please explain.*