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EXPERIENCES OF MENNONITE IMMIGRANT WOMEN ACCESSING AND RECEIVING SERVICES IN THE MENTAL HEALTH CARE SYSTEM IN ESSEX COUNTY

by

Diane Quadros

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Abstract

Although the success rate for treating mental illness is high, relatively few people, especially immigrants, seek help. Therefore, the purpose of this study was to gain an understanding of the experiences of six Mennonite immigrant women who have received services in the mental health care system in order better understand and improve upon this populations' access to services.

A qualitative methodological approach was used to study this topic in depth. Findings offer insight about how internal and external barriers such as lack of knowledge about mental illness; experiences of judgement and lack of support from the Mennonite community; language barriers; lack of transportation; and submissive spousal relationships affected their experiences accessing and receiving mental health services. Social work practice implications with this population highlighted the importance of cultural/religious sensitive practice, using an empowerment framework, and providing education about mental illness at the micro, mezzo and macro levels of practice.

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Problem Statement

Scope and Significance of the Problem

This study focuses on immigrant women, particularly Mennonite immigrant women, and their experiences accessing and receiving mental health services in Essex County, Ontario. In 2001, an estimated 450 million people worldwide were diagnosed with a mental health disorder (Nierenberg, 2002). This number includes 121 million people with depression, 24 million with schizophrenia, 37 million with dementia, and 140 million with addiction disorders (World Health Organization, 2002). Worldwide, nearly 1 million people commit suicide each year and between 10 to 20 million attempt suicide. According to the World Health Organization, five of the ten leading causes of disabilities are psychiatric conditions; unipolar depression, schizophrenia, bipolar disorders, alcohol dependence, and obsessive-compulsive disorder (Murray & Lopez, 2003). In the last twenty years there has been an explosion of progressive mental health policy statements in several countries. The United Kingdom, Canada, Australia, New Zealand and the United States have all published national policy documents and have set national standards to measure system performance (Canadian Mental Health Association, 2004).

In Canada, mental illness directly affects one in five of the total population and indirectly affects every citizen through family or friends (Health Canada, 2002). This translates into over six million Canadians having a mental illness, 2.2 million of whom live in Ontario alone (Canadian Mental Health Association, 2007). Anxiety disorders and depression are the most common mental illnesses. For example, it is estimated that one in ten people are affected by an anxiety disorder (Canadian Mental Health Association,

2007) and Shields (2004) found that 750,000 Canadians aged 15 or older had a social anxiety disorder which is only one of many forms of anxiety disorders. Approximately 2.5 million Canadian adults, or over 10% of the population 18 and older, have a depressive disorder (Canadian Mental Health Association, 2007). In addition to depression and anxiety disorders, bi-polar disorder and schizophrenia together will affect yet another 2% of the general adult population (Canadian Mental Health Association, 2007).

Economic Implications of Mental Illness

Mental illness impacts not only the individual experiencing the illness, but the entire society. For example, the Canadian economy is seriously impacted in terms of productivity losses and health care costs of treatment associated with hospitalizations due to mental illnesses. The estimated cost is about $15 billion a year, $6.5 billion in direct medical costs and $8.5 billion in lost productivity (Goar, 2003). This places mental illness as the second leading cause of hospital use in Canada (Canadian Mental Health Association, 2007) and the British Columbia Partners (2005) reported that hospital care costs for mental illness alone was one and a half times more than hospital care costs for cancer. The societal impact of mental disorders extends beyond the costs of the mental health services and there is no way to measure what non-economic costs for pain and suffering should be added to this total annually. For example, unrecognized depression has an enormous impact in the workplace since depression hits people hardest between the ages of 25 and 54, who make up 70 percent of the workforce (British Columbia Partner). Over 70% of people with a mental illness are unemployed and two-thirds of homeless people have some form of mental illness (Canadian Mental Health Association, 2007). These figures may indicate that employees are not getting the help they need in the early stages of their illness. Unrecognized and untreated mental illness can become more severe over time resulting in greater cost to employers and the economy (British Columbia Partners). The economic and societal burdens are much too high for mental illness to be ignored. Furthermore, mental illness can be effectively treated which reduces the cost to the health care system; however, people need to be able to access the system to receive the treatment (Kirmayer & Minas, 2000).

There are no known cure for mental illnesses; however, early intervention at the onset of symptoms can provide a positive outcome for the individual and for society (Health Canada, 2002). According to the National Alliance on Mental Illness (2004), the early treatment success rates for mental illnesses are 60 to 80%, making them well above the approximate 40 to 60% success rates for common surgical treatments such as heart disease. Furthermore, mental health is key to overall physical health and early detection and treatment can result in a substantially shorter and less disabling course of illness (National Alliance on Mental Illness).

According to the Canadian Mental Health Association (2007), most people with a mental illness recover and are able to lead fulfilling lives in the community when they receive appropriate treatment and support. For example, The College of Family Physicians in Canada (2007) report that early treatment of depression can offer the following benefits: help keep the depression from worsening or lasting a lengthy period of time, help people return to their "normal" self, help prevent further episodes of depression, and with depression some people experience thoughts of suicide and treatment can make these suicidal thoughts go away. It is important to note that although mental illness itself is not life threatening more than 90% of people who take their lives have a diagnosed mental disorder (Moscicki, 1999). In addition, Starkes, Poulin & Kisely (2005) found that 80% to 90% of people with depression can be treated successfully.

With early diagnosis and the right treatment people can avoid the suffering that comes from anxiety disorders. However, some anxiety disorders can be treated more easily than others. The Anxiety Disorders Association of Manitoba (2007) found that 80% of people with panic disorder reported no panic attacks after treatment while those who also had depression or had another secondary diagnosis showed about a 50% success rate.

Help Seeking for Mental Illness

Although the success rates for treating mental illnesses are high, relatively few people seek help (Starkes, Poulin & Kisely, 2005). The respective average rate of people with a mental illness who actually seek help is approximately 20% (Bland, Newman & Orn, 1997; Starkes, Paulin, & Kisely, 2005). Seeking help seems to be affected by the seriousness of the illness. For example, according to Stuart (2000) findings from the Global Burden of Disease Survey suggest that in countries such as North America and Europe approximately 80% of persons with schizophrenia access treatment, while only 15% of persons with an anxiety disorder access treatment. Stuart goes on to report that a lack of Canadian research has meant that locally relevant data is unavailable to inform emerging health policy, new delivery systems, and cost containment strategies.

Studies have shown cultural differences in how, and when, people access mental health care (Snowden & Yamada, 2005; Reitz, 1995). Specifically, Canadian studies found that minorities, including immigrants, have low rates of utilization of various social services including mental health services, despite evidence of substantial need (Halwani, 2001; Kafele, 2004; Whitley, Kirmayer & Groleau, 2006; Reitz, 1995). In addition, Health Canada (2002) proposed that in its current health care delivery system there are disparities in access to all health care by various cultural groups across provinces.

The gap in service among minorities and immigrants is complex with many policy and societal variables that can present themselves as barriers. Barriers include obstacles such as: lack of available services (Kaplan, 2004); limited awareness of existing services (Egan & Gardner, 1999; Kafele, 2004; Kouyoumdjian et al. 2003); financial barriers (Documet & Sharma, 2004; Health Canada, 2002); stigma (Arboleda-Florez, 2003; Barkhimer, 2003); lack of trust of the service system (Hines-Martin, Malone, Kim, & Brown, 2003); language barriers (Kouyoumdjian et al. 2003); and different treatment seeking pathways that individuals may chose to get help (Gallo et al., 1995; Sussman et al., 1987). The identified problem area is that individuals who are of minority status access the mental health care system at lower rates than the general population and this may be due to this population experiencing immigrant specific barriers such as language issues or trust issues that Canadian born individuals may not experience (Health Canada, 2001).

In recent years, there has been a marked increase of the number of immigrants coming from different countries into Canada. In 2004, Canada welcomed 235, 823 immigrants and more then half of these individuals call Ontario their home (Immigration & Citizenship, 2004; Ng, Wilkins, Gendron & Berthelot, 2005). In Southwestern Ontario, large immigrant populations live in areas such as Kitchener-Waterloo, London, and Windsor (Ontario Immigration, 2005).

While minorities, including immigrants, are less likely to use mental health services, immigrants are also at greater risk for developing a mental health concern due to the stressors of the migration process (Bhugra, 2004; Potocky-Tripodi, 2002). Although migration can, at times, equate with greater individual freedom and educational opportunities, research has demonstrated that the immigration process is a stressful experience (Bhugra, 2004; Tobora & Flakerud, 1994). Upon arrival in a new community, a person may face stressful experiences due to culture change, cultural conflict, isolation, language problems, and discrimination (Kuo & Tsai, 1986).

In addition, due to high immigration and settlement costs, when first arriving in Canada, some immigrants begin their new lives as part of the lower class (Janzen, 1998). Eaton and Muntaner (1999) reported that stress is a more potent activator of mental illness in the lower class than any other socioeconomic class. Williams & Harris-Reid (1999) identify that low socioeconomic status, racism, migration, and acculturation significantly increase an individual's chance of experiencing a mental illness.

Furthermore, Williams & Harris-Reid (1999) encourage all professionals who work with individuals from different cultural backgrounds to identify ways in which social, economic, political, and cultural factors shape the experiences of minority populations in ways that affect their mental health. Therefore, immigrants with a mental health concern have been identified as a vulnerable population in Canadian society. These trends suggest that mental health providers will increasingly have to provide services to individuals who are immigrants.

Focus of Current Study

This study focuses on immigrant women, particularly Mennonite immigrant women, and their experience of accessing and receiving mental health services. Women, in general, are approximately twice more likely to have depression and/or anxiety disorders than men (Rhodes, Goering, To & Williams, 2002). As well, women are at greater risk to have unmet needs such as lack of support and unmet health needs (Wu, Penning & Schimmele, 2005).

In general, immigrant women are a uniquely vulnerable population. According to Thornhill (1991) Immigrant women have been reported to live at the bottom of society because of their unique experiences of triple oppression, that is, race, gender and class. They have been found to have received unnecessarily harsh treatment from health care staff including mental health and have been discriminated against (Brand, 1993). The conditions under which immigrant women live and work have profound effects on their health (Anderson, Blue, Holbrook & Ng, 1994) and immigrant women should be considered a population that is at higher risk for physical and mental distress (Meleis, 1991).

Mennonite immigrant women face unique challenges according to Draper (2004) who found that Mennonites experience a clash of social worlds when they immigrate to Canada. Mennonites' value farm work and a community life while western society values individualism and economic gain. Furthermore, Mennonite people are taught to be obedient, to accept suffering, and to deny self, in contrast to the Canadian ideal of striving to get ahead (Draper). The characteristic of obedience inadvertently makes this culture more vulnerable to majority legislative laws that oppress new Canadian citizens. Additionally, Draper noted that the Mennonite culture has been weakened by economic difficulty and that Mennonites, during times of difficulty, try to protect themselves by holding even more tightly to their traditions.

Currently, over 30,000 Mennonites from settlements in Mexico are permanently living in Ontario's prime vegetable belt which spans from Windsor to Niagara Falls (Towell, 2000). From the years of 1991 to 2004, 651 Mennonite families settled in Leamington alone with a family, on average, consisting of six individuals including a husband, wife, and children (Dueck, 2002). When these figures are multiplied, it is found that approximately 2,600 people from this particular cultural background have settled in Leamington, Ontario.

The purpose of this study was to describe the perceptions of Mexican Mennonite women's experiences with the mental health care delivery system. The following served as the over arching research questions for this study:

1. What does mental health mean to Mennonite women?
2. What are the experiences of Mennonite women accessing and receiving services through the Canadian mental health care system in Windsor Essex County?
3. What are the strategies developed by immigrant Mennonite women in response to the challenges they have encountered in their interactions with the mental health care system?

Although research has been conducted about the help seeking behaviors of people from Chinese, Hispanic and African American cultures, after an exhaustive review of the literature, there was no research found with regard to Mennonite women seeking mental health services. Answers to these questions can help inform social work practitioners, particularly mental health service providers, about the ways in which to better serve the needs of this population.

Chapter 2

Literature Review

This chapter provides an overview of the literature with regard to the social construction of mental illness and the interconnected relationships between culture and mental health, and mental health and gender, namely women. In addition, help seeking behaviour models and the psychological stages of migration are introduced and an overview of the history of the Mennonite population in Canada including the role of Mennonite women is provided. Furthermore, the internal and external barriers to receiving mental health services as well as a discussion of multicultural social work practice in this area is presented.

Social Constructionism

Ontology

The term ontology derives from the Greek word "onto" (being) and "logia" (written or spoken discourse). It is a branch of metaphysics that seeks to describe the basic categories and relationships of "being" or existence and attempts to answer questions such as: What exists? What constitutes the identity of an object? And, when do things cease to exist rather than change? (Berger & Luckman, 1966; Gruber, 1993). In other words, ontology looks at how humans come to know what is real.

There are two ideological orientations of ontology: essentialism and constructionism. Rosenblum & Travis (2006) explain that essentialism is the notion that reality exists independent of our perceptions of it; therefore, reality is objective. In addition, there is an assumption that there are essential differences between categories of objects. From this perspective, reality exists apart from any social processes. For example, Ore (2003) suggests that the essentialist ontological position on the categories of gender, race, or other group characteristics, consider these to be fixed traits that do not vary between individuals or over time. A second example is how many of us use an essentialist ontological perspective when thinking about race, gender, or disability by viewing these differences as the result of biology.

On the other hand, according to Rosenblum & Travis (2006), constructionism suggests that reality cannot be separated from the way a society perceives it and makes sense of it. For example, race and gender are concepts that do not exist until they are constructed through a social process described in more detail below.

The Process of Socially Constructing Reality

According to Berger & Luckmann (1966) the sociological theory of social constructionism focuses on the ways in which individuals participate in the creation of their perceived reality. Van Steenberghen (1970) adds to this view by explaining that every human experience is an experience of "being". Humans use groupings to aid in the organization of these experiences, which then results in every person having their own personal catalogue of the *types* of things they assume to exist. According to Berger & Luckmann social constructionism looks at the ways that social phenomena are created, institutionalized, and made into tradition by humans. According to this theory reality is ever changing based on people's interpretations of everyday life. An example of this would be when society believed the world was flat; however, due to technological advances reality changed and we now believe that the world is round. Furthermore, within social constructionism, a social construct is an idea that may appear to be obvious to those who accept it, but in reality it is an invention of a particular culture or society (Berger & Luckmann).

Furthermore, according to Berger & Luckmann, (1966) there is a three-stage process in which reality is socially constructed. The first stage is called *externalization.* Externalization means "to put something outside of its borders", "to express in an outward form, to attribute external reality" (Webster, 1988, p.335). In this stage cultural products are created through social interactions. These cultural products may be material artifacts, social institutions, or values and beliefs. The second stage, *objectivation*, occurs when the cultural products created in the first stage appear to take on a reality of their own, becoming independent of those who created them. Individuals are the creators of their social and cultural environment and of their interpretations of reality.

Lastly, *internalization* is the process through which a person incorporates the meaning about the cultural products that have been created into their everyday experiences through social interactions. People interact with the understanding that their respective perceptions of reality are related, and as they act upon this understanding their common knowledge of reality becomes reinforced. Since people negotiate this basic knowledge, human typifications, significations and institutions come to be presented as part of an objective reality (Berger & Luckmann, 1966). As a result, people learn the ways of society and one's specific roles within their social position. We learn from birth the differences between male and female. For example, common perceptions are that males are to be physically strong and competitive while females are to be calm and co-operative.

Social Construction of Group Memberships

In addition to the process by which people create reality, a process also exists in which we create social group memberships. Society constructs categories of people the same as they do other items; these categories of people are founded on perceived differences. Rosenblum & Travis (2006) provide a clear outline of how differences of group memberships are socially constructed. First, difference is constructed by *naming* categories of people by giving them a specific label. For example the labels of, Canadian, American, Asian, Caucasian, and immigrant are used to identify a country of origin. The labels of Black, Hispanic, and Asian are used to distinguish differences between races and homosexual, heterosexual, and bisexual are listed to identify and categorizes sexuality and sexual preference. The names that are used change over time often due to political and social movements. Rosenblum & Travis give an example of this; the name used for people from Africa has changed through the years from Negro to Black to African American. These changes in names reflect how reality is a constructed process.

Secondly, *aggregating* occurs; this is when groups are combined together based on their labels or names. Frequently, these aggregates emerge as dichotomies, which is the next step. To *dichotomize* is not only to divide something into two parts but also to see those parts as mutually exclusive and in opposition of each other. For example, a person is disabled or not disabled, coloured or white, masculine or feminine.

Lastly, Rosenblum & Travis (2006) propose that people attribute meaning to difference among categories, including categories of people, by giving a value to difference as "good" or "bad". For example, having a disability would be considered "bad" while not having a disability would be considered "good". However, reality is not as simple as being apart of one group or another, in reality an "in-between" exists which is sometimes referred to as the "grey" area. We use the example of sexuality to illustrate this point. The two main dichotomies for sexuality would be heterosexual or homosexual; however, in today's society we are aware that some individuals do not fit one group exclusively, but belong to both groups, this group has then been categorized as bi-sexual. However, when we review the research regarding sexuality we find that there is a large spectrum of sexual orientations that are on a continuum. Humans use categories and dichotomies to help simplify their ability to create their reality.

Social Construction of Mental Health

Mental illness has been dichotomized into two categories based on socially constructed concepts of what is normal and what is abnormal (Prior, 1999; Sands, 2001). Therefore, Sands (2001) proposes that mental illness, as a social construction, seeks to locate deviant or abnormal behaviour in individuals. She further explains that the social construction of mental illness has been a long process of trial and error guided by political attitudes and medical theories. Historically, each society developed their own set of definitions and responses to mental illness and by tracking these developments we can gain a better understanding of society's beliefs about mental illness.

In prehistoric times, before written history, mental illnesses were assumed to stem from magical beings that interfered with the mind. Shamans or traditional healers developed their own rituals and spells in an attempt to cure the individual. Examples of common treatments during this era were exorcisms, in which the shaman would attempt to remove the evil spirit from the body or a primitive form of surgery was used to attempt to remove the spirit. For example, trepanation was a practice of drilling a hole through part of the skull to allow the spirits trapped inside to be released (Bloom & Schafer, 2006). Trepanning is the oldest form of surgery dating back 10,000 years (Think Quest, 2007). An article released in 2000 warned people not to complete the trepanning procedure at home after a woman in the U.K. and a man in the U.S. completed the procedure themselves. They had heard about the procedure on the internet which promised relief from depression (Abergavenny, 2000).

Later in history, approximately four thousand years ago, or 1900 B.C., the ancient Egyptians did not differentiate between mental and physical illnesses and believed all illnesses had physical causes. They thought the physical heart was responsible for mental symptoms. This was the first sign of change in the treatment of mental illness with the introduction of the first psychiatry text and the first known mental hospital. Moving forward to 460 B.C. Hippocrates and the early Greeks continued to believe that all illness resulted from biological malfunctions. For example, the Greeks believed that depression was a result of an excess of "black bile" in the digestive system (Bloom & Schafer, 2006; Sands, 2001). Therefore, procedures such as bloodletting, enemas, and emetics were used to restore balance to the body. Later, during the 1700's many people with a mental illness were simply locked away by their families. Poorer individuals were jailed or placed in publicly funded institutions.

In the 18th century, in western societies, progression occurred with the continued biological investigation of mental illness; however, treatment was still primitive and inhuman (Sands, 2001). Individuals were subjected to being locked up in asylums or madhouses, underwent a primitive form of electroconvulsive therapy, and public perception was fear due to little understanding of mental illness. Around the turn of the 19th century, Europeans introduced "Moral Management" as a new approach to the treatment of mental illness. This approach assumed that the environment played a vital role in the treatment of mental illness. Beds in asylums, pictures and decorations replaced shackles, chains, and cement cells. In western culture, it was not until the 20th century with the introduction of psychotropic medications that another paradigm shift occurred. This shift was one of deinstitutionalisation. Psychotropic medications gave most patients with a mental illness a reduction of symptoms that allowed them to function in society (Newman, 1998). Individuals who were once confined to asylums or psychiatric hospitals were now living in the community.

Smith (1990, as cited in Fee, 2000) provides a model for how mental illnesses are socially constructed in modern times by the scientific community. First, the researcher identifies a difference that deviates from the social norm. For example, people with depression were first identified by their inability to perform normal activities of daily living such as maintaining their personal hygiene, eating and sleeping regularly, and keeping a job. Secondly, the illness, with its identifying symptoms and behaviours, in this example depression, is described and published in a professional journal or text. Next, other medical professionals encounter patients with the same symptoms and are diagnosed with depression by their doctor who was educated using the professional literature. However, additional symptoms present themselves along with the already classified and defined symptoms that cannot be found in the textbook such as disrupted sleep. This leads to further research and papers to be written for journals describing the initial illness of depression along with the new symptoms or behaviours that now become present. Last, a new textbook, or new edition of the textbook, is published that includes depression plus the additional symptoms as part of the clinical description.

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV-TR) is such a text that provides examples of the social construction of mental illness in North America. This text was first developed in 1952 and is the manual used to define and diagnose mental illness. A review of the previous editions of the DSM illustrates how the practice of psychiatry and defining mental illness has been controversial and has changed over time. For example, over thirty years ago, in the DSM-II (1972), homosexuality was considered a mental disorder in American psychiatry. Years later, the American psychiatry establishment lead the way in refusing to pathologise homosexuality and had it removed from the 3rd edition of the DSM (1980). The psychiatric profession argued against treatment practices used to turn gay people straight and with these changes homosexuality was no longer seen as an illness of the brain that should be treated. The change of homosexuality from mental illness to non mental illness illustrates the continual process of social construction of groups of people that were once labelled as different and were behaving in a way that was less valued than others.

Since our knowledge and social construction of mental illness has changed over time, and will continue to change, we turn to the DSM-IV-TR's current working definition of mental disorder to provide the most current understanding of mental illness in western society. Therefore, according to the DSM-IV-TR (2000) mental illness is when a person displays a pattern of considerable change in their mood and/or behaviour that is associated with a disability or distress and this change is a deviation from cultural norms.

Delgado, Jones & Rohani (2005) propose that this definition of mental illness and the western model of mental health care may be problematic. This is because since the DSM's first edition the DSM is based on research conducted by western professionals in a mostly white, Anglo, Christian context in a predominantly patriarchal society. However, in the current edition of the DSM-IV-TR (2000) special attention has been added to include an awareness of cultural differences. The text acknowledges that a clinician who is unfamiliar with an individual's cultural frame of reference may incorrectly diagnose an individual. An example illustrated in the DSM is that in certain religious practices it is not uncommon for a loved one to see or hear a deceased relative during bereavement; this may be mis-diagnosed as a psychotic disorder if not looked at along side the individual's cultural norms.

Social Construction of Women's Mental Health

From a social construction perspective, gender is a society's division of people into differentiated categories of "masculine" and "feminine" and gender is an intrinsic part of many societies' social orders (Lorber & Moore, 2002). Boys and girls are taught their society's expectations of appropriate behaviour based on their sex and grow up to follow these gendered social roles (Lorber, 1997). For example, traditional gender roles for women are domestic duties such as cooking and cleaning in the home while men are expected to protect and provide financially for the family by leaving the home to work (Fox, 1993). Lorber & Moore propose that the content of these differences depends on the society's culture, values, and economic and family structure and that those men and women who deviate from their expected role may be considered to have a mental illness. For example, Galanti (2004) highlighted the case of a married Asian woman who was institutionalized in a small community in Asia because she was expressing the desire to work outside the home and/or go back to school. In the Asian culture this is seen as abnormal behaviour for a married woman; therefore, she was thought to be experiencing delusional thinking and required treatment. This is in contrast to thinking in other cultures, such as the North American culture, where women are encouraged to work outside the home and/or attend post secondary education regardless of their marital status.

In Chesler's (2005) review of published scholarly material, as well as published and unpublished diaries of women who have been institutionalized over the last century, she concluded that women were over represented in asylums. In addition, based on her review of the published literature with regard to women's mental health, Rosenthal (2000) suggests that more married women were identified as suffering from a psychiatric illness than single women. Chesler (2005) offers an explanation to Rosenthal's findings stating that married men, in the 1940's, could and would have their wives committed when their wives began to strive for independence such as wanting to pursue post secondary education. Since female independence was not viewed as socially acceptable behaviour, deviating from the norm would be defined as having a mental illness. A narrow social construction of women's behaviours existed at this time, a women's role was to be submissive.

In addition, Chesler (2005) reports that socially constructed gender biases existed in the diagnosis of mental illness that made women more vulnerable to be committed than men. Women were diagnosed more frequently with a psychiatric illness while men, presenting similar symptoms, were more likely to be diagnosed with physical illnesses. For insistence, a woman and a man may go to their physician presenting the same symptom, for example, disrupted sleep, and the woman is more likely to be diagnosed with depression or anxiety while the man may be diagnosed with a sleep disorder. Furthermore, historically, rape, harassment, discrimination, and other forms of abuse were defined as part of a women's psychiatric illness rather than a social concern. For example, when a woman claimed that she was raped, many times the female would be persecuted for falsely accusing a male for an action she most likely provoked (Chesler). In addition, Rosenthal (2000) suggests that the symptoms of depression are comprised of mainly feminine behaviours such as crying, fatigue, feelings of guilt, and low self esteem, that women adopted over time to be able to survive under sexist, oppressive conditions.

Rosenthal (2000) offers possible reasons why women continue to be diagnosed with depression more frequently than men. Explanations that view mental illness as a social construction suggest that women tend to seek help more than men. Marwaha & Livingston (2001) adds to this discussion with their findings that women and men defined depression differently and therefore used different coping and treatment methods to deal with the same symptoms and that individuals defined that it was socially more acceptable for women to seek help for depression than men. This may account for the higher numbers in treatment. Furthermore, women tend to grieve the loss of their spouses in later life due to higher life expectancy rates. Explanations related to biology and genetics include, the genetic theory, which postulates that depression may be inherited through the X chromosome. Since women have two X chromosomes and men have only one, this theory suggests that it is only natural that women suffer twice the incidence of depression. Also, in today's society, childbearing is believed to carry the risk of a women suffering from postpartum depression. In summary, women have different life experiences, different biological functions, and different social roles in society, which defines women's reality of the world as different (Bergh, 1995).

Help Seeking Model

The way in which mental health and mental illnesses are socially constructed by our society dictates the methods by which we provide service. In addition, the definition of mental illness changes and so do the treatment approaches and the way in which people seek help. For example, when mental illness was thought to be a spiritual problem, as mentioned earlier, treatment was grounded in religious methods such as prayer and exorcism. Today, mental illness is seen more as a biological problem and treatment comes in the form of prescribed medication that is monitored by a physician. Therefore, understanding help seeking behaviours is important in order to ensure that the national health care system and social service delivery system are providing the services individuals need and are doing so in an effective manner (Lin, Goering, Offord, Campbell & Boyle, 1996).

Help seeking models were first developed in the 1960's to assist in understanding why families use health care services. Andersen (1995) used the help-seeking model in his research and redeveloped the model through several subsequent investigations. The initial model yielded large outcome measures that were too broad.

Following models attempted to provide more specific measures. In the late 1990's, phase four of the behavioural model emerged which was specifically geared to better understand individual help seeking behaviours. This model emphasized the dynamic and recursive nature of receiving or accessing health services and was the first to include individual's health status outcomes. This model highlighted that environment, demographic characteristics, the person's health seeking behaviour, and outcomes were inter-related. In Anderson's investigation, he found that people's attitudes, values, and knowledge about health and health services influenced their perceptions of need and use of the available health care services. It was determined that health beliefs provide one means of explaining how our social structure might influence obtaining resources, perceived need, and usage of the service system.

Cauce, Paradise, Domenech-Rodriguez, Cochran, Shea et al. (2002), investigated the behaviours of ethnic minority youth seeking mental health services. It was determined that seeking help for mental health services was characterized as the interconnections of the following three components: a) problem recognition, b) decision to seek help, and c) service selection.

Problem recognition. Help seeking cannot begin until a problem or need is recognized. A need can be defined in one of two ways; as an epidemiologically defined need (an evidence based study of factors of health) or as a perceived need (what someone believes to be a need). Culture groups differed on what they perceived to be a mental health problem. Culture and contextual factors also played a key role with respect to defining need. Marwaha & Livingston (2001) offer an example of the effects of problem definition and its relation to seeking treatment in their semi-structured qualitative study of forty ethnic adults. It was uncovered that ethnic elders avoid psychiatric services because they do not define depression as a mental illness even though their symptoms could have possibly benefited from treatment. In this case, ethnicity impacted the conceptualisation of depressive symptoms.

The decision to seek help. People obtain help from mental health services either by coercive or voluntary means and that help seeking is most likely to occur when a mental health problem is recognized as undesirable and when it is determined that it will not go away on its own. Even after a problem is identified as undesirable the decision about whether to seek help and how to seek help varies by culture and context.

Service selection. Service selection is defined as where or whom individuals turn to after identifying the problem and deciding to seek help. Service selection includes informal supports (ie: friends and family) or formal mental health services (ie: psychiatrists, psychologist, and social workers) from private or government funded agencies. The network of formal treatment providers and pathways into treatment become even more complex when one recognizes that many attempts to get help for mental health problems begins within the informal network of family and friends. This is particularly true for ethnic minorities. It has been identified that because of the strong influence of these informal networks on decisions about treatment, context and culture may have their greatest impact at the point of service selection.

The following studies further inform our understanding of help seeking behaviour for mental health services among various ethnic groups. In the literature, it is noted that ethnic clients usually seek medical help for psychiatric issues first because they present their mental health symptoms in somatic ways such as loss of appetite, weight loss, headaches and pain through out the body (Nelsen, 2002). In Nelsen's qualitative review of forty-four articles in the mental health literature she articulated that all social workers should have a basic understanding that symptoms present themselves in different ways for different people. Barn & Sidhu (2004) and Ahmad, Shik, Vanza, Cheung, George &

Stewart (2004) in their qualitative studies also found similar results. Barn & Sidhu's participants described their worries through physical symptoms. Ahmad and colleagues' (2004) participants verbalized physical symptoms such as headaches, back pain, joint pain, hair loss and fatigue to describe their depression and anxiety.

In 2005, Wynaden and colleagues investigated the factors that influenced Asian communities access to mental health care with a convenience sample of 10 participants. Findings suggested that this minority group tended to seek help for mental health services only when the family was no longer able to care for the ill individual. Wynaden et al. illuminate that all cultures have their own health belief systems that determine how members respond to illness. These findings are consistent with other studies that identified people from ethnic groups seek help within their own cultural network rather than accessing care from formal health sector. A qualitative study by Booth et al. (2003)'s using eighty-one youth focus groups too found that participants were most likely to seek help from family, friends, or others they trusted before using formal services.

Choi & Gonzalez (2005) also used qualitative methods to investigate the barriers to help seeking by minority older adults to mental health care by interviewing geriatric mental health clinicians in the United States. They interviewed 18 adults over the age of 55 (13 non-Hispanic whites, 3 Hispanics, 1 African American and 1 Asian American). They found that professional mental health treatment was only used as a last resort because the participants and their families interpreted seeking outside help as a sign of weakness; therefore they tried to deal with the problem on their own. Four circumstances were identified from this study in which minority adults accessed outpatient mental health care: (1) lack of social support in times of loss or life changes;

(2) family conflict and relationship issues; (3) depletion of the family's care giving resources; and (4) caregiver stress and issues of guilt related to care giving.

A large quantitative study by Commander, Odell, Surtees & Sashidharan (2003) reviewed 2169 psychiatric hospitalization admission records. Findings suggest that ethnic minorities were admitted into the hospital as involuntary patients at higher rates than non minority citizens. They concluded that a delay in seeking help may account for why minority groups tend to have higher involuntary rates of admission to psychiatric hospitals than the general population. An individual can only be admitted as an involuntary patient if they are perceived as a danger to self or to others, which usually occurs in the latter stages of symptom progression (Mental Health Act, 2000). Unfortunately, many ethnic minorities' first experiences with the mental health care system is when they are most ill and vulnerable, and their experiences may be a negative experience due to the coercive nature of involuntary committal in psychiatric hospitals. In addition, the individual's desires to continue to seek informal supports may also account for why individuals from ethnic minority groups do not continue formal treatment once discharged from the hospital (Snowden & Yamaha, 2005). Furthermore, Snowden & Yamaha suggest that certain cultural groups seek help from the general medical sector rather than from mental health professionals. Barn & Sidhu (2004) found in their qualitative study of Bangledash ethnic women that not only does socio-economic status and availability of service impact access to care, but how the problem was defined (as physical or emotional) impacted access to service as well.

Lastly, Liao, Rounds & Klein (2005) found that college students were more likely to seek help when their distress levels were high and their attitude toward counselling was positive. They further found that self-concealment of the problem was related to having a limited social support network, a high level of distress, and less favourable attitude towards counselling. Liao, Rounds & Klein sampled 202 Asians and 336 white college students and had them complete a series of standardized tests including the Help Seeking Survey (2005).

Barriers to Mental Health Care

A barrier is any obstacle, real or perceived, that presents itself when someone is trying to advance (Marriam-Webster, 2009). A barrier impedes free movement and is anything serving to maintain separation by obscuring vision or access (Word Reference, 2003). Based on findings of the Baycrest Research Centre (2006) common general barriers to accessing any type of health care including mental health care are: 1) architecture such as how a building is designed, layout of rooms and size of doorways; 2) physical barriers such as objects that are added to the surroundings for example doors, elevators, furniture and bathroom hardware; 3) informational or communication barriers such as difficulties receiving information or communications either in person, by correspondence, telephones, signage, or verbal communication; 4) attitude barriers from persons who do not know how to communicate with people in a socially appropriate manner, or from persons who display discriminatory behaviours; 5) technological barriers such as computers, telephones, inadequate or inappropriate assistive technologies; and 6) policy and practices such as rules, regulations and protocols that restrict people. Barriers specifically related to mental health services are broken down into two main categories: external and internal barriers.

External Barriers

External barriers are obstacles related to the physical environment and are created by gaps in society. Researchers have identified financial barriers, lack of available services, and limited awareness of existing services as the most prominent external barriers to accessing mental health services (Snowden, Collinge & Runkle,

1982) and each of these will be discussed below.

Financial Barriers. Financial barriers are the most predominate barrier to accessing both general health care services and mental health care services (Documet & Sharma, 2004; Health Canada, 2002). Although Canada has a universal health care system that provides free basic health care to its citizens, finances still prove to be an obstacle for those accessing mental health care services (Health Canada, 2001). Health Canada (2001) and Kouyoumdjian, Zamboanga & Hansen (2003) identified the following as the monetary costs associated with receiving mental health services: a) limited availability of time to seek services; b) cost of day-care when a parent leaves to receive services; c) cost of transportation either through paying for bus fare, taxi services, or purchasing a car and gasoline to run the car; and d) any costs associated with receiving services such as administration fees or fees to attend mental health treatment groups.

Lack of available mental health services. Availability of service refers to situations when no services are available in the community, or when there are long waiting lists for services, or when rural geographical locations limit the services available (Health Canada, 2001). International statistics indicate that over twenty-five percent of people with a mental illness are found in poor rural areas, areas that cannot afford to provide services (Kaplan, 2004). In addition, Canadian Mental Health Association (2006) reports a shortage of mental health professionals and regional disparities of services overall in Ontario. In addition, the association proposed that some community-based services (e.g. prescription drugs, psychological services) considered being essential for recovery are not publicly funded, and some populations (people with severe and persistent mental illness) are in particular need. Finally, services that do not have flexible hours for individuals who are unable to take time off of work also create a barrier (Health Canada).

Lack of awareness of services. A lack of awareness of available services by both consumers and professionals has also been indicated as an external barrier inhibiting access to mental health services (Kouyoumdjian et al., 2003). A portion of the general public are still unaware of what mental health services are and how they can help. Furthermore, Kouyoumdjian et al. propose that some of the general public are also unaware that services for mental health care exist outside of an institutional setting (i.e.: hospital or asylums). Egan & Gardner (1999) report that there is a lack of knowledge particularly among immigrant women of health care services available to them. Furthermore, the Office of Minority Health (2006) and Kafele (2004) suggest that health care providers as well as members of the clergy are unaware of mental health treatments and services available. The office of Minority Health and Kafele's articles both highlight the importance of informing health care providers as well as members of the clergy because they are, in many cases, the first people that come in contact with individuals who are seeking help for their mental health symptoms.

The following studies further inform our knowledge of external barriers to receiving mental health services. Lin, Goering, Offord, Campbell & Boyle (1996) sought to describe the distribution and predictors of mental health service usage in Ontario households with residents aged 15 to 64 years. This quantitative study, of 9953 surveyed households, identified lack of services in their geographic region as a barrier. They also highlighted that the strongest motivation for people to seek help was having a diagnosis.

In a qualitative study of 24 participants, researchers Hines-Martin, Malone, Kim & Brown-Piper (2003) investigated barriers to mental health care as perceived by African Americans. Using reiterative comparisons, theoretical sampling, and saturation of codes, this report found that participants identified having difficulties finding options for mental health services within their community. Participants identified that services were not easily identifiable and available. This study also identified the negative impact of professionals' attitudes about access and services as perceived by the participant. In addition, a study involving focus groups with both a snowball sample of ethnic older adults and a purposeful sample of medical practitioners in Toronto's Chinese and Tamil communities found similar external barriers as described by Hines-Martin, Malone, Kim & Brown-Piper (2003) (Sadavoy, Meier & Ong, 2004). All groups demonstrated a surprisingly low level awareness of the available services that existed in their community. Frontline workers and administrators in local agencies expressed their frustrations at the lack of culturally sensitive mental health training for workers. Furthermore, the reluctance of both mental health consumers and their family members to acknowledge and disclose problems was a key barrier to receiving services.

A Canadian study by Ma & Chi (2001) found similar results in their sample of 279 Chinese Canadians. Participants were age 18 and above and resided in the Greater Toronto Area. There were 139 female respondents and 140 male respondents. The majority of respondents had been in Canada for less then 20 years. A random sampling method was used and telephone interviews were conducted by trained interviewers. Complaints included: lack of knowledge about services; difficulty accessing services; complicated applications for receiving services; unavailability of the services needed; and long waiting lists.

Two large studies using data from the National Hospital Ambulatory Medical Care Survey (NHAMCS), with sample sizes over 115 000, found differences between whites and minorities in receiving mental health services. Richardson, Anderson, Flaherty & Bell (2003) found that after controlling for diagnosis and other factors African Americans were less likely than white people to receive counseling services, but were more likely to receive medication for their illness. Furthermore, African Americans had more hospitalizations than whites. Similarly, Lasser, Himmelstein, Woodhandler, McCormick & Bor (2002) found that minorities (Hispanic and African American) received mental health services such as counseling, anti-depression and anti-anxiety prescriptions less frequently than people who identified themselves as white. The authors from this study noted that these differences may be due to primary care providers not referring to psychiatric services due to misdiagnosis or under diagnosis.

Internal Barriers

According to Snowden & Yamada (2005) external barriers are important; however, they fail to address the full range of reasons for under service utilization. They identified that even if all external barriers were removed other barriers such as internal barriers, would still exist hindering people's access to mental health services. Researchers such as Singer (2001) and Arboleda-Florez (2003) identified personal or internal barriers as a set of additional barriers obstructing people's access to mental health services. A personal or internal barrier is not something that can be physically seen or moved, it is an internal part of the individual which is learned by one's culture. Internal barriers include: 1) stigma and lack of acceptance by their community; 2) ethnocentrism; 3) lack of trust towards the system and professionals; 4) language barriers, which includes the lack of the consumers proficiency with the English language; 5) different treatment seeking pathways that favour informal methods of treatment and also include a culture's distinctive style of expressing mental health; and 6) mental illnesses that can diminish the afflicted person's ability to take care of him or herself. Each of these will be described below in greater detail.

Stigma and lack of acceptance. Goffman (1963) suggested in his theory that a stigma is a social construct that changes over time and varies by cultural context.

Stigma is strong and generally increases the more an individual's behaviour differs from that of the normal population. Despite the mental health community's attempts to educate the general population about mental health, stigma is still a major barrier to accessing treatment. According to the World Health Organization (2001), stigma is defined as a mark of shame, disgrace or disapproval that results in an individual being shunned or rejected by others. Historically, the word stigma, to brand with hot irons or tattoos, described a distinguishing mark on slaves or criminals so that they would be easily identifiable and this mark meant that these individuals were less valued as members of society (Arboleda-Florez, 2003; Barkhimer, 2003). Although the term did not apply to individuals with a mental illness, stigmatizing attitudes about persons with a mental illness became part of society and were associated with concepts such as shame, loss of face, and humiliation (Arboleda-Florez). Furthermore, according to Barkhimer (2003) despite efforts from the psychiatric profession to combat stigma toward mental illness, the problem may actually be worsening. He proposed that American's now endorse the idea that people with a mental illness are dangerous even though there is no substantiating evidence to support this notion.

Corrigan & Watson (2006) propose that the impact of stigma is two fold. First, *public stigma* is the reaction that the general population has about people with a mental illness. Public stigma results from misconceptions of mental illness. As a result people with mental illness are discriminated against and disadvantaged from receiving opportunities such as good jobs, safe housing, and satisfactory health care. Secondly, *self stigma* occurs when the person with a mental illness embraces their own stereotypes, prejudices and discrimination about mental illness and internalizes these beliefs. An individual may begin to believe that they are worthless members of society that cannot participate in 'normal' societal functions such has full time employment and do not deserve help or treatment. Furthermore, Corrigan & Watson suggest that a person's self esteem suffers as does the person's confidence in his or her future.

Both public and self stigma may be understood in terms of three components: stereotypes, prejudices, and discrimination. Each of these components builds upon and facilitates the creation of the other. Schumacher, Corrigan & Dejong (2003), define stereotypes as collectively agreed upon notions about people. Stereotypes are "efficient" because people can quickly generate impressions and expectations of people who belong to a stereotyped group (Corrigan & Watson, 2006). Schumancer, Corrigan & Dejong (2003) defined prejudice as the endorsement of the negative stereotypes and generate negative emotional reactions as a result. A prejudice is fundamentally a cognitive and affective response which leads to discrimination. Discrimination is defined as the behavioural reaction to prejudice. Discrimination can be characterized as direct or indirect (Government of Canada, 2007). Direct discrimination is apparent and involves treating someone less favourably than other because he or she possesses a disliked attribute (e.g., sex, race, disability, or having a mental illness) while indirect discrimination is less apparent and includes setting a condition or requirement that fewer people with the disliked attribute can comply with.

Stigma not only affects the client but the client's family as well. This was illustrated in the spring of 2003 and summer of 2004 issues of Schizophrenia Digest. Stigma was portrayed as the "Great Barrier" for persons with a mental illness to seek treatment and was an attempt to promote breaking the silence of mental illness among consumers and their family members. The magazine's focus was to demystify mental illness and encourage people to discuss mental illness openly. In addition, the Canadian Mental Health Association (2004) and the Centre for Addictions and Mental Health

(2004) reported that stigma contributes to a lack of public support for services and inadequate funding that consumers with a mental illness and their families.

Stigmatization and prejudice are the two main reasons why many people do not seek mental health assistance or choose to postpone seeking assistance until their illness has advanced to the point where they are unable to seek treatment voluntarily (Arboleda-Florez, 2003). Individuals are fearful of the stigma attached to mental illness and do not want to be associated with a label that may accompany a diagnosis (Hines-Matin, Malone, Kim & Brown-Piper, 2003). Furthermore, even more strikingly is how Barkhimer (2003) described that even professionals in the mental health field verbalized that they would not disclose to other professionals or family members if they had a mental illness due to fear of being treated less competent.

Ethnocentrism. Ethnocentrism, the belief that one particular ethnic group is superior over another and thereby has the right to dominance (Philosophy, 2009), also occurs in mental health care services. Bhugra & Bhui (2001) outline the following three items as forms of racial barriers to mental health services. First, misdiagnosis can be a form of ethnocentrism since psychiatric diagnostic systems deal with categories that have been created by western practitioners. Although the DSM-IV has begun to consider the impact of culture when diagnosing, everyday interactions by professional who do the diagnosing may not be affected by these changes. Second, there is the temptation to make sweeping generalizations concerning cultural differences in behaviours that are not supported by empirical evidence. Bhugra & Bhui suggest that both under diagnosis and over diagnosis are often a result of the observer's lack of effort in making any attempt to understand the person's cultural norms. Third, management can create ethnocentrism. According to this argument, when a clinical setting is pressured to be "colour-blind" or blind to a person's ethnic group in managing psychiatric conditions, an underlying racism and ethnocentrism can exist. For example, some treatment theories, such as Freud's theory of psychoanalysis, have been criticized as racist; specifically when analysts and mental health professionals use it to help others without awareness or consideration of its cultural biases that can be damaging (Bhugra & Bhui).

Lack of trust. Hines-Martin, Malone, Kim & Brown-Piper (2003) suggest that people do not use services if they do not trust either the service being provided and/or the competency of the service providers. Some individuals may mistrust the mental health care system and with good reason. The system is not flawless and treatment can be coercive at times which may leave consumers weary of the system. Trust in the mental health care system influences whether a person seeks help or not (Snowden & Yamada, 2005).

In addition, according to the National Institute of Mental Health (1999) people of minority groups may be more likely than others to mistrust government-operated institutions. For example, people from El Salvador who experienced imprisonment or watched government officials murder family members, or engage in other atrocities may have an especially strong mistrust of any governmental authority. Many immigrant families with relatives who may not have their legal documentation in order may also be less likely to trust authorities for fear of being reported and having the family member deported. In addition, McDonald & Kennedy (2004) verbalize concerns should be raised with regard to those immigrants who decide not to verbalize any ill health due to fear of deportation.

According to Schiver (2004) trust issues among consumers and mental health care providers needs special attention especially when dealing with people of different cultural backgrounds. Both consumer and practitioner bring with them experiences from their external environment. For example, people of colour when working with a white practitioner may bring feelings of mistrust based on discriminatory treatment by whites in the larger society. In addition, consumers may assume that the white practitioner does not know about their culture and therefore has little of value to offer in understanding or solving their problems. Documet & Sharma (2004), in their study of 205 Latino's, found that minority group consumers regarded mental health practitioners as cold and disinterested. On the other hand, Schiver also suggests that it may be the white practitioner who is unwilling to trust the consumer who is a minority and therefore this may inhibit constructing a positive working relationship. Furthermore, minorities are often labeled as being "different" by society. For example, people may experience negative reactions, such as name calling, from others due to the colour of their skin or the choice of clothing that they wear or speaking with an accent. Therefore, they are often left mistrusting main stream services due to their negative experiences in the community at large (Schroeder, 2003).

In addition, it seems reasonable to assume that for many people, despite their culture, trust that their privacy will not be intruded upon beyond the confines of the clinical relationship is important. Concerns regarding confidentiality may cause individuals to withhold certain types of sensitive information during treatment, or avoid seeking care all together (National Institute of Mental Health, 1999).

Gender also adds a layer of complexity to the issue of trust. Chesler (2005) proposed that historically, women, especially minority women, were often institutionalized in mental health facilities where they were abused and heavily medicated at higher rates than men. Based on these past occurrences, it is no wonder women mistrust the mental health care system. They have been seen as inferior and have been abused by the system that has been set up to help them.

Language Barrier. Kouyoumdjian, Zamboanga & Hansen (2003) identified language as one of the most important barriers to consider when discussing access to mental health care because language inhibits service access on several levels. First, there is a lack of agencies that can provide services in languages other than English or French. Second, a lack of language proficiency impacts an individual's ability to locate services. Of the total immigration population forty-six percent do not speak English or French (Statistics Canada, 2000). These figures strongly suggest that language is a barrier to service utilization because if almost half of immigrants cannot speak the dominate language then society cannot expect immigrants to use services that they cannot communicate with. For example, Schroeder (2003), an immigrant, talks about her early experiences in Canada and describes her mistrust due to negative discriminatory experiences in the community. She states, "I learned English very quickly *because I needed to defend myself against the bigotry that is experienced by those who are different*." This is a theme that runs deep in the literature when studying minority groups or any other vulnerable population.

Secondly, another issue related to language is the person's ability to convey the appropriate meaning. Words, used to communicate, have different meanings and are understood using context and our social understanding of the words. A word's meaning can be lost in translation; therefore, the client may have difficulty conveying the intended meaning of their statement to the mental health professional. This may lead to misinterpretation and ultimately misdiagnosis. Third, language also prevents individuals from being able to obtain adequate resources needed to obtain services such as; people may be uncomfortable using public transportation, obtaining a drivers license, and/or comprehending the required paperwork for services.

Lu, Lum, and Chen (2001) articulated in their research that language is a crucial part of culture. Language is an individual's primary means by which culture transmits its beliefs, values, and norms (Lefley & Pederson, 1986). Consumers who can use their native language when receiving services tend to be more expressive and perceive the clinician as more credible, which in turn made individuals more comfortable. Therefore, researchers indicate that there is a need not only to be able to translate, but to understand language in a person's cultural context (Halwani, 2004). In summary, it was suggested that there may be immigrant specific barriers to accessing health care. Immigrants have more unmet needs by the health care system because of language problems, not knowing where to get services, and believing that health care services would be inadequate (Wu, Penning, and Schimmele, 2005).

Different treatment seeking pathways. Among adults, there is considerable evidence that minorities are less likely than non minorities to seek outpatient treatment in the mental health sector (Gallo et al., 1995; Sussman et al., 1987). One reason for this is given by Snowden & Yamada, (2005) and Galanti (2002) who suggest that people of various cultural backgrounds have a greater tendency to express symptoms as somatic complaints and therefore may seek treatment from the general medical sector instead of the mental health sector. This may result in under-diagnosis of mental illness. Another hypothesis is that people of minority groups use conventional care less because they prefer alternative practices and practitioners (Snowden & Yamada). For example, a person may treat symptoms of mental illness with intense prayer and therefore seek counseling with a clergy member.

Diminished ability for self care. Mental illness can diminish the afflicted person's ability to take care of him or herself. The World Health Organization (2001) suggests that the undefined burden of mental health problems is that it affects the functioning and thinking processes of the individual, greatly diminishing his or her social role and productivity in the community. This diminished capacity also affects the person's ability to seek out treatment. In addition, because mental illnesses are disabling and can last for many years, they take a tremendous toll on the emotional and socio-economic capabilities of relatives caring for their family member.

In addition, the following empirical investigations further expand our knowledge about the internal or psychological and sociological barriers experienced by people seeking mental health services such as the internal barriers of stigma, ethnocentrism, lack of trust, and language barriers. Angermeyer, Beck, Dietrich & Holzinger (2004) discovered that the sheer anticipation of experiencing stigma prevented their sample of 210 mental health patients from seeking appropriate help for their illness and that stigma negatively impacted on their self worth. In addition, Angermeyer, Beck, Dietrich & Holzinger's qualitative study found that the participants anticipated stigmatizations more frequently than they actually experienced it. Defined forms of stigmatization included rejection by others, avoidance of contact by people, negative media coverage, being turned down for a job or housing. Although anticipated stigmatization was higher than actually experienced incidences, the rates of actual occurrences of stigma were still high, approximately sixty percent for individuals with schizophrenia. The sheer anticipation of that stigma was enough to defer treatment.

Corrigan, Watson, Warpinski & Gracia (2004) used a sample of 159 college students to test their theory about resource allocation. They found that stigmatization of mental illness was associated with the allocation of mental health resources. If people had negative views about mental health they allocated less resources to the illness. They added that authoritarian methods of treatment, such as making treatment mandatory, were preferred by those of the general population who had no received education about mental illness; and that, mandatory programs were favoured. However, Roeloffs and colleagues (2003, as cited in Snowden & Yamada, 2005) found that stigma did not affect use of the mental health services by their sampled population of individuals of African American decent. These findings may be explained by how that particular group defines mental illness.

Only one Canadian study was found that attempted to investigate immigrant's health care utilization. Surprisingly, this Canadian study found that immigrants did not acknowledge having any unmet health care needs (Wu, Penning & Schimmele, 2005). However, the authors strongly critiqued their findings and highlighted that their descriptive results yielded that there are immigrant specific barriers to health care. Immigrants did indeed have more unmet needs because of immigrant specific barriers such as; language barriers, not knowing where to access services, and believing care would be inadequate.

Documet & Sharma's (2004) qualitative study of 205 Latino's found that participants reported there were no consistent interpreting services available when they tried to access service. However, language was found in this study to go beyond translation. Despite some consumers' higher proficiency of the English language, they experienced difficulties communicating in English when they were experiencing symptoms of their mental illness.

Mennonite's in Canada

According to the Mennonite Historical Society of Canada (1999), the term Mennonite emerged from the sixteenth century Anabaptist religion and is the most common designation for the largest continuing Christian tradition. According to Redekop (1989), this group did not always call themselves Mennonite, but rather self-designations for the early Anabaptists varied by their geographical location or as followers of various leaders. For example, in Switzerland they referred to themselves as "the Brethren" while in North Germany, they called themselves Melchiorities, after Melchior Hoffman, Obbenites, after Obbe Philips, and Menists, after Menno Simons. The term Menists gradually became the name for the entire group, which then evolved into the term Mennonite. Redekop mentions that this could be due to Simons' extensive writings on the faith and doctrine. Today, the term Mennonite is used to describe a group of people who follow the Mennonite faith.

The term Mennonite in this paper refers to individuals who follow the religious and ethnic traditions of any of the Anabaptist churches. Low German and Mexican Mennonite are also terms used to categorize the Mennonite people who have recently moved to Canada from Latin America (Janzen, 1998). Low German is primarily a spoken language that had no published literature available until the publication of the Low German Bible in 2004. Therefore, the term Low German both refers to a language and a particular group of Mennonite people.

History of Migration to Canada

Mennonites have suffered many forms of oppression in their history and thus became nomadic to be able to preserve their culture. This culture's history in Canada is complex. According to the Mennonite Historical Society of Canada (1999), Mennonite ethnicity is divided essentially into two groupings, which are the Swiss and the Russian. According to Suderman (1998), the Swiss Mennonites began migrating to Canada in 1785 and settled in the Niagara Peninsula and the Grand River in Ontario to avoid religious persecution. They also migrated to Canada to avoid their youth being drafted into the Swiss army, which was mandatory at the time in their homeland.

The Russian Mennonites, unlike the Swiss Mennonites who trickled into Canada from 1780's to 1800's, came in large masses at once (Suderman,1998). There were three distinct waves of Mennonite immigrants from Russia to Canada. The first wave occurred from 1873 to 1884 and is the group of Mennonite's that is the focus population for this research paper. The second wave occurred in the 1920's and consists of those Mennonites who decided to stay in Canada and establish themselves in the Canadian economy. Wave three consists of Mennonites who migrated to Canada from Russia via Germany post World War II.

First wave. From 1873 to 1884 about eight thousand Russian Mennonites migrated to Manitoba to practice their religion and provide for their growing families. During this era, the Canadian government was looking for immigrants to cultivate their land in the prairies, which was recently acquired by the Hudson Bay Company (Ens, 1994). The Canadian government saw that the Mennonite people had a strong work ethic so they offered the Mennonite immigrants land in trade for productive labour. These immigrants were able to successfully obtain Canadian citizenship.

The Canadian government gave these Mennonites the right to maintain their culture through the Privilegium, a Canadian federal government document. Ens (1994) explains that the Privilegium, which was negotiated with a representative of the Mennonite faith, promised the full freedom of religion, total exemption from the military and the right to their own schools, however, they were not given independence of governance. The Mennonite people slowly learned that their Privilegium had not clearly defined their separate status. Furthermore, they soon discovered that the government laws were filled with false hope and the provincial Canadian education laws were soon governing their private schools. The Canadian government enacted a law requiring that English become the major language of instruction in schools, and that the provincial school curriculum be taught. Up until that point the Mennonites had taught their children in German and used their own curriculum (Driedger, 2000). It was this issue that forced many Mennonites to either assimilate to the dominant Canadian culture or leave Canada in search of another county that would offer them the freedom to practice their own faith in isolation of the outside world. At this time, the Old Colony Mennonite (first wave) had chosen Mexico as a country in which they could become established and preserve their way of life. In March 1922, the first group of Mennonites from this first wave began to move to Mexico and from Mexico there migrated to areas such as Belize, Paraguay, Boliva, and Argentina. According to Sawatzky (1971), approximately 6000 Mennonites moved to Mexico from Canada at that time.

Second wave. In 1919, while many Mennonites from the first wave of immigrants were leaving to countries in Latin America, mainly Mexico, there was a second wave of Russian Mennonites arriving in Canada. Approximately 22,000 Mennonites moved to Canada to avoid persecution after the Russian Revolution and they too settled in Manitoba and Southern Ontario (Suderman, 1998). This wave of new immigrants were more liberal that the Old colony Mennonites who moved to Latin America. They used more modern technology and established other churches, which created a more liberal religious influence and different economic systems (Driedger, 2000).

Third wave. After the end of World War II in 1945 conditions in Russia, formally known as the USSR, were not positive for Mennonites. It was defined as a time of continued suffering and it was not until the death of Joseph Stalin in 1953 that conditions began to relax in Russia (Dyck, 1981). At this time many Mennonites were allowed to move to Canada to join their families.

All three waves are defined by the Mennonite leaders as controlled migrations or church migrations. This means that the migrations were controlled and organized by the church and were planned in advance. The church chose a location and a large number of Mennonites would move to that location in a short period of time. Furthermore, within

Canada small groups of Mennonites broke away from the larger migration group and moved to small towns in rural Canada in search of more land for their growing families (Driedger, 2000).

Immigration to Southern Ontario

The first group of Mennonites to come to Ontario were the Mennonites from the second wave into Canada. These were the Mennonites who held more liberal views. In 1924, the Russian Mennonites of Ontario started a committee for the purpose of finding work for this growing group of people (Driedger, 1972). According to Driedger, delegates were sent from the Waterloo area to Essex County to confirm whether there were jobs. Shortly after, the Lohrenz family was the first to move to the area followed by sixteen new families in 1925. These individuals established themselves quite well by purchasing property and opening their own businesses within a short period of time. For example, according to Driedger, the Tiessen family was among the first families to move to the area. Today in Essex County the family name owns Tiessen flower and apple farms, mechanic shops and other small businesses.

Post World War II Mennonites from Europe or what was earlier identified as Mennonites from wave three were the next group to call Ontario their home. As mentioned earlier these Mennonites were allowed to join their families in Canada once tension decreased after the war. There is not much literature with regard to this group of people, which may be due to the support they received by their families who were already settled in Ontario.

After the 1950's, a large group of Mennonites returned to Canada from Mexico and other parts of Latin America. According to Regehr (1996) these Mennonites were apart of the group, either personally or decedents of those, who had left Manitoba in the 1920's and were the first Mennonites in Canada who were now settling in Ontario. This group of Mennonites began coming to Ontario due to economic difficulties, drought, and limited land for their growing families in Mexico. This group is now commonly referred to as Mexican Mennonites or Low German speaking Mennonites. Many of these returning Mennonites had not become Mexican citizens and thus had maintained their Canadian citizenship. With regard to the children of this population the Canadian Citizenship Act, 1947, states that first generation Canadian children born abroad could apply for citizenship; however, they would have to do so between the ages of twenty one and twenty two or they lost their rights. Therefore, many of the Mennonites who have and are currently migrating to Ontario have Canadian citizenship rights. Although according to Regehr (1996) many of these returning Mennonites arrived without proper passports or other legal documents that make obtaining their Canadian status difficult.

Today, there is still a division of socioeconomic classes between the Mennonites who are coming back to Canada from Latin America and those who have remained in Canada since migrating from Russia. Most of the first Mennonites who migrated during 1924 have been successful in establishing themselves financially. However, due to low paying jobs, seasonal employment available, and substandard housing, the Mexican Mennonites have had a more difficult time establishing themselves financially. Suderman (1998) adds that as of 1998, there were twenty distinct groups of Mennonites active in Southern Ontario. From these groups, the Old Order Mennonites are the most recognizable due to their uniform like mode of dressing and modes of transportation. However, the majority of Mennonites cannot be easily distinguished from the rest of society.

According to Janzen (1998) there were approximately twenty five thousand migrant Mennonites from Mexico in Southern Ontario in 1997. At that time in Southern Ontario there were approximately nine distinct churches started by those who were coming from Mexico. Five of these nine churches are in Essex County (Janzen, 1998). Church teachings vary from very traditional, ascribing to the fundamentalist principals of the bible, to less traditional, using an interpretive approach.

Religion

The Mennonites define themselves by their faith rather than their country of origin. Their lack of affiliation with a country is due to their nomadic history. Religion is a fundamental aspect of this culture and the Mennonites have moved several times in history to preserve their religious beliefs. According to Dyck (1981) the Anabaptists' value community and togetherness and regularly worship God. They believe, when they are together as a group, the Spirit of God becomes present and overrules their human weaknesses and this allows for God to be known to all of them in their gathering. Therefore, the Anabaptist religion leaves little room for interpretation since the Spirit of God should touch everyone in the same way, and everyone should also have similar interpretations of the scriptures (Dyck, 1981).

The Mennonite faith is also based on a belief of peace and brotherhood. They believe in working together to achieve success (Third Way Café, 2006). Like other religions, the Anabaptist religion values truth, goodness, reverence for life, and happiness (Redekop, 1989). In an attempt to summarize the religious protests of the Anabaptists, Troeltsch (1960), a social scientist, offers the clearest outline of the issues that separate the Anabaptists from other religions (as cited in Redekop (1989, p.52):

1. Formation of the church to include only truly converted believers.
2. Voluntary membership in the church, symbolized by baptism. Infant baptism was rejected as a contradiction of this principle.

3. The necessity of church discipline for all who had committed themselves voluntarily to join the fellowship. This principle implied the right to excommunicate the recalcitrant.
4. Rejection of the doctrine of the efficacy of the sacraments. Hence, the Lord's Supper became a "festival of Christian fellowship".
5. Emphasis on a holy life that expressed itself as follows: (a) detachment from the state, including service to it; (b) refusal to swear oaths; (c) refusal to engage in violence of any sort, including war and capital punishment; (d) taking up the cross and suffering injustice as the Christian disciple's share of the suffering of Christ.
6. Emphasis on equality and mutuality. Church members were to be considered equal...
7. Following the precepts of the Sermon on the Mount...

Within the Mennonite community, religion and cultural beliefs have defined and re-defined what constitutes mental illness. The Mennonite community's diversity reflects their social constructions of mental illness. The Mennonite churches that adopted a less traditional approach have been in the forefront of establishing centres where individuals with mental illness can receive support and education with regard to medical services, for example medication, when appropriate. However, the more traditional Mennonite church groups define mental illness as a spiritual power. These individuals are encouraged to turn to prayer and are discouraged from receiving other formal supports outside their group and particularly from taking medications (Dueck, personal communication, February 2006).

Kulig and Hall (2004) studied the health and illness beliefs among Mexican Mennonites in Alberta. With regard to mental illness, they found that Mennonites believed that everyone could experience mental illness and that it originated in the heart. Some causes of mental illness have been associated to worry or sadness or engaging in inappropriate behaviours and a small portion of people believed that mental illness was caused by Satan or by having a bad conscience. All views of mental illness were intertwined with religion. Nerve problems were believed to be based on guilt because a person did not act according to the church. Furthermore, they believed that treatment would only work if the person wanted help. These results were attainted from a qualitative study with a non-random sample.

Mennonite Culture

The traditional Old Colony Mennonites believe that God wanted them to be farmers and the Low German Mennonites migrating from Mexico continue to show these beliefs (Driedger, 2000). However, due to global economic changes decreasing the opportunities for farming, the Low German Mennonites have demonstrated great skills in areas such as welding, blacksmith, mechanics and other trades. In summary, the Mennonite faith is based on community building and collectivism, while following the teachings of the Bible (Draper, 2004).

In the Old Colony Mennonite families, it was not uncommon to have ten or more children to aid with farm work. However, Driedger (2000) reports that today many Mennonite families, including those coming to Canada from Mexico, are having between two and six children. Since families are no longer agricultural, it may no longer be an asset to have many children. Furthermore, Mennonites usually marry other Mennonites and before 1955 divorce and separation were unheard of; by 1977, a few cases of divorce were found (Driedger, 2000). In addition, children were given standard names such as John, Jacob, Peter, Abram, Henry, and Isaac for boys and Mary, Margaret, Helen, Susie, and Tina for girls. According to Driedger these names are still popular; however, a variety of other names are used as well.

Education

The first Mennonite settlers in Ontario have successfully established their own schools such as the Canadian Mennonite University, The Anabaptist-Mennonite Scholars Network, and in Essex County they have established their own private high school, United Mennonite Education Institution. These schools exist in order to provide a strong academic education in a Christian environment. The school's goal is to remain faithful to the biblical mandate, to reach out to the larger community, and a part of their mission is to make their young people active helpers in the community.

Regehr (1996) proposes that the Mexican Mennonites coming to Canada found the public schools unacceptable. Some families engaged in seasonal farm work in Canada in the spring and returned to Mexico in the winter to avoid Canadian schools. Canadian school attendance became more attractive to families when they received family allowance for having children in school. According to Regehr (1996), this was an attractive incentive for most of the Mexican Mennonites who were poor and had large families. In addition, according to Paul's (2004) research with Mexican Mennonites, although Mennonites valued education they also believed that too much education was not a good thing and that an eighth grade education was enough. They also value work experience and therefore encourage working at an early age.

Mennonite Gender Roles

The Low German Mennonite family is patriarchal in nature. A man rarely does female tasks, although women are expected to help with most of the male tasks (Vacc, DeVaney & Wittner, 1995). Religion is a fundamental aspect of this culture. When reviewing the literature that speaks to Mennonite women a common theme is presented.

Most simply explained, the Mennonite women's lives are described as "domesticity, hidden from public view" (Loewen, 2001, p.52).

Mennonite women have written many stories both privately and publicly that illuminate the nature of their gendered lives (Loewen, 2001). These writings illustrate how Mennonite women perceive a strikingly different world than what is described by their male counterparts. Loewen illustrates this point by highlighting how Mennonite women present themselves in their writings as multidimensional people, while men define women by the domestic duties they perform. According to these women's writings, they seemed to agree that a woman's domain is the household, as outlined by male writers, but also includes their responsibilities of the entire economy of the farm. Since 1995, Mennonite women have held academic conferences in the United States celebrating the Anabaptist Women's History (Redekop, 1996). Mennonite women have been a driving force worldwide establishing and running charitable organizations for various populations such as seniors, children, and new immigrants (Redekop).

Mexican Mennonites

According to Mr. Harms (2006), a guest speaker at the Annual Networking Day for Mennonites, it is important to understand where Mennonites are migrating from in order to aid in their transition to Canada. Current Mennonite immigrants are coming from areas in Latin America, including Mexico, that have few laws and moving to Canada where there are many laws guiding social behaviour. In addition, they are coming from a more homogenous culture to a multi cultural community and from living on a farm to city life. Migration to Canada is now out of necessity for economic stability rather than preservation of culture. Mr. Harms identified this migration of the first uncontrolled migration of the Mennonite people. Furthermore, Mr. Harms reported that in the colonies in Latin America, including Mexico, the Mennonite's traditions and way of life have not changed for generations. In Mexico they were mostly agrarian and they did not plan on ever having to leave a farm setting; therefore, they did not encourage formal education. The Mexican Mennonites are good workers. Lastly, those with disabilities were supported in the colony setting. However, in Canada, due to the individualistic nature of our society they are left with no supports because many of the extended family remained in Mexico.

Gingrich (As cited in Draper, 2004) conducted qualitative research on the Low German Mennonite culture for her doctoral work at the University of Toronto. She conducted more than 75 interviews with Low German speaking people and service providers in various locations. She found that Mennonites from Mexico were very grateful for the help they received during their early days in Canada. Furthermore, she found that Mennonites experienced a clash of social worlds when they immigrated to Canada. Gingrich found that Mennonite people are taught to be obedient, to accept suffering and to deny self, in contrast to the Canadian ideal of striving to get ahead. They strive for the greater good of their community rather than individual gain. Additionally, her findings highlighted that the Low German Mennonite culture has been weakened by economic difficulty. This group has tried to protect itself by holding even more tightly to its traditions that are under attack by assimilation.

Migration Model

In addition to the help seeking models, migration models are a useful tool when working with immigrants. Upon arrival in a new community, the immigrant may face stressful experiences due to cultural change and cultural conflict, isolation, language problems and discrimination (Kuo & Tsai, 1986). Social workers must be cognizant of the stages of migration to be culturally competent and work effectively with this population (Lum, 2003). Potock-Tripodi (2002) outlined three stages at which migrants experience stress. First, the pre-migration and departure stage entails the decision making process of leaving ones country of origin and choosing the host country. This stage entails many losses such as family, friends and familiar environment. Grief is a common reaction among immigrants in response to multiple losses. Social workers need to be alert to the possibility of grief arising at any time in the immigration process and also to the possibility that some overt reactions such as anger may have their roots in grief. Second, the transit phase is the actual travelling process to the host country. For many immigrants they have never been on a plane or the journey itself can take several hours to several days which can be a stressful experience. Last, the resettlement phase is at which point most social workers come in contact with the new immigrant. This phase deals with establishing the new immigrant in their new environment.

Multicultural Social Work Practice

The social work profession has identified the need for culturally competent practice, but what is cultural competence? In this last section of the literature review, cultural competence will be defined and models of culturally competent multicultural practice will be presented. Anti-oppressive social work practice will also be presented as a method to provide effective culturally appropriate service at multiple levels. In addition, the Canadian Association of Social Workers (CASW) and the National Association of Social Workers (NASW) codes of ethics will be reviewed as these provide the social work profession with guidelines for culturally competent practice.

Cultural competence is a distinct concept that has systemic meaning and application. For example, in Williams' (2004) presentation about the importance of cultural competency in the helping professions she describes cultural competence "as a set of congruent practices, attitudes and policies that come together in a service system, an agency or among professionals to work effectively across cultural differences." Individuals, organizations and service systems should demonstrate cultural competence. Furthermore, Lum (2005) adds that cultural competence is the worker having cognitive awareness that differences and similarities exist between groups, but there is no assignment of value to these differences. Furthermore, a culturally competent worker is one that transforms knowledge about individuals into specific standards, policies, practices, and attitudes to be able to work effectively in different cultural contexts (Lum).

Dewees (2001) identifies that "Social work, as an institution of culture, has historically reflected dominant interests by sometimes seeking to "treat" or change those persons who do not share those interests rather than the conditions that create the dominance." (p.37). Dewees expands by mentioning that social workers are of the privileged class because they have attained higher education and power. Therefore, social workers are called upon to develop a culturally competent generalist praxis that affirms any individual's strengths (Dewees). Professionals need to respect that all cultures are different and require different service programs, which would be addressed using the equity theory. Williams (2004) recommends that equity theory be used in practice rather than the equality theory. Equality theory creates cultural obliviousness because it neglects to treat individuals of different cultures in different culturally sensitive ways while equality theory acknowledges that people are different.

Furthermore, Al-Krenawi & Graham (2003) explain that cultural competency can be defined as a continuum. At one end of the continuum is cultural incompetence, which is defined as the worker's cognitive obliviousness to differences in culture. At this level the worker has an apathetic affect toward consumers, is unskilled in the area of cultural appropriate practice, and their overall effectiveness is destructive. Moving along the continuum, Al-Krenawi & Graham identify that culturally sensitive practitioners have a sympathetic affect, lack some skills, and have an overall neutral effect when helping the consumer. Furthermore, at this level the worker is committed to change, is considered highly skilled, and has a constructive overall effect in social work practice (Al-Krenawi & Graham). In addition, according to Al-Krenawi & Graham (2003) 'emic' and 'etic' are perspectives that are frequently used in social work practice. The view point of a person of a particular culture is called the emic perspective while an etic perspective is the viewpoint from an outside point of view. Social workers run the risk of bringing the etic perspective of a culture when defining the problem and creating an intervention. Therefore, it is best to appreciate the emic view that the client can contribute.

Various models of cultural competency exist to inform the professional. Al-Krenawi & Graham (2003) provide two contrasting models of culturally competent multicultural practice. First, the cultural literacy model suggests that the social worker's knowledge is superior to that of the client's therefore identifying the practitioner as expert. This model does not take into account the client's unique experiences and expression of their own culture, but rather views culture as a homogeneous system. Furthermore, social worker's run the risk of using stereotypical "cultural specific" interventions. On the other hand, this model provides the worker with a general model of how to work with individuals.

In contrast, Al-Krenawi & Gramham (2003) propose the experiential-phenomenological model which recommends that the social worker maintains a stance of openness, curiosity, and being a learner in the transaction between worker and client rather than an expert as stated in the cultural literacy model. In the experiential-phenomenological model a worker's assumptions are suspended. Social workers use an understanding of their own culture and its biases as a means to understand other cultures. Furthermore, they propose that the social worker understands the process of social constructionism. However, this model may leave a client feeling that the worker is unknowledgeable since the worker is asking the client to explain their culture and is asking how the client would like to guide their treatment (Al-Krenawi & Graham, 2003).

In addition, Lum (2003; 2005) provides another model similar to Al-Krenawi & Graham (2003) that emphasizes a skill set of cultural awareness. The model outlines four main points: 1) Cultural awareness is an awareness of personal assumptions about human behaviour, values, biases, preconceived notions, and personal limitations. Cultural awareness is the development of understanding of another group and involves internal changes of attitudes and values that create an openness and flexibility to others. In summary cultural awareness is the understanding of the culturally different client without negative judgments; 2) Knowledge acquisition is the gathering of information such as facts, principles, and concepts that influence the refinement of theories used to help others; 3) Skill development is the development and practice of appropriate, relevant, and sensitive intervention strategies and skills in working with culturally different clients; 4) Inductive learning includes how professionals continue to evaluate his or her multicultural practice and carries out the learning process of exploring new information.

Furthermore, Mullaly (2002) presents the Personal Cultural Structural model (PCS model). This model proposes that oppression lies beyond the interactions between individuals and the model is used as a working model for anti-oppressive social work practice. According to this model, all social work practice should occur at the personal, cultural, and structural levels to provide effective, supportive, and thus culturally competent interventions.

Personal Level

Anti oppressive intervention at this level can take the form of individual or group work that includes intra-psychic change of the client. The goal of intra-psychic change is to build strengths in the individual so they can develop solidarity and community with others who have experienced similar problems and challenges. The goal of group work is to allow a client the arena to share experiences and find common patterns of experiences of oppression in other's stories. In group work the problem is moved from private to political because the problem no longer lies within the person but now has been brought out of the personal and placed into the political arena, in this case the group.

For example, Waxler-Morrison & Anderson (2005) mention that when working with an individual client with regard to a specific problem the culturally competent worker has the task is to negotiate an understanding of the problem and decide what to do about it. This process is a cultural transaction between both parties. When both parties are from similar cultural backgrounds this can be a gratifying process for both individuals because both parties have similar beliefs with regard to diagnosis and treatment. However, when the health professional and client are from different cultural backgrounds, the negotiations can often be ineffective and unsatisfactory because both parties have differing viewpoints with regard to diagnosis and treatment. It is unrealistic and unhelpful to ignore cultural differences. Instead, the professional who is aware of cultural differences will more easily find a mutually agreed upon way to deal with the problem for which the client seeks help (Waxler-Morrison & Anderson).

Cultural Level

According to Mullaly (2002) anti oppressive social work practice attempts to create change at the cultural level as well. At the cultural level these attempts to create change look toward large venues such as the mass media, educational institutions, churches, publishing industry, and other cultural agents which can perpetrate stereotypes and dominant discourses. Practice on the cultural level forces the dominant group to see itself as a specific culture and not the norm.

Structural Level

Anti oppressive social work practice at the structural level focuses on confronting and changing social institutions, policies, laws, and economic and political systems that operate in a way that benefit the dominant group at the expense of the subordinate group. Cultural competence at this level is about adapting mental health care services to meet the needs of consumers from diverse cultures. At this level Mullaly (2002) highlights two methods at which change can occur. For example, social workers can create necessary changes by creating alternative social service organizations that serve and are operated by members of a particular culture. In addition, social workers can take part in social movements and coalition building and participate in critical social policy practice. Lastly, Halwani (2004) adds that equality of access is not ensured by uniformity of services in a multiracial society. Thus, culturally competent delivery of mental health care is a necessity if equal access to services is a goal.

Professional Guidelines

The Canadian Association of Social Workers (CASW) and the National Association of Social Worker (NASW) have both established guidelines which are presented in the form of the Social Work code of ethics. The National Association of Social Workers (2001) explains that "cultural competence is never fully realized, achieved, or completed, but rather cultural competence is a lifelong process for social workers who will always encounter diverse clients and new situations in their practice" (p.5). In addition to the cultural competence models discussed prior and their own social work code of ethics, the NASW has adopted one of the most comprehensive statements on cultural competence of any other helping profession (Lum, 2005). The NASW distributed the 2001 Standards for Cultural Competence in Social Work Practice, which address the following 10 areas:

1. Ethics and values: Social workers shall function in accordance with the values, ethics, and standard of the profession, recognizing how personal and professional values may conflict with or accommodate the needs of diverse clients.
2. Self Awareness: Social workers shall develop an understanding of their own personal and cultural values and beliefs as a first step in appreciating the importance of multicultural identities in the lives of people.
3. Cross-cultural knowledge: Social workers shall have and continue to develop specialized knowledge and understanding about the history, traditions, values, family systems, and artistic expression of major client groups served.
4. Cross-cultural skills: Social workers shall use appropriate methodological approaches, skills, and techniques that reflect the workers' understanding of the role of culture in the helping process.
5. Service delivery: Social workers shall be knowledgeable about the skillful in the use of services available in the community and broader society and be able to make appropriate referrals for their diverse clients.
6. Empowerment and advocacy: Social workers shall be aware of the effect of social policies and programs on diverse client populations,

> advocating for and with clients whenever appropriate.
>
> 7. Diverse workforce: Social workers shall support and advocate for recruitment, admissions and hiring, and retention efforts in social work programs and agencies that ensure diversity within the profession.
>
> 8. Professional education: Social workers shall advocate for and participate in educational training programs that help advocate cultural competence within the profession.
>
> 9. Language diversity: Social workers shall seek to provide and advocate for the provision of information, referrals, and services in the language appropriate to the client, which may include the use of interpreters.
>
> 10. Cross-cultural leadership: Social workers shall be able to communicate information about diverse client groups to other professionals. (NASW, 2001)

Although the CASW has not outlined a specific set of standards for cultural competence its' code of ethics provides a set of 10 general standards. However, only two directly deal with cultural competence to guide social work practice. Like the NASW set of standards for cultural competence the CASW's general standards ensures that "social workers shall always maintain the best interest of the client" (Standard 1) and "a social worker shall maintain competence in the provision of a social work service to a client" (Standard 3).

Summary of Literature Review

In summary this review of the literature provided an overview of social constructionism. The process of socially constructing reality was reviewed as well as the social construction of group memberships, mental health, and women's mental health. In addition, literature pertaining to help seeking models was discussed and both internal and external barriers to mental health were outlined. Lastly, multicultural social work practice along with social work's professional guidelines were presented in the final section of this literature review.

Chapter 3

Methodology

This chapter outlines the methodology used to conduct this study. This section begins by discussing the overall approach and justification for the use of a qualitative method. Next, the sampling, data collection, researcher's role, as well as the data analysis, rigor and ethics will be discussed.

Overall Approach and Justification

A qualitative methodology was used for this study. It is necessary to clarify what is meant by a qualitative approach before outlining the specific method in order to justify why it was used. Like all research, qualitative research attempts to strengthen the social work profession's knowledge base (Tutty, Rothery & Grinnell, 1996). According to Rice & Ezzy (1999), qualitative method is relevant when researching the area of health care utilization because the methodology places an emphasis on the need to both describe and understand people's behaviour and experiences. Qualitative research is exploratory and places emphasis and value on the human interpretative aspects of knowing about the world. It attempts to understand how individuals interpret and give meaning to their personal experiences (Grinnell, 1997; Rice & Ezzy, 1999). Furthermore, qualitative research explores these lived experiences in order to reveal connections between the social, cultural, and historical aspects of people's lives (Snape & Spencer, 2003).

Patton (1990) proposes that the qualitative method allows the researcher to study a selected issue in depth and with detail, and does not constrain the study by predetermined categories of analysis which may occur in quantitative research designs. Therefore, samples tend to be smaller in size than quantitative studies, but the data collected is rich (Tutty, Rothery & Grinnell, 1996). Flexibility is another advantage of qualitative research because the research design can be modified at any time (Rubin &

Babbie, 2005). This allows for greater spontaneity and adoption of the interaction between researcher and participant. The researcher is active; this means, the participant can be elaborate in their responses and, in turn, the researcher is able to respond immediately by tailoring subsequence questions (Holosko, 2005). For these reasons qualitative methodology, including audio taped interviews in the person's environment was used to answer the research questions of this study.

In qualitative research, data analysis is inductive which means that the researcher is not testing pre-conceived hypotheses, but rather building patterns from the data collected (Patton, 1990). This method fit well with the research questions of this study because of its facility to examine subjects in depth and provide a unique tool for studying what lies behind a decision, attitude, or behavior. In addition it allowed associations to be made that occur in people's thinking and/or acting (Snape et al., 2003).

Exploratory qualitative research is conducted to explore a topic that is of new interest (Rubin & Babbie, 2005). Although many studies have examined immigrant's overall health, health care utilization rates, and barriers to mental health care, there has been little research done on the specific experiences of Mennonite women when they have accessed mental health care. This becomes an even more relevant investigation because organizations in Southwestern Ontario, such as Canadian Mental Health Association, Children's Aid Society, and the Health Unit, are in the process of developing programming geared specifically for addressing the needs of the increasing immigrant Mennonite population in Southwestern Ontario which includes Essex County.

To better understand Mennonite immigrant women's experiences and their activities related to help seeking, we must analyze their lived experiences in their social, political, economical, and historical contexts. The vast majority of immigrant women's individual experiences are presented mainly from a male point of view. Therefore, in addition to the qualitative research design the researcher was mindful of the feminist research philosophy. As Boyd (1984) suggested, immigrant women have been ignored in research because of their dependent legal status when they enter this country. Although awareness of the need to understand their experience is growing the voices of immigrant women have been excluded from feminist research (Anderson, Blue, Holbrook & Ng, 1994).

In addition, many feminist researchers propose that a large body of knowledge comes from research that has been done by men and analysed by traditional scientific methods (Harding, 1987). These traditional research methods do not usually reflect women's realities because women and men have had different experiences according to class, race, and gender, (Klein, 1983). Ramazanoglu (as cited in Letherby, 2003) suggested that research from a feminist methodological standpoint should provide insight of women's experiences as they understand it. The feminist literature has outlined criteria when completing feminist research that was incorporated in this qualitative study (Letherby, 2003). The research was done by a woman; had the potential to help the subjects by offering referrals to services; and the study focused on women's experiences. Furthermore, the study was done for women and lastly the findings are reported in non-sexist language.

In summary, this qualitative investigation allowed for an in depth inquiry about Mennonite women's experiences with the mental health care system. The findings from this study describe Mennonite women's personal insights and experiences which can be used to inform professional practice and policy recommendations. Furthermore, feminist research is intended to be done by women, for women and about women's lives. By inquiring about women's experiences, knowledge was gained to explore the challenges that they face in society. Through exploration of these everyday life experiences, women can recognize and understand the sources of their own oppression. This can lead to developing personal and political strategies for ending their oppression (Anderson, 1991). The ideals of feminist research was used to help the investigator be mindful of recognizing the potential tension which could occur while studying a patriarchal culture which the researcher was not seeking to transform. The researcher is not trying to change the Mennonite women or their culture in any way, but rather trying to learn from their experiences.

Sampling

All participants were of Mennonite faith and had directly migrated from parts of Mexico and Paraguay. Only adult women 18 years of age, or older, were chosen for this study. Individuals in this age range are considered to have more autonomy than adolescents to seek professional help and thus are better able to accurately address and provide information that answered the research questions. In addition, only women with a working knowledge of English were selected to participate in order to eliminate the need for a translator. All the women who took part in the study consented to have their interviews audio taped and interviews were conducted in their homes.

There are numerous disorders classified as a mental illness in the Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-IV-TR). Due to the complexity of psychotic disorders that increases ethical concerns of obtaining informed consent the focus of this investigation was on women who sought help for a non-psychotic mental disorder. Non-psychotic mental health disorders include uni-polar mood disorder (more commonly known as depression), generalized anxiety disorder, or a substance related disorder. Of the six women who participated they all reported having both depression and anxiety and one of the women also reported that she had a substance use disorder.

Sampling Procedure

A purposeful criterion sampling procedure was used for this study. According to Patton (2002) purposeful sampling leads to selecting information rich cases for study. Information rich cases are those from which a great deal can be learned about an issue of importance. According to Patton (1990) there are several different strategies for purposeful selecting. This specific sampling method sets out to pick only those participants who meet the predetermined criteria described above. This method of sampling helps increase quality assurance (Patton, 1990).

Recruitment Strategies

Qualitative researchers have few strict guidelines for when to stop the data collection process. Criteria include: 1) exhaustion of resources; 2) emergence of regularities; and 3) overextension, or going too far beyond the boundaries of the research (Gobi, 1978). Sandelowski (1995) adds that determining an adequate sample size is ultimately a matter of judgment by the researcher. The decision to stop sampling took into account the research goals, the need to achieve depth through triangulation of data sources, and the possibility of greater breadth through examination of a variety of sampling sites. The overall goal was to choose an adequate sample size that was not too large to hinder deep, case oriented analysis and not to small to hinder gaining a new understanding of experience. Based on Morse's (1994) suggestion that studies directed towards examining the essence of people's experiences should include at least six participants. The same goal of sampling six women was selected for this study in hopes of achieving the above criteria.

All referrals for participants for this investigation came from a front line worker at the Mennonite Central Committee (MCC). In order to recruit participants for this study, appointments were made with management personal at the community organization to discuss and review the purpose of the study, obtain letters of permission, obtain ethics clearance, and ask for their assistance in recruiting participants. Specifically, they were asked to provide the names of front line workers in the organization who had the opportunity to work with Mennonite women and who could inform potential participants about the study and refer them to the researcher if they wanted to participate. These front line workers were informed about the research and the process of recruitment (Appendix A) and were provided with a letter of information about the study to give to potential participants (Appendix B). The referring organization had their own procedures to follow regarding the release of information which they had to complete with the participants in order to make a referral to the researcher.

Once the referral source at the MCC had a woman who was willing to participate in the study the contact information was forwarded to the researcher, at which time the researcher telephoned the participant. Historically the Mennonite population has tended to socially isolate themselves from the dominant culture to preserve their way of life; however, they have responded well to invitations to take part in services as mentioned in Gingrich (as cited in Draper, 2004). Furthermore, according to key informants, as well as the researcher's personal experience with the Mennonite population, the best way to engage this particular cultural group is to contact the potential participant directly; therefore, that is what was done and it was successful.

Data Collection

Interview Process

This study used a semi-structured interview format to collect data. According to Patton (1990) semi-structured interviews are guided by a list of questions or general topics that the interviewer wants to explore during each interview. This method was used to ensure that the same basic information was obtained from each participant. The investigator was not looking for predetermined responses and was free to probe and explore beyond these predetermined areas of inquiry. The interview guide ensured good use of limited time; it made interviewing multiple subjects more systematic and comprehensive; and it helped to keep interactions focussed. In addition to the above advantages of interview guides, the wording of interview questions was decided in advanced and reviewed by other professionals who were of Mennonite faith to ensure that the questions were culturally sensitive. A key informant from the Mennonite community reviewed the interview guide and made suggestions for improvement. All interviewees were then asked the same basic questions; therefore, making responses increasingly comparable. This method facilitated the organization and analysis of data (Patton, 2002). The limitation was that the interview guide may have constrained and limited the natural flow of conversation; however, the interview guide provided a more time efficient component to the data collection process which was highly important since participants were volunteering their time. The interview guide is presented in appendix C.

Each participant was interviewed individually. It was important that the interview was at a place where both the researcher and participant could talk in private and the participant could feel free to answer the questions honestly. Interviews took place at the participant's homes and were conducted between 11:00 a.m. and 4:00 p.m. as per the participant's requests. The environment in which people are interviewed impacts the story they tell. Therefore, having the interviews take place in the participant's home set an informal tone. This is unlike an office where a formal tone would have been given and the participant may have felt more intimidated by the setting. The hope was to enable the participant to feel relaxed to tell their storey and allow the researcher to provide a thick description of the context of the interview outside of an office setting. Interviews also took place at a time of day that was most convenient for the participant. In addition, participant's interviews were audio recorded with their consent. Audio tapes were then labelled with a code to ensure confidentiality. At the end of each interview, the researcher reviewed the data with the participant and asked the participant if the researcher had captured her intended responses. Since English was not the participants' primary language, this allowed the interviewer to check if the participants intended message had been understood.

The interview guide is found in appendix D. Most of the interviews were completed in one visit; only two women required a second visit to complete the interview. All interviews were conducted in person by the researcher. Since the research was done through a qualitative perspective, the participants were allowed to ask questions and were encouraged to digress about details in their personal lives to limit the hierarchal effect attached to interviewing (Denzin & Lincon, 1998).

During the first interview the consent form was reviewed and signed (Appendix D). In all but two of the interviews, the interview questions were asked and answered in the first interview. Two of the women required a second interview to complete this portion. A referral to community mental health services was made for a participant with their full written consent. This participant did receive a call from the researcher to confirm that the referral had been made and had been received by the community agency. In addition, the researcher had one last contact with the participants which were done in person. This last contact was used as a members check to review the researchers findings and confirm that the researcher had obtained the correct themes that the women had disclosed. This last contact was also used as closing contact to thank participants for their participation and to inform them of where the results of this study could be found on the University of Windsor website.

Researcher's Role

There are a number of possible limitations when working with diverse groups of individuals. The possible limitations of this research include language barriers, biases and values implicit in interview questions. Grinnell (1997) points out that it is also possible that the lack of relationship between the researcher and research participant can be experienced as intimidating by someone from another culture which can inhibit the participant from disclosing their storey. This is why the referral source is so important, because it aids in developing trust with the participant. In this study, the researcher took the following precautions to try to decrease these limitations. The researcher was not from the Mennonite culture and had a personal set of values and beliefs which were acknowledged. The researcher began to prepare to work with this culturally specific population by attending two Mennonite Networking Conferences where speakers from the culture informed social service workers about the culture and how to engage with Mennonite people. In addition, the researcher had acquainted herself with this culture's history and met with people of this culture on several occasions to gain insight and learn culturally appropriate behaviours. The investigator also had the opportunity to work closely with a key informant from this community to be able to gain access to participants from this population.

Data Analysis Strategy

Qualitative studies are a source of well grounded, rich descriptions and explanations of processes in identifiable local contexts (Miles & Huberman, 1994). Miles & Huberman further mention that qualitative data analysis is labour intensive because of the time demands of processing and coding the rich data. In addition, Patton (2002) suggested that qualitative research has no direct formula for translation. The inductive process of qualitative analysis allows for a unique data interpretation strategy to be done by each inquirer; however, in all qualitative analysis the researcher seeks to acknowledge the patterns and themes which are extracted from the content gained from the interviews. Since this study used a narrative data collection strategy the content of the interviews were coded for themes and patterns. Therefore, once the audio recordings were transcribed, including not only the verbal script but also such things as pauses and sighs, the data was coded to ensure the confidentiality of the participant.

In addition, Dublin's (1996) suggestions on thematic analysis, described below, was used because it offers the participants an equal opportunity to inspect the issues and themes early on in the research design. This process allows both participants and researcher to refine, or make sure, that intended themes are present as related to their experiences in accessing mental health care. Based on the guidelines of thematic analysis developed by Rubbin & Babbie (2005) and Patton (1990) the following strategies were used for data analysis:

Listing and Classifying Different and Unique Experiences as well as Similar Experiences

Patton (1990) proposes that the first decision that needs to be made in analyzing interviews is whether to begin with case analysis or cross case analysis; however, if a researcher tries to do both at the same time it will lead to confusion. Therefore, individual case analysis was conducted first. The aid of a word processing program was used to transcribe the interviews and to set up folders to keep data in various categories. All of the participant's information was reviewed one by one and themes were identified and moved to a separate file. Next, Patton (1990) expands by stating that inductive analysis is when themes, patterns, and categories of analysis come from the data and the researcher looks for natural variations in the data. Therefore, data analysis began to look for key phrases or themes that emerge from reviewing and re-reviewing the data obtained from the interviews. Each interviews text was given a colour where by the researcher was the only person who could identify which transcript belonged to which participant.

Reducing the Participant's Reported Experiences into Descriptive Terms

Patton (1990) proposes that description must be carefully separated from interpretation. Description must come first to ensure rigor of qualitative analysis and involves answering basic questions such as: What was the experience? What are the effects? On the other hand interpretation is the process of explaining the findings. At this stage, the researcher created Word documents using the each of the twelve questions that were a part of the interview guide. Next the researcher began going through each transcribed interview and used the cut and paste options of the computer program and began cutting and pasting each statement made by the participants in one of the twelve headings. In order to see patterns within themes at the end of each document the themes were listed. This way the researcher could look at the end of each of the twelve Word documents and easily find any repeating themes.

Placing Experiences not Directly Related to Mental Health Care Utilization into a Separate Category

This step was used to further categorize and separate data so it was more manageable. This data included the demographic data which was placed in a spread sheet format. Or the type of information that did not speak directly to accessing or receiving mental health services, which was placed into the Word document that dealt with the last question asked from the interview guide. This data was considered very important to obtain so the researcher could look for any other patterns not previously identified.

Generate the Main Themes

At this point main themes and patterns began to emerge and the data could to be easily cross case analyzed. Cross case analysis was used to investigate the similarities and differences that arose from the various interviews. This step allowed the researcher to begin to look at which experiences were similar or different between participants and once completed the findings could begin to be interpreted. Interpretation of the findings included looking at how mental illness was constructed, help seeking experiences, barriers that these women faced when they tried to access mental health care, and what the women verbalized as unmet needs in the mental health care system.

Validating the Findings with Participants in a Later Interview

In order to validate the findings of the study participants were asked to review the data with the researcher to ensure the data was correctly understood. Further information about this procedure is discussed below.

Rigor

According to Rice & Ezzy (1999) the term "rigor" refers to a study's ability to achieve validity and reliability. Validity occurs when the research method measures what it is intended to measure, while reliability is concerned with the replicability of the research findings, and whether or not they would be repeated if another study was conducted using the same, or similar, method. Furthermore, Rice & Ezzy (1999) report that validity and reliability have several functions; however, the most important is that they are used to assess whether a study's findings can be trusted as a basis for further research. Therefore, qualitative studies that are more rigorous are more trustworthy and useful (Rice & Ezzy). Trochim (2006) discussed rigor in social research methods and highlights the work of Guba & Lincoln (1989) who proposed the following four criteria for judging the soundness of a study: credibility, dependability, transferability, and confirmability which was used in this study.

Credibility

Trochim (2006) explains that credibility involves making sure results are believable from the perspective of the participant. Therefore, the participants are the only ones who can legitimately judge the credibility of the results. This study used member's check whereby the participant was asked to confirm the results of the data collected. To ensure rigor, after the end of each interview the researcher asked the participant to review the overall concepts and ideas that were discussed during that session. This helped to guarantee that the researcher understood what the participant was trying to convey and gave the participants an opportunity to clarify and correct any misunderstandings. In addition, once the data was analysed and findings section of this study was completed the research conducted a second members' check. Four of the six participants were available to participate in this level of members checking which was conducted by the investigator over the telephone. At this time, participants were read the overview of the findings (Appendix E) to ensure that the identified themes were correct. Participants were also encouraged to ask questions or clarify if needed. All the themes were confirmed by the participants to be accurate of their experiences.

Dependability

Trochim (2006) proposes that dependability emphasizes the need for the researcher to account for the changing context within which research occurs. This means that the researcher is responsible for describing the changes that occur in the setting and how these changes affected the way the study was conducted. This researcher used a field journal to record observations. The recorded notes included information regarding the date, setting, who was present, interactions that occurred, and activities that occurred while conducting the study. Therefore, the researcher wrote down her biases before starting the study. The researcher recorded things such as what she thought the women would be like and what she thought the participants would report about their experiences.

Transferability

This term refers to the degree to which the results from the study can be transferred to other settings. According to Trochim (2006) transferability is the responsibility of the researcher. To enhance transferability the researcher must engage in doing a thorough job describing the research context. Patton (1990) offers the concept of thick description which will aid in achieving transferability for this study. Thick description is a way of presenting data in detail of cultural context, emotion, and the webs of social relationships. It also establishes the significance of an experience. During step two of data analysis, this concept was used to aid in describing the participant's experiences.

Confirmability

Lastly, confirmability refers to the degree to which the results can be affirmed by others (Trochim, 2006). During this study the data was checked and rechecked by the thesis chair. The researcher also met with all committee members as a group on three separate occasions during the study to discuss the study questions and literature review, to review the methodology, and to review the findings. Prior to the third meeting with the entire committee, committee members were sent a copy of two transcripts so that the members would be able to confirm presenting themes.

Ethics

Participation in this study was entirely voluntary and was not coerced in any way. Subjects were informed that refusing to participate would not lead in termination of existing services or resources. Furthermore, participants were informed that they were able to terminate the interview at any time with no negative repercussion. At the end of the interview process, appropriate referrals were made for those individuals who identified any unmet need. The participants were fully informed of the research purpose in the first interview as well as the findings. Audio recordings were either returned to the participants after the study was complete or were destroyed, as per the participant's request. Confidentiality was maintained by coding all the transcriptions as well as the audio tapes. Referral information was kept safely stored in a locked filing cabinet in the researcher's home, as well, all electronic data was stored on the researcher's laptop which was secured with a password. No one had, or has access, to the password. All confidential information will be destroyed once the study is complete.

Participants were also informed that they could withdraw from the research study, but only up to the point of data analysis because their individual information would not have been able to be separated from the complied data once the analysis began. Referral sources were not made aware of which of their referrals participated in the study and were not privy to the interview information. All interview questions will reviewed by a key informant in the Mennonite culture to ensure that the questions were not too intrusive thus helping reduce emotional harm to the participant. This also helped to ensure that the language used was not offensive to this particular population.

Chapter Four

Results

In this chapter are the following extrapolated findings and themes emerging from the data: 1) how the participants defined mental health, 2) how the women sought and received help, 3) the barriers that the women verbalized, 4) are the treatment needs voiced by the women. This chapter will begin by discussing the participant's demographic information and the environmental content in which the interviews took place.

Participant Characteristics

A total of six Mennonite women who migrated from Mexico and have sought help for a mental illness were interviewed. They ranged in age from 41 to 72 years old and the average age of the participants was 54 years old. All women were born in Mexico, received their primary education there, and although their primary language was Low German they all had working knowledge of the English language. Half of the women had completed English as a second language course in Canada and one woman was currently working on attaining her high school diploma. Their length of residence in Canada ranged from 14 to 42 years and average length was 23 years. Four women no longer wore the traditional Mennonite homemade clothing. All the women defined themselves as being married; however, three women were no longer living with their spouse. In addition, all the women had children and five of the women had experienced the death of at least one child.

When asked why they decided to migrate to Canada, five women responded that they moved here to find work and provide for their families and the other woman explained that she was not completely sure why she moved, and that it was her spouse's decision. All the women were the primary care givers to their children and four of the women worked outside of the home. Lastly, all the participants reported that they sought help for depression and anxiety and one participant also sought help for her addiction to alcohol.

Additional Information Gathered from the Researcher's Notes

In addition to transcribed interview data, the researcher took notes before and after each interview. The notes contained information regarding the interview setting, the researcher's perception of the interview, and information provided by the participants before and after the taping of the interview. This information was rich with data and offered additional insight about this population. Discussion about this information will occur in the proceeding section.

The homes ranged from single-family dwellings to small bachelor apartments. Despite the size of the home all living environments were clean, uncluttered, well kept, and unpretentious with modest furnishings. Four of the interviews were only conducted with the participant and researcher in the home. When a spouse was present, according to the participant, he did not speak or understand English. She also explained that her husband was not happy about the researcher's presence and the inquisitive nature of the visit; however, since he did not speak or understand English she was able to talk freely. All the homes were quiet and did not have noise coming from such items as a television or radio even when others were around. For example, during one of the other interviews, a small child came down the stairs to ask her mother for a drink. It was so peaceful in the home that the researcher was unaware anyone else was around. The participant explained how she had asked her two children to wait upstairs during the interview and they did so quietly.

In addition, all the women greeted the researcher with a pleasant smile. The women agreed to be audio taped; however, once the tape recording began their answers became very short and it became hard for the researcher to engage them in free flowing conversation. Once the tape recording stopped the researcher noticed that the conversation became free flowing once again. When this occurred, the researcher relied on her notes to capture the data. At the end of the interview, all of the women commended the researcher for taking an interest in them and hoped that some change through the investigation would occur to help others who are ill. One woman gave the researcher a hug, which according to a key informant is rare and a gesture that she liked the researcher.

Mental Health Defined

This study sought to learn more about how mental illness is defined in the Mennonite culture. Presented in this section is how the women talked about mental illness and the terms they used to describe their experiences. This also included context-surrounding mental illness such as themes of secrecy, lack of understanding about mental illness, judgment within the Mennonite community, and lack of support.

How Mental Illness is Viewed in the Mennonite Community

When the women were asked about how they defined mental illness, two terms emerged in their stories. All the women defined their experiences with depression and anxiety as having had a "breakdown" or that they experienced "nerves". For example, "we say we are down with 'nerves'," and "Oh, we also say 'breakdown'. We say when people aren't well that they have 'breakdowns'."

It seemed that the term "breakdown" is used to define the moment when they were no longer in control of their symptoms of depression and/or anxiety and when they had to reach out for help from family, church, or their doctors. Many of the women talked about experiencing life altering events that they attributed to their breakdowns. One woman talked about how her spouse's infidelity affected her, "my husband made

The woman talked about how they felt they had to keep their feelings of depression and anxiety a secret from family, friends, and especially their spouses. One woman mentioned how she has not shared her sadness with her family. She stated, "I don't talk about it with the family, always put on a happy face." Another woman talked about not being able to share her feelings with her spouse stating, "I always have to be careful of what I am doing and what I am saying. So around him (husband) you have to be happy." This woman explained how around her husband she had to hide her feelings of depression and anxiety from him to avoid upsetting him. There existed an expectation that the women were not to burden their spouse with their feelings and should be content when their spouse is at home. One woman explained how she once tried talking to others about her feelings of depression and the response was not positive. She explained how the persons response made her feel like she was "complaining" and that she was "making things worse than they were." Therefore, keeping her feelings secret was the only thing she felt she could do.

> And I say I'm tired today and I can't sleep and they [friends] say, oh we can't sleep either. But they don't know the pressure. A lot of people say that I can't sleep at night either but this is a different way that I feel now. So I don't want to say anything because those people might think that you want to be babysit or something, then you put in all in your heart and that is harder

In addition, as mentioned in the above quote, half of the women also spoke about holding the pain associated with depression and anxiety in their "hearts." One of the participants explained how she carried it alone in her "heart" and did not share the pain she was experiencing with anyone. The expression "heart" explained the private place inside of them those feelings such as worry and sadness are kept. Another of the women explained how she kept her true feelings inside of her and tried to be content when her family was around her. This woman stated "my heart is heavy and still sometimes sad. I work very hard at trying to be happy, for my family. I put on a happy face but heavy heart."

When one of the participants was asked if she was able to talk to anyone about her feelings of depression her response was clear and simple, "No I was locked down. I kept everything inside." To this participant the term "locked down" meant that she could not share with anyone what she was feeling or thinking, she felt emotionally imprisoned. The women were taught that the negative feelings of depression and anxiety such as sadness' or worry were to be kept quite within themselves. For example one woman stated, "I wish women would ask for help before they go so far down, like me. I wish I hadn't kept the secret."

Lack of Understanding of Mental Illness

In addition to secrecy, there was a lack of understanding about what mental illness truly is. This lack of knowledge occurred at the individual level, family level and the community level. At the individual level, the women were not taught about the signs and symptoms of mental illness as well as the difficulty one faces when one has this illness. The following statement illustrates one woman's acknowledgment of her lack of understanding with regard to the seriousness and how difficult depression is to overcome.

> I never even thought about it like it is, depression. I always thought it was like a bad time and I didn't think it was very very hard. That's what I thought about depression but its very hard.

The women talked about how they began to experience feelings of "pressure", or feeling "lost, alone worthless, and not deserving to live." They did not know that these prolonged and intense feelings were signs and symptoms of depression.

because they were weak religiously and if they would just be more religious then they would feel better. For example, they were told, "you need more faith, you're weak and that's why you don't feel well," "they [other Mennonites] tell me to go to church and pray, that would help," and "I've been taught to pray." Lastly, one woman commented that the lack of understanding about mental illness was one of the main reasons the community did not help her in times of mental distress. For example, she stated, "Mennonite can be not nice sometimes, if they don't know about what you're going through."

Judgement Against Non-Conformity

In several of the stories, the women talked about experiences of being judged by other Mennonites in their community. It seemed, to the researcher, that the judgement occurred whenever the women deviated from normal Mennonite traditions. For example, one of the participants decided not to wear traditional home made clothing anymore or make her children do so. She talked about how she felt persecuted by other Mennonite people and how this judgement affected her.

> I was accused of so many things that I would change my clothes and would change my hair style and things they just put so much pressure on me that I just couldn't handle it anymore that I broke down.

For these women, feelings of being judged came in the form of phone calls verbally reprimanding them for their behaviours. For one woman these calls were made both to her home directly as well as to her loved ones. She reported, "People used to call me and my parents saying that I was bad and that I needed to go to church to get better." In addition, a couple of the participant's families received telephone calls by other members of the Mennonite community advising the families about how the participant's behaviours were not appropriate.

> My husband actually received a phone call a couple of months ago about me, that I was on too much medication and that I wasn't being the wife that I should be and the mother that I should be and nobody knows the damage that that can cause because my husband himself believes that if your strong enough that you don't have to be on that [medication]. That makes it hard.

The individuals who made these calls may have done so with concern for the individual and were well meaning members of the community; however, as presented in the above quotes their actions were more damaging than helpful. The judgemental manner of reaching out to the person to offer help resulted in the women feeling further isolated from their family and their own religious community. One woman stated, "they used to put me down, that doesn't make me better that made me not care anymore." Not only did these women feel judged by members of the Mennonite community, they also felt the pressure of being judged by their church. As one of the woman put it, "Mennonite people, especially the church, they judge you from what you do." Furthermore, it seemed that the fear of being judged by their peers also strengthened there feeling of having to keep their illness secret. An example of this is found in the statement, "and like a lot of Mennonite people are afraid to open up to other people because of what they [other Mennonites] are going to say."

Lack of Support Within the Mennonite Community

There was a lack of support felt by four of the participants from their family members as well as by their church. It was not until the women were asked about formal mental health care services that they began talking about receiving support and understanding for their illness. One woman stated that she "found that they [hospital staff in the psychiatry ward] were caring, not so much the doctor but the nurses. That was something totally new for me. No one had cared before." Most of the women talked about how little to no support they received from their family. For example one woman stated, "no, I had no family support." One woman who did feel some support from her family was the oldest member of the group who verbalized her symptoms in somatic ways. In this case, she was taken frequently to her family doctor and was given a "brain scan." It was only when the doctor physically could not find anything to cause her presenting symptoms that she was referred to a psychiatrist." The other woman who received modest support from family explained that she had other family members who dealt with anxiety and depression and it was those family members who she felt supported her.

One of the participants explained that it was acceptable to seek out medical help for medical problems. She reported that within the Mennonite community people who were physically ill are supported with home visits and meals by members of the church, but when an individual is ill due to a mental illness that same support seems not to exist. Although the women discussed how the church was not very helpful when they reached out for support, all but one of the women stated that church continued to be very important in their lives in other ways.

> Like for me I went to the church first, the church was okay to tell you to go to church but they don't follow through. They said to me that they were going to help but never did. If they can't help themselves then they should get other people who know how to help the people that need the help. I needed help every day, not just on the weekends when the church would call.

When the women turned to the church for help they were met with disappointment and lack of support. Not one participant shared a positive experience with regard to her initial requests for aid by the church. One of the oldest participants explained that there are several different types of Mennonite churches here in Essex

County ranging from strict fundamentalist teachings to views that are more liberal. She went on to explain that in her experience the newer churches that are being formed have more knowledge about mental illness and are therefore providing some support by helping their members get professional help. However, she stated that there are still many churches that do not.

Treatment Seeking

The second set of themes that emerged from the data were those related to how the women sought help and the treatment they received. This section will described the women's journey in: 1) accessing treatment for their illness; 2) what treatment methods they used; and 3) their attitudes towards getting treatment from the current mental health care system.

Accessing Treatment

Participants used both informal and formal methods to access treatment for their mental illness. This section will present how the participants accessed professional mental health care. More than half of the women stated that they began seeking informal treatment by reaching out to their church for support. One woman stated, "I went to church to see if they could help." However, as mentioned earlier they felt a lack of support.

In regards to receiving formal care for their mental illness two women reported that they first accessed mental health care through their family doctor and after physical illnesses were ruled out, depression was suspected and later diagnosed by a psychiatrist. One woman described how her family doctor was also helpful with teaching her coping skills.

> Yes, that is the only one I went to [family doctor]. He had [delivered] my children. He was the only one. He was very nice, he would listen to me, what I have to

> say, and he gave me pills and told me exactly what to take, how to act, what to say, and how to relax, and if I think things were going bad he tell me to say, "that's ok, that's ok, let it go, let it go" and I did and it worked.

Both of the women who saw their family doctor initially for the mental illness were hospitalized in Windsor for treatment. It should be noted that there is a hospital located in Leamington, which would be the closest hospital to where all the participants lived; however, it is only at Hotel Dieu hospital in Windsor that a psychiatric ward exists. One of the women described her hospitalization in Windsor as a collaborated decision between her and her family doctor.

> I go back to the doctor and say these pills are helping nothing. I couldn't feel like that so he say what if we go to the hospital, if we could try if it would help and I say yes that I would try if it would help. And it helped a lot.

For these two women, neither family doctor referred them to community mental health care. However, both women were referred to some form of community mental health care post hospitalization by the hospitals social work team.

Three women initially accessed care for their mental illness by being brought to Leamington's emergency department after experiencing a "breakdown" either by a family member or by a friend who was not of the Mennonite faith. Of the women that were brought in by a family member one did not have a family doctor, therefore, the emergency department was her only access to medical care. She was admitted to Leamington hospital, transferred to Windsor psychiatric hospital for admission and later referred to a psychiatrist as well as a community medical practitioner by the discharge planner through the hospital. The second woman who was brought to the hospital by a family member described how she went to the Leamington emergency department for help for her nerves and they kept her for a couple of days to help her feel calm. She explained that during this hospital stay or any of her previous stays she was not referred to any community program. It was only when she had an admission in Windsor psychiatric hospital at she was referred to community treatment for both her mental illness and addiction issues. This woman stated, "The nurse and social worker in the hospital [Windsor psychiatric ward] made sure I had some help when I left the hospital." She further explained that this was helpful. The third women explained that she first accessed mental health care because her child's homecare worker brought her to the emergency department. "The worker [daughter's homecare worker] was the one who found the help. So she said enough was enough and she brought me into hospital." She was admitted into the psychiatric ward in Windsor. She too was referred to a psychiatrist and community mental health care for follow up after her hospitalization.

The sixth participant first accessed mental health care when she entered a shelter. A friend had explained to her that abused women could find safety in a shelter. One night she called the police and was brought to the shelter with her children. "A friend told me that [About the shelter] and I called the police and they brought me right there." Once in the shelter she was referred to a psychiatrist.

Experiences Receiving Treatment

The women were also asked about their experiences once they began receiving treatment for their mental illness. They all spoke very positively about their experiences with regard to their psychiatrist, staff in the psychiatric unit at the hospital, and community based mental health. With regard to their psychiatrists, they talked about how they felt that the doctor was listening to them and that the doctor was really trying to help. For example one woman stated, "Yes, they listen to you. For me, I cry. I couldn't stop crying and that's why he gave me the medication, so I could stop crying. But now I can live without crying and without medication." Another woman commented that she felt her doctor was nice, “Oh yes, he’s nice.” A third woman stated she was happy with her doctor “I’m happy with my doctor.” It was important to these women that they felt heard by the professionals treating them. As one woman explained, she did not have a good rapport with her first psychiatrist because he did not explain her illness or medications to her. However, she was content with her new psychiatrist who took the time to talk to her about her illness.

> I’m happy with my new doctor now that is what this doctor did [explain her medications] before he [her pervious doctor] never say something of what it is [illness] or for what it for [medications].

Regarding their experiences in the psychiatric hospital, the women talked about how it was a structured environment which was not pleasant at the time but did help with their treatment. For example one woman stated, “I mean they were strict which I think was a good thing. If they had just left you alone, it wouldn’t have worked. I found that they cared, and that was a big help for me.” Another woman made a similar comment about her experience in the hospital stating “They [nurses] come to check to make sure you’re are ok. Then they make you go out to groups. I didn’t like at first but then it was good for me and I felt good.”

Most of the participants attended some form of community support group for their depression and anxiety. Two women were linked with a mental health case manager. Again, all comments about this experience were positive. One of the women stated, “I would say that if I didn’t have them [doctor, nurses, and worker] I don’t think I would be here. They were a big help for me. They were all good to me.”

> I talked in meetings, and that was good. It helped to talk to other people who were going through something like me. My worker at the time helped me a lot

> with taking me to my doctor and helping me talk to tell my doctor the important things of my feelings.

In summary, overall, these women expressed positive experiences when they have accessed treatment for mental illness. For the woman it was the first time they felt like they could talk about how they were feeling. It was also the first time that the woman felt compassion and understanding.

Treatments Used

Much like their treatment seeking behavours, the women used both informal and formal methods of treatment. Informal methods included going to church and using prayer to help them through the "hard times." Religion is a large part of these women's lives. For example common statements made were, "Praying helped me a lot," and "I been taught to pray, I would just pray, I would pray every day." The women explained that they prayed for many different kinds of help, they would pray for strength, to feel better, and two women explained how they had prayed to die. For example one woman stated, "I would pray every day that someone would kill me so I wouldn't be there anymore." Suicide is against their religion, therefore they just prayed that death would take them away from their pain.

All the women spoke of the importance of psychotropic medication. Comments made were, "Oh yes, that's my medication, that's my strength," and "I always take my medication that is what helps me with my nerves." Another women said, "I have been on medication and I have tried musical and church. Honestly, the only thing that really helped me was the medication."

While discussing the use of medication, another theme emerged. Although these women took their medications, found relief from their symptoms of depression and anxiety, and were able to return to their activities of daily living, there was a continued lack of support and understanding by their family and community with regard to why they had to continue taking medication once the symptoms subsided. As the following woman, explained:

> My sister in law she helped, but now said that I don't need medication anymore, I just need to go to church more. Mennonite people tell me 'why do you take medication, you don't need that anymore' but they don't understand.

Another woman stated, "My son in law is a minister there [in Mexico] he doesn't believe that people should take medication." Based on these comments, it appears to the researcher that long-term use of medication is not encouraged or supported in the Mennonite culture.

Woman's Attitudes After Seeking Treatment

All the participants verbalized that within the Mennonite culture it was acceptable to seek medical care, but not mental health services. Therefore, for these women seeking care from their doctor and the hospital was considered socially acceptable methods to care for ones' health. One woman accounts how before getting services she felt "stupid" and her husband just thought she was "worthless." However, after being told by a doctor that she was suffering from an illness things "got a little easier". Lastly, on several occasions, one woman stated she wished that like herself other women would get help for mental illness before it is too late. She stated, "I wish I had gotten help before things go bad. Even my kids watched me. It's not nice for the kids."

Barriers to Seeking Help

Beyond experiencing a lack of understanding, lack of support, and a sense of secrecy surrounding their symptoms, there were additional barriers to seeking help. These included language barriers, differences in religious beliefs, lack of transportation, and submissiveness in spousal relationships. Each of these barriers will be discussed below. However, it should be noted that free health care in Canada removed financial barriers to service. For example, four of the women mentioned that because access to doctors was covered by OHIP they were more willing and able to seek medical treatment in Canada than they would be in Mexico. In Mexico, patients have to pay to see a doctor, which hinders seeking treatment. As one women put it, "Oh no, no, I never talked about it [mental illness] in Mexico. We didn't have the money."

Language Barriers

Although all the women in the study had a good understanding of the English language, many of the women verbalized that this can be a barrier to getting help for many other Mennonite women who do not speak English. This theme emerged when the participants were asked how other Mennonite women could be reached. One woman explained that she knew of other women who needed help for depression, but these women did not know how to speak English so they were unable to explain their symptoms to their doctors. Another participant explained, "They need to ask for help. Sometimes English is a problem, some people don't talk English."

Religious Beliefs

The Mennonite's believe that prayer and being strong of faith will see its followers through the hard times. This belief can become a barrier to accessing mental health care because often mental illness is viewed as weakness of faith. For example one woman stated, "Mennonites say that you are weak and that is why these things happen and you need to go to church to stay strong, but it's not like that." Another woman was told, "You need more faith, your weak and that's why you don't feel well." In addition, the Mennonite religion can also isolate women from going into the larger community. "The religion say that the women need to be at the home" explained a participant; the "women are expected to stay home and tend to the children and housework."

Lack of Transportation

All the women reported that they were willing to continue receiving mental health care. However, some of the women were unable to complete the treatment groups due to lack of transportation. One woman stated, "I was in a group for therapy and I couldn't be there for all of them due to not having a way to get there," and "Lots of German women don't have driver's licenses so they can't go there by themselves." In addition, some of the other participants mentioned that they were not able to begin any of the available treatment groups due to lack of transportation to the groups. However, one participant got her driver's license without any support from her spouse because she was frustrated about having to rely on her spouse to get places.

Submissiveness in Spousal Relationships

Submissiveness in the spousal relationship was a barrier for many Mennonite women. The barrier occurred when the spouse did not support their wife in accessing or receiving treatment for their mental illness. Most of the women talked about how the woman's role in the Mennonite culture is to be submissive to one's spouse. One woman explained, "The Mennonite culture, they teach women to you need to take care of your children And you have to obey your husband." Therefore, if the woman's spouse is not supportive of treatment seeking then it becomes difficult for the woman to seek help. This submissive role can also prohibit women from talking about their illness to others. One participant explained, "Lots of German women, if their husbands are home, then they cannot meet and they couldn't say nothing. I feel like I know what they are talking about." In addition, another one of the woman frankly stated that she would like to attend group therapy; however, her husband would not allow it. This same woman sought help for her mental illness at an emergency department without the support from her spouse. Her spouse became upset with her because she was going against cultural norms and seeking help for her nerves. When she was advised by the hospital to seek further treatment from her family doctor, her spouse did not agree and therefore did not allow her to do this. She felt that she had no other option and called police for assistance.

> One Sunday, I went to emergency to see if they could help me because my nerves but my husband got mad at me that I was doing that because he thought that I was trying to make it hard on him. And, they say that I needed to go to my family doctor because I needed help but he didn't want to hear that and that is why I called the police because I wanted help.

Meeting Mennonite Women's Mental Health Needs

A side from medication, all the women agreed there were additional services that were, or would have been, helpful when they were ill. This included in-home support for their activities of daily living, counselling, support offered through the church, therapeutic groups, services conveniently located in the area, issues surrounding culture and gender in the therapeutic relationship. Each item is discussed below.

In-Home Support

In-home support was mentioned as something that would extremely helpful, not only to complete what needs to be done in the home but also to aid with the pressures that can hinder treatment. One woman explained, "Yes, if somebody was in the house with me that would have helped me a lot. Also then, they could say I could rest when I had too much pressure. I wish I had a lady that knew what I was going through and could help me with the house." Another of the participants stated, "It would be nice when I was sick someone to call me during the weekdays to see if I was ok. It would be nice to have the help with the kids and the house so not to lose them (to Children Aid Society)."

Counselling

In addition to having in-home support, counselling was mentioned as an important and useful part of their treatment. A counsellor was someone who they could talk to about their illness without feeling negative about it.

> It helped me a lot to talked to people that understand. My husband couldn't understand how I was feeling. He just think that I wanted to make it hard for him, but that wasn't the point, I didn't want to do that. If I wanted to do that then I wouldn't have gone to the doctor to get help, I wanted to make it easier for him and for the children.

Since there seems to be a lack of support and understanding within the family and Mennonite community, it was important that these women found someone to support them through their breakdowns. However, in this same discussion it was mentioned that there is a gap in services with one woman who waited over two years to receive one on one counselling that was recommended by the mental health aftercare program.

Support Offered Through the Church

Religion and church is a fundamental part of life for Mennonites. Therefore, it was not surprising to hear that all the women thought it would be positive to have the church more involved in helping its members access mental health treatment and be more understanding of mental illness. One woman stated, "I think that would be a huge difference." Another woman explained, "Well, it would be nice for the church to be okay with the programs and tell people about the programs."

Importance of Groups and Services in the Community

The importance of groups was reported as one of the most useful treatment methods. One woman explained, "Well, after hospital I talked in meetings, and that was good. It helped talking to other people who were going through something like me." All the women who attended groups reported that the groups were positive, however, location of the current availability of groups posed a problem with regard to transportation to and from the groups. At the time of this study, there were no mental health treatment groups available in Windsor Essex County other than in the city of Windsor. That meant an individual who lived in Leamington, for example, would have to travel approximately 45kms to the city to access treatment groups. According to the women, groups have existed in the county before, however, currently do not. In addition, educational groups were reported to be beneficial and all the women spoke about the interest of social groups. For example, one woman stated, "I think women would like a place where she could go somewhere that she can do something she liked, like farming or if she's tired to have a place to rest."

Culture and Gender Issues in the Therapeutic Relationship

Lastly, participants were asked if the cultural background of the service provider was an issue of concern. All six women reported that culture was not an issue when they sought mental health treatment. Interestingly, some of the women added that they felt more comfortable when the service provider was not Mennonite. One woman stated, "No, culture doesn't matter. Everybody is good and I think that sometimes it's better if it's not Mennonite. Mennonite can be not nice." Another woman mentioned, " I find that Mennonite people are not, it's not a good idea to talk to them. I have quite a few hurts when I have talked to other Mennonites, that hurt. I find that I can talk to a different culture, it makes it a lot easier."

Although culture did not seem to be an issue when discussing treatment providers, gender was an issue for several of the women for a couple of reasons. First, Mennonite culture prohibits male female relationships other than spousal. This was given as a reason why it was important to have a female worker work with a Mennonite woman. One woman explains, "Well, the religion says that because women can't talk to other men if you are separated and should not talk to men if you're married so for women it would be good to have a women worker." Secondly, unrelated to religion, a woman reported that she felt more comfortable speaking to another woman. She stated, "I would feel more comfortable with a woman. I feel they understand more, what you are going through."

Summary of the Findings

In summary, the findings illustrated how mental illness is not discussed formally in the Mennonite culture. Individuals from this culture use terms such as "breakdown" and "nerves" to explain their symptoms of mental illness. Within the Mennonite culture the women keep their illness secret from family and friends. They carry the weight of the illness within their "hearts" as not to upset anyone in their lives. In addition, it was found that there is a lack of understanding about mental illness within the culture. This lack of understanding was found at the individual level, family level, and the community level which included the church. Judgment against non-conformity within the Mennonite culture was also identified. It was found that it was important for the women to follow the cultural norms which was difficult at times when coping with their mental illness. In addition, there was a lack of support from family and the Mennonite community when the women reached out to access support for their mental illness.

Furthermore, the findings presented issues with regard to treatment seeking. It was found the women did seek support from their church; however, they began receiving treatment only when they were admitted into a psychiatric hospital. Once receiving treatment by a professional mental health provider the women experienced positive support to having a mental illness. The women not only used medication to reduce symptoms they also attended therapy groups and community mental health services.

Barriers to service were identified. Such barriers included, lack of English skills, religious beliefs about mental illness, lack of transportation, and submissiveness is spousal relationships. Lastly, the findings discussed identified ways to meet the needs of Mennonite women as presented by the participants. The women discussed the usefulness of in home support services, accessible counseling, and having the church's support for accessing mental health treatment. It was found that when working with the Mennonite population it was more important to have female counselors work with female clients instead of having a Mennonite worker work with this population. In fact, it was reported that having a worker from another culture provide the treatment was beneficial than if the worker was also Mennonite.

Chapter 5

Discussion and Implications

Review of Study Purpose

The purpose of this study was to gain an understanding of the experiences of Mennonite immigrant women who have accessed and received services in the mental health care system in Essex County. Findings from this investigation offer guidelines for effective social work practice with this unique population. The goal of social work is to strengthen people's ability to cope with the task and problems they face in life and to promote improvements in the environment to more adequately meet human needs (Macht & Quam, 1986). This person in environment perspective provides the framework for discussing the implications of this study. Social work practice implications when working with this population at the micro, mezzo, and macro levels are presented. Following this is a discussion about the implications for social work education as well as the study's limitations and suggestions for future research.

Micro Level Social Work Practice

Micro level social work practice involves working directly with the client (Johnson, 1998). Based on the findings from this study, the following section discusses how mental health care workers can provide direct services at the micro level that are specifically geared toward helping the Mexican Mennonite female population. These direct interventions should include education, outreach and empowerment that includes religiously sensitive practice.

Education at the Micro Level

The findings from this study suggest that these Mennonite women did not have much formal knowledge about mental illness, that the culture blamed the women for having symptoms, and that there was a lack of support within the Mennonite community for these women. Mennonite Media (2005) documentary investigating Mennonites' experiences with mental illness reported similar findings. First, the women in both investigators had a mental illness; however, they did not have any knowledge that what they were experiencing was a treatable condition. Therefore, education at this level should provide information about the signs and symptoms of mental illnesses such as mood and anxiety disorders, the biology of mental illness, various treatment options, where to go for treatment, and information to counter act the self-blame often expressed by participants. Providing this type of education could result in earlier intervention resulting in a shorter and less disabling course of the illness (National Alliance on Mental Illness, 2004; Health Canada, 2002). While previous investigations did not identify a lack of knowledge about mental illness as a barrier to receiving services, a lack of awareness of services was cited by several studies (Kouyoumdjian et al., 2003; Egan & Gardner, 1999; Kafele, 2004). Therefore, as a part of direct intervention at the micro level Mennonite women should not only be educated about mental illness they should also be made aware of services that are available to them in their community.

Second, women in the study as well as in the documentary (Mennonite Media, 2005) reported that they received no support for their illness by the Mennonite community. For example, the documentary reported that mental illness was the only illness for which a person would not receive a "covered dish" meaning a casserole. Participants in this current study expressed similar sentiments. Lastly, both participants in the current study as well as the documentary (Mennonite Media, 2005) reported that their husbands, children, and parents began to show some support, but only after the family received an explanation about mental illness. Therefore, educating family members or including the family as part of the women's recovery process may be beneficial.

Outreach

Outreach at the micro level is a direct service approach designed to address existing barriers to psychological growth and well-being (Lewis et al., 1998). Vera et al. (2006) explain that outreach means the worker leaves his/her office setting and makes contacts with their clients in their natural environment essentially bringing services to where the people are. Home based therapy is a useful outreach approach when transportation or session attendance is a problem. Outreach of this nature is a useful method to deal with the specific barriers of transportation that study participants from this investigation identified. In addition, this form of outreach could also reduce the resistance by spouses who do not support mental health treatments when it requires the woman to leave the home. Furthermore, when providing services in the home social workers, at the request of the woman, need to be flexible enough to co-ordinate their visits during times when the woman's spouse is not at home since many participants expressed that their husband opposed them from seeking treatment because it was against cultural norms.

In addition to in-home counselling, setting up home care services specific to the needs identified by the women in this study should be another practice approach at the micro level. Specifically, the women identified wanting help with their duties as a homemaker. This is especially important to Mennonite woman since the woman's role is that of homemaker and mother. When a Mennonite woman is not able to fulfil that role it can increase psychological distress even more so than a non-Mennonite women and therefore hinder efforts of recovery. Creating and providing such a service that would aid women who are suffering from a mental illness during their times of need could prove to be a beneficial adjunct to treatment for this population. The service would be short term and would aid in housework such as laundry, cooking, and cleaning. The idea is that this role is so intertwined with the Mennonite women's identity and that having these tasks taken care of would greatly ease the burden physically and psychologically for the woman while she is recovering.

Another outreach effort would establish therapeutic support groups to work with the female Mexican Mennonite population. This form of outreach would include a mental health professional providing therapeutic support group opportunities which would focus mental health issues (Corey & Corey, 1997). Therapeutic support groups offer individuals education about a problem, coping strategies and a safe environment to talk about these issues, which can begin to reduce feelings of self-blame that the women talked about in this study. In addition, according to Corey & Corey, group interventions provide a sense of community, which can reduce the isolation that the participants in this study also identified. Again, these groups need to be offered in the community where Mennonite women live to reduce barriers such as transportation.

Feminist-based Empowerment

Empowerment involves increasing personal, interpersonal, or political power so that individuals can take action to improve their life situation (Lorraine, 1990 as cited in Hinkelmen, 2005). Feminist-based empowerment enables women to receive benefits that society has to offer and increases their ability to work towards ending the conditions that prevent them from meeting their needs (Johnson, 1998). Empowerment has been suggested to be effective when working with members of minority groups, populations at risk, and women (Hinkelmen, 2005). Feminism and feminist practice can be defined in different ways and have differing goals; however, the over arching goal of this philosophy is to give women a voice (Laird, 1995). Feminism seeks to include women's experiences in all formulations of their human experience and to reduce or eliminate the dominance of male assumptions (Walters et al. 1988 as cited in Laird). Common strategies used to empower clients are to provide support, mutual aid, and validation of their perceptions and experiences (Johnson, 1998). This theory is particularly useful in understanding and intervening with this population because Mennonite women are oppressed within their current social context. The women from this study reported that they did not feel supported by their community, that their spouses controlled whether they were able to seek treatment or not, and they had to maintain the specific role of mother and care taker.

When working with the female Mennonite population from Mexico it is important to understand, and be sensitive to, the social construction of the gender differences within this culture in such a way that seeks to comprehend and address the socialization process that maintains a power imbalance between Mennonite men and women. As previous investigations found, Mennonite women define themselves within the household domain much like the Mennonite men, but also are considered the primary person responsible for managing the finances of the household (Redekop, 1996; Loewen, 2001). Therefore, improving upon the current power imbalance within the Mexican Mennonite home should include giving these women a voice within these domestic roles.

In addition, for this particular population reducing self-blame needs be a part of the empowerment process offered by social workers. As mentioned in the findings many women felt that their illness was a deficiency caused due to a lack of faith. Providing empowerment would help show the client that mental illness is not caused by a lack of faith, but is a medical condition that involves a chemical imbalance in their brain.

Furthermore, Hinkelman (2005) suggests that empowerment and social support can be enhanced through participation in organized socialization groups. Socialization groups use program activities such as outings to help members accomplish goals

(Toseland and Rivas, 1998). In the Mennonite community, this could take the form of a women's group or a social club. This would be a valuable type of group to start in the Mennonite community since the participants in the study presented it as a useful strategy to dealing with their mental health. As stated above it may increase social supports by joining women with mental illness together. This may aid in the women not feeling like they are not the only ones that have this illness.

Another way to improve women's empowerment with their role in the family is to focus on their religion and spirituality as reported by Hinkelmen (2005). Hinkelmen explains that in therapy, religion can be supportive by reinforcing church going and prayer. This may be useful when working with Mennonite women since, as mentioned by the participants in this study, prayer and church were important practices in their lives. In addition, there are several studies that support using religion in the treatment of mental illness when it is used by a well-informed practitioner (Basky, 2000; Larson, 2005; Tepper et al., 2001). However, it is equally important to remember that not all Mennonite women are the same and a worker should not assume that religion will be important to every Mennonite woman. Incorporating religious beliefs into the helping process should be client driven and the worker should take a supportive role.

There are times, however, when a person's religious beliefs are harmful to their psychological growth and well being. Therefore, it is important for the working practitioner to be aware of the negative aspects of using religion in therapy such as religious leaders may disagree with mental health treatments (Fallot, 2001). Griffith & Griffith (2002) explain that mental health practitioners need to be well educated with regard to dealing with the destructive consequences of religious experience in therapy to be able to utilize the benefits of an individual's spirituality in treatment. Several studies report that social workers are more likely to help clients consider ways their religious or spiritual beliefs and support systems are helpful than they are to help clients consider ways that these beliefs and support systems are harmful (Canda & Furman, 1999; Kvarfordt & Sheridan, 2007; Murdock, 2004; Sheridan, 2004).

Faiver et al. (2001) offer four general guidelines in this area that practitioners should consider. First, the practitioner should seek clarity about their own spiritual and religious beliefs. Second, practitioners should have an in-depth understanding of the client's spiritual and religious beliefs. Third, it is recommended that practitioners participate in study groups where the issues above can be further explored. Lastly, practitioners should be actively engaged in their own spiritual journey. One particularly relevant guideline when working with Mennonite women may be to collaborate with Mennonite leaders who are knowledgeable about psychological health and issues of mental illness. In addition, Sheridan (2008) has delineated 8 general practice principles for spiritually-sensitive and competent practice:

1. Be respectful of different religious or spiritual paths and be willing to learn about the role and meaning of various beliefs, practice, and experiences for various client systems (individuals, groups, communities).
2. Critically examine your own values, beliefs, and biases concerning religion and spirituality and be willing to work though any unresolved or negative feelings or experiences in this area that may adversely affect your work with clients.
3. Inform yourself about both the positive and negative role of religion and spirituality in the fight for social justice by various groups and be sensitive to this history in working with members of oppressed populations.
4. Develop a working knowledge of the beliefs and practices frequently encountered in your work with clients, especially those of newly arriving

> immigrants/ refugees or nondominant groups.
>
> 5. Engage in ongoing self-reflection about what brings purpose, meaning, and connection in your own life and make disciplined efforts toward your own spiritual development, however you define this process.
> 6. Conduct comprehensive spiritual assessments with clients at all levels and use this information in service planning and delivery.
> 7. Acquire the knowledge and skills necessary to employ spiritually based intervention techniques appropriately, ethically, and effectively.
> 8. Seek information about the various religious and spiritual organizations, services, and leaders pertinent to your practice and develop good working relationships with these resources for purposes of referral and collaboration. (pp. 264-265).

In addition, Hinkelmen (2005) proposed that when working with immigrant women treatment goals should include empowering them to be self aware of their environment. Mennonite women experience the daily stress of balancing domestic duties, childcare, and the role of wife. The women in the study discussed feeling "pressures" related to this that occurred in their lives, which increased their symptoms of mental illness. One of the participants explained how she found it beneficial when her family doctor provided her with some techniques to deal with these stresses. Therefore, a recommendation is to provide a treatment approach that not only is empowering, but also focuses on teaching woman effective coping strategies. Hinkelman (2005) further explains that treatment should focus on the client's strengths and assisting women to look at their options and choices. In addition to other intervention efforts this may also then lead to positive identity and increased self-esteem.

Mezzo-Level Social Work Practice

Mezzo-level social work practice means that the practitioner is working at the community level to create change (Johnson, 1998). Education, coordination of services and networking are important mezzo level practice strategies that would help facilitate change within the Mexican Mennonite women population. In addition Fairbanks (2000) purposes a creative outreach program for religious communities, which may also be adapted to be effective for the Mennonite population. All of these aspects of mezzo social work practice are discussed in more detail below.

Community Focussed Education

The social construction of mental illness is created and maintained by a culture's knowledge and perceptions. For example, in many parts of North America the social construction of mental illness has evolved from trial and error guided by political attitudes and medical theories (Sands, 2001). In addition, a report released by the Canadian Conference of Mennonite Churches (2008) explained that symptoms of mental illness such as deep sadness or lack of motivation are viewed as extremely negative in the Mennonite culture and does not illicit much support for those exhibiting these behaviours. Other symptoms of mental illness that create thought disturbances leading to a person acting impulsively or destructively elicits a no non-sense response from the church for what it considers to be "sinner" behaviour or the person may be considered to have little or no faith. In this way, many of the Mennonite congregations continue to believe that mental illness is a character flaw for which the person is blamed.

Therefore, education that increases awareness and reconstructs the meaning behind the signs and symptoms of mental illness is one way to bring about positive change for the Mennonite community. This would consist of mental health professionals

Fairbanks (2000) the programs organizational chart should have the church as the head of operations, followed by the pastor who would be supported by trained counsellors, and then the congregation. Church-based counselling agencies are available in the geographical area; however, they do not currently exist within the Mennonite faith communities. A program such as this would address stigma that hinders individuals from seeking treatment and offers professional treatment at an earlier stage of their illness.

In addition, as mentioned in the findings Mennonite women felt judged by other Mennonites for their symptoms and therefore they suggested it might be better if the individual providing service was not Mennonite. Another benefit to this approach would be to offer services from Mennonite and non-Mennonite professionals. This may be useful in reducing any fears of being judged as well as providing a forum that may be more acceptable to differing viewpoints and ideas.

Macro Level Social Work Practice

Macro level practice tends to be "large-scale" practice, which focuses on solving social problems and making changes to social policy at the societal level (Brueggemann, 1996; McMahon, 1996). This section discusses advocacy, working to remove societal stigma about mental illness, using the media to create positive change and lobbying for mental health reform.

Advocacy

The findings from this study indicate that advocacy for Mexican Mennonite women, as well as all new immigrants, needs to occur. Although costly, a recommendation would be to offer each new migrant a case manager to help them navigate through the Canadian health care system. The case manager could provide short-term support and education with regard to various aspects of settling in a new country such as the social services that are relevant and available to them. Mennonite women could be educated about programs such as sick leave, which can be accessed when a working individual has to take time off work for medical reasons such as mental illness. Policy changes at the federal level of government would be needed in order to create such a large scaled program.

Removing Societal Stigma

The stigma associated with mental illness is socially constructed and, therefore, changes over time as well as varies by cultural context (Goffman, 1963). Stigma is identified as being two fold because an individual faces both public stigma as well as self-stigma (Corrigan & Watson, 2006). The findings from this study illustrated how Mexican Mennonite women face both self-stigma and public stigma within their culturally community. At the micro and mezzo levels combating stigma is in the form of education; however, there also needs to be a macro level approach to dealing with the stigma of mental illness for all Canadian citizens. One of the benefits to reducing societal stigma is to increase public support for services and government funding as both Canadian Mental Health Association and Centre for Addiction and Mental Health reported that this is one of the barriers to increasing services that addresses the needs of person's with a mental illness.

Furthermore, successful efforts to reduce the stigma associated with mental illness relies heavily on the involvement of many levels of government, social institutions, clinicians, caregivers, the public, consumers, and their families. Acceptance of individuals with a mental illness as a part of our social fabric can only be achieved by engaging all facets of the public in a true dialogue. This dialogue needs to include discussion about the nature of mental illness and the devastating effects of mental illness on the individual and communities, and the promise of some better treatment programs (Arboleda-Florez, 2003).

Media Resources

The media is a driving force that can provide a medium to create positive change about the societies socially constructed ideas of mental illness. Government should sponsor funding for the use the media as a method of societal and political change. Media campaigns with the use of radio, newspaper, and television are important parts of educating the public on the reality of current circumstances for vulnerable populations (Brueggemann, 1996). However, caution should be taken regarding the manner in which information is presented. Overly radical ideas can be dismissed by the public if a strategic plan is not in place. Using researched based information about mental health to guide public awareness and education campaigns is necessary to ensure that media is used effectively and is culturally sensitive to all ethnic populations including the Mennonite population.

Lobbying

It is important to remember that continued lobbying for mental health reform and community mental health services are vital for keeping the issue of mental illness at the forefront of public concern. Without government funding for mental health research, education awareness programs, and community based mental health services would seize to exist. It is important while lobbying for programs supporting mental health issues that governing bodies focus on the research that indicates that individuals from ethic groups do have low utilization rates (Halwani, 2001; Kafele, 2004; Reitz, 1995; Snowden & Yamada, 2005; Whitley et al., 2006). The findings from these studies provide insight regarding why Mennonite women are not accessing care, such as lack of support by the Mennonite community, lack of education, and so on, however, funding is required to begin new initiations that down those barriers to service utilization.

Implications for Social Work Education

The Canadian Association of Social Workers (CASW) and the Ontario College of Social Workers and Social Service (OCSWSSW) set professional standards for Ontario social work practitioners. It is the responsibility for all registered social workers to be knowledgeable about the standards of practice. In addition to these two bodies the Canadian Association for Social Work Education (CASWE) provides standards for the post secondary institutions that provide the Bachelor, Masters and Doctoral level social work degrees.

The CASW provides eight guidelines for ethical practice. However, only one of the guidelines specifically speaks to cultural competence which states that social work practitioners need to "demonstrate cultural awareness and sensitivity" (Guideline 1.2). While the findings from this study suggest that participants were content with the services they received from professionals including social workers the lack of clear standards for cultural competence illustrates a gap in the Canadian social work profession. The CASW should adopt cultural competence standards similar to the National Association of Social Workers (NASW) in the United States. The NASW, in 2001, released ten standards solely addressing cultural competence. These standards address areas such as the importance of cross-cultural knowledge whereby social workers need to continue to develop knowledge about the history and traditions of client groups.

The OCSWSSW works in accordance with the 1998 Social Work and Social Service Work Act to establish and enforce professional and ethical standards with pertain to the members of the college. Once an individual obtains their Bachelors in Social Work from an accredited University, they can make application to become a

Registered Social Service Worker (RSSW) with the college. In addition, master level social workers can make application and become Registered Social Workers (RSW). All RSSW's and RSW's must follow the standards of practice set by the college. There are eight general standards of practice, none of which specifically address cultural competence. Therefore, both the current professional governing bodies for social work in Canada (CASW and OCSWSSW) need specific guidelines for cultural competence.

Ensuring that cultural competence standards are clearly established is important because all individuals perceive and interpret their problems through a socially and culturally constructed lens. Sands (1991) explains that this lens is how a cultural group defines what behaviours and emotional states are problematic and what responses to the behaviours should be considered. This is important to keep in mind when social workers are working with groups of individual from cultural backgrounds different from their own. An outside professional unfamiliar with a particular culture may deem certain actions, behaviours, or treatment as unacceptable when it is appropriate and effective within the cultural context. Without cultural awareness the professional can inadvertently cause more harm than good. For example, the Mennonite population is rooted in a religion that encourages woman to be submissive to their spouse and any deviation from this may be seen as socially unacceptable. It is important for social workers to know how to work in a culturally sensitive manner that is effective with a population firmly grounded in patriarchy.

The CASWE's mandate is to support schools of social work in providing quality professional education. This is done by advancing the standards, effectiveness and relevance of social work education in Canada. The CASWE's mission statement speaks to equitable education, the commitment to defend academic freedom, and to developing effective and empowering methods of education and research relevant to a diverse society. For a university's social work program to be accredited by the CASWE, it has to prepare its students to understand and work against oppression.

In regards to social work education, Dewees (2000) mentions that professors should teach students about the importance of developing culturally appropriate attitudes, skills, and strategies by engaging in self-awareness exercises and learning about different ethnic groups. Boyle & Springer (2001) suggest that while the social work profession is making efforts to incorporate culturally competent content and instruction into education, a gap still exists and cultural competence remains more of an abstract ideal than a measurable outcome. Boyle & Springer suggest that the profession needs to work towards developing more reliable measurement scales in this area in order to ensure that cultural competency training when provided is effective.

Researcher's Roles

Whenever possible, respondents should be engaged as collaborators in the research process. As collaborators, respondents have a great deal to offer and can add to the research process. As this study suggests, participants can help shape social work practice on many levels. Who better to ask what changes should be made than the participants themselves? Collaboration is important for members of oppressed populations such as Mennonite women, who have not been given an opportunity to discuss their unique experiences. Respondents of this study were grateful and thanked the researcher for taking the time to conduct this study and ask about their stories. Member checking is important in this regard in order to ensure that their story was an accurate reflection of their experiences.

Respondents were invested because they were eager to know about the findings. Participants not only want their story be heard but for change to occur. Therefore, the research process should include dissemination of findings through publication in professional journals, presentation to organizations that would reach professionals who may work with the Mennonite populations, and public speaking in the community about the issues.

One of the most important lessons learned while conducting this study was that professional key informants are essential when sampling this hard to reach population. The connections with key informants can be made by contacting leaders in national organizations that serve this population, such as the Mennonite Central Committee, as well as attending conferences related to this population. Participants for this study were recruited through a key informant who was raised as a Mennonite and who is regarded as a leader in helping the Mennonite population. He is highly respected within this community, which was important because he was able to vouch for the researcher's trustworthiness thus facilitating the participants willingness to participate in the study.

Study Limitations and Future Research

As with all research the findings of this investigation need to be considered in light of its limitations. The first limitation is that all participants had been living in Canada for a minimum of fourteen years. This may be due to excluding women from the study who did not speak English. Future research may want to look at the experiences of newly migrant women to compare and see if the findings from this study are generalizable. Second, the sample size was also small with six participants. Although saturation of information occurred future research might want to look at a larger sample to investigate if any other concerns surface. Lastly, all the participants of this study derived from one referral source. Although a second referral source was approached it was the referral source who was a key informant that was able to encourage women to participate in this study. Further research may want to look at obtaining participants from several referral sources to be able to compare and contrast their stories. However, given these limitations this study provides useful insight into Mennonite women's experiences accessing and receiving mental health care system in Essex County.

Further research should address Mennonite men's experiences with accessing and receiving mental health care. This would be beneficial to compare and contrast to the experiences of women and gain a better understanding into the Mennonite community as a whole. In addition, further research may want to include interviewing the church leaders to find out if what their views are with regard to mental illness and appropriate methods of seeking and receiving treatments. A comparison of the views of men, women, and church leaders would provide confirming and opposing views and lead to better understanding of the mechanisms that support and hinder seeking help for mental illness.

In addition, it was mentioned in this study that there are other Mennonites who are transient and mix their medications from country to country. It was specifically mentioned that some individuals would mix their medications from Mexico with those prescribed here in Canada. Looking at the actual prevalence and effects that this may have on treatment outcomes may be of importance when working with this population because a piece of treating mental illness is medication and medication management. Furthermore, other cultural groups should be studied to obtain an improved understanding of societal implications of migration, accessing, and receiving mental health care in Canada.

Summary

Findings from this qualitative inquire has provided a deeper understanding about the barriers that exist for Mennonite immigrant women accessing and receiving mental health care in Essex County, Ontario. Some of these findings include: how mental illness is viewed in the Mennonite community, the existence of secrecy and judgement about mental illness in this population, a lack of understanding about mental illness, as well as a lack of support for those suffering from a mental illness. In addition, participants reported that language barriers, lack of transportation, and submissive spousal relationships also contribute to their difficulties of accessing services. Based on the findings from this investigation the following suggestions to improve social work services using an empowerment framework at the micro, mezzo, and macro level are discussed below.

At the micro level, providing education to individuals as well as families that mental illnesses such as depression and anxiety are medical illness, about the physical symptoms of mental illness, as well as available services is needed as a strategy to improve access to mental health treatment. In addition, providing outreach to this population in the form of in-home support, individual counselling, and therapeutic groups were identified as beneficial. At the mezzo level, continuing education about mental illness for the Mennonite community is important to begin to positively change the current negative perceptions of mental illness. In addition, coordination of services, networking of services and working with the Mennonite church leaders to provide religiously sensitive church assistance programs are strategies that can be used to increase accessibility to services. At the macro level, social workers need to continue to advocate for individuals with a mental illness, especially immigrants for their rights to be informed about services. Removing stigma associated with mental illness is another goal at the macro level to improve individuals willingness to seek services. Lastly, using the media to aid with educating about mental illness as well as continuation of lobbying for mental health reform are ways that social worker can create positive change at the macro level. Furthermore, the social work accrediting bodies need to continue to strive for cultural competence by setting clear and specific standards about cultural competency.

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Appendix A: Letter of Information for Referral Source

UNIVERSITY OF
WINDSOR

Letter of Information for Referral Sources

Experiences of Mennonite immigrant women accessing and receiving services in the mental health care system in Essex County

My name is Diane Quadros. I am a graduate student in the School of Social Work, University of Windsor. I am conducting a study to explore the experiences of Mennonite immigrant women (specifically women coming from Mexico) with the mental health care system in Essex County, Ontario, Canada. From the literature, I have learned that there is an increased need to learn more about immigrant women's health problems and their use of the health care delivery system. However, very little has been known about their experiences when they encounter mental health care services. Particularly, Mennonite immigrant women's voices have seldom been heard about this issue. I would like to know more about what it is like to be a Mennonite immigrant woman using the mental health care services in Essex County.

I am looking for referrals of adult Mennonite immigrant women from Latin America; ages 18 and over, who self identify themselves as having a mental health concern such as depression, anxiety, and/or an addiction. Participants will be interviewed approximately 2 times individually, by me, during the course of this study.

In this study, confidentiality will be assured by removing the participant's name from the information gathered after the interviews are completed and codes (known only to the researcher) will be used instead. Audio tapes will be used with the participant's consent, and will be returned to the participant, or erased, at the end of the study. Information received from the participants will remain confidential at all times. The study adheres to the Tri-County Ethics standards and has been approved by the ethics review board at the University of Windsor.

The study's findings will be available to your organization at your request. I would be more than happy to provide a copy of the approved report or conduct a short presentation of the findings to your agency. If you have any questions, please feel free to contact me at — ext. — during business hours or —— (home) after hours.

I appreciate your efforts in referring Mennonite immigrant women who meet the criteria to participate in my study. Attached you will find a copy of the referral sheet along with instructions you are to use when referring participants to my study.

Sincerely,

Diane Quadros R.S.W.

Graduate Student, School of Social Work

University of Windsor

Referral Form for the Study Titled:

Experiences of Mennonite immigrant women accessing and receiving services in the mental health care system in Essex County

Please complete the following questions for the potential study participant. You may omit any questions the woman prefers not to answer. Once the form is completed please contact Diane Quadros at 519-567-0829 to have the form picked up. Confidentiality will be maintained at all times.

<u>A signed consent for release of information (contact information only) must accompany this referral.</u>**

1. Name of participant:

2. Address:

3. Telephone:

Referral source contact information:

Name of referral source: ______________________________

Referring agency: ______________________________

Address: ______________________________

Telephone: ________________________

Appendix B: Letter of Information to Participate

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Letter of information for Consent to Participate in Research

Experiences of Mennonite immigrant women accessing and receiving services in the mental health care system in Essex County

You are asked to participate in a research study conducted by Diane Quadros, graduate student from the School of Social Work at the University of Windsor, Windsor, ON. Results of this research will contribute to my thesis.

If you have any questions or concerns, please feel free to contact,

student researcher, Diane Quadros at ------ during the day or -------. You may also contact my advisor at the University of Windsor, Dr. Connie Kvarfordt, at 519-253-3000 ext 3078.

What is the study about?

I am doing this study to gain an understanding of the experiences that Mennonite immigrant women have when they try to get help for their mental health concerns. Information obtained from this research study will be used to understand how mental health is defined in the Mennonite culture. I am also interested in learning more about your supports systems, concerns, customs, beliefs, and values in regard to mental health so that I, and other mental health professionals, can better understand your experiences and hopefully provide better services. In addition, I would like to know more about any barriers you ran into, as well as the effective strategies you used, when seeking help for your mental health concerns.

What will happen to me if I choose to be in the study?

If you want to be a part of this study, you will be asked to sign this consent form after you have had all of your questions answered and understand what will happen while you are a part of this study.

After you say you want to be a part of the study and have signed the consent forms we will begin our first interview. It is important that the interview is at a place where we both can talk in private and you can feel free to answer the questions honestly. For this reason, I am asking that we meet and conduct the interviews in your home. During the first interview you will be asked questions about yourself and then questions about how you have learned about mental illness, what kinds of things you have used to treat you depression, anxiety, or addiction, and what your experiences have been accessing and receiving mental health services. This interview will last about 1-2 hours. A second interview will then be set up to review any questions that we did not have a chance to finish, and we will review what we have talked about to make sure I understood what you wanted to tell me, and make any referrals to any other services that you feel you may need. This second interview will be approximately 1/2 to 1 hour. Because I want to be accurate in understanding what you are telling me, all interviews will be tape recorded with your consent. In addition, after I have completed the data analysis I will deliver a one page summary of the main themes that were found from the study and ask you to review it and give me feedback. There will be a fourth contact made by phone to discuss the themes on the summary sheet and inform you where the results of the study can be found on the University of Windsor website or, if you prefer, a copy of the thesis can be delivered to you.

You choose whether you want to be a part of this study or not. You can also choose not to answer some or all of the questions. You will not experience any changes in current or future services either way.

Results from this study will be posted on the University of Windsor Website.

Potential Risks and discomforts

Our meetings to answer my questions will take up some of your time and I understand that it may be hard for you to talk about your experiences with depression, anxiety, or addictions. Some people may also worry, or feel embarrassed, or feel emotionally uncomfortable talking about these things. Also, I must report to child protective services, if it comes to my attention, that any child is being abused or neglected. You should think about each of these things before you agree to be part of this study.

Potential Benefits to Subject and/or Society

During the interview process we may find that there are community services that may be of benefit to you. Information or a referral to these services will be provided to you if you want. Also, you may feel good about providing information that will be used to inform mental health providers about Mennonite women's views on mental illness and their experiences accessing these services because this study may help create positive change for others like you.

Costs and Payment

There are no costs to you for being in this study and you will not be paid for participating. Interviews will take place in your home.

Confidentiality

I will not tell anyone the answers you give me. However, I must report to child protection services if it comes to my attention that any child is being abused or neglected. What I find from this study will be a part of my thesis, may be shared at meetings, or written in papers, which may be published. However, your name or any identifying information will not be used in these presentations or papers.

All audio tapes and transcripts will be labeled with a code to protect your identity. These documents as well as referrals and consent forms will be kept in a locked cabinet in my home until after the study is over. Once the study is completed audio tapes will either be returned to you or destroyed by the researcher.

Participation and Withdrawal

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw up until 7 days after your last interview without consequences of any kind. After seven days your information will be combined with the stories of other Mennonite women and I will not be able to remove it from my electronic files. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so

Feedback of the results

Once the thesis is completed in Fall, 2008, the results will be posted on the University of Windsor web site or I can deliver a copy of the thesis to you. You can decide at our last interview how you would like to receive the results of this study.

Subsequent use of Data

This data will be used for subsequent studies.

Do you give consent for the subsequent use of the data from this study? ( )Yes ( ) No

Rights of Research Subjects

You may withdraw your consent up to seven days after your second interview. You may at any time discontinue participation without penalty. If you have any questions regarding your rights as a research subject, contact:

Research Ethics Coordinator — Telephone: 519-253-3000 ext. 3948

University of Windsor — E-mail: ethics@uwindsor.ca

Windsor, Ontario

N9B 3P4

Signature of the Investigator

These are the terms under which I will conduct research.

Signature of investigator Date

Appendix C: Interview Guide

Demographic Questions

Where were you born?

How many years have you been in Canada?

Where have you lived in Canada?

What other places have you lived and for how long?

What schooling have you completed and where?

What were your reasons for moving to Canada?

Did you have a job back in Mexico? If so what did you do?

Do you have a job here in Canada? If so what do you do?

Does anyone live with you? If so who? No specific names please.

Date you began to feel the depression/ anxiety/ addiction?

What help have you received for your illness?

Questions for Information Gathering

1. How did you learn about the term mental illness?

    How do you explain depression or anxiety to people you talk to?

    When you think about mental illness what comes to mind?

    How do others in your community describe mental illness?

2. What kinds of things have you used or done to treat your depression/ anxiety?

    What kinds of things do you do to feel better?

    Have you started medications or changed medications?

    Has the depression/ anxiety/ or addiction affected you physically?

3. Do you think your mental health has changed since coming to Canada?

    If so, how? Better? Worse? Different?

4. Did you manage our depression/ anxiety/ addiction differently depending on the country you were living in?

    Has family been involved and how so?

    Has the community been involved and how so?

5. At what point did you make the decision to seek help here in Canada?

    How did family help with this process?

    How did your community help with this process?

    Did anything happen to force you to get help?

6. What kinds of things have affected your ability to get help in Canada?

    How did you find help?

    What was your process?

    Where you able to find help when you started looking?

    Did you find it easy or hard to get to the help?

    Has family been helpful or not?

    Has community been helpful or not?

7. What has it been like *getting* treatment from mental health and/or services?

    Do you tell people you have depression/ anxiety/ addiction?

    If not, why?

    Has culture been an issue?

8. What have been your experiences once you've received care by your mental health care provider?

    Is there anything you wish would have happened differently?

    Were there any positive things that happened?

    How do you find communication between the two of you/ do you understand each other?

    What made this work or didn't work?

    Do you feel comfortable with the service/ worker?

9. Describe your experiences after visits with your mental health care provider?

    How did you feel when you first received help?

    How do you feel now?

    How long did it take to feel comfortable with each other?

10. How can the mental health care system here in Canada better help you?

    Is there anything you needed help with and couldn't find help?

    Is there anything that you think would make getting help easier for you and others?

    Locations: is there anywhere you think people would be more comfortable going to for help?

How much does it matter who provides the service? Men / Women / Mennonite

11. What programs do you think could be helpful for you or other Mennonite women?

For others who have depression/ anxiety in your community and aren't getting help is there anything you think could help them that is not offered?

Would you like to see the church more involved?

12. Is there anything you would like to add.

Appendix D: Consent Form

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Consent to Participate in Research

Experiences of Mennonite immigrant women accessing and receiving services in the mental health care system in Essex County

You are asked to participate in a research study conducted by Diane Quadros, graduate student from the School of Social Work at the University of Windsor, Windsor, ON. Results of this research will contribute to my thesis.

If you have any questions or concerns, please feel free to contact, student researcher, Diane Quadros at ------------ during the day or -----------. You may also contact my advisor at the University of Windsor, Dr. Connie Kvarfordt, at 519-253-3000 ext 3078.

What is the study about?

I am doing this study to gain an understanding of the experiences that Mennonite immigrant women have when they try to get help for their mental health concerns. Information obtained from this research study will be used to understand how mental health is defined in the Mennonite culture. I am also interested in learning more about your supports systems, concerns, customs, beliefs, and values in regard to mental health so that I, and other mental health professionals, can better understand your experiences and hopefully provide better services. In addition, I would like to know more about any barriers you ran into, as well as the effective strategies you used, when seeking help for your mental health concerns.

What will happen to me if I choose to be in the study?

If you want to be a part of this study, you will be asked to sign this consent form after you have had all of your questions answered and understand what will happen while you are a part of this study.

After you say you want to be a part of the study and have signed the consent forms we will begin our first interview. It is important that the interview is at a place where we both can talk in private and you can feel free to answer the question comfortably. For this reason, I am asking that we meet and conduct the interviews in your home. During the first interview you will be asked questions about yourself and then questions about how you have learned about mental illness, what kinds of things you have used to treat you depression, anxiety, or addiction, and what your experiences have been accessing and receiving mental health services. This interview will last about 1-2 hours. A second interview will then be set up to review any questions that we did not have a chance to finish, and we will review what we have talked about to make sure I understood what you wanted to tell me, and make any referrals to any other services that you feel you may need. This second interview will be approximately 1/2 to 1 hour. Because I want to be accurate in understanding what you are telling me, all interviews will be tape recorded with your consent. In addition, after I have completed the data analysis I will deliver a one page summary of the main themes that were found from the study and ask you to review it and give me feedback. There will be a fourth contact made by phone to discuss the themes on the summary sheet and inform you where the results of the study can be found on the University of Windsor website or, if you prefer, a copy of the thesis can be delivered to you.

You choose whether you want to be a part of this study or not. You can also choose not to answer some or all of the questions. You will not experience any changes in current or future services either way.

Results from this study will be posted on the University of Windsor Website.

Potential Risks and discomforts

Our meetings to answer my questions will take up some of your time and I understand that it may be hard for you to talk about your experiences with depression, anxiety, or addictions. Some people may also worry, or feel embarrassed, or feel emotionally uncomfortable talking about these things. Also, I must report to child protective services, if it comes to my attention, that any child is being abused or neglected. You should think about each of these things before you agree to be part of this study.

Potential Benefits to Subject and/or Society

During the interview process we may find that there are community services that may be of benefit to you. Information or a referral to these services will be provided to you if you want. Also, you may feel good about providing information that will be used to inform mental health providers about Mennonite women's views on mental illness and their experiences accessing these services because this study may help create positive change for others like you.

Costs and Payment

There are no costs to you for being in this study and you will not be paid for participating. Interviews will take place in your home.

Confidentiality

I will not tell anyone the answers you give me. However, I must report to child protection services if it comes to my attention that any child is being abused or neglected. What I find from this study will be a part of my thesis, may be shared at meetings, or written in papers, which may be published. However, your name or any identifying information will not be used in these presentations or papers.

All audio tapes and transcripts will be labeled with a code to protect your identity. These documents as well as referrals and consent forms will be kept in a locked cabinet in my home until after the study is over. Once the study is completed audio tapes will either be returned to you or destroyed by the researcher.

Participation and Withdrawal

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw up until 7 days after your last interview without consequences of any kind. After seven days your information will be combined with the stories of other Mennonite women and I will not be able to remove it from my electronic files. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so

Feedback of the results

Once the thesis is completed in Fall, 2008, the results will be posted on the University of Windsor web site or I can deliver a copy of the thesis to you. You can decide at our last interview how you would like to receive the results of this study.

Subsequent use of Data

This data will be used for subsequent studies

Do you give consent for the subsequent use of the data from this study? ( ) Yes ( ) No

Rights of Research Subjects

You may withdraw your consent up to seven days after your second interview. You may at any time discontinue participation without penalty. If you have any questions regarding your rights as a research subject, contact:

Research Ethics Coordinator

Telephone: 519-253-3000 ext. 3948 E-mail: ethics@uwindsor.ca

University of Windsor

Windsor, Ontario

N9B 3P4

Signature of Research Subject/Legal Representative

I understand the information provided for the study Mennonite immigrant women's experiences accessing and receiving services in the mental health care system in Essex

County as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Name of Participant

Signature of Participant Date

Signature of the Investigator

These are the terms under which I will conduct research.

Signature of investigator Date

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Letter of consent to have the interviews audio taped or notes taken during the study

I consent to the audio taping of my interviews with the researcher for the purpose of this study. I understand these are voluntary procedures and that I am free to withdraw at any time during the interview by requesting that the taping be stopped. In addition, I will be asked my permission before each interview whether I wish to have the interview tape recorded. I also understand that my name will not be revealed to anyone and that taping will be kept confidential. Tapes are filed by a code only and will be stored in a locked cabinet.

I understand that confidentiality will be respected and the viewing of materials will be for professional use only.

Interview

I agree to have this interview audio taped:

Signature of participant Date

When the study is complete, do you want the tapes returned to you or destroyed by the researcher? ________ Returned to me ______ Destroyed by the researcher

Please note that if after reasonable efforts the researcher is unable to reach you, your tape recorded interview will be destroyed.

In which way do you want to results of the study share with you?

______Delivered to me _____I will locate it on the Universities website.

Researcher's Signature Date:

Appendix E: Members Check

Members check of the findings

1. About mental illness

   Use words like “breakdown” and “nerves” to talk about depression and anxiety

   Breakdown means that a person has to get help, are not able to handle it by themselves anymore

   Don’t really talk about it in the culture

2. Women feel like they need to keep how they are feeling a secret from family and other people in the community.

3. Mennonite people do not really understand what mental illness is.

   family do not understand what loved ones with depression are going through

4. Mennonite people judge when someone is not doing exactly what the Mennonite people think they should be doing. For example, if someone is not feeling well enough to cook for their family or keep the house clean.

   Sometimes this fear of being judged keeps woman from talking about what they are feeling.

5. When someone is sick with a mental illness there is not much help from the Mennonite community.

   When someone looks for help from the church their answer is to pray more

   Family do not help much when someone is depressed or has anxiety

6. Getting help started with talking to a doctor either a family doctor or one at the hospital.

7. Being in the psychiatric ward in hospital was a hard experience but did help

8. Medications were used and for some are still taken to help with their illness.

9. The groups that were available were helpful

10. It is alright to get medical help from doctors, people do not judge when you go to a doctor for help

11. Barriers

    Lack of transportation

    No groups in the area

    Not being able to speak English

    Church does not help people feel like they can get help for a mental illness.

    If a husband does not want their wife to get help the woman can not

12. Things that could help

    In home support – where someone comes to your home and help with cleaning, cooking so you can take time to get better

    Counseling

    Groups

    Having someone in the church that can help you find help.

13. It is important to have a woman working with a Mennonite woman but it does not matter what culture that person is. Sometimes it is better if the worker helping is not Mennonite.

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